Agenda

Greater Manchester Strategic Commissioning Committee (Public)

Date: 6 May 2026

Time: 14:00pm to 16:00pm

Venue: MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:00	5 mins	Welcome, Introductions and Apologies received – Attendance Matrix & Terms of Reference on a Page	Verbal Paper	Information	Dame Sue Bailey *Chair*
2.			Declarations of Interest	Paper	Noting	
3.			Minutes, matters arising and actions from previous meeting held on 1 April 2026	Paper	Approval	
Strategic Updates						
4.	14:05	10 mins	Strategic Commissioning Committee Workplan and Supporting Groups	Paper	Information	Charlotte Bailey, *Chief Strategy, People and Partnerships Officer – Population Health / Place*
5.	 14:15 14:30 14:45 14:55	50 mins	Chief Officers Update Reports: • Chief Clinical Officer Report • Chief Commissioning Officer Report • Chief Reform and Improvement Officer Report • Chief Strategy, People and Partnerships Report	Paper	Discussion	Manisha Kumar, *Chief Clinical Officer /* *Katherine* Sheerin, *Chief Commissioning Officer /* Nicola Hepburn, *Acting Chief Reform and Improvement Officer /* Charlotte Bailey, *Chief Strategy, People and Partnerships Officer – Population Health / Place*
6.	15:05	10 mins	Performance Report	Paper	Information	Nicola Hepburn, *Acting Chief Reform and Improvement Officer*

7.	15:15	20 mins	Oldham SEND inspection outcome	Paper	Information	Steve Larking *Director for Children's Health*
8.	15:35	10 mins	Mental Health Productivity: Inpatient Reduction, Flow and Commissioning Decisions	Paper	Information	Melissa Maguinness, *Programme Director Commissioning Development*
9.	15:45	10 mins	Frailty Update	Paper	Information	Manisha Kumar, *Chief Clinical Officer*
For Information						
	15:55	5 mins	Any other business Board Paper Escalations Meeting Reflections	Verbal	Discussion	All
Date and time of next meeting: **Wednesday 3 June 2026, 14:00pm – 16:00pm** **MS Teams**						

Strategic Commissioning Committee Attendance Matrix from April 2026

Key:

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

Member	***Title***	***Apr-26***	***May-26***	***Jun-26***	***Jul-26***	***Aug-26***	***Sep-26***	***Oct-26***	***Nov-26***	***Dec-26***	***Jan-27***	***Feb-27***	***Mar-27***
Dame Sue Bailey	Non Executive Director (Chair of SCC)												
Rachel Egan	Non Executive Director												
Jackie Njoroge	Deputy Chair/Senior Independent Director												
Leigh Vallance	NHS GM Partner Member												
Manisha Kumar	Chief Clinical Officer												
Katherine Sheerin	Chief Commissioning Officer												
Nicola Hepburn	Chief Reform and Improvement Officer												
Charlotte Bailey	Chief Strategy, People and Partnerships Officer												
Attendee													
Chris Gaffey	Associate Director of Corporate Services												
Ben Squires	Director of Primary Care (deputising for Katherine Sheerin)												
Paul Lynch	Director of Strategy												
Kathy Roe	Chief Finance Officer												

Terms of Reference on a page

Purpose

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

The Committee will have a strong focus on improvement, prevention, population health and the left-shift as set out in the 10-Year Health Plan.

The Committee will operate within an agreed shared governance model with the People and Resources Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals.

Key duties

Strategic Commissioning

- Apply constructive challenge to the strategic commissioning arrangements and make recommendations to the Board or People and Resources Committee regarding procurement, and evaluation of contractual delivery.
- Oversight of development and implementation of the Commissioning Strategy, ensuring this is developed within the resources available.
- Ensure that opportunities for service redesign in line with the Commissioning Strategy are optimised.
- Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the People and Resources Committee will scrutinise financial implications and make relevant decisions, or where appropriate, escalate recommendations to the Board.
- Receive assurance on the commissioning processes and decisions across all commissioned services, including:- Primary Care, Hospital and Community Health Services, Specialised Services, Services commissioned from VSCFE providers, NHS GM Place Based Partnerships.

Other key duties:

- Clinical Strategy
- Performance and Planning
- System Oversight
- Continuous improvement
- Digital Strategy
- Population Health
- Data and Intelligence
- Strategic Risks
- Statutory Functions

Other duties

- Apply constructive challenge to the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- Apply constructive challenge to the oversight of EPRR arrangements.

Membership

The membership of the committee shall comprise of the following members:

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

Only members of the Committee have the right to attend Committee meetings.

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Bailey, Ms. Charlotte Elizabeth	Y			Nil			
Kumar, Dr Manisha	Y	Financial Interest	Outside employment	Salaried GP at the Robert Darbishire Practice - 1 session per week		2004	Ongoing
Kumar, Dr Manisha	Y	Non-financial professional interest	Loyalty interests	Honorary Professor University of Salford		01/05/2023	Ongoing
Kumar, Dr Manisha	Y	Non-financial personal interest	Loyalty interests	Husband has the following roles: • Operations Director - Primary Eye Care Services LTD • Case Examiner – General Optical Council		2021 2019	Ongoing
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son works in the finance department at Tameside and Glossop NHS Foundation Trust.		14/10/2024	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	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Bailey, Dr Susan Mary	Y	Financial Interest	Outside employment	Independent NED on the board of KOOTH PLC, a mental health online digital platform. I am remunerated for this work. Neither any members of my family or I hold shares in this PLC		2022	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	Chair of Centre for Mental Health. The centre and myself advocate for better mental health outcomes for all through the delivery of evidenced based policy briefings and lobbying at a national and Regional level		2018	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Council member university of Salford		2016	
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	BEVAN commissioner - Bevan through evidence base support improved health and social care outcomes For the population of Wales.		2014	Ongoing
Egan, Rachel Mrs	Y			Nil			
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	
Partner Members	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
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 Strategic Commissioning Committee

Date: 1 April 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Prof. Manisha Kumar (MK) – Chief Clinical Officer Ben Squires (BS) - Director of Primary Care (deputising for Katherine Sheerin) Leigh Vallance (LV) – VCSE Partner Member Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director Chris Gaffey (CG) – Associate Director of Corporate Services Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer Paul Lynch (PL) – Director of Strategy Faye Vaughan (FV) – Governance Advisor (Minutes)	Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Rachel Egan (RE) – Non-Executive Director

Item No.	Topic	Action
1.	**Welcome, Introductions and purpose of first meeting** SB welcomed everyone to the first Strategic Commissioning Committee meeting. The above apologies were noted. It was explained that the purpose of the committee would be to obtain assurance on behalf of the ICB Board, that the ICB had the right commissioning strategy and approach, supported by intelligence, delivering its quality performance, population health and oversight functions, whilst ensuring that the ICB operated as a strategic commissioner. The importance of alignment, collaboration and co-design was emphasised.	
2.	**Declarations of Interest** SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	

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3.	**Minutes from Transition Committee meeting held on Wednesday 4 March 2026** The minutes were accepted as a true record of the previous Transition Committee meeting held on 4 March 2026.	
4.	**Terms of Reference – Update & Next Steps** The report provided the committee with the Terms of Reference for the Strategic Commissioning Committee that were approved by the ICB Board in March 2026. It was explained that a three-month post-implementation review of the two newly established committees would be conducted to further identify areas of potential improvement and amendment to the arrangements, which may include further changes to the Terms of Reference. It was confirmed that any changes would be considered by the committee, before consideration by the ICB Board for approval. **The Committee:** • **Noted the Committee Terms of Reference (Appendix One).**	
5.	**Sub Groups & Draft Workplan – Introductory Discussion** CG informed the committee of the discussions that had taken place with committee Chairs and Chief Officers regarding the establishment of supported governance, noting that existing subgroups would continue to meet statutory requirements and that reporting would be assurance focused and thematic. It was confirmed that the work plan would be developed in alignment with the five-year commissioning strategy and committee priorities. CB emphasised that place partnerships governance remained part of the constitution and should continue reporting to the committee until any changes were made, highlighting the importance of maintaining alignment and collaboration. MK suggested the need to review the committees effectiveness in the summer, including a reflection on whether the business had aligned with the committees strategic positioning and how sub-governance was used in the most effective way with the right partners.	
6.	**Board Assurance Framework and Risk Report** The report confirmed the Board Assurance Framework (BAF) and Corporate Risks that would be considered by the newly established Strategic Commissioning Committee (SCC). As a new committee of the ICB Board, it was explained in the paper that the committee would be responsible for consideration and monitoring of these risks and to provide the ICB Board with the appropriate assurance that they are being appropriately managed. Two key areas highlighted to the committee: **SR4 (Good Employment) & SR9 (Emergency Incidents):** Reduced risk scores due to improved staffing and resilience. **SR5 (Health Inequalities):** Showed variation that would be analysed and reported back to the committee at the next meeting in May 2026.	

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	The outlined plans for the improvements in the risk reporting were shared with an aim to ensure risk narratives would be more meaningful and dynamic, with regular updates and alignment to committee objectives. The committee were asked whether a deep dive should be conducted by the Audit Committee, noting the workload implications. The committee supported maintaining deep dives at the Audit Committee, however, emphasised open communication around resource impacts would need to continue. JN suggested integrating performance data with risk assurance to move beyond meetings as sources of assurance and leveraging the committees rich data to strengthen the BAF and statutory compliance. LV highlighted the need to ensure that the voluntary sector were not overlooked in risk and assurance planning, noting their ongoing challenges and contributions to system targets. **The Committee:** • **Considered the risks presented in the report.**	
7.	**Chief Officers Update Reports** <u>Chief Clinical Officer Report:</u> The report provided assurance on how the ICB Board was discharging its statutory duties for quality, safety and clinical governance across the organisation and the system as a whole. It brought together intelligence from established governance routes and demonstrated how statutory clinical governance and quality functions were being exercised to identify and manage risk, reduce unwarranted variation, and support safe, effective and equitable care across Greater Manchester. MK outlined the plans for future thematic reporting covering population needs, quality and service transformation and the identified paediatric audiology as a top risk area, with ongoing cross Northwest efforts to mitigate risks. The committee were made aware of the new guidance on corridor care, with the systems ambition to eliminate corridor care, especially for vulnerable groups and plans for nursing-led walk round to ensure compliance. The committee were further informed of the recent work from the Clinical Effectiveness and Governance Group (CEG) on policies for drugs of low clinical value and a system-wide plan to reduce non-best practice describing. It was reported that there was a Prevention of Further Deaths review which highlighted gaps in shared care protocols, prompting a commitment to review and update all out-of-date protocols and improve patient information at the point of care, with feedback provided to NHS England and the coroner. MK also informed the committee of updates on the Clinical Transformation and Dementia Strategy, including direct access MRI to reduce neurology wait times, a new cancer model and the regions strongest performance in dementia diagnosis with ongoing co-production and prevention initiatives. **The Committee:** • **Noted 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. • **Noted 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.** • **Endorsed 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.** Chief Commissioning Officer: NH informed the committee of the participation in the NHSE led strategic programme, including the commissioning academy, leadership development and the commissioning intelligence centre, with collaborative development and external funding. The committee were also made aware that the ICB would be an early adopter for SEND Reform, emphasising the development of 10 local SEND reform plans with active partnership with local authorities. The importance of leveraging local expertise was raised. NH further reported the positive review by the Northeast Clinical Senate of arterial, vascular and cardiac surgery reconfiguration which was shared with written feedback pending and recognition of national alignment and collaborative approaches. NH noted the finalisation of commissioning intentions with a focus on prevention, primary and community care and reported improvements in cancer and early diagnosis performance, ranking highly among cancer alliances. **The Committee:** • **Noted the report.**	
8.	**Strategic Commissioning Plan – Assurance Approach & Reporting Cycle** The report set out a simple framework for how the Strategic Commissioning Committee received assurance regarding progress being made towards delivery of the Strategic Commissioning Plan. PL presented the next steps for the strategic commissioning plan, including programme milestones, reporting cycles and alignment with place outcomes. The process for detailing programme milestones and outcomes was outlined, proposing a flexible reporting cycle to bring major themes to the committee and seeking committee feedback on the approach. MK recommended sub-segmenting large programmes such as mental health for detailed work plans, adding womens health and diagnostics as priorities and	

	ensuring reporting reflected the full commissioning cycle. The committee advocated incorporating lived experience and alternative reporting formats such as videos and community stories to provide assurance on outcomes with support from the voluntary sector to facilitate. **The Committee:** • **Considered and confirmed the proposal for how the Strategic Commissioning Committee receives assurance regarding progress being made towards delivery of the Strategic Commissioning Plan.**	
9.	**Place Outcomes Framework / Outcomes Driven Commissioning** It was explained that the outcomes framework was nearing final draft, with alignment to neighbourhood plans and health and well-being boards. It was confirmed that the governance recommendations would clarify accountability and the relationship between place partnerships and NHS GM. LV suggested developing co-production guidance and integrating the newly agreed accord into place partnerships. It was confirmed that there were ongoing engagement and plans to bring all elements together for locality review. The need for a shared narrative, quantifying contributions from all sectors, including the voluntary sector and managing the systems collective resources to drive outcomes and reduce inequalities, with ongoing work to engage all collaboratives was emphasised.	
10.	**Performance Report** The report provided an update on Greater Manchesters progress in achieving NHS operational planning goals, including outlined significant risks faced by providers along with key improvement actions and a summary of quarter 3 Locality Assurance Meetings (LAMs). The committee were provided with the year-end updates showing improved Urgent and Emergency Care performance approaching 75% and progress on elective standards with ongoing efforts to address challenges in specific Trusts and service areas, including mutual aid and industrial action planning. The committee thanked all involved. **The Committee:** • **Agreed the recommended status of partial assurance.** • **Agreed the levels of assurance and delivery risks.**	
11.	**Winter Vaccination Update** The report provided 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 built on the previous paper presented to the Quality & Performance Committee in November 2025 and reflected the end of season delivery position, emerging risks and additional assurance relating to communications and engagement activity. MK detailed the high uptake in flu and maternal vaccinations, successful COVID delivery and targeted approaches for underperforming groups, including	

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	commissioning additional services and tailored community engagement. It was explained that the programme used tailored communications strategies, recognising that trusted influencers vary by community and committed to addressing health inequalities by analysing uptake data and adapting approaches for different groups. MK flagged the upcoming transition to the Office of Pan ICB Commissioning (OPIC) and the need to maintain neighbourhood health focus and population health management, with plans to continue reporting on statutory health protection functions. JN suggested leveraging social housing providers and large employers for outreach. It was agreed that they would pursue these opportunities and reference existing agreements to support prevention and screening initiatives. **The Committee:** • **Noted 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.** • **Noted the 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.** • **Noted 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.**	
12.	**Any other business** None were raised.	

NHS Greater Manchester

Strategic Commissioning Committee Work Plan and Supporting Groups

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS GM Strategic Commissioning Committee

6 May 2026

Report information.

Required information.	Details.
Title of report.	Strategic Commissioning Committee Workplan and Supporting Groups
Author.	Chris Gaffey, Associate Director of Corporate Services Jo Street, Programme Director – Transition
Presented by.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
Contact for further information.	Chris Gaffey, Associate Director of Corporate Services chris.gaffey@nhs.net
Executive summary.	This report provides the Committee with progress on the development of the Workplan and Supporting Groups for the Strategic Commissioning Committee.
The benefits that the population of Greater Manchester will experience.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, which will benefit the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, which will support the delivery of the ICP Strategy, and in turn, reduce health inequalities in GM communities.

The decision to be made and/or input sought.	The Committee is asked to: 1. Provide comment and views on the current proposals on the Committee workplan and supporting groups.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, and one of the objectives of moving to a new Committee structure is to ensure that the Board and its Committees have the required strategic focus. This will support the delivery of the ICP Strategy, as well as ensure focus on the Board Assurance Framework.
Key milestones.	17 December 2025 – Agreement of Transition Arrangements by Board 18 March 2026 – Board approval to establish new Committee structure 1 April 2026 – Implementation of new Committee structure
Leadership and governance arrangements.	The Chief Strategy, People and Partnerships Officer is responsible for Corporate Governance arrangements, supported by the Associate Director of Corporate Services. The Strategic Commissioning Committee will be chaired by Sue Bailey, Non-Executive Director.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Proposals were initially 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 have taken place with Committee Chairs, as well as a meeting of Chief Officers on 26 April 2026.

Financial or Legal Implications	No formal legal or financial implications as part of this report.

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

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

Table 2: Assurance needed about the document.

1.0 INTRODUCTION

Following the establishment of the new Committee structure, implemented from April 2026, further work has been done to progress the establishment of the supporting structures for these Committees, as well as developing the workplan.

This report sets out the progress made to date, with drafts of the supporting groups and workplan appended.

2.0 WORKPLANS AND SUPPORTING GROUPS

2.1 Purpose and shape of Committee workplan

- The current draft workplan (Appendix One) captures all necessary assurance and statutory items, but are too long and insufficiently strategic at present.
- It is proposed that workplans should not translate into standalone agenda items for every line; instead, items should flow through supporting groups and into Chief Officer reports, with committees receiving the relevant assurance rather than operational detail.
- The intention is to move away from exhaustive itemisation towards strategic oversight, triangulated through supporting groups and reporting mechanisms (e.g. assurance / AAAA-style reports).

2.2 Inclusion of cross-cutting "thematic deep dives"

- To support the movement to a more strategic approach, it is proposed that the Committee requires a small number of cross-cutting thematic deep dives focused on transformation, outcomes and impact (e.g. mental health, primary care transformation, population groups).
- These deep dives would be seen as distinct from statutory / annual assurance items and would be critical to demonstrating strategic value.
- A list of themes is in development, based on the 5-Year Commissioning Plan, with an initial long list to be prepared by lead officers and refined through Chief Officer discussion at a planned away day in May.

2.3 Categories of business coming to Committees

- It is proposed that there would be **five categories** of business for committees:
    1. Governance, standing business, and assurance (e.g. ToR, BAF, risk, minutes, Chief Officer reports)
    2. Statutory and annual reports/plans

3. Process and pipeline items (e.g. commissioning plans, procurement pipelines)
4. Thematic deep dives (cross-cutting, transformational)
5. Items for decision

- This would provide a shared organising framework for simplifying and restructuring workplans.

2.4 Nature of supporting groups

- The proposed supporting groups are not necessarily new meetings – many already exist as part of day-to-day business; the emphasis will be on using existing forums pragmatically to provide assurance, rather than creating additional layers.
- Supporting groups can function as both working and oversight mechanisms, provided they support escalation of strategic risks, decisions and assurance to the Committee.

2.5 Chief Officer reporting

- It is proposed that the Chief Officer reports will be the primary mechanism for bringing together inputs from multiple supporting groups, as opposed to each group providing their own report for the Committee.
- These reports will describe key quality, risk and performance issues, rather than replicate papers considered by the supporting groups.
- For now, separate Chief Officer reports will continue to be taken to each Committee meeting, aligned to the Committee's remit, with the option to revisit convergence once arrangements bed in.

3.0 AREAS OF FURTHER WORK REQUIRED

3.1 Finalisation of workplans

- Further comments on the current workplan are expected from lead officers by the end of April.
- Workplans will then be updated to:
  - simplify structure,
  - reflect the five agreed categories of business, and
  - explicitly include a section on thematic deep dives (further information on this in the next section).

3.2 Development of thematic deep dive list

- A group of lead representatives across portfolios will be convened to develop an initial long list of thematic areas.
- This list should be informed by:
  - the operational and five-year commissioning plans, and
  - known strategic pressures and transformation priorities.
- The draft list will support discussion and prioritisation at the next Chief Officer time-out.

3.3 Standing up of Supporting Groups

Work is now actively ongoing to stand up the remaining supporting groups. Further work is required in some areas to clarify the of some of these groups, including:

- **Commissioning Development Group (formerly Commissioning Oversight Group)** – requires further clarity of purpose and role in relation to the five-year commissioning strategy.
- **Estates** – needs continued oversight to ensure set-up and scope are appropriate.
- **Population Health, Neighbourhood Health, and Place Partnerships Groups (working title)** – proposal to broaden the Population Health Group to also oversee Neighbourhood Health and Place Partnerships.
- **System-level groups** (e.g. UEC, electives, mental health) – need clearer visibility within the overall assurance picture.

3.4 Reporting pathways (data, digital, performance)

- Further work is needed to map how data intelligence, digital/IT and performance activity:
  - feeds operational commissioning work, and
  - provides proportionate assurance to both Strategic Commissioning and People & Resources Committees, without generating duplicate reporting or excessive burden.

4.0 RECOMMENDATIONS

The Committee are asked to:

1. Provide comment and views on the current proposals on the Committee workplan and supporting groups.

Forward Plan Public Meeting		April	May	June	July	August	September	October	November	December	January	February	March	
Standing Items	**Comments**													
Apologies for Absence and Quoracy		X	X	X	X	X	X	X	X	X	X	X	X	
Declarations of Interest		X	X	X	X	X	X	X	X	X	X	X	X	
Matters Arising, Action Log & Minutes of Last Meeting		X	X	X	X	X	X	X	X	X	X	X	X	
Forward Plan Review (at end of meeting in preparation for the next one)	Review upcoming items; ensure alignment to ToR	X	X	X	X	X	X	X	X	X	X	X	X	
Governance and Committee Effectiveness														
Terms of Reference Review		X												
Review 2026/27 Committee Priorities														
Committee Development Session /Review of Effectiveness														
Good governance review														
Committee handover	Handover from closed committees- QPC, Population Health and Primary Care Commissioning Committee	X												
Clinical														
Clinical Strategy & Clinical Governance Assurance	Implementation updates on patient safety, clinical effectiveness, improvement, complaints, mortality													
SCN Annual Report	Provides assurance on specialised clinical networks' contribution to commissioning.													
Annual Medicines Report	Required assurance on medicines optimisation, safety and value.													
Patient Safety Annual Report	Annual statutory requirement and key component of quality assurance.													
Safeguarding Annual Report	Whole-system statutory safeguarding update.													
Safeguarding Children Partnership Annual Report	Statutory safeguarding requirement.													
Safeguarding Bi - annual Report	Regular assurance cycle on safeguarding themes and risks.													
Patient Safety, Clinical Effectiveness & Patient Experience Themes	Provides whole-system learning and quality improvement insight.													
Health Protection & Outbreak Management - Quarterly Statutory Responsibilities Update (June / September / December / March)	Sub Group - Population Health			X			X			X			X	
S7a Public Health Commissioning - Quarterly Statutory Responsibilities Update (May / August / November / February)	Sub Group - Population Health / Primary Care Commissioning		X			X			X			X		
Medicines Optimisation & Medicines Safety	Mid-year assurance on medicines performance and quality.													
AMS (including deterioration, AMR, Infection Prevention & Control Assurance)	Required annual assurance on safety and compliance.													
Safeguarding (Adults & Children) System Assurance	Mid-year thematic safeguarding review.													
Mortality Governance & Learning from Deaths	Required oversight of mortality, learning from deaths and quality concerns.													
Major System Transformation Areas	CYP, Mental Health, Primary Care etc													
Commissioning														
Annual Commissioning Strategy Delivery Plan (including clinical strategy)	Provides quarterly oversight against the strategic commissioning architecture (needs assessment, prioritisation, market shaping, resource shift, joint commissioning). Anchors multiple duties in a single reporting cycle.													
Commissioning Strategy & Decisions	5 Year Strategic Commissioning Plan, Strategic commissioning updates, procurement, contracting decisions													
All Age Continuing Care	Quarterly Report													
SEND Inspection Outcome Reports														
Primary Care Commissioning Assurance	Assurance on Primary Care Commissioning													
Clinical Strategy Progress Review	Required oversight of quality planning, control and improvement.													
Contract Performance Variation Analysis	Enables oversight of provider performance and contractual delivery.													
Equality & Health Inequalities in Commissioning	Supports population health improvement and equity duties.													
Procurement Pipeline & Major Commissioning Decisions	Ensures Committee fulfils delegated authority around procurement and commissioning decisions.													
System Reform														
BAF and Risk Register - Assurance	Review BAF risks assigned to the Committee; monitor mitigations													
EQIA of Organisational Change Review	To understand impact of organisational reforms													
Integrated Performance and Quality Report	Core standing assurance item reviewing constitutional standards, SOF metrics, population health indicators													
Year End Review of System Oversight Framework	Ensures systematic review of SOF performance metrics.													
EPRR Annual Assurance & Winter Readiness	Statutory requirement and risk area for system resilience.													
Strategy, People and Partnerships (including Population Health)														
Comprehensive Population Health Activity & Impact Update covering the full breadth of ICB Population Health activity and expenditure Mid-Year (Oct 26) and End of Year (April 27)	Sub Group - Population Health							X						Apr-27
Population Health Investment Standard Feasibility Assessment (November / December 2026)	Sub Group - Population Health								X	X				
GM Prevention Demonstrator Quarterly Update (June / September / December / March)	Sub Group - Population Health			X			X			X			X	
Population Health & Inequalities Deep Dive and implication for strategic commissioning and operational planning (September 2026?)	Sub Group - Population Health						X							
GM Public Health Network Transformation - Quarterly Update (June / September / December / March)	Sub Group - Population Health			X			X			X			X	
Other														
Mersey Internal Audit Agency Plan	Required annual assurance on internal audit coverage and risk-based assurance.													
Issues/Alert log- Assurance	Short updates on issues relating to quality oversight, safety, safeguarding, IPC, EPRR, medicines optimisation, equality & diversity (would also be a paper in the private section of the meeting)	X	X	X	X	X	X	X	X	X	X	X	X	

Strategic Commissioning Committee - Proposed Supporting Structure

Strategic Commissioning Committee

- **Clinical Portfolio**
  - Clinical Effectiveness Group (CEG) — Chair: Manisha Kumar; Lead Officer: Claire Lake / Jim Ritchie
  - Quality Group — Chair: Manisha Kumar; Lead Officer: Anita Rolfe
  - Safeguarding Group — Chair: Manisha Kumar; Lead Officer: Andrea Patel
- **Commissioning Portfolio**
  - Primary Care Commissioning Group — Chair: Katherine Sheerin; Lead Officer: Ben Squires
  - Commissioning Development Group — Chair: Katherine Sheerin; Lead Officer: Gill Baker
  - Specialised Services Oversight Group — Chair: Katherine Sheerin; Lead Officer: Louise Sinnott
- **Strategy, People and Partnerships Portfolio**
  - Involvement Assurance Group — Chair: Leigh Valance; Lead Officer: Claire Connor
  - Population Health, Neighbourhood Health, and Place Partnerships Group — Chair: Charlotte Bailey; Lead Officer: David Boulger
- **System Reform and Improvement Portfolio**
  - Performance Group — Chair: Nicola Hepburn; Lead Officer: Ed Dyson
  - Data and Intelligence Group (Intelligence Element) — Chair: Nicola Hepburn; Lead Officer: Matt Hennesey
  - Digital and IT Services Group (Strategy Elements) — Chair: Nicola Hepburn; Lead Officer: Laura Hosey-Davies

NHS Greater Manchester

Chief Clinical Officer Report

May 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

6th May 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 Claire Foster, Deputy Chief Pharmacist Sarah Owen, Associate Director of Maternity Assurance Susan Mckernan, Senior Medicines Optimisation Pharmacist Boby Raja, Adult Community Mental Health Transformation Programme Manager Helen Bretten, Programme Manager – Urgent & Emergency Care Siân Goodwin, Programme Manager - GM Elective Care Recovery and Reform Programme
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive summary	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 wider system. It brings together intelligence from established governance routes and demonstrates how 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. The report highlights key areas of assurance and oversight, including the Paediatric Hearing Services Improvement Programme; maternity and neonatal safety oversight (including escalation routes through the Local Maternity and Neonatal System (LMNS) Safety Assurance Panel); learning from national patient safety event data (LFPSE) and never events; independent sector provider quality assurance; and the management of commissioning risks such as Right to Choose activity and associated legal challenge. The report also sets out emerging system risks and improvement activity, including the affordability and implementation position for updated National Institute for Health and Care Excellence (NICE) NG28 guidance on type 2 diabetes medicines, and the use of NHS IMPACT Learning and Improvement Networks (LINs) to accelerate

	improvement (for example, elective interface reform through Advice and Guidance (A&G), Single Point of Access (SPoA) development, and mental health length of stay improvement). Collectively, this provides evidence of strengthened governance and clearer escalation routes, supporting delivery of the NHS GM strategy and assurance against relevant Board Assurance Framework risks.
The benefits that the population of Greater Manchester will experience.	NHS GM's statutory quality and clinical governance functions support people across Greater Manchester to experience safe, effective and continuously improving services. Through targeted quality improvement, strengthened oversight and refreshed governance pathways, the system is better able to identify risks earlier, intervene more consistently and reduce unwarranted variation. This directly supports improved experience and outcomes for patients and communities.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy, including early identification of inequality-related risks in urgent care, mental health, medicines optimisation and system improvement programmes. It supports more consistent governance and escalation, helping to reduce unwarranted variation and strengthen equitable access and outcomes across Greater Manchester.
The decision to be made and/or input sought	The Committee is asked to: • Note the key areas of risk and assurance highlighted within the report, including the Paediatric Hearing Services Improvement Programme, and support continued system-level oversight and escalation through established governance routes. • Note the assurance and improvement activity described, including maternity and neonatal safety oversight, system learning from national patient safety event data (LFPSE) and never events, independent sector provider quality processes, and active oversight of Right to Choose activity and associated risks. • Note the emerging system risks and proposed approaches set out in the report, including the interim holding position for implementation of updated NICE NG28 guidance (pending a phased, affordable commissioning proposal) and the use of LINs to accelerate improvement; and advise on any areas where further deep-dive reporting is requested. • Approve the addition of Azathioprine 10mg/mL suspension for inflammatory bowel disease (IBD) to the GM formulary (AMBER shared care), following Clinical Effectiveness and Governance Sub-Committee (CEG) clinical approval. • Approve the updated GM Direct Oral Anticoagulants (DOACs) Commissioning Statement, enabling switching and supporting system-wide cost savings, following CEG clinical approval. • Approve the NHS GM Independent Sector Rheumatology Service Specification, following Clinical Policy, Audit and

	Standards Group (CPAS) challenge/amendment and CEG clinical approval.
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and the progress made to improve them relate to Board Assurance Framework risk SR5.
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	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.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as it is produced for Strategic Commissioning Committee and has not been presented elsewhere. The intelligence and papers used to formulate this report have been drawn from the NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group.
Financial or Legal Implications;	This paper is primarily an assurance report; however, it describes a small number of areas with potential financial and/or legal implications that are being managed through established governance routes. Updated NICE NG28 guidance on type 2 diabetes medicines is described as having a significant affordability impact for NHS GM (estimated £60–£85m per annum). An interim holding position is in place to mitigate risk while recommendations are reviewed and a phased, equitable commissioning proposal is developed within available budget. The report reflects continued compliance with statutory clinical governance responsibilities, including having due regard to NICE guidance, national clinical audit requirements and national patient safety guidance. It also notes ongoing legal and financial risks associated with Right to Choose activity (particularly attention deficit hyperactivity disorder (ADHD) and autism assessments) where risks relating to over-performance against indicative activity plans and potential provider challenge remain live; these are under active oversight through relevant contracting and governance forums. Where information governance, digital assurance or legal input is required for changes described, this will be sought prior to implementation.

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

Alert

Paediatric Hearing Services Improvement Programme

These services continue to present significant risk across GM as there is currently an unquantified number of children who may require recall to ensure they don't have a delayed or misdiagnosed hearing loss. This number will be quantified through the completion of the five-year cohort reviews which are currently underway. These have been completed for 2 of the 4 sites and the target completion date for the remaining 2 is by the beginning of May 2026. Significant improvement work is underway, and full engagement is seen from all services.

Important to Note – GM had the highest overall level of assurance in the North West region following the initial Paediatric Audiology Quality Assurance Tool (PASQAT) Assessment and whilst there were 5 services rated as partial assurance from the site visits, all of these had good, safe clinical practice noted and acceptable mitigations and plans in place for their improvement areas. The two sites with low assurance initiated immediate recovery and improvement actions which have been well embedded and are demonstrating significant improvement in their service delivery.

Challenges:

- Development of technical guidance and changes in approach in early stages has not helped NW region in terms of timescales
- Continuing difficulty in getting subject matter expert (SME) support – so much of the processes are dependent on subject matter experts and there have been difficulties, first in recruiting and secondly in terms of the time they have available for supporting the programme. All of the SME's are active audiologists and have considerable staffing pressures in their own services and are mainly delivering this role in their own time.
- SME's who were working on certain reviews had to stop due to their own services being under review elsewhere in the country – despite their own practice not being under question and them having gone through the assessment processes to become an SME, when this has happened, the work that they had already done had to be re-reviewed by a different SME which has added to both timeliness and capacity issues.
- Trusts are experiencing staff fatigue within the services and there have been capacity issues due to increased sickness, coupled with recruitment issues and other planned leave.
- Trusts are experiencing a lower uptake in overtime due to the ability to work as an SME elsewhere for higher pay, which along with staff sickness and recruitment issues has heavily impacted on the preparation of data for review, maintaining services and reducing waiting lists.

Mitigations:

- Important to note: Any priority 1 (risk of hearing loss) patients found within the reviews is immediately acted on to prevent further delay. All priority 1 patients from the Stockport recall have been reviewed and appropriate pathway ensured. No priority 1 children have been found as part of the other 3 site reviews to this point.
- The key issues we have faced have been around SME availability – this comes from the national SME supply and has been a big factor in the delay of getting the quality assurance visits undertaken and then the subsequent reviews underway. Further SME's have been recruited to the national team and a co-ordinator at regional level has been appointed.
- Peer review checks on current Auditory Brainstem Response (ABR) testing is in place for all review sites to ensure ongoing safe practice.
- Adjusted approach for data collection to speed up the review process whilst maintaining quality, safety and efficacy of the review
- GM oversight group well established with Directors of Governance to ensure Trust ownership at senior level
- Regular conversation at Provider Oversight Meetings (POMs) with Trusts in review stages

In parallel to the oversight of the 4 review sites, the improvement plans for all sites are monitored and guidance has been issued to enable ICB decision making on movement of sites from partial to full assurance. A review of all improvement plans against these criteria is now underway.
A full report detailing Paediatric Audiology can be provided for SCC if required.

Maternity and Neonatal Services Quality and Safety: Non-compliance with Perinatal Pelvic Health full-service implementation.

Perinatal Pelvic Health full-service implementation refers to the establishment of Perinatal Pelvic Health Services (PPHS) in maternity units across England. These services aim to improve access to early intervention and support for women and people experiencing symptoms of pelvic floor dysfunction. GM are the only ICB reporting non-compliance with this implementation.

This was a national requirement – full (recurrent) funding in place from the ICB from 25/26 financial year. The areas of exception are as follows:

- Bolton NHS Foundation Trust (BFT) have experienced challenges with trust level financial approval for recruitment to 0.8 whole time equivalent (wte) Band 3/4 Physiotherapy support required to be able to declare full compliance.
- Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust (WWL) have experienced challenges with trust level financial approval for recruitment to 0.4wte Band 3/4 Physiotherapy support required to be able to declare full compliance.

Mitigation:

- Both providers have assured the GM Local Maternity and Neonatal System (LMNS) that the PPHS service has been implemented within their maternity services, ensuring that women have access to this support when needed following childbirth.
- Commitment to raising these concerns during Provider Quality Review Meetings, with the objective of working collaboratively with the provider to address and resolve these issues.

Updated National Institute for Health and Care Excellence (NICE) NG28 – System Position and Risk

The updated NICE NG28 guidance (February 2026) significantly expands eligibility for SGLT2 inhibitors and incretin therapies (GLP-1 receptor agonists and tirzepatide) for people living with type 2 diabetes (T2D). While these recommendations are cost-effective, (over the long term), adoption at scale would generate a substantial short- to medium-term budgetary pressure. The estimated financial impact for NHS GM is between £60-£85million per annum. This level of expenditure cannot be accommodated within current prescribing allocations.

Whilst ICB have a statuary duty to pay regard to NICE guidance when discharging their functions, there isn’t a mandate to implement NICE guidance (unlike NICE Technology Appraisals). Full implementation of NG28 has the potential to improve long-term health outcomes and support the strategic left shift towards prevention. However, affordability is a significant issue. The commissioning for incretin therapies is particularly challenging due to high public demand and an overlap of patient cohorts and eligibility across other treatment pathways. For example, tirzepatide is indicated for both weight management and T2D; and semaglutide is indicated for T2D, weight management with a NICE Technology Appraisal(TA) in development proposing use for cardiovascular disease risk reduction.

To mitigate against early adoption of NG28 recommendations in advance of a formal commissioning position, an interim GM holding position has been put in place. This will ensure the

ICB has time to:

- Review and prioritise the individual recommendations made within the NICE guidance
- Develop a proposal which supports fair and equitable implementation of NG28, which is phased within available budget
- Ensure access to incretin therapies in GM is aligned across clinical pathways

Glossary:

- GLP1: glucagon-like peptide-1 is a hormone produced in the gut that plays a crucial role in regulating blood sugar levels and appetite, and it is used therapeutically in managing type 2 diabetes and obesity.
- Incretin therapies are treatments that utilise incretin hormones to help manage blood glucose levels, primarily in individuals with type 2 diabetes.
- Semaglutide is a prescription GLP-1 receptor agonist used to treat type 2 diabetes, support weight management, and reduce certain cardiovascular and liver-related risks.
- SGLT2i: Sodium-glucose co-transporter-2 inhibitors are medications that lower blood sugar by preventing glucose reabsorption in the kidneys, promoting its excretion in urine, and offering additional benefits for heart and kidney health.
- Tirzepatide is a dual glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 receptor agonist, meaning it includes GLP-1 activity but also targets GIP receptors for broader metabolic effects.

Advise

National Patient Safety Event Data- quarter 3 (Q3)

The National Patient Safety Event Data has been published for Q3 and provides some summary reporting for all organisations in relation to patient safety events recorded on LFPSE - Patient safety event data: Quarter 3 2025/26 (October to December 2025)

Summary data is provided below to show the number of patient safety events (including good care events) recorded per 1000 bed days for each of the NHS GM Trusts, including a comparison to Q2 data:

Recording Organisation Code	Organisation Name	Median Day Lag	Number of Incidents	Activity Denominator	Recording Rate Type	Q3 Recording Rate	Q2 Recording Rate
RMC	Bolton NHS Foundation Trust	0	4,229	50,039	Per 1,000 Bed Days	84.5	84.7
RXV	Greater Manchester Mental Health NHS Foundation Trust	0	10,121	65,833	Per 1,000 Bed Days	153.7	155.2
R0A	Manchester University NHS Foundation Trust	0	15,832	181,570	Per 1,000 Bed Days	87.2	85.7
RM3	Northern Care Alliance NHS Foundation Trust	0	11,055	133,083	Per 1,000 Bed Days	83.1	84.8
RT2	Pennine Care NHS Foundation Trust	0	2,365	40,610	Per 1,000 Bed Days	58.2	62.5
RWJ	Stockport NHS Foundation Trust	0	4,314	54,704	Per 1,000 Bed Days	78.9	85.4
RMP	Tameside and Glossop Integrated Care NHS Foundation Trust	0	5,051	40,018	Per 1,000 Bed Days	126.2	135.1
RBV	The Christie NHS Foundation Trust	1	2,155	15,410	Per 1,000 Bed Days	139.8	140.4
RRF	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	0	4,138	46,666	Per 1,000 Bed Days	88.7	87.7

ICB observations in relation to the data are as below – any discussion points or gaps in assurance will be picked up as part of the new programme of NHS Trust Quality Review Meetings.

- Greater Manchester Mental Health NHS Foundation Trust (GMMH) continues to have one of the highest recording rates (per 1,000 bed days) in the country for Mental Health (MH) Trusts – his is due in part to the number of ‘good care’ events they are reporting in addition to incidents but potentially also reflective of a positive reporting culture.
- Pennine Care NHS Foundation Trust (PCFT) continues to have one of the lowest recording rates in the country for MH Trusts and the recording rate has decreased vs Q2. The ICB will

seek feedback from the Trust around this to understand why this may be the case (is it a case of under-reporting, issues with the local risk management system (LRMS) interface with LFPSE or due to other factors e.g. patient acuity or good safety controls and risk management)

- Variation in recording rates from Q2 to Q3 across the acute trusts is notable considering that that the Q3 data may have been impacted by winter pressures – in some cases this has resulted in an increased recording rate (potentially due to the increase in incidents) and others have seen a decrease (possibly the impact of pressures/capacity issues on the organisation's ability to report incidents).
- The Quality Review Meetings (QRM) with each Trust will also be focussing on the learning from never events. Northern Care Alliance NHS Foundation Trust (NCA) and Manchester University NHS Foundation Trust (MFT) have both had a number of never events that are being investigated to understand the causal factors

Provider Staff Survey Results

The 2025 NHS Staff Survey results for hospitals in Greater Manchester give an important picture of how staff are feeling about their work and workplace. The survey asks employees about their experiences, wellbeing, and views on leadership and teamwork.

Overall, many staff continue to feel proud of the care they provide, but the results show that working in the NHS remains challenging. Across most Greater Manchester hospital trusts, fewer staff than last year said they would recommend their organisation as a place to work. Some trusts saw little change, while others experienced a noticeable drop. This suggests that pressures such as workload, staffing shortages and the ongoing demands on services are continuing to affect how staff feel about their jobs.

Staff feedback also shows a mixed picture across different areas of working life. Many people reported positive experiences within their teams and felt supported by colleagues and immediate managers. Some trusts, including specialist providers, continue to score well for leadership, respect, and inclusion. However, common concerns were raised around feeling stretched at work, maintaining morale, and feeling valued and recognised, which are issues affecting staff across the NHS nationally.

Thousands of staff across Greater Manchester took part in the survey, providing valuable insight into day-to-day working life in local hospitals. These results will help organisations and NHS Greater Manchester understand what is working well and where improvements are needed. Listening to staff voices remains a key part of improving support for NHS workers and ensuring they are able to continue delivering high-quality care to patients and communities across Greater Manchester. We will consider the findings of the results along with other key metrics when triangulating quality and patient safety data.

Independent Sector Providers

The Quality and Safety team oversees around 110 Independent Providers, delivering services such as hip replacements, cataract surgery, heart checks, and patient advice.

A number of providers are asked to complete an annual quality and safeguarding self assessment. High-priority services were asked first and are due to return their information in the next few weeks. Other providers will submit later in the year, with all responses due by September.

Once returned the Quality and Safety team will then review each submission to check whether standards are being met. Providers will be rated as fully meeting standards, partially meeting standards (with support to improve), or not meeting standards (with more frequent support).

In addition, all providers must follow a Quality Schedule that forms part of their NHS contract. This includes regular reports such as patient experience and safety information. The team reviews these to check progress and help providers improve where needed.

Maternity and Neonatal Services Quality and Safety

Data Escalation from GM LMNS Safety Assurance Panel
Saint Mary's North Manchester (MFT) showed a statistically significant deviation in rates of early neonatal deaths in January 2026. MFT has been asked to complete a review of the underlying data and provide assurance on themes, learning and any required actions to the next LMNS Safety Assurance Panel. Neonatal mortality intelligence is also monitored through the Neonatal Operational Delivery Network (ODN); a detailed report has been shared with the ODN and forwarded to the LMNS for system assurance.

MFT/GMMH Perinatal Mental Health Mother and Baby Unit Closure for estates works
There is a planned temporary closure of the Mother and Baby Unit (MBU) to enable essential estates works, with alternative care pathways in place to maintain safety and continuity.

- Estates works commenced in February 2026 and are planned to last 29 weeks.
- Interim arrangements are in place and antenatal and postnatal women (without babies) are being cared for on North Manchester adult psychiatric wards, with perinatal mental health support maintained.
- Where required, postnatal women with babies are being transferred out of Greater Manchester (currently within the North West), and placements are being coordinated to maintain safety and minimise disruption.

Tameside and Glossop Integrated Care NHS Foundation Trust (TGFT) Neonatal Cot Closures 15/12/2025 – 18/5/2026
TGFT has temporarily reduced neonatal cot capacity to enable essential estates works, with system oversight in place.

- Neonatal cot capacity has been reduced from 13 to 7 cots (average occupancy 9.3) for the period 15/12/2025 to 18/5/2026 while estates works are completed.
- During the capacity reduction period, admission criteria have been adjusted from >27 weeks to >32 weeks' gestation.
- To date, no harm incidents or adverse outcomes have been recorded, and oversight is being maintained through the LMNS and Neonatal ODN.

Right to Choose

Right to Choose is a legal right for patients to choose their NHS funded healthcare provider for a consultant-led outpatient appointment (it applies to mental health and physical health providers and is frequently used for ADHD and Autism assessments, most often with Independent Sector providers). The referral must come from a GP to the selected provider. ICBs do not need to hold a contract directly with the provider as long as the provider holds a contract with an ICB in England.

There is a comprehensive Recovery Plan in place relating to ADHD and Autism referrals under Right to Choose. Indicative Activity Plans have been put in place with all Independent Sector providers and a clinical commissioning policy and service specification with quality standards have been issued alongside this. Meetings are being held with all providers alongside close monitoring of activity, however the risks relating to over performance against the plan and legal challenge from providers remain live.

Assure

Quality & Safety Management Model

The NHS GM model for proposed Quality and Safety Management was presented to Regional colleagues at NHS England in March and was very well received. The model outlines the ICB approach to ensuring the ICB duties in relation to quality and safety are met, detailing the governance and infrastructure that is being put in place to bring the necessary assurance of Provider contractual compliance with Quality and Safety standards. The Integrated Care Board need to be assured that the commissioned care is meeting the needs of the GM population in a safe and efficient way, and that there are mature processes in place to inform the Board's understanding. The arrangements described build on a firm foundation of assurances that we know work well. Working from the principle of continuous improvement, the approach taken will ensure current and up to date clinical and professional and managerial strategies are used to enable safe and effective care.

The model focusses on how quality within the commissioning and contracting cycle is a key outcome measure for both safe and effective care, as well as financially efficient care provision. Quality assurance will be led by the Clinical team; however, it will be key that matrix working enables a collaborative and positive culture to be role modelled across all directorates and the system. Partnership working will be essential with all system partners to effectively embed the approach, achieving improved outcomes for the people of GM.

Key developments for 26/27 are to develop the QRM approach to reach beyond NHS Trusts, and to include commissioner oversight of service quality for primary care, Hospice Care and Independent Sector providers.

GM Assertive Outreach

Assertive outreach is an enhanced approach to community mental health care for people with severe mental illness who struggle to engage with routine services and are at higher risk of relapse, harm or deterioration. It involves proactive, flexible and persistent engagement, delivered mainly in the community, with an emphasis on continuity of care, relationship-based working, shared risk management and avoiding disengagement or discharge due to non-attendance. The approach supports people to remain in the community wherever possible and reduces reliance on crisis and inpatient care, while strengthening involvement of families and carers.

Following national learning from mental health homicide reviews, including the Nottingham case, Integrated Care Boards were asked by NHS England to review local arrangements for assertive outreach and provide public assurance that risks were being addressed. In response, Greater Manchester Integrated Care Board undertook a system review and developed a Greater Manchester Assertive Outreach action plan, which has previously been presented to Trust and Integrated Care Board Public Boards (Item 10 on the agenda 20250521-nhs-gm-integrated-care-board.pdf.) The review identified variation in delivery across Greater Manchester, workforce and capacity constraints within community mental health teams, and the absence of a dedicated and consistently applied assertive outreach function for this high-risk group.

In response to the national ask, Greater Manchester has established a standing Assertive Outreach Working Group, bringing together mental health providers, commissioners, adult social care, clinical leaders and lived experience representatives. The Greater Manchester Assertive Outreach action plan is being delivered through this group, with clear actions, milestones and escalation of risks through established governance routes.

Progress to date includes improved visibility of the assertive outreach cohort, greater consistency in care coordination and risk management, and clearer governance oversight of high-risk care. Both mental health trusts have completed audits to identify people who meet assertive outreach criteria and have strengthened core practices, including removal of discharge solely due to non-attendance, improved care coordination, enhanced family and carer involvement, updated risk assessment and safety planning, and targeted staff training. Assertive principles are increasingly embedded within community mental health teams; however, delivery remains constrained by workforce pressures and the absence of dedicated funding for a full assertive outreach model at scale.

Alongside this, work is underway to develop Greater Manchester assertive outreach delivery models, informed by national evidence and local learning. These models consider different delivery options, including embedding assertive outreach within community mental health teams or delivering it through more specialist arrangements, dependent on future investment. Emerging model options are being discussed through the Greater Manchester Community and Crisis Mental Health Strategic Group to support system-wide agreement and alignment.

Delivery of the Assertive Outreach action plan is overseen through the Greater Manchester Assertive Outreach Working Group, with progress and risks escalated through established mental health governance, including the Mental Health Partnership Group (MHPG) and the Community and Crisis Mental Health Strategic Group. Oversight is maintained through Trust Public Boards and the Integrated Care Board, with ongoing updates provided to regional and national NHS England for assurance. The short/medium term actions in the plan are on track. The key risk relates to the longer-term action and national ambition of whole system coverage of Assertive Outreach without additional funding ('dedicated funding' referenced in paragraph 4). To mitigate the group are developing AOT options / models for consideration at the next GM Community and Crisis MH Strategic Group in May with the potential of integrated fund opportunities, if national funding is not possible. This risk is fully documented and logged on the MHPG risk register.

Summary of items considered at CEG (March 2026)

The Clinical Effectiveness and Governance (CEG) Committee met in April 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.

This table sets out, for each CEG item:

- The decision being made
- Whether SCC approval is required
- The explicit instruction to SCC, or confirmation where SCC action is not required

CEG paper / item	Specific decision	Instruction to SCC
GMMMG – Azathioprine 10mg/mL suspension for IBD	Approve addition to the GM formulary (AMBER shared care), noting net system financial impact	Approve the formulary addition following CEG clinical approval
GMMMG – GM DOACs Commissioning Statement	Approve updated commissioning statement, enabling switching and supporting system-wide cost savings	Approve the updated GM DOACs Commissioning Statement following CEG clinical approval

CEG paper / item	Specific decision	Instruction to SCC
GMMMG – GM Heart Failure Toolkit	Approve toolkit for publication (no financial impact)	No SCC decision required. Note CEG clinical approval
GMMMG – GM Travel Abroad Guidance	Approve updated guidance for publication (no financial impact)	No SCC decision required. Note CEG clinical approval
GMMMG – Removal of sotrovimab (Xevudy)	Approve removal from GM formulary following national discontinuation	No SCC decision required. Note CEG clinical approval
GMMMG – Vutrisiran for transthyretin amyloidosis (TA1115)	Approve addition to formulary in line with NICE technology appraisal	No SCC decision required. Note CEG clinical approval
CPAS – Independent Sector Rheumatology Service Specification	Approve revised NHS GM service specification following CPAS challenge and amendment	Approve the NHS GM Independent Sector Rheumatology Service Specification following CEG clinical approval
CPAS – General Surgery IS Service Specification (minor amendments)	Note non-material clarifications arising from CPAS challenge	No SCC decision required. Note CEG oversight only
CPAS – Orthopaedic IS Service Specification (minor amendments)	Note non-material clarifications arising from CPAS challenge	No SCC decision required. Note CEG oversight only
Perinatal Mental Health Deep Dive Review	Note progress, delays and delivery risks; support prioritisation of data access and continuation of clinical leadership capacity	No SCC decision required at this stage. Escalate only if commissioning action or statutory mitigation is required
End of Life – NCA Multi-Faith Group	Endorse achievements and support sharing of best practice across GM	No SCC decision required. Note CEG clinical endorsement
CYP Neurodevelopmental Transformation Programme – supporting documentation for new Autism and ADHD multi-agency triage process	Endorsement of the supporting documentation to be issued to autism and ADHD assessment providers to support with the implementation of the new clinical criteria and multi-agency triage process.	No SCC decision required. Note CEG clinical endorsement
Clinical Portfolio Risk – CCPL16 (Vaccination uptake)	Approve closure of risk and management through business-as-usual	No SCC decision required. Note CEG approval of risk closure
Clinical Portfolio Risk – New maternity and neonatal oversight risk	Note new corporate risk and ongoing oversight arrangements	No decision requested. Risk escalates to SCC through routine risk reporting if thresholds are met

CEG paper / item	Specific decision	Instruction to SCC

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.

Secondary Care and Long Term Conditions Group Meeting April

The Group considered a range of strategic issues across long-term conditions, secondary prevention and frailty, highlighting both progress and key areas requiring further development.

Frailty and healthy ageing
The Group welcomed the progress made on frailty, including the system stocktake, draft governance arrangements and emerging improvement plan. There was strong consensus that frailty needs to be positioned as a whole-system, prevention-led agenda, with greater emphasis on continuity of care, proactive management, medicines optimisation and out-of-hospital support. Alignment is required with the new Neighbourhood Health Framework, place-based delivery and the wider reform agenda.

Medicines, NICE guidance and affordability
The Group discussed the significant challenge posed by recent NICE guidance on diabetes medicines. While the clinical benefits are recognised, the scale of the financial impact was highlighted as a major risk, with limited affordability within current budgets. Members raised concerns about the gap between national expectations and local funding, the complexity of overlapping guidance, and the potential for inequitable access. Further work is required to develop a prioritised and transparent commissioning approach.

Working with the pharmaceutical industry
The Group supported the proposal to strengthen and standardise the system approach to working with the pharmaceutical industry. This was seen as important to reduce fragmentation, manage financial risk and improve sustainability of innovation. Members emphasised the need for clear governance, avoidance of duplication with existing structures, and strong engagement with primary care and community pharmacy.

Diabetes care processes and outcomes
Progress on delivery of the eight diabetes care processes was noted, with Greater Manchester performing well compared to national benchmarks. However, significant variation remains between localities and practices, particularly for urine testing and foot checks. The Group stressed the importance of targeted improvement using data, addressing inequalities, and ensuring a balanced focus on outcomes beyond incentivised metrics.

Clinical outcomes and assurance
The Group noted the development of a system-wide clinical outcomes framework to link strategic intent to measurable outcomes over time. This was recognised as a key enabler for assurance, alignment across strategies and effective delivery oversight.

Risk discussed and new risk identified
Risks discussed and/or newly identified through this report include: • Paediatric Hearing Services Improvement Programme: ongoing risk of delayed/missed diagnosis; mitigations include immediate action on priority 1 cases, strengthened subject matter expert capacity and established GM oversight with senior Trust ownership. • Maternity and neonatal: Perinatal Pelvic Health non-compliance at specific providers; LMNS Safety Assurance Panel escalations (including review of outlier early neonatal death rates); and short-term capacity/safety risks linked to planned service disruptions (MBU closure for estates works and neonatal cot closures), managed through LMNS/provider governance with escalation routes in place. • NICE NG28: emerging affordability/implementation risk for updated type 2 diabetes medicines guidance (estimated £60–£85m per annum); interim GM holding position in place while a phased, equitable commissioning proposal is developed. • Right to Choose (ADHD and autism): ongoing legal and financial risk due to potential over-performance against indicative activity plans and provider challenge; mitigations include recovery plan, strengthened commissioning policies/specifications and enhanced contract monitoring. • Watchpoints: variation in patient safety event reporting rates and workforce/capacity constraints that may affect pace and consistency of improvement delivery, monitored and escalated through established governance routes as required.

Learning for sharing

Learning and Improvement Networks

Learning and Improvement Networks (LINs) continue to be positioned as a core improvement vehicle within NHS IMPACT, bringing clinical, operational and improvement leaders together to test, learn and spread effective practice at pace against agreed priorities. The current national model supports three LINs:

- Urgent and Emergency Care (UEC)
- Elective Care
- Mental Health

The emphasis within GM has been on using the LINs to accelerate pace, support shared learning across places and reduce unwarranted variation, building on current work rather than creating parallel programmes of work

The Learning Improvement Networks (LINs) are funded through a central regional allocation, with an initial £750k made available to support LIN activity across mental health, elective care and urgent and emergency care (UEC). This funding is managed at regional level, with oversight through the LIN governance arrangements.

Funding is released in two main ways. First, a proportion is used centrally to cover programme-wide costs, including collaborative events and the Advancing Quality Alliance (AQuA) improvement support. Second, a significant element of the funding is transferred via ICBs to provider organisations to support delivery of LIN-aligned activity on the ground. While future funding is expected to be tighter, the North West position is to maintain pace and progress, using existing learning to shape next steps rather than pausing for national direction.

For GM, the key implication is that current activity should continue, with a clear line of sight from LIN work to GM strategic programmes and governance. This includes ensuring LIN learning supports established GM approaches such as elective reform and interface improvement, including the use of getting it right first time (GIRFT) resources to reduce unwarranted variation.

Mental Health LIN

The core improvement focus for the MH LIN is reducing inpatient length of stay across adult mental health services, older adult services and Psychiatric Intensive Care Units (PICU). This includes understanding variation, testing improvement approaches, and tracking impact over time using more robust data methods.

- Adult mental health services
- Older adult services
- Psychiatric Intensive Care Units (PICU)

Mental Health LIN activity across the region remains in a testing and capability-building phase, with a strong focus on improving data quality, definitions and consistency. Regional discussion has highlighted the need to strengthen how impact is measured, given known lags in formal data, and to support teams to use more timely measures where possible.

Within GM, the focus is on ensuring clarity and consistency in reporting and supporting providers to present improvement activity using statistical process charts and run charts, alongside agreed definitions (including ensuring appropriate capture of Mental Health Act cohorts).

The region is progressing a capability offer using the Virginia Mason improvement approach. NHS GM Trusts will engage early with this offer to maximise benefit across providers, recognising that the primary value for GM in this LIN is likely to be system-wide capability development rather than GM-specific funding.

Elective Care LIN – GM progress

The core focus of the Elective Care LIN was Advice & Guidance (A&G). Activity has now evolved from A&G optimisation alone towards supporting delivery of Single Point of Access (SPoA) / booking models, explicitly relying on strengthening the primary–secondary care interface. This aligns closely with GM elective reform and the direction set out in GIRFT interface guidance. There is a continued explicit link to GIRFT A&G and interface toolkits/templates, which will be used to support standardisation and adoption as SPoA pathways mature.

GM has established the GM Elective LIN with a £30k allocation to support improvements in GP A&G use (including Consultant Connect), focusing on Beyond Core Contract (BeCCoR) Equality Impact scheme objectives and the transition to Trust specialty SPoAs and e-referral service (eRS) changes across 2025/26 and into 2026/27. Current GM activity includes:

- Delivery of an initial system-wide webinar focused on Q4 delivery and learning from 2025/26 and setting expectations for BeCCoR 2026/27.
- Transition into facilitated learning sets with AQuA, grouping practices into cohorts to support peer learning, shared problem-solving and identification of practical improvements to increase effective A&G utilisation (including Consultant Connect) and strengthen referral processes.
- Use of the LIN structure to enable meaningful GP engagement in pathway development with providers, supported by funded backfill where appropriate, to strengthen the primary–secondary care interface and reduce unwarranted variation.

In parallel, GM is progressing SPoA implementation support through a further £60k LIN allocation to accelerate SPoA delivery through GP–provider pathway design, targeted provider support and structured improvement methods. Initial work is focused on Phase 1 specialties including Gastroenterology, Cardiology, Ear, Nose and Throat (ENT) and Gynaecology, using structured improvement methods (iterative testing, shared learning and data-informed review) to support consistent rollout and reduce variation, with learning informing wider rollout ahead of October 2026.

Urgent and Emergency Care LIN

Within GM, UEC LIN activity has focused on frailty and admission avoidance, supporting place-based teams to test and embed frailty-attuned approaches that reduce avoidable attendance and admission. GM places have progressed targeted tests of change including whole-system approaches to advance care planning, falls prevention in care homes, urgent community response for people with higher frailty scores, and alternative pathways for older people following falls while on anticoagulation.

This work has been supported by AQuA and the regional team through improvement coaching, facilitation and analytical support, helping teams clarify aims, test interventions and strengthen cross-system relationships across primary, community, acute and social care services.

GM has also engaged in regional learning to accelerate impact. Two GM systems developed and submitted UEC-focused funding proposals aligned to prevention and admission avoidance, including initiatives to reduce polypharmacy and anticholinergic burden and targeted falls prevention using community-based and creative health approaches. GM has secured £41k funding for at least one pilot, and learning from GM has contributed to shared regional themes (proactive

identification of frailty, medicines optimisation, strengthening neighbourhood responses, and supporting people to remain safely at home during sustained operational pressure).

Several GM localities have been involved including Stockport, Manchester and Oldham, with Bury and Wigan joining later. Activity is now being aligned more explicitly with the GM Frailty and Healthy Ageing Oversight Group and the GM Frailty and Healthy Ageing Improvement Plan to strengthen continuity and sustainability.

Key GM risks and watchpoints

Key risks for GM relate to capacity constraints across clinical and improvement teams, which can affect pace and consistency of engagement across places (particularly during periods of sustained operational pressure), and the risk of fragmentation if LIN activity is not clearly aligned with existing GM governance and strategic programmes.

Funding and prioritisation remain a watchpoint, particularly for elective reform where delivery plans may need to flex depending on confirmed allocations and the pace of SPoA rollout. Data quality and comparability is a further cross-cutting issue, especially for Mental Health and UEC where system-level data maturity varies and can constrain the ability to demonstrate impact.

Forward look and next steps

A single all-LIN collaborative event is being planned to showcase learning, celebrate progress and support region-led priority setting. GM will use this opportunity to ensure that elective reform and interface working, frailty and neighbourhood approaches, and GM's focus on tackling inequalities are visibly represented.

In advance of the next phase, GM will continue to:
- Maintain alignment between LIN activity and GM strategic programmes and governance, including elective reform, neighbourhood development and frailty.
- Use LIN learning to influence region-led priorities, ensuring GM's experience is reflected in the next phase.
- Strengthen the link between improvement activity and operational delivery, including through the application of GIRFT resources to support standardisation and reduce unwarranted variation.

Achievements

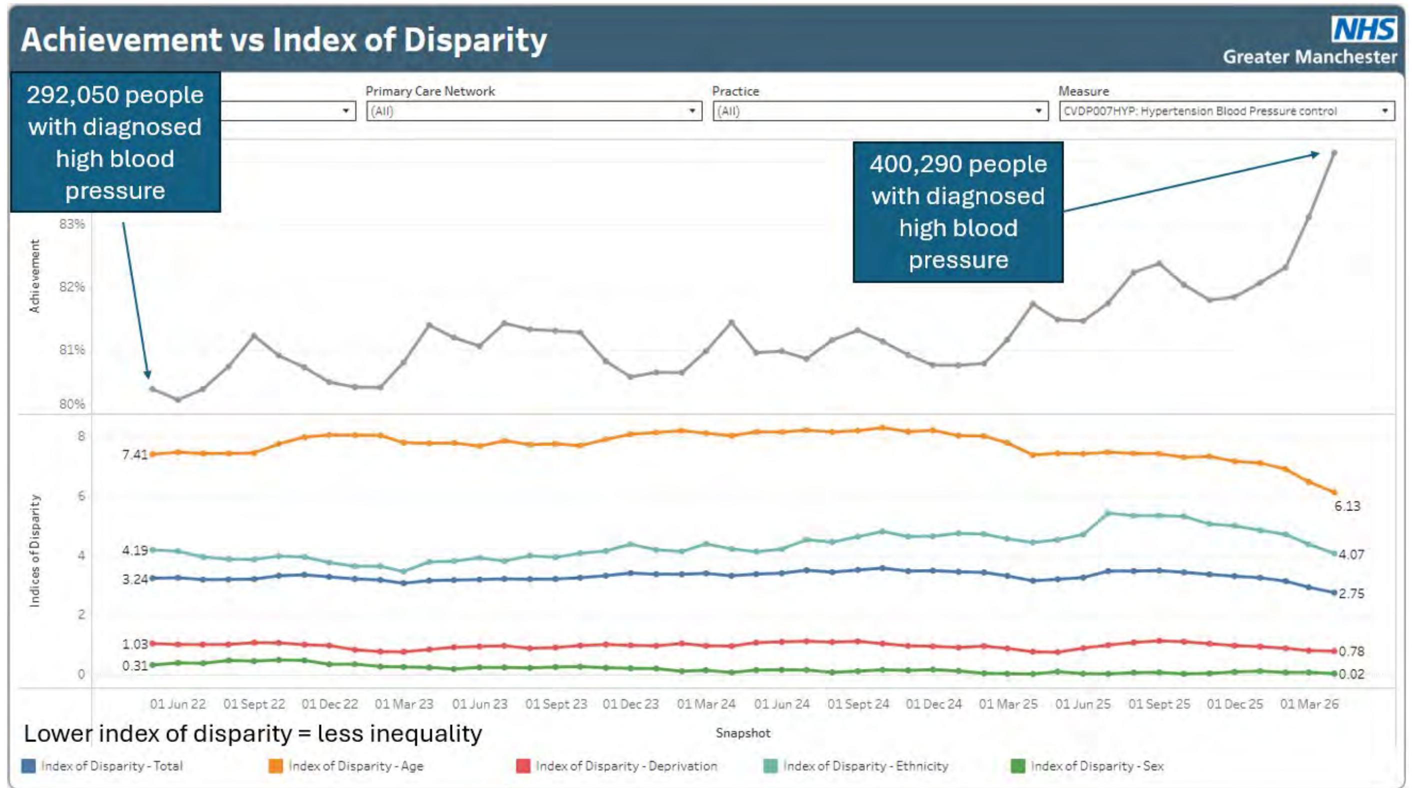
Exceptional system progress in cardiovascular disease (CVD) prevention

This update provides assurance on exceptional system progress in cardiovascular disease (CVD) prevention across Greater Manchester.

Greater Manchester has now exceeded the national ambition for hypertension management, with over 84% (against a national hypertension target of 80%) of people with diagnosed hypertension treated to target. This has been achieved while substantially expanding the number of people brought into diagnosis and management, from 292,050 to 400,290 people with recorded high blood pressure — an increase of more than 108,000.

Importantly this progress has been accompanied by a reduction in overall inequality on the new Index of Disparity, including improvement in deprivation-related disparity, demonstrating that gains are being realised across communities as well as in the average. This reflects sustained clinical leadership, strong partnership working across primary care and system partners, and effective use

of population health data to support targeted prevention and neighbourhood-based delivery. It provides strong assurance that Greater Manchester's long-term, equity-focused approach to CVD prevention is delivering measurable impact at scale.



GM Local Maternity & Neonatal System (LMNS): Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year7

The NHS Resolution Maternity Incentive Scheme (MIS) continues to be a central mechanism for driving improvements in maternity safety, governance, and workforce planning across England. Year 7 of the scheme required providers to evidence compliance against ten safety actions designed to reduce avoidable harm, strengthen data quality, and embed robust clinical governance. Within Greater Manchester (GM), all six maternity providers engaged fully with the process, supported by the Local Maternity and Neonatal System (LMNS) through coordination, shared learning, and system wide oversight. It was the responsibility of the Chief accountable officer for the ICB to sign the declaration form for submission of the overall Trust Declaration to NHS Resolution.

Key achievements include:

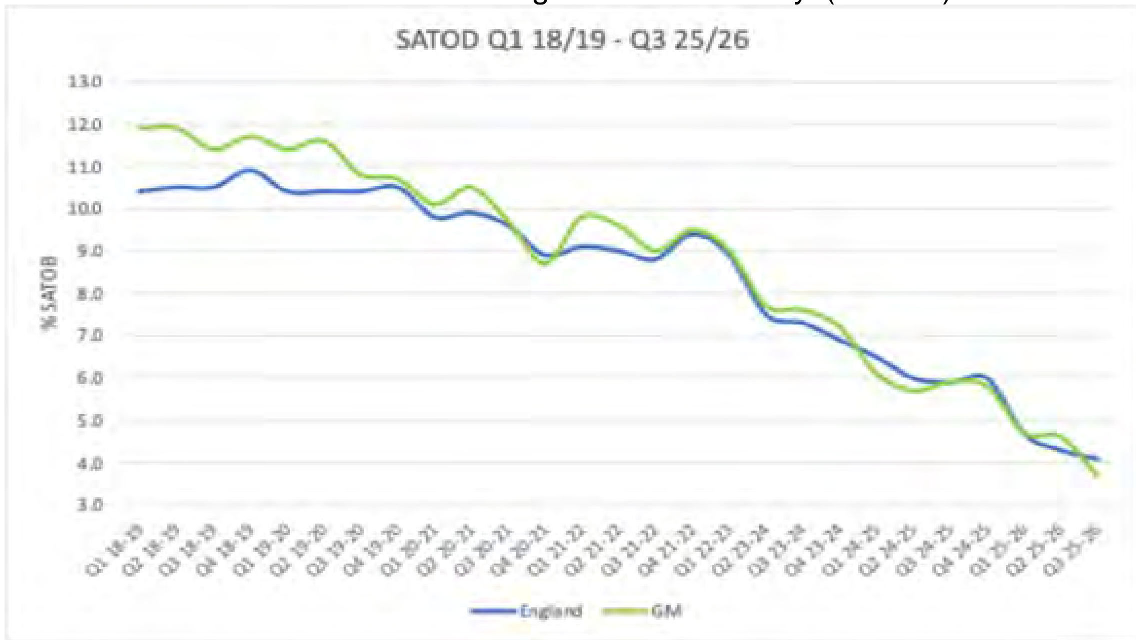
- **All six maternity providers in Greater Manchester have now achieved full compliance with all ten of the MIS Year 7 safety actions**
  The table below demonstrates individual provider improvement over the past 4 years

	Bolton				MFT				NCA				Stockport				Tameside				WWL			
Years 4 - 7	2022/3	2023/4	2024/5	2025/6	2022/3	2023/4	2024/5	2025/6	2022/3	2023/4	2024/5	2025/6	2022/3	2023/4	2024/5	2025/6	2022/3	2023/4	2024/5	2025/6	2022/3	2023/4	2024/5	2025/6
Safety Action 1 - PMRT																								
Safety Action 2 - MSDS																								
Safety Action 3 - T.Care																								
Safety Action 4 - Medical Workforce																								
Safety Action 5 - Midwifery Workforce																								
Safety Action 6 - SBL																								
Safety Action 7 - Patient Feedback																								
Safety Action 8 - In-house Training																								
Safety Action 9 - Safety Champions																								
Safety Action 10 - ENS																								
Total	3/10	10/10	10/10	10/10	10/10	10/10	10/10	10/10	9/10	10/10	10/10	10/10	10/10	10/10	10/10	10/10	8/10	10/10	4/10	10/10	8/10	10/10	10/10	10/10

- Strong governance processes, high quality assurance and Trust Board engagement
  - Supported by the LMNS with hosted webinar sessions on:
    - Governance & Board Reporting
    - GM Triangulation of Claims data with Safety & Learning
- Consistent use of the Perinatal Mortality Review Tool
  - Ensuring timely and meaningful reviews of all maternal or neonatal deaths, completed in collaboration with women and families
- High quality Maternity Service Data Set (MSDS) data submissions
  - Continuing the GM commitment to move to a fully digital electronic patient record system and electronic data submissions.
- Progress against the Saving Babies' Lives Care Bundle (version 3)
  - Supported & funded by the ICB/LMNS to share resources and bring providers together to ensure standardisation and reduce inequalities across GM.
  - Supporting a continuing decline in overall stillbirth rates in GM

	2023	2024	2025
GM Stillbirth Rate (per 1000)	4.89	4.41	4.22

  - Lowest ever recorded 'Smoking at time of delivery' (SATOD) rates



- Workforce planning aligned to national standards
    - All providers funded establishments meet or exceed Birth Rate Plus recommendations
    - Increase in overall midwifery establishment from 1611wte (Jan '23) to 1796wte (Jan '26)
    - Reduction in midwifery vacancy rate from 135wte/8.4% (Jan '23) to 11wte/0.6% (Jan '26)
    - Reduction in midwifery turnover rate from 15.5% (Jan '23) to 8.2% (Jan '26)
      (wte = whole time equivalent)

Recommendations:

The Committee is asked to:

- Note the key areas of risk and assurance highlighted within the report, including the Paediatric Hearing Services Improvement Programme, and support continued system-level oversight and escalation through established governance routes.
- Note the assurance and improvement activity described, including maternity and neonatal safety oversight, system learning from national patient safety event data (LFPSE) and never events, independent sector provider quality processes, and active oversight of Right to Choose activity and associated risks.
- Note the emerging system risks and proposed approaches set out in the report, including the interim holding position for implementation of updated NICE NG28 guidance (pending a phased, affordable commissioning proposal) and the use of LINs to accelerate improvement; and advise on any areas where further deep-dive reporting is requested.
- Approve the addition of Azathioprine 10mg/mL suspension for inflammatory bowel disease (IBD) to the GM formulary (AMBER shared care), following Clinical Effectiveness and Governance Sub-Committee (CEG) clinical approval.
- Approve the updated GM Direct Oral Anticoagulants (DOACs) Commissioning Statement, enabling switching and supporting system-wide cost savings, following CEG clinical approval.
- Approve the NHS GM Independent Sector Rheumatology Service Specification, following Clinical Policy, Audit and Standards Group (CPAS) challenge/amendment and CEG clinical approval.

Greater Manchester

Greater Manchester

NHS Greater Manchester Strategic Commissioning Committee

Report from Chief Commissioning Officer

6 May 2026

Report from:	Chief Commissioning Officer
Date of Meeting:	6th May 2026

ALERT
1. **Cardiac and Vascular Service Changes** • **Clinical Senate and Assurance** The North East and Yorkshire Clinical Senate review was supportive, identifying a small number of areas for improvement across the PCBCs. The cardiac proposals have been shared with the NHS England North West Region as part of the Stage 2 assurance process, and the financial case is currently being finalised. Vascular proposals are scheduled to be shared on 30 April 2026. • **Oldham Vascular Provision – Key Challenge** A significant issue remains in defining the future vascular services currently provided at Royal Oldham Hospital once the MRI centralised model is implemented. Ongoing collaboration between NCA and MFT is focused on developing a clear service specification. This specification is essential to inform activity and financial modelling and is currently delaying progress on the Financial Case. There is a material risk to the overall programme timeline if this issue is not resolved by 6 May 2026, when recommendations are due to be made on whether to consult on the preferred options. While the commissioning assumption remains cost neutrality, unresolved estate constraints at Oldham

continue to complicate the assessment of stranded costs and future service configurations.

- **GM Vascular Network Alignment**

Alongside this, work will be progressed by the Greater Manchester Vascular Network to standardise spoke-site provision. This approach aims to improve equity of access to ICB-commissioned district general hospital vascular services and to ensure consistent clinical support from MFT across all spoke sites, particularly where services are clinically co-dependent.

2. Development of a Single Major Trauma Centre Service

It was agreed at the April Major Trauma Implementation Board that timelines for the implementation of this service would need to be revised due to delays in the recruitment of the Clinical Lead (exacerbated by recent Resident Doctor Industrial Action) and capacity to drive the programme forward. Interviews for the Clinical Lead are scheduled for 30th April 2026 and additional programme capacity is now in place. As such, the timelines will be revised for agreement at the May programme board with a likely 2-3 month delay to implementation.

3. National Dental Contract Reforms to be introduced 1st April 2026. Key issues to note:-

- Mandated **8.2% urgent care requirement** and new complex care pathways create immediate operational and financial risk for practices.
- Overlap identified with GM's **urgent dental care provision** and the existing GM Patient Access Quality Scheme, creating duplication and potential unfunded cost pressures from April 2026.

The next steps agreed at Primary Care Commissioning Group were to review GM urgent care and PAQS specifications to avoid duplication and to undertake detailed financial modelling to understand any pressures and how these can be mitigated.

ADVISE

1. **Development of the Office for Pan ICB Commissioning (OPIC)**

Work is moving at pace to develop the Office for Pan ICB Commissioning (OPIC) across the North West. This will be jointly owned by the three ICBs with a proposal that it is hosted by NHS Lancs and South Cumbria ICB to offer commissioning support for areas determined by NHSE as follows:-

- Health and Justice services, including Sexual Assault Referral Centres (SARCs)
- Specialised commissioning:
  - Acute services
  - Mental Health, Learning Disability and Autism services
- Vaccination services
- Screening services
- Child Health Information Services (CHIS)

Additional areas which could be included in the North West are under discussions, including ambulance commissioning and LeDER. Timelines for this work is driven by the dis-establishment of NHSE to ensure a coherent approach to HR issues.

The Chief Clinical Officer and Chief Commissioning Officer are directly involved in work to develop structures for the new teams and to work with colleagues to ensure a robust structure is developed which both respects local commissioning arrangements and optimises opportunities for economies of scale in approaches across the North West. A detailed paper will be presented to the May meeting of NHS GM Board for decision making.

2. **Independent Prescriber Pathfinder project report**

The evaluation of the Independent Prescriber Pathfinder programme where independent prescribers operated in community pharmacies for an agreed range of clinical conditions found significant benefits in the scheme including –

- Improved access
- Reduced GP workload
- Reached high-deprivation populations
- Can safely deliver beyond minor illness, including cardiovascular care

Across the programme, 78% of patients reported the service prevented a GP appointment—a key message for GM's primary care access and recovery plans. GM also demonstrated strong GP referral routes compared with some other regions, reflecting better-established system relationships in parts of GM. And GM pharmacists reported increased confidence managing complex care, including cardiovascular risk and escalation of suspected cancer. The programme has also supported GM's readiness for 2026 onwards, when all newly qualified pharmacists will be Independent Prescribers.

As such, a proposal to extend this into 2026/27 utilising scheme slippage was approved by Primary Care Commissioning Group (April). Whilst this is on a smaller scale to the original scheme, independent prescribing is now part of the pharmacy undergraduate curriculum and national discussions are underway to embed this as part of community pharmacy activity.

3. Covid-19 vaccination delivery proposal

There are currently gaps in delivery for patients in care homes or are housebound. The Primary Care Commissioning Group approved funding to commission a small number of Community Pharmacies to deliver these vaccinations.

GM has no alternative provider model that can travel, meet safety and IT requirements within the timeframe. The Community Pharmacy providers will deliver through extended contracts already procured via tender.

All providers will be expected to deliver appropriate Making Every Contact Count intervention to ensure each patient receives the greatest possible benefit and is supported to access the most suitable services. This could be hypertension case finding service or blood pressure checks working with the patient's practice to ensure correct eligibility.

4. Retinopathy of Prematurity (ROP) Screening

The North West Neonatal Operational Delivery Network (NWNODN) is delivering a major transformation of Retinopathy of Prematurity (ROP) services through the implementation of a standardised regional screening model. Significant progress has been achieved during the first year of mobilisation, including full regional coverage of WFDRI cameras, near-complete implementation of Link Nurses, establishment of two Reading Centres, and substantial progress on training and competency standardisation.

Despite this progress, several material risks remain that must be addressed to enable the safe and effective launch of the model at scale in 2026/27. The principal constraints relate to:

- Workforce resilience – outstanding recruitment to nurse screener roles, with associated risks to sustainability and cover
- IT and digital interoperability – significant variation in PACS systems, slow progress with image integration across Cheshire and Mersey, and unresolved requirements for image storage
- Cross-trust working – the absence of a unified honorary contract solution, limiting the peripatetic deployment of screening staff
- Equipment lifecycle management – a proportion of WFDRI cameras are approaching end of life, with no confirmed replacement pl an in place

Without targeted action to mitigate these risks, the full benefits of the model — including improved equity of access, stronger clinical governance, and reduced clinical risk — may not be fully realised.

Improvement plans are monitored on a monthly basis with all providers, and overall delivery and assurance of the programme is overseen by NWNODN.

5. NW Adult Critical Care Transport (ACCT) Services

The Specialised Commissioning Oversight Group supported a proposal to pause development of the single North West ACCTS in 2026/27, reflecting the absence of a clear and credible route to securing the essential capital funding required to deliver the programme at this time.

The Group received assurance that appropriate interim mitigations remain in place through existing interim commissioning arrangements, which continue to be closely monitored by the regional ACC Clinical Networks. Work to identify capital through local programmes will be pursued at pace.

6. Specialised Mental Health Services

The Specialised Services Oversight Group reviewed an assurance report covering provider changes, service transformation, capacity issues, and the need for improved strategic links and reporting between ICBs, Lead Provider Collaboratives (LPCs), and providers. Work is planned to create better links between teams to support strategic (5-year) transformation planning, regular assurance reporting.

Key points from the Assurance Report:

- **Women's Secure Pathway Transformation:** Work is ongoing to transform the women's secure pathway, with Mersey Care proposing a blended low and medium secure service. National specifications are expected by June/July, and the use of the Aspen Wood unit is under consideration due to reduced Learning Disability referrals.
- **Delayed Discharges and Prison Waits:** There are persistent challenges in securing local authority placements for patients ready for discharge from secure services, particularly in Manchester, and ongoing issues with

transferring patients from prison to Psychiatric Intensive Care Units (PICUs), with efforts underway to resolve these with ICBs and secure units.

- **Anderson Mother and Baby Unit Relocation:** Due to significant building issues at Laureate House, the Anderson unit has temporarily relocated patients to other units, with ongoing discussions about suitable interim locations and concerns about the impact on service users from South Manchester and Cheshire.
- **Service Updates and Capacity:** Updates were provided on the reopening of Sunflower House, pressures in adult eating disorder services, the opening of Sapphire Ward for nasogastric tube feeding, and ongoing work to restore capacity at the Cove CAMHS unit, with a continued focus on mutual aid and repatriation.

Mental health assurance updates to be provided to GM SCOG on a quarterly basis, with escalation by exception. Next Update expected July 2026.

ASSURE

1. Specialised Services

a) 2026–2027 Planning

The Group reported that most GM specialised contracts are nearing completion and signature, with minor outstanding queries at Stockport and Bolton and agreement that IAP detail will be finalised and varied post-signature.

b) Quality Report

The Quality report was noted. Quality issues are escalated through established GM quality governance routes, Actions relating to spinal surgery and renal dialysis reviews in progress.

c) Finance Update

The Group received an update that GM system delivered an overall surplus, supported by deficit funding in 25/26 and that specialised commissioning delivered broadly to plan. Forward planning has highlighted pressure from reduced deficit

support in future years. The Group noted improved financial coherence across the system compared with the previous year.

d) Performance Report

The Group reviewed the Performance and noted MFT activity variance and increased outpatient activity relative to surgical throughput. A welcome increase in complex endometriosis surgery supporting long-wait reduction. No major concerns flagged by the Cancer Alliance despite reported variances in Head and Neck and Urological Cancer surgery. MFT has offered to support Cardiac surgery pressures at Blackpool with some mutual aid. The Group noted anticipated challenges moving from 65-week to 52-week reporting metrics

2. Primary Care UEC Bank Holiday Arrangements

Confirmation of arrangements in place for primary care services over the Easter Bank Holiday period forms part of the NHS GM Assurance return to NHS England.

ACHIEVEMENTS

1. SEND Re-inspection in Oldham

Committee members will note the outcome of the SEND re-inspection in Oldham which is covered in a separate report. Whilst there are areas for on-going improvement, it is important to note that the re-inspection finds significant progress in the areas highlighted in the original inspection, including more coherent shared governance arrangements between the NHS and the Local Authority and strengthened partnership working, resulting in improved experiences for children and families.

NHS Greater Manchester

Acting Chief Reform & Improvement Officer Report

2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester People and Resources Committee

April 2026

Required information	**Details**
Title of report	Acting Chief Reform & Improvement Officer Report
Author	Gill Baker – GM UEC Programme Director Dan Gordon – Director of elective care Ed Dyson – Director of performance, improvement and assurance
Presented by	Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM
Contact for further information	Nicola.Hepburn1@nhs.net
Executive summary	This report provides an analysis of assurance relating to NHS Greater Manchester Integrated Care Board discharging its statutory duties for performance. It follows the Alert, Advise, Assure framework. It brings together intelligence from established governance routes and illustrates examples of actions taking place to deliver performance. The report shows varying levels of assurance in delivery of standards. It demonstrates Greater Manchester continues to show continuous improvement against standards.
The benefits that the population of Greater Manchester will experience.	The Greater Manchester population will gain improved health outcomes and experience as the Greater Manchester system makes continuous improvement in key standards.
How health inequalities will be reduced in Greater Manchester's communities.	A focus on reducing variation in provision across Greater Manchester will narrow variation in outcomes across geographical boundaries. Deep dives take place to look at variation across protected characteristic groups.
The decision to be made and/or input sought	The Committee is asked to: • Receive and discuss the report. • Note scrutiny of performance takes place at the Strategic Commissioning Committee and is reported to Board.
How this supports the delivery of the strategy and mitigates the BAF risks	Performance is held within BAF risk SR2.
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	Performance reports to Strategic Commissioning Committee and Board.
Engagement* to date ***Engagement: public,**	Development of the operational plan and its work programmes incorporate these aspects of engagement.

clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report. Financial impacts are reported as required. Financial decisions are taken through the appropriate governance. There is a relationship between achievement of financial objectives and delivery of performance standards due to the required levels of funded activity to require standards.

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

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

Alert

The following national priority metrics are currently rated as Alert and continue to be monitored through established recovery and performance arrangements:

- Urgent and Emergency Care – A&E 4-hour performance (GM providers)
- Urgent and Emergency Care – A&E 12-hour waits
- Elective – Incomplete RTT pathways of 52 weeks or more
- Diagnostics – 6-week diagnostic wait performance
- Mental Health – Average length of stay in adult acute mental health beds
- Learning Disabilities – Inpatient care for autistic adults

Advise

The following metrics are rated as Advise, with improvement plans in place and ongoing system oversight:

- Elective – Incomplete RTT pathways within 18 weeks
- Elective – Pathways waiting over 18 weeks for a first appointment
- Cancer – Patients receiving treatment within 62 days
- Learning Disabilities – Inpatient care for adults with learning disabilities
- Primary Care – Appointments in general practice
- Primary Care – Population access to NHS dentistry

Urgent Care focused update:

- System pressures: The UEC system has remained stable month to date. Isolated escalations have been managed effectively through the System Control Centre (SCC) and local escalation arrangements, with no sustained system-wide pressures identified.
- NEPTS: Procurement activity has progressed in line with plan. The evaluation phase has concluded, with moderation scheduled to commence w/c 20 April.
- Winter review: System-wide input has been completed, engaging locality partners and acute providers. Learning is being consolidated and will be shared through the UEC Reform Board to inform future planning and improvement.
- UEC Capacity Fund: Evaluation of funded schemes is underway using a standardised methodology. Completed proformas are due by the end of April, with system-level review and reporting planned for May through agreed governance routes.
- UEC Capital: NHS England has provided an update on UEC capital bids submitted as part of the wider capital programme. Letters of Key Engagement (LKOEs) have been requested from providers, with decisions on progression expected by the end of April.

EPRR on-call model: A revised on-call model has been agreed, supported by a new Standard Operating Procedure (SOP) and engagement through the Partnership Forum. Phased implementation will commence from 20 April to support an orderly transition.

Elective care focused update:

- Q4 sprint ended 31st March demonstrating significant improvement in performance especially RTT 18 weeks and total list size - Trusts are validating March position to the end of April to ensure most accurate position possible is reported
- Through planning round trusts have been funded to deliver target RTT performance to March 27,

NCA were lagging but have had a significant investment and should continue to improve, improving overall GM position

- **Consultant Connect** platform continues to see strong growth (March 15% above February levels) and being extended to March 27 (current annualised activity is c24,000 which is 50% above 24/25 levels)
- **BeCCoR** scheme approved for 2nd year, with a focus on targeted reduction in new referral rates and increase use of Trust SPOAs and Advice and Guidance
- **Community services**: ENT business case approved and mobilisation underway, Gynaecology service provision

Assure

The following metrics remain rated as Assure and are performing within national expectations:

- Cancer – Patients receiving communication of diagnosis, or ruling cancer out, within 28 days
- Mental Health – Access to Children and Young People's Mental Health Services
- Prevention – Hypertension treated in line with NICE guidance
- Prevention – Cholesterol management for patients with recorded cardiovascular disease

Governance, escalation, and assurance arrangements across UEC remain robust. Key programmes and workstreams continue to progress as planned, and there are no issues requiring escalation to Chief Officers beyond routine reporting at this time.

Risk discussed and new risk identified

Focus is now turning to 27/28 delivery. Many of the core standards, including the four-hour target, 18 weeks and 62 day cancer, have had target extended. This means a similarly challenging year ahead in terms of operational focus, productivity and transformation. As with 26/27 there is friction between delivery of financial and performance objectives. Focus on demand management brings the opportunity to mitigate these in a mutually inclusive way in some instances.

This risk is set out in BAF risk SR2.

Achievements

GM has continued to show continuous improvement over the last three years in all key indicators. We expect to see an improvement in relative performance to other ICBs when March rankings are published. Other than the A&E 4 hour target all year end figures are currently forecast. Final published figures and national rankings can be between eight and ten weeks following the year end. A summary of key indicators is as follows.

Standard	**Target**	**Forecast achievement**	**Improvement from March '25**
A&E 4 hour	> 78%	74.1% (confirmed)	+2.9%
18 week RTT	> 60.7%	61.4%	+8%
52 week RTT	<1%	1.75%	-2%
Cancer 62 day	>75%	75.6%	+3.9%
Cancer FDS	>80%	82.3%	+2%

UEC Focus

System working and the UEC March Sprint processes supported the delivery of the 4hr standard of care in March achieving 74.1%. This is an almost 3% improvement on the previous year and the table below highlights that all but 1 provider delivered improvement on the previous year.

Provider	March 26	March 25 Actual	Difference
Bolton FT	68.1%	71.8%	--3.7%
MFT	77.2%	73.9%	+3.3%
NCA	73.6%	68.8%	+4.5%
Stockport	70.1%	69%	+2.1%
Tameside	68.9%	67.1%	+2.8%
Wigan (WWL FT)	78.1%	71.7%	+6.3%
GM Total	**74.1%**	71.2%	+2.9%

Ambulance performance and the delivery of the Cat 2 response time remains higher than national average and Ambulance handovers are delivered in a timely manner across the GM footprint.

Throughout 25/26 the GM UEC Reform Programme has worked with system partners to achieve a fully implemented single telephony platform for Integrated Care Coordination. A number of localities have implemented a true Single Point of Access model to support the redirection of patients to more appropriate urgent community services, with other localities working through phased implementation plans.

It is too early to provide Trust specific figures across other indicators. These will be provided when published data is available.

NHS Greater Manchester

Chief Strategy, People and Partnerships Officer - Alert Report

April 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

27 April 2026

Required information	Details
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report
Author	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Presented by	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Contact for further information	Charlotte.bailey37@nhs.net
Executive summary	This paper alerts, assures and advises the Committee regarding key priorities, risks and mitigations relating to; - Live Well - Population Health Transformation - Place Partnerships development - Neighbourhood health plans
The benefits that the population of Greater Manchester will experience.	Develop and deliver a programme of work to improve health outcomes and enable the left shift towards prevention and care closer to home.
How health inequalities will be reduced in Greater Manchester's communities.	Develop and deliver a programme of work to improve health outcomes for all and further facilitate the left shift towards prevention and care closer to home.
The decision to be made and/or input sought	The SCC is asked to: Note the report
How this supports the delivery of the strategy and mitigates the BAF risks	SR1, SR4 and SR5 by reducing demand drivers, improving resilience in communities, and narrowing inequalities
Key milestones	New model commenced in April 2026 – priorities and associated KPIs to be reviewed.
Leadership and governance arrangements	This paper is produced for this committee and has not been elsewhere.
Engagement* to date	There has been no formal engagement on

***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	this paper as it is produced for The Committee and has not been elsewhere.
Financial or Legal Implications;	n/a.

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

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

Key Updates and Escalations

Alert
Place Partnership Mobilisation Place partnership mobilisation is a highly sensitive phase of reform, requiring careful sequencing of engagement to maintain confidence across NHS trusts, local authorities and place leadership. See the assure section for further details on how this is mitigated.
Advise
Work is underway to develop and align the ICB governance for these 4 major programme areas (Neighbourhood Health, Place Mobilisation, Population Health and Live Well) to ensure seamless strategic direction, delivery and oversight.
Assure
GM Population Health Transformation Work is ongoing to establish an integrated GM Public Health Network(GMPHN), bringing together the existing GMPHN (led by the 10 LA Directors of Public Health) and the NHS GM Population Health function into a single integrated team, with a single plan, and measured against a shared outcome framework under the system leadership of the Directors of Public Health. This is a part of the wider ICB organisational change programme and was a part of the staff consultation. A shared action plan for 2026/27 has been developed and the two staff teams are moving towards operating as an informal integrated structure from 1/6/26 under the day-to-day leadership of the NHS GM Associate Director of Population Health. The new entity will be legally structured through a s75 Agreement between NHS GM and Manchester City Council (on behalf of GMPHN). A Phase 1 s75 will be in place from 1/10/26 and will cover pooled budgets, shared outcome framework, key deliverables and decision-making/governance arrangements. A phase 2 s75 will be in place from 1/4/27 and will cover the future staffing model. **Neighbourhood Health as part of Live Well** Neighbourhood Health is at the forefront of the 10-year Health Plan published last summer. Guidance issued to ICBs in October 2025 asked places to commence work on Neighbourhood Health Plans for agreement by local Health and Well Being Boards. DHSC and NHSE committed to providing further detail on these requirements – however, this was delayed and was only published on 17th March. Here Given the maturity of neighbourhood working in Greater Manchester, partners agreed, through the Neighbourhood Coordination Group and Live Well Board, that we should develop Neighbourhood Plans for 2026/27 as part of Live Well. Localities were asked to provide these in draft form in February 2026 recognising that they would need to be

updated when the DHSC/NHSE guidance was published. GM is therefore ahead of the national picture on neighbourhood plans.

Now that the national NHS Framework for Neighbourhood Health is published, it is important that we continue to build on the draft local plans in the first part of 2026/27 so that they are in the strongest position possible – both to meet the national requirements and to go further on our ambition for neighbourhood working as part of Live Well in GM. As part of this, it will be key to work through the role that neighbourhoods will play in delivering the ICB's strategic commissioning priorities.

As we enter 2026/27, neighbourhood working will increasingly become our core business as a system. This will need to be informed by a full programme of engagement with system partners to build a clear understanding of the expectations and opportunities. If we get this right, neighbourhood health as part of Live Well can be the platform for real NHS transformation across GM.

NHS GM and GMCA will jointly lead a programme of engagement in the first quarter of 2026/27. This will include:

- Foundation trusts via the Trust Provider Collaborative
- GM Primary Care Board
- NHS GM Executive Committee
- NHS GM Extended Leadership team
- GM Alternative Provider Collaborative
- GM Live Well Board
- Health and wellbeing Boards and place governance
- GM Housing Providers CEOs
- Other GM System Groups as we develop the engagement programme

We will bring together the outputs from this engagement work to a dedicated System Leaders' Group session on neighbourhood health to be held towards the end of June to inform the next stages of our approach in Greater Manchester.

Through the engagement, we will discuss how culture and practice could evolve in GM as we increasingly work on neighbourhood footprints. For example, this could include – breaking down barriers between sectors and services and working to place and neighbourhood before organisation, and how we can strengthen the connection between Live Well and Neighbourhood Health and secondary care clinicians whose practice will be increasingly defined by population health rather than waiting lists and bed numbers.

The engagement will include early discussions on the new contractual and organisational models set out in the national guidance on neighbourhood health – and how we might draw on these to support the strategic direction in Greater Manchester.

In parallel to this system engagement, localities are asked to continue to develop their neighbourhood plans. We ask localities to bring an updated version of the neighbourhood plans to the first meeting of their Health and Well Being Board (or local partnership equivalent) from September onwards. This is to ensure that localities can both incorporate the outputs from the system engagement between now and the end of June into their plans and the following key elements:

- Align the final Place Health and Care Partnership Agreements, Place Outcomes Frameworks and Live Well metrics to neighbourhood plans
- Fully utilise the neighbourhood data packs made available to all 10 localities in March.
- Use the data to model the impact of neighbourhood working on activity, cost and population health improvement
- Build in the NHS Neighbourhood Framework guidance
- Include a clear description of how GM-level programmes (for example, Mental Health, Housing and Homelessness, Special Educational Needs and Disabilities (SEND) Reform, Dementia) dock into neighbourhood models
- Describe how GM-level enablers such as estates and digital support neighbourhood plans
- Reflecting the importance placed on Health and Well Being Boards (HWBB) in the national frameworks, set the how the HWBB relates to other health and care partnership governance in the locality. HWBBs are described in the NHS guidance has having final approval for Neighbourhood Health Plans at place level.

The engagement will need to run alongside the development of our plans for the Prevention Demonstrator in 2026/27 where localities will be asked to lead on key elements of roll out.

Place Partnership Development and Mobilisation

We are now at a point in our place mobilisation journey where the foundations are genuinely taking shape. The core design principles are clear, the intent is shared, and we have a growing alignment across partners about what a mature place model needs to look like. We have moved beyond abstract design into the early stages of practical mobilisation: understanding the implications for people, funding flows, governance, and partnership behaviours. We are not underestimating the scale of the task, but we are making steady, thoughtful progress, and we are doing it together. This is complex work, but being approached it with realism, collaboration, and a strong commitment to getting it right. The Place Partnership Agreement has been established through a multi disciplinary and organisational approach to rapidly advancing the iterations of Agreement and Place Outcomes Framework, ensuring clear outcomes and metrics for Place. A final draft of the Partnership Agreement is nearing completion, with wider engagement and agreement across partners planned over the summer period. Through the development process it has been essential to draw together both sector-based and locality-based perspectives, ensuring the final Agreement has the necessary breadth, depth and legitimacy across GM.

The proposal for the Place Fund has been fully drafted and refined through extensive co-production with local teams, providers, section 151 officers and NHS GM colleagues, resulting in a clear articulation of scope, exclusions, governance principles and the phased glide path. Engagement materials are now in use across all stakeholder groups, ensuring consistent messaging and enabling Localities to test the model, challenge assumptions and shape the final version. Technical workstreams are progressing the detailed components of the Place Funding, including Left Shift methodology, Primary Care Locally Commissioned Scheme (LCS) standardisation, and gain/risk-share design. The Place Team element of the programme has moved from early design into development. The purpose, principles and core capabilities of Place Partnerships are now clearly defined, and partners share a consistent understanding of what Place Teams are expected to deliver. NHS GM's contribution model, including the five competency areas and associated funding, has been agreed, giving each Place a clearer foundation for shaping its local team. Engagement across the partnership has tested the emerging model, with strong support for a collaborative, multi-agency approach rather than a prescriptive structure. From Monday 20 April a four-week sprint commenced to bring all outputs together into a final, linked suite of documents. Our intention is to hold a final review of this suite of proposals with Chief Officers in mid-May. Following this, we will circulate the full suite of documents for review locally, enabling each Place to consider the totality of the proposals, suggest any minor refinements, and support local discussion. Following this will be review through the Executive Committee, alongside further discussion with partners through the Place Mobilisation Group.

Risks discussed and new risks identified

<u>Place Partnership Development and Mobilisation</u>

- Mobilising the place model is a complex endeavour, involving staff movement into a new structure, ways of working and the possibility of future transfers out.
- Funding flows will need to shift through expanded mechanisms, creating financial, governance and assurance risks during transition.
- Governance, accountability and partnership behaviours will all change simultaneously, increasing system-wide interdependency risk.
- BAU delivery and ongoing transformation must continue in parallel, stretching capacity and heightening operational risk.

<u>Neighbourhood Health as part of Live Well</u>

- A risk register is under development

<u>GM Population Health Transformation Update</u>

- The risk register has recently been reviewed in light of the provisional confirmation of an agreed hosting Local Authority.

- Risks regarding the potential to not move forward without a host have been reduced or removed
- New risks have been identified regarding the mobilisation phase of the work

Learning for sharing

- No current Learning to Share

Achievements

GM Work Well Partnership Vanguard

In October 2024, NHS GM commenced England's largest WorkWell Partnership Vanguard aimed at supporting people with health needs to remain in or return to good employment. The initial vanguard came to end on 31/3/26 and has now been scaled up nationally for a further three years. The funding has been included in the GM Integrated Settlement, and the GM WWP model will now form part of more comprehensive locality models going forward, rather than sitting as a standalone project. Key headlines for GM are as followed:

- The GM system co-produced and established separate vanguards across each of our 10 localities, building upon the assets that existed and the needs of their specific populations. It was the largest, most complex and most sustainable of the 15 national vanguards.
- The GM system established an integrated pan-GM programme management function, led by the ICB and in partnership with the CA and LA colleagues
- Over the 18-month pilot, the vanguards provided support to **6,084 people** in GM for whom health was a significant barrier to employment. This is by far the largest number of any of the 15 national vanguards.
- The WWP Vanguard drew **£6.6million** of external grant funding into the GM system.

Greater Manchester Live Well

GMCA and NHS GM have confirmed maintenance of the current level of Live Well Implementation Support Funding in each locality for 2026/27. As part of this, there is a commitment to sustain the implementation support funding through to 2027/28 and 2028/29 as Live Well continues to develop.

The purpose of the funding is to support the local implementation of Live Well, with a clear expectation that 50% of Live Well investment flows directly to the local Voluntary, Community, Faith and Social Enetrprise (VCFSE) sector. This remains essential to ensuring that Live Well continues to be rooted in community assets, meeting local needs and building trusted relationships with people and place and provides sufficient capacity to develop Live Well alongside wider public services.

The Implementation Support Fund now sits alongside a significant investment from the National Lottery Community Fund into 10GM that will enable the VCFSE sector to grow Live Well spaces and boost everyday support across every neighbourhood. This is part of a wider effort to connect and align a wide range of resource across both the VCSFE and public services (for example, employment support and health). Together, the aligned investments create a £46.5m programme over the next three years that combines community-rooted delivery with long-term public sector commitment, positioning Live Well as a consistent, trusted offer across Greater Manchester.

NHS
Greater Manchester

Performance Report 2026-2027

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Strategic Commissioning Committee

May 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 Nicola Hepburn – Acting Chief Reform and Improvement Officer
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

NHS
Greater Manchester

Performance and Quality Delivery Report
Strategic Commissioning Committee

May 2026

Part of Greater Manchester
Integrated Care Partnership

Reporting Approach for Strategic Commissioning Committee (26/27)

Purpose of this report

This report reflects a transition point between the 2025/26 year-end outturn and the early delivery position for 2026/27. Final validated positions for some 2025/26 measures are subject to national reporting timelines; therefore, where validation is not yet complete, forecast positions have been used to provide an early view of performance and delivery risk.

Key features of the reporting approach

- Performance is presented using an Alert / Advise / Assure (AAA) framework at domain level, to support consistent assessment of delivery risk and assurance.
- Narrative commentary is provided for Alert domains only, to focus Committee attention on areas of material delivery risk requiring system oversight.
- For each domain, two slides are provided where applicable:
    - Domain Oversight Summary – current position, key issues, delivery risk and links to the Board Assurance Framework (Strategic Commissioning Committee focus).
    - System Actions & Delivery – high-level system actions, expected outcomes and delivery risks (system-level visibility).

Reporting frequency

- Monthly domains: Elective Care, Diagnostics, Cancer, Mental Health, Urgent and Emergency Care, Learning Disabilities and Autism.
- Quarterly domains: Primary Care.
- The NHS Oversight Framework (NOF) will be reported quarterly, aligned to national publication timelines.

Executive Summary

Overall position
There are material delivery risks in Urgent & Emergency Care, Elective, Diagnostics and Mental Health, reflected by metrics on alert. Cancer performance is stable and better than plan, with no alert metrics. Risks are managed through enhanced oversight or routine assurance.

Alerts (narrative provided on domain slides)
- Urgent & Emergency Care: Accident and emergency four-hour waits and twelve-hour waits remain worse than plan, reflecting ongoing system flow constraints despite escalation.
- Elective Care: Improvements in referral to treatment (RTT) 18-week performance and waiting list size have been achieved; however, 52-week waits remain behind plan.
- Diagnostics: Six-week diagnostic waits remain worse than plan, despite favourable national benchmarking.
- Mental Health: Average length of stay in adult acute mental health beds remains worse than plan, sustaining pressure on inpatient capacity.

Advise (enhanced oversight)
- Elective Access: RTT 18-week performance (overall) has met target at provider level and is improving, but requires continued monitoring to ensure performance is sustained at ICB level.
- Learning Disabilities & Autism: Inpatient care for adults with Learning Disabilities and autistic adults remains behind plan in parts of the system.
- Primary Care: Access to General Practice and NHS Dentistry behind plan.

Assure (on-track / adequate control)
- Cancer: 28-day faster diagnosis standard and 62-day performance are ahead of plan and expected to meet end-March 2026 targets.
- Elective Care: RTT 18-week time to first appointment has ended year better than plan.
- Urgent & Emergency Care: CAT 2 ambulance response times and ambulance handover performance.
- Mental Health: Access to children and young people's mental health services.
- Prevention: Hypertension and cardiovascular disease indicators.

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

End of year Delivery

NHS Greater Manchester

The finalised positions for Urgent and Emergency Care at the end of March 2026 will be included in this report. For other areas, fully validated 2025/26 performance data will not be available until May. As a result, and to support early oversight of high-risk domains such as elective care and cancer, forecast outturn positions have been used where necessary. These provide early insight into delivery and may be updated following validation.

Urgent and Emergency Care – A&E 4-hour standard:
Greater Manchester's March A&E four-hour performance was 74.1%, representing a 2.9 percentage-point improvement compared to March 2025, but remaining worse than the 78% operational target. Performance improved year-on-year at all providers except one, which remained static. The latest national benchmarking (March 2026) places the ICB 28th of 42, compared to 32nd of 42 in the same period last year, indicating relative improvement despite continued delivery challenge.

Elective recovery – RTT 18-week position:
RTT 18-week performance shows significant improvement, with GM providers collectively forecast to achieve 61.9% at the end of March, better than the March plan of 61%. If delivered, this represents an 8.1 percentage-point improvement compared to March 2025 and a 5.4 percentage-point improvement during the final quarter. National benchmarking (February 2026) shows the ICB ranked 31st of 42, compared to 38th of 42 at the same point last year, reflecting a marked improvement in relative position.

Elective recovery – RTT 52-week waits:
Post-validation, 52-week waits account for 1.6% of the total waiting list, compared with a planning assumption of 1%. Only two of the six acute providers are forecasting more than 1% of their waiting list at or above 52 weeks. Overall, the March 2026 forecast is 2.2 percentage points better than March 2025 actuals, with national benchmarking (February 2026) showing the ICB ranked 30th of 42, compared with 37th of 42 in the same period last year.

Cancer – Faster Diagnosis Standard and 62-day standard:
For the Faster Diagnosis Standard, all providers are forecasting delivery against plan at the end of March 2026, representing an aggregate 1.9 percentage-point improvement compared to March 2025. National benchmarking (February 2026) places the ICB 10th of 42, an improvement from 22nd of 42 in the previous year. For the 62-day standard, the aggregate forecast is slightly better than the operational plan, although performance varies across providers. If forecasts are achieved, the GM provider aggregate would represent a 5.0 percentage-point improvement on March 2025, with benchmarking improving from 18th to 7th of 42 year-on-year.

Headline Operational **ICB** Planning Metrics

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	Mar-26	00:20:58	<00:30:00	<00:30:00	00:21:43	-00:00:45	↓			
	A&E % of patients managed within 4 hours	ICB	Mar-26	73.4%			70.2%	3.2%	↑	32/42	28/42	↑
	A&E (type 1) % waits over 12 hours	ICB	Mar-26	8.4%			9.5%	-1.1%	↓	16/42	18/42	↓
Elective	% of incomplete RTT pathways of 52 weeks or more	ICB	Feb-26	1.8%	1.2%	0.9%	3.6%	-1.8%	↓	37/42	30/42	↑
	Number of incomplete RTT pathways of 52 weeks or more	ICB	Feb-26	7,359	4,723	3,425	15,829	-8,470	↓			
	% of incomplete RTT pathways of 18 weeks or less	ICB	Feb-26	60.7%	59.8%	60.8%	54.0%	6.7%	↑	38/42	31/42	↑
	% of pathways waiting no longer than 18 weeks for a first appointment	ICB	Mar-26	68.4%	68.1%	68.1%	58.0%	10.4%	↑			
	Total number of incomplete RTT pathways	ICB	Feb-26	405,873	381,692	377,212	435,249	-29,376	↓			
Diagnostics	% waiting 6+ weeks	ICB	Feb-26	10.0%			11.6%	-1.6%	↓	10/42	6/42	↑
Cancer	% of patients receiving communication of diagnosis within 28 days	ICB	Feb-26	83.6%	78.9%	80.2%	80.2%	3.4%	↑	22/42	10/42	↑
	% of patient with cancer receiving treatment within 62 days	ICB	Feb-26	74.0%	73.5%	75.3%	67.8%	6.2%	↑	18/42	7/42	↑
Mental Health	Access to CYP mental health services	ICB	Feb-26	55,770	55,000	55,000	55,405	365	↑	02/42	02/42	↔
	Average Length of Stay in Adult Acute, Older Adult Acute and Psychiatric Intensive Care beds	ICB	Feb-26	64.9	57.8	57	71	-6.1	↓	37/42	36/42	↑
Learning Disabilities	Inpatient care for children and young people with a learning disability and/or autism	ICB	Mar-26	*	9	9						
	Inpatient care for Adults with Learning Disabilites (who may also be autistic)	ICB	Feb-26	**50	46	46						
	Inpatient care for Autistic Adults (with no learning disability)	ICB	Feb-26	**50	39	39						
Primary Care	Appointments in General Practice	ICB	Feb-26	1,402,265	1,449,589	1,449,589	1,368,309	33,956	↑			
Prevention	% of patients with hypertension treated according to NICE guidance	ICB	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	ICB	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.

These metrics underpin the Alert / Advise / Assure assessment and domain reporting.

Headline Operational **Provider** Planning Metrics

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	Mar-26	74.1%	78.0%	78.0%	71.2%	2.9%	↑
	A&E (type 1) % waits over 12 hours		Mar-26	8.3%	7.5%	7.5%	9.6%	-1.3%	↓
	Ambulance average handover time		Mar-26	00:20:54	00:24:10	00:24:10	00:23:34	-00:02:40	↓
Elective	% of incomplete RTT pathways of 52 weeks or more		Feb-26	2.0%	1.3%	1.0%	4.0%	-2.0%	↓
	Number of incomplete RTT pathways of 52 weeks or more		Feb-26	8,919	5,685	4,123	19,011	-10,092	↓
	% of incomplete RTT pathways of 18 weeks or less		Feb-26	59.0%	60.0%	61.0%	53.0%	6.0%	↑
	% of pathways waiting no longer than 18 weeks for a first appointment		Mar-26	68.5%	68.2%	68.2%	58.1%	10.4%	↑
	Total number of incomplete RTT pathways		Feb-26	437,683	436,690	431,564	480,062	-42,379	↓
Diagnostics	% waiting 6+ weeks		Feb-26	10.3%	7.1%	5.4%	12.2%	-1.9%	↓
Cancer	% of patients receiving communication of diagnosis within 28 days		Feb-26	83.6%	78.9%	80.3%	80.4%	3.2%	↑
	% of patient with cancer receiving treatment within 62 days		Feb-26	74.3%	73.5%	75.4%	67.7%	6.6%	↑

Headline Operational Metrics – AAA Framework (25/26)

Greater Manchester

Area	Metric	Alert	Advise	Assure
Urgent and Emergency Care (UEC)	A&E % of patients managed within 4 hours (GM Providers)			
	A&E (type 1) % waits over 12 hours (GM providers)			
	CAT 2 response times			
	Average ambulance handover times			
Elective	% of incomplete RTT pathways of 52 weeks or more			
	% of incomplete RTT pathways of 18 weeks or less			
	% of pathways waiting no longer than 18 weeks for a first appointment			
Diagnostics	6 week diagnostic performance (not a planning metric but key enabler for elective and cancer delivery)			
Cancer	% of patients receiving communication of diagnosis within 28 days			
	% of patient with cancer receiving treatment within 62 days			
Mental Health	Access to CYP MH services			
	Average Length of Stay in Adult Acute Mental Health Beds			
Learning Disabilities	Inpatient care for Adults with LD			
	Inpatient care for Autistic Adults			
Primary Care	Appointments in General Practice			
	% of resident population seen by an NHS dentist			
Prevention	% of patients with hypertension treated according to NICE guidance			
	% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidelines			
Total		5	5	8

NHS Greater Manchester

Domain Performance – Elective Care & Diagnostics

Domain Performance – Elective Care & Diagnostics

Narrative provided for alerts only

Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• The proportion of patients waiting over 52 weeks remains above plan, indicating continued challenge in reducing long-wait backlogs. • Diagnostic 6-week wait performance remains significantly off-plan, contributing to delays earlier in the elective pathway.	• Clearance of 52-week waits remains challenging, with the pace of reduction varying across providers. • Diagnostic capacity constraints continue to limit pathway flow, impacting both time to first appointment and long-wait recovery.	• Ongoing escalation and oversight of RTT <18-week and long-wait trajectories through elective recovery governance. • Continued system-level prioritisation of long-waiter clearance. • Targeted recovery actions for diagnostic 6-week waits, including escalation of off-trajectory providers and use of Independent Sector capacity where appropriate.	SR2

Elective recovery actions continue at system level, including escalation and targeted pathway interventions, with Independent Sector capacity supporting delivery alongside NHS activity. This has contributed to improvement in overall RTT performance and waiting list management; however, progress remains uneven across pathways. Residual delivery risk remains due to ongoing challenges in long waits, and diagnostic capacity. Diagnostic constraints continue to influence pathway flow and limit the pace at which further sustainable improvement can be achieved. As such, while progress is evident, sustained system-wide improvement has not yet been fully demonstrated.

Diagnostic group Actions & Delivery

NHS Greater Manchester

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Reduce waiting times for Cardiac CT	Diagnostics and Pharmacy Partnership Group	Waiting times reduction for Cardiac CT (a specific GM capacity issue) and CT generally	Comprehensive Capacity and Demand review Options appraisal for system wide solution	Amber / Green: financial considerations may reduce options
THRIVE implementation and improvement	Diagnostics and Pharmacy Partnership Group	Improvement in key productivity measures: utilisation, late starts, turnaround times, tests, reduction in IS costs	Endo network focus on increasing list capacity (10.5 pts) and patient cancellations Rollout to Physiological sciences: Echo, Sleep, and deep dive into the dataset	**Green**
Did not attend improvement across all modalities	Diagnostics and Pharmacy Partnership Group	Reduction of Did not Attends (DNAs) to maximum 5% for all modalities. Increase in capacity and activity. DM01 improvement.	Identification of shared learning and improvement opportunities Improvement planning with outlying services	**Green**
Reduce unwarranted Endoscopy referrals	Diagnostics and Pharmacy Partnership Group	Reduce unwarranted referrals by 20% and / or % referrals returned	Improve Provider processes: Inclusion / exclusion criteria, vetting processes, Step down / redirection Development of GM wide standardised processes	**Green**
Review of Non Obstetric Ultrasound	Diagnostics and Pharmacy Partnership Group	Reduce acute NOU referrals Improve NOU DM01	Review existing commissioning model and options appraisal Agreement of new commissioning model to inform future Direct Access Diagnostics (DAD) contracts	Amber / Green: financial considerations may reduce options

Elective Care system group Actions & Delivery

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Beyond Core Contact Review, Elective Quality Improvement Scheme (BeCCoR EQIS)	Elective Recovery Board	2-5% reduction in referrals from 10 high volume specialties, reducing demand by 9,000 – 22,000	Complete 25/26 appeals and Elective Board reporting; Fully embed 2026-27 EQIS; target PCNs with rising referrals and low Consultant Connect usage. Align learning and feedback loops with Advice and Guidance and SPoA communications	**Green / Amber**: Elective lead left during VR and lack of elective team capacity to pick up whilst posts are being filled; capacity of Place-based teams to receive routine reporting and follow-up on lines of enquiry with GP providers
Advice & Guidance	Elective Recovery Board		Stabilise reporting; begin formal service review; target promotion in low-uptake PCNs	**Green / Amber**: Capacity of Place-based teams to receive routine reporting and follow-up on lines of enquiry with GP providers; delay in contractual clarity for 2027-28 could undermine confidence and behaviour change
Community Services	Elective Recovery Board	ENT – incrementally avoid 5,000 pathways Gynae – incrementally avoid 10,000 pathways	ENT - Apportion funding between Trusts and issue MoUs; Agree KPIs and reporting; move ENT SPoA into initial delivery; early Wigan phases to be implemented and agree whether Bolton is aligned to the Wigan Service Gynae – Service Specification completed & approved. Additional funding earmarked for 26/27 but not yet agreed	**Amber**: Slippage in funding, contracting or SPoA decisions may materially delay delivery
Single Point of Access	Elective Recovery Board	In Trust Plans	Complete baseline mapping; agree Phase 1 go-live dates with Trusts including detailed specialty level implementation plans. Confirm diagnostic and triage responsibilities; align processes with A&G	**Green / Amber**: Trust readiness (e-RS, job planning) and specialty variation could delay implementation, GP capacity to be involved in the co-production of clinical pathways

Domain Performance – Urgent and Emergency Care (UEC)

Domain Performance – Urgent and Emergency Care (UEC)

Narrative provided for alerts only

Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• A&E four-hour performance remains worse than plan across GM providers, indicating ongoing pressure on front-door performance. • Twelve-hour waits continue to be worse than plan, reflecting persistent system flow constraints despite escalation actions.	• Limited system flow and operational headroom continue to constrain improvement in four-hour performance. • Ongoing pressure on inpatient capacity is contributing to sustained levels of 12-hour waits. • While actions are in place, improvement has not yet been sustained or consistent in the metrics currently off plan.	• System-wide escalation through established UEC governance and oversight arrangements. • Continued focus on discharge improvement, flow optimisation and surge management across providers. • Targeted provider support aligned to UEC recovery and resilience planning.	**SR2**

Urgent and Emergency Care performance remains under pressure, with accident and emergency four-hour performance and twelve-hour waits continuing to be worse than plan at system level. These metrics reflect ongoing constraints in patient flow and limited operational headroom across GM providers. System escalation and oversight arrangements are established through UEC governance, with a continued focus on discharge improvement, flow optimisation and surge management. However, these actions have not yet resulted in sustained improvement in the key performance measures currently off plan. UEC therefore remains an alert area, with continued system-wide focus and oversight required until consistent improvement in four-hour performance and a reduction in twelve-hour waits are demonstrated.

Urgent and Emergency Care (UEC) system group Actions & Delivery

The UEC Reform Board is the primary system level forum driving urgent and emergency care improvement across NHS Greater Manchester (GM). UEC performance remains a key barometer of overall system effectiveness, reflecting how well the whole health and care system functions together rather than the performance of any single area. The GM approach is explicitly system wide, bringing together acute providers, mental health, primary care, adult social care, children and young people's services, diagnostics, prevention, and palliative and end-of-life care within a single system oversight plan.

The GM UEC single system oversight plan is focused on a small number of core improvement objectives: reducing avoidable demand on emergency departments, improving discharge and patient flow, and strengthening access to timely and appropriate community based alternatives. Each programme and intervention within the plan is designed to contribute to one or more of these objectives, supporting a sustained shift towards care being delivered in the most appropriate setting and reducing reliance on hospital-based urgent and emergency care.

In light of the ICB's ongoing organisational change programme, there is a planned refresh and relaunch of both the UEC Reform Board and the underpinning single system oversight plan. This refresh will ensure clarity of purpose, updated membership and accountabilities, and alignment with the ICB's emerging operating model and reform portfolio. As part of this process, a GM UEC Reform Programme Development Session is scheduled for 26th May 26. This session will provide the opportunity to reset collective ambition, agree priorities for the next phase of delivery, and shape the next iteration of the GM UEC reform programme at a system level.

Further detail on specific actions, delivery trajectories and supporting schemes will be shared following the development session and formal relaunch of the Board, once the refreshed governance and programme structure has been agreed.

It is recognised that performance continues to vary across the system and that some providers and places face more significant challenges than others. These issues are addressed through established provider oversight arrangements and place-based improvement processes, supported by tailored organisational action plans and system escalation where required. This ensures that targeted delivery and recovery actions sit alongside, and are complementary to, the overarching GM UEC reform programme.

Domain Performance – Cancer

Domain Performance – Cancer

Narrative provided for alerts only

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert				

Cancer performance is currently better than plan, with both 28-day Faster Diagnosis Standard and 62-day performance above plan and expected to meet the end-March 2026 targets. As such, Cancer is not identified as an alert area at this time.

Cancer Alliance Actions & Delivery

Greater Manchester

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Cancer Faster Diagnosis & Waiting Times Improvement	Greater Manchester Faster Diagnosis, Operational Performance & Treatment Variation Programme Board	Improved 28-day FDS, 31-day & 62-day standards; reduced pathway delays	Targeted provider improvement plans; alliance-wide pathway actions; enhanced breach analysis	**Amber -** Performance above plan; delivery vulnerable to pathway fragility and diagnostic/surgical capacity dependencies.
Diagnostics Modernisation – CXR AI (Artificial Intelligence Diagnostics Fund)	As above	Faster diagnosis; improved detection; reduced unnecessary CT demand	Extend AI solution; transition to business as usual commissioning; pathway refinement	**Green**
Multidisciplinary Team Reform & Pathway Efficiency	As above	Faster, more efficient cancer pathways.	MDT process standardisation; escalation protocols; pathway board oversight	**Amber -** Residual risk from variable MDT timeliness and post-MDT delays.
Cancer Workforce Capability (ACCEND)	As above	Improved workforce resilience and consistency across cancer pathways	Provider implementation plans; quarterly reporting; e-Portfolio assurance	**Green**
Cancer Governance & System Assurance	Cancer Alliance / ICB Performance Group	Clear accountability and earlier escalation of cancer risks	Updated terms of reference; escalation framework; alignment with ICB performance oversight	**Green**

NHS Greater Manchester

Domain Performance – Mental Health & Learning Disabilities and Autism

Domain Performance – Mental Health & Learnind Disabilities and Autism

Narrative provided for alerts only

Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• Average Length of Stay (ALOS) in adult acute mental health inpatient beds remains worse than plan. Latest position February 2026: 64.9 bed days, compared to a plan of 57.8 bed days (and 57.0 bed days at end-March).	• Length of stay remains above plan, limiting inpatient capacity and contributing to pressure across acute mental health services. • Delays in discharge and constraints in step-down and community provision continue to affect patient flow. • Improvement has not yet been sufficient to bring ALOS back towards planned levels.	• Ongoing system oversight through established Mental Health governance arrangements. • Continued focus on discharge planning, improved patient flow and use of step-down alternatives where available. • Work underway with providers and partners to support reductions in length of stay; however, impact has not yet translated into performance at plan level.	**SR2**

Average Length of Stay in adult acute mental health beds remains worse than plan, with February 2026 performance at 64.9 bed days compared to a planned trajectory of 57–58 bed days. This reflects ongoing challenges in patient flow and discharge, placing sustained pressure on inpatient capacity.While actions are in place through system oversight and provider-level improvement work, performance has not yet demonstrated sustained improvement towards plan, and Mental Health therefore remains an alert area requiring continued system-wide focus.

Mental Health and Learning Disabilities and Autism Group Actions & Delivery

NHS Greater Manchester

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Inpatient care for Adults with Learning Disabilities (who may also be autistic)	Learning Disability & Autism Transforming Care Group	Target reduction of LD/A inpatient numbers from 99 (position at 1 April 2026) to 85 by 31 March 2027	NHSE capital funds/complex needs project focussed on Mcr inpatients with complex discharge barriers.	**Red** – Mcr locality inpatients remain well above target. All other localities on track.
Inpatient care for Autistic Adults (with no learning disability)	Learning Disability & Autism Transforming Care Group	As above		**Red** - Requires creation of crisis/admission avoidance and community step down alternatives.
Average Length of Stay in Adult Acute, Older Adult Acute and Psychiatric Intensive Care beds	GM Mental Health Partnership Group (via GM Inpatient Quality Transformation Group)	Current average length of stay 64.9 days (Feb 26), with a end of year target of 57.	• 10 high impact changes being implemented • Clinically Ready for Discharge (CRFD) targets set at locality level (net impact 25% reduction across GM)	**Amber** – CRFD reductions at place are critical to delivery of the reductions in length of stay

NHS Greater Manchester

Summary of delivery against NHS Oversight Framework (**NOF)** Metrics **Q1-Q3**

NHS Oversight Framework (NOF) – Q3 Summary

Overall position

There has been no material change in the NHS Oversight Framework (NOF) position since the last quarterly update. The NOF view confirms the areas of delivery risk identified through the Alert / Advise / Assure assessments in this report, particularly in Urgent & Emergency Care, Elective Care and Productivity.

NOF metrics continue to be monitored internally to support preparedness for future national publication. A full NOF update, including provider segmentation and ICB metrics, will be provided as part of the next quarterly report.

Provider position (Q2→Q3):

- No change in segment for any trust in Q3.
- Segment stability masks underlying volatility, with mixed movement in trust rankings and average scores.

Financial position:

- Largely unchanged across the system.
- Manchester University NHS Foundation Trust moved out of financial deficit; all other positions stay unchanged.

System themes:

- Continued variation in access, workforce, quality, and effectiveness.
- Pressures remain system-wide rather than isolated to individual providers.

ICB NOF metrics (internal / pre-publication):

- Metrics are not yet nationally published and are used for internal preparedness only
- Several indicators lack ranking pending technical guidance.
- Where available, quartiles show mixed performance aligned with provider level pressures.

Oversight and next steps:

- Ongoing oversight of challenged areas continues.
- Internal NOF metrics support preparedness rather than external benchmarking.
- Further updates will align with national publication and wider performance and quality intelligence.

NHS Oversight Framework Metrics ICB – latest available data

Greater Manchester

NHS Oversight Framework

This view displays ICB performance against NOF metrics, alongside individual trust-level performance. It combines nationally published dashboard data with the most up-to-date locally available.

Select a metric to open benchmark & trend.

Organisation

- Bolton FT
- MFT
- NCA
- Stockport FT
- T&G ICO FT
- WWL FT
- Christie
- GM ICB

ICB Additional
No

Select a measure to open additional charts

Domain	Measure	Date	Latest	Previous	Change	Rank	Quartile
Access to services	Percentage of patients to describe booking a general practice appointment as easy	Dec 25	74.1%	78.9%	-4.8%	N/A	N/A
Access to services	Year on Year percentage change incomplete pathways	Jan 26	-6.5%	-6.5%	0.0%	10/42	Inter
Effectiveness and experience	% of CHC referrals completed within 28 days	Dec 25	90.7%	89.2%	1.5%	11/42	Inter
Effectiveness and experience	Average Discharge Delay	Jan 26	4.9	6.6	-25.4%	11/42	Inter
Effectiveness and experience	Cancers Diagnosed at an Early Stage by Tumour Site (12-Month Rolling Reporting)	Dec 25	60.7%	60.7%	-0.1%	20/42	Inter
Effectiveness and experience	NHS Staff Survey Staff advocacy theme score	Dec 25	6.6	6.7	-2.2%	28/42	Inter
Effectiveness and experience	Number of acute bed days per 100,000 head of population	Apr 26	21,497.0	181,078.0	-88.1%	N/A	N/A
Effectiveness and experience	Patients with GP recorded CVD (narrow definition), whose most recent blood cholesterol level is LDL-cholest..	Sep 25	50.8%	50.0%	0.8%	N/A	N/A
Effectiveness and experience	Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment t..	Sep 25	69.3%	69.4%	-0.1%	N/A	N/A
Effectiveness and experience	Percentage of inappropriate out of area adult acute mental health bed days	Jun 25	3.0%	3.0%	0.0%	18/42	Inter
Effectiveness and experience	Proportion of diabetes patients that have received all eight diabetes care processes	Mar 25	59.2%	41.2%	18.0%	7/42	Upper
Finance and productivity	New Implied Productivity Growth (year-to-date compared to last year)	Jul 25	4.1%	4.1%	0.0%	N/A	N/A
Finance and productivity	Planned surplus/deficit	Jul 25	-0.56%	N/A		36/42	Lower
Finance and productivity	Variance year-to-date to financial plan	Jul 25	0.00%	N/A		14/42	Inter

NHS Oversight framework Metrics Providers Q1-Q3

Trust		Overall Segment	Average Score	Trust Rank	Trust in financial deficit	Domain Segment Scores				
						Access to services	Effectiveness & Experience of Care	Patient Safety	People and Workforce	Finance and Productivity
Bolton NHS Foundation Trust	Q1	3	2.28	59 / 134	Yes	2	3	1	2	4
	Q2	3	2.23	55 / 134	Yes	2	3	1	2	4
	Q3	3	2.45	76 / 134	Yes	2	3	1	3	4
The Christie NHS Foundation Trust	Q1	1	1.51	3 / 134	No	N/A	1	1	1	2
	Q2	1	1.59	7 / 134	No	N/A	1	1	1	3
	Q3	1	1.36	3 / 134	No	N/A	1	1	1	1
Manchester University NHS Foundation Trust	Q1	3	2.41	71 / 134	No	3	2	2	4	1
	Q2	3	2.5	85 / 134	Yes	4	1	2	4	2
	Q3	3	2.36	65 / 134	No	3	2	2	4	2
Northern Care Alliance	Q1	4	2.81	116 / 134	Yes	4	4	3	4	2
	Q2	4	2.82	112 / 134	Yes	4	3	3	4	3
	Q3	4	2.87	115 / 134	Yes	4	3	3	4	3
Stockport NHS Foundation Trust	Q1	3	2.48	86 / 134	Yes	3	2	2	3	4
	Q2	3	2.33	62 / 134	Yes	2	3	2	3	2
	Q3	3	2.2	45 / 134	Yes	2	3	2	3	2
Tameside and Glossop IC NHS Foundation Trust	Q1	3	2.28	59 / 134	Yes	1	3	4	3	3
	Q2	3	2.17	44 / 134	Yes	2	2	4	3	2
	Q3	3	2.09	40 / 134	Yes	2	2	4	3	2
Wrightington Wigan and Leigh NHS Foundation Trust	Q1	3	2.54	92 / 134	Yes	3	2	3	4	4
	Q2	4	2.86	119 / 134	Yes	3	4	4	3	4
	Q3	4	2.89	117 / 134	Yes	4	4	3	4	4
Greater Manchester Mental Health NHS Foundation Trust	Q1	5	3.02	58 / 61	Yes	4	4	4	4	2
	Q2	4	2.94	58 / 61	Yes	4	4	4	4	2
	Q3	4	2.99	58 / 61	Yes	4	3	4	4	2
Pennine Care NHS Foundation Trust	Q1	3	2.41	36 / 61	No	4	3	3	3	1
	Q2	3	2.5	39 / 61	No	4	4	3	3	1
	Q3	3	2.47	40 / 61	No	4	4	3	3	1

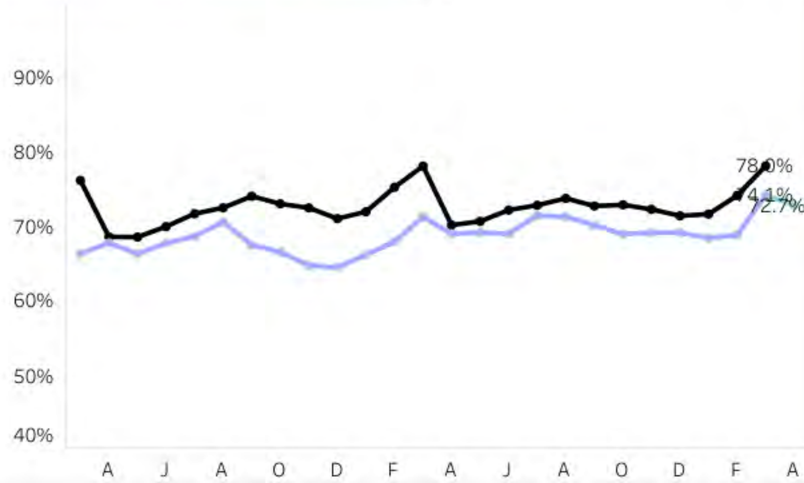
NHS Greater Manchester

Appendices

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

2024/25/26 Performance

GM Acute Providers | Unvalidated In Month | Plan |



Regional Benchmarking

	Dec 25	Jan 26	Feb 26	Mar 26
Greater Manchester	69.1%	68.3%	68.7%	74.1%
North West	71.3%	70.8%	71.1%	74.9%
England	73.7%	72.3%	73.9%	77.0%

A&E 4-hour wait performance at year end was 74.1%, worse than the 78.0% target. Performance in April (1st–22nd) has declined further to 72.7%. In March, NHS Greater Manchester Integrated Care Board ranked 28th of 42 nationally.

		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	22 Apr
Bolton FT	Actual	71.8%	66.3%	70.3%	64.9%	64.8%	64.6%	65.7%	62.1%	61.0%	60.2%	62.2%	63.8%	68.1%	71.7%
	Plan	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%	68.0%
MFT	Actual	73.9%	70.5%	71.4%	71.3%	74.3%	72.2%	70.6%	71.7%	72.4%	73.3%	71.6%	72.7%	77.2%	76.1%
	Plan	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%	78.0%
NCA	Actual	68.8%	67.9%	68.1%	68.1%	72.0%	72.2%	71.4%	69.4%	68.3%	69.1%	70.3%	69.0%	73.6%	71.1%
	Plan	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%	70.0%
Stockport FT	Actual	69.0%	68.3%	65.4%	74.0%	68.0%	69.4%	68.1%	67.1%	69.5%	69.0%	66.3%	69.2%	70.1%	68.2%
	Plan	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%	71.3%
T&G ICO FT	Actual	68.9%	66.2%	61.6%	58.8%	63.6%	66.0%	65.1%	61.0%	64.7%	64.4%	60.3%	61.0%	68.9%	66.3%
	Plan	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%	67.7%
WWL FT	Actual	71.7%	71.4%	72.2%	71.6%	75.6%	77.0%	74.6%	72.5%	70.8%	66.8%	65.7%	65.0%	78.1%	75.9%
	Plan	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%	75.0%
GM Acute Providers	Actual	71.2%	68.9%	69.1%	68.9%	71.4%	71.2%	70.1%	68.9%	69.1%	69.1%	68.3%	68.7%	74.1%	72.7%
	Plan	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%	73.0%
GM Registered	Actual	70.2%	67.9%	68.3%	68.0%	70.2%	70.0%	68.9%	67.8%	68.2%	68.1%	67.5%	68.0%	73.4%	72.7%
	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

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

Proportion of type 1 patients spending 12+ hours in an emergency department

2024/25/26 Performance

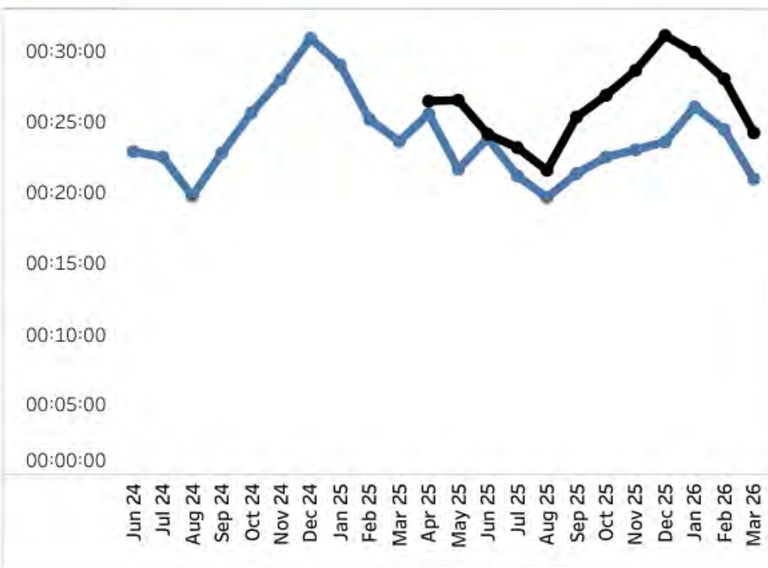
GM Acute Providers | Plan |

At year end (March), 8.8% of patients attending Type 1 A&E departments spent more than 12 hours in the Emergency Department, worse than the plan of 7.5%. Latest unvalidated data for April (1st–22nd) shows a further deterioration to 10.5%.

From 2026/27, the metric will change to include all emergency care types, not just Type 1 attendances.

		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	22 Apr
Bolton FT	Actual	7.8%	12.3%	6.4%	9.1%	9.5%	11.6%	8.6%	11.2%	12.3%	14.4%	14.7%	13.7%	10.6%	11.9%
	Plan	N/A	17.0%	16.7%	16.2%	17.0%	15.5%	17.0%	17.0%	17.0%	17.0%	16.6%	15.9%	17.0%	N/A
MFT	Actual	4.7%	6.2%	4.7%	5.0%	3.6%	5.2%	5.5%	5.2%	5.4%	4.9%	7.2%	5.8%	4.0%	4.1%
	Plan	N/A	6.6%	6.2%	5.6%	5.2%	4.8%	4.5%	4.2%	4.0%	3.6%	3.3%	2.7%	2.0%	N/A
NCA	Actual	12.7%	12.3%	11.2%	12.1%	10.1%	11.8%	12.5%	14.0%	13.2%	13.1%	14.8%	13.9%	11.2%	12.2%
	Plan	N/A	12.1%	12.5%	11.2%	11.4%	10.5%	9.7%	9.7%	8.6%	8.6%	8.7%	7.0%	7.8%	N/A
Stockport FT	Actual	11.9%	12.2%	12.5%	6.0%	10.5%	8.1%	12.4%	15.4%	13.9%	12.7%	16.5%	13.2%	11.0%	16.6%
	Plan	N/A	11.0%	10.5%	9.0%	9.0%	7.0%	9.0%	10.0%	10.5%	14.5%	15.5%	10.5%	10.5%	N/A
T&G ICO FT	Actual	7.2%	9.7%	15.0%	15.4%	11.3%	10.9%	12.9%	13.4%	13.3%	15.2%	17.6%	16.7%	7.1%	14.8%
	Plan	N/A	5.8%	6.5%	5.3%	8.6%	5.8%	8.6%	10.0%	9.3%	13.1%	11.0%	9.6%	8.7%	N/A
WWL FT	Actual	21.0%	22.5%	18.2%	18.2%	17.5%	14.9%	17.3%	18.1%	16.9%	18.7%	22.4%	25.0%	19.6%	19.4%
	Plan	N/A	19.6%	19.2%	18.8%	18.4%	17.9%	17.5%	17.1%	17.7%	18.5%	17.4%	15.4%	15.0%	N/A
GM Acute Providers	Actual	9.6%	10.7%	9.7%	9.7%	8.6%	9.4%	10.2%	11.1%	10.8%	11.1%	13.2%	12.1%	8.8%	10.5%
	Plan	N/A	10.7%	10.5%	9.7%	9.9%	9.0%	9.1%	9.1%	8.7%	9.5%	9.1%	7.6%	7.5%	N/A
GM Registered	Actual	9.5%	10.7%	9.6%	9.7%	8.5%	9.4%	10.2%	11.0%	10.7%	11.1%	13.1%	12.0%	8.8%	10.4%
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Average Hospital Handover Time

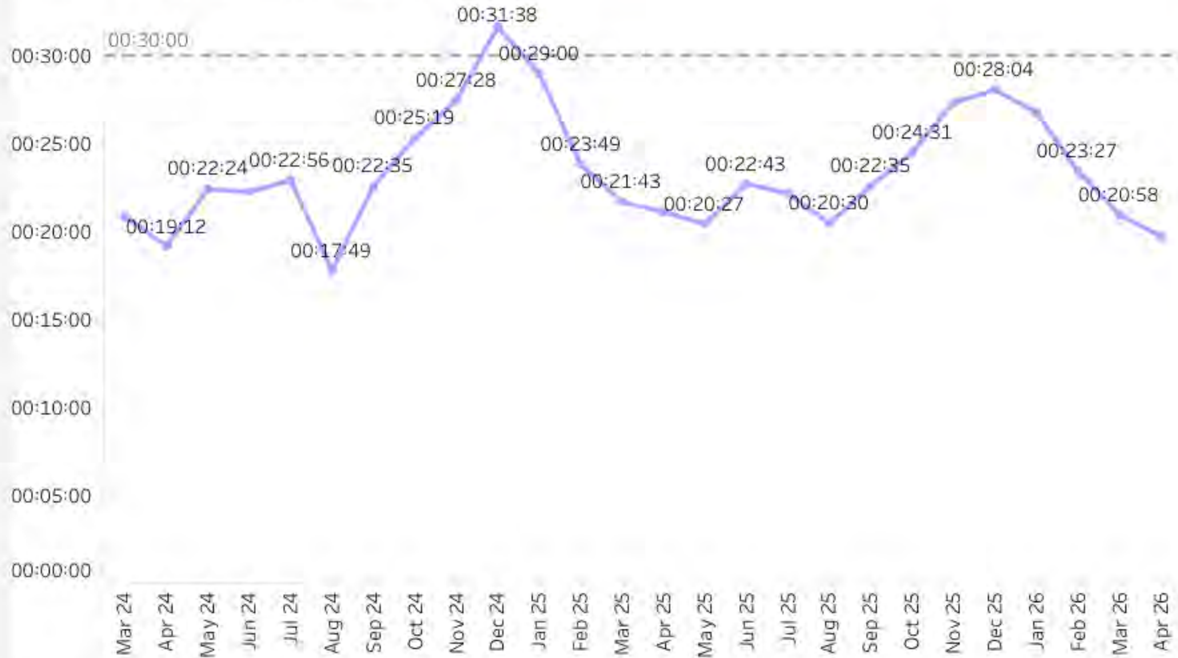


In March, the average ambulance handover time was 20 minutes and 54 seconds. The target has been achieved throughout 2025/26.

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

		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	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	00:19:45
	Plan	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	00:33:08
MFT	Actual	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	00:17:07
	Plan	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	00:14:34
NCA	Actual	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	00:23:30
	Plan	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	00:30:00
Stockport FT	Actual	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	00:23:25
	Plan	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	00:21:24
T&G ICO FT	Actual	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	00:17:40
	Plan	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	00:20:10
WWL FT	Actual	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	00:26:27
	Plan	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	00:37:00
GM Acute Providers	Actual	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	00:20:54
	Plan	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	00:24:10

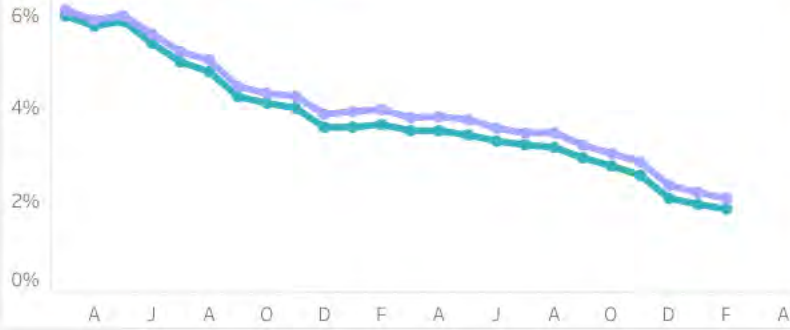
Cat 2 Ambulance Response Times



In March, average Category 2 ambulance response times across Greater Manchester were 20 minutes and 58 seconds.

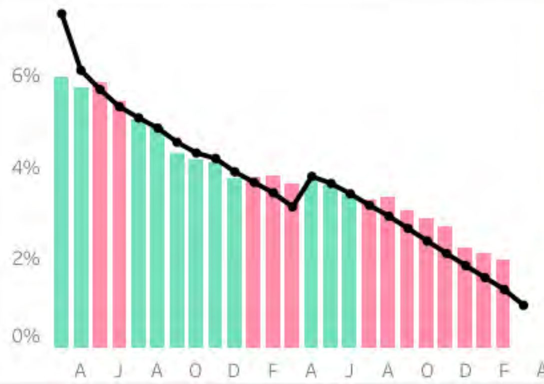
Year-to-date performance for 2025/26 ended well within the 30-minute threshold, at an average of 23 minutes and 29 seconds.

% of RTT waits over 52 weeks for incomplete pathways



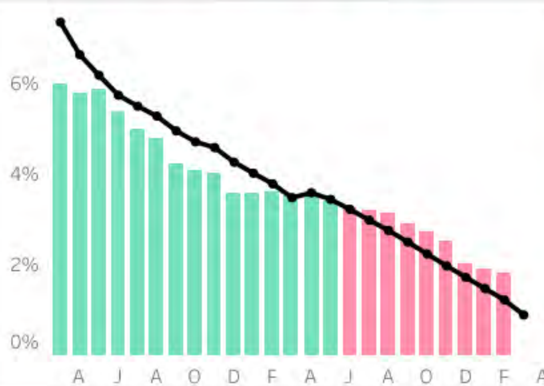
GM Acute Providers

2.0%
▼ -0.14%
Previous 2.2%



GM Registered

1.8%
▼ -0.10%
Previous 1.92%



Data in the purple box is weekly and unvalidated

		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	March 2.. April 20.	
Bolton FT	Actual	3.3%	3.1%	3.3%	3.5%	3.1%	3.3%	3.1%	2.9%	2.8%	2.9%	2.4%	1.8%	1.5%	1.2%	1.7%
	Plan	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%	0.9%
MFT	Actual	4.6%	4.4%	4.4%	4.3%	4.0%	3.8%	3.8%	3.5%	3.3%	3.0%	2.0%	1.8%	1.4%	1.2%	1.3%
	Plan	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%	1.1%
NCA	Actual	3.6%	3.5%	3.6%	3.7%	3.7%	3.7%	3.7%	3.4%	3.2%	3.1%	3.1%	3.3%	3.5%	3.3%	3.3%
	Plan	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%	3.2%
Stockport FT	Actual	4.6%	4.6%	4.1%	3.5%	2.9%	2.7%	2.4%	2.1%	2.1%	2.0%	1.7%	1.3%	1.0%	0.8%	0.9%
	Plan	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%	9.0%
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	0.2%	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%	0.0%
WWL FT	Actual	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%	2.1%	2.3%
	Plan	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%	2.0%
Christie	Actual	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%	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	4.0%	3.8%	3.8%	3.7%	3.6%	3.5%	3.5%	3.2%	3.0%	2.8%	2.3%	2.2%	2.0%	1.8%	1.9%
	Plan	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%	1.8%
GM Registered	Actual	3.6%	3.5%	3.5%	3.4%	3.3%	3.2%	3.1%	2.9%	2.7%	2.5%	2.0%	1.9%	1.8%		
	Plan	3.8%	3.5%	3.6%	3.4%	3.2%	3.0%	2.8%	2.5%	2.2%	2.0%	1.7%	1.5%	1.2%		

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 February, 2.0% of pathways were breaching the 52-week threshold, exceeding the end-of-month target of 1.3%.

Elective – RTT Incomplete: % within 18 weeks

GM Acute Providers

59.0%

▲1.94%

Previous 57.1%

GM Registered

60.7%

▲ 2.1%

Previous 58.5%

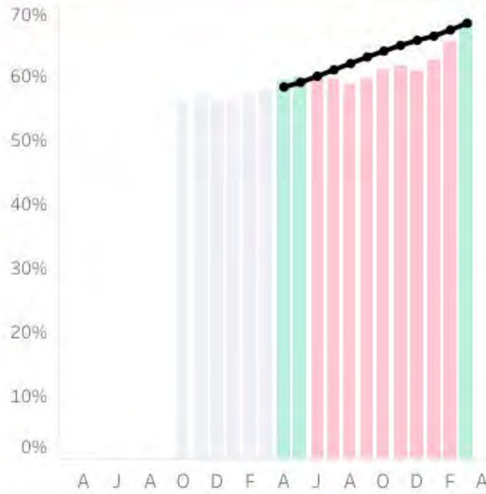
		Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Bolton FT	Actual	54.8%	55.4%	54.9%	55.8%	56.9%	57.2%	58.0%	59.1%	59.1%	58.6%	57.4%	57.5%	59.8%	
	Plan	N/A	N/A	55.8%	56.2%	56.7%	57.0%	57.5%	57.9%	58.4%	58.7%	59.2%	59.5%	60.0%	60.3%
MFT	Actual	50.4%	51.4%	51.0%	52.4%	53.2%	53.3%	52.7%	53.8%	53.8%	54.1%	56.1%	57.6%	60.0%	
	Plan	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%	60.5%
NCA	Actual	52.0%	52.6%	52.4%	54.0%	53.7%	53.6%	52.7%	53.6%	54.2%	53.7%	52.9%	52.4%	54.4%	
	Plan	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%	60.0%
Stockport FT	Actual	54.3%	55.2%	55.2%	56.6%	57.1%	56.8%	56.0%	57.0%	57.8%	57.1%	58.4%	59.6%	60.1%	
	Plan	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%	60.0%
T&G ICO FT	Actual	71.1%	70.3%	70.8%	71.8%	72.2%	71.6%	70.4%	72.7%	73.7%	73.6%	72.8%	73.3%	74.7%	
	Plan	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%	73.3%
WWL FT	Actual	54.6%	56.0%	56.6%	58.2%	57.9%	56.5%	56.5%	57.4%	57.7%	58.4%	57.5%	58.0%	59.0%	
	Plan	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%	60.0%
Christie	Actual	96.3%	95.1%	94.6%	94.6%	94.2%	93.6%	94.3%	95.7%	97.1%	97.1%	97.1%	97.5%	97.1%	
	Plan	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%	97.2%
GM Acute Providers	Actual	53.0%	53.8%	53.6%	55.0%	55.4%	55.2%	54.7%	55.7%	56.1%	56.1%	56.5%	57.1%	59.0%	
	Plan	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%	61.0%
GM Registered	Actual	54.0%	55.0%	54.9%	56.3%	56.6%	56.2%	55.8%	57.0%	57.5%	57.4%	57.8%	58.5%	60.7%	
	Plan	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%	60.8%

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 February 59.0% 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

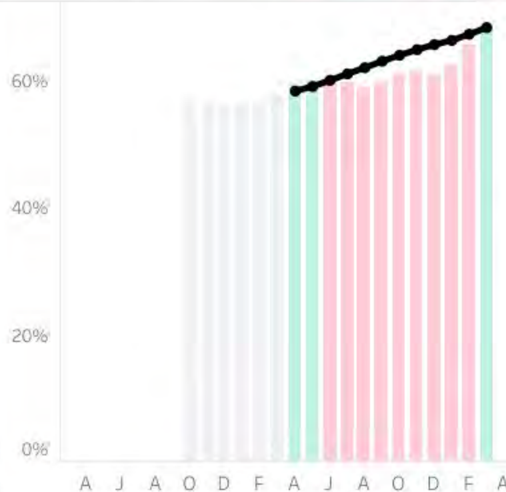
GM Acute Providers

68.5%
▲3.3%
Previous 65.2%



GM Registered

68.4%
▲ 3.3%
Previous 65.1%



		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	61.1%	61.8%	63.0%	64.0%	65.9%	66.2%	66.8%	67.6%	67.7%	64.9%	64.9%	69.8%	72.4%
	Plan	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	53.8%	55.2%	55.6%	56.0%	56.3%	55.8%	56.3%	57.1%	57.9%	58.4%	61.7%	64.9%	67.7%
	Plan	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	57.5%	58.1%	58.8%	57.1%	56.8%	55.4%	56.7%	58.9%	59.2%	56.8%	56.2%	58.7%	64.2%
	Plan	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	61.5%	63.6%	64.8%	64.5%	64.7%	63.1%	62.1%	64.9%	64.4%	65.3%	66.3%	68.1%	69.5%
	Plan	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	81.1%	81.6%	80.7%	80.1%	78.8%	77.9%	79.4%	82.3%	82.6%	81.0%	83.4%	86.4%	88.5%
	Plan	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	61.9%	63.6%	64.4%	63.0%	61.7%	61.7%	61.7%	62.4%	64.1%	62.1%	64.6%	66.6%	68.7%
	Plan	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%	99.1%	99.0%	99.4%	99.2%	99.1%	99.2%	99.3%	99.3%	99.2%	99.6%	99.6%	99.2%
	Plan	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	58.1%	59.3%	59.9%	59.4%	59.5%	58.8%	59.4%	60.9%	61.5%	60.7%	62.4%	65.2%	68.5%
	Plan	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	58.0%	59.2%	59.7%	59.2%	59.4%	58.7%	59.4%	60.7%	61.3%	60.4%	62.1%	65.1%	68.4%
	Plan	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 March 68.5% of pathways were seen within 18 weeks exceeding the end of year plan.

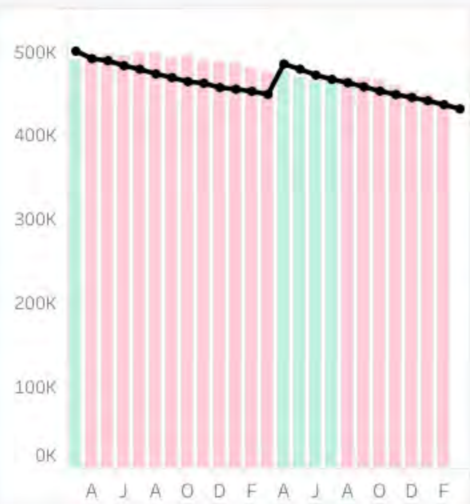
Elective – Total Referral to Treatment pathways

GM Acute Providers

437,683

▼ -2.3%

Previous 447,782



GM Registered

405,873

▼ -1.8%

Previous 413,376

		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	39,987	39,518	38,173	37,308	37,252	37,565	37,521	37,555	37,366	37,478	37,532	38,836	37,369	
	Plan	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	36,124
MFT	Actual	197,034	192,638	192,230	190,129	186,865	186,088	187,912	185,690	183,865	179,651	178,093	174,556	171,407	
	Plan	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	175,291
NCA	Actual	136,673	138,011	138,712	137,853	136,427	137,339	139,016	140,404	140,935	137,786	135,354	134,110	130,603	
	Plan	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	120,110
Stockport FT	Actual	35,824	35,589	35,190	34,798	34,356	34,772	35,231	34,954	35,049	34,647	34,556	34,319	34,274	
	Plan	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	28,932
T&G ICO FT	Actual	17,448	17,033	17,206	17,152	17,017	17,203	17,096	17,273	17,116	17,009	16,808	16,984	16,400	
	Plan	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	17,210
WWL FT	Actual	50,098	50,122	50,409	50,200	49,368	48,840	49,337	48,473	48,514	47,410	46,450	45,540	44,382	
	Plan	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	51,324
Christie	Actual	2,998	3,115	2,807	2,834	2,766	2,735	2,700	2,786	3,652	3,525	3,266	3,437	3,248	
	Plan	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	2,573
GM Acute Providers	Actual	480,062	476,026	474,727	470,274	464,051	464,542	468,813	467,135	466,497	457,506	452,059	447,782	437,683	
	Plan	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	431,564
GM Registered	Actual	435,249	432,101	430,720	427,956	429,227	428,230	426,679	425,600	424,909	418,560	414,419	413,376	405,873	
	Plan	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	377,212

In February there were a total of 437,683 referral to treatment open pathways, marginally above the Feb plan of 436,390.

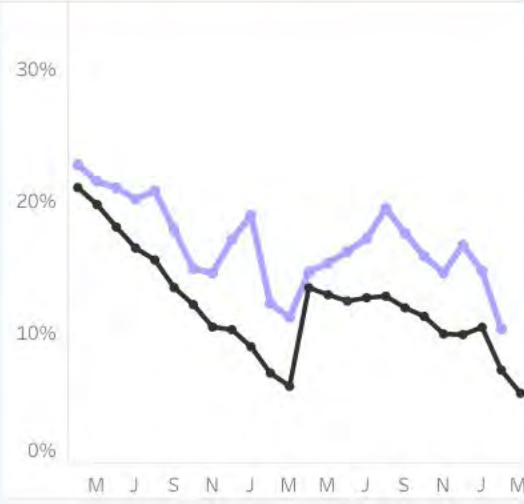
Diagnostics: % waiting 6 weeks+

GM Acute Providers

10.3%

▼ -4.4%

Previous 14.7%



In February, the GM Acute Providers' 6-week wait (6ww) performance across all DM01 tests was 10.3%, against an end of month target of 7.1%

GM Registered performance stood at 10.0%, ranking GM 7th out of 42 nationally.

	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	12.2%	3.7%	10.8%	13.6%	14.8%	17.8%	14.3%	12.7%	6.3%	4.3%	5.0%	3.5%	2.6%	
	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%	5.0%
MFT	14.2%	11.7%	13.3%	14.2%	13.2%	12.7%	13.9%	13.0%	11.7%	11.9%	13.5%	12.5%	8.2%	
	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%	5.5%
NCA	9.1%	9.3%	12.8%	10.9%	12.3%	13.4%	17.2%	14.0%	13.2%	12.5%	15.7%	13.8%	10.0%	
	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%	5.0%
Stockport FT	21.2%	23.3%	27.4%	21.1%	22.0%	22.7%	24.2%	21.3%	18.6%	16.3%	16.1%	16.4%	16.3%	
	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%	5.0%
T&G ICO FT	0.3%	0.4%	1.6%	3.2%	2.6%	2.7%	1.6%	0.8%	0.6%	0.6%	0.0%	1.1%	0.3%	
	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%	4.4%
WWL FT	10.0%	10.1%	18.0%	25.0%	30.4%	33.5%	38.6%	37.0%	34.5%	30.6%	35.2%	30.4%	18.9%	
	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%	7.3%
Christie	0.5%	0.8%	1.7%	1.7%	2.1%	2.6%	3.1%	1.3%	0.6%	0.8%	1.4%	2.6%	3.8%	
	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	12.2%	11.1%	14.6%	15.3%	16.1%	17.1%	19.4%	17.5%	15.8%	14.5%	16.6%	14.7%	10.3%	
	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%	5.4%
GM Registered	11.6%	10.5%	13.9%	14.6%	15.4%	16.3%	18.5%	16.6%	14.8%	13.7%	15.7%	13.9%	10.0%	

28 Day Wait from Referral to Faster Diagnosis: All Patients

GM Acute Providers

83.6%

▲ 6.5% Previous 77.2%

4.8% From Plan

GM Registered

83.6%

▲ 6.4% Previous 77.2%

4.7% From Plan

In February, 28-day FDS performance was delivered at 83.6% against a period target of 78.9%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 10th out of 42 nationally. The GM plan is to deliver 80% by March 2026.

		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	90.4%	90.3%	88.4%	89.3%	87.7%	86.8%	84.4%	85.8%	87.0%	87.7%	86.6%	81.0%	84.5%	
	Plan	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%	80.0%
MFT	Actual	76.3%	76.0%	76.3%	75.2%	78.4%	75.3%	73.3%	72.1%	78.1%	80.8%	80.3%	78.7%	84.5%	
	Plan	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%	80.7%
NCA	Actual	79.4%	77.3%	74.6%	74.2%	77.7%	76.8%	74.2%	73.1%	74.2%	72.8%	75.7%	73.2%	80.7%	
	Plan	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%	80.0%
Stockport FT	Actual	80.5%	82.0%	79.5%	77.6%	80.3%	79.2%	82.4%	83.7%	85.3%	84.7%	82.7%	80.9%	85.1%	
	Plan	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%	80.0%
T&G ICO FT	Actual	83.6%	86.3%	85.8%	84.3%	85.2%	84.2%	80.8%	80.3%	80.8%	82.2%	82.5%	80.1%	85.8%	
	Plan	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%	80.1%
WWL FT	Actual	82.4%	85.7%	81.5%	76.2%	76.3%	76.5%	75.2%	76.2%	73.6%	71.6%	76.4%	72.8%	84.1%	
	Plan	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%	80.2%
Christie	Actual	87.5%	87.0%	94.7%	82.6%	89.3%	84.2%	87.5%	91.7%	94.4%	94.4%	79.5%	80.6%	90.6%	
	Plan	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%	80.0%
GM Acute Providers	Actual	80.4%	80.3%	78.8%	77.6%	79.8%	78.2%	76.3%	75.7%	78.3%	78.7%	79.7%	77.2%	83.6%	
	Plan	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%	80.3%
GM Registered	Actual	80.2%	80.2%	78.7%	77.0%	79.7%	77.9%	76.1%	75.7%	78.4%	78.8%	79.8%	77.2%	83.6%	
	Plan	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%	80.2%

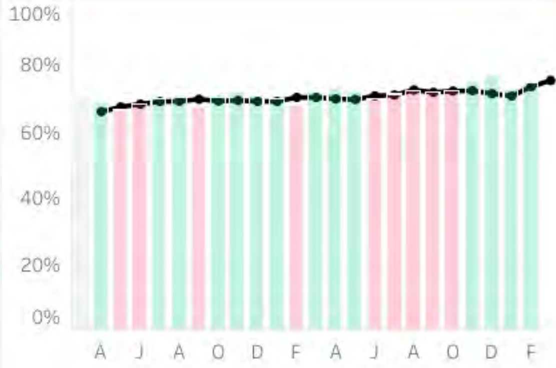
62 Day Wait from Referral to First Treatment: All Patients

GM Acute Providers

74.3%

▲ 1.9% Previous 72.4%

0.8% From Plan

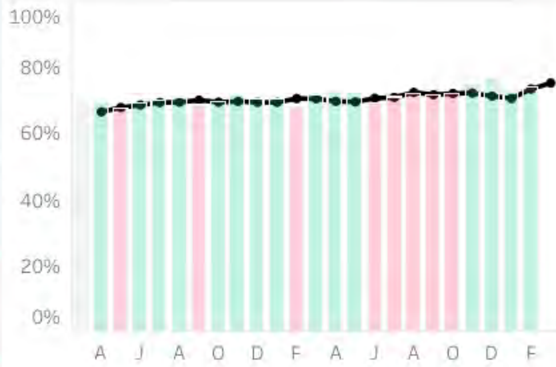


GM Registered

74.0%

▲ 0.9% Previous 73.1%

0.5% From Plan



In February performance for 62-day referral to treatment for All GM NHS Acute Providers was 74.3% against a period target of 73.5%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 7th out of 42 nationally The GM plan is to deliver 75% by March 2026.

		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	81.9%	80.6%	87.0%	87.7%	87.3%	83.4%	81.7%	77.4%	80.4%	82.9%	85.4%	79.1%	67.8%	
	Plan	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%	75.2%
MFT	Actual	58.6%	63.1%	64.9%	65.5%	61.4%	61.4%	63.1%	62.7%	64.2%	66.2%	73.3%	70.1%	74.0%	
	Plan	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%	75.3%
NCA	Actual	64.9%	70.8%	74.0%	71.7%	69.6%	74.4%	74.0%	78.9%	72.8%	78.0%	75.3%	75.7%	73.5%	
	Plan	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%	75.0%
Stockport FT	Actual	72.6%	74.3%	71.1%	72.1%	62.6%	70.2%	76.7%	72.1%	83.3%	77.7%	79.6%	79.7%	81.1%	
	Plan	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%	75.0%
T&G ICO FT	Actual	74.4%	80.9%	76.6%	80.6%	81.6%	78.6%	79.2%	83.1%	78.9%	78.4%	78.5%	77.4%	82.6%	
	Plan	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%	76.3%
WWL FT	Actual	73.5%	78.1%	82.3%	77.1%	73.2%	68.8%	68.7%	66.8%	71.5%	67.2%	67.8%	61.3%	66.1%	
	Plan	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%	75.9%
Christie	Actual	73.5%	75.7%	72.3%	68.9%	74.3%	78.1%	77.1%	75.1%	76.5%	85.6%	83.5%	69.0%	81.2%	
	Plan	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%	75.2%
GM Acute Providers	Actual	67.7%	71.7%	73.1%	72.1%	69.5%	70.9%	71.8%	71.5%	71.8%	74.7%	76.4%	72.4%	74.3%	
	Plan	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%	75.3%
GM Registered	Actual	67.8%	71.5%	72.6%	72.2%	69.2%	70.9%	71.8%	71.4%	71.7%	74.7%	76.6%	73.1%	74.0%	
	Plan	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%	75.3%

Access to Children and Young People Mental Health Services

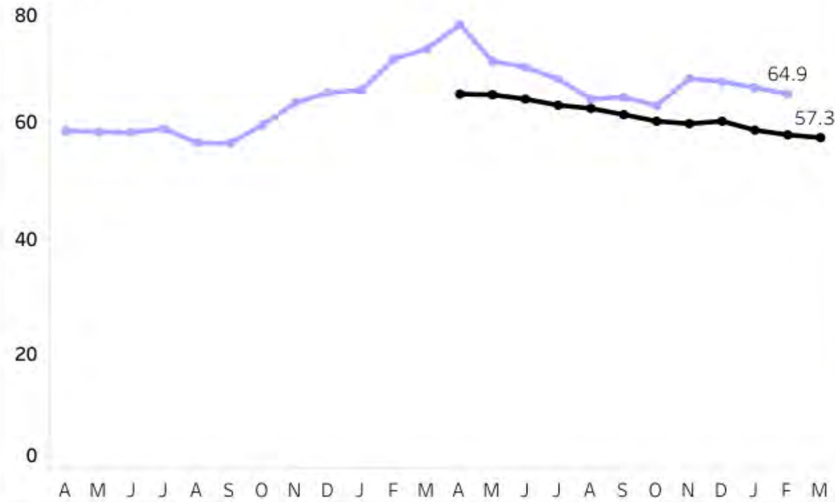
55,770
▲ 0.4% Previous 55,540

1.4% From Plan

		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
GM Registered	Actual	55,405	55,230	55,065	54,910	55,135	54,935	54,640	55,010	55,245	55,335	55,425	55,540	55,770	
	Plan	54,310	54,310	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000

A total of 55,770 children accessed mental health services in the 12 months to January 2025. This is better than end of year plan of 55,000.

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



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 February was 64.9 days against a target of 57.8 days.

GMMH average LOS was 75.4 in February, which was worse than plan and PCFT was 60.1 days against a plan of 54.0 days

		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
GMMH	Actual	80.9	84.1	94.1	85.9	83.9	72.7	68.8	67.1	65.1	69.7	72.6	75.1	75.4	
	Plan	N/A	N/A	67.8	67.5	66.2	66.0	65.1	63.3	62.4	61.7	62.4	61.5	60.2	59.4
PCFT	Actual	67.1	64.4	63.1	64.4	64.7	73.3	70.9	70.5	68.0	70.5	67.9	63.7	60.1	
	Plan	N/A	N/A	60.5	60.5	60.5	58.2	58.2	58.2	56.6	56.6	56.6	54.0	54.0	54.0
GM Providers	Actual	75.1	75.7	80.8	76.8	75.6	72.9	69.7	68.4	66.2	70.0	70.5	69.9	68.3	
	Plan	N/A	N/A	64.9	64.8	64.0	63.0	62.4	61.3	60.2	59.8	60.2	58.7	57.8	57.3
GM Registered	Actual	71.0	72.7	76.9	70.6	69.5	67.5	64.0	64.4	62.9	67.6	67.0	66.0	64.9	
	Plan	N/A	N/A	64.9	64.8	64.0	63.0	62.4	61.3	60.2	59.8	60.2	58.7	57.8	57.3

Appointments in General Practice

2024/25 Performance

GM ICB | Plan |

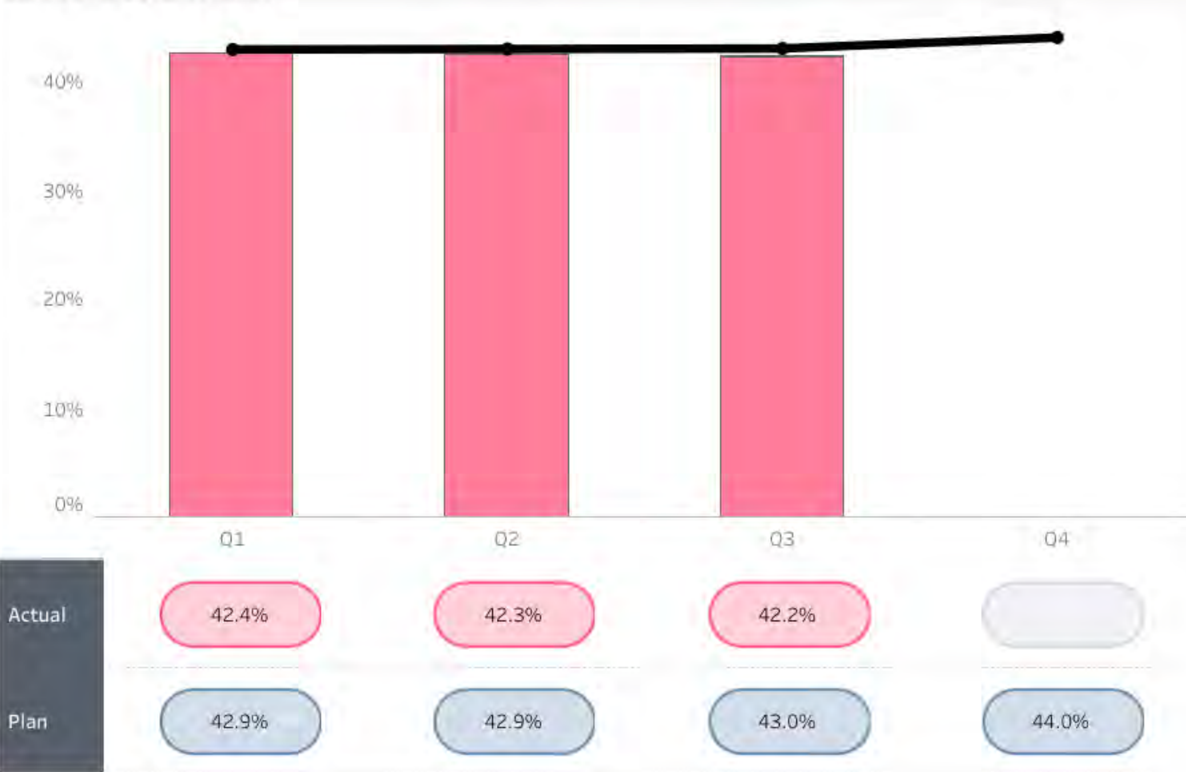
150..
100..
500K
0K

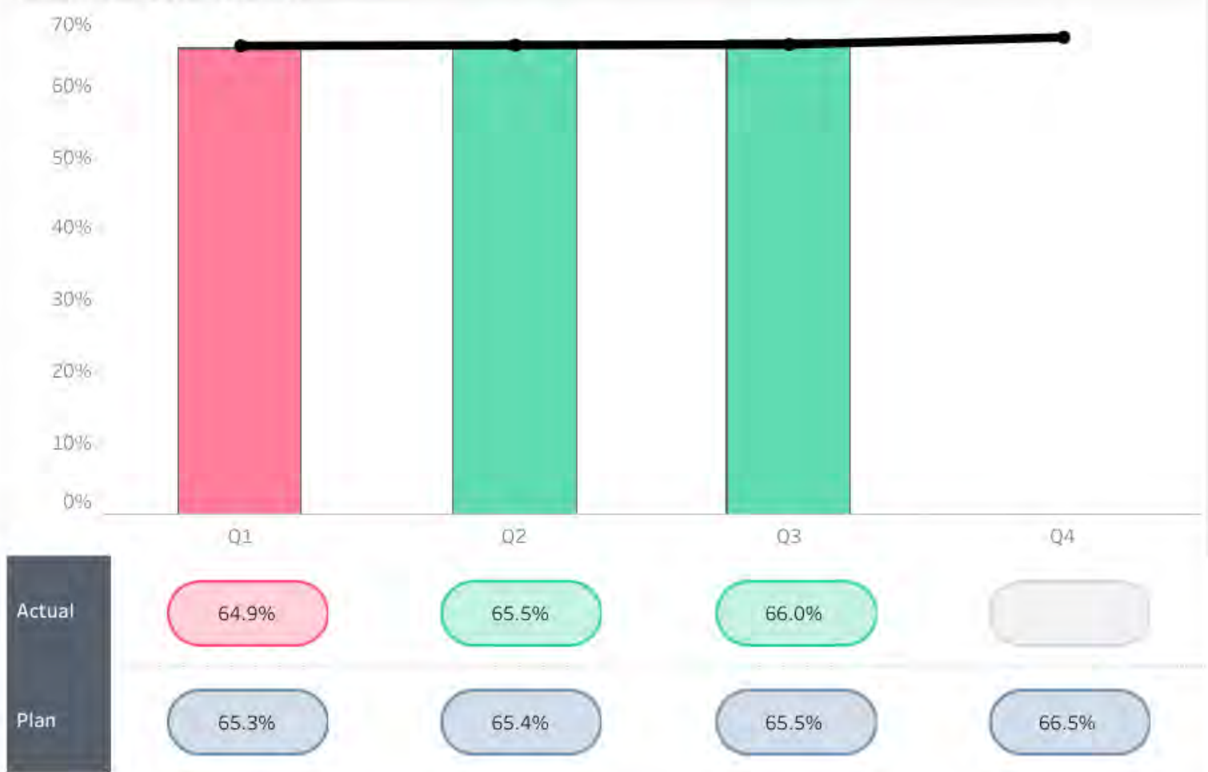
A J A O D F A J A O D F

		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
GM Registered	Actual	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	1,402,265	
	Plan	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	1,449,590

GM ICB has set a target of 1,449,589 GP appointments per month throughout 2025/26. In February 2025, 1,402,265 appointments were delivered.

% of Resident Population Seen by an NHS Dentist



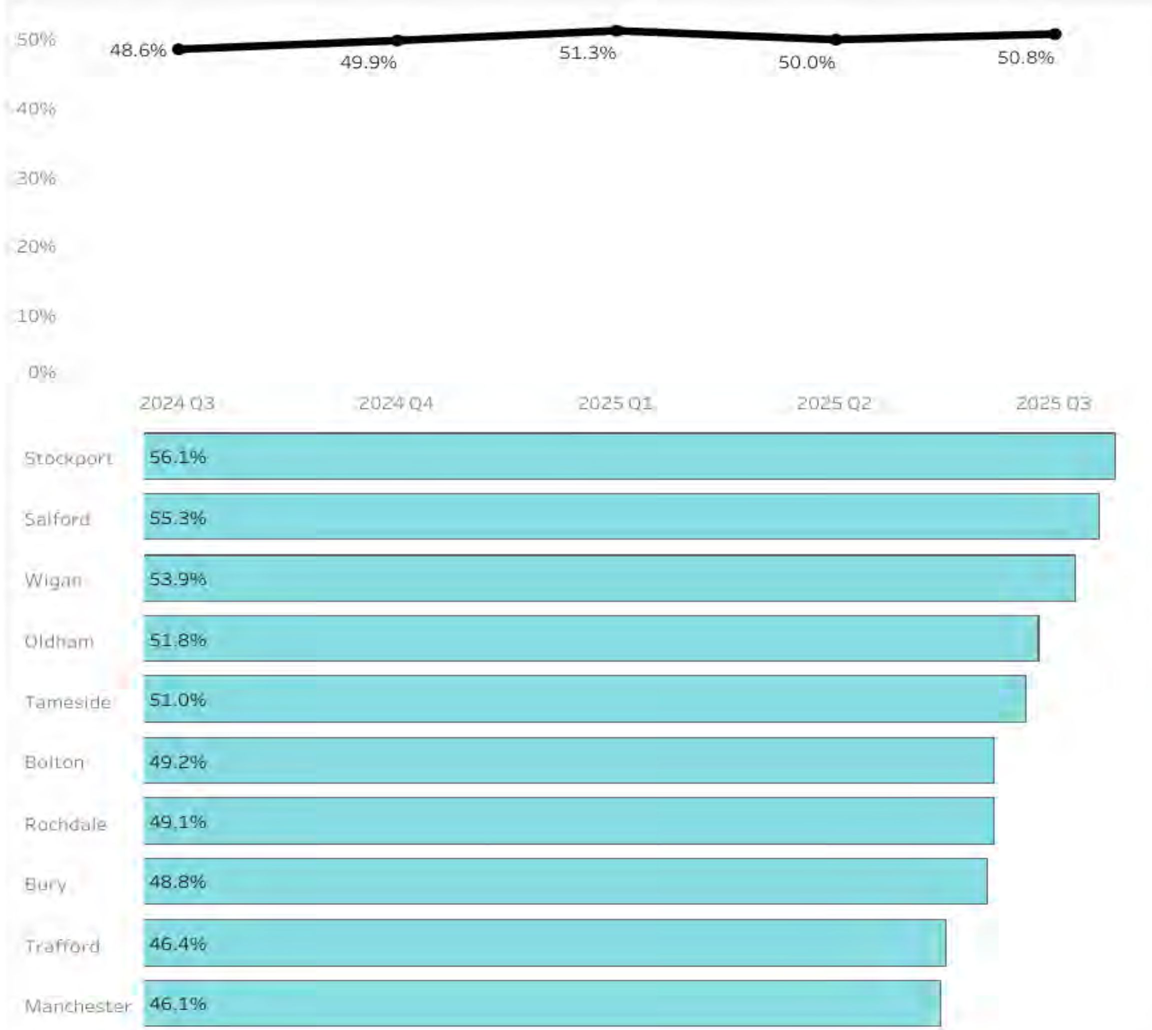


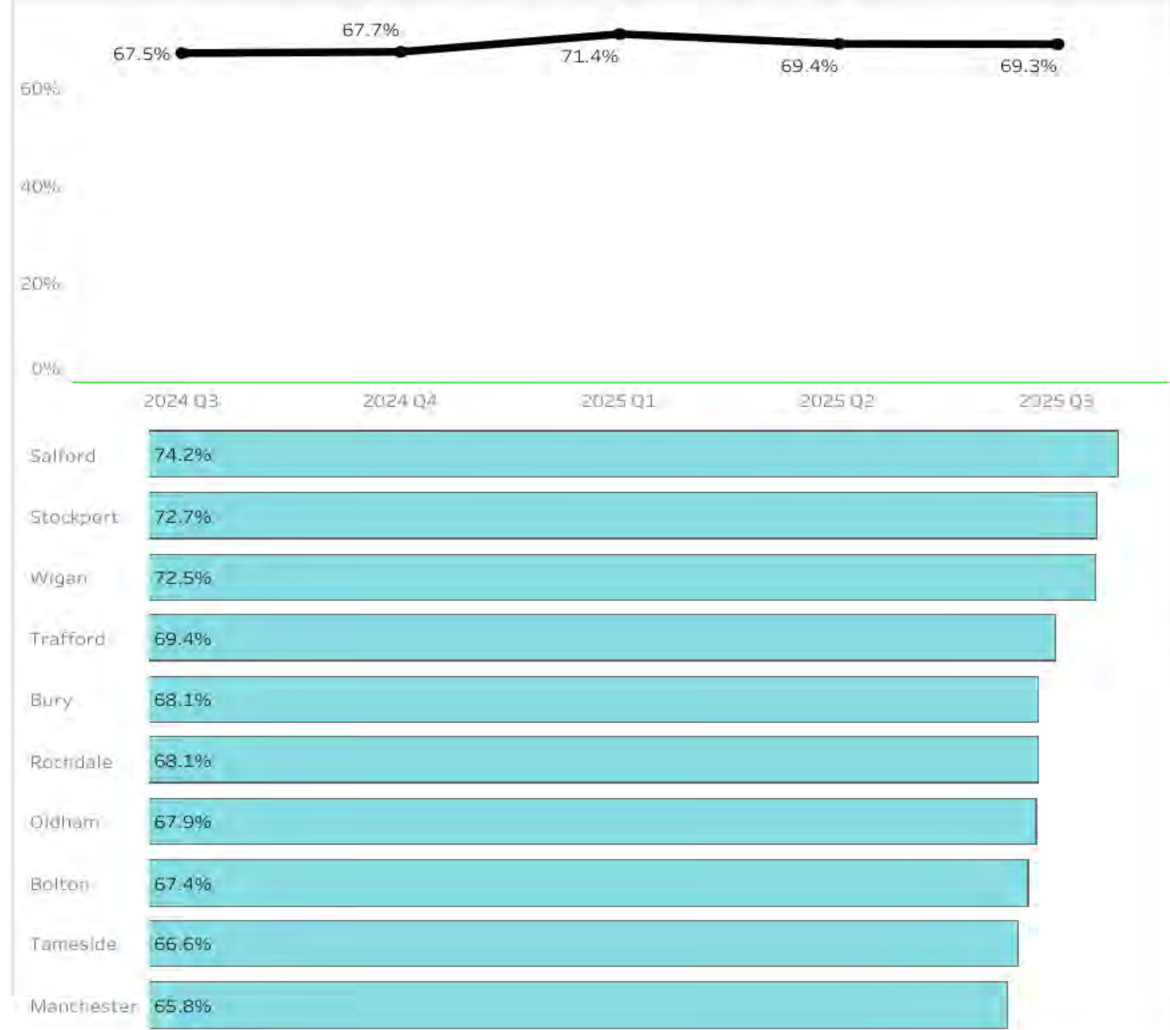
Systems are expected to monitor and improve access to NHS dental services for both children and adults. This includes tracking the percentage of the population seen by an NHS dentist within the recommended timeframes:

- 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





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.

NHS
Greater Manchester

Oldham's Area SEND Monitoring inspection:

Outcome, Improvements, Issues and Risks

2026-2027

Part of Greater Manchester
Integrated Care Partnership

Strategic Commissioning Committee

06 May 2026

Required information.	Details.
Title of report.	Oldham's SEND Monitoring Inspection: Improvements, Issues and Risks
Author.	Steve Larking Director for Children's Health (OMBC / GM ICB (Oldham Place)
Presented by.	Steve Larking Director for Children's Health (OMBC / GM ICB (Oldham Place)
Contact for further information.	Steve Larking Director for Children's Health (OMBC / GM ICB (Oldham Place) s.larking@nhs.net (07957 942531)
Executive summary.	Between 24 November and 26 November 2025, Ofsted and the Care Quality Commission (CQC) revisited Oldham Partnership, to decide whether effective action has been made in relation to each of the areas for priority action detailed in the inspection report published on 26 June 2023. As a result of the findings of the initial inspection HMCI required the local area partnership to prepare and submit a priority action plan (area SEND) to address the two identified areas for priority action. The local area has taken effective action as it has taken reasonable steps to address both of the areas for priority action identified at the initial inspection. The inspection process did, however, highlight a number of system improvements that could be made to support localities during an inspection.

The benefits that the population of Greater Manchester will experience.	Improvements to systems and processes around locality support for SEND inspections will improve delivery and services for children and young people with SEND.
How health inequalities will be reduced in Greater Manchester's communities.	Outcomes for children and young people with SEND
The decision to be made and/or input sought.	The Committee is asked to: 1. Note the improvements made by Oldham SEND partnership and the "effective action" outcome of the Local Area SEND Monitoring visit inspection. 2. Note the recommendations for system improvements to support for locality SEND systems and agree where this work can be further discussed and progressed.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This report supports the work of the committee's responsibilities for SEND assurance and oversight and the forward plan for Children and Young People.
Key milestones.	Local Area SEND Monitoring Inspection Outcome: Effective Action (November 2025)
Leadership and governance arrangements.	Future development and improvement will be overseen by the Oldham Local Inclusion Partnership Executive Board and the Oldham SEND & Inclusion Improvement Programme Board
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A

Financial or Legal Implications	N/A

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

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

Introduction

1.1. Between 24 November and 26 November 2025, Ofsted and the Care Quality Commission (CQC) revisited Oldham Partnership, to decide whether effective action has been made in relation to each of the areas for priority action detailed in the inspection report published on 26 June 2023. The inspection was conducted under section 20 of the Children Act 2004

1.2. As a result of the findings of the initial inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, HMCI required the local area partnership to prepare and submit a priority action plan (area SEND) to address the two identified areas for priority action

1.3. A joint Ofsted/CQC area SEND inspection of the Oldham partnership took place between Monday 26 June 2023 and Friday 30 June 2023. During the inspection, it was recognised that local partnership leaders and parents/carers had co-produced a new and ambitious SEND & Inclusion Strategy, in collaboration with children and young people, education, health, and social care partners. The inspection report stated that the strategy was well thought out and reflective of the then needs within Oldham. Areas for development have been embedded within the SEND & Inclusion Improvement Programme, which underpins the strategy.

1.4. The inspection report also recognised that the local area partnership worked actively with Oldham Parent Carer Forum (PCF), whose members represent the families of children and young people with SEND and that the PCF has strategic influence and is part of the SEND partnership board. This helps to join up services and keep children and young people at the heart of leaders' plans.

1.5. Despite the positive elements identified in the inspection report, other areas were identified as significant concern, particularly in partnership working at the organisational level and in access to health services and provision.

1.6. As a result of the inspection, Ofsted required the local area partnership to prepare and submit a Priority Action Plan (PAP) to address the two identified areas for priority action. Oldham's local area partnership PAP was approved by Ofsted and the Care Quality Commission (CQC) in October 2023.

1.7. Our parent/carer organisation, POINT, remain integral throughout our partnership response. Actions relating to areas for development have been embedded in our existing SEND & Inclusion Improvement Programme, which Ofsted/CQC felt was ambitious.

1.8. Delivery of the PAP has been overseen by the Local Inclusion Partnership Executive Board, which meets monthly to drive partnership accountability, assess progress, monitor risks and impact. The LIP Exec is informed by key partners through the Local Inclusion Partnership Programme Board, which brings together key workstreams.

Priority Action Plan Completion and SEND Improvements in Oldham

1.9. Following the local area inspection in June 2023, in August 2023 the managing director of children and young people for Oldham council and the chief executive of greater Manchester integrated care board received the inspection report, which determined the following outcome: *There are widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently.*

1.10. As a result of the inspection, Ofsted required the local area partnership to prepare and submit a priority action plan (PAP) to address the identified areas for priority action, which consist of:

1.11. **Priority area one**: Leaders at Oldham Metropolitan Borough Council and NHS Greater Manchester Integrated Care Board should cooperate to urgently improve the shared strategic governance, oversight, support, challenge, and planning to deliver effective strategies to meet the needs of children and young people with SEND in Oldham.

1.12. **Priority area two**: Leaders at Oldham Metropolitan Borough Council and NHS Greater Manchester Integrated Care Board, including commissioners and providers, should act urgently to identify and address the delays and gaps in service provision to meet the full range of needs of children and young people with SEND, aged 0 to 25, in Oldham. This includes speech and language provision, neurodevelopmental pathways and community paediatrics.

1.13. In addition to the priority areas of action, the report stated three areas for improvement:

1.14. **Area for improvement one**: Leaders across the partnership should improve transitions between children's and adult services in health, education and social care, and improve their strategy in relation to preparing children and young people with SEND for adulthood from the earliest years.

1.15. **Area for improvement two**: Leaders across the partnership should embed and improve processes for the quality assurance of EHC plans and use this to further improve the quality and timeliness of outcomes and provision in new and existing EHC plans.

1.16. **Area for improvement three**: Leaders across the partnership should improve annual review processes so that the finalised review documentation is completed and returned in a timely manner.

1.17. To address the priority areas and the areas for development, the local area partnership worked to develop the PAP, which was submitted to Ofsted/CQC for approval in October 2023, gaining approval shortly after.

1.18. For the purposes of this paper, details of the whole PAP and actions taken will not be fully comprehensive but will focus on the improvement actions and outcomes and the system issues identified that are of primacy of importance for Greater Manchester ICB to understand and take note of.

1.19. In Oldham, we have established strong, coherent systems across the SEND and Inclusion Partnership that are directly driving measurable improvements. We have shown that we understand what it takes to improve outcomes, and we are maintaining the momentum needed to keep accelerating progress for our children and young people. As the *most improved council* (LGC Awards 2025) and with our Council Leader recognised nationally as *Leader of the Year* (CCLA 2025), Oldham has demonstrated its ability to deliver meaningful, high-impact change. This same ambition and clarity of vision underpins our approach to transforming SEND services.

1.20. The June 2023 Area SEND inspection was the defining turning point for Oldham's local area SEND system. Inspectors identified widespread and systemic failings, including weak joint governance, inconsistent thresholds, significant delays across key health pathways, and variable quality and timeliness of EHCP processes. The outcome was to create a Priority Action Plan and a clear expectation that the partnership urgently rebuild shared oversight, improve consistency and take coordinated action to reduce delays and improve lived experience. This moment reset the system: it created a shared acknowledgement of the scale of challenge and the need for a fundamentally different way of working across education, health and care.

1.21. From late 2023 through 2024, the partnership began a deliberate shift from fragmented activity to a more unified system. New governance and assurance structures were put in place; the SEND & Inclusion Strategy (2023–27) set a clearer vision; the Local Offer was strengthened; and a strong school-facing model emerged through QEST, APST, the SLCN/ELSEC Balanced System, and the creation of the SEND & Inclusion Hub. At the same time, sufficiency planning pivoted towards mainstream-plus, ARPs and satellites, and pathway reforms and commissioning gaps in SaLT, CAMHS, ND and community paediatrics began to tackle the longest waits and access to specialist services. These changes marked a shift from reactive case management to a more preventative, partnership driven, locality-aligned system.

1.22. By 2025, the partnership was consolidating and scaling this improvement. The Ofsted monitoring visit (Nov 2025) acknowledged "effective action" on both priority areas, recognising clearer joint governance, stronger commissioning arrangements and pathway grip and visible progress in reducing delays in access to services. Additional capacity was secured through Year 3 of the North West Change Partnership Programme (CPP), which invested in QA, early identification, annual reviews and amendments, and AP stabilisation. At the same time, the system continued to face rising demand, backlogs in annual reviews, inconsistent post-16/19 pathways and pressures in later-stage transitions. These challenges, alongside stronger outcomes in attendance, exclusions and inclusive practice, have shaped a system that is now more aligned, more accountable and more capable, while still on a journey to full recovery and consistency.

Effective Action Findings and updated Priority Action Plan

1.23. Since the June 2023 Area SEND inspection identified widespread and systemic failings, Oldham has strengthened partnership governance, improved oversight and decision-making of key pathways and expanded the inclusive offer across schools and settings through QEST, ELSEC/SLCN transformation, APST outreach and the SEND & Inclusion Hub. The November 2025 Ofsted monitoring visit recognised “effective action” in both priority areas, noting clearer shared accountability, better system grip and visible progress in reducing delays across SLCN, ND and community paediatrics. EHCP quality is improving, with 72% of audited plans judged good or better, and statutory timeliness remains well above national performance, reflecting greater consistency and earlier intervention.

1.24. Demand, however, continues to rise. Oldham now maintains just over 4,000 EHCPs and continues to have a larger than average EHCP cohort, while SEN Support levels are moving closer to national rates as early identification improves. Decision making remains under pressure, with refusal to assess and issue rates higher than national, requiring strong communication and consistent application of thresholds. Provision is gradually shifting towards local options: a growing proportion of children are supported in maintained or academy mainstream settings, and INMSS use remains low compared with national levels. This shift is important in the context of high INMSS costs and the need for a sustainable local system.

1.25. Annual Reviews and amendments remain the most significant delivery challenge. Backlogs persist, with large numbers of review meetings, reports and decisions overdue, and amendment timeliness remains low. Transition performance is strong at key points, particularly Nursery to Reception and Year 6 to Year 7, though later transitions require continued focus. Workforce capacity is slowly improving. The Educational Psychology service has expanded through new appointments and targeted agency support, although timeliness fluctuates as statutory and preventative demands are balanced. The SLCN/Balanced System has significantly improved access, reduced waits and strengthened support-while-waiting for families. At the same time, system wide inclusion indicators are strong, Secondary attendance is one of the strongest in the country, exclusions and suspensions are falling, and schools report high confidence in QEST, APST and the SEND and Inclusion Hub. Families describe better navigation of SLCN and ND pathways but continue to ask for more proactive updates and support while waiting.

1.26. Sustainability is being reinforced through Oldham’s Year-3 participation in the North West Change Partnership Programme, bringing over £1.1m of investment into workforce capacity, quality assurance, early identification, annual reviews and AP stabilisation. In summary, Oldham is improving the quality and timeliness of statutory processes and strengthening inclusion, while still managing rising demand, backlogs in reviews and amendments, and variation in later stage transitions. Continued investment, workforce consolidation and refreshed sufficiency and post-16 planning remain critical to maintaining momentum and embedding improvement. Oldham’s system is more inclusive in practice, earlier advice, better mainstream support, stronger timeliness and lower reliance on INMSS but inclusion is not yet consistent everywhere, with annual

review/amend timeliness, later transitions, stakeholder communication during waits, and demand management remaining the main drivers of variable experience.

1.27. The focus on early identification, timely EHC assessments, and clear diagnostic pathways has improved support for children and young people with SEND.

Impact of actions taken so far

- With 83% of EHC Needs Assessments completed within 20 weeks and a reduction in diagnostic waiting times, children are receiving the right help more quickly.
- The collaborative work of educational psychologists, schools, and health services ensures that children with SEND are supported holistically, leading to improved learning outcomes and well-being.
- Oldham LA is currently responsible for 3567 EHCP's, an increase of 100% since 2017 and forecasted to rise by 15% year on year up to 2030 at least. However, statutory performance remains significantly higher than national average. Oldham are in the top twelve of the highest performing local areas.
- There has been a significant reduction in wait times within the Community Paediatric Service, from 46 weeks in July 2023 to 20 Weeks in September 2024.
- Was Not Brough rate has reduced from 12% in 2023 to 5% in September 2024.
- There has been an increased awareness of global needs in targeted schools fed into plans for DBV & Improvement programme.
- The EP Service has assessed all current Y6 looked after children and have provided a report for all of them (30) to support transition from mainstream to mainstream (rather than moving from mainstream to special).
- All schools who are having enhanced support re: SEMH in September have been selected and initial planning meetings with EPs have been carried out.
- Advice and information for social workers around SEND has been developed and disseminated including through regular weekly drop-ins and attendance at multi-agency meetings.
- Patient experience surveys (FFT) reporting 98-100% positive experience (September 2024).
- As part of the DBV programme, needs are being identified locally through POINT and SENCo surveys. The team are currently finalising target schools for specific aspects of the work. All DBV work will be monitored through Early intervention and Prevention strand of the SEND Improvement Programme Board.

1.28. Over the last 12 months in Oldham, **we have delivered** the following to ensure children and young people are receiving the right help at the right time:

- The Speech and Language Service produced a waiting list recovery plan and there has also been validation of the mainstream waiting list. All parents/carers have been contacted by Therapists via telephone to discuss any current areas of concern re: SLCN and schools if further information needed. Where no concerns the child has been discharged from the service.

- Waiting well advice has been provided to parents and schools for children who still require S< input and they remain on the waiting list. Opt-in letters have been sent to parents/carers who were not contactable with a 2-week deadline to respond.
- The S< waiting list has been reduced by over 1,000 children and young people who are either currently in receipt of specialist support, have completed the clinical support and now have improved outcomes or are able to manage their needs within the home and school or who were clinically discharged from the service.
- Plans to continue to reduce number of children on S< waiting list and further reduction of waiting times. Further improvement of waiting well offer in co-production with POINT to improve the offer for older children.
- Revised clinical report and care plan templates in consultation with parents/carers and schools.
- Within the CAMHS Service in Oldham, Optimise were commissioned (in 23/24 until Sep 24) by GM ICB to provide Neurodevelopmental assessments for this cohort with an improved access time of 4 months. This was to address a lack of clinical capacity for the 16-18 age range.
- There has been a full refresh of the iTHRIVE Directory of Services.
- The Community Paediatric Service and CAMHS worked together to utilise the Single Point of Entry to support any complex decisions in relation to the most appropriate clinical assessment.
- CAMHS have reported faster access for Neurodevelopmental assessment (16-18 range), improved referral rate (for under 8s) and reduced risk of CAMHS inpatient admission.
- A focused project is underway to refresh and implement a consistent, core evidence-based offer for children and young people with moderate to severe mental health. A task and finish group were tasked with leading this work.
- The update will align the service with current needs and priorities, ensuring that all CYP in GM receive a reliable, comprehensive service, no matter where they access CAMHS.
- Oldham Council has now updated the shared strategic governance, oversight, support, challenge, and planning processes to ensure more effective delivery for children and young people with SEND. In addition to the revised local governance, the following outlines additional structures related to CYP mental health for awareness and alignment.
- The Community Paediatric Service has shown improvement in quality of referrals and triage process (audit results show improved consistency in decision making).
- Was Not Brought rate has reduced from 12% to between 4-6%.
- Waiting times for new patient appointments has also reduced from 46 weeks to 20 weeks.
- A sleep proposal has been developed and is currently going through approval processes.
- A Health Passport has been shared with working group members for young people with complex health care needs.
- The number of new patients on the neuro-developmental waiting list continues to reduce and in early May this was reduced to 216 with a waiting time of 24 weeks. By comparison the waiting time in July 2023 was 46 weeks with 470 new patients waiting. By June 24 there were 207 patients on the new patient waiting list and the wait time was 24 weeks for most new patients. This is in the context of staff sickness, which has impacted on clinical capacity in June. By September 24 there was significant improvement, with waiting times reducing from 46 to 22 weeks.

1.29. Within the Area SEND Monitoring Inspection letter a number of areas of further improvement were highlighted and these have been added to an updated Priority Action Plan. These are primarily around needs led approaches to health services. The updated Priority Action Plan is available here

System findings and recommendations for NHS Greater Manchester

1.30. The inspection itself was managed by the locality team in full partnership with the Local Authority through a Director for Children's Health leadership, Women's and Children's Programme Manager and the Designated Clinical Officer. We also had contributions from the locality Mental Health Manager. It was crucial that the locality had a system leader for health to meet with inspectors and coordinate inspection preparedness and reactive responses during the inspection.

1.31. Inspectors specifically asked for ICB GM governance and oversight processes. The well established support provided by Louise Rule and Emma Storer and the arrangements put in place was a necessary evidence base for the ICB demonstrating oversight and assurance, including the HLR to the GM SEND groups.

1.32. During the inspection GM support was sporadic and limited. Locality leaders, when faced with scrutiny of the ND and CAMHS Transformation work requested specific updates from our GM colleagues. What we received did not assure inspectors and we therefore had to produce our own chronology of activity and escalations in order to demonstrate effective

action. It is widely felt by Oldham SEND leaders that had we not done so, we would not have been assessed as having taken effective action against Priority Action 2. This was a real cause for concern during the inspection process and one we really feel needs system change to avoid for other localities.

1.33. Oldham locality team found it difficult to obtain Oldham analysis for GM Led change programmes in general, but specifically around the CAMHS changes. Inspectors spoke to the Oldham SEND team leaders and cited their difficulty in citing their frustrations of GM Programmes not providing locality level impact data within a local area inspection. They concluded that they couldn't provide this feedback overtly within our report but that they would discuss this within their own organisations (OfSTED / CQC).

1.34. Oldham SEND leaders believe that their needs to be an ability to make proposals for change programmes for approval by GM, either to be led by GM or by locality as a pilot. This new approach would allow those localities requiring a faster pace of change to act as a pilot but with scrutiny from GM as a Strategic Commissioner to provide approvals or amendments to any proposal ensuring it is in line with regional commissioning intentions but allowing for timescales to not be detrimental to inspection preparedness of a locality.

CAMHS, Learning Disability and Neurodevelopmental findings from the Area SEND monitoring inspection

1.35. CAMHS waiting lists remain high, however, inspectors found that *"Improvements have been made to address gaps in services that were identified at the last inspection, including the lack of provision for children and young people aged 16 to 18 who required access to child and adolescent mental health services (CAMHS)."*

1.36. Whilst we demonstrated programmes of work to address long waits inspectors were clear that the pace of change hadn't happened as quickly when led by Greater Manchester as our own locality reforms *"It has taken too long to address the lengthy times that children and young people, particularly aged 8 to 18 wait for initial assessment, intervention and diagnosis of autism and ADHD. Although there is ongoing work to redesign the neurodevelopmental pathways across Greater Manchester ICB, partnership and system leaders need to work closely together to make sure that this happens at pace"*

1.37. During the inspection, the CQC inspector made clear that there was difficulty in assessing actions taken at a locality level against a regional transformation programme. Following the CAMHS focus meeting with practitioners Oldham SEND Inspection team leaders held a debrief. The feedback was concerning and led us to hold a briefing with inspectors to further understand their line of enquiry and to provide some assurances. It emerged that inspectors felt that whilst the CAMHS Specification changes and the ND Transformation programme were positive, the analysis of projections and impact on locality was not understood and we had not been sufficiently supported.

1.38. The locality team therefore produced a chronology of escalations of concern document for inspectors. This demonstrated our own local discussion at programme board and Local Inclusion Partnership Executive Board, as well as locality commissioners engagement in these GM led programmes. We produced letters and meeting evidence

where we had raised our own concerns and identified risks and it was only by doing this that inspectors explained had showed assurance and effective action had been taken. Had we not done so, it was collectively felt that we may not have shown effective action against Priority Action 2

1.39. Oldham Locality and Oldham Council SEND leaders wish to reiterate previous escalations that any Greater Manchester led programme of change must always include impact analysis, including projections of waiting list reductions, for each of the 10 places. There must always be a locality report produced at the earliest opportunity, even if it is iterative and revised, on impact analysis,

1.40. The process of providing assurances around CAMHS, ND and LDA waiting lists and systems highlighted a need for greater integration around these services. There are a large number of co-dependent programmes and partners [MHST, MHiE, CAMHS, ND Hubs, VSE] that in reality are disparate and disjointed. Oldham locality firmly believes that there needs to be a programme across Greater Manchester to bring Social, Emotional and Mental Health partner organisations and services into a single strategic team in each locality with the corresponding neighbourhood MDT delivery.

1.41. Having to pull the waiting list and waiting time information together it became clear that a single coherent function would have served strategic planning and oversight much better. It would also allow for changes to pathways, away from a Top down referral process (into CAMHS and back out) and more a Single Point of Access MDT Triage where a needs led approach is created, supported by Mental Health Navigators to support parent/carers and referrers [Schools & Primary Care] through the wide range of available services and support.

1.42. We believe that the large number of Did Not Attend numbers at VCSE led mental health services is primarily due to parental disengagement following a CAMHS referral rejection. We have feedback from our Parent Carer Forum that supports this view. Parent / Carers feel, following a CAMHS rejection, that the other services are somehow inferior and we believe that a change to a SPoA for all SEMH services would greatly lessen this false perception.

1.43. The approach identified above would be a seismic shit and bring all mental health services into line with the new ND Hub and ND MDT processes and aims. The ND Transformation and new ND Hub in Oldham has been widely accepted as a positive change by our Parent Carers at a recent listening event led by POINT and supported by ICB Locality commissioners. We believe that a similar change and approach for mental health would be equally welcomed and would demonstrate further needs led improvements.

Learning Disability Assessments, Dynamic Support Register (DSR) and Care, Education and Treatment Review (CETR)

1.44. Inspectors found that "*There is a lack in strategic and operational clarity around diagnosing children and young people with a learning disability. This is a concern because having a diagnosis enables access to important services, such as the dynamic support register and annual health checks".* Inspectors also insisted on the partnership providing

Diagnostic Wait times for Learning Disabilities. Whilst we challenged them on their focus on diagnosis and pushed back on whether this was a meaningful metric for performance, we did accept that there remains a lack of clarity around the management of LDAs and also a consistent approach to DSR and CETR.

1.45. A consistent steer from GM around the DSR and CETR in localities is a much need requirement for future inspections.

Recommendations

1.46. The NHS GM Committee is asked to:

1.46.1.1. Note the outcome of Oldham's Local Area SEND Monitoring Inspection Outcome, and to understand and note the improvement work on waiting lists and waiting times most notably for Speech and Language Therapy and Community Paediatrics.

1.46.1.2. To agree where further discussion and development of the request for additional support from Greater Manchester for localities when undertaking regional change programmes, notably by providing each locality with an impact analysis report as well as agreeing a GM SEND system of support and oversight can be progressed.

1.46.1.3. To agree where further discussion and development of the request for a CYP MH change programme to ensure alignment of the wide ranging Mental Health and Wellbeing services can be undertaken, to include a consistent approach to LDA, DSR and CETR.

1.46.1.4. To understand the discrepancies in timescales for change programmes led by GM and the needs of localities needs to be resolved and agree where this can be considered and discussed.

NHS
Greater Manchester

Mental Health Productivity: Inpatient Reduction, Flow and Commissioning Decisions

May 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

6th May 2026

Required information	**Details**
Title of report	**Mental Health Productivity: Inpatient Reduction, Flow and Commissioning Decisions**
Author	Mel Maguinness, Programme Director Commissioning Development Sandeep Ranote, Clinical Director Mental Health
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
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Executive summary	This report brings together planned activity and emerging evidence across mental health, learning disability and autism (MHLDA) services in Greater Manchester to support strategic oversight and commissioning decisions for 2026/27. It summarises system priorities for the coming year, progress and learning from the Mental Health Inpatient Quality Transformation Programme, and the commissioning-led approach to inpatient bed reduction and improved flow through Clinically Ready for Discharge (CRFD) modelling. Collectively, the work demonstrates how Greater Manchester is moving from transformation and improvement programmes to firm commissioning decisions that lock in quality, safety, value for money and reduced reliance on inpatient and independent sector provision. The report provides assurance that plans for 2026/27 are clinically-led, evidence-based and aligned to both national policy and GM strategic ambitions.
The benefits that the population of Greater Manchester will experience.	Our statutory Quality and Clinical Governance functions ensure that people across Greater Manchester experience safe, effective, and continuously improving services. Through targeted quality improvement, strengthened oversight, and refreshed governance pathways, we are better able to identify risks earlier, intervene more consistently, and reduce unwarranted variation. This directly improves care experience, outcomes, and population health. The population of Greater Manchester will benefit from: • Improved access to high-quality, therapeutic and least-restrictive inpatient care when admission is required. • Reduced use of out-of- area and independent sector placements, enabling individuals to receive care closer to home. • Shorter lengths of stay and improved flow through inpatient services, reducing disruption to people's lives and supporting recovery. • Increased investment in community-based, crisis and rehabilitation alternatives that support people earlier and closer to home.

How health inequalities will be reduced in Greater Manchester's communities.	This programme supports the reduction of health inequalities by: • Rebalancing investment away from inpatient care towards prevention, neighbourhood and community mental health services that disproportionately benefit groups experiencing poorer outcomes. • Strengthening consistent standards of care across GM, reducing unwarranted variation between localities and providers. • Embedding culture of care, reasonable adjustments and autism- and trauma-informed approaches into inpatient services. • Improving flow and discharge, including for people with complex needs who are at higher risk of prolonged inpatient stays and institutionalisation.
The decision to be made and/or input sought	The Strategic Commissioning Committee is asked to: • Note the planned commissioning priorities for 2026/27 across MHLDA services. • Note the progress and learning from the Mental Health Inpatient Quality Transformation Programme. • Endorse the commissioning intent and approach to inpatient bed reduction and CRFD improvement, including the planned exit from block contracted independent sector acute beds by March 2027
How this supports the delivery of the strategy and mitigates the BAF risks	The proposals directly support delivery of the GM Mental Health and Wellbeing Strategy and wider GM Strategy by: • Driving left-shift, prevention and neighbourhood-based care. • Improving quality, safety and patient experience within inpatient services. • Strengthening system grip on demand, capacity, flow and financial sustainability. The work mitigates Board Assurance Framework risks related to quality, access, financial sustainability and reliance on independent sector provision through clearer commissioning intent, stronger oversight and evidence-based decision making.
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	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.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/**	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

approval by groups/ committees.	
Financial or Legal Implications	The programme is designed to improve value for money by reducing reliance on costly inpatient and independent sector provision and reinvesting resources into community-based alternatives. Financial implications are managed through aligned commissioning intentions, contracts and the Mental Health Integrated Fund. No new legal risks are identified beyond those managed through existing NHS commissioning, contracting and quality assurance frameworks.

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

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

Purpose of this Paper

This report brings together planned activity and emerging evidence across mental health, learning disability and autism (MHLDA) services in Greater Manchester to support strategic oversight and commissioning decisions for 2026/27. It summarises system priorities for the coming year, progress and learning from the Mental Health Inpatient Quality Transformation Programme, and the commissioning-led approach to inpatient bed reduction and improved flow through Clinically Ready for Discharge (CRFD) modelling.

Collectively, the work demonstrates how Greater Manchester is delivering transformation and improvement through strategic commissioning, collaborative working and locking in quality, safety, value for money and reduced reliance on inpatient and independent sector provision. The report provides assurance that plans for 2026/27 are clinically-led, evidence-based and aligned to both national policy and GM strategic ambitions.

Overview

NHS GM has a system wide transformational strategic plan for redesigning Mental Health, Learning Disability and Autism MH LDA) services. This directly links to the Strategic Commissioning Plan, GM Mental Health and Wellbeing Strategy and national standards and is focused on improving quality of care, productivity and outcomes. 2026/27 represents a deliberate pivot from time-limited transformation programmes to embedded, system-wide commissioning decisions

The agreed system priorities for MH LDA have been clearly articulated in the commissioning intentions, with aligned financial plans, contracts (with outcome-based service specifications), supported by robust governance and a Mental Health Integrated Fund.
Specific focus of the plan in 2025/26 and into 2026/27 are

- Reducing the reliance on inpatient care by focusing on the left shift to community-based care, reducing delays in discharge from inpatient beds, length of stay and avoiding admission wherever possible
- Improving the quality of care people receive in inpatient settings, ensuring a therapeutic approach and needs-led care through delivery of the priorities of the GM Mental Health Inpatient Quality Transformation programme

Aligned Planning

Greater Manchester

- The focus for the year ahead for MHLDA strategic commissioning and system transformation is on embedding previous improvements, locking in left-shift, and ensuring that quality, safety and financial sustainability are delivered. Planning is explicitly aligned to the GM Mental Health and Wellbeing Strategy, the GM operating model and national priorities, particularly the reduction in reliance on inpatient beds (notably in the independent sector).
- Commissioning intentions for 2026/27 have been agreed at system level, with financial allocations aligned to priority programmes and reflected through provider contracts. Delivery of these priorities will be overseen through streamlined GM governance including Provider Contract and Oversight Meetings.
- To support this, a GM-wide MHLDA Performance and Outcomes Framework has been developed, providing a consistent line of sight between strategic ambition, commissioning intent and measurable improvement. The framework aligns to the GM Mental Health and Wellbeing Strategy and wider GM and NHS priorities, including prevention, neighbourhood models and Live Well approaches. Performance will be monitored through a shared dashboard, with quarterly reporting used to provide system-level assurance and inform any required escalation.
- Across 2026/27 the primary programme focus is on completing and embedding inpatient quality transformation, strengthening community and prevention pathways across adult and children and young people's services, expanding crisis and alternatives to admission, progressing rehabilitation and complex needs pathways, and continuing improvement across learning disability and autism services. A full overview of the programmes is attached as an Appendix.

Strategic Approach to Reducing Mental Health Bed Use

Greater Manchester

- Reducing reliance on inpatient care, and in particular block-contracted independent sector beds, is a core strategic commissioning priority for Greater Manchester. System learning from recent years shows that block-contracted beds are associated with poorer flow, longer lengths of stay and higher cost.
- For 2026/27, the system has a clear commissioning intention to end all block-contracted independent sector acute mental health beds by March 2027. Where independent sector provision is required in future, this will be on a time-limited, spot-purchase basis, used only where clinically necessary and subject to explicit commissioning controls and regular review.
- A clinically-led and commissioning-led modelling approach has been used to inform the 2026/27 bed trajectory. This modelling demonstrates the relationship between admissions, length of stay and discharge, and quantifies the impact that improved performance on Clinically Ready for Discharge can have on bed demand. Delivery of the agreed trajectory is dependent on sustained reductions in length of stay, continued improvement in discharge pathways including housing and social care interfaces, and the availability of community, crisis and rehabilitation alternatives.
- Clear Clinically Ready for Discharge (CRfD) reduction targets have been set at locality level. Performance against these targets will be monitored through existing dashboards and governance arrangements, with escalation where required. The CRFD framework is positioned as a shared system accountability tool, rather than a provider-only performance measure, and is integral to both quality improvement and financial sustainability.

Mental Health Inpatient Quality Transformation Programme

NHS Greater Manchester

What is our aim?

To improve the Quality and Safety of care people experience in Mental Health, Learning Disability and Autism inpatient settings by introducing a new bold, radical, reimagined model of care for the future.

To do this we need to:

Explore and accelerate different therapeutic offers, including community-based alternatives to admission and a culture within inpatient care that is safe, personalised and enables patients and staff to flourish.

Have a clear oversight and support structure that is sustainable and transparent, where issues are identified early. Services that are challenged will have timely, effective, and coordinated recovery support.

What are the themes?

- Localising and realigning inpatient services, harnessing the potential of people and communities
- Improving the culture of care and supporting staff
- Supporting systems and providers facing immediate challenges
- Making oversight and support arrangements fit for the sector

Headlines for Greater Manchester

'Know your people'

- ICB has a dashboard with all acute OAPs, including with demographic information/health inequality data to inform strategic developments.
- Gaddum has been commissioned to ensure plans are co-produced and the voices of people who access GM MHLDA services (and their loved ones) are heard and acted upon.
- MH rehabilitation baseline completed and centralized list and actions, held and reviewed every month by commissioning lead for rehab in GM.

'Bring them home'

- There has been a significant reduction in MH acute inappropriate out of area placements, despite increasing pressure from people being CRFD.
- There has been a reduction of people with LD being in MH inpatient care in GM.
- Dedicated teams to support people back into area and out of hospital have been resourced and there is a robust infrastructure in GM to address any barriers to discharge and manage escalations.
- Recovery in Community (RIC)- a VCFSE offer was commissioned in Manchester to support people out of hospital, including OOA, which has had positive impacts and realized efficiencies.
- Capital was secured to develop step down rehabilitation flats that will not only support a reduction in inpatient beds, but a least restrictive option for people with rehabilitation needs to step out of hospital.

'Keep them close'

- Extensive work to implement the 10 high impact initiatives and maximise flow is ongoing to maximise local inpatient capacity for those who require it and there has been investment in safer staffing across GMMH and PCFT including enhanced workforce modelling, and large-scale recruitment to improve safety, quality and the therapeutic offer, in order to support people to recover more quickly.
- Complex needs programme has already supported people with LDA out of hospital, and is commencing work with people with MH needs and a strategic housing plan is in development.
- Positive relationships with VCFSE and wider system partners from living well models of care are being strengthen to enhance the community offer and further developments.
- Demand and capacity modelling is being used to inform the local bed base (and enhanced community services) required to better meet the needs of the GM population.
- Integrated Fund has shifted investment from inpatient spot-purchased placements into strengthened community services, including Crisis Resolution and Home Treatment Teams (CRHTT) and VCSE crisis spaces, alongside CMHT improvements, reducing reliance on OAPs and supporting more local care.
- Capital bids have been submitted to develop 24/7 MH Neighbourhood Hubs.

MH LDA Inpatient Quality Transformation

Greater Manchester

Delivery of the second year of the Mental Health Inpatient Quality Transformation Programme has strengthened consistency and scale across adult mental health, rehabilitation, learning disability and autism inpatient care (all age). The programme has supported more system-wide ways of working and benefited from participation in North West improvement collaboratives, enabling shared learning and the adoption of more consistent standards, particularly in relation to length of stay, flow and quality of care.

Over the past 12 months there has been a clear improvement in system grip on inpatient care, supported by more robust admission and discharge processes, stronger clinical gatekeeping and a sustained focus on reducing both length of stay and delays for people who are clinically ready for discharge. This has contributed to a measurable reduction in inappropriate out of area placements and reliance on spot-purchased beds. Alongside this, targeted investment has supported safer staffing, workforce stabilisation and the delivery of more therapeutic models of care.

Progress has also been made in embedding Culture of Care and the use of I and We Statements, ensuring that lived experience, least-restrictive practice and delivery of therapeutic care are central to inpatient services. Oversight of rehabilitation services has continued to strengthen through clearer definitions, developing service specifications and improved visibility of individuals placed in spot-purchased provision.

The third and final year of the programme, delivered in 2026/27 is focused on embedding improvements into routine commissioning, contracting and governance arrangements, finalising and implementing GM-wide inpatient service specifications and sustaining gains in length of stay, flow and patient experience. Particular emphasis will be placed on commissioner oversight of independent sector use during the transition period and on ensuring that culture of care, reasonable adjustments and autism- and trauma-informed practice are fully embedded across inpatient services. This marks the transition of inpatient quality transformation from programme-based improvement into routine commissioning, contracting and assurance arrangements.

Recommendations

The Strategic Commissioning Committee is asked to:

- Note the planned commissioning priorities for 2026/27 across MHLDA services
- Note the progress and learning from the Mental Health Inpatient Quality Transformation Programme
- Endorse the commissioning intent and approach to inpatient bed reduction and CRFD improvement, including the planned exit from block-contracted independent sector acute beds by March 2027

Appendix: Key Programmes 2026/27

Programme area	Programme	What this will deliver
Inpatient Quality Transformation	Safer Staffing	Provision of safely staffed services providing quality and therapeutic support (phase 2)
CYP MH Community and prevention	Expansion of Mental Health Support Teams in line with national ambitions to achieve 77% coverage by end March 2027.	VCFSE Transition – End of GM Blended Model and safe transition of VCFSE settings to NHS CAMHS Providers by March 2027 Expand MHST teams annually to 100% settings by December 2029- includes expansion by 8 teams across 2 NHS providers by January 2027 Recovery & Performance Improvement- Improve performance, including access, impact and outcomes reporting and compliance to reporting
	Expansion of Perinatal Mental Health Services in line with Long Term Plan Commitments	To address safety and quality issues and increase access. Critical due to quality/ safety issues and recent maternal deaths. Mobilisation in progress. See increase in access by expanding provision as part of the business case expansion
	Parent Infant Mental Health	Review and redesign of consistent and equitable pan GM offer as part of the GM perinatal ad Parent Infant Programme- aligned with the Perinatal expansion
	Core CAMHS inc. Full implementation of the CAMHs service specification (including the neurodiversity triage and assessment)	Trusts to develop business cases for delivery of the Core CAMHS service specification informed by audits of current provision by June 2026. Mobilisation from September 2026. Expansion aligned to the core specification will support earlier identification, reduce unwarranted variation across Greater Manchester, increase access, reduce waiting times, support national access targets, and improve consistency and quality of outcomes Implementing the neurodiversity triage and assessment, will reduce CAMHS waiting lists by addressing system pressures associated with neurodevelopmental diagnostic pathways. The introduction of clear triage and assessment criteria from April 26 will ensure support is needs-led, with the right clinical intervention provided at the right time, prioritising those with the greatest level of need.

Key Programmes 2026/27 continued

Programme area	Programme	What this will deliver
CYP MH Community and prevention	Full implementation of the Cared for Children and Young People CAMHs service at PCFT.	Consistent, dedicated mental health support for looked-after children across the footprint, embedded as business as usual and as a core part of the GM CAMHS offer by September 2026.
	Digital Early support in primary schools supporting and promoting good emotional health and wellbeing	Delivery of new models of care, the “left shift” and neighbourhood models of care/Live Well / Digital offer. This will also support increasing reach of MHST enabling us to reach national targets.
	Children and Young People’s neurodiversity new model of care	Full implementation of the MDT triage and assessment for Autism and ADHD for CYP who meet the new clinical criteria
	Children’s community eating disorders to address gaps in ARFID provision	Sharp rise in need locally and there have been child deaths in GM. Critical due to Quality/ Safety Issues. Significant variation in provision across localities
CYP MH Crisis	Phased implementation of the mental health offer into the Skyline Homes	SIROC model to be procured for start date of April 2026. Will Deliver financial savings by reducing inpatient care

Key Programmes 2026/27 continued

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Programme area	Programme	What this will deliver
Adult MH Community and prevention	Adult ADHD/Autism services	Procurement of new central triage system and delivery of Adult ADHD and Autism assessments for those who meet the new clinical criteria
	Increased capacity in Talking Therapies services to meet national access and recovery targets	Expansion of Talking Therapies will increase access and recovery for people with common mental health disorders, aligned to national targets, while complementing wider system pathways for people with severe mental illness.
	Individual Placement Support (IPS)	Expansion of IPS will increase access to employment for people with mental health needs, supporting recovery and independence, with additional investment accelerating delivery at scale across GM.
	Shared Care	Delivery of a GM Shared Care pathway test of change will strengthen Primary and Secondary Care interfaces, improve medication management and support timely step down from specialist services.
	Complex Emotional and Relational Needs pathway implementation	Phase 2 implementation across the GMMH footprint will strengthen workforce capability, embed consistent clinical approaches and improve care for people with complex emotional and relational needs, reducing escalation and improving outcomes.
	Review of Rehabilitation services, with strengthening of community-based services	Rebalancing rehabilitation provision through investment in community services will reduce inpatient bed use, support discharge and enable more people to receive care closer to home.
	Neighbourhood delivery models	Expansion and transformation of the Thrive offer addressing unwarranted variation, developing a core offer across GM Embedding neighbourhood-based mental health models will strengthen prevention, early intervention and integrated working across Primary Care, VCFSE and local authority partners, reducing demand on specialist services.

Key Programmes 2026/27 continued

Greater Manchester

Programme area	Programme	What this will deliver
Adult MH Community and prevention	GM Inpatient Transformation and Bed Reduction	Final year delivery of the GM MHLDA Inpatient Quality Transformation programme will focus on reducing Independent Sector reliance and sustaining the out of area position, improving length of stay and flow through strengthened discharge and community pathways, and optimising bed capacity in line with GM demand and capacity modelling. This will be underpinned by the development of a GM-wide inpatient service specification to set consistent standards, expectations and system accountability.
Crisis MH Adults	Adults Mental Health Crisis Services	Investment to ensure core fidelity across all Crisis Response and Home Treatment Teams (CRHTs) delivered by PCFT.
	Adults Community Mental Health Teams (CMHTs)	Delivery of a GM-wide CMHT service specification will reduce unwarranted variation, clarify core functions and accountability, and strengthen interfaces with Primary Care, VCSE and local authority partners. This includes consolidation of Early Intervention standards and the development of a consistent GM Assertive Outreach model to support people with the highest complexity and reduce reliance on inpatient care.
	Alternatives to Inpatient Admission including Gatekeeping and IDTs	Strengthening gatekeeping, Integrated Discharge Teams and community alternatives will reduce avoidable admissions, improve flow and ensure people are supported in the least restrictive setting, with consistent GM-wide approaches to admission decision-making and discharge.
	Health Based Place of Safety	Improves timeliness, safety and quality of Section 136 pathways through enhanced capacity, consistent standards, and reduced police to health handover delays.
	Digital Transformation including CPA replacement	Implementation of digital care planning tools, including DIALOG+, will modernise CPA replacement, improve clinical oversight and enable more person centred, outcomes focused community mental health care, supported by a GM-wide sustainability plan.
	Mental Health Liaison Services	Delivers timely mental health assessment within acute hospitals to reduce Emergency Department waits, support appropriate admission and discharge, and improve patient flow.

Key Programmes 2026/27 continued

Programme area	Programme	What this will deliver
Crisis MH Adults	Mental Health A&E, Urgent Care Centres	Strengthens mental health provision within Emergency Departments and Urgent Care Centres to reduce waiting times, improve assessment quality, and support diversion to appropriate community pathways.
	Implementing NHS 111 and text service	Delivers a 24/7 single point of access to mental health crisis support via NHS 111 (Option 2) and text-based support, enabling timely triage, clinical response, and reducing demand on emergency services.

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Frailty Update
May 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

6th May 2026

Required information	**Details**
Title of report	Frailty Update
Author	Dr Leigh Wilson, Frailty clinical lead
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	leigh.wilson@nhs.net
Executive summary	As with all regions, frailty is a significant and growing system-level issue across Greater Manchester, with a direct impact on urgent and emergency care performance, flow, and the experience of older people. People living with frailty are disproportionately affected by delays in assessment, admission and discharge, and are therefore at greater risk of long emergency department waits, extended trolley waits, deconditioning and avoidable harm during periods of operational pressure. This paper provides an integrated update for the committee, drawing together learning from Long Term Conditions (LTC) and Urgent and Emergency Care (UEC) work. It summarises the impact of frailty on our population, what the system is currently experiencing, what our GM frailty stocktake tells us, and the overall direction of travel. The paper is intended to provide assurance on understanding, grip and alignment rather than detailed service or pathway design.
The benefits that the population of Greater Manchester will experience.	Strengthening the system response to frailty will support earlier identification, more proactive care and improved alternatives to hospital admission. For residents of Greater Manchester, this will mean improved access to care closer to home, reduced exposure to long waits and inappropriate care environments, safer transitions across pathways and better overall experience, particularly for older people and those living with multiple long-term conditions.
How health inequalities will be reduced in Greater Manchester's communities.	Frailty is more prevalent in communities experiencing higher levels of deprivation, multimorbidity and social isolation. A system-wide approach that standardises frailty identification and response, strengthens neighbourhood and community-based provision, and improves consistency of access to services will reduce unwarranted variation between places. This supports more equitable outcomes by ensuring people with the greatest need are identified earlier and supported appropriately, regardless of where they live.

The decision to be made and/or input sought	The Strategic Commissioning Committee is asked to note the scale and importance of frailty as a system issue; the link between frailty, older people's experience, long waits and system performance; the baseline findings from the GM stocktake; and the direction of travel including alignment with neighbourhood health models and forthcoming national service expectations.
How this supports the delivery of the strategy and mitigates the BAF risks	This work supports delivery of the GM Clinical Strategy and associated UEC and LTC priorities, including Home First, admission avoidance, improved flow and neighbourhood-based models of care. Strengthening the frailty response contributes to mitigation of Board Assurance Framework risks relating to urgent care performance, patient safety, health inequalities and system resilience by reducing avoidable harm and pressure associated with frail cohorts.
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	System leadership and oversight for frailty are provided through the GM Frailty and Healthy Ageing Oversight Group, with links to both the Long-Term Conditions and Secondary Prevention Oversight Group and the GM Urgent and Emergency Care Development Group. Delivery is supported through locality governance arrangements and place-based teams, ensuring alignment between system priorities and local implementation.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement to date has included clinical, operational and programme leadership across primary care, community services, acute providers, adult social care and the voluntary and community sector. Improvement activity has been supported through UEC Learning Improvement Network work with AQuA and regional partners. Equality considerations are embedded through the focus on frailty, prevention and neighbourhood-based approaches. Ongoing assurance is provided through existing system oversight and committee structures.
Financial or Legal Implications;	At this stage, the paper does not seek approval for new investment or changes with direct legal implications. Activity is being progressed within existing programmes and resources, supported by aligned improvement funding where available. Any future proposals with financial or legal implications will be brought forward through appropriate governance routes.

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

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

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What is frailty and how does it affect our population?

- Frailty is a loss of resilience, or the ability to 'bounce back' from health shocks such as a fall, acute illness, new medication, or a change in care environment. It affects one in ten adults over 65 in the community and over half of adults in hospitals and care homes. [1]
- Frailty is not an inevitable part of ageing and, in some cases, can be prevented, stabilised or reversed. [1]
- Increasing frailty leads to increasing dependence on others for activities of daily living. It is life-limiting and associated with increased risk of death. People living with frailty are at higher risk of falls, immobility, delirium, incontinence, and medication-related harm. Increasing frailty is closely associated with emergency admissions and longer lengths of stay in hospital.[1]
- Variation in frailty identification, assessment and proactive support means opportunities can be missed to intervene early, maintain independence and prevent deterioration.
- People living with frailty are less resilient to delays and disruption within the health system and are therefore disproportionately affected during periods of high operational pressure.

1. Hendry, A. (2023). *Joining the Dots: A blueprint for preventing and managing frailty in older people.* [Online]. British Geriatrics Society. Available at: https://www.bgs.org.uk/Blueprint [Accessed 22 April 2026].

Frailty and front-door pressure: How they are linked?

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- Older people living with frailty are the highest users of health and social care services in the NHS, with the highest levels of emergency hospital admissions.[1]
- In England, more than half of those over 75 wait over 12 hours in either the emergency department or a temporary escalation area.[2] This has a detrimental effect on both patient experience and clinical outcomes, as frail older adults are at higher risk of pressure damage, delirium and deconditioning.[3]
- The GM system has thus far prioritised front-door frailty models because national standards (such as The Model Acute Pathway) and best practice emphasise rapid frailty assessment and same-day discharge wherever possible.
- **However, whilst this work is essential to improve acute care, we know we cannot solve frailty at the front door of the hospital; a whole-system, neighbourhood-based approach is required to deliver a truly proactive model of care.**

1. Prof. Chris Whitty. (10 November 2023). *Chief Medical Officer's annual report 2023: health in an ageing society*. [Online]. Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society [Accessed 5 September 2024].
2. GIRFT. (September 2025). *Co-ordinated frailty care for better outcomes*. [Online]. NHSE/GIRFT. Available at: https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/07/Coordinated-frailty-care-for-better-outcomes-V3.4-September-2025.pdf [Accessed 22 April 2026]
3. Hendry, A. (2023). *Joining the Dots: A blueprint for preventing and managing frailty in older people*. [Online]. British Geriatrics Society. Available at: https://www.bgs.org.uk/Blueprint [Accessed 22 April 2026].

Current system position on frailty

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Governance and leadership

- At system level, we have established the NHS GM Frailty and Healthy Ageing Oversight Group. This group will inform strategic leadership and coordination for frailty initiatives whilst ensuring alignment with urgent care and LTC priorities through reporting links into both LTC oversight and UEC development structures.
- At locality level, most places have established frailty oversight arrangements, although there is variation in whether formal strategies are in place and the maturity of terms of reference and meeting cadence.

GM frailty stocktake (December 2025)

- Our recent frailty stocktake indicates that all GM acute sites have a front-door frailty offer (including frailty clinician in-reach to ED, frailty SDEC and short-stay frailty zones), and that acute frailty services are in place across the system. However, the stocktake also highlights variation in SDEC operating days and hours, with some services not operating on weekends, and some providers do not have the full suite of services operating across every acute site.
- Our short-term goals for improvement align with The Model Acute Pathway's 72-hour standards with a focus on strengthening front-door frailty capacity, maximising frailty streaming and SDEC utilisation, achieving early frailty screening upon ED arrival, and implementing frailty and delirium assessment with timely senior review, within the first 72 hours of admission.
- The stocktake indicates that all localities have Hospital at Home frailty pathways and that most localities report community frailty offers and care home support, with variation in community MDT coverage and Hospital at Home capacity across the system.
- Overall, the current position reflects strong local innovation and delivery intent but with variable consistency, capacity and integration across the end-to-end pathway, limiting collective impact on flow, admission avoidance and experience for people living with frailty.

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GM Frailty stocktake summary [December 2025]

Locality	Frailty strategy	Frailty steering group	ToR defined for steering group?	Record CFS in ED?	Frailty at the front door offer	Acute frailty service	Frailty SDEC	Hospital @ Home	Community MDTs	Community frailty service	Care home support
Bolton	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes
Bury	Yes - Acute Strategy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Manchester & Trafford	In draft	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oldham	Yes - Acute Strategy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rochdale	Yes - Acute Strategy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Salford	Yes - Locality Strategy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Stockport	No	Yes	In draft	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tameside	No	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Wigan	In draft	Yes	In draft	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Risks and issues across the system

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- Risks and issues identified include:
    - Variation in frailty identification and response across settings and localities, limiting early intervention and consistent decision-making at the front door.
    - Inconsistent capacity and operating models for alternatives to acute admission, including variable access to SDEC, UCR and Hospital at Home, reducing the system's ability to support Home First reliably during sustained pressure.
    - Uneven maturity of governance and data grip across localities, making it harder to benchmark consistently, target improvement where it will have greatest impact, and demonstrate outcomes.
    - Siloed data repositories between care providers which can make collection and comparison of data across the whole patient journey a challenge.
    - Discharge delays within acute providers which have a subsequent impact on patient experience earlier in the hospital treatment pathway.
    - Resource and capacity constraints across all parts of the health system make it hard to move away from crisis management and towards a true preventative approach to frailty.

- These challenges reinforce the need for coherent system leadership, standardisation where appropriate, and focused support to reduce variation.

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Opportunities and Next Steps for frailty in GM

- Key opportunities identified include:
  - The upcoming launch of the dementia and frailty Modern Service Framework
  - Strategic commissioning of a GM frailty pathway that spans prevention, care at home, hospital care and end of life.
  - Embedding a whole system focus on frailty, with strong joint working between GMCA and NHS GM – this would allow us to influence improvement to the wider determinants of health that often lead to frailty in our older population
  - Maximising the data and evidence base within the ADSP, with the opportunity to accelerate digital tool development to further target evidence-based interventions towards patients and communities who could benefit the most

- We have identified four key areas of focus for the future, where evidence-based interventions can improve patient outcomes and our population's experience of ageing:
  - Falls and fragility fractures
  - Problematic polypharmacy
  - Dementia, delirium and cognitive impairment
  - Very severe frailty, including palliative and end of life care

Recommendations

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The Strategic Commissioning Committee is asked to note:

- the scale and importance of frailty as a system issue;
- the link between frailty, older people’s experience, long waits and system performance;
- the baseline findings from the GM stocktake; and
- the direction of travel including alignment with neighbourhood health models and forthcoming national service expectations.