NHS
Greater Manchester

Agenda

Greater Manchester Integrated Care Board (Public)

Date: 18th November 2026

Time: 2.30pm to 4.30pm

Venue: Manchester 1, Tootal Buildings

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	2.30	5 mins	Welcome, Introductions and Apologies: Anthony Hassall	Verbal	-	Jackie Njoroge, Acting Chair
2.	2.30		Declarations of Interest	Verbal	-	Jackie Njoroge, Acting Chair
3.	2.30		Minutes of previous meetings and matters arising	Paper	Approval	Jackie Njoroge, Acting Chair
Actions: Log attached						
Leadership Reports						
4.	2.35	5 mins	Chair's Briefing including appointment of partner member and reappointment of NED	Verbal	Information	Jackie Njoroge, Acting Chair
5.	2.40	10 mins	Acting Chief Executive's Update including Reform and OPIC	Paper	Discussion	Colin Scales, Acting Chief Executive
Strategic Updates						
6.	2.50	10 mins	NHS GM Winter Plan	Paper	Decision	Nicola Hepburn, Acting Chief Reform and Improvement Officer
7.	3.00	10 mins	Board Assurance Framework	Paper	Decision	Chris Gaffey, Associate Director of Corporate Governance
8.	3.10	10 mins	Annual Engagement Report	Paper	Information	Claire Connor, Director of People, Communications & Engagement
9.	3.20	10 mins	Public Health Transformation	Paper	Decision	Charlotte Bailey, Chief Strategy, People and Partnerships Officer

10.	3.30	10 mins	GM HIV Strategy	Paper	Decision	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
11.	3.40	10 mins	Independent CMHT Review	Paper	Information	Manisha Kumar, Chief Medical Officer
Assurance Reports and Updates						
12.	3.50	10 mins	People and Resources: • Committee Report • Finance Report	Paper Paper	Information Discussion	Kal Kay, Non-Executive Director / Chair of the People & Resources Committee Kathy Roe, Chief Finance Officer
13.	4.00	15 mins	Strategic Commissioning: • Committee Report • Thirlwell Inquiry • Quality & Performance Report	Paper Paper Paper	Information Information Approval / Discussion / Information	Sue Bailey, Non-Executive Director / Chair of the Strategic Commissioning Committee Manisha Kumar, Chief Clinical Officer Anita Rolfe, Deputy Chief Clinical Officer
14.	4.15	5 mins	Audit Committee: Audit Committee Report	Paper	Information	Richard Paver, Non-Executive Director / Audit Chair
15.	4.20	5 mins	Remuneration Committee	Verbal	Information	Rachel Egan, Non-Executive Director / Chair of the Remuneration Committee
For Information						
16.	4.30	5 mins	Approved minutes of Committees: • People and Resources Committee • Strategic Commissioning Committee • Audit Committee	Paper	Information	-
17.			Any other business	Verbal	-	Jackie Njoroge, Acting Chair
18.			Date and time of next meeting: 20th January 2027, 2-4pm	Verbal	Information	

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

Tootal Buildings, 56 Oxford Street, Manchester M1 6EU
www.gmintegratedcare.org.uk

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	
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
Scales, Mr. Colin	Y	Non-financial professional interest	Loyalty interests	Honorary Professor of UCLan		2024	
Scales, Mr. Colin	Y	Indirect interests	Outside employment	Wife works at NCA as a nurse		19/09/2024	Ongoing
Sheerin, Mrs. Katherine Mary (Katherine)	Y	Non-financial professional interest	Loyalty interests	Trustee and Deputy Chair of the Board of the The Whitechapel Centre, a charity which works to prevent homelessness and support people who are homeless, operating across the Liverpool City Region.	This is a voluntary role with no remuneration or expenses paid.	01/01/2025	Ongoing
Non-Executive Directors	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Bailey, Dr Susan Mary	Y	Financial Interest	Outside employment	Independent NED on the board of KOOTH PLC, a mental health online digital platform. I am remunerated for this work. Neither any members of my family or I hold shares in this PLC		2022	Ongoing

Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	Chair of Centre for Mental Health. The centre and myself advocate for better mental health outcomes for all through the delivery of evidenced based policy briefings and lobbying at a national and Regional level		2018	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Council member university of Salford		2016	
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	BEVAN commissioner - Bevan through evidence base support improved health and social care outcomes For the population of Wales.		2014	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Patron of the Foundation for Professionals in Services to Adolescents {FPSA]		2024	Ongoing
Egan, Rachel Mrs	Y			Nil			
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Outside employment	Interim FD Derian House Childrens Hospice		06/10/2025	
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Shareholdings and other ownership interests	Director and Shareholder of GSD Financial Consulting Ltd	Set up my own consultancy firm	01/04/2025	
Kay, Mrs. Khalida (Kal)	Y	Non-financial personal interests	Outside employment	Great Academies Education Trust	Trustee (non remunerated)	20/04/2020	
Kay, Mrs. Khalida (Kal)	Y	Non-financial professional interest	Shareholdings and other ownership interests	Association of Camerados	Non Exec, non remunerated director	22/10/2018	
Paver, Mr. Richard	Y			Nil			
Partner Members	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Chief Medical Officer for Health Innovation Manchester		Dec-25	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Clinical Director, Gorton and Levenshulme Primary Care Network		Apr-19	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Executive Committee Member, Manchester Local medical Committee		Jan-26	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Salaried GP, West Point Medical Centre		Apr-23	Ongoing
Hassall, Anthony	Y	Financial interest	Outside employment	Chief Executive, Pennine Care NHS Foundation Trust		2022	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	CEO of Bolton Hospice which is part funded by an NHS Grant		2023	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	As Chair of Bolton CVS, (a voluntary sector infrastructure body) who are in receipt of NHS funding		Ongoing	
McKenzie Folan, Alison	Y	Financial interest	Outside employment	Chief Executive at Wigan Council		2019	Ongoing

NHS
Greater Manchester

Minutes

NHS GM Integrated Care Board (Public)

Date: Wednesday 16th September 2026
Time: 2pm to 3:30pm
Venue: Boardroom, 1st Floor, The Tootal Buildings

Present		
Members:		
Jackie Njoroge	JN	Acting Chair, NHS GM
Dame Sue Bailey	SB	Non-Executive Director and Chair of the Performance & Quality Committee, NHS GM
Kal Kay	KK	Non-Executive Director and Chair of the Finance Committee/Senior Independent Director, NHS GM
Richard Paver	RP	Non-Executive Director and Chair of Audit Committee, NHS GM
Anthony Hassall	AH	Board Member bringing the perspective of Mental Health, Chief Executive of Pennine Care NHS Foundation Trust
Leigh Vallance	LV	Board Member bringing the perspective of the Voluntary Community, Faith and Social Enterprise (VCFSE) Sector, Chief Executive of Bolton Hospice (via MS Teams)
Dr Vish Mehra	VM	Board Member bringing the perspective of Primary Care, General Practitioner
Kathy Roe	KR	Chief Finance Officer, NHS GM
Professor Manisha Kumar	MK	Chief Clinical Officer, NHS GM
Colin Scales	CS	Acting CEO, NHS GM
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer, NHS GM
Katherine Sheerin	KS	Chief Commissioning Officer, NHS GM
Executives:		
Nicola Hepburn	NH	Acting Chief Reform & Improvement Officer, NHS GM
Attendees / Participants:		
Jenny Noble	JNo	Board and Committee Secretary, NHS GM (Minutes)
Cathy Cane	CC	Executive Assistant, NHS GM
Chris Gaffey	CG	Associate Director of Corporate Services, NHS GM (Item 7 only)
Lindsay Kirby	LK	Head of Internal, Stakeholder and Media Relations (Deputising for Claire Connor)
Anita Rolfe	AR	Deputy Chief Clinical Officer (Nursing and Nurse Advisor to the Board), NHS GM
Apologies:		
Alison McKenzie-Folan	AMK	Chief Executive Wigan Council, Place Based Lead Health & Care for Integrated Care Partnership
Rachel Egan	RE	Non-Executive Director and Chair of the Remuneration and Population Health Committees, NHS GM
Dr Owen Williams	OW	Board Member bringing the perspective of Acute Providers, Chief Executive of Northern Care Alliance (NCA) NHS Foundation Trust

	Topic	Action
1.	Welcome, Introductions and Apologies JN welcomed attendees and members of the public to the Board meeting. Apologies were noted. JN confirmed the recording wasn't working due to technical issues so the meeting could not be livestreamed.	
2.	Declarations of Interest (DOI) JN reminded Board members to ensure their declarations of interest were accurate and up to date. VM declared a conflict of interest in item 7 as below.	
3.	Minutes of previous meetings and matters arising The minutes of the previous public Board meeting were approved as an accurate record. No matters arising were raised.	
4.	Chair's Briefing JN congratulated AH who had been reappointed as a Partner Member on the Board for a second three-year term. Thanks were noted to Owen Williams who was stepping down from his role at the end of September.	
5.	Acting Chief Executive's Update including Reform and OPIC CS reported on OPIC's ongoing preparations for the transfer of NHS England's direct commissioning functions to ICBs from 1 April 2027. RP sought clarification on ICB representation on the Board. It was reported that the transition group would establish a new committee with broader membership than the current arrangements. The meeting scheduled for the previous week had been stood down as there were no decisions required. The need for a clearer patient voice within these arrangements was highlighted. It was reported that, as announced earlier in the year, the ICB Chair was expected also to assume the responsibilities of Health Commissioner for Greater Manchester, working closely with the Mayor. Consequently, the region had mandated an amendment to the NHS GM Constitution. The Inclusive Leadership Steering Group had been launched, with its inaugural meeting scheduled for the following day. The Group brought together colleagues from across the organisation, including staff and peer networks, trade unions, senior leaders and those with lived experience, to help shape and improve inclusive leadership, organisational culture and workforce experience. The Group would report to PRC. An update was provided on NCA. The System Improvement Board, whose remit included quality and safety, had met for the first time during the previous month. Representation included the Place Lead for Oldham and the Chief Executive of Oldham Council. Industrial action had taken place towards the end of August, with	

	Topic	Action
	further action planned. SB would maintain oversight of quality at NCA through SCC. Planning was under way for winter 2026/27 not 27/28 as it said in the report, with a focus on strengthening system resilience and readiness to manage seasonal pressures. The Board would be kept informed as the plan developed. **The Board:** • **Noted the contents of the Acting CEO's Report to the Board including the 2025/6 Annual Assessment Letter.** • **Noted the proposed amendment to the constitution.** • **Provided feedback on any future topics they wish to be covered within the Acting CEO's Report to the Board in November 2026.**	
6.	<u>Neighbourhood Delivery Plans</u> CB introduced the report, outlining progress in establishing the foundations for preventative and proactive neighbourhood care through Greater Manchester's Live Well approach. This included neighbourhood health planning, engagement, intelligence and delivery infrastructure, aligned with NHS England's Neighbourhood Health Framework and Greater Manchester's broader Live Well ambitions. The report was taken as read. NHS England's Neighbourhood Health Framework had been published in July. Neighbourhood data profiles were expected to be completed by the end of September, with a soft launch of neighbourhood plans planned for October and November. It was emphasised that neighbourhood health represented a system-wide transformation in ways of working and was integral to, rather than separate from, commissioning intentions. Progress to date was acknowledged and thanks were expressed for the report. LV highlighted the importance of triangulating data and information and clarifying how the various frameworks and strategies aligned. Greater emphasis on co-production and co-commissioning was requested. In response, it was noted that accountabilities had been addressed through the engagement process. Practical guidance would be helpful and should be incorporated into future plans, bringing partners together and building on existing work. CS confirmed that commissioning intentions would be shared with system partners by the end of the month. KK welcomed the report and sought assurance on the accuracy of the data and the measures in place to ensure that analytical approaches were not biased. NH emphasised the need to analyse data appropriately and address gaps in information from other sectors. Expectations would need to be managed, given the scale of the work required and the need to improve data quality to support sound decision-making. AH acknowledged the ICB's role as a strategic commissioner but sought greater clarity on what providers were expected to deliver under the framework. Concerns were raised about the national neighbourhood health approach, including the extent	

	Topic	Action
	to which it addressed mental health and existing barriers between providers. The framework needed to address the challenges of integrated working across physical and mental health services. VM questioned how doctors would work together at neighbourhood level. This would require management at place level, with the ICB responsible for establishing the necessary infrastructure. MK acknowledged the point and noted that the work was entering its next stage. Appropriate Live Well indicators were needed. There were positive indications from MHST provision and early signs that the ADHD hub model was working. The Primary Care Roundtable would review the table on page 47 of the pack which was inaccurate. SB sought quantifiable evidence of progress and the effectiveness of the approach, building on the points raised by other members. CB thanked colleagues for their comments and the update was welcomed. **The Board:** • **Supported the GM approach to Neighbourhood Health, through a broader Live Well ambition, with partners.** • **Noted the foundations being put in place to deliver on the requirements of NHS Neighbourhood Health Framework.**	
7.	<u>Committee Operating Principles</u> CG presented the proposed operating principles for NHS GM committees, covering meeting arrangements, transparency, Executive, Non-Executive and Partner Member involvement, and formal governance. The Board was asked to endorse the principles and approve the proposed amendments to the NHS GM Constitution and the Terms of Reference of the Strategic Commissioning Committee (SCC) and People and Resources Committee (PARC). VM declared conflicts of interest in his capacity as a Partner Member and highlighted the balance between substantive governance changes and transparency. He questioned the consistency of arrangements under which one committee would continue to meet in public while another would not. The timing of the proposed changes was questioned, given the potential for the NHS Bill to alter ICB arrangements and necessitate further governance changes. RP supported the concerns raised and questioned whether changes affecting public transparency should be made before the appointment of the new Chair. AH acknowledged the concerns about timing but noted that it was unusual for Board committees to meet in public. KR explained that the ICB's transition to a strategic commissioning role would have implications for partner organisations. She noted that AAA reports to the Board would provide a means of maintaining transparency. JN acknowledged the sensitivities surrounding the proposals and the	

	Topic	Action
	importance of considering the concerns raised. She considered that a decision should not be deferred until the new Chair was in post and proposed approval of the arrangements, with a further review once the new Chair had taken up the role. The importance of considering practice in other ICBs was noted. It was reported that NHS GM's current arrangements, under which all committees met in public, differed from those generally adopted elsewhere and NHS GM was an outlier. **The Board:** • **Agreed the overarching principles for the operation of the Board's committees set out in this report.** • **Approved the proposed change to the NHS GM Constitution as set out in paragraphs 1.17 of this report.** • **Approved the proposed changes to the Terms of Reference for the Strategic Commissioning Committee and People and Resources Committee, which are appended to this report.**	
8.	<u>Modern Day Slavery Statement</u> MK presented the updated Modern Slavery and Human Trafficking Statement 2026–27, which reaffirmed the organisation's legal commitment under the Modern Slavery Act 2015 to prevent slavery and human trafficking across its operations and supply chains. RP sought clarification on how terms and conditions could be enforced where no contract was in place. In response, it was explained that an existing process applied even in the absence of a contract. Although this would not prevent modern slavery or human trafficking from occurring, there would be consequences where it was identified. It was also confirmed that a self-assessment was undertaken before a contract was signed. **The Board:** • **Approved the ICB Modern Day Slavery and Human Trafficking Statement 2026-27.** • **Recommended publication on the ICB website as per statutory requirements.**	
9.	<u>People and Resources Committee Report</u> KK presented the committee report highlighting significant pressures being experienced across the Greater Manchester system as a result of the developing situation at the Northern Care Alliance (NCA) noting patient safety remained the priority. **The Board noted the report.**	

	Topic	Action
	Finance Report KR updated the Board on NHS GM's Month 4 financial position as at 31 July 2026. She highlighted the financial pressures and reported that additional measures were being put in place, with substantial work under way to manage costs and identify opportunities. She acknowledged the scale of the challenge and confirmed the commitment to addressing it. KR confirmed that the Board would be kept informed of progress, noting that risks remained alongside the opportunities identified. AH noted that the financial year had reached Month 6 and highlighted the need for sight of the plans for 2027/28. CS confirmed that commissioning intentions would be issued by the end of the month and plans were aiming to be signed off by Christmas. **The Board:** • **Noted the Month 4 year to date and forecast reported financial position which was in line with the balanced plan including Deficit Support Funding.** • **Noted and discussed the areas of key risks, pressures and the requirements for early intervention and mitigations to bring spend back in line with plan, and planned presentation of the monitoring of the recovery plans which were in development.** • **Noted the delivery of CIP as at Month 4 of £50.8m against a plan of £44.9m, an over delivery of £5.9m YTD.** • **Noted that the forecast capital position was expected to deliver in line with the allocation including the additional allocation notified for GPIT.** • **Noted the NHS GM cash position which continued to be closely monitored.** • **Noted that enhanced financial controls remained in place to strengthen financial grip and control, ensuring that only essential additional expenditure was committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.**	
10.	Strategic Commissioning Committee Report SB presented the committee report, drawing attention to the Chief Clinical Officer's Report and the move towards AAA reporting. Inaccuracies were identified in the minutes and would require review by the Committee Chair. Typographical errors in the report were also noted and would be corrected in the next report. **The Board noted the report.** Quality Report The report was taken as read. AR drew attention to NHS Talking Therapies,	

	Topic	Action
	enhanced scrutiny at NCA and the closure of Laureate House at GMMH. **NHS GM Board discussed and agreed the levels of assurance set out in this report.**	
11.	Audit Committee It was reported that the Audit Committee was scheduled to meet the following day. Data and IT matters would be considered under Part B of the agenda. The Committee would also consider further work to be commissioned from MIAA, including assurance relating to maternity services. At its previous meeting in June, the Committee had approved the annual report and accounts, which were subsequently presented at the Annual General Meeting. **The Board noted the verbal report.**	
12.	Remuneration Committee It was reported that the Remuneration Committee had met the previous week to approve compulsory redundancies. **The Board noted the verbal update.**	
13.	North-West Specialised Commissioning Committee The North-West Specialised Commissioning Committee report was included in the meeting papers. It was reported that OPIC development continued to progress, supported by a governance task and finish group focused on implementation from October 2026. The final business case would need to return to the Board for consideration. **The Board noted the report and the need to cross-reference specialised commissioning risks with the strategic risks.**	
14.	Approved minutes of Committees The approved minutes of Committees were included in the meeting papers for information noting the Strategic Commissioning Committee minutes would ned to be reviewed.	
15.	Any other business It was noted that the Thurwell Inquiry report had been published the previous day. The implications for the ICB would be considered, and a report would be presented to the Board via the Strategic Commissioning Committee.	
16.	Date and time of next meeting The next meeting is planned to take place on Wednesday 18 November 2026.	

Actions Log: ICB Board							
No	**Date**	**Item**	**Details of action agreed**	**Action Lead**	**Deadline**	**Status**	**Further Detail**
Completed at Previous Meeting (Audit Trail)							
1	17/07/2024	4. Chair's Briefing	WH to meet with members of the KONP group to discuss the petition and agree next steps	WH	18/09/2024		The meeting went ahead on the 20th August, and the group submitted questions back to WH which the Communication Team are collating the answers.
2	17/07/2024	6. Single Improvement Plan	Single Improvement Plan should be shared with members of the board as soon as it is available showing progress against the plan.	MF	18/09/2024		The plan was shared with members at the Board strategy session on 21st August and updates will be provided.
3	18/09/2024	3. Matters arising	The Chair to meet with MP and team regarding the data in the performance report following concerns raised at the previous meeting	MP/CS	20/11/2024		The performance matrix is still under review and discussed at QPC. Meeting with the Chair has taken place.
4	18/09/2024	4. CEO Report	RB to provide update on Health and Care Review at next meeting in November.	RB	20/11/2024		On agenda for November meeting
8	19/02/2025	4. 2025/26 operational plan	Board meeting to be reconvened prior to final submission of the draft plan on 27th February which would be held in public.	JN	27/02/2025		Meeting reconvened on 26th February
9	26/02/2025	4. Annual plan 25/26 update	Board seminar to be arranged prior to formal meeting.	JN	26/03/2025		Seminar held on 19th March and formal meeting moved to the 26th
6	15/01/2025	7. Board Assurance Framework	Risk appetite to be discussed as part of operational planning at February Board.	CS	05/02/2025		Deferred to June Board development session. Complete
7	15/01/2025	13. Quality and Performance	MP and JW to meet with SMc and SB to discuss maternity workforce issues.	MP/JW	05/02/2025		Meeting took place on 7th April
10	26/03/2025	7. Baord Assurance Framework	CS to meet with Committee Chairs in April prior to Board Seminar.	CS	16/04/2025		Meeting took place on 14th April
11	21/05/2025	7. Committee ToR	JN to amend the Quality and Performance TOR after the meeting.	JN	16/07/2025		Complete
14	16/07/2025	6. NHS Reform	MP to meet with RE to discuss the process and decision behind the safeguarding as part of the reform agenda	MP/RE	17/09/2025		Complete
15	16/07/2025	6. VR Scheme	CB to share the EIA that had been to the T&F Group.	CB	17/09/2025		Complete
16	16/07/2025	16. GM Alcohol Harm Strategy	WH to share map of drug and alcohol services in GM.	WH	19/08/2025		Info can be found here: https://gmintegratedcare.org.uk/find-a-service/type/alcohol-and-drug-support/
5	17/07/2024	12. Primary Care Blueprint Delivery Update	RB to work with John Herring and his team to provide a briefing to the People and Culture Committee and bring a position statement back to Board at a future meeting.	RB	20/11/2024		A paper has been prepared and presented to the PC Blueprint Group. This is in respect to FTSU for Primary Care. We have a proposed model , with delivery through PCB but delivery resource dependent. Update on Primary Care Blueprint provided in Sep 25
13	21/05/2025	10. Assertive outreach	To share report with AMK and other place leads via the Exec Committee	MK	TBC		Complete
17	17/09/2025	3. Matters arising	MK to provide update on the ADHD consultation after the meeting	MK	ASAP		Update provided and paper on agenda for November meeting
12	21/05/2025	9. Federated Data Platform (FDP)	To bring FDP back to Board at later date.	WH	19/11/2025		Paper to come back to the board 6 months following the last meeting. Update provided in CEO report
18	19/11/2026	8. Draft Clinical Strategy	Commissioning intentions including plan to be presented to Board at strategy session in December.	KS	17/12/2025		Presented at December meeting
20	19/11/2026	15 People and Culture Report	Freedom to Speak Up report to be shared with RP.	CB	21/01/2026		Sent to RP on the 21/11/25
21	17/12/2026	3. Approval of 2026/7 planning submission	JN to reschedule February Board meeting from the 18th to the 11th and arrange seminar in January.	JN	11/02/2026		Complete
22	18/03/2026	6. Governance and SORD update including new committee structures	CG to check primary care delegations and report back to Board	CG	20/05/2026		Verbal update provided at May meeting
23	20/05/2026	6. Financial Scheme of Delegation Amendments	Updated FSoD paper to be taken to next Committee meetings	CG	15/07/2026		

NHS
Greater Manchester

Acting CEO's Report to the Board

November 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

Board

18 November 2026

Report for Information

Required information.	Details.
Title of report.	Acting CEO's Report to the Board
Author.	Jenny Noble on behalf of Professor Colin Scales
Presented by.	Professor Colin Scales
Contact for further information.	gmhscp.gmicb.corporate@nhs.net
Executive summary.	The paper details updates from the Acting CEO with reference to the national, regional and local system positions.
The benefits that the population of Greater Manchester will experience.	The NHS Greater Manchester (GM) response to NHS Reform, with consideration being made through the necessary due diligence.
How health inequalities will be reduced in Greater Manchester's communities.	Proactively responding to the independent review into maternity and neonatal services at.
The decision to be made and/or input sought.	The Board is asked to note the contents of the CEO's Report to the Board. Also, disseminate and cascade the necessary key messages and information as appropriate.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Delivering key messages in the context of NHS Reform which is BAF SR10.

Key milestones.	Key messages in the context of NHS Reform.
Leadership and governance arrangements.	For consideration and dissemination by the Board.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement has already commenced with the GM system's key stakeholders and NHS GM staff in response to NHS Reform. Any formal decisions to be taken, will proceed through the necessary governance routes.
Financial or Legal Implications	NHS GM proceeding with the organisational change programme in response to NHS Reform.

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

Introduction

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

National and Regional Updates

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

Discontinuation of Enforcement Undertakings

1.3. I am pleased to report that NHS England has confirmed compliance with, and approved the discontinuation of, NHS Greater Manchester's remaining enforcement undertakings relating to financial planning. This follows the discontinuation of the other undertakings in January 2026 and marks an important milestone for the ICB.

1.4. This progress reflects the sustained hard work and commitment of colleagues across NHS Greater Manchester over the past two years. I would like to thank everyone who has contributed to reaching this position, with that effort also recognised by NHS England in its letter. Whilst this is an important step forward, we recognise that challenges remain within our system. We will continue to address these challenges and build on the progress made to improve services and outcomes for the people of Greater Manchester.

Performance Accountability Framework

1.5. The Performance Accountability Frameworks (PAF) purpose is to provide a holistic, clear, proportionate and supportive approach to assuring that ICBs and providers are well-governed, capable and successful in delivering their statutory responsibilities.

1.6. The PAF is a NHSE regional assessment of ICB and NHS Trust performance and delivery risk. The framework results range from PAF 1 (least risk) to PAF 4 (greatest risk) and NHS GM has recently received a rating of 2.

1.7. Whilst we have risks, being rated as 2 reflects NHSE's confidence in the ICB to effectively manage these. Looking back just two years, where the ICB was in formal undertakings (see above) this is a very positive shift in our overall organisational effectiveness and reflects the improvement in delivery of key standards.

1.8. Thank you to colleagues across our organisation as well as wider system partners for getting us this position.

Transfer of NHS England Direct Commissioning Functions and Office of Pan-ICB Commissioning (OPIC)

1.9. Building on the update provided in September, the three North West ICBs and NHS England North West continue to develop the arrangements for the Office of Pan-ICB Commissioning (OPIC), ahead of the planned transfer of NHS England direct commissioning functions from 1 April 2027, subject to the required legislation.

1.10. The next phase focuses on integrated transition planning and developing shadow operating arrangements to test future commissioning and governance processes before transfer. The OPIC Transition Board will oversee readiness and delivery, while the OPIC Management Group will develop the future operating model. Existing NHS England and

ICB statutory accountabilities and formal decision-making arrangements remain in place during this period.

1.11. Further work will bring together transition milestones and dependencies, staff engagement and ways of working across the three ICBs, alongside commissioning priorities and medium-term planning for 2027/28. The focus remains on continuity of services and a safe and effective transfer, with Lancashire and South Cumbria ICB as the planned host for OPIC.

NHS England (NHSE) Staff

1.12. A new Special Health Authority under an NHS Group within DHSC will employ many NHSE regional staff, with the aim of keeping regional expertise while moving NHSE's central functions into DHSC. The process is scheduled for completion by April 2027, pending legislation and final organisational decisions.

Greater Manchester (GM) System Updates

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

The NHS GM Board

2.1. Recruitment to appoint Sir Richard's successor as ICB Chair is still under way. As announced earlier this year, this role is expected to also take on the Health Commissioner responsibilities for Greater Manchester, working closely with the Mayor. In the interim, Jackie Njoroge will continue as Acting Chair until 31 March 2027.

2.2. As a reported at the last meeting, Anthony Hassall has been reappointed as a partner member for a second three year-term from 1 August 2026. Since then, Fiona Noden has been appointed as partner member representing NHS Trusts and Foundation Trusts from 1 November 2026 replacing Owen Williams on the Board and Rachel Egan has been reappointed as a Non-Executive Director for a second three-year term from 1 January 2027.

Board Lead Roles

2.3. I would like to update the Board on our designated lead roles, which we are reconfirming to reflect changes in our leadership arrangements and maintain clear accountability for key responsibilities. These roles support delivery of our statutory duties and NHS

England's requirements and expectations for ICB governance and leadership. The updated schedule of lead roles is below:

Lead role	**Undertaken by (role)**	**Undertaken by (name)**
Accountable Emergency Officer	Acting Chief Reform and Improvement Officer	Nicola Hepburn
Senior Information Risk Officer (SIRO)	Acting Chief Reform and Improvement Officer	Nicola Hepburn
Caldicott Guardian	Chief Medical Officer	Manisha Kumar
Conflict of Interest Guardian	Audit Committee Chair	Richard Paver
Equality & Diversity Lead	Partner Member	Vish Mehra
Freedom to Speak Up and Whistleblowing Lead (Non-Executive)	NED	Sue Bailey while Jackie Njoroge is Acting Chair
Freedom to Speak Up and Whistleblowing Lead (Executive)	Acting Chief Executive	Colin Scales
Wellbeing Guardian	NED	Sue Bailey
Safeguarding Lead	Chief Medical Officer	Manisha Kumar
Children and young people (aged 0 to 25)	Chief Medical Officer	Katherine Sheerin
Children and young people with special educational needs and disabilities (SEND)	Chief Medical Officer	Katherine Sheerin

Safeguarding (all-age), including looked after children	Chief Medical Officer	Manisha Kumar
Learning disability and autism (all-age).	Chief Medical Officer	Manisha Kumar
Down syndrome (all-age)	Chief Medical Officer	Manisha Kumar
Women's Health Lead	Chief Medical Officer	Manisha Kumar
Mental Health Lead	Board Member bringing the perspective of Mental Health, Chief Executive of Pennine Care NHS Foundation Trust	Anthony Hassall
Senior Independent Director	NED	Kal Kay while Jackie Njoroge is Acting Chair

2.4. I can confirm that Nicola Hepburn, Acting Chief Reform and Improvement Officer, has been appointed as our Senior Information Risk Owner (SIRO). Sue Bailey is our Non-Executive Lead for Freedom to Speak Up and Whistleblowing while Jackie Njoroge serves as Acting Chair. Kal Kay will also act as Senior Independent Director (SID) while Jackie serves as Acting Chair. These arrangements maintain continuity of Board-level leadership and oversight during this period of change.

NHS Reform Programme

2.5. Place Partnership arrangements continue to progress across Greater Manchester, with the core Place documentation suite now nearing completion. Engagement with Place Partnership Directors, Chief Officers and partner organisations has helped shape the final arrangements, supporting a consistent approach while recognising local priorities and operating models.

Care Together Pilot

2.6. NHS Greater Manchester has been selected as the pilot site for Care Together, working along with three of their local authority partners. Care Together will test and evaluate a new care model which will provide children and young people in social care settings, as well as and their parents, carers, or guardians, with greater access to mental health support by embedding mental health professionals in children's social care teams. The Department of Health and Social Care and NHS England will be investing up to £7 million over 3 financial years into this pilot with another potential £3 million to be invested by the Department for Education. The latest children in need, children in care (including adopted children), and care leavers figures across Greater Manchester's three local authority partners show there are more than 7,000 children and young people in this cohort. The Care Together pilot will provide access to needs-matched and evidence-informed support for these young people. The pilot is set to mobilise in early 2027 and run until 2029. During the pilot, an evaluation will be undertaken to assess the potential to scale the programme.

Casey Commission on Adult Social Care

2.7. In September NHS GM and Greater Manchester Combined Authority sent a joint letter to Baroness Casey – outlining what Greater Manchester could contribute to the Casey Commission on Adult Social Care. The letter supported the Commission's ambition to establish a sustainable, fair and preventative adult social care system that enables people to live the lives they choose with dignity, independence and purpose. We set out our belief that the future of social care is as a core part of a preventative, person-centred Live Well model delivered in neighbourhoods. We offered to work with Government and the Commission to test new approaches that could be implemented quickly as part of our integrated models at place and neighbourhood – and which offer the potential for national application.

Peer Networking

2.8. Colleagues from NHS GM met with peers from Lancashire and South Cumbria ICB on 3rd November to share learning on our key priorities and challenges. This included a live demonstration of the Neighbourhood Health data products we have developed and examples of our work on Neighbourhood Health, Live Well, Place Partnerships and the Commissioning Framework. We received positive feedback for this and will continue to share best practice between both organisations.

DHSC Session

2.9. Both NHS GM and the Greater Manchester Combined Authority were invited to join a session with the Department of Health and Social Care Permanent Secretary (Sam

Jones) and her senior team to share our work on Live Well, Neighbourhood Health and the Prevention Demonstrator. We described the potential for Greater Manchester to deliver rapidly, and at scale, on the three shifts at the heart of the 10-Year Health Plan and to implement the NHS Framework for Neighbourhood Health and enhance this through the connection to Live Well. We offered to work with the Department and Number 10 North to develop how the principles of the Rewiring the State approach could apply to health and care in Greater Manchester.

Smoking Rates in GM

2.10. Smoking rates in Greater Manchester have fallen to their lowest level on record, with the proportion of adults who smoke almost halving over the past decade – with the city-region remaining firmly on track to achieve its Smokefree 2030 ambition. Released by the Annual Population Survey during Stoptober, the national campaign that encourages smokers to quit during October and take the first step towards becoming smokefree. The new data shows that smoking rates among adults aged 18 and over in Greater Manchester fell to 10.6% in 2025, down from 11.7% in 2024. The latest estimates indicate that the number of adults who smoke in Greater Manchester was nearly 26,000 lower in 2025 than in the previous year, highlighting continued progress in tackling the single biggest cause of preventable illness and premature death.

Northern Care Alliance industrial action

2.11. Further industrial action by theatre staff at the Northern Care Alliance is planned for 18-19, 23-25 and 27-28 November.

2.12. The Trust is prioritising patient safety and continuity of care, with some activity potentially needing to be provided elsewhere, particularly given concerns about elective hubs. More than 3,200 patients have experienced disruption from industrial action to date.

2.13. The Trust remains in dialogue with UNISON and has reiterated its commitment to improving the working environment and wellbeing of theatre colleagues, alongside longer-term investment in theatre services.

Greater Manchester partners shortlisted for three HSJ Awards 2026

2.14. Greater Manchester partners will find out next week if they have been successful in this year's HSJ Awards (Thursday 19 November).

2.15. GM nominations were secured at the 2026 awards, recognising innovation and collaboration across mental health, patient safety and workforce development. They include Care Closer, Care Smarter, which has reduced out-of-area mental health placements; the GM Care Record System-Wide Clinical Safety Model; and the Greater

Manchester T Level Health & Care Industry Placement Programme, which is expanding routes into health and care careers.

Greater Manchester Joint Health Scrutiny Committee

2.16. I attended the Joint Health Scrutiny Committee meeting on Tuesday 10 November to provide an update on Integrated Care Board (ICB) Reform, Performance and Finance. Colleagues also attended to provide updates on NHS Greater Manchester Environmental Sustainability and Strategic Commissioning Plan, Neighbourhood Health and Place Partnerships.

Health Innovation Manchester (HInM) Update

2.17. October has provided a number of opportunities to demonstrate Health Innovation Manchester's contribution locally and internationally, as our partnership continues to be strengthened. The publication of their Annual Impact Report 2025/26 brings together the impact being achieved through innovation, data and partnership working across Greater Manchester. Ben Bridgewater also represented GM on the recent northern mayors-led visit to India, supporting the city-region's ambitions to deepen international links, including in health innovation and life sciences.

2.18. I was also pleased to see the publication of the Greater Manchester migraine report, a piece of work lead by HInM and developed with AbbVie UK, which sets out both the significant burden of migraine and clear opportunities to improve pathways and outcomes. The next phase offers an opportunity to move from understanding the challenge to reimagining services with patients, clinicians, industry and system partners. I look forward to seeing this progress as a tangible example of what can be achieved when Greater Manchester works differently with industry to improve health outcomes.

Recommendations

3.0 The NHS GM Board is asked to:

3.1. Note the contents of the Acting CEO's Report to the Board including undertakings and lead roles.

3.2. Provide feedback on any future topics they wish to be covered within the Acting CEO's Report to the Board in January 2027.

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NHS GM ICB Winter Plan

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Integrated Care Partnership

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Greater Manchester Integrated Care Board

18 November 2026

Report information.

Required information.	**Details.**
Title of report.	NHS GM ICB Winter Plan
Author.	Cara Pursall and Greg Lawson
Presented by.	Nicola Hepburn
Contact for further information.	Acting Chief Reform and Improvement Officer nicola.hepburn1@nhs.net
Executive summary.	The NHS GM ICB Winter Plan 2026/27 sets out a coordinated, whole-system approach to managing winter pressures across Greater Manchester. It prioritises prevention, care closer to home, safe hospital flow and discharge, resilient mental health and wider services, and coordinated escalation. Through strong partnership working, demand and capacity oversight, and system-wide escalation arrangements, NHS Greater Manchester will seek to maintain safe, timely and equitable care throughout winter

The benefits that the population of Greater Manchester will experience.	The delivery of this plan will support Greater Manchester residents to stay well over winter, access timely care when needed and receive more services closer to home. By strengthening prevention, improving system flow, and coordinating responses to periods of increased demand, partners will work together to reduce delays, improve patient experience, and maintain safe, equitable access to urgent, emergency and planned care services across the conurbation
How health inequalities will be reduced in Greater Manchester's communities.	The plan is designed to reduce health inequalities by targeting support towards communities and individuals most at risk of poor winter outcomes. Through the use of population health intelligence, proactive identification of vulnerable residents, targeted vaccination and prevention programmes, and improved access to care closer to home, partners will work to ensure that those with the greatest health needs receive timely and appropriate support. This approach will help improve access, reduce unwarranted variation in outcomes and support more equitable health and care services across Greater Manchester
The decision to be made and/or input sought.	The **Board is asked to approve the NHS Greater Manchester Winter Plan 2026/27** and support the collective actions set out within it to ensure the system is prepared to respond effectively to winter pressures, maintain safe services and improve outcomes for the people of Greater Manchester

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The Winter Plan supports delivery of the NHS Greater Manchester strategy by promoting prevention, reducing health inequalities, strengthening neighbourhood and community-based care, and improving access to timely, high-quality services. Through coordinated action across health and care partners, the plan supports safe patient flow, resilience across urgent and emergency care pathways, and the delivery of care closer to home. The plan also contributes to the mitigation of key Board Assurance Framework risks by strengthening system resilience, improving preparedness for periods of increased demand, enhancing operational oversight and escalation arrangements, and reducing risks associated with patient safety, access, capacity, discharge delays and service continuity during winter pressures.
Key milestones.	September 2026: Completion of planning, stress testing, and assurance processes. 30 September 2026: Board approval and submission of the Board Assurance Statement. October 2026: Winter readiness arrangements confirmed. 5 November 2026: NHS GM Winter Event to take place with system partners. October 2026 to March 2027: Plan delivery, monitoring, and system coordination. March 2027: End of winter period and review of delivery and learning.

Leadership and governance arrangements.	Overall accountability for delivery of the Winter Plan will rest with NHS Greater Manchester, supported by a Nicola Hepburn as the named Executive Winter Lead and executive leads across provider organisations. The ICB will provide strategic oversight, coordination, and assurance, while providers and partners remain accountable for delivery of their local winter plans and operational performance. A winter delivery group has been established in October 2026. Governance and operational oversight will be supported through established NHS Greater Manchester arrangements, including the System Coordination Centre (SCC), Provider Oversight Meetings, contract management processes, and system-wide escalation frameworks. Progress, risks, performance, and delivery will be monitored throughout the winter period, enabling timely escalation, coordinated decision-making and collective action where system pressures emerge
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	To note NHS GM Chief Officers have had sight of a draft and final version of this Winter plan and have endorsed it to be presented at the NHS GM ICB Board.
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	*Yes*	*No*	*/ No*	*No*	*/ No*	*Yes*	*No*

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

Introduction (H2)

Winter places significant pressure on health and care services across Greater Manchester, with increased demand impacting urgent and emergency care, primary care, community services, mental health, social care, and hospital discharge pathways. This paper presents the NHS Greater Manchester Winter Plan 2026/27, which sets out the system's coordinated approach to preparing for, managing, and responding to winter pressures. Developed in partnership with NHS providers, local authorities, social care and wider system partners, the plan provides the framework for maintaining safe, timely and effective services for Greater Manchester residents throughout the winter period.

GM Approach

Greater Manchester's approach to winter planning is based on a whole-system response, recognising that pressures in one part of the health and care system can have significant consequences across the wider urgent and emergency care pathway. The plan has been developed jointly with NHS providers, primary care, community and mental health services, local authorities, social care, the North West Ambulance Service and VCSE partners, ensuring a coordinated and collaborative approach to winter preparedness and response.

The approach focuses on five interconnected priorities: prevention and early intervention, care closer to home, safe hospital flow and discharge, resilient mental health, and wider services, and coordinated escalation and response. Through these priorities, Greater Manchester aims to reduce avoidable demand, improve access to timely care, support people to remain independent for longer and ensure patients receive care in the most appropriate setting.

Delivery will be underpinned by strong system leadership, shared operational intelligence, and coordinated escalation arrangements. The Greater Manchester System Coordination Centre will provide oversight of demand, capacity, and operational pressures across the system, enabling partners to take collective action, deploy mutual aid where required and maintain safe, effective services throughout periods of increased winter demand.

System Coordination Role

The Greater Manchester System Coordination Centre (SCC) is a core component of the winter operating model, providing system-wide oversight of demand, capacity, and operational pressures across urgent and emergency care pathways. By maintaining a single operational picture across Greater Manchester, the SCC supports shared situational awareness, proactive risk management, and coordinated decision-making, enabling partners to respond quickly to emerging pressures and maintain patient safety.

Working closely with providers, Places, NHS Greater Manchester, North West Ambulance Service and regional partners, the SCC coordinates action across organisational boundaries where pressures cannot be resolved locally. It monitors system performance, patient flow, discharge, bed capacity, and escalation activity, facilitating collective action, mutual aid and risk balancing across the health and care system to ensure services remain responsive during periods of increased demand.

The SCC also plays a key role in winter preparedness and escalation, supporting surge and extreme-surge planning, maintaining oversight of community and hospital capacity, and providing a clear route for escalation to senior

operational, clinical, and executive leaders. Through robust intelligence, operational leadership and effective coordination, the SCC helps ensure a consistent and resilient whole-system response throughout the winter period.

Winter Delivery Group

A Greater Manchester Winter Delivery Group will be established from October 2026 to provide system-wide oversight of winter preparedness, delivery, and performance throughout the winter period. The group will bring together senior representatives from primary care, mental health services, adult social care, the System Coordination Centre (SCC), vaccination and immunisation teams, providers, local authorities, and other key partners to ensure a coordinated and joined-up approach to winter delivery.

The group will be responsible for monitoring progress against the actions and priorities set out within the Winter Plan, reviewing operational intelligence, identifying emerging risks, and maintaining oversight of system resilience. It will provide a forum for partners to share learning, resolve barriers to delivery, and ensure collective action is taken to maintain safe, timely and effective services for Greater Manchester residents throughout the winter period.

Where risks, issues or performance concerns are identified, the Winter Delivery Group will coordinate appropriate mitigation and escalation through established governance and operational structures. This will ensure that system leaders maintain oversight of winter pressures, that decisions can be taken at pace where required, and that support is mobilised quickly to respond to emerging challenges and protect patient care.

Recommendations

The NHS GM Board is asked to:

Approve the NHS Greater Manchester Winter Plan 2026/27, recognising that it provides a comprehensive, clinically led and system-wide framework for winter preparedness, response, and recovery.

Note the coordinated approach being taken across Greater Manchester, bringing together NHS providers, primary care, community services, mental health services, local authorities, social care, and wider partners to maintain safe, effective, and timely care throughout the winter period.

Support the governance and oversight arrangements outlined within the plan, including the establishment of a Greater Manchester Winter Delivery Group and the ongoing role of the System Coordination Centre in monitoring delivery, managing risks, and coordinating system responses to emerging pressures.

Receive assurance that arrangements are in place to monitor delivery and escalate risks, enabling timely action to maintain resilience, patient safety, and performance throughout winter 2026/27.

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NHS GM Winter Plan

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Executive Summary

The NHS Greater Manchester Winter Plan 2026/27 sets out the collective approach to preparing for, managing and responding to winter pressures across Greater Manchester. It brings together the contributions of NHS providers, primary care, community and mental health services, North West Ambulance Service, local authorities, social care and voluntary, community and social enterprise partners across Greater Manchester's ten localities.

The plan provides the Greater Manchester framework for understanding whole-area demand and capacity, managing dependencies between services and organisations, coordinating escalation and mutual aid, and maintaining safe and effective care during periods of surge and extreme surge. It complements the more detailed winter plans and delivery arrangements held by individual providers, commissioners and localities.

The plan is aligned with NHS England's *Winter planning 2026/27 – expectations and assurance*. It reflects the national requirement for clinically led and deliverable plans developed jointly by system partners; named executive winter leads within NHS Greater Manchester and each provider; whole-area demand and capacity analysis; regional stress testing in September; and Board approval through the Board Assurance Statement process by 30 September 2026.

Greater Manchester's scale and complexity mean that operational pressure affecting one organisation or pathway can have consequences across the conurbation, including for ambulance response, neighbouring providers, specialist pathways and the availability of mutual aid. The plan therefore addresses winter as a whole-system challenge rather than a collection of separate organisational responses.

Planning is focused on the principal risks associated with seasonal respiratory illness and infectious disease, severe weather, ambulance response and handover delays, emergency department crowding and corridor care, delayed discharge, mental health crisis demand, workforce availability and maintaining essential elective, cancer and other services during periods of increased urgent demand.

The Greater Manchester response is organised around five connected priorities:

1. **Prevention and early intervention:** maximising vaccination uptake, particularly among children, frontline staff and people at greatest clinical risk; using population health and health inequality intelligence to target proactive support; and strengthening arrangements for people vulnerable to winter illness and cold weather.
2. **Care closer to home:** ensuring resilient same-day primary care, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours arrangements, including

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across weekends and holiday periods; maximising Urgent Community Response, Virtual Ward and Hospital at Home capacity; and providing timely access to senior clinical decision-making through coordinated points of access.

3. **Safe hospital flow and discharge:** implementing the Model Emergency Department, Model Acute Pathway and Model Discharge Pathway requirements; supporting 15-minute ambulance handovers, with no handover exceeding 45 minutes; reducing prolonged emergency department waits and corridor care; planning and delivering discharge seven days a week; and working with local authorities and social care partners to reduce avoidable hospital occupancy ahead of Christmas and throughout winter.
4. **Resilient mental health and wider services:** maintaining effective all-age mental health crisis services, crisis alternatives, liaison psychiatry and appropriate plans for high-risk patients and frequent attenders; strengthening infection prevention and control; supporting staff wellbeing and workforce resilience; and maintaining essential elective, cancer and other services.
5. **Coordinated escalation and response:** coordinating the Greater Manchester winter response seven days a week through the System Coordination Centre, using the Integrated OPEL Framework and agreed escalation, surge and mutual-aid arrangements. Operational pressure affecting one provider will be considered in the context of its consequences for NWAS, neighbouring providers, specialist pathways and the wider Greater Manchester system.

These priorities are supported by established and developing Greater Manchester capabilities, including 780 commissioned Hospital at Home and Virtual Ward beds, additional Clinical Assessment Service capacity through GMUPCA, the reactive Falls Lifting Service, primary-care intelligence and performance dashboards, Pharmacy First and urgent dental pathways, the Greater Manchester Directory of Services and the 24-hour Mental Health First Response Service. The Greater Manchester UEC Capacity Fund will support schemes contributing to admission avoidance, patient flow, urgent primary and community care and wider system resilience.

Following a recent visit from the GIRFT National Team, it was recommended that the ICB will start to work towards following the Clinical Operational Standards across urgent and emergency care pathways, using them as a practical framework to reduce unwarranted variation, improve patient flow and support timely access to care.

The standards emphasise early senior clinical decision-making, effective specialty engagement,

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prompt assessment and treatment, and strong multidisciplinary working to ensure patients receive the right care, in the right place, at the right time. With emergency departments and inpatient services expected to experience sustained pressure over the winter period, it is essential that these standards are routinely applied and reinforced across operational and clinical teams, supporting safer care, improved flow, and a reduction in excessive waits throughout the UEC pathway.

A named NHS Greater Manchester executive winter lead, supported by named executive leads in each provider organisation, will provide accountability for preparedness, response and delivery. Providers will remain accountable for their organisational winter plans and operational performance. NHS Greater Manchester will lead the Greater Manchester plan, commission appropriate capacity, coordinate the system response and identify where collective action, mutual aid or escalation is required. NHS England's regional team will oversee and assure preparedness and coordinate mutual aid across ICB boundaries where necessary.

Preparedness will be assessed through whole-system demand and capacity analysis, agreed planning assumptions, scenario-based stress testing and confirmation of the capacity, workforce, leadership and operational arrangements required to respond to surge and extreme-surge conditions. This will include testing escalation routes, on-call arrangements, business continuity, mutual aid and the ability to maintain safe services during sustained pressure.

Delivery will be monitored throughout winter using quantitative performance information, local operational intelligence and direct liaison with providers and partners. System risks, actions and mitigations will be reviewed through NHS Greater Manchester governance and operational coordination arrangements, enabling the system to respond to changing conditions and apply learning throughout the winter period.

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1. Introduction and Purpose

Winter pressures affect the whole health and care system. Seasonal respiratory illness, infectious disease, severe weather and increased workforce absence can intensify existing pressures across urgent and emergency care, primary care, community services, mental health, social care and hospital discharge. These pressures can also affect the ability of providers to maintain elective, cancer and other essential services.

Greater Manchester's size, population diversity and complex provider landscape create significant interdependencies between services and organisations. Pressure within one locality, provider or pathway can quickly affect ambulance response, neighbouring hospitals, community and social care capacity, specialist services and patient flow across the wider system. Effective winter planning therefore requires both strong local delivery and coordinated action at Greater Manchester level.

The purpose of this plan is to establish the shared framework through which Greater Manchester partners will prepare for and respond to winter 2026/27. It:

- sets out the collective priorities for winter preparedness and delivery;
- brings together whole-area demand and capacity assumptions;
- describes the principal services, pathways and commissioned capacity supporting the winter response;
- identifies the roles of providers, localities, commissioners and system partners;
- establishes arrangements for operational oversight, escalation, surge, mutual aid and regional engagement; and
- provides the basis for monitoring delivery, managing risks and assuring preparedness throughout winter.

The plan covers services for adults, children and young people across the urgent and emergency care pathway and the wider services needed to prevent avoidable deterioration, support care closer to home and maintain safe patient flow. It includes prevention and vaccination, primary and community care, NHS 111, ambulance services, mental health crisis care, acute hospital services, discharge, social and intermediate care, workforce resilience, infection prevention and control and continuity of essential planned services.

This is a Greater Manchester-level plan. It complements, and does not replace, the detailed operational plans held by individual NHS providers, primary care, local authorities, social care partners and localities. Those organisations remain responsible for delivering their services, maintaining appropriate local escalation and business-continuity arrangements and responding

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to pressure within their areas. The Greater Manchester plan focuses on collective risks, cross-organisational dependencies, commissioned system capacity and the circumstances in which coordinated action or mutual aid is required.

The plan has been developed in accordance with NHS England's Winter planning 2026/27 – expectations and assurance. It is informed by provider and locality plans, whole-system demand and capacity analysis, population-health intelligence, operational experience, existing service and pathway information and the NHS England Board Assurance Statement requirements. It will be tested through the NHS England regional stress-testing exercise and updated to reflect the outcomes of that exercise and any further assurance undertaken before final Board approval.

In line with the national operating model, NHS Greater Manchester is responsible for leading the whole-area winter plan, commissioning appropriate capacity and coordinating the system response. Providers are accountable for operational delivery, while NHS England North West will oversee preparedness and performance and coordinate support across ICB boundaries where required. Day-to-day Greater Manchester coordination will be undertaken through the System Coordination Centre, working with local operational teams, NHS Greater Manchester on-call arrangements and regional partners.

The remainder of the plan is structured around the five connected priorities set out in the executive summary: prevention and early intervention; care closer to home; safe hospital flow and discharge; resilient mental health and wider services; and coordinated escalation and response. Together, these provide the framework for preparing for winter, responding to sustained operational pressure and maintaining safe, timely and equitable care for Greater Manchester residents.

2. Priorities

The priorities provide the organising framework for Greater Manchester's winter response. They focus on the areas where coordinated action is most needed: preventing avoidable deterioration, maintaining access to urgent and emergency care, supporting safe patient flow, protecting wider services and ensuring the system can respond effectively to sustained pressure.

1. **Prevention and early intervention** is included to reduce avoidable illness, deterioration and urgent demand by maximising vaccination uptake, using population health intelligence and targeting proactive support to people most at risk from winter viruses and cold weather.
2. **Care closer to home** is included to ensure people can access timely primary, community, pharmacy, NHS 111 and out-of-hospital services, reducing unnecessary ambulance conveyance, emergency department attendance and hospital admission.

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3. **Safe hospital flow and discharge** is included to address the risks associated with emergency department crowding, ambulance handover delays, corridor care, delayed discharge and avoidable bed occupancy, particularly during periods of peak winter pressure.
4. **Resilient mental health and wider services** is included to ensure people experiencing mental health crisis can access appropriate support, while also protecting infection prevention and control, workforce resilience, staff wellbeing and essential elective, cancer and other services.
5. **Coordinated escalation and response** is included because winter pressures often affect multiple services and organisations at the same time. It sets out how the System Coordination Centre, OPEL arrangements, mutual aid and regional escalation will support a single Greater Manchester response when pressures increase.

3. Priority 1: Prevention and Early Intervention

3.1. Vaccination Uptake and Maximising Uptake in Children

Prevention and early intervention are central to Greater Manchester's winter approach. Seasonal vaccination programmes will continue across all localities, aligned to national eligibility criteria and focused on protecting priority cohorts from winter illnesses. Delivery of flu, COVID-19, RSV and pneumococcal vaccination programmes will be monitored through established system governance and reporting arrangements, enabling timely action where uptake varies and ensuring resources are directed towards communities with the greatest need.

The programme will focus on reducing health inequalities and improving access for underserved populations. Working with local authorities, primary care, provider organisations and VCSE partners, Greater Manchester will support targeted initiatives including mobile outreach, maternity immunisation services, extended access, community engagement and tailored approaches for newly eligible and vulnerable groups, including people experiencing homelessness. Call and recall mechanisms will also be strengthened to maximise uptake among higher-risk cohorts. To further reduce missed opportunities, eligible vaccines may be co-administered where clinically appropriate, improving convenience and strengthening protection before peak winter activity.

Children aged two and three can access seasonal flu vaccination through participating general practices and community pharmacies. For 2026/27, the Greater Manchester Integrated Vaccination and Immunisation Service (GM IVIS) will offer vaccination in preschools attached to schools. School-aged children will be offered vaccination at school and through community catch-up; from 1 December 2026, children who miss these opportunities can access vaccination through participating community pharmacies as part of a new national initiative. The GM IVIS service will also provide catch-up and outreach for older adolescents, including Year 12 and

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Year 13 students where appropriate.

The Greater Manchester Care Record and population health management capabilities underpin the system's approach to identifying and supporting vulnerable residents throughout the winter period. Intelligence and risk stratification tools are used across neighbourhoods, places and provider organisations to identify individuals at increased risk of deterioration, admission and poor winter outcomes. These insights enable partners to target preventative interventions earlier, monitor vaccination uptake, identify emerging risks and ensure that support is directed towards those most likely to benefit.

Risk-stratified approaches are embedded across primary care, community services and neighbourhood teams to proactively manage vulnerable populations and reduce avoidable hospital attendances and admissions. Interventions include personalised care planning, medicines optimisation, pre-winter health checks, access to antiviral treatments where clinically appropriate, and wider community-based support. Through targeted winter investment and access and inequalities funding, local systems are enhancing proactive care planning arrangements for individuals at greatest risk of emergency department attendance or hospital admission, helping to maintain independence and wellbeing during periods of increased winter pressure.

Multidisciplinary working at neighbourhood level will strengthen this approach. A proactive MDT programme will support primary care and community teams to identify and manage high-risk individuals through coordinated, person-centred interventions. Neighbourhood MDTs will continue to support people experiencing crisis or requiring wider system intervention, ensuring that care is coordinated across organisational boundaries and delivered as close to home as possible.

3.2. Proactive support for people most at risk from winter viruses and cold weather

Risk identification will not be restricted by age and will include people with multiple long-term conditions, respiratory or cardiovascular disease, diabetes, renal or liver disease, immunosuppression, frailty, significant medication-related risks, previous emergency department attendances or hospital admissions and high use of urgent care services. It will also include younger people with significant co-morbidities, people with severe mental illness or learning disabilities, care-home residents, people who are housebound and other clinically or socially vulnerable cohorts who may be more susceptible to serious illness or admission because of winter viruses.

Delivery will be supported by NHS Greater Manchester's 2026/27 “Keep Protected this Winter” campaign, which will provide a single public-facing vaccination hub with tailored information for pregnant women, children and young people, older people and children and adults with long-

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term health conditions. Our flu vaccination programme has already started for children and young people which helps keep children well over winter and reduces lost school day. Communications will distinguish between time-limited seasonal programmes and year-round vaccinations that are particularly important in reducing serious respiratory illness and hospitalisation during winter. National and local communications, proactive invitations, the NHS App, text messages, letters, social and digital media, provider and place-based channels and VCSE partners will be used to reinforce uptake and direct people to general practice, pharmacy, the National Booking Service, walk-in provision and NHS 119 for COVID-19 support.

Prevention planning will also include proactive support for people most at risk from winter viruses and cold weather, including targeted advice, welfare and community support were wider determinants such as fuel poverty, housing conditions or isolation may increase risk of deterioration.

4. Priority 2: Care Closer to Home

4.1. Primary Care, NHS 111, Community Pharmacy and Out-of-Hours Provision

Primary care will play a central role in Greater Manchester's winter response, providing both routine and urgent access to care while supporting system-wide admission avoidance. Winter planning will consider anticipated demand, planned and surge capacity, escalation arrangements, and out-of-hours provision, including weekends and bank holidays. General Practice, Integrated Urgent Care (IUC), Clinical Assessment Services (CAS) and other primary care services will work together to ensure that patients can access timely care in the most appropriate setting, reducing unnecessary demand on emergency departments and acute services.

System oversight will be provided through the Greater Manchester System Coordination Centre (SCC), which will maintain operational awareness of pressures across primary care, NHS 111 and admission avoidance pathways throughout the winter period. The SCC will utilise operational intelligence, escalation processes and system coordination arrangements to identify emerging risks, support local responses where capacity becomes constrained and take action where primary care pressures have the potential to impact patient flow or wider urgent and emergency care performance.

The system will also maintain oversight of NHS 111 capacity and urgent care pathways so that people are directed to the most appropriate service first time wherever possible. Through ongoing collaboration between urgent care providers, ambulance services, community teams and primary care, partners will seek to maximise alternatives to emergency department attendance and support clearer patient navigation during periods of sustained pressure.

Through the BeCCoR programme, GP practices will work collaboratively with neighbourhood

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teams, local authorities, and voluntary, community, faith and social enterprise (VCFSE) partners to identify and support cohorts who are less likely to engage with preventative healthcare services and who may be at greater risk of poor health outcomes during the winter period.

Neighbourhood Action Plans will be developed through local engagement and co-production, using neighbourhood intelligence, demographic insights, and understanding of population need to target interventions where they can have the greatest impact. These plans will set out agreed priorities, actions, outcomes and partnership arrangements to improve access to care, address barriers to engagement, promote healthier lifestyles, and connect people to wider community support. This approach will help reduce health inequalities, strengthen preventative care, and enable earlier intervention for vulnerable residents before health needs escalate.

The programme will also support stronger integration between primary care, neighbourhood teams and community partners through established neighbourhood forums. This will enable coordinated action to improve access to clinical services, strengthen referral pathways to local wellbeing and social support offers, and ensure that both clinical and non-clinical interventions are aligned to local priorities. By improving engagement with high-risk cohorts and supporting people to access the right care and support earlier, the programme is expected to contribute to improved wellbeing, reduced avoidable demand on health services, and enhanced system resilience throughout winter.

Delivery will be supported through a dedicated Neighbourhood Prevention Allocation, overseen through place-based governance arrangements to ensure investment aligns with local neighbourhood priorities and delivers measurable outcomes. An evaluation framework will be used to monitor the impact of interventions and provide assurance that neighbourhood-based preventative approaches are delivering benefits for both the identified BeCCoR cohorts and the wider population, supporting the objectives of the Greater Manchester Winter Plan.

The VCSE sector is a critical partner in supporting winter resilience across Greater Manchester, providing a wide range of preventative, community-based and targeted services that help reduce demand on urgent and emergency care.

Across all boroughs, VCSE organisations deliver mental health and wellbeing support, counselling, family support, carer services, disability and sight-loss support, cancer support, advocacy, welfare advice, public health initiatives and programmes aimed at vulnerable groups, helping people access support earlier and maintain their independence within their communities. These services are particularly important during winter, when pressures on health and care services increase and individuals may be at greater risk of deterioration, social isolation or crisis.

VCSE partners also play a significant role in addressing health inequalities and supporting

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populations that may otherwise struggle to access statutory services. Organisations provide specialist support for diverse communities, including people experiencing mental ill health, carers, disabled people, LGBTQ+ communities, women, ethnic minority populations and those requiring interpreting and advocacy services. Through close collaboration with NHS, local authority and community partners, the sector contributes to prevention, early intervention, wellbeing, social prescribing and community capacity, helping to keep people well at home, reduce avoidable attendances and admissions, and strengthen system resilience throughout the winter period

4.2. Same-day urgent appointments and NHS 111 direct booking

Access to primary care services will continue to be closely monitored to ensure delivery against contractual requirements, including opening hours, online consultation, same-day clinically urgent access and the availability of appointments for NHS 111 direct booking. A comprehensive suite of intelligence and performance dashboards, including the GM Intelligence Hub GPAD dashboards, GM GP Quality Dashboard and a locally developed version of the national GP dashboard, will provide timely oversight of access, activity and demand trends. Intelligence on primary care performance will be regularly reviewed through established governance arrangements and fed into wider winter planning, assurance and escalation processes.

Assurance will include monitoring access throughout contractual core hours; availability of online consultation throughout core hours; appropriate same-day response for clinically urgent matters; and provision of the required daily capacity for NHS 111 direct booking, including a minimum of one appointment for practices with up to 3,000 registered patients and one appointment for each whole 3,000 registered patients for larger practices. Progress against the national planning ambition for 90% of clinically urgent patients to receive a same-day appointment will also be monitored through established primary care commissioning and contract-management arrangements.

4.3. Enhanced access, out-of-hours provision and holiday arrangements

Primary Care Network (PCN) Enhanced Access arrangements will provide additional capacity outside of core practice hours, supporting patients to access appropriate care closer to home. Winter planning will focus on maximising the utilisation of available appointments, including enabling NHS 111 services to make greater use of unused same-day capacity where appropriate. Enhanced intelligence capability will enable the system to monitor trends in NHS 111 demand, GP activity and urgent care utilisation, supporting proactive planning and targeted interventions during periods of increased pressure.

Under the Network Contract DES, PCNs are required to provide a minimum of 60 minutes of

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Enhanced Access appointments per 1,000 adjusted population each week and to make unused same-day appointments available to NHS 111 during Network Standard Hours. Greater Manchester will triangulate available activity, demand and utilisation data with contractual and local operational intelligence, recognising current limitations in Capacity, Booking and Telephony data before drawing conclusions about compliance or operational impact.

4.4. Community pharmacy, Pharmacy First, Urgent Dental Care and the Directory of Services

Community pharmacy services will form a key component of Greater Manchester's winter demand management and admission avoidance offer. Continued expansion of Pharmacy First and wider community pharmacy referral pathways will support the redirection of patients with lower acuity conditions away from emergency departments and urgent treatment centres into community-based care. Dedicated support is in place across the community pharmacy and general practice interface to maximise referrals and promote consistent utilisation of pharmacy services. Weekly system oversight and locally developed performance dashboards will support continual monitoring, issue resolution and service improvement throughout the winter period.

Pharmacy First activity will be monitored through dashboards within the GM Intelligence Hub, supporting practices, PCNs and locality teams to understand referral activity and service use. The GM Services Working Group, a weekly collaboration between NHS GM and the Local Pharmaceutical Committee, will continue to review delivery, identify operational barriers and coordinate action. NHS GM is also working with emergency departments and urgent treatment centres to implement and increase use of the UEC Pharmacy First referral pathway, with most GM Acute sites expected to be live before winter.

Additional admission avoidance benefits will be delivered through the Community Pharmacy Discharge Medicines Service, which supports safe transfer of care following discharge and helps reduce avoidable re-admissions. The ICB is also continuing to support implementation of the Urgent and Emergency Care Pharmacy First pathway across emergency departments and urgent treatment centres, enabling the direct referral of suitable patients into community pharmacy services and ensuring they receive care in the most appropriate setting.

Urgent dental services will continue to provide an important alternative to emergency department attendance during the winter period. Existing Greater Manchester arrangements, including urgent dental helplines, seven-day emergency dental provision and urgent dental hubs, will be maintained and monitored through established commissioning arrangements to ensure access is sustained during periods of increased demand and reduced availability over holiday periods. This work will be complemented by a coordinated public communication approach designed to promote awareness of available primary care, community, pharmacy, dental and urgent care services, helping residents access the right care, in the right place, at the

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right time throughout winter.

Effective Directory of Services (DoS) management will underpin the success of NHS 111, CAS and admission avoidance pathways. The DoS team will work closely with Places and providers to ensure that service information, referral criteria, operating hours and any additional winter capacity are accurately reflected within the Directory of Services. This will support NHS 111 and clinical triage services to direct patients appropriately and ensure that operational intelligence can be used to identify and resolve pathway issues quickly should pressures emerge during the winter period.

As part of winter readiness, the GM Directory of Services team will coordinate a review with Places and providers to validate priority primary care and community service profiles against planned operational capacity. This will include ensuring additional winter capacity is reflected before it becomes operational and that changes to opening hours, referral arrangements or service availability, including over Christmas and New Year, are updated promptly. A clear route will be maintained for escalating and resolving discrepancies or capacity pressures arising during periods of increased demand.

4.5. Community services: Urgent Community Response, Virtual Wards, Hospital at Home and Single Points of Access

Community services are central to Greater Manchester's approach to winter resilience, supporting admission avoidance, care closer to home and timely discharge. Winter planning will maximise commissioned Urgent Community Response, Virtual Wards, Hospital at Home, Clinical Assessment Services and other community-based alternatives, supported by clear referral routes and operational oversight.

Single Points of Access are established across Greater Manchester localities and will continue to support referral into UCR, Hospital at Home, Virtual Wards, Same Day Emergency Care and other alternatives to admission. Each locality will confirm access to senior clinical decision-making through its SPoA for at least 12 hours a day, seven days a week, in line with the national expectation.

Hospital at Home and Virtual Ward services currently provide 780 commissioned beds across Greater Manchester, supporting both step-up care from the community and step-down care from acute providers. Available capacity across localities will be actively maximised throughout winter, with the final winter plan bringing together demand, commissioned capacity, activity and utilisation information across UCR, Virtual Wards, Hospital at Home, SPoAs and relevant community diagnostic pathways to test capacity against anticipated winter demand and identify unwarranted variation or underutilisation.

Recognising the importance of senior clinical assessment in avoiding unnecessary conveyance

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and hospital attendance, NHS Greater Manchester has commissioned additional Clinical Assessment Service (CAS) capacity through GMUPCA. This investment will provide enhanced clinical support for NHS 111 and 999 services, enabling more lower-acuity patients to be safely assessed and managed through alternative pathways closer to home. By increasing access to clinical advice at the earliest stage of the patient journey, the system aims to improve patient experience, reduce unnecessary emergency department attendances and ensure more effective utilisation of urgent and emergency care resources.

The ICB has also commissioned a reactive Falls Lifting Service for patients who have experienced a non-injurious fall within their home environment. This service provides an important alternative response for patients who do not require emergency clinical intervention, reducing avoidable ambulance conveyance and supporting people to remain safely at home. In addition to delivering improved patient and carer outcomes, this approach will help release UCR capacity to respond to higher-acuity patients and contribute to overall system resilience during periods of increased demand.

Partners will also continue to support existing direct access pathways that are reducing unnecessary acute demand. Clinicians and operational teams will be encouraged to use these pathways wherever clinically appropriate, so patients can access the right service first time and avoid unnecessary transfers between services.

The Greater Manchester System Coordination Centre (SCC) will provide system-wide oversight of community capacity throughout the winter period. Through routine monitoring of operational intelligence and system pressures, the SCC will maintain visibility of urgent community response services, Hospital at Home provision, Virtual Ward occupancy and other community-based capacity that supports admission avoidance and discharge. This will enable the early identification of emerging constraints and support coordinated action where capacity pressures risk impacting patient flow, discharge performance or wider system resilience.

These arrangements will help Greater Manchester make best use of community-based services throughout winter 2026/27. By strengthening links between primary care, community services, acute providers, ambulance services, local authorities and social care partners, the system will support earlier intervention, reduce avoidable admissions, improve discharge outcomes and maintain safe care during periods of increased demand.

4.6. Commissioning and maximising out-of-hospital capacity

Greater Manchester will maximise out-of-hospital capacity through a coordinated whole-system approach that enables people to receive care in the most appropriate setting, reduces avoidable conveyance and admission, and supports earlier discharge. This will require close collaboration between acute providers, community services, primary care, ambulance services, local

authorities and social care partners so that available capacity is visible, accessible and aligned to patient need.

The ICB will work with system partners to improve visibility, access and utilisation of community and admission avoidance pathways, including Urgent Community Response (UCR), Hospital at Home, Virtual Wards, Same Day Emergency Care (SDEC) services and other community-based alternatives to admission. Through established referral routes, operational coordination and proactive capacity management, partners will seek to ensure that patients are directed to the most appropriate service first time, reducing unnecessary attendance at Emergency Departments and supporting care closer to home wherever clinically appropriate.

A significant focus throughout the winter period will be understanding how commissioned capacity is being utilised across the system and ensuring that any unused, underutilised or constrained capacity is identified and acted upon quickly. The ICB will maintain oversight of pathway utilisation, access criteria, service performance and operational pressures through established governance arrangements, including Provider Oversight Meetings, service review meetings, contract management processes and the Greater Manchester Urgent and Emergency Care Development Group. These forums will provide assurance that commissioned services are delivering their intended benefit and enable timely challenge, escalation and resolution where barriers to utilisation are identified.

Senior clinical and executive leaders will remain sighted on operational performance throughout winter, enabling informed decision-making where intervention is required. Routine review of operational intelligence and performance information will support early identification of risks, collective problem solving and continued focus on optimising patient flow and out-of-hospital capacity.

4.7. Urgent and Emergency Care Capacity Fund

The Urgent and Emergency Care (UEC) Capacity Fund is a system-wide investment designed to provide additional capacity and resilience across Greater Manchester's urgent and emergency care services. The fund supports a range of initiatives across place-based systems, community services, primary care and wider urgent care pathways, helping services respond to periods of increased demand while maintaining safe and timely care for patients. The 2026/27 review has focused on ensuring that investment remains aligned to deliverability, winter relevance and measurable impact on UEC outcomes.

The fund plays a key role in supporting winter resilience by strengthening patient flow, reducing avoidable admissions, improving access to urgent and community-based care, and supporting delivery of key operational standards. By investing in capacity outside of traditional hospital settings, the fund helps patients access care closer to home while reducing pressure on

emergency departments and inpatient services during periods of peak demand. The review recognised that protecting effective schemes is essential to avoid destabilising operational performance during winter.

A number of schemes have been assessed as continuing because they demonstrate a clear contribution to winter delivery and system resilience. These include system resilience schemes, admission avoidance initiatives, high-intensity user support models, CRP Point of Care Testing enhanced primary and community care provision, and other place-based programmes designed to improve patient flow and reduce pressure across urgent and emergency care pathways. The assessment considered factors such as winter relevance, deliverability, evidence of impact and alignment with wider UEC priorities.

Alongside protecting schemes that support winter performance, the review also introduces a strengthened mobilisation and assurance approach to ensure funded initiatives are delivered as intended and generate the expected benefits. This will provide greater oversight of implementation, help identify opportunities for learning and improvement, and support the development of a more transparent, evidence-led commissioning framework for future years. Overall, the UEC Capacity Fund remains a critical enabler of Greater Manchester's whole-system approach to winter planning, helping services maintain resilience, support patient access and improve outcomes across the urgent and emergency care system.

5. Priority 3: Safe hospital flow and discharge

5.1. Flow, occupancy and discharge

Effective patient flow and timely discharge remain central to Greater Manchester's approach to maintaining operational resilience throughout the winter period. System partners across acute, community, mental health, primary care, local authority and social care services will continue to work collectively to ensure patients receive care in the most appropriate setting and are supported to return home as soon as they are clinically ready to do so.

Established seven-day operational processes are in place across providers to support patient flow and discharge, including daily review of demand and capacity, oversight of patients with No Criteria to Reside (NCTR), discharge planning, and management of long delays. These arrangements are supported by robust escalation and coordination processes, including daily system operational calls, regular reviews of out-of-area patients and senior multi-agency escalation meetings focused on resolving barriers to discharge. During periods of increased operational pressure, escalation arrangements will be enhanced to ensure additional capacity can be mobilised rapidly and that system-wide risks are managed collectively.

The ICB will work alongside Places and providers throughout the winter period to strengthen local discharge and flow initiatives, including the use of Perfect Weeks, MADE events,

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enhanced ward and board rounds and actions designed to accelerate discharge ahead of anticipated periods of peak demand. Particular focus will be given to understanding and maximising the contribution of Home First services, Urgent Community Response (UCR), Hospital at Home, Virtual Wards and community capacity to support patients to remain at home wherever clinically appropriate. Working in partnership with local authorities and the GM Adult Social Care Transformation Team, the ICB will also maintain oversight of care home and domiciliary care capacity to support effective discharge arrangements across Greater Manchester.

A continued priority for the system is the further embedding of Home First and Discharge to Assess principles. Partners will work together to ensure assessments take place outside of hospital wherever possible, enabling more people to return home promptly and reducing avoidable hospital occupancy. Alongside this, providers will review discharge pathway utilisation against national model discharge expectations, identifying opportunities to reduce reliance on Pathways 2 and 3, increase Pathway 0 and 1 discharges and shorten the time between patients becoming medically fit and returning home. Places will provide assurance to the ICB that discharge pathway reviews have been undertaken and that appropriate challenge processes are in place to support optimal pathway allocation and flow.

Discharge planning will continue to be delivered through collaborative multi-disciplinary arrangements involving NHS organisations, local authorities and social care partners. Strong links between Care Transfer Hubs, community teams and hospital-based services will support early identification and resolution of discharge barriers, timely decision-making and coordinated care transitions. The ICB will support Places in strengthening these arrangements, sharing learning and identifying opportunities to improve consistency of practice across Greater Manchester.

Reducing and ultimately eliminating corridor care remains a key objective for the system. Providers and Places will continue to prioritise actions that improve flow through the urgent and emergency care pathway, reduce discharge delays, improve ambulance handovers and ensure escalation processes are enacted at the earliest opportunity. Winter plans will include clearly defined escalation thresholds, patient safety mitigations and agreed actions to be taken when demand exceeds available capacity. The system will also continue to promote early planning for discharge, including timely identification of transport requirements and proactive management of patients requiring repatriation through established out-of-area discharge processes.

Provider winter plans will confirm implementation of the national Model Emergency Department, Model Acute Pathway and Model Discharge Pathway requirements ahead of winter. This will include actions to improve front-door streaming and assessment, acute pathway performance during the first 72 hours of care, timely senior decision-making, discharge pathway allocation

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and reduction of avoidable bed occupancy, while treating the elimination of corridor care as a patient-safety priority.

The 2026/27 Better Care Fund (BCF) plans and assurance returns provide a valuable source of both narrative and financial intelligence to support winter demand and capacity modelling, particularly in relation to patient discharge, intermediate care and out-of-hospital capacity. They offer a comprehensive understanding of how health and social care partners jointly plan, fund and manage services at Place level, including intermediate care provision, community beds and hospital discharge pathways.

The BCF submissions also demonstrate the strength of partnership working and multidisciplinary collaboration across Greater Manchester, providing assurance that health and social care resources are being aligned to support timely discharge and reduce delays. Using the approved 2026/27 BCF plans to inform winter planning will strengthen NHS GM's ability to model and respond to seasonal pressures, ensuring that capacity is targeted effectively, discharge pathways remain resilient, and patients are supported to leave hospital safely and promptly throughout the winter period.

The GM Hospices Capacity & Operational Pressures Escalation (COPE) dashboard is now live, providing daily visibility of hospice capacity and pressures across Greater Manchester. The dashboard provides near real-time information on inpatient and Hospice at Home capacity, live workforce pressures, and hospice-specific Operational Pressures Escalation Levels (OPEL) ratings, to support operational decision-making and system flow.

Work is already underway with hospices, the System Coordination Centre and ICB colleagues to promote routine use of the dashboard and agree appropriate system escalations, to ensure that hospice capacity is quickly visible to stakeholders, issues are quickly unblocked, and services are utilised optimally for the timely care of patients with appropriate Specialist Palliative Care needs.

Engagement is also underway to explore how the dashboard could support winter planning arrangements. As NHS GM will have visibility of all adult inpatient hospice bed capacity, including closed beds, the dashboard could identify commissioning opportunities should the need to step up more capacity become apparent. This would need to be a planned, controlled and funded process due to the workforce implications - with early, more localised, provider-specific conversations being had, with clear timescales of opening and closure of those escalated beds and agreed criteria for referrals.

Recognising the predictable pressures associated with the Christmas and New Year period, providers will develop specific holiday flow and occupancy plans as part of their winter readiness arrangements. These plans will identify opportunities to create capacity ahead of

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holiday periods through enhanced discharge activity, additional clinical review processes and strengthened partnership working with adult social care and community services. The ICB and SCC will maintain system oversight throughout this period to monitor performance, coordinate escalation where required and ensure continuity of operational support during periods of sustained pressure.

Together, these arrangements will help improve patient flow, reduce avoidable occupancy and discharge delays, and support safe, high-quality care in the most appropriate setting throughout winter 2026/27.

5.2. Social care, intermediate care and reducing occupancy ahead of Christmas

Social care and intermediate care capacity will be commissioned and planned jointly with local authorities, with discharge arrangements agreed across NHS providers, Places and social-care partners. The winter plan will maintain oversight of discharge demand, Pathway 0–3 capacity, care-home and home-care availability, and agreed actions to reduce avoidable hospital occupancy ahead of Christmas and New Year.

5.3. Ambulance pathways and handovers

Ambulance pathway delivery will be monitored with providers and North West Ambulance Service against the national expectations to improve Category 2 response performance, maximise hear-and-treat, see-and-treat and referral into alternatives to emergency departments, and support 15-minute handovers with none exceeding the 45-minute maximum. Corridor-care and ambulance-handover risks will be considered together so that risk is not transferred between parts of the urgent and emergency care pathway.

6. Priority 4: Resilient mental health and wider services

6.1. All-age mental health crisis services, NHS 111, crisis alternatives and liaison psychiatry

Mental health services will contribute to winter resilience through coordinated improvement across urgent, crisis and inpatient pathways. The focus is on ensuring people experiencing a mental health crisis receive timely support in the most appropriate setting, reducing pressure on emergency departments and supporting safer flow across the wider urgent and emergency care system.

A key area of work is the reduction of mental health-related long waits within emergency departments. System-wide improvements are being implemented through enhanced crisis pathways, workforce development and strengthened inpatient flow arrangements. These interventions are designed to improve assessment times, reduce delays in accessing specialist support and minimise avoidable attendances and prolonged stays within emergency

departments, supporting overall winter performance across acute services.

Alongside this, the Inpatient Quality Transformation Programme is delivering improvements in staffing, recruitment and governance, helping to strengthen the quality and resilience of inpatient mental health services. This is being supported by demand and capacity modelling to better understand future service requirements, improve patient flow and reduce the need for out-of-area placements. Together, these initiatives will help ensure inpatient services are better able to respond to winter demand while maintaining high standards of care.

The Mental Health First Response Service through NHS 111 and 999 is strengthening the system's response to urgent mental health needs. Operating as a 24/7 "hear and treat" model, the service provides expert mental health triage, supports blue-light services and helps direct people to the most appropriate care pathway. This will reduce unnecessary ambulance conveyance and emergency department attendance while improving access to timely crisis support.

6.2. Crisis plans for high-risk patients and frequent attenders ahead of winter

In line with national winter expectations, Greater Manchester will assure resilient all-age mental health crisis provision, including urgent mental health support via NHS 111, crisis alternatives and liaison psychiatry. Crisis plans will be reviewed ahead of winter for high-risk patients and frequent attenders, with operational risks escalated through mental health, urgent care and system governance where they may affect emergency department demand, ambulance conveyance or inpatient flow.

6.3. Infection prevention and control in care homes and the wider care sector

Infection prevention and control forms part of Greater Manchester's winter commissioning and assurance approach, with particular attention to safe practice in care homes and the wider care sector. Providers, local authorities and care-sector partners will review readiness for respiratory viruses, norovirus and other seasonal infection risks, including vaccination, outbreak management, PPE, isolation arrangements, escalation routes and the potential impact of outbreaks on discharge, care-home capacity and patient flow.

6.4. Workforce resilience and staff wellbeing

Workforce resilience remains a key component of winter preparedness. Providers will identify potential workforce vulnerabilities and develop local mitigation plans to support service continuity during periods of increased demand, high vacancy levels, industrial action, seasonal illness or other operational pressures. The ICB will work with partners to maintain visibility of significant workforce risks and support a coordinated response where pressures affect system resilience or patient safety. Attention will be given to maintaining critical services, supporting operational flexibility and ensuring sufficient staffing is available to support escalation capacity

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where required.

6.5. Maintaining elective, cancer and other essential services

- Winter delivery will seek to maintain elective, cancer and other essential capacity throughout the winter period wherever clinically and operationally safe to do so. Providers will identify risks to agreed 2026/27 trajectories arising from winter pressure, escalation capacity, workforce constraints or infection-prevention requirements, with mitigations escalated through provider and system governance.
- Business continuity and contingency planning will remain a core part of wider service resilience, including arrangements for severe weather, infectious disease outbreaks, industrial action, workforce disruption and other foreseeable risks that could affect service continuity during winter.
- With regards to Children and Young People, our long-term conditions transformation efforts continue year-round and include salbutamol weaning plans piloted in 7/10 district general hospitals.
- We have finalised primary care asthma standards finalised, ensuring consistent practice across GM during high-pressure months and there is an asthma prescribing guideline in development.
- Asthma friendly schools have been launched with a framework and policy distributed to schools across Greater Manchester.
- T2D screening pilot progressing, with ABL Health embedding screening tools and training into family weight-management sessions.
- There is an updated PEWS digital risk assessment, strengthening deterioration pathways; further digital updates are planned.
- Core standards of care for epilepsy services have been agreed by the GM CYP Epilepsy group and an audit is planned to understand where gaps lie across services.
- GM will seek to fully optimise surgical hub assets and Independent Sector providers to ensure continued operating over winter period

7. Priority 5: Coordinated escalation and response

7.1. Whole-area demand and capacity analysis

Greater Manchester's winter planning brings together acute, community, primary care, ambulance, mental health, social care and local authority partners to prepare for increased

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seasonal demand. Planning assumptions reflect anticipated activity, patient-flow pressures, workforce resilience and escalation requirements, enabling partners to develop coordinated and proportionate responses throughout winter.

The pre-winter demand and capacity review has provided NHS GM with a comprehensive understanding of system capacity, demand pressures, discharge pathways and surge arrangements across Greater Manchester. Through the review, partners have identified available capacity, key risks and mitigation plans, ensuring that the system has the intelligence required to plan for and respond to winter pressures. This evidence base will continue to inform operational decision-making, demand and capacity modelling, and the deployment of resources throughout the winter period.

Oversight of the review findings and associated actions will be maintained through the GM Operational Winter Group, which will provide a forum for ongoing monitoring of demand, capacity, flow and discharge performance. This will enable system partners to identify emerging pressures early, coordinate responses, track the delivery of agreed actions and ensure that collective system capacity is utilised effectively to support resilience and maintain safe patient care throughout winter.

The GM System Coordination Centre, GM Care Record and Analytics and Data Science Platform will provide the intelligence capability supporting winter planning and operational decision-making. This will enable system partners to maintain visibility of demand, capacity, flow and emerging risks, and to understand how pressure in one part of the pathway may affect other services. Draft surge and extreme-surge arrangements will be tested through planned winter-preparedness and system-exercise activity, with findings, gaps and required improvements incorporated into final delivery, escalation and resilience arrangements before winter.

7.2. Surge and extreme-surge planning

Recognising that periods of sustained demand can place significant pressure on services, providers have established surge and escalation arrangements that set out the actions required during periods of heightened operational challenge. Winter plans will include defined surge and extreme-surge responses, supported by clear escalation routes, operational leadership and decision-making processes. These arrangements will be tested through winter preparedness exercises and assurance processes to ensure organisations are able to respond effectively to both anticipated and unexpected pressures.

7.3. Mutual aid and regional escalation

Mutual aid arrangements will be agreed with system partners before winter and tested as part of escalation and surge preparedness. Where reasonable local mitigations have been exhausted,

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the SCC will coordinate consideration of mutual aid between providers or localities, taking account of current system pressures, available capacity, the impact on the supporting organisation and the balance of risk across the pathway. Where pressures exceed Greater Manchester capacity or involve pathways commissioned outside ICB arrangements, escalation routes will enable engagement with NHS England North West and regional coordination of support where required.

7.4. Bed escalation capacity

Providers are reviewing and confirming bed escalation capacity as part of winter readiness planning. Plans will define activation triggers and decision-making authority, anticipated lead times, workforce, equipment and clinical-support requirements, clinical suitability criteria, infection-prevention arrangements and clear criteria for de-escalation and closure. Escalation capacity will comprise planned and clinically appropriate space and will not rely on routine use of corridor-care areas. The ICB will maintain a system-wide view of available escalation capacity and associated risks so capacity can be coordinated effectively where system-wide action is required.

7.5. Stress testing and assurance

The demand and capacity analysis will be tested explicitly against surge and extreme-surge scenarios through the NHS England regional stress-test exercises in September. Outputs from testing will inform the final winter plan, Board Assurance Statement and any required updates to escalation, mutual aid, command, workforce, discharge and capacity arrangements.

Throughout winter, the ICB and SCC will maintain oversight of operational performance, demand and capacity pressures, escalation arrangements and system resilience. Through partnership working, proactive planning and coordinated operational leadership, Greater Manchester will seek to keep services responsive, resilient and able to meet patient need during periods of increased and sustained demand.

7.6. System Coordination Centre, OPEL, escalation and mutual aid

The Greater Manchester System Coordination Centre (SCC) is a core part of the winter operating model, providing operational oversight, coordination and intelligence to support management of system pressures across Greater Manchester. Working with providers, Places, NHS Greater Manchester, ambulance services and regional partners, the SCC enables a coordinated whole-system response to emerging challenges, supporting patient flow, operational resilience and risk management.

The SCC provides system-wide operational oversight during core operating hours, maintaining situational awareness across urgent and emergency care, patient flow, bed capacity, discharge performance and escalation activity. Through routine monitoring of operational intelligence,

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OPEL status and system pressures, the SCC supports timely identification of emerging risks and facilitates coordinated action where intervention is required across organisational boundaries. This enables the system to respond proactively to pressures before they escalate and supports effective risk balancing across Greater Manchester.

To ensure continuity of operational leadership and oversight, the SCC works closely alongside NHS Greater Manchester's established on-call arrangements outside of core operating hours. During winter 2026/27, the ICB will further strengthen and clarify the interface between SCC operations, provider escalation processes and NHS Greater Manchester on-call functions to ensure there is a seamless approach to escalation, decision-making and leadership support throughout the day and night. This will provide partners with clear routes for escalating concerns and accessing senior operational, clinical and executive support when required.

Greater Manchester's SCC already operates above the national minimum requirement, providing Hub Manager coverage from 08:00 to 20:00 seven days a week, supported by a 24-hour, seven-day coordination function. These arrangements provide a strong foundation for managing day-to-day operational pressures and supporting provider coordination across the conurbation. As part of winter preparedness planning, the ICB and SCC will review the additional workforce, leadership and operational arrangements required to enhance capacity further during periods of exceptional demand or sustained system pressure, ensuring the operating model remains flexible and responsive throughout the winter period.

The SCC operating model will be reviewed for resilience during sustained periods of pressure, including staffing capacity, skills and competencies, rota resilience, handover arrangements, role clarity and access to senior clinical and executive decision-makers. The final winter plan will confirm the triggers and authorisation routes through which SCC operating capacity can be extended or enhanced during sustained or extreme pressure, including interfaces with NHS GM on-call and EPRR command structures.

The SCC will also maintain oversight of significant corridor care risks, discharge constraints and community capacity pressures, ensuring that emerging challenges are considered through a whole-system lens and escalated where local mitigations are insufficient.

The SCC facilitates communication, coordination and escalation between system partners. By maintaining a single operational picture across Greater Manchester, it supports shared situational awareness and coordinated action in response to capacity constraints, patient-flow challenges and emerging risks. Where local mitigations have been exhausted, the SCC will support escalation, mutual aid and whole-system action to maintain patient safety and operational resilience. It will also maintain engagement with NHS England North West through routine reporting, communication of system pressures, escalation of significant operational risks and requests for regional support where required.

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NHS Greater Manchester will maintain proactive engagement with NHS England North West throughout winter, including participation in regional assurance processes, submission of the Board Assurance Statement, regional stress testing and escalation of material risks or dependencies that cannot be resolved within Greater Manchester. This will support regional oversight of preparedness and performance and enable access to cross-ICB mutual aid or specialised pathway support where required.

Through operational leadership, robust intelligence and close collaboration across health and care partners, the SCC will provide the coordination and oversight needed to support safe and effective services throughout winter 2026/27. These arrangements will help Greater Manchester maintain a consistent system-wide view of performance, escalate pressures promptly and coordinate action to manage demand across the urgent and emergency care system.

8.0 Conclusion

The Board are asked to note that this NHS GM Winter Plan has been written collaboratively from teams across the Integrated Care Board (ICB). The plan is now in a final version, but should the Emergency Care team receive any updates it will be reflected in this document with a version control to support our patients to remain safe and well this Winter time.

8.1 Recommendations

The ICB Board are asked to note the Winter plans content thus far; and agree that board members feel assured that NHS GM have a completed Winter Plan that can be shared across the GM system once signed off by the NHS GM ICB Board after 18th November 2026.

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NHS
Greater Manchester

Board Assurance Framework

18th November 2026

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

18th November 2026

Required information	Details
Title of report	Board Assurance Framework
Author	Chris Gaffey, Associate Director of Corporate Services Tom Conyers, Head of Corporate Governance & Risk
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Executive summary	This report presents the initial post-reform Board Assurance Framework (BAF) for Board review and approval. The eight strategic risks have been developed with Chief Officers following agreement of the Strategic Objectives over the summer, with the timetable influenced by reform. The current position reflects continuing financial and service pressures, alongside dependencies on workforce capacity, partnership delivery and resilience. All eight strategic risks are currently rated as having partial assurance, with further evidence needed to demonstrate the consistent operation and effectiveness of controls and mitigating actions. The next stage of development will aim to strengthen assurance assessments and the evaluation of mitigating actions, building on the Audit Committee's deep-dive learning. This includes clearer evidence of impact, system dependencies and consistency in risk reporting. Given the limited time remaining in 2026/27, this BAF will continue into 2027/28 without a separate annual refresh, while remaining subject to ongoing review and improvement.
The benefits that the population of Greater Manchester will experience.	Effective management of strategic risks supports delivery of the organisation's objectives and intended benefits for people and communities.
How health inequalities will be reduced in Greater Manchester's communities.	The BAF includes risks to population health improvement and reducing inequalities, supporting oversight of progress against these

	priorities.
The decision to be made and/or input sought	The Board is asked to: • Review and approve the initial post-reform Board Assurance Framework. • Note that, given the limited time remaining in 2026/27, this BAF will continue into 2027/28 without a separate annual refresh, while remaining subject to ongoing review and development. • Agree the proposed approach to strengthening assurance assessments and evaluating mitigating actions, and identify any strategic risks or material assurance gaps requiring prioritised development or targeted scrutiny through the relevant committee.

How this supports the delivery of the strategy and mitigates the BAF risks	The BAF links strategic risks to the Strategic Objectives and supports Board and committee scrutiny of mitigations, assurance gaps and delivery priorities.
Key milestones	November 2026: Board consideration of the BAF. Further development over the coming months, with ongoing review into 2027/28.
Leadership and governance arrangements	Each strategic risk is owned by a Chief Officer and considered by the responsible committee. The BAF is reported to and considered by the Board at each of its meetings.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Development with Chief Officers, including a September BAF workshop and consideration by the relevant committees of some risks. The approach also draws on the Audit Committee's March deep dive and April learning report.
Financial or Legal Implications	None.

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

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

1.0 Introduction

1.1 This report presents the initial post-reform Board Assurance Framework (BAF) for Board review and approval. It aligns the organisation's strategic risks to the Strategic Objectives agreed over the summer and reflects the ICB's responsibilities as a strategic commissioner in line with the ICB Model Blueprint and new Operating Model.

1.2 The Strategic Objectives and high-level proposed strategic risks were agreed by the Board at its July meeting. The BAF risks have since been developed with Chief Officers, including through a September Chief Officers' BAF workshop and consideration of some risks by the relevant committees. The development timetable has been influenced by reform earlier in the year.

1.3 The risks have also been drafted in the context of learning from the Audit Committee's March 2026 deep dive, summarised in its April learning report. The five learning areas below have informed the approach and will continue to guide further development and improvement of the BAF over the coming months:

- **Focus on impact and outcomes:** Demonstrate whether mitigations are making a difference, rather than relying on evidence of controls and processes alone.
- **Clear ownership and system dependencies:** Distinguish ICB-owned mitigations from partner dependencies, with clear accountability and assurance arrangements.
- **Sharper prioritisation of strategic risks:** Use the BAF to focus leadership attention, resources and scrutiny on the most material risks.
- **Stronger use of data, indicators and evaluation:** Use meaningful measures to assess progress and inform whether mitigations remain appropriate.
- **Proportionate improvement:** Support clearer information and better decision-making without creating burdensome processes.

1.4 Given the limited time remaining in the current financial year, a separate BAF refresh will not be undertaken for 2027/28. This BAF will continue into the next financial year through ongoing review and development. Each strategic risk is owned by a Chief Officer and considered by the responsible committee, with the BAF reported to the Board at each of its meetings.

2.0 Current Position

2.1 Table 1 below shows the initial post-reform strategic risks, aligned to the Strategic Objectives, and their current risk scores.

NHS GM Board Assurance Framework
November 2026

Strategic Objectives

Population health, prevention and reducing inequalities	Statutory responsibilities; population health & inequalities; system transformation	Statutory Responsibilities	System Transformation	All Strategic Objectives	Statutory Responsibilities

Strategic Risks

SR1	SR2	SR3	SR4	SR5	SR6	SR7	SR8
Population health improvement & reduce inequalities	**Effective quality, clinical governance, and safeguarding arrangements**	**Financial Sustainability**	**Transform services through strategic commissioning**	**Collaboration across providers, LAs, places and neighbourhoods**	**Leadership, workforce capacity & organisational capability**	**Emergency Incident**	**Cyber Security**
Risk Score 4 (L) x 4 (I) = **16**	Risk Score 4 (L) x 4 (I) = 16	Risk Score 5 (L) x 4 (I) = 20	Risk Score 3 (L) x 4 (I) = **12**	Risk Score 2 (L) x 4 (I) = **8**	Risk Score 4 (L) x 4 (I) = **16**	Risk Score 3 (L) x 4 (I) = **12**	Risk Score 4 (L) x 5 (I) = **20**
Trend: ⇔	Trend: ⇔	Trend: ⇔	Trend: ⇩	Trend: ⇔	Trend: ⇔	Trend: ⇔	Trend: ⇔
Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 2 (L) x 4 (I) = 8	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 5 (I) = 15
Final Target Score **8** (2031)	Final Target Score 8 (2031)	Final Target Score 8 (2031)	Final Target Score **8** (2031)	Final Target Score 8 (2031)	Final Target Score 8 (2031)	Final Target Score 6 (2027)	Final Target Score 15 (2028)
Riskc Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Open	Risk Appetite: Cautious to Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious
5 - 15	**5 - 15**	**10- 20**	**5 - 15**	**10 - 20**	**10 - 20**	**5 - 15**	**5 - 10**

2.2 Appendix One contains the details for each of the risks. Some current risk scores reflect the September position, while others reflect November, in line with when the risks were discussed at their respective committee meetings. Work will be undertaken to align the scoring periods for future BAF reports.

2.3 The BAF identifies eight strategic risks covering delivery of NHS GM's strategic objectives, statutory responsibilities and the organisational and system capabilities needed to support them. The overall position reflects continuing financial and service pressures alongside the implementation of the new operating model. Progress has been made in establishing strategic direction, governance and delivery arrangements, but significant residual risks remain while these arrangements are embedded and evidence of their effectiveness develops.

2.4 The principal themes arising from the current risk assessments are:

- Population health and service transformation (SR1 and SR4): The Strategic Commissioning Plan and associated programmes provide a clearer basis for delivery. However, achieving a sustained shift towards prevention and neighbourhood-based care remains dependent on coordinated implementation, investment, partner capacity and evidence of improvements in outcomes and inequalities.

- Quality, clinical governance and safeguarding (SR2): Oversight and escalation arrangements are being strengthened, including provider, safeguarding and maternity assurance. The current risk reflects the need to demonstrate consistent application and measurable improvement across commissioned services, alongside continuing service pressures.

- Financial sustainability (SR3): The ICB was reported to be on plan at month six, supported by strengthened financial monitoring and savings assurance. Nevertheless, the position remains challenging, with continuing risks relating to delivery of the full savings requirement, expenditure pressures and recurrent financial sustainability. Following discussion at the People and Resources Committee meeting, the assurance rating has been revised from acceptable to partial, while the risk score remains 20. This represents a revised assurance judgement rather than a change to the underlying financial position or risk narrative.

- Partnership working and organisational capability (SR5 and SR6): Established Greater Manchester partnerships provide an important foundation for delivery. Further assurance is needed on the effectiveness of evolving place and neighbourhood arrangements and whether post-reform workforce capacity, strategic commissioning capability and new ways of working are sufficient to support the organisation's priorities.

- Emergency preparedness and cyber resilience (SR7 and SR8): Revised response arrangements and ongoing improvement activity provide a stronger foundation for resilience. Remaining risks include the testing of plans and recovery arrangements, specialist capacity, partner and supplier dependencies, and delivery of essential technology improvements.

2.5 All eight strategic risks are currently rated as having partial assurance. Controls and improvement activity are in place, but evidence of consistent operation and impact requires further development. The shared rating does not imply that the evidence, assurance gaps or residual exposure are identical across risks; these require consideration individually. Stronger assurance and sustained risk reduction will depend on demonstrating effectiveness, not simply completing planned activity.

2.6 The risks are also interdependent. Financial headroom, workforce capacity, digital resilience and effective partnership working influence the ability to deliver prevention, transformation and statutory responsibilities. For the Board, the key consideration is whether the combined risk position is being managed through clear priorities, deliverable mitigations and timely escalation, particularly where progress depends on constrained resources or wider system action.

2.7 The Board is invited to consider the following questions:

- What further evidence would give the Board sufficient confidence that the principal risks are being effectively managed?
- Where are the most significant gaps in that confidence, and what is needed to address them?
- Where might the current mitigations need to be strengthened, adapted or reprioritised?

3.0 Further Development of the BAF

3.1 The initial risks show progress in describing risk drivers, system dependencies and control and assurance gaps. Building further on the Audit Committee's learning, the next stage of the BAF's development will aim to strengthen assurance assessments and the evaluation of mitigating actions, applying the approach consistently across all risks.

3.2 Further review will seek to improve consistency between risk narratives, scoring tables, tolerance ranges, assurance assessments and action updates. Aligning these elements and reporting periods should provide a clearer basis for Board and committee consideration.

Levels of assurance and effectiveness of mitigating actions

3.3 Risk scores and levels of assurance provide different, but complementary, information. The risk score reflects the assessed likelihood and impact of a risk materialising, while the assurance assessment should indicate confidence in the arrangements for managing it, based on the evidence available. A high risk may remain despite effective controls, particularly where significant external factors or system dependencies are involved. Equally, an unchanged or lower score should not, in itself, be taken as evidence that mitigations are effective. As the BAF develops, the aim will be to make both the residual exposure and the strength of evidence supporting assurance ratings clearer for the Board.

3.4 Further development will seek to strengthen evidence through the three lines of defence, distinguishing between controls being established, operating as intended and achieving impact. This includes evidence of prevention and transformation outcomes, effective partnership delivery, effectiveness of financial controls, and tested resilience arrangements. The aim is to support clearer assurance judgements through meaningful indicators, baselines, trajectories and escalation thresholds, drawing on existing measures and explaining evidence limitations and the steps needed to strengthen confidence.

3.5 The aim will be to develop action plans to show the intended effect, accountable lead, timescale and measures of progress for material mitigations, including the evidence needed to support target scores. Where possible, reviews would increasingly focus on their contribution to managing risk, not simply activity completion, using interim measures where outcomes take longer to demonstrate. Existing evaluation, audit and exercise findings would help inform whether actions need adapting.

3.6 Further refinement will seek to distinguish control gaps from gaps in evidence of effectiveness, linking actions to the gap they address and the exposure remaining. This should help avoid treating additional reporting or scrutiny as a substitute for addressing delivery weaknesses.

3.7 Work with Chief Officers will seek to build on the distinction between ICB-controlled actions and partner dependencies, clarifying how partner delivery is monitored, how assurance is obtained, its limitations and the arrangements for coordination and escalation where delivery is uncertain.

3.8 As reporting develops, the aim will be to bring the most material risk drivers, significant exposures, assurance gaps and delayed or ineffective mitigations into sharper focus. Clearer links between risks should support decisions on capacity, resources and targeted committee scrutiny. Where scores remain unchanged, reporting will seek to explain whether this reflects expected timescales, limited evidence of impact or a need to adapt the response.

3.9 The intention is to take this development forward proportionately with risk owners and the relevant committees through ongoing BAF review, drawing on existing reporting and scrutiny arrangements. The aim will be a concise, evidence-based BAF that shows what is working, what remains uncertain and where Board attention is needed, without unnecessary additional processes.

4. Recommendations

4.1 The Board is asked to:

- Review and approve the initial post-reform Board Assurance Framework.
- Note that, given the limited time remaining in 2026/27, this BAF will continue into 2027/28 without a separate annual refresh, while remaining subject to ongoing review and development.
- Agree the proposed approach to strengthening assurance assessments and evaluating mitigating actions, and identify any strategic risks or material assurance gaps requiring prioritised development or targeted scrutiny through the relevant committee.

Strategic Risk **SR1**	**Failure to deliver prevention-led population health improvement and reduce inequalities.** There is a risk that NHS Greater Manchester, working with system partners, does not make sufficient progress in shifting resource, leadership focus and delivery towards proactive care, neighbourhood working and prevention. This could result in widening inequalities, avoidable demand on services, poorer outcomes for people and communities, and reduced confidence in delivery of the Strategic Commissioning Plan and wider Greater Manchester Strategy ambitions.		
Strategic Objective	Population health, prevention and reducing inequalities.		
Chief Officer / Committee	**Risk owner:** Chief Clinical Officer **Primary committee:** Strategic Commissioning Committee		
Risk Appetite Level	**Cautious to Open**	Risk Tolerance Range 5 - 15	**5-15**

Rationale for Risk Score and Progress made in the quarter

The current risk score remains high, reflecting the scale of change required across Greater Manchester to deliver a measurable shift towards prevention, improve population health outcomes and reduce inequalities. While strategic direction has been agreed, the risk remains above tolerance because delivery requires coordinated action across commissioning, provider organisations, local authorities, neighbourhoods and community partners, alongside sustained system-wide alignment during a period of organisational and service reform.

Progress has been made through approval of the Strategic Commissioning Plan, agreement of strategic objectives and continued development of the strategic commissioning operating model. Year one deliverables have been incorporated into committee workplans, providing greater clarity of ownership and shorter-term indicators of progress. Delivery continues across a number of key programmes, including Live Well, BeCCoR, primary care blueprint implementation, clinical strategy delivery, frailty and secondary prevention. These developments provide stronger foundations for delivery and assurance.

However, there is not yet sufficient evidence of a measurable shift in activity, outcomes, inequalities or resource allocation to support a further reduction in the risk score. The principal drivers of the risk remain the pace and consistency of neighbourhood implementation, the ability to shift investment towards prevention, variable maturity of place-based delivery arrangements, and the challenge of demonstrating measurable improvements in population health and inequalities outcomes. The risk will remain above tolerance until there is clearer evidence that strategic priorities are translating into sustained improvements in outcomes, reductions in inequalities and a demonstrable shift towards prevention-led models of care.

Key Controls

ICB-owned controls

-Delivery of the NHS GM Strategic Commissioning Plan and associated Year 1 deliverables.

-Strategic Commissioning Committee oversight and committee workplans aligned to strategic objectives.

-NHS GM operating model for strategic commissioning, including prioritisation, assurance and escalation arrangements.

-Clinical leadership and programme governance for priority areas including prevention, frailty, secondary prevention and long-term conditions.

-Quality, governance and assurance arrangements which incorporate equity and inequalities as a core consideration.

-Use of population health, quality, activity, finance and inequalities intelligence to support prioritisation, decision-making and assurance.

-Development of a strategic outcomes framework and performance reporting aligned to prevention, neighbourhoods and inequalities.

System controls and dependencies

-Greater Manchester Strategy and wider Integrated Care Partnership strategic framework.

-Live Well programme and neighbourhood health model.

-Place partnership arrangements and place-based delivery plans.

-Public health leadership and collaboration with local authorities and GMCA.

-Primary care, provider, community and VCFSE delivery arrangements.

-Prevention Demonstrator programme and associated learning.

ICB role

As strategic commissioner, NHS Greater Manchester provides prioritisation, system leadership, coordination, escalation and assurance for agreed population health outcomes. Delivery is shared across places, providers, local authorities, primary care, community partners and the VCFSE sector. Delivery risks, dependencies and barriers are escalated through established programme, place and committee governance arrangements where these threaten achievement of strategic objectives.

Gaps in Control or Assurance

The main control gaps relate to alignment between prevention priorities, investment decisions, commissioning and contracting levers, and measurable outcomes. While strategic objectives and delivery programmes are established, there is not yet a sufficiently mature outcomes framework to demonstrate whether investment and commissioning decisions are delivering the intended shift towards prevention and reductions in inequalities. Variable maturity of neighbourhood and place-based delivery arrangements also creates inconsistency in implementation and delivery assurance across Greater Manchester.

Key assurance gaps include the absence of an agreed set of strategic indicators, baselines, trajectories and escalation thresholds to evidence progress against prevention, neighbourhood development and inequalities objectives. Demonstrating progress remains challenging due to the long timescales over which prevention benefits are realised and the difficulty of evidencing outcomes that have been avoided. As a result, assurance is often based on delivery activity rather than measurable impact and outcomes.

Delivery is also dependent on partner capacity and capability, shared intelligence and data, digital maturity, VCFSE sustainability, and the ability to maintain strong clinical, professional and place-based leadership during ongoing organisational reform. Further work is required to strengthen escalation arrangements where system dependencies, partner delivery or capacity constraints threaten achievement of strategic outcomes

	Risk Scoring and Tolerance									
	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	4	4	4				**3**	**2**	
Impact	5	5	5	4				**4**	**4**	**31 March 2031**
Risk Level	**25**	**20**	**20**	**16**				**12**	**8**	

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

Assurance	Assurance Level
Assurance is currently assessed as partial. First-line assurance is provided through programme and portfolio reporting, delivery oversight, performance reporting and monitoring of strategic commissioning priorities. Second-line assurance is provided through Strategic Commissioning Committee oversight, aligned committee workplans, and governance arrangements with place partnerships, public health leaders and Greater Manchester Combined Authority partners. Emerging assurance is also provided through strategic programme reporting and development of outcomes measures linked to prevention, neighbourhood health and inequalities priorities. Third-line assurance is developing through external review, national policy and guidance, public reporting and independent evidence relating to population health and prevention. However, assurance remains partial because there is not yet a fully developed set of agreed indicators, baselines, trajectories and escalation thresholds to demonstrate whether current arrangements are delivering measurable improvements in population health outcomes, reducing inequalities and shifting activity and investment towards prevention-led models of care. The assurance level should remain under review until there is clear evidence that controls are operating effectively and translating into measurable improvements in outcomes, reductions in inequalities, and sustainable shifts in activity and resource allocation towards prevention and neighbourhood-based care.	**Partial**

Action	Complete/ BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Agree and implement strategic indicators, baselines, trajectories, tolerances and escalation thresholds.	Sep-26	Initial metrics identified through strategic objectives and year-end deliverables; further work required to agree dashboard owners and reporting frequency.	**Delayed**
2	Strengthen the route from programme plan and delivery into SCC and Board assurance, including explicit reporting on risks, mitigations, dependencies and escalation.	Nov-26	Committee workplan alignment has started. Further refinement required to ensure papers provide clear assurance rather than activity description.	**On Track**
3	Clarify ICB-owned controls and system dependencies for Live Well, neighbourhood health, BeCCoR, primary care blueprint and prevention delivery.	Jan-27	Dependencies identified; further work required to agree the escalation route where partner delivery or capacity threatens strategic outcomes.	**On Track**
4	Implement an SR1 assurance framework/dashboard demonstrating progress against prevention and inequalities outcomes	Sep-26	Draft populated. Requires risk owner review, agreement of scores and confirmation of evidence sources before submission.	**On Track**

Strategic Risk **SR2**	**Failure to maintain effective quality, clinical governance, and safeguarding arrangements.** Risk: NHS GM is unable to maintain effective quality, clinical governance and safeguarding arrangements across its own functions and commissioned services. Cause: Insufficient system-wide quality oversight, and clinical governance arrangements; inconsistent escalation, learning and improvement processes; variation in safeguarding and maternity assurance across providers and partners; and limited capacity to respond to emerging quality, safety, maternity and safeguarding concerns. Impact: Quality, safety, patient experience, maternity and safeguarding risks are not identified, escalated or addressed in a timely way, resulting in avoidable harm, poor outcomes, increased inequalities, regulatory or statutory non-compliance, and reduced public confidence in NHS GM and commissioned services.		
Strategic Objective	Statutory responsibilities; population health and inequalities; system transformation		
Chief Officer / Committee	**Risk owner:** Chief Clinical Officer **Primary committee:** Strategic Commissioning Committee		
Risk Appetite Level	**Cautious to Open**	Risk Tolerance Range 5 - 15	**5-15**

Rationale for Risk Score and Progress made in the quarter

The current risk remains high because of the potential impact on patient safety, effectiveness of care, patient experience, safeguarding statutory duties, maternity assurance, provider quality oversight, regulatory compliance, inequalities and public confidence. The national Quality Strategy for NHS-funded care in England reinforces that quality should be the organising principle for NHS activity. Whilst progress has been made, the risk should remain static until there is clearer evidence that revised governance, quality oversight, safeguarding and maternity assurance arrangements are operating consistently and delivering measurable improvements in quality and outcomes.

NHS GM is strengthening its clinical governance approach through a more robust quality management and improvement system. Recent progress includes continued development of the NHS GM Provider Oversight Model, strengthened quality escalation routes, revised safeguarding leadership arrangements, enhanced reporting through the Chief Clinical Officer report, and the development of standalone maternity assurance reporting.

There is increasing evidence of improving control maturity through Quality Review Meetings, Clinical Effectiveness and Governance oversight, LMNS maternity and neonatal assurance arrangements, and Deputy Delegated Safeguarding Partner arrangements. However, assurance remains partial as several controls continue to be embedded and there is not yet consistent evidence that learning from quality concerns is systematically translated into improvement and evaluated for impact across all commissioned services. Significant system pressures also remain, including provider quality concerns, mental health capacity, maternity oversight requirements and statutory safeguarding responsibilities.

Key Controls

Key ICB-owned controls

-NHS GM clinical governance framework, quality management and improvement framework, and associated governance arrangements.

-Strategic Commissioning Committee oversight, supported by the Chief Clinical Officer report and Alert, Advise and Assure framework.

-NHS GM Provider Oversight Model, including Quality Review Meetings, risk stratification, escalation processes and contractual quality oversight.

-Clinical Effectiveness and Governance Committee oversight of clinical effectiveness, quality improvement, audits, learning and assurance.

-Safeguarding governance arrangements, including executive leadership, Deputy Delegated Safeguarding Partner arrangements and statutory reporting processes.

-Maternity and neonatal assurance arrangements, including LMNS oversight, CNST assurance requirements and escalation routes.

-Quality, patient safety, safeguarding, equality and clinical impact assessment processes.

-Use of quality, safety, safeguarding, patient experience and outcomes data to support oversight, escalation and assurance.

Key system controls and dependencies

-Provider quality governance and board assurance arrangements.

-Quality Review Meetings and contractual quality management processes across commissioned services.

-Local safeguarding partnerships and adult safeguarding board arrangements.

-LMNS governance, provider maternity assurance processes and national maternity safety requirements.

-System learning from incidents, investigations, complaints, patient safety events, reviews and external scrutiny processes.

-Regional and national oversight, including regulatory and quality assurance arrangements.

Gaps in Control or Assurance

The main control gaps relate to consistency, capacity and evidence of embedded practice rather than the absence of governance arrangements. While quality, safeguarding, maternity and clinical governance arrangements are established, further work is required to demonstrate consistent application of risk stratification, escalation processes, learning systems and assurance arrangements across all commissioned services and sectors. Assurance remains more mature for some provider oversight routes than others, particularly within non-acute, primary care, independent sector and multi-locality commissioned services.

Key assurance gaps include the absence of an agreed set of indicators and evidence thresholds to demonstrate that quality concerns, incidents, reviews and assurance activity are consistently translated into improvement and evaluated for impact. Evidence remains variable across the three national quality domains of safety, effectiveness and experience, and further work is required to demonstrate consistent oversight of inequalities as a cross-cutting consideration.

Continued assurance is also required regarding the embedding of revised safeguarding governance arrangements, maternity and neonatal assurance processes, and the sustainability of clinical, quality and safeguarding capacity within the agreed operating model. Significant system pressures, including provider quality concerns, mental health capacity, maternity oversight requirements and statutory safeguarding responsibilities, continue to influence the level of residual risk.

	Risk Scoring and Tolerance									
	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	4	4	4				**3**	**2**	
Impact	5	5	5	4				**4**	**4**	**31 March 2031**
Risk Level	**25**	**20**	**20**	**16**				**12**	**8**	

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

Assurance	Assurance Level
First line assurance is provided through operational management of the Clinical Portfolio, quality and safeguarding teams, provider Quality Review Meetings, contractual quality schedules, Chief Clinical Officer reporting to Board and SCC, and internal escalation routes. Reports to Strategic Commissioning Committee provide evidence of active oversight of provider quality concerns, safeguarding developments, maternity assurance, health protection, medicines governance and clinical effectiveness matters. Assurance is currently assessed as partial because, whilst reporting and escalation routes are established, evidence of consistent operation and impact across all commissioned services continues to develop. Second line assurance is provided through Strategic Commissioning Committee, Clinical Effectiveness and Governance arrangements, relevant subgroups, safeguarding partnership routes, LMNS safety assurance arrangements, executive oversight, risk reporting and Board Assurance Framework review. These routes provide collective clinical, professional and system assurance, with escalation to SCC where approval, noting or endorsement is required. Assurance remains partial whilst revised governance, maternity reporting and safeguarding arrangements continue to be embedded and monitored. Third line and external assurance includes NHS England regional oversight, regulatory intelligence, CQC findings, national patient safety and maternity assurance frameworks, safeguarding statutory expectations, external review findings, Audit Committee review of the BAF, and independent reviews where relevant. External assurance supports the continued development of governance and oversight arrangements but also demonstrates that residual risk remains elevated whilst improvement actions are embedded and there is not yet consistent evidence that learning from quality concerns is translated into measurable improvement across commissioned services	**Partial**

Action		On Track
	Complete/ BAU	
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Embed the NHS GM Provider Oversight Model across commissioned services, including risk stratification, QRM standards, quality schedules, escalation thresholds and evidence requirements..	Dec -26	The model is being tested through existing oversight arrangements. Further evidence is required to demonstrate consistent application across all commissioned services and measurable improvement following intervention.	**On Track**
2	Confirm and embed the revised safeguarding governance model, including DDSP arrangements, annual reporting, partnership links and multi-agency escalation processes.	Nov -26	The revised DDSP model was implemented in July 2026 and partners notified. Further evidence is required to demonstrate consistent operation, effective partnership interfaces, and timely escalation and closure of safeguarding actions.	**Complete/ BAU**
3	Develop and present the first formal maternity and neonatal assurance report to SCC, including frequency, core dataset, escalation triggers, alignment with LMNS, CNST and provider assurance routes, and the future reporting cycle.	Dec -26	Standalone maternity paper planned for SCC with twice-yearly maternity assurance placeholder and updates through the CCO report. Further clarity needed on the final assurance dataset, escalation route and evidence required to support any future reduction in likelihood.	**On Track**
4	Develop and embed NHS GM's clinical governance, quality management and improvement frameworks, including arrangements for monitoring improvement impact and organisational learning.	Mar -27	Key programme and clinical governance roles have been recruited, horizon-scanning has commenced, and revised quality reporting, governance and assurance arrangements are being developed and implemented through the Clinical Effectiveness and Governance Committee.	**On Track**
5	Establish and implement quality assurance metrics aligned to the national quality domains of safety, effectiveness and experience, including agreed indicators, reporting thresholds, escalation triggers and evidence requirements to support future risk reduction	Nov -26	Initial evidence has been identified through CCO reports, the Provider Oversight Model and safeguarding and maternity assurance updates. Further work is required to agree the final metrics, reporting cycle and evidence thresholds to support future risk reduction.	**On Track**
6	Develop and embed NHS GM's patient safety framework, including oversight of patient safety intelligence, learning from incidents and investigations, identification of emerging risks, and evaluation of improvement actions and their impact on patient outcomes.	Mar -27	Patient safety oversight currently operates through the CCO report, provider quality assurance routes and governance arrangements. Further work is required to define a consistent patient safety intelligence framework, reporting arrangements and measures of impact across commissioned services.	**On Track**

Strategic Risk **SR3**	**Inability to Deliver Financial Sustainability** Risk: The ICB does not deliver the in-year financial plan and deliver medium-term financial sustainability. It should be noted that whilst the ICB is no longer directly responsible for managing the overall GM system financial position, as the strategic commissioner: • The ICB will work closely with NHSE to ensure the delivery of individual provider positions and the overall system position. • Financial viability of providers is critical to ensuring delivery of operational performance and quality of care. The overall system position demonstrates credibility with NHS England, which influences the ability to access national capital and revenue funding.
Strategic Objective	Statutory Responsibilities
Chief Officer / Committee	**Risk owner:** Chief Finance Officer **Primary committee:** People and Resources Committee
Risk Appetite Level	**Open** — Risk Tolerance Range 5 - 15 — **10 to 20**

Rationale for Risk Score and Progress made in the quarter

- Current score remains 20 (Likelihood 5 x Impact 4), unchanged from the inherent score.
- The in-year position remains extremely tight, with significant financial challenges in key areas.
- NHS GM is on plan at month 6 and has strengthened run-rate reporting, grip and control, and CIP assurance.
- A four-week review validated CIP schemes and identified alternatives where planned values reduced. However, a gap remains against the full £150m 2026/27 CIP target.
- Recovery plans being developed for areas of operational risk.
- Medium and long-term plans were approved by the Board on 11 February 2026. The target score is 12 by 31 March 2027.

Key Controls

- The ICB has submitted a balanced plan for the period 2026/27 to 2028/29
- Medium- and long-term financial plans were approved by the Board on 11/02/2026.
- Currently on plan at month 6.
- The enhanced levels of grip and control and financial assurance established during 2025/26 continue across NHS GM, including Cost Improvement Plan (CIP) governance.
- ICB has revised the reporting pack with a focus on run rate to allow identification of potential issues and mitigation plans have been implemented to address the risks on in year delivery.
- Recovery plans are in progress for areas of expenditure that are forecast to overspend.
- An intensive review of all current CIP schemes has been undertaken to validate the planned values and to confirm their delivery status. Where planned values in year have been reduced alternative schemes have been identified to maintain the current trajectory of delivery. During this time in addition to the fortnightly Core Delivery Group meetings attended by scheme SROs and operational and finance leads, a fortnightly dedicated CO meeting was stepped-up to maintain focus and scrutiny.

Gaps in Control or Assurance

- Areas of overspend/performance may not be picked up in a timely manner due to a time lag in information.
- Time lag in financial / performance (Acute activity and prescribing) information may lead to ineffective or delayed decision making.
- Savings plans are not fully developed in a timely manner or do not realise the necessary savings or on a recurrent basis.
- Planning does not adequately reflect growth and/or impact of strategic decisions, and prevention investments on all parts of the system or budgets.
- Impact of NHS Reforms may delay development of new control measures.
- The risk on the CIP programme, both in terms of unidentified schemes and delivery risk.
- Overspends on individual packages of care due to operational grip and demand.
- Prescribing because of national pressures e.g. NCSO. There still remains some plans in the progress stage and the opportunities which need rapidly progressing into fully developed or implemented plans. Capacity to deliver some of the schemes also remains a challenge.

	Risk Scoring and Tolerance									
	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	**5**	**5**	**5**	**5**				**3**	**2**	
Impact	**4**	**4**	**4**	**4**				**4**	**4**	**31 March 2031**
Risk Level	**20**	**20**	**20**	**20**				**12**	**8**	

Number of Linked Risks on Corporate Risk Register

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

Assurance	Assurance Level
Enhanced financial monitoring and reporting takes place on a monthly basis, and is reported to Chief Officers, People & Resources Committee, NHS GM Board, and NHSE. A separate more detailed monthly Contract Report is also presented to Chief Officers and People & Resources Committee. CIP schemes have been identified for 2026/27 which are being taken through current governance processes as may	**Partial**

require decommissioning or further restriction of activity. However, there currently remains a risk to achieving the full £150m CIP target for 2026/27 for NHS GM.	

Action	Complete/ BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Review of existing and new savings opportunities to identify which can be implemented quickly and have an early impact.	Monthly	On-going monthly review	.
2	Monthly financial reporting to continue, including close attention to contract performance and cash management.	Monthly	On-going monthly reporting	.
3	Development and approval of recovery plans for the key financial risk areas	October 2026	Financial Recovery Plan presented at Board on 21st October 2026	
4	Delivery of recovery plan	Monthly	On-going monitoring through reporting	

Strategic Risk **SR4**	**Failure to transform services through strategic commissioning** There is a risk that NHS GM fails to influence and transform health and care services through effective strategic commissioning.		
Strategic Objective	System transformation.		
Chief Officer / Committee	**Risk owner:** Chief Commissioning Officer **Primary committee:** Strategic Commissioning Committee		
Risk Appetite Level	**Cautious to Open**	Risk Tolerance Range 5 - 15	**5-15**

Rationale for Risk Score and Progress made in the quarter

Proposed current score: 12 (likelihood 3 x impact 4), within tolerance. The risk has been reduced slightly due to progress / developments in a number of transformation initiatives however still remains a moderate risk as ongoing transformation requires simultaneous change to funding, contracting, workforce, clinical models, digital capability and provider behaviours across GM. Principal drivers are: sustained demand and financial pressure; strategic commissioning capacity and capability; variable maturity across places, neighbourhoods and providers; limited headroom to invest ahead of releasing acute capacity; workforce constraints; incomplete impact modelling and benefits realisation; fragmented data/digital adoption; approach to consistent implementation discipline; and resistance to service redesign. Progress: the five-year Strategic Commissioning Plan sets the three shifts and outcomes; a performance scorecard is intended for Board and Strategic Commissioning Committee reporting; place partnership arrangements and provider collaboration are identified as delivery mechanisms; and a system method for modelling the Left Shift is planned during 2026/27. Risk reduction depends on translating the strategy into a prioritised delivery plan, quantified trajectories, accountable programme governance, investment and disinvestment decisions, and consistent implementation across all ten places.

Key Controls

- Board-approved NHS GM Five Year Strategic Commissioning Plan 2026-2031, Clinical Strategy and Outcomes Framework.
- Strategic Commissioning Committee oversight, supported by Board reporting through the Strategic Commissioning Plan performance scorecard.
- Commissioning Delivery Group for oversight of delivery and escalation of risk
- Refreshed NHS GM Operating Model, Place Partnership Agreements, Place Outcomes, Place Fund and place teams.
- Neighbourhood Health and Live Well commissioning framework, locality neighbourhood plans and Prevention Demonstrator learning.
- Programme governance for primary care, healthcare commissioning, community services, population health, mental health, elective care, urgent and emergency care, digital and innovation.
- Provider collaboration through the Trust Provider Collaborative, Primary Care Provider Board and Alternative Provider Collaborative.
- Financial planning, contracting, procurement, market development and proposed outcomes/value-based commissioning mechanisms.
- GM data infrastructure, including the GM Care Record and analytical platforms, to support population health management and evaluation.
- Engagement and co-production with residents, clinicians, local government and VCFSE partners, underpinned by the GM VCFSE Accord.
- Quality, equality, clinical, financial and delivery impact assessment through programme and commissioning governance.
- Commissioning Framework for 2027/28 • VCSFE Market Development Strategy

Gaps in Control or Assurance

- No single, fully quantified system-wide transformation portfolio linking activity shifts, capacity changes, cash-releasing savings, investment requirements and outcomes.
- Left Shift modelling methodology and longitudinal return-on-investment approach are not yet fully embedded across programmes and provider contracts.
- Limited assurance that resources can be moved from reactive acute provision to prevention and community services at the required pace without destabilising current services.
- Outcome measures, baselines, annual trajectories and benefits ownership are incomplete or not consistently applied Approval of co-produced Market Development Strategy across all programmes.
- Market capacity and sustainable funding for primary, community and VCFSE provision may be insufficient to absorb the planned shift in activity.
- Dependence on national policy, allocations, capital and contracting mechanisms remains only partly within NHS GM control.

Risk Scoring and Tolerance

	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	4	4	3			3	2	
Impact	5	4	4	4	4			4	4	**31 March 2031**
Risk Level	22	16	16	16	12			12	8	

Number of Linked Risks on Corporate Risk Register

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

Assurance	Assurance Level
Assurance level: partial / developing. Positive assurance is provided by the approved strategic plan, defined outcomes, governance routes, established place arrangements and programme infrastructure. Structures are now being filled and commissioning and programme teams embedded. However, assurance is not yet sufficient to demonstrate that transformation is fully quantified, resourced, contractually enabled and consistently deliverable across GM. The score should remain above tolerance until delivery trajectories, benefits, resources and accountabilities are evidenced.	**Partial**

Action			Complete/ BAU	On Track
			Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Approve a single prioritised Strategic Commissioning Delivery Plan with named SROs, milestones, dependencies, outcome measures and escalation routes.	30 June 2027	Plan architecture to be aligned to the approved five-year plan and Board/Committee reporting cycle.	On Track
2	Complete and approve the GM Left Shift impact-modelling methodology covering activity, finance, workforce, quality, inequalities and population outcomes.	31 Mar 2027	Method is identified in the plan as a 2026/27 requirement; system agreement and consistent application are required.	On Track
3	Establish baselines and annual trajectories for investment moving to prevention, primary care, community and VCFSE provision, including benefits and disinvestment rules.	31 Mar 2027	Baseline and trajectory development required to evidence the intended shift in resource.	Delayed
4	Agree GM-wide commissioning, contracting and payment approaches that incentivise outcomes, prevention, collaboration and reduced pathway fragmentation.	31 Mar 2027	. Options include outcomes-based and value-based mechanisms; implementation plan and early test areas required.	On Track
5	Implement regular update reports of delivery and risk from all thematic areas to the Commissioning Delivery Group to monitor progress and any risk to delivery.	31 Jan 2027	Establishment of the Commissioning Delivery Group in September with representation from Programme Directors, functional leads and Place Directors	On Track
6	Approval of the co-produced Market Development Strategy	31 Mar 2027	Ratification of the VCFSE Market Development Strategy aligned to priorities and outcomes of the 5 Year Strategic Commissioning Plan which will inform / shape the market to respond to the priorities	On Track

Strategic Risk **SR5**	NHS GM is unable to secure the collaboration required across providers, local authorities, places and neighbourhoods to deliver its strategic objectives.		
Strategic Objective	Enabling delivery of all strategic objectives.		
Chief Officer / Committee	**Risk owner:** Chief Strategy, People and Partnerships Officer **Primary committee:** Strategic Commissioning Committee		
Risk Appetite Level	**Open**	Risk Tolerance Range 5 – 15	**10 to 20**

Rationale for Risk Score and Progress made in the quarter

The risk is assessed as being at the target score because whilst delivery of NHS GM's strategic objectives depends upon collaborative action across a wide range of organisations with differing statutory responsibilities, priorities, governance arrangements and financial positions. NHS GM does have a proven track record of delivering in a partnership environment where it is not directly in control of the organisations responsible for delivery and must therefore secure influence, alignment and shared ownership across the system.

A mitigation to this risk is the long and strong history of collaborative and partnership working across public sector organisations within GM. This is supported by co-terminosity within a Mayoral Combined Authority City Region. The fact that GM is not undergoing local government reform is a strength that mitigates compared to the level of risk that would be experienced in other Integrated Care Systems.

Further progress has been made through continued development of governance arrangements, clarification of responsibilities between NHS GM and Place Partnerships, development of neighbourhood approaches, strengthened partnership engagement and continued alignment of strategic objectives across the system.

However, arrangements continue to evolve and there remains variability in governance maturity, role clarity and delivery capacity across places and partners. We can summarise the position against three domains.

Governance and Accountability: Do we have sufficiently clear governance, decision-making and accountability arrangements across the system?

- Greater Manchester has established governance arrangements across NHS, local government and voluntary sector partners and a strong history of collaborative working. However, current assurance is weighted towards the existence of partnership structures and forums rather than their effectiveness and impact. Further evidence is required to demonstrate that collaboration is leading to shared decisions, collective ownership, timely resolution of issues and delivery of agreed outcomes and improvements.

Partnership Effectiveness: Are relationships, behaviours and incentives aligned sufficiently to enable collaboration?

- Greater Manchester has developed its partnerships and collaborative arrangements over many years. Further development is needed on how incentives are built in to support even more effective collaboration and that are aligned to strategy and outcomes. This will require a clearer definition of the relationship between partnership working and the right incentives and behaviours to change cultures and ways of working,

Delivery Through Places and Neighbourhoods: Can intended outcomes actually be delivered through Place and Neighbourhood structures?

- Place and neighbourhood arrangements continue to develop and will be formalised through Place Agreements. We recognise however, that maturity, capacity and governance remain variable. Further assurance is required to demonstrate that agreed priorities are being translated consistently into delivery and measurable outcomes through Place and Neighbourhood arrangement

Key Controls

NHS GM controls

Strategic and governance alignment

- Principally that the 5 Year Strategic Commissioning Plan and Strategic Objectives are aligned with system strategies and priorities through the ICP Strategy and GMS
- Committee workplans are aligned to the Strategic Objectives and therefore support delivery and oversight of shared priorities
- Governance, performance and assurance arrangements aligned with the strategic commissioning operating model.
- Defined escalation arrangements for issues that cannot be resolved through routine partnership working.

Partnership leadership

- Integrated Care Partnership arrangements with a commitment to continue.
- Chief Officer and executive partnership forums- being updated to reflect new strategic and partnership context
- Provider, local authority, Place and neighbourhood engagement arrangements.
- Partnership Assessment Tool survey to be run in January 2027 to establish a baseline assessment of partnership effectiveness and identify priority areas for improvement actions. We will report progress and evidence of impact through the appropriate governance routes
- Joint programmes and transformation boards.
- Place Partnership document suite
- Neighbourhood delivery plans and neighbourhood commissioning framework
- Agreed mechanisms for monitoring shared actions, dependencies and delivery

System conditions supporting collaboration

Established system relationships

- Long-standing history of collaboration across Greater Manchester.
- Established relationships across NHS, local government and voluntary sector partners.

Strategic alignment

- Alignment between the GM Strategy, ICP Strategy and NHS GM Strategic Objectives.

System architecture

- Coterminous geography with the Greater Manchester Combined Authority.
- Established Place Partnership arrangements and developing neighbourhood infrastructure
- Sufficient capacity within partner organisations to deliver agreed outcomes.

Gaps in Control or Assurance

Control Gaps

- Place governance arrangements continue to evolve and are not yet fully embedded (see action 2)
- Collaborative working matrices and escalation routes remain under development (see actions 2 and 3)
- Consistent arrangements for monitoring delivery through Places and Neighbourhoods are not yet fully established (see actions 2 and 3)
- NHS GM relies on influence rather than formal authority where partner priorities diverge. (see action 6)
- Clear arrangements are required to identify, escalate and resolve cross-system issues that cannot be addressed through routine partnership arrangements. (see action 2 and 3)

Assurance Gaps

- Limited objective measurement of whether partnership arrangements are improving decision-making and delivery. (see action 5)
- Limited evidence that agreed system actions and decisions are consistently implemented. (see action 5)
- Limited measurement of unresolved cross-system issues and the effectiveness of escalation arrangements. (see action 5)
- Limited evidence of delivery against shared outcomes through Places and Neighbourhoods. (see action 5)
- Limited independent assurance of partnership effectiveness. (see action 5)
- Partnership effectiveness measures, including action completion, shared outcomes and unresolved escalations, require further development. (see action 5)

	Risk Scoring and Tolerance									
	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	**2**			**2**				**2**	**2**	
Impact	**4**			**4**				**4**	**4**	**31 March 2031**
Risk Level	**8**			**8**				**8**	**8**	

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

Assurance	Assurance Level
July 2026- IC Board approval of strategic objectives and Strategic Commissioning Plan Current assurance demonstrates that established governance and partnership arrangements are in place across Greater Manchester, including the Integrated Care Partnership and established forums with providers, primary care, the voluntary sector and other partners. However, assurance of the effectiveness of these arrangements remains developing. Further evidence is required to demonstrate that partnership working is resulting in timely decisions, delivery of agreed actions, effective resolution of escalated issues and achievement of shared outcomes. The Partnership Assessment Tool provides an opportunity to establish a more objective assessment of partnership effectiveness and identify areas for improvement. Further assurance should be developed through measures of action completion, shared outcomes, unresolved escalations and Place and Neighbourhood delivery. To strengthen these partnerships, GM will appoint (likely autumn 2026) a single person to take the role of ICB Chair and Deputy Mayor for Health in the GMCA. This role will be supported by an MOU between the organisations. There are established forums in place to coordinate partnerships with other key stakeholders in GM, including. In the case of the VCFSE and HIMN these are supported by formal accords/MOUs. • Trust Provider Collaborative • Primary Care Board • VCFSE Leadership Group • Health Innovation Manchester (via MOU Steering Group)	**Partial**

Action	Complete/ BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Agree new System Leadership Group with refreshed membership clear responsibilities, decision-making authority and escalation routes. Review its effectiveness following implementation, including evidence of decisions made, actions completed and issues resolved.	31/10/ 2026	Draft paper to Chief Officers in August 2026. To be considered alongside proposals on refreshed Exec Committee	On Track
2	Broaden NHS GM Chief Officer meetings to include place representation and review whether the revised arrangements strengthen Place input, shared decision-making and resolution of cross-system issues.	31/10/ 2026	Place nominations received and new membership to be confirmed	On Track
3	Refocus the Executive Committee to strengthen partnership representation and its focus on neighbourhoods, with a review of effectiveness	31/10/ 2026	Proposals to be brought to Chief Officers for new Executive Committee	On Track

	following implementation to assess decision-making, accountability and oversight of neighbourhood delivery.			
4	Confirm the future leadership arrangements for the ICP Board, including the GM Mayor's continued role as Chair, and clarify responsibilities, decision-making and accountability.	25/09/2026	Issue raised with GMCA at ICP Strategy Group on 01/09/26. Mayor's office to confirm	On Track
5	Complete the Partnership Assessment Tool to establish a baseline assessment of partnership effectiveness, identify priority areas for improvement actions. Report progress and evidence of impact through the appropriate governance route.	31/01/2027	Partnership Assessment Tool survey to be run in January 2027 to establish a baseline assessment of partnership effectiveness and identify priority areas for improvement actions. We will report progress and evidence of impact through the appropriate governance routes	On Track
6	Confirm the new ICB Chair/Deputy Mayor arrangements and supporting governance, with a subsequent review of whether the arrangements strengthen system alignment, shared accountability and decision-making.	31/10/2026	Some delays due to elections in 2026. Working group established between NHS GM and GMCA to coordinate	**Delayed**

Strategic Risk **SR6**	NHS GM lacks the leadership, workforce capacity and organisational capability required to deliver the strategic commissioning plan.		
Strategic Objective	Enabling delivery of all strategic objectives.		
Chief Officer / Committee	**Risk owner:** Chief Strategy, People and Partnerships Officer **Primary committee:** People and Resources Committee		
Risk Appetite Level	**Open**	Risk Tolerance Range 5 - 15	**10 to 20**

Rationale for Risk Score and Progress made in the quarter

This risk been assessed using 3 domains:

- Leadership Capability
- Workforce Capacity
- Organisational Capability

The current risk is elevated because NHS GM is implementing a new operating model and strategic commissioning approach following significant organisational change and a reduction in management capacity. Leadership and workforce structures are continuing to stabilise, with some interim arrangements, vacancies and areas of limited resilience. The effectiveness of matrix working as a mitigation for reduced capacity is not yet fully evidenced, and capability requirements for strategic commissioning have not yet been assessed consistently across the organisation.

Progress has been made through development of the organisational OD and culture plan, communication of the new strategic objectives, introduction of the NHS Staff Standards and Leadership and Management Framework, development of the Strategic Commissioning Academy and work to establish common approaches to delivery, assurance, evaluation and benefits realisation. However, several of these controls are at an early stage of implementation and do not yet provide evidence of sustained impact.

The risk is therefore driven by workforce numbers as well as by the combined effect of leadership stability, capacity in critical functions, clarity of roles and accountabilities, organisational resilience, and the pace at which strategic commissioning capabilities and new ways of working become embedded.

Key Controls

Leadership and accountability controls

- Approved organisational and leadership structures.
- Defined executive and senior leadership accountabilities.
- Development of collaborative working matrices and revision of governance and escalation routes.
- Succession and talent arrangements for critical roles.
- Leadership and Management Framework and NHS Staff Standards implementation.

Workforce capacity and resilience controls

- Workforce establishment, vacancy, turnover, sickness and wellbeing monitoring.
- Workforce planning and prioritisation against strategic objectives and Year 1 deliverables.
- Recruitment, retention, redeployment and suitable alternative employment arrangements.
- Business continuity and succession arrangements for critical functions and single points of failure.

Organisational capability controls

- OD and Culture delivery plan.
- Strategic Commissioning Academy and wider capability-development offer.
- Organisational and team-level training needs assessments.
- Development of common delivery, risk, dependency and programme-management standards.
- Evaluation and Benefits Realisation Framework.
- Digital-first delivery and collaboration approach.

Gaps in Control or Assurance

Control gaps

- No completed organisation-wide capability assessment against the skills and behaviours required of a strategic commissioner. (See action 1 & 2)
- Common programme management, benefits-realisation and evaluation arrangements not yet fully embedded.
- Matrix working arrangements, role clarity and escalation routes not yet consistently established or tested across portfolios. (See action 3)
- Digital-first delivery tools and associated training not yet consistently adopted.
- Workforce capacity has not yet been fully reconciled against the cumulative requirements of the strategic objectives and Year 1 deliverables.

Assurance gaps

- Limited longitudinal colleague-experience data across the transition period. (See action 6)
- New Staff Standards and Leadership and Management Framework are not yet sufficiently implemented to demonstrate impact. (See action 2)
- Limited objective evidence that OD and capability interventions are improving delivery. (See action 4)

- Limited independent assurance on whether the post-reform operating model has the capacity and capability required to deliver the Strategic Commissioning Plan. (See action 5)

	Risk Scoring and Tolerance									
	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	**4**			**4**				**3**	**2**	
Impact	**4**			**4**				**4**	**4**	**31 March 2031**
Risk Level	**16**			**16**				**12**	**8**	

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

Assurance	Assurance Level
Approval of OD plan - (Chief Officers - 1st Line) April 2026 Approval of organisational development priorities and interventions intended to strengthen leadership, culture, workforce resilience and organisational effectiveness. Provides assurance that improvement activity is planned and governed but not yet evidence of impact. July 2026- Workforce report (PRC- 2nd Line)- Confirmation of workforce establishment, vacancy, turnover, sickness and workforce metrics, together with committee scrutiny of emerging workforce risks. Report provided assurance that workforce risks are being monitored but did not yet fully demonstrate that capacity and capability are sufficient to deliver the strategic commissioning plan. Feb 2026- ICB Model ICB Assurance Statement (IC Board- 2nd Line)- acceptable assurance- Assessment concluded that NHS GM had acceptable assurance regarding implementation of the required ICB model. Provides assurance regarding organisational design and governance arrangements 3rd line- Internal Audit Plan Measures – To Be Confirmed	**Partial**

Action	Complete/ BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Complete an organisation-wide strategic commissioning capability assessment	Dec 2026	Scoping of workplan for People and Culture Team	Delayed
2	Develop and implement the NHS GM response to the leadership and Management Framework	Q4 2026/27	Scoping of workplan for People and Culture Team	Delayed
3	Develop, implement and review matrix working arrangements	Q4 2026/27	Scoping of workplan for People and Culture Team	Delayed
4	Establish monitoring of OD and Culture plan	Q3 2026/27	Scoping of workplan for People and Culture Team	On track
5	Develop a 3rd line assurance plan for this risk, utilising internal audit plan where possible	Q3 2026/27	Scoping of workplan for People and Culture Team	On track
6	Implementation of the quarterly Pulse survey and the National Staff Survey.	Oct 2026		On track

Strategic Risk **SR7**	Failure to maintain effective and resilient EPRR planning, response and recovery arrangements, aligned to Category 1 responder duties.		
Strategic Objective	Meet statutory obligations and maintain organisational and system resilience.		
Chief Officer / Committee	Nicola Hepburn, Acting Chief Reform and Improvement Officer Strategic Commissioning Committee		
Risk Appetite Level	**Cautious to Open**	Risk Tolerance Range 5 - 15	**5-15**

Rationale for Risk Score and Progress made in the quarter

The current risk score is 12, comprising likelihood 3 and impact 4. This reflects the potentially significant consequences of the ICB being unable to provide effective strategic leadership, coordination and assurance during a major, concurrent or prolonged incident.

The principal risk drivers are the need to ensure that NHS Greater Manchester's EPRR arrangements are comprehensive, consistently implemented and capable of sustaining an extended system response. This includes the effectiveness of command and control arrangements, organisational and system-level plans, business continuity and recovery arrangements, training and exercising, situational awareness, partner coordination, and the availability of sufficient capability and capacity to support both preparedness and response activity.

Progress has been made through implementation of the revised NHS GM on-call model in June 2026, replacing ten locality arrangements with a standardised two-tier tactical and strategic model. This provides a clearer and more consistent basis for escalation, decision-making and coordination during incidents. NHS GM continues to work with NHS providers, Greater Manchester Category 1 responders, neighbouring ICBs and NHS England North West to support coordinated planning, training, exercising and incident response.

The residual risk remains because the revised arrangements require further testing and assurance, including evidence that plans are current and interoperable, staff undertaking response roles are trained and competent, lessons from incidents and exercises are implemented, and the ICB can sustain an effective response during concurrent or prolonged disruption. Workforce capacity and senior leadership resilience remain contributing factors but should be considered within the wider assessment of organisational and system preparedness.

Key Controls

Governance and accountability

- Designated Accountable Emergency Officer leadership and oversight.
- Executive and committee oversight of EPRR risks, compliance, preparedness and incident response arrangements.
- Defined strategic and tactical command structures, escalation routes and decision-making responsibilities.
- Regular reporting of material preparedness, resilience and response risks.

Planning and assurance

- Organisational and system-level EPRR plans covering prevention, preparedness, response and recovery.
- Annual EPRR Core Standards self-assessment and associated improvement plan.
- Arrangements for reviewing, approving and testing emergency and business continuity plans.
- Processes for capturing and implementing lessons from incidents, exercises and debriefs.
- Oversight of provider preparedness and escalation of material system risks.

Incident response arrangements

- Standardised two-tier strategic and tactical on-call model implemented in June 2026.
- Defined arrangements for incident notification, escalation, coordination, situational reporting and strategic decision-making.
- Mechanisms for coordinating the health response with NHS providers, Greater Manchester partners, neighbouring ICBs and NHS England.
- Arrangements to support recovery, restoration of services and formal stand-down following incidents.

Training and exercising

- Training programme for personnel undertaking strategic, tactical and supporting incident-response roles.
- Exercising programme to validate plans, command arrangements, communications, interoperability and recovery arrangements.
- Training-needs analysis and competency oversight for relevant response roles.
- Exercise and incident action tracking to confirm that identified improvements are completed and embedded.

Capacity and resilience

- Prioritisation and oversight of the EPRR work programme against statutory requirements and identified risks.
- Monitoring of EPRR capacity, capability, succession arrangements and critical dependencies.
- Additional resilience provided through the support arrangement with Lancashire and South Cumbria ICB
- Escalation arrangements where capacity or competing operational demands threaten statutory preparedness or incident response.

Gaps in Control or Assurance

Assurance is not yet sufficiently developed to demonstrate consistently that all NHS GM emergency, business continuity and recovery plans are current, aligned and tested against relevant risks.

The revised strategic and tactical on-call arrangements require further testing and evaluation to confirm that escalation, decision-making, information flows and interfaces with providers and partner agencies operate effectively during significant, concurrent or prolonged incidents.

Training-needs analysis, competency assessment and exercise coverage for all personnel who may undertake an incident-response role are not yet fully embedded within a single assurance framework.

Arrangements for tracking and confirming completion of actions arising from incidents, exercises, debriefs and the EPRR Core Standards process require further strengthening.

Consolidated assurance concerning provider preparedness, business continuity, mutual aid, critical dependencies and recovery readiness requires further development.

Capacity and leadership resilience remain constrained, including reliance on temporary additional support and limited resilience during concurrent incidents or an extended response.

	Risk Scoring and Tolerance									
	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	3	3	3	3				3	2	
Impact	4	4	4	4				4	3	September 2027
Risk Level	12	12	12	12				12	6	

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

Assurance	Assurance Level
First-line assurance is provided through management oversight of the EPRR work programme, incident-response arrangements, training and exercising activity, plan review, risk escalation and regular engagement between the EPRR lead and the Accountable Emergency Officer. Second-line assurance is provided through executive and committee oversight, the annual EPRR Core Standards process, review of provider and system preparedness, and reporting of significant incidents, exercises, identified gaps and improvement actions. External and third-line assurance is supported through engagement with NHS England North West, peer challenge with neighbouring ICBs and Greater Manchester partners, and relevant review or audit activity. Assurance should remain partial until there is sufficient evidence that plans, command arrangements, training, exercises, partner interfaces, business continuity and recovery arrangements have been tested; identified actions have been closed; and NHS GM can sustain an effective response to concurrent or prolonged incidents.	**Partial**

Action			
		Complete/ BAU	On Track
		Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Approved framework; clearly defined governance and accountability arrangements; mapped EPRR plans and key system dependencies; documented command, control and escalation arrangements; and agreed assurance and reporting routes.	March 2027	*Needs embedding:* *GM EPRR Co-ordinating Group has been established providing clarity around planning, command and control, governance and accountability, etc.*	On Track
2	Training and exercising assurance Complete the EPRR training-needs analysis and implement a risk-based training and exercising programme for personnel undertaking strategic, tactical and supporting incident-response roles.	March 2027	*Required:* *Role-based competency requirements; training compliance information; exercise schedule; evaluation reports..*	On Track
3	Core standards and improvement plan Complete the 2026/27 EPRR Core Standards self-assessment and agree a prioritised improvement plan addressing material compliance, control and assurance gaps.	January 2027	*Required:* *Approved self-assessment (evidence repository); named action owners; delivery dates; exception and escalation reporting via EPRR Co-ordinating Group*	On Track
4	Test command control and co-ordination Exercise and evaluate the revised NHS GM strategic and tactical response arrangements, including escalation, decision-making, situational awareness, provider interfaces, multi-agency coordination and sustained response arrangements.	March 2027	*Required:* *Exercise reports; lessons identified; action plans; confirmation of action closure; Accountable Emergency Officer assurance.*	On Track
5	Business continuity and recovery Strengthen assurance that critical NHS GM functions and key system dependencies have current, tested and mutually compatible business continuity and recovery arrangements.	June 2027	*Required* *Critical-function mapping; business-impact analysis; tested continuity and recovery plans; dependency and mutual-aid assessment.*	On Track
6	Capacity and leadership resilience Review whether the EPRR operating model has sufficient leadership, capability and capacity to deliver statutory preparedness activity while	March 2027	*Required: Demand-and-capacity assessment; resilience and succession plan; review of the Lancashire and South Cumbria support arrangement; agreed mitigation and escalation decisions.*	On Track

	sustaining concurrent or prolonged incident response.			

Strategic Risk **SR8**	**There is a risk that NHS Greater Manchester is unable to prevent, withstand, respond to and recover from a significant cyber incident or digital service failure, due to increasing threat levels, legacy and end-of-life technology, inconsistent cyber maturity across partners, gaps in asset and supplier assurance, constrained specialist capacity, untested or incomplete continuity and recovery arrangements, and the current absence of comprehensive financial modelling and confirmed funding sources for end-of-life replacement and other essential IT procurement pressures. This could delay or prevent timely risk treatment; disrupt critical clinical, commissioning and corporate services; compromise sensitive information; cause patient safety harm; weaken statutory delivery; and result in regulatory, financial and reputational consequences.**		
Strategic Objective	Meet our statutory obligations		
Chief Officer / Committee	**Chief Officer:** Chief Reform and Improvement Officer **Committee:** People and Resources Committee		
Risk Appetite Level	**Cautious**	Risk Tolerance Range (e.g 5 – 15)	**5 to 10**

Rationale for Risk Score and Progress made in the quarter

Current score: 16 (Likelihood 4 × Impact 4), high; trajectory static with early signs of improvement. The likelihood remains likely because the health and care system continues to face persistent hostile activity, inconsistent cyber maturity, end-of-life devices, unpatched vulnerabilities, third-party dependencies and constrained specialist capacity. The impact remains major because loss of critical digital services or data could disrupt patient care, system coordination and statutory functions across Greater Manchester.

During the quarter, operational stability and patching performance improved, and a system-wide cyber operating model and prioritised investment programme were progressed. Exercise Chaffinch has strengthened the focus on prolonged cyber disruption, executive decision-making and recovery. However, the risk remains above tolerance because the end-of-life device treatment plan is not yet complete; the aggregate cost and phasing of EOL remediation and wider IT procurement pressures have not been comprehensively modelled; no confirmed recurrent or capital funding sources are currently identified to meet these pressures; supplier assurance has material weaknesses; ownership of information assets and some specialist cyber roles remains incomplete; and evidence of tested recovery for all critical services is not yet sufficiently mature.

The intended route to tolerance is to reduce likelihood through stronger identity and privileged access controls, vulnerability and attack-surface management, asset lifecycle controls and supplier assurance, while reducing impact through immutable backups, tested recovery plans, exercised business continuity arrangements and coordinated incident response. Key indicators will include critical patch compliance, end-of-life assets by exploitability, privileged accounts protected by MFA, critical suppliers with current assurance and tested recovery evidence, DSPT/CAF improvement-plan delivery, and actions closed following exercises and incidents.

Key Controls

ICB-owned controls

• Board and executive accountability through the SIRO, Chief Officer ownership, CDIO leadership, People and Resources Committee scrutiny and Audit Committee assurance.

• Annual DSPT submission aligned to the NCSC Cyber Assessment Framework, supported by a time-bound cyber and information governance improvement plan and independent audit.

• Security operations covering national cyber alerts, endpoint protection, monitoring, vulnerability triage, patching and incident escalation.

• Technology and information asset registers, lifecycle management, Information Asset Owner arrangements, access control and privileged-account governance.

• Business continuity, disaster recovery and cyber incident response plans integrated with EPRR, including exercises, lessons capture and escalation arrangements.

• Procurement, contract management and supplier due diligence incorporating cyber security, information governance, continuity, recovery, exit and incident-notification requirements.

System dependencies coordinated by the ICB

• Provider and supplier compliance with agreed minimum standards; timely reporting of incidents, vulnerabilities and recovery readiness; participation in exercises; and remediation of DSPT/CAF gaps.

• Alignment with national monitoring, threat intelligence and incident response services. The ICB will hold the ring through system standards, coordinated prioritisation, escalation, shared exercises and consolidated assurance reporting. Effective cross system utilisation of National funding for Cyber resilience is a key dependency and is hampered by lack of clarity on funding process and timelines

Gaps in Control or Assurance

1. Asset information is not yet sufficiently complete and risk-based to demonstrate the exploitability, operational criticality and replacement priority of all end-of-life devices and legacy systems.
2. There is no consolidated multi-year financial model for EOL replacement, cyber remediation, licensing, infrastructure capacity and other unavoidable IT procurement pressures. The model must show demand, timing, capital and revenue implications, procurement lead times, affordability scenarios and consequences of deferral. Confirmed funding sources are currently absent, preventing assurance that required mitigations are affordable and deliverable.
3. Supplier and commissioned-service assurance is inconsistent: some legacy contracts lack standard cyber, data protection, continuity, recovery, exit and testing provisions, and due diligence is not yet embedded across the full lifecycle.
4. Evidence that recovery time objectives, backups and disaster recovery arrangements for all critical services are current, ransomware-resistant and regularly tested is incomplete; exercise actions require tracked closure.
5. Cyber, IG and information-asset responsibilities are not fully resilient following organisational change, with vacancies and incomplete IAO/IAA assignments reducing management capacity and assurance.
6. System-wide visibility of provider cyber maturity, medical-device exposure, shared dependencies and cross-organisational recovery arrangements remains variable, limiting consolidated Board assurance.

	Risk Scoring and Tolerance									
	Inherent risk score	May 26	July 26	Sept 26	Nov 2026	Jan 27	March 27	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	4	4	4				3	3	
Impact	5	5	5	5				5	5	**31 March 2028**
Risk Level	25	20	20	20				15	15	

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

Assurance	Assurance Level
1st line – Internal management. Digital & IT operational reporting provides evidence of stable service delivery, improving patching and active management of incidents, vulnerabilities and end-of-life devices. The assurance is qualified because specialist vacancies, incomplete asset risk treatment, variable recovery evidence, and the absence of an agreed multi-year financial model and identified funding sources for EOL and essential IT procurement pressures mean that delivery and affordability cannot yet be demonstrated. **2nd line – Organisation and system.** SIRO, IG, EPRR, corporate risk and committee oversight review DSPT/CAF improvement, cyber alerts, exercise findings, supplier risks and action delivery. System coordination is being strengthened through the proposed GM cyber operating model and common standards, but provider maturity and dependency reporting remain variable. **3rd line – External and independent.** The annual DSPT independent assessment and internal audit programme provide independent scrutiny. The recent IT supplier management review gave limited assurance and identified high-rated weaknesses in roles, due diligence, contracts and continuity evidence, demonstrating that controls require further strengthening. **Overall assurance: Partial.** There is evidence that principal risks are understood and improvement activity is underway, but the current body of assurance is not yet sufficient to demonstrate consistently effective controls across all critical assets, suppliers and system dependencies.	**Partial**

Action		Complete/ BAU	On Track
		Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Complete a risk-based asset and end-of-life technology treatment plan and an integrated multi-year financial model covering EOL replacement, cyber remediation, licensing, infrastructure capacity and other unavoidable IT procurement pressures. The model must set out capital and revenue requirements, phasing, procurement lead times, affordability scenarios, consequences of deferral and proposed funding sources; secure executive agreement to a funded replacement and remediation roadmap.	1st Jan 2027	Asset data has been refined and desktop refresh options developed. Financial modelling is complete and funding sources are currently being approved, including an NHS England business case. Next steps are to proceed to procurement of hardware via Head of Market Management/SBS and recruitment of Agency staff to support device refresh. A STAR is in progress to approve the NHS England capital spend.	On Track
2	Implement the IT supplier audit action plan: assign accountable owners, standardise cyber/IG/BCP/DR/exit clauses, complete due diligence and risk assessments for critical suppliers, and introduce periodic assurance reporting.	31 Jan 2027	Audit findings and actions are recorded; accountable ownership and delivery sequencing require finalisation following organisational change. Completion will reduce third-party risk and improve 3rd-line assurance. Actions have been assigned to accountable owners. Following a meeting with MIAA the requested documentation has been supplied, and several actions have now been completed and closed in line with the Phase 1 plan. The remaining actions are being progressed.	On Track
3	Map critical digital dependencies and recovery objectives; validate ransomware-resistant backup arrangements; test recovery and prolonged-outage playbooks with EPRR and providers; and track closure of Exercise Chaffinch lessons.	31 Mar 2027	Exercise activity is underway and has highlighted coordination, intelligence, escalation and prolonged-recovery requirements. Completion will reduce impact and provide objective evidence that critical services can be restored within agreed tolerances. Exercise Chaffinch lessons learnt and actions pending from NHS England.	Delayed
4	Agree and mobilise the GM cyber operating model and maturity accelerator, including common minimum standards, identity and privileged-access improvement, vulnerability management, medical-device visibility, shared performance metrics and escalation routes.	31 Mar 2027	Programme proposition and priority areas are defined; funding, governance and delivery ownership require confirmation. Completion will improve system-wide prevention, visibility and coordinated assurance. NHS GM ICB Cyber Security role interviews booked for 24th and 25th November.	On Track

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NHS
Greater Manchester

Working with People and Communities

Public Engagement Annual Report 2025/26

Part of Greater Manchester Integrated Care Partnership

Greater Manchester (GM) Integrated Care Board (ICB) Public Board

18 November 2026

Required information.	Details.
Title of report	Working with People and Communities: Public Engagement Annual Report 2025/26
Presented by	Claire Connor Director of People, Communications and Engagement Claire.Connor@nhs.net
Contact for further information	Claire Connor Director of People, Communications and Engagement Claire.Connor@nhs.net
Executive summary	This report provides an overview of how NHS Greater Manchester worked with people and communities during 2025/26, and how the insight gathered informed strategic planning, commissioning and service improvement. During the year, NHS Greater Manchester directly engaged with more than 6,000 residents and patients through more than 150 events, workshops, focus groups and community activities, alongside wider engagement through digital channels. The report includes examples of how public feedback has influenced proposals, pathways and decision-making. It sets out our approach to inclusive engagement, including how we seek to reach communities less likely to be heard, our governance and assurance arrangements, and priorities for 2026/27
The benefits that the population of Greater Manchester will experience.	Meaningful public involvement helps NHS Greater Manchester make better-informed decisions by ensuring that the experiences, needs and priorities of residents and patients are understood when services are planned, commissioned and improved. It provides people and communities with opportunities to influence decisions that affect them and helps ensure services are more responsive, accessible and appropriate for the diverse communities of Greater Manchester

How health inequalities will be reduced in Greater Manchester's communities.	Our approach seeks to focus the bigger part of our engagement capacity on bringing in the voices of people who have been marginalised, disadvantaged and most likely to experience health inequalities. By targeting engagement using equality analysis, we are able to ensure that services are designed with the perspectives of people experiencing health inequalities front and centre.
The decision to be made and/or input sought	The Board is asked to note the Public Engagement Annual Report 2025/26 and the breadth and impact of public involvement undertaken during the year, and to note the priorities and direction of travel for 2026/27. The Board is also asked to take assurance that NHS Greater Manchester has continued to put arrangements in place to involve people and communities in planning, commissioning and service improvement, including communities whose voices are less likely to be heard.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Public involvement supports delivery of NHS Greater Manchester's strategic objectives by ensuring that the experiences and needs of people and communities inform planning, commissioning, service change and improvement. The approach supports the organisation to identify and address inequalities, understand the impact of proposed changes and maintain meaningful involvement with communities. Effective and proportionate engagement also helps mitigate equality, statutory, reputational and stakeholder risks by ensuring that affected communities have appropriate opportunities to inform decisions and that there is a clear evidence trail of involvement
Key milestones	Engagement activity covered by the report: 1 April 2025 to 31 March 2026. Annual report considered by the Involvement Assurance Group: 28 September 2026.

Leadership and governance arrangements.	Public involvement is overseen through NHS Greater Manchester's Involvement Assurance Group (IAG), which provides oversight and assurance in relation to involvement and equality duties. The engagement function sits within the wider communications and engagement function, with senior leadership responsibility for engagement strategy and delivery. IAG provides a route for scrutiny and assurance of significant engagement and service-change programmes
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The report details a wide range of public engagement work as well as co-working with a wide range of partners and stakeholders.
Financial or Legal Implications	NHS Greater Manchester has statutory duties to involve people in the planning, development and consideration of changes to health services. The annual report provides evidence of the arrangements and activity undertaken during 2025/26 to support NHS Greater Manchester in discharging its public involvement duties. Equality analysis and targeted engagement are also used to support consideration of equality and health inequality impacts when engagement activity is planned and delivered.

NHS Greater Manchester

Working with People and Communities

Public Engagement Annual Report 2025/26

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1. Foreword

Welcome to NHS Greater Manchester's People and Communities Annual Report 2025/26.

This report provides an overview of how we have worked with people and communities across Greater Manchester, the insights gathered and how they have informed planning, commissioning and service improvement.

Working with people and communities helps us understand their experiences, identify barriers to care and make better-informed decisions. It also supports our work to tackle inequalities by reaching communities whose voices have not always been heard.

During 2025/26, we directly engaged with more than 6,000 residents and patients through over 150 events, workshops, focus groups and community activities. We heard about issues including service change, waiting times, digital access, interpretation services and experiences of care.

A significant focus was two major public consultations on adult ADHD services and the standardisation of NHS-funded IVF cycles across Greater Manchester. These complex and sensitive programmes generated valuable insight from residents, patients, staff, community organisations and stakeholders. They also reinforced the importance of reaching people who may be disproportionately affected by change.

We continued to strengthen inclusive engagement through targeted equality work, accessible and translated information, British Sign Language resources and a mix of face-to-face, online, telephone and community-based opportunities.

Partnership working has been central to our approach. During the year, we worked closely with local authorities, Healthwatch and voluntary, community, faith and social enterprise organisations to reach people through trusted relationships. The Community Voices model builds on this by supporting communities and local organisations to explore the issues that matter to them.

We must also be realistic about the year ahead. As NHS Greater Manchester becomes a leaner organisation, we will need to work differently. We will combine digital methods and partner networks with targeted face-to-face engagement to address exclusion, meet accessibility requirements or support meaningful discussion.

Thank you to everyone who shared their experiences, expertise and challenge, and to the community organisations, partners and colleagues who made this work possible. Your contribution helps us understand the communities we serve and make more informed decisions for the people of Greater Manchester.

Colin Scales
Acting Chief Executive

2. Introduction

During the last 12 months we have directly engaged with over 6,000 residents and patients from across Greater Manchester. The team held over 150 events, workshops, focus groups and stalls, and reached hundreds of thousands of people with information about engagement opportunities through our website and social media channels.

Through this activity, people's feedback, experiences and ideas have shaped service changes and influenced the outcomes of policy decisions.

Through this report, you can find out more about this activity, what we have achieved, and how we work.

2.1 About this report

The report covers our activity for the period 1 April 2025 – 31 March 2026.

This report reflects on the engagement carried out by NHS GM during 2025/26 to inform strategic planning, service improvement and commissioning decisions. It restates our commitment to work in partnership with local people and communities. It sets out our strategic approach, key principles and our governance arrangements. We have also included case studies demonstrating how engagement has led to impact.

Further information on how we engage and current opportunities for involvement can be found on our website.

2.2 Our statutory duties

There are clear legislation and guidelines for public involvement and consultation that we must follow when reviewing or planning services. There is a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- **Section 242, of the NHS Act 2006,** places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.

- **Section 244, of the NHS Act 2006**, requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees).

- **The NHS Act 2012, Section 14Z45,** places a duty on Integrated Care Boards (ICBs) to make arrangements to ensure that individuals to whom the services are being or may be

provided are involved (whether by being consulted or provided with information or in other ways); in the planning of the commissioning arrangements by the Integrated Care Board or in the development and consideration of proposals by the Integrated Care Board for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them.

We also need to make sure that our engagement activities meet the requirements of The Equality Act 2010, which requires us to demonstrate how we are meeting our Public Sector Equality Duty and how we take account of the nine protected characteristics of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The Equality Act 2010, imposes the obligation to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Act.
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not.

Section 14Z35 of the National Health Services Act 2006 also outlines the responsibility of ICBs to reduce inequalities: each ICB must, in the exercise of its functions, have regard to the need to:

- reduce inequalities between patients with respect to their ability to access health services, and
- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

Further information about how we discharge our equality duties is included in our Public Sector Equality Duty Report contained on our website.

2.3 The GM Approach

The Greater Manchester (GM) Integrated Care Partnership Strategy sets out our ways of working with partners. We work to:

- ✓ **Involve communities and share power**
- ✓ **Take action to understand and tackle inequalities**
- ✓ **Share risk and resources**
- ✓ **Spread, adopt, and adapt**
- ✓ **Be open, invite challenge, take action**
- ✓ **Listen – people are names, not numbers**



Figure 1: Engaging with the Stockport Knit 'n' Natter group

3. Our commitment to working with people and communities

3.1 People and Communities Participation Strategy

Our People and Communities Engagement Framework, developed in 2022, has paved the way to develop and strengthen relationships with people, communities and the voluntary, community, and social enterprise (VCSE) sector in GM. Developed in partnership with 10GM, GM=EqAL, providers, local authorities and Healthwatch, this framework presented a shared vision for moving from passive involvement to active engagement and participation. It brings communities closer to decision making and allows us to listen at every stage of decision making – from needs assessments right through to option development and implementation.

Our approach seeks to:

- Focus the bigger part of our engagement capacity on bringing in the voices of people who have been marginalised, disadvantaged and most likely to experience health inequalities.
- Take a partnership approach, both at system and locality levels to ensure we are making full use of all available assets and joining up work to remove duplication and repetition.
- When supporting service improvement and change, ensure we have a good understanding of which communities are not well served, or who may be differentially impacted by change – and ensuring our targeting and methodologies reflect this understanding.
- Ensure that agenda setting is shared with our communities so they can raise subjects which matter to them, feel heard and see resulting action.

3.2 Principles

Underpinning our strategy are the ten key principles adopted from NHS England (NHSE).



Figure 2: The 10 principles for working with people and communities

4. Discharging our duties

4.1 Planning and Delivery

Ultimately, NHS GM has a statutory responsibility to involve the public in its work. However, the prime reason we want to involve residents in our work is that the weight of evidence shows that meaningful engagement with local people – such as capturing their lived experiences, gathering their views, and understanding needs and issues, enables commissioners to make better and more informed decisions.

To enable us to reach people and communities in an effective way, and ensure we involve underserved communities, we plan and deliver engagement together with our Greater Manchester Integrated Care Partnership (ICP) partners.

The ICP System Participation Group is one of the ways we seek to co-ordinate, share best practice and support each other across the Greater Manchester system. It brings together representatives across the health and care system including the voluntary, community, faith and social enterprise (VCFSE) sector, the providers and Healthwatch.

Each locality has a locality participation group (LGP) in line with the People and Communities

Participation Strategy. Membership is made up of engagement professionals from health and care partners as per the model below.

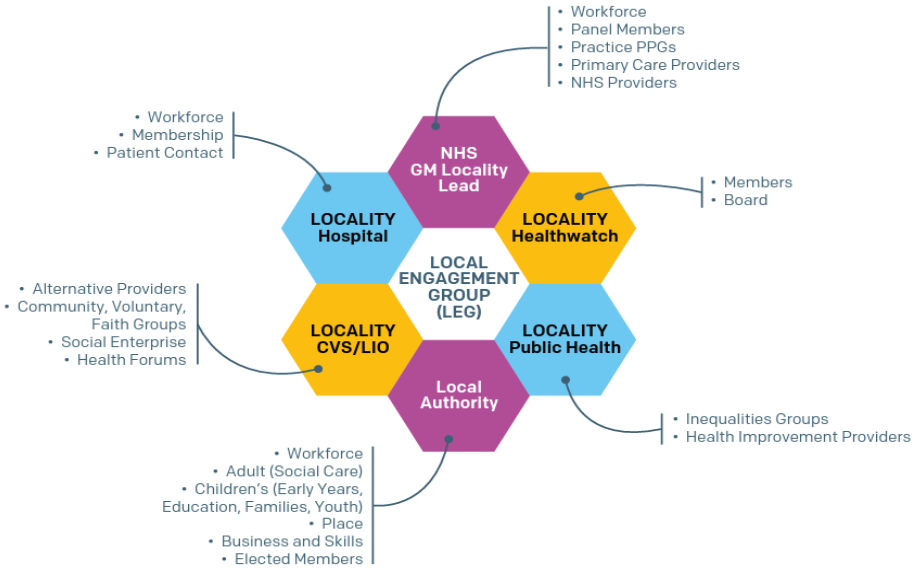


Figure 3: The Local Participation Group Model

Each LPG is supported by a named member of the NHS GM Engagement Team. Terms of reference vary according to local needs, but the primary function is to ensure partners across the locality work together to plan and deliver engagement. This includes engagement to inform work being driven from the locality, as well as at a larger footprint, including the whole GM system.

4.2 Reaching underserved communities

Crucial to understanding the needs of communities is ensuring we find ways to listen to those who most need to be heard but are less likely to be involved. We have worked with partners and communities to improve our understanding of what is needed to ensure no one is left behind when we carry out engagement.

All of our engagement work is informed by an Equality Impact Analysis (EIA) to truly understand who we need to reach. We have built on the EIA to enable us to be as proactive as possible in our communications and methodologies, to encourage and empower involvement of our diverse communities. This includes development of our pioneering Targeted Equality Engagement Matric (TEEM). Using information from the EIA, TEEM helps us identify communities who may be disproportionately affected by a proposal and sets out targeted approaches to remove barriers to participation, ensuring engagement is accessible, representative and reaches those most likely to experience health inequalities.

A TEEM assessment is carried out before we begin to engage and sets out the tactics we will use to achieve inclusive engagement including:

- BSL videos
- Easy read information and engagement methodologies
- Diverse and varied ways to engage including WhatsApp, one-to-one telephone support, and online and paper surveys
- Working with the VCFSE sector and partners to reach diverse and underserved communities
- Engaging in the heart of communities and in places where people are likely to meet or be present for example, shopping centres, hospitals, community venues, support groups and neighbourhood venues.

We believe that working with people to develop our approaches allows us to be even better at listening.

Improving engagement with the Deaf community

This year we have made strides to improve our engagement with the Deaf community.

In 2019, in partnership with Salford Healthwatch and the Northern Care Alliance, we developed a lived experience coproduction group for Deaf service users. The group, Silent Voices, have supported and advised the health and care system across GM to improve ways of listening to and involving the Deaf community, identifying opportunities for changes to services where there are known barriers.

This year, responding to the issues raised by Silent Voices we coproduced a toolkit for our Communications and Engagement team, which supports them to engage and communicate with the Deaf community in a meaningful way and to make communications and engagement activity more accessible.

The group, which meets every two months, worked with trusted communication professionals and British Sign Language (BSL) interpreters to give advice and guidance on how NHS GM should communicate and engage with Deaf people.

The toolkit also advises on building trusted relationships, arranging public events, accessible information standards, style guides and working with BSL interpreters.

The following groups contributed to and influenced the final document:

- Trafford Deaf Partnership, including Trafford Deaf network
- Bolton Deaf Society
- Salford d/Deaf Community Gathering

- Manchester Deaf Club

The toolkit is a permanent point of reference for communications and engagement professionals to use when communicating with Deaf people and British Sign Language (BSL) speakers. It has already been used to support NHS GM's digital and social media content in creating targeted and effective communication.



Figure 4: Silent Voice group meeting

Engaging ethnic minority communities during the IVF consultation

We know that despite our attempts to be inclusive with engagement we don't always get it right first time, therefore we have built learning and evaluation into all of our activities. This enables us to reflect and diversify our methodologies where necessary. For example, when we carried out engagement for Adults ADHD, we found that the voices of people in the justice system were not evident, so we worked with partners from the Criminal Justice System to include their views in the consultation.

Listening to the voices of diverse communities also means that rather than expecting them to come to us, we must sometimes go to communities themselves and work with known and trusted voices within that group.

To help shape our six-week IVF Cycles consultation, we completed an EIA which identified individuals and communities who may be disproportionality affected by the fertility treatment changes. This included people from ethnic minority communities, particularly Black African and Caribbean and South Asian communities.

We carried out targeted engagement, working with voluntary and community organisations to reach people in trusted community settings. This included engagement with the Support and Action for Women's Network (SAWN), who support Black African women in Oldham, and De Butterfly CIC based in Stockport, which provides accessible mental health support for Black and ethnic minority groups. Information was also made available in accessible formats, including an Urdu translation of consultation materials and an Easy Read version.

Participants told us that fertility and infertility can be particularly sensitive subjects within some communities and cultures, with individuals often experiencing stigma, pressure, and isolation.

Some also felt that the system made them feel lost and abandoned, as services did not consider language needs, cultural differences and religious considerations.

This engagement provided valuable insight into the lived experiences of people who may not otherwise have participated in the consultation. The findings were incorporated into the final consultation report, ensuring decision makers understood the potential impact of proposals on different communities and were able to take these considerations into account during the decision-making process.

To support the inequalities agenda and reach those who need us most, our People and Communities Participation Strategy reflects the GM Fairer Health for All Framework, recognising the intersecting inequalities in relation to demographics, geography, and socio-economic factors. Enabling inclusive participation requires us to take into account these intersecting inequalities to understand the barriers faced by people and communities.

NHS GM is represented on the Tackling Inequalities Board, which provides strategic leadership to the programmes of work taking place across Greater Manchester's public services, to reduce inequality and prejudice, and create a fairer and more equitable society.

There are a range of leaders from the public, voluntary and community, and business sectors, including the Greater Manchester Equality Panels and the Greater Manchester Equality Alliance who contribute to and are also members of the Tackling Inequalities Board.



Figure 5: Engaging at the Westwood Community Centre in Oldham as part of the IVF consultation

4.3 Using data and insights

The GM Health and Care Intelligence Hub

The GM Health and Care Intelligence Hub hosts a range of web-based intelligence tools, which have been co-designed to powerfully consolidate data and insights from public and VCFSE sector partners across the city region into a single portal. The whole population and person-level longitudinal data set links care records across acute, community, mental health, adult social care, and primary care. This aids person-centred care but also helps us to better understand population health needs and target action to address health inequalities.

The new Fairer Health for All dashboard, which sits within the Hub, shows baseline data and trajectories against our 2030 long-term targets and monitors annual progress by looking at a combination of metrics including:

- Neighbourhood and Place level data (e.g. housing, poverty and employment)
- Data on access, experience, and outcomes of care
- Data on the social and economic impacts of the health and care system (e.g. measuring social value through employment procurement and commissioning)

We are actively looking at ways to log and share qualitative insight across the system. This would effectively provide a library of case studies, engagement outcome reports and other intelligence, which can ensure the most is made of the insight we gain thus, improving outcomes and helping avoid repeated requests from communities for input on the same topics.

Quality and Performance Committee

The Quality and Performance Committee meets monthly. Its purpose is to:

- Provide clear accountability and responsibility for quality.
- Bring together the right people to respond in a timely and proactive way addressing gaps in intelligence.
- Develop a shared vision for quality and patient safety with oversight of the strategy delivery.
- Used as an assurance mechanism for the progress of addressing system-wide inequalities and advancing equality strategies and plans.

Healthwatch in Greater Manchester and NHS GM's Patient Services and Engagement teams collaboratively produce a quarterly report for the Committee. This has now progressed to a

thematic analysis of patient experiences from across Greater Manchester.

The purpose of this triangulated approach is to present a rich and diverse view and allow a deeper understanding of patient experience across services, as well as from the wider public – highlighting hotspots, significant themes and trends that are comprehensive and actionable.

4.4 Engagement activity

We work closely with our partners to deliver engagement in line with the priorities of our People and Communities Participation Strategy and to fulfil our statutory duties, with four main participation priorities:

- Mobilising people and communities to take charge of their health
- Fulfilling statutory duties
- Delivering insight
- Responding to feedback

A review of our engagement activity, including two public consultations, in 2025/26 is below:

Public Consultations

In Vitro Fertilisation (IVF) Cycles public consultation

Background

In Vitro fertilisation (IVF) is one of several ways available to help people with fertility problems.

Previously, in Greater Manchester, the number of cycles offered to those who are eligible, depended on where in the city region someone lived. This was because the, now closed, clinical commissioning groups in each Greater Manchester borough had different policies offering between one and three cycles.

NHS Greater Manchester wanted to seek feedback from residents, communities, stakeholders and staff about the number of IVF cycles eligible people should be offered.

The preferred option was to standardise the number of cycles to one, plus an additional attempt should this be cancelled or abandoned (referred to as 1+), to eligible women aged 39 and under. This proposal would ensure equity across the Greater Manchester region.

The engagement team sought the views and opinions of residents, communities, stakeholders, and staff about how many NHS funded IVF cycles should be available to those eligible across Greater Manchester.

Activity

The consultation took place over 6 weeks with over 2,200 people engaged with in a variety of ways as highlighted in the table below:

Method	Public Engagement Reach
Online survey	1074 responses
Public engagement stalls	28 sessions, 829 conversations
Focus groups	5 sessions, 123 participants
Targeted communities	8 sessions, 189 participants
Website	7,893 page visits
Social media	Organic posts – 22,700 total views
Printed press advertisements	Adverts in 13 publications across GM 358,282 potential readers
Media releases	2 media releases 22 pieces of media coverage

By completing an EIA, we identified that people from ethnic minority communities, particularly Black African and Caribbean and South Asian communities, may be most impacted by the proposals. We therefore targeted our public engagement to these people. Throughout the consultation we also worked closely with our local authority and voluntary sector partners, and our Lived Experience Advisory Group (LEAG), who gave advice and challenges before and during the consultation.

We produced literature and printed surveys in different languages as well as in an Easy Read format. The translation tool on our engagement platform, Go Vocal, translated the consultation information a total of 272 times.

Key insight

There was significant support from respondents for the number of NHS funded IVF cycles to be standardised across Greater Manchester. However, almost all of those we engaged with strongly opposed the one cycle (1+) offer, based on clinical evidence, personal experiences, concerns about true fairness and the potential hidden impact on people's mental health.

Many people wanted to see NHS Greater Manchester follow the National Institute of Health and Care Excellence (NICE) guidance, which recommended three cycles. Almost all those who responded were clear that if the aim was to achieve standardisation, the offer of cycles should be levelled up (to two or three cycles).

Most people told us that any changes to policy should not affect people who have already started their IVF journey. Changing the goalposts mid-journey could be emotionally and financially damaging.

Throughout the consultation, concerns were raised about the potential for some people and communities to be more impacted than others. The most common observation was around the cost of additional cycles for people on a low income. We also heard concerns about the impact on single-sex couples and single women who already pay for some parts of the IVF pathway.

Further and significant concerns were raised about the impact on people with long-term health conditions or disabilities that may either reduce fertility or make it harder to get pregnant and reach full-term. It was regularly raised that infertility is a medical condition.

Many people highlighted the potential impact of the policy and infertility on long-term mental and emotional health.

Infertility and IVF is already a sensitive issue in some faiths and cultures and there were concerns that this could exacerbate these.

The full report can be viewed online.

The impact

This report, along with supporting information and the EIA, went through our internal governance process, before being reviewed by the Greater Manchester Health Oversight Scrutiny Committee. A final decision to standardise the number of cycles to one (+1) was made by the Greater Manchester Integrated Care Board.

Adult ADHD public consultation

Background

Attention Deficit Hyperactivity Disorder (ADHD) is a condition that makes it more difficult for those affected to focus, sit still, and control their impulses. ADHD is part of a group of neurodevelopmental conditions that affect how our brain functions.

We estimate that there are approximately 25,000 adults waiting for an ADHD assessment across Greater Manchester, with more being added every day.

If the delivery of services were to stay the same, people could be waiting over seven years for assessment and diagnosis and some could experience a wait of up to 10 years.

NHS Greater Manchester wanted to change adult ADHD services so that they could better support the people who needed them.

There were two potential options for improving access to adult ADHD services and support:

- Option A – Everyone with potential symptoms is referred for a face-to-face triage against referral criteria and then offered an appropriate level of support.

- Option B – Everyone with potential symptoms is first signposted to support tools and services. If these don't help, they will then be referred for a face-to-face triage against the referral criteria and get offered an appropriate level of support.

NHS Greater Manchester's preferred option was option A, as it means that people who are at risk of harm will be reviewed faster.

Activity

The engagement team gathered views from patients, relevant NHS specialists, partners and stakeholders to help commissioners design a new pathway to reduce the amount of time people wait for assessment, diagnosis, and support.

An eight-week public consultation gave people in Greater Manchester an opportunity to choose between two proposed options for the ADHD pathway for adults, referred to as options A and B. This consultation built on previous engagement with adults living with ADHD, and a past review of Adult ADHD services.

We engaged with 2,500 people through community group workshops, pop-up stalls across Greater Manchester and an online survey. People were also able to get involved through text and WhatsApp messages, phone calls, voice notes, and emails.

We made sure to target people who were at a higher risk of ADHD and those groups that might not always have the same access to information as others. The communities we focused on were:

- Women's and men's groups
- LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning, plus) communities
- Deprived communities
- People with experience of being in the criminal justice system
- People who have misused drugs and alcohol
- People with learning disabilities

A task and finish group of professionals was also set up to look at different options for change. We shared these with service users to understand their perspective and gather feedback.

The variety of ways we engaged with people are highlighted in the table below:

Method	Public Engagement Reach
Online survey	1038 responses
Public engagement stalls	30 sessions, 1,341 conversations
Focus groups	12 sessions, 168 participants
Website	12,963 page visits
Social media	Organic posts – 63,117 total views Paid for posts – 121,365 total views
Printed press advertisements	Adverts in 12 publications across GM 355,282 potential readers
Phone calls	9
Texts/WhatsApp messages	33
Letters/audio file	7

Key insight

Option A was overwhelmingly preferred to option B.

Most people felt option A would give faster access to assessment and support, reducing feelings of being ignored or left behind. The earlier triage appointment would also help prioritise those with the greatest need. We found that most health professionals we spoke to also agreed that option A was better.

Concerns were raised that triage might become a challenge if not properly resourced. Other concerns included that existing problems would remain under a new patient pathway, such as lack of communication from services, long wait times, insufficient funding, and certain groups of people being overlooked.

Option B received less support because people felt it would add to the delay in getting an assessment and diagnosis. The team heard from those with lived experience, that in most cases, people would already have tried the self-help support available, done their research, or struggled to get by on their own for a long time. Most people felt that option B wouldn't be effective for people with ADHD, as they have difficulties with organisation and follow through. Having to organise a second GP appointment would lead to more barriers for accessing support.

Other insights included:

- The design of a new service should involve people with experience of living with ADHD
- Waiting times is the biggest priority problem for people with experience of the existing service
- The needs of diverse and at-risk groups should be considered to ensure inequalities are not widened
- There needed to be a range of ways to access the service
- Health professionals such as GPs, triage teams and those working with people with potential ADHD should be given the training, skills, knowledge and expertise to recognise, support and refer people for appropriate help. This was particularly important when supporting vulnerable people.

The full report, with detailed findings and insights can be viewed online.

Impact

The commissioners of Adult ADHD services reviewed the feedback from the consultation. The report, alongside supporting information and clinical evidence, was used to inform the final recommended model.

The new model is based on option A, which most people supported as their preferred option. Some changes to the model were made as a result of the feedback, including 1-hour-long face-to-face appointments that allow for richer observation, better safeguarding assessments, and more accurate evaluation of co-occurring conditions.



Figure 6: Engaging in Oldham with an Asian Women's Group for the ADHD consultation

Projects in brief

Ambulance Handover – Tameside Hospital

Background: Nationally, demand on Accident and Emergency (A&E) services is a challenge, with many areas experiencing demand on services that exceeds capacity.

This additional pressure on NHS trusts is affecting performance against the national standard that 95% of patients attending A&E should be admitted, transferred or discharged within four hours of arrival.

NHS Greater Manchester's current performance is below this target, at 78%, and we wanted to better understand the reasons for this.

Aim: To understand people's experience of using A&E, in particular the decision-making process and what drives people to attend.

This will help us understand what choices people make and why. It will also enable NHS GM to develop interventions to reduce unnecessary attendance.

Activity: Working in partnership with Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT), we engaged with patients attending A&E to understand their experiences.

We focused particularly on their ambulance journey and handover experience, including whether they experienced any care in the corridor. Corridor care is a significant concern for both patient safety and patient experience, so we wanted to hear directly from patients about their experiences and understand the impact this had on them.

We spoke to 48 people – patients as well as their family members, across four separate visits to the Tameside Acute Medical Unit.

Key insight:

- Many respondents report extended waits, sometimes exceeding 24–36 hours. This is a consistent source of frustration and distress. The majority of people who shared their experiences felt that they spent much of their wait in corridors, often on beds or trolleys, with some describing a lack of privacy, dignity, and comfort.
- Many patients felt poorly informed about their care or what was going to happen to them and when.
- People frequently praised staff, including paramedics, for doing their best, despite difficult circumstances, describing their approach as caring and positive.
- Despite challenges, a number of respondents had very positive experiences,

particularly when they were seen quickly or when staff went above and beyond for their care.

- Positive staff interactions are a consistent strength, but systemic pressures are impacting patient experience.

Impact: Findings were shared with staff at Tameside and Glossop Integrated Care NHS Foundation Trust. The report will be presented at the Trust's Urgent and Emergency Care Governance Meeting and Patient Experience Meeting. The NHS Greater Manchester engagement team also has plans take the project to the other Emergency Departments across Greater Manchester.

Children and Young People's ADHD Lived Experience Advisory Group

Background: Attention Deficit Hyperactivity Disorder (ADHD) is a condition that can make it more difficult to focus, sit still, and control impulses.

ADHD is part of a group of neurodevelopmental conditions that affect how our brain functions. Other neurodevelopmental conditions include Autism and speech and language conditions. Neurodevelopmental conditions are not mental health conditions. Based on national data, we estimate that there are nearly 30,000 children and young people with ADHD in Greater Manchester.

NHS GM continue its work to improve wider neurodevelopmental support for children and young people, focusing on ADHD and Autism.

Aim: To understand the emotional, practical, and wellbeing impact on children and young people waiting a long time for an ADHD assessment.

To understand the experiences of young people with ADHD and establish a lived experience advisory group that can provide feedback on waiting times, access to support and wider barriers within the system. This insight will help inform commissioning decisions and the development of services that better meet the needs of young people with ADHD.

Activity: NHS GM partnered with the Greater Manchester Youth Network to develop an advisory group of young people with lived experience of ADHD. The advisory group consists of 10 members, some have been formally diagnosed with ADHD, and some are still awaiting assessment.

The lived experience advisory group created a structured programme of engagement. This included face-to-face sessions with individuals, giving young people space to explore their experiences in detail. There were also monthly group sessions where young people shared ideas, challenged assumptions, and shaped recommendations for commissioners.

The group approach gave these young people a sense of community, encouraging and supporting each other. This feeling of belonging and trust helped them share their experiences more openly.

Commissioners funded a creative project, where the group worked with a local artist to co-produce a creative booklet, known as a zine. It shares information on the group's own experiences, with advice on managing ADHD and navigating services. The zine was designed as a tool to support other young people with ADHD and those awaiting assessment, as well as an aid for professionals having conversations with children and young people around ADHD. The zine will be distributed across Greater Manchester in community spaces, clinics and GP practices.

Impact:

NHS Greater Manchester commissioners regularly engage with the lived experience advisory group to gather feedback and insight on proposals for service improvement. The group's lived experience and expertise can highlight issues and considerations that may not be identified through a solely clinical perspective.

Digital Access – Analogue to Digital

Background: In 2024–25, the NHS GM engagement team delivered the Fit for the Future engagement project, which sought views from the public on how NHS GM could ensure local services were effective and sustainable.

A key theme which emerged from this engagement was the increasing use of digital platforms to access health services. While participants recognised the potential benefits of digital approaches, many expressed concerns about the impact of this shift on people who may be unable or less confident to use technology, and the risk of them being disadvantaged as a result.

Aim: As the shift from analogue to digital is a key pillar of the NHS 10 Year Health Plan, we wanted to better understand the reasons for this reluctance, and particularly the potential impact on older people.

Activity: The NHS GM engagement team worked in partnership with local arts organisation, Made by Mortals, to produce a series of podcast episodes.

The episodes were part of an ongoing podcast series, Armchair Adventures, aimed at young children. Episodes are co-produced with an established group of older people, using their experiences, interests and stories as a starting point for the episodes. The series has covered themes such as identity, wellbeing and culture.

We used producing episodes which explored older people's experience with technology, as an opportunity for discussion with this key audience.

We arranged two, in-person workshops with the older people's group. Using interactive techniques, such as role play and debate, we gained insight into people's views and experiences of digital platforms and why some were resistant to them.

Using that insight, an episode was created involving an older character, Teresa, learning to use apps, with a younger character helping her. The story explores things such as building confidence, explaining technology clearly, not rushing someone who is struggling, and the value of younger and older people helping each other.

Key insight:

- Older people did not feel resistance to change towards a shift to digital, but they did express a lack of confidence and knowledge.
- Key concerns centred around online misinformation and the security of personal information.
- Many shared that with the right support and reassurance, they were keen to take advantage of the benefits that digital accessed offered.

Impact: This innovative and creative engagement approach allowed us to explore not just how people thought and felt but discuss their ideas on how to overcome specific issues. These insights will help NHS Greater Manchester as it rolls out digital initiatives in the future.

Fit for Winter

Background: Winter is a time of increased pressure for the NHS as cold weather affects people with existing health conditions and illnesses like flu and Covid-19 spread.

Aim: To understand how residents across Greater Manchester, particularly vulnerable groups and people on low incomes, experience, prepare for and feel about winter health pressures. The engagement also provided an opportunity to share winter health advice and signpost residents to local services and sources of support.

Activity: The NHS GM Engagement team attended 13 events and community sessions across Greater Manchester, including at least one in each borough, engaging with approximately 200 people. Engagement was targeted towards groups more likely to experience winter health pressures, including through food banks, day centres and soup kitchens, as well as high-footfall locations such as shopping centres.

Key insight:

- Residents described the challenges associated with winter as multi-faceted, extending beyond health concerns alone. Key themes included the cost of heating the home, staying warm, and avoiding illness, as well as isolation and loneliness.
- Residents valued accessible and timely healthcare and information, support with energy costs and emotional support.
- Also highlighted were the difficulties some older, vulnerable and disabled people experience when accessing services digitally. Some residents relied on family members, friends or other support networks to access digital services, creating potential inequalities for those without this support. Concerns about fraud, scams and online security also affected some residents' confidence in using digital health platforms.

Impact: The findings provided insight to inform future communications and engagement activity, including the messages, approaches and channels most likely to reach and engage different audiences. Findings were also shared with leaders in each Greater Manchester borough, providing locally relevant insight to inform their understanding of winter health pressures within their communities.

Interpretation and Translation

Background: It's important that all patients have access to information and receive the care and support they need. We want to make sure that communication isn't a barrier for people who don't speak, or find it difficult to speak, English, people who don't read English, patients who use BSL or have other communication requirements.

NHS GM commissions free-of-charge interpretation and translation services for primary care settings like GP surgeries, pharmacies, and dental practices to support patients.

Aim: To gather feedback on interpretation and translation support within primary care services and understand people's experiences of accessing this support. The engagement explored awareness of the interpretation and translation services available, how easy the process of requesting support was, people's overall experiences and where improvements could be made.

Engagement with the Deaf community also sought to understand how experiences of accessing BSL interpretation in primary care had changed since feedback was last gathered.

Activity: The NHS GM engagement team heard from more than 400 people across all 10 Greater Manchester boroughs through 22 face-to-face opportunities. This included people who spoke 27 different community languages and more than 100 people who used BSL.

Face-to-face engagement, supported by VFSE organisations, was carried out at English language community classes and at focus groups with refugees and migrant communities.

The team also attended Deaf clubs and organisations to hear from Deaf residents, as well speaking with BSL interpreters, advocacy workers and VCFSE organisations to gather their experiences of supporting service users with translation and interpretation services.

In-person engagement was supported by an online survey, which was promoted via NHS GM's social media channels.

Key insights:

- Communities shared that not being able to communicate effectively or access an interpreter when using primary care services could be stressful and cause anxiety.
- Those who had accessed interpretation and translation services, had valued the support they received.
- Awareness of the support available was not consistent, and there were some people found the process of requesting interpretation or translation difficult to navigate.
- Experiences also varied between providers, with different processes in place for accessing support.

Impact: NHS GM gained a better understanding of the challenges faced by those whose first language is not English. This insight can support any future service redesign.

Experiences of Musculoskeletal (MSK) treatment

Background: Musculoskeletal (MSK) conditions affect almost a third of the UK population. It can impact joints, bones, muscles and the associated tissues around the nerves. They can range from minor injuries to long-term conditions.

NHS treatment for MSK conditions is delivered via a number of different pathways, including primary care and community settings such as physiotherapy clinics. Some specialised and more complex services are also provided in hospitals.

Aim: To understand people's experiences of navigating MSK treatment in Greater Manchester, to assess what is working well and where are improvements are needed.

Activity: From 22 December 2025–8 March 2026 (11 weeks), the NHS GM engagement team ran an online survey, hosted on the Go Vocal platform. The survey promotion was supported by MSK treatment providers, who distributed it via their patient lists. 200 responses were received over the 11-week period.

Key insight:

- The majority of patients access MSK care through their GP due to limited knowledge of alternative routes such as self-referral to community services.
- Waiting times and experience of care varied.
- Services are most positively received when patients are provided with clear advice, reassurance, and support with managing their condition long-term**.**
- Poor handovers between services, unclear or delayed information, and a lack of joined-up care led many people to chase appointments or repeat their medical history multiple times.

Impact: This engagement provided a snapshot of views. It was recommended that this engagement should be done on a larger scale to assist commissioners with any future redesign of the pathways or services.

Myalgic Encephalomyelitis or Chronic Fatigue Syndrome (ME/CFS) and Long Covid

Aim: To find out what people thought a new ME/CFS and Long Covid service should look like. NHS GM wanted to make sure the views and experiences of people living with these health conditions were heard in supporting the design and development of a new service by NHS GM commissioners.

Activity: We engaged with people across six one-hour workshops, with afternoon and evening sessions made available to accommodate different working patterns and personal responsibilities. We also considered energy and concentration levels when planning the workshops responding to feedback from support groups.

One-to-one telephone interviews took place to give people more opportunities to have their say. For those unable to join a workshop or telephone interview, an online survey was created, with paper copies made available on request.

The engagement helped us understand more about how people live with these long-term conditions, their experience of using primary care and other NHS services, along

with the type and effectiveness of any therapy or treatment they had had. We also wanted to hear about people's interactions with healthcare professionals and what they needed to support them to manage their long-term condition and live a better quality of life.

We spoke to a range of people from different backgrounds and ages, males and females, patients, parents and carers.

Impact: The findings were shared with the commissioners designing the new service. The engagement contributed to the design of the proposed service model and patient pathway. A fully costed business case is pending approval with the Greater Manchester Integrated Care Board.

Ophthalmology services

Background: NHS ophthalmology services provide medical and surgical eye care, ranging from routine vision tests and minor treatments to complex eye surgery.

An increase in demand across Greater Manchester for ophthalmology treatment, is putting services under pressure and increasing waiting times.

Aim: To use the feedback from the engagement to ensure that, as demand for ophthalmology services increases, care is sustainable, inclusive and designed with patients at the centre.

Activity: We spoke with over 170 people from across Greater Manchester, from a range of different backgrounds.

The NHS GM engagement team worked in partnership with voluntary organisations which support those with sight loss or other vision-related conditions, to organise engagement sessions.

Targeted engagement aimed at older people was also carried out at locations such as care homes, and the team visited ophthalmology service spaces across Greater Manchester such as the Manchester Royal Eye Hospital and Spa Medica sites, to speak to patients.

The team also set up public facing stalls with information and literature and offered one-to-one phone calls from an engagement specialist.

In addition, over 100 people were able to share their feedback via an online survey.

Key insight:

- Most people we spoke to were accessing ophthalmology services because they had cataracts or were doing so as part of a diabetes treatment or monitoring plan.
- Overall, there were mixed views and experiences of ophthalmology services in Greater Manchester.
- Patients were kept informed about upcoming appointments however, information about what to expect at appointments, aftercare, and treatment plans was often lacking.
- Most patients were not given a choice of hospital or provider, even if the patient challenged or questioned it. The importance of location and transport links was frequently mentioned. Distance from home was cited as the most important factor when choosing care, mainly because of the challenges travelling to and from appointments with sight loss conditions or after receiving treatment.

Impact: The findings and recommendations of the engagement will feed into the Greater Manchester Ophthalmology Strategy to help to shape the work of the wider ophthalmology programme and the Clinical Reference Group.

Procedures of Limited Clinical Value (PLCV)

Background: Procedures of Limited Clinical Value (PLCV) are treatments, operations, or interventions that the NHS considers having limited evidence of benefit for some patients, or where the benefits are only proven in specific circumstances. As a result, access is often restricted to patients who meet clearly defined clinical criteria.

The aim is to ensure that NHS resources are used for treatments that provide the greatest health benefit and that patients are protected from unnecessary procedures that carry risks but may offer little improvement.

Aim: To improve the quality and efficiency of services, by reviewing several procedures, ensuring that sure they are only used when needed. We wanted to understand whether the proposed changes would affect specific individuals or communities more than others, as well as gather opinions on whether treatment should only be offered when clear criteria, proven benefit and good value for money can be evidenced.

Activity: A series of public engagement activities took place between August 2025 and March 2026 to gather views and promote an online survey. The engagement supported the following PLCV clinical reviews:

- Pinnaplasty (Aug-Sept)
- Rhinoplasty (Aug-Sept)
- Varicose Veins (Sept-Oct)
- Split and Torn Earlobes (Sept-Oct)
- Tendinopathies (Dec-Jan 2026)
- Shoulder Pain (Feb-April 2026)

Engagement was aimed at those with current or previous experience of the above conditions or treatments, as well as those considered to be at risk of developing conditions or requiring treatment as identified during the EIA.

The NHS GM engagement team employed a variety of methods to engage with members of the public. There was an online survey, social media campaign and emails targeted to specific groups, such as those with sports injuries. Feedback could also be emailed directly to NHS GM's Policy Team

Impact: Findings, which were shared with NHS GM's Policy team, are currently moving through the appropriate governance processes, including development of recommendations and decisions on whether to approve and implement changes.

Structured Education for People with Type 2 Diabetes

Background: Structured diabetes education is a short course of usually face-to-face (but sometimes online) information sessions.

These sessions are designed to give people who are newly diagnosed with type 2 diabetes knowledge and confidence about managing their condition.

Those who attend will learn such things as, how diabetes affects your body and how making some simple lifestyle changes could help you stay healthy.

Giving people the right tools and information is important because people with diabetes mainly manage their condition themselves as part of their daily lives, sometimes with the help of a carer or family member.

Aim: A review of diabetes education services in Greater Manchester found a number of issues with the current offer, including lower attendance rates than other areas in England, limited refreshed courses available and lack of accessibility for those who don't have English as a first language.

We wanted to understand how people received and used information that helped them manage their condition, so that improvements could be made to the structured education for people with type 2 diabetes in Greater Manchester.

Activity: The NHS Greater Manchester engagement team ran a six-week public engagement exercise in January 2026.

Engagement was aimed at seeking views from those living with type 2 diabetes, their family, friends, and carers, as well as healthcare professionals. We were particularly interested to hear from people from some underrepresented communities who are a much greater risk of developing diabetes, including:

- South Asian communities
- Black African Caribbean communities
- People with learning disabilities.

Targeted engagement was carried out with different communities through an online survey, which was available in the 10 most read languages across Greater Manchester.

We produced 2,000 information postcards which were displayed in GP practices and other public buildings and printed advertisements were placed in all local newspapers, across Greater Manchester.

We also carried out a social media campaign, which featured an animated film and a call-to-action film, featuring a GP, delivered focus groups and community workshops and facilitated pop-up stalls across Greater Manchester.

Over 400 people shared their views and experiences.

Key insight:

- Structured diabetes education is welcomed to help those living with type 2 diabetes understand their condition and manage it effectively.
- More awareness is required to promote what is on offer.
- The referral process needs to be improved to be more inclusive.
- More accessible courses are key to increasing attendance and participation.
- Bespoke courses are required, for certain communities at higher risk of developing type 2 diabetes.
- Session facilitators should represent audiences, where possible.
- A varied offer of both online and face-to-face sessions would be beneficial.
- Education sessions should be hosted in community settings, with established groups.
- Dietary information needs to be specific to the audience and sensitive to

different cultural practices and beliefs.

- Refresher course would be beneficial at different intervals.
- The referral pathway and communication between professionals and providers needs to improve, to ensure the patients access timely education sessions.



Impact: The findings, along with a draft specification, were shared with NHS GM commissioners, Greater Manchester and Eastern Cheshire Strategic Clinical Network, and the Diabetes Network.

It has been acknowledged by commissioners that structured diabetes education needs to be more accessible so that all users of the service can access, participate and learn.

A draft plan has been drawn up which includes offers a number of different training sessions designed to meet the needs of people who may need additional support and that materials are made available in other formats, such as easy read and in different languages.

Reaching underserved communities

To enable us to advance equalities within our engagement, all our engagement programmes undergo an equality analysis to ensure we are reaching those who most need to be heard in an accessible way.

We have a range of ways to ensure our engagement is accessible including developing easy read information, producing everything in large print, publishing BSL films for all engagement, offering the information in different languages, and taking requests for any additional support for people to get involved should they need it.

Whilst we always have a significant online element to our engagement, we also extensively engage offline, with a significant amount of engagement taking place face-to-face or through other methods. This includes through focus groups, workshops, events, telephone calls, WhatsApp messages, emails, and community engagement.

Our TEEM tool, which uses information from the project EIA, helps us target our engagement appropriately and mitigate any barriers to access.



Figure 7: Engaging with a Kashmir women's group in Rochdale

4.5 Partnership working

NHS GM works closely with partners across the health and care system and VCFSE sector to plan and deliver engagement. Partners are directly involved in planning via the System and Locality Participation Groups (LGPs), as well as through bilateral meetings as required.

We have a strong relationship with the 11 Healthwatches across Greater Manchester, one in each of the ten boroughs plus Healthwatch Greater Manchester. They are members of the System Participation Group and the various local participation groups, with regular updates and meetings. We share learning, opportunities for involvement, and co-ordinate where possible to reduce duplication.

We also work closely with the VCSE sector in accordance with the partnership agreement set out in our VCSE Accord. This agreement provides a framework for collaboration based on a relationship of mutual trust, working together and sharing responsibility.

We recognise that sector organisations are often able to engage with people, families and children who may not want to engage directly with public sector organisations – including people who experience systemic health inequalities.

Examples of our work with LPGs this year include:

Health and wellbeing event for women in the Roma community

The NHS GM engagement team worked together with Action Together, Healthwatch Oldham and Oldham Council to deliver a successful community health and wellbeing event for women from the Roma Community.

The Roma community in Oldham faces huge difficulties accessing healthcare due to language barriers, lack of trust, and past negative experiences. This results in poor health outcomes and late help-seeking.

The event had a fantastic turnout, bringing over 60 women and 39 families to the event. To reward and encourage participation, incentives were given to the women, including vouchers for Tesco.

Stalls were hosted by 18 local partnership organisations, who volunteered their time, covering important health topics such as maternity, oral health, smoking cessation, primary care (including attendance from local GP who spoke Romanian), breastfeeding, school nursing and more. Local community interpreters guided small groups of about five women around the stalls, ensuring information was translated and understood.

As a partnership group we're going to build on this and hopefully continue engagement with this community in future.



Figure 8: Engaging at Health and Wellbeing Event for Roma Women

ADHD consultation and support event

Members of Stockport's local participation group, the Community Voice Partnership, joined forces to deliver an all-day engagement event in Stockport Town Centre. The event was designed to not only get people's views but to signpost people to the support groups and services in Stockport.

Community Voices

Local Infrastructure Organisations (LIOs)

We continue to work closely with the VCSE sector in accordance with the partnership

agreement set out in our VCSE Accord. This agreement provides a framework for collaboration based on a relationship of mutual trust, working together and sharing responsibility.

This year we are excited to embark on a new relationship with the VCSE sector, honouring our commitment to shift the balance of power to communities and enable a new level of engagement whereby communities themselves are in the driving seat, informing and shaping engagement around issues that are most important to them.

We are pleased to fund and support this innovative model, shaped and driven by partners with 10GM taking the lead on establishing and delivering a framework for engagement supported by local infrastructure organisations and grass root communities.

Each Local Infrastructure Organisation (LIO) has been granted funding to deliver against a range of plans based on the priorities of their borough. The money will be distributed to equity groups and the LIO will support them to deliver engagement and present the findings. These are the LIOs in each area:

- Action Together (Oldham)
- Action Together (Salford)
- Action Together (Tameside)
- Bolton CVS
- Bury VCFA
- Manchester Community Central (MACC)
- Sector3 Stockport
- Trafford Community Collective
- Wigan Borough Community First

Aligned with NHSE guidance and the VCSE Accord, this investment represents a pioneering approach that positions Greater Manchester as a national leader in collaborative, community-driven health engagement.

The next steps include the creation of a working group to look at insights and data and how they can be used to effect change. There is also a requirement for regular insight reports to be produced by 10GM and shared with NHS Greater Manchester.

Healthwatch

Throughout the year we have sought to further our co-working with colleagues at Greater Manchester's ten local Healthwatch organisations, recognising and valuing their unique statutory role in obtaining the views of people about their needs and experience of local health and social care services.

This has included funding the appointment of a co-ordinator role and attending each other's meetings to build relationships and share work plans and learning.

5. Governance and assurance

Our core engagement team sits as part of the wider communications and engagement function, under the leadership of the Chief Officer of Strategy and Innovation. This positioning ensures a strong connecting link between the organisation's overall direction/vision and the requirements for participation and engagement.

The Associate Director for Communication and Engagement has senior level responsibility for developing strategy and there is an engagement team overseen by the Head of Digital Communications and Engagement.

5.1 Involvement and Assurance Group (IAG)

NHS Greater Manchester's Involvement Assurance Group (IAG) continues to provide assurance to the ICB Board for the delivery of the statutory duties around public involvement. It provides oversight of all participation and involvement work, with a focus on delivering the statutory duties relating to involvement and equalities. IAG reports to the Quality and Performance Committee, which in turn reports to the Board.

Chaired by a VCFSE representative from the NHS GM Board, membership includes Healthwatch, the voluntary, community and social enterprise sector, the Councils and Greater Manchester Combined Authority and NHS GM's Engagement and Equality, Diversity and Inclusion teams. System programme leads are invited to the IAG to test bed and gain assurance for greatest equality impact of their programmes.

The IAG is a sub-group of NHS GM's Quality and Performance committee, which receives patient complaints and experience information, enabling the triangulation of insight and feedback.

This year the IAG has provided assurance on the following projects, amongst others:

- Improving Adult ADHD services
- Improving Children and Young People's ADHD services
- Standardising the number of IVF cycles offered across Greater Manchester
- Permanent closure of Altrincham Minor Injuries Unit
- Reviewing some Procedures of Limited Clinical Value, and
- Reviewing structured diabetes education for people with type 2 diabetes

6. Forward planning

This year has seen significant progress on 2024-25 which was predominantly focused on setting up processes, governance and teams. As a result, we have engaged with lots more people across Greater Manchester, directly being in contact with over 6,000 people. We anticipate building on this significantly during the next 12 months, with some significant projects planned.

Following the implementation of the new operating model as part of the NHS Reform, we now have a more limited engagement team. With reduced capacity, it is no longer realistic for a small team to deliver large volumes of face-to-face engagement across Greater Manchester. Our proposed digital+, not digital only model aims to maximise reach, improve responsiveness, strengthen insight gathering and ensure engagement remains inclusive, proportionate and compliant with statutory duties. It prioritises the use of websites, social media, paid digital targeting, virtual engagement, social listening, partner networks and community-led digital channels to reach larger and more diverse audiences efficiently. Face-to-face engagement will continue to play an important role where it is required to address digital exclusion, meet equality and accessibility requirements, support more in-depth discussion, or mitigate legal and reputational risk.

For 2026/27, we will be focusing on:

- Changes to specialist cardiac surgery services and specialist vascular surgery services (two consultations running concurrently)
- Major trauma services
- A&E experience
- Oral and Maxillofacial Surgery (OMFS) services
- Improving neonatal care in the North West
- Paediatric audiology



Figure 9: A collage of photographs from various engagement activities

NHS
Greater Manchester

Population Health Transformation

18 November 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Integrated Care Board

18 November 2026

Report information.

Required information.	Details.
Title of report.	Population Health Transformation
Author.	David Boulger - Associate Director of Population Health
Presented by.	Charlotte Bailey – Chief Officer for Strategy, People and Partnerships
Contact for further information.	David Boulger - Associate Director of Population Health david.boulger@nhs.net
Executive summary.	This report updates the Integrated Care Board on the progress made in implementing the Population Health Transformation Programme and seeks formal governance approval from the ICB to move to implementation. The proposals have been approved by NHS GM Chief Officers, People and Resources Committee and Strategic Commissioning Committee.
The benefits that the population of Greater Manchester will experience.	The transformation proposals aim to establish a more effective and efficient approach to the delivery of pan-GM prevention and population health programmes which will increase the impact of these activities on health outcomes and health inequalities.

How health inequalities will be reduced in Greater Manchester's communities.	The transformation proposals aim to establish a more effective and efficient approach to the delivery of pan-GM prevention and population health programmes which will increase the impact of these activities on health outcomes and health inequalities.
The decision to be made and/or input sought.	Integrated Care Board are asked to: • Approve the Population Health transformation proposals set out in this report. • Approve the s75 Agreement set out in the appendix to this report.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This proposal primarily supports the delivery of the NHS GM 5 Year Strategic Commissioning Plan priority to "take targeted action on population health and prevention". This proposal primarily mitigates BAF Risk 1: "Failure to deliver prevention-led population health improvement and reduce inequalities"
Key milestones.	NHS GM Chief Officers: 14/10/26 **(Approved)** People and Resources Committee (for FSOD approval): 28/10/26 **(Approved)** Strategic Commissioning Committee (for endorsement): 4/11/26 **(Approved)** Integrated Care Board (for Approval): 18/11/26 S75 Start Date: 1/4/2027

Leadership and governance arrangements.	The change programme has been overseen by a Transformation Programme Board co-chaired by the ICB Transition Director. The SRO for this transformation programme is the NHS GM Chief Officer for Strategy, People and Partnerships. NHS GM Chief Officer approval for these proposals was given on 14/10/26. The governance responsibility for Population Health sits with the Strategic Commissioning Committee who will have responsibility for overseeing the s75 agreement on behalf of the GM Integrated Care Board. SCC approved these proposals and the s75 agreement on 4/11/26. Financial Scheme of Delegation approval sits with the People and Resources Committee who approved the proposals on 28/10/26. The Population Health and Neighbourhoods Subgroup will ensure delivery is fully aligned to Live Well, Neighbourhood Health and Place Partnership arrangements. If approved, the S.75 agreement will be signed by the NHS GM Chief Finance Officer in line with agreed contract signature processes.

Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	This transformation programme has been under development for over 12 months and has been subject to extensive system engagement, including an independent review commissioned by the GMPHN which engaged a wide range of system partners. NHS GM Chief Officers, and key colleagues within NHS GM, have received several updates in relation to this transformation programme. The Transformation Programme Board and the underpinning task and finish workstreams have had the direct involvement of NHS GM staff from Corporate Governance, Finance, People Services, Clinical Directorate, and Strategy, People and Partnerships Directorate who have also all reviewed the proposed s75 Agreement.
Financial or Legal Implications	This transformation involves: • NHS GM financial contributions of almost £39million over 5 years. • NHS GM entering a s75 Legal Agreement with Manchester City Council. • Existing NHS GM Staff transferring out of the organisational by way of secondment.

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

1. Introduction

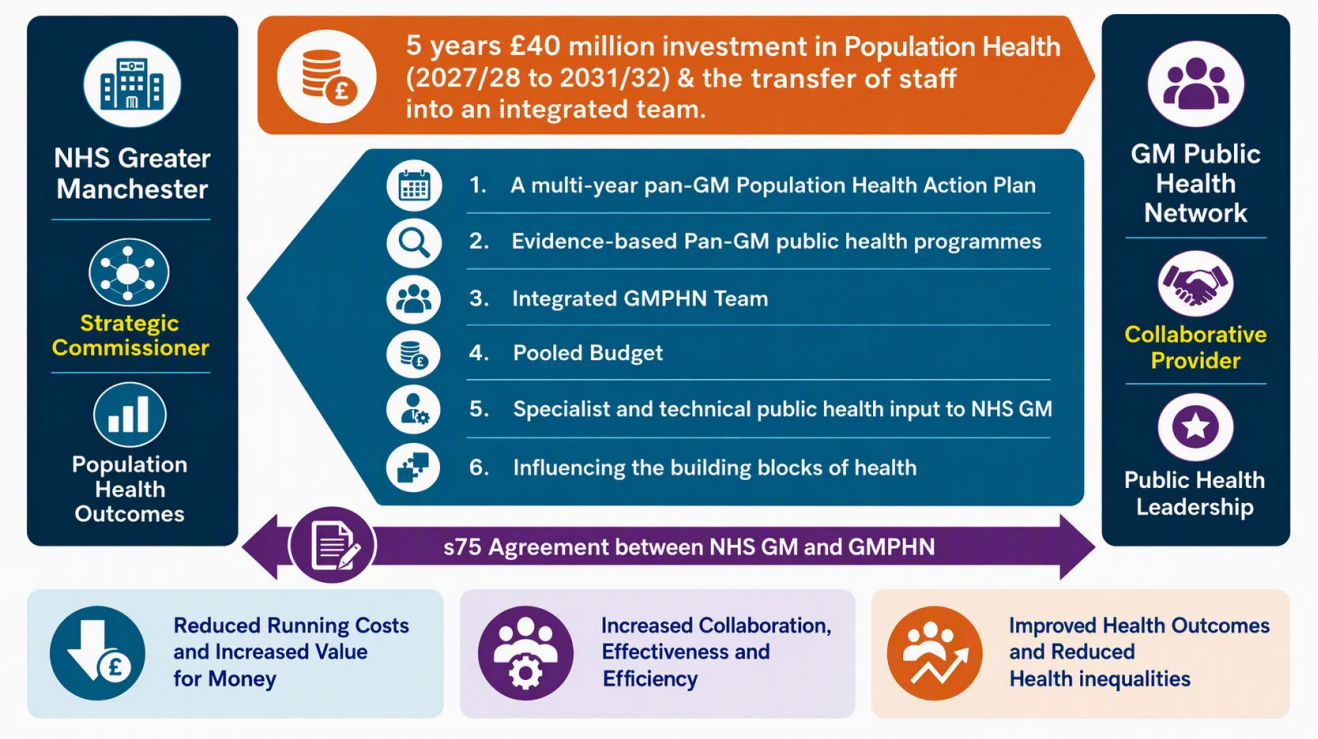
1.1 In the context of the wider Organisational Change programme, work has been ongoing to transform the NHS GM Population Health Function. At the heart of this transformation is a proposal to delegate the delivery of the Population Health improvement programmes and activities that have previously been undertaken internally by the NHS GM Population Health function, to the Greater Manchester Public Health Network (GMPHN), under the distributed leadership of the ten Local Authority Directors of Public Health.

1.2 This shift will be underpinned by the secondment out of the staff employed within the NHS GM Population Health function and the allocation of a proportion of the existing recurrent NHS GM Population Health budget to the GMPHN.

1.3 Under this arrangement, the GMPHN will discharge several functions which were previously undertaken internally by the NHS GM Population Health function, as well as establishing new activities which will support the ICB in discharging its role as a strategic commissioner, effectively meeting its statutory responsibilities and enabling the delivery of neighbourhood health and Live Well.

1.4 The arrangement will be underpinned by a formal legal agreement under s75 of the NHS Act 2006 between NHS GM and Manchester City Council (MCC) on behalf of the GMPHN. The agreement will cover the period 1st April 2027 to 31st March 2032.

1.5 A summary overview of the proposal is set out below:



1.6 The ongoing implementation of the proposals has been overseen by a Transformation Programme Board, co-chaired by the NHS GM Transition Director and the Chair of the

GMPHN, overall SRO leadership has been provided by the Chief Officer for Strategy, People and Partnerships, and governance oversight has been provided by the Strategic Commissioning Committee.

1.7 Whilst no statutory ICB accountabilities will be transferred under this arrangement, the ICB is delegating a number of functional responsibilities to the GMPHN to undertake on their behalf. The delivery of these functional responsibilities by the GMPHN of behalf of NHS GM, will support the ICB to effectively, visibly and demonstrably discharge its statutory duties in relation to public health and population health.

1.8 It is expected that the transformation will have several beneficial outcomes including:

- Increased system integration and a strengthening of relationships between the NHS and Local Government.
- Improved health outcomes and reduced health inequalities through the scaling up of evidence-based and insight-informed targeted population health interventions aligned to priorities set out in the s75 agreement.
- Reduced ICB expenditure through immediate recurrent savings and the reduction in future demand and cost through an improvement in health outcomes.
- Enhanced provision of technical and specialist public health advice and guidance from GMPHN to the ICB.
- Increased effectiveness, efficiency and value for money achieved through unprecedented levels of integration and co-operation.
- Enhanced collaboration between the NHS and Local Government in relation to data, intelligence, analytics and research

1.9 The proposals have been subject to extensive due diligence, and were approved by NHS GM Chief Officers on 14/10/26, NHS GM People and Resources Committee on 28/10/26, and NHS GM Strategic Commissioning Committee on 4/11/26.

2 Section 75 Agreement

2.1 A Section 75 Agreement for the period 1st April 2027 to 31st March 2032 has been co-produced by NHS GM, MCC and GMPHN (**Appendix 1**) and has been subject to legal due diligence, on behalf of NHS GM, by Hill Dickenson Solicitors.

2.2 The Section 75 Agreement has been approved by Chief Officers (14/10/26) and Strategic Commissioning Committee (4/11/26).

2.3 Following ICB approval, the Section 75 Agreement will be progressed through MCC governance with approval by the MCC Executive expected in December 2026.

2.4 The key points to draw out from the s75 Agreement are as follows:

- The background section sets out the context, parameters and overarching expectations of the agreement.

- S2 confirms the term of the Agreement as 1/4/2027 to 31/3/2032

- S3 sets out the general principles underpinning the agreement

- S4-8 set out the core functionalities required to enable the agreement to work in practice.

- S9 confirms the NHS GM financial contribution of £7.8million per year from 2027/28 to 3031/32.

- S10A confirms that the architecture to underpin future staffing arrangements will be via a separate secondment agreement.

- S11 confirms the treatment of overspend and underspend, including the safeguards in place to mitigate overspends, and the general principles underpinning decisions around underspends.

- S18 describes the overarching governance including a GMPHN Directors of Public Health Group that makes recommendations, a s75 Partnership Board (with senior NHS GM and MCC representation) and connectivity into wider ICB and MCC governance arrangements.

- S22 creates a provision for either partner to terminate the agreement subject to providing 6 months' notice.

- Schedule 1 Part 1 sets out the priority deliverables required from the GMPHN under this arrangement. This includes:

    - Providing specialist, technical public health advice and guidance to NHS GM

    - Delivering a range of priority programmes to address key causes of poor health and health service demand / cost

    - Retaining the ability to redeploy staff and resources towards emerging issues, major incidents and emergencies such as a pandemic response.

- Schedule 1 Parts 3 and 4 are placeholders for a 4-year GMPHN Action Plan and Investment Strategy for 2027 to 2031 that are under development and scheduled for completion by January 2027.

- Schedule 2 Part A provides a more detailed overview of the governance arrangements described in S18 including specifying membership of the Programme Board for the NHS GM Chief Officer for Strategy, People and Partnerships and Chief Clinical Officer.

- Schedule 3 provides more detail on the finance arrangements referenced in S9 and S11, including a process for the NHS GM Chief Finance Officer and Chief Officer having a decision-making role in relation to any proposed year to year carry forward of underspend.

- Schedule 5 provides a high-level description of the NHS GM and GMPHN staff who are in scope of the future staffing model.

3 Financial Impact

3.1 These proposals generate a recurrent annual saving of £2.1million to the ICB through a combination of existing NHS GM staffing costs being met by GMPHN (£1.3million) and a saving of £800k that has already been applied to the Population Health programme budget from 2026/27 based upon on assumption that the more integrated model would generate efficiencies.

3.2 The ICB commitment to the model is £39million in total over the 5-year period, broken down as £7.8million per annum.

3.3 Non-progression of the proposals will generate a recurrent £2.1million pressure within the ICB budget.

3.4 The proposals will lead to the creation of an aligned budget with the annual contributions from Local Authorities to GMPHN also flowing into MCC from 1/4/27 to create a pooled budget, under the day-to-day management of the NHS GM Associate Director of Population Health / GMPHN Programme Director. This is already in place in shadow form.

3.5 The funding committed under this arrangement is from the existing dedicated Population Health function budget and does not represent the totality of ICB Population Health investment, with the majority of existing funding remaining within the ICB.

4 Staffing Impact

4.1 Following approval by NHS GM Chief Officers on 14/10/26, it is proposed that seventeen NHS GM Population Health Function staff will be seconded from NHS GM to Manchester City Council (as the host of the GM Public Health Network) for the duration of the s75 Agreement.

4.2 This will require a period of staff engagement and formal staff consultation, and this will be completed during Q3 2026/27.

4.3 Under the terms of the s75 agreement, GMPHN would meet the entirety of the staffing costs for this cohort of employees (c£1.3million).

4.4 The ICB staff will work as part of an integrated team alongside the existing GMPHN staff under the single leadership of a GMPHN Programme Director – a role that will be fulfilled by the NHS GM Associate Director of Public Health. This integrated structure is already in place in shadow form.

5 Recommendations

5.1 NHS GM Integrated Care Board are asked to:

- Approve the Population Health transformation proposals set out in this report.
- Approve the s75 Agreement set out in the appendix to this report.

NHS
Greater Manchester

APPENDIX 1

S75 AGREEMENT

Dated **2026**

THE COUNCIL OF THE CITY OF MANCHESTER

and

NHS GREATER MANCHESTER INTEGRATED CARE BOARD

PARTNERSHIP AGREEMENT PURSUANT TO SECTION 75 NHS ACT 2006 RELATING TO THE GREATER MANCHESTER PUBLIC HEALTH NETWORK

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THIS AGREEMENT is made on day of 2026

PARTIES

(1) **MANCHESTER CITY COUNCIL** of Town Hall, Albert Square, Manchester M60 2LA ("**Council"**); and

(2) **NHS GREATER MANCHESTER INTEGRATED CARE BOARD of** Tootal Buildings, 56 Oxford Street, Manchester, M1 6EU (the "**NHS GM"**),

each a "**Partner**" and together the "**Partners**".

BACKGROUND

(A) Greater Manchester has a lengthy track record of working collaboratively across organisations and places to improve the health of the population and tackle health inequalities and is recognised nationally and internationally as an exemplar. This strong existing platform has created an opportunity to go further and to establish an unprecedented level of collaboration and integration within which the 10 Local Authority Directors of Public Health, acting together through the GM Public Health Network and hosted by the Council, will take on delegated responsibility for the exercise of a number of functional activities currently undertaken by the Population Health team employed by NHS Greater Manchester. This transformational shift will be underpinned by the integration of the NHS GM Population Health function staff and existing GMPHN staff into a single team, with access to a multi-year investment of almost £40 million from NHS GM and the existing GMPHN funding streams and overseen through the collective system leadership of the GMPHN and the Local Authority Directors of Public Health who make up its membership.

(B) The Greater Manchester Public Health Network (the "**GMPHN**") is a collaborative network bringing together the Directors of Public Health of the 10 Greater Manchester Councils to undertake joint pan-GM activity aimed at improving health outcomes and reducing health inequalities across the entire Greater Manchester area (https://www.gmphn.com/). The GMPHN is overseen by the **GMPHN Directors of Public Health Group**, and hosted by the Council. Terms of reference and membership of the GMPHN Directors of Public Health Group as at the date of this Agreement are attached at Schedule 2, Part B.

(C) NHS GM has the responsibility for commissioning health services pursuant to the 2006 Act across the entire Greater Manchester area (the "**GM Area**"). In meeting this responsibility, NHS GM directly commissions a number of prevention and population health programmes that are discharged through a Population Health function. In delivering these, NHS GM collaborates with the GMPHN who also commission programmes and services (the "**GMPHN Programmes**"). As at the date of this Agreement the GMPHN led programmes are commissioned and delivered by a team who are employees of Tameside Council (the "**GMPHN Team**"). Through this transformation programme, both sets of staff will work together as a joint team. Further information regarding workforce arrangements as at the Commencement Date is set out in Schedule 5.

(D) The Council is one of the 10 Greater Manchester Councils which together with Bolton Council, Bury Council, Oldham Council, Rochdale Council, Salford City Council, Stockport Council, Tameside Council, Trafford Council and Wigan Council form the Constituent Councils of the Greater Manchester Combined Authority (the "**GM LAs**"). Each of the 10 GM LAs has responsibility for commissioning and/or providing social care services and public health services on behalf of the population of their own GM LA area. This agreement does not replace those local responsibilities and instead provides additionality to them.

(E) NHS GM wishes to make arrangements to delegate responsibility for the commissioning and delivery of the prevention and population health activities and programmes that are currently led by the NHS GM Population Health function to the "**GMPHN**" through the Council as the host (the "**GMPHN Host LA**") on behalf of all of the 10 GM LAs, the GMPHN and NHS GM). The Council has agreed with NHS GM, the GMPHN Directors of Public Health Group and the other

9 GM Local Authorities that the Council will act as the GMPHN Host LA during the period from 1 April 2027 to 31 March 2032.

(F) Under this arrangement, the GMPHN will deliver against the following key delegated responsibilities which have been discharged to date by the NHS GM Population Health function:

- Develop and implement an action plan to prevent some of the key causes of poor health and health inequalities in Greater Manchester.
- Lead, commission, implement and evaluate programmes to achieve the ambitions set out in the action plan.
- Oversee a joint team of staff made up from the current NHS GM Population Health function and existing GMPHN staff employed by Tameside Council and cover the pay costs of the NHS GM staff deployed to work on the delivery of the plan.
- Manage a pooled set of financial resources aligned to the priorities set out in the action plan
- Provide expert, specialist and technical public health advice and guidance to NHS GM to enable NHS GM to meet its statutory duties and achieve its strategic ambitions with a specific focus on healthcare, public health, health protection / outbreak management, strategic commissioning, safeguarding people and organisational 'left shift'.

As at the date of this Agreement the "**Key Deliverables**" for the collaborative work programme are set out at Schedule 1 to this Agreement.

(G) Section 75 of the 2006 Act gives powers to local authorities and integrated care boards to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(H) The purpose of this Agreement is to set out the terms on which the GMPHN Directors of Public Health Group, NHS GM and the Council as GMPHN Host LA will collaborate and establish a framework through which the GMPHN Directors of Public Health Group, NHS GM and the Council as GMPHN Host LA can secure the future commissioning and delivery of the NHS GM prevention and population health programmes which are the subject of this Agreement through lead commissioning arrangements, and through which NHS GM and the Council as GMPHN Host LA will pool funds for the commissioning and delivery of the programmes as set out in this Agreement.

(I) The aims and benefits of the Partners in entering into this Agreement are to:

a) benefit the population of the entire GM area by improving the quality and efficiency of the commissioning and delivery of prevention and population health programmes that are joint priorities of the GMPHN and NHS GM;

b) make more effective use of resources through the establishment and maintenance of a pooled fund (the "**GMPHN Pooled Fund**"), hosted by the Council, for revenue expenditure on the GMPHN Programmes; and

c) ensure that all 10 GM LAs are involved in decisions regarding the "**GMPHN Plan", "Annual GMPHN Pooled Budget Plan"** and the delivery of a shared work programme.

(J) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act, to the extent that exercise of these powers is required for the Partners to comply with their obligations under this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2027-2031 Financial Years GMPHN Pooled Fund Plan means the financial plan which will be adopted by the GMPHN Directors of Public Health Group for each of the 2027-28, 2028-29, 2029-30, 2030-31 and 2031-32 Financial Years, setting out the agreed high-level strategic priorities for Greater Manchester Public Health for these five Financial Years, and the main GMPHN Programmes which will be funded through the GMPHN Pooled Budget for these five Financial Years. Once the 2027-32 Financial Years GMPHN Pooled Fund Plan has been agreed by the GMPHN Directors of Public Health Group it will be inserted at Schedule 1, Part 4 of this Agreement.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Annual Pooled Fund Plan means the plan which will be produced by the GMPHN Directors of Public Health Group in Q4 of each Financial Year of this Agreement setting out planned expenditure for the following Financial Year.

Annual Report means the annual report produced by the Greater Manchester Public Health Network in accordance with Clause 20 (Review).

Approved Expenditure means any expenditure approved by the Partners in writing or as set out in the Annual Pooled Fund Plan in relation to a GMPHN Programme Contract over and above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date.

Commencement Date means 00:01 hrs on 1 April 2027.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of any GM LA, or the interests of a Service User; or

(c) which is a trade secret.

Contract Price means any sum payable under a GMPHN Programme Contract as consideration for the provision of goods, equipment or services as required as part of the

GMPHN Programme and which, for the avoidance of doubt, does not include any Default Liability.

Data Protection Legislation means all applicable data protection and privacy legislation in force from time to time in the UK including the UK GDPR, the Data Protection Act 2018 and the Privacy and Electronic Communications (EC Directive) Regulations 2003 and any guidance and codes of practice issues by any Regulatory or Supervisory Body from time to time.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a GMPHN Programme Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a GMPHN Programme Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant GMPHN Programme Contract, liable to the Provider.

End Date means 23:59 hrs on 31 March 2032.

Financial Contributions means the financial contributions made by the Partners to the GMPHN Pooled Fund in any Financial Year in accordance with Clause 9.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies; or

(g) any form of contamination or virus outbreak,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health- Related Functions

GM Area means the entire Greater Manchester Area covered by the 10 GM LAs.

GM LAs means the Council and each of Bolton Council, Bury Council, Oldham Council, Rochdale Council, Salford City Council, Stockport Council, Tameside Council, Trafford Council and Wigan Council.

Greater Manchester Public Health Network (GMPHN) means the collaborative network bringing together the 10 GM LA Directors of Public Health to undertake joint pan-GM activity aimed at improving health outcomes and reducing health inequalities (https://www.gmphn.com/) across the entire GM Area.

GMPHN Action Plan means the plan agreed by the Directors of Public Health group as the means of discharging the responsibilities set out in this Agreement.

GMPHN Directors of Public Health Group means the group which oversees the GMPHN. Terms of reference for the GMPHN Directors of Public Health Group as at the date of this Agreement are attached at Schedule 2, Part B.

GMPHN Host LA means the Council.

GMPHN Pooled Fund means the GMPHN pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

GMPHN Pooled Fund Manager means such officer of the Host Partner which includes a Section 115 Officer for the GMPHN Pooled Fund as nominated by the Host Partner from time to time to manage the GMPHN Pooled Fund in accordance with Clause 8.

GMPHN Programme Contract Specification means a specification setting out the arrangements for an individual GMPHN Programme Contract recommended by the GMPHN in the 5 year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 and commissioned by the Council (acting as the Host Partner of the GMPHN Pooled Fund) under this Agreement.

GMPHN Programme Contract means an agreement entered into by the Council in exercise of its obligations under this Agreement to secure the provision of a GMPHN Programme in accordance with the Annual Pooled Fund Plan.

GMPHN Programme(s) means any prevention, health and social care programmes and services that are agreed by the GMPHN and intended to benefit the population of the entire GM area (including preventative services) or a specified population within GM as recommended by the GMPHN in the 5 year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32, and commissioned and delivered by the Council under the arrangements set out in this Agreement and more specifically defined in each GMPHN Programme Contract Specification.

GMPHN Team means the NHS GM and Tameside Council employees engaged in commissioning and delivering the GMPHN Programmes at the Commencement Date. They will remain employed by their respective organisations after this Agreement takes effect and will be seconded to the Council from the Commencement Date. The Council will enter into separate arrangements with Tameside Council for its employees who are members of the GMPHN Team.

Host Partner means the Council as host of the GMPHN Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Health-Related Functions means those of the health-related functions of the Council specified in Regulation 6 of the Regulations, as relevant to the commissioning of the GMPHN Programmes.

ICB Statutory Duties means the duties of NHS GM pursuant to Sections 14Z32 to 14Z44 of the 2006 Act.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which the Council, acting as the Host Partner, commissions and delivers the GMPHN Programme Contracts in relation to individual GMPHN Programmes which are detailed in the Annual GMPHN Pooled Fund Plan.

Lead Partner means the Council, acting as Host Partner, which is responsible for commissioning and delivering an individual GMPHN Programme Contract under a GMPHN Programme Contract Specification as detailed in the Annual GMPHN Pooled Fund Plan.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the NHS GM as are relevant to the commissioning of the GMPHN Programmes.

Non-Recurrent Payments means funding provided by a Partner to the GMPHN Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 9.4.

Overspend means any expenditure from the GMPHN Pooled Fund in a Financial Year which exceeds the aggregate value of the Financial Contributions for that Financial Year.

Partner means each of NHS GM and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the Partnership Board responsible for oversight of this Agreement and the operation of the GMPHN Pooled Fund as set out in Clause 18 and Schedule 2 or such other governance arrangements as the Partners agree. In the refreshed GMPHN governance arrangements, the function of the Partnership Board will be carried out through the GM System Assurance Group.

Partnership Board Quarterly Reports means the reports that the GMPHN Pooled Fund Manager shall produce and provide to the Partnership Board on a Quarterly basis.

Permitted Budget means in relation to a GMPHN Programme where the Council is the Provider, the budget that the Partners have set in relation to a particular GMPHN Programme.

Permitted Expenditure has the meaning given in Clause 7.4.

Personal Data has the meaning given to it in the Data Protection Legislation.

Provider means a provider of any GMPHN Programmes commissioned and delivered under the arrangements set out in this Agreement including the Council where the Council is a provider of any GMPHN Programmes.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended from time to time).

Regulatory or Supervisory Body means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Partner must comply or to which it must have regard and includes the Information Commissioner.

Special Category Personal Data means Personal Data that falls within the scope of special categories of Personal Data specified in Article 9 of the UK GDPR.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual GMPHN Programme as the Council reasonably and properly incurs in the proper performance of its obligations under this Agreement and as approved by the Partnership Board.

Underspend means any expenditure from the GMPHN Pooled Fund in a Financial Year which is less than the aggregate value of the Financial Contributions for that Financial Year.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different

currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until the End Date or until it is terminated in accordance with Clause 22.

2.3 The duration of each individual GMPHN Programme Contract shall be as set out in the relevant GMPHN Programme Contract or if not set out, for the duration of this Agreement unless terminated earlier by the Partners in accordance with Clause 22.3.

3 GENERAL PRINCIPLES

3.1 The Partners agree that the GMPHN Pooled Fund has been created to enable the Council (acting as the Host Partner) to commission the GMPHN Programmes and activities detailed in the GMPHN Action Plan as approved by the GMPHN Directors of Public Health Group and aimed at meeting the following responsibilities:

- Develop and implement an action plan to prevent some of the key causes of poor health and health inequalities in Greater Manchester
- Lead, commission, implement and evaluate programmes to achieve the ambitions set out in the action plan.
- Oversee a joint team of staff made up from the current NHS GM Population Health function and existing GMPHN staff employed by Tameside Council and cover the pay costs of the NHS GM staff deployed to work on the delivery of the plan.
- Manage a pooled set of financial resources aligned to the priorities set out in the action plan.
- Provide expert, specialist and technical public health advice and guidance to NHS GM to enable NHS GM to meet its statutory duties and achieve its strategic ambitions with a specific focus on healthcare public health, health protection / outbreak management, strategic commissioning, safeguarding people and organisational ‘left shift’.

3.2 Nothing in this Agreement shall affect the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations.

3.3 The Partners agree to:

3.3.1 treat each other with respect and an equality of esteem;

3.3.2 be open with information about the performance and financial status of each; and

3.3.3 provide early information and notice about relevant problems.

3.4 For the avoidance of doubt, the aims and outcomes relating to an individual GMPHN Programme Contract will be set out in the relevant GMPHN Programme Contract Specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission the GMPHN Programmes detailed in the Annual GMPHN Plan which has been approved by the GMPHN Directors of Public Health Group. This includes the following commissioning mechanisms:

4.1.1 Lead Commissioning Arrangements (with the Council acting as Lead Partner);

4.1.2 the establishment of the GMPHN Pooled Fund,

in relation to individual GMPHN Programme Contracts (the "**Flexibilities**").

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework for the operation of the GMPHN Pooled Fund through which the Partners (acting on the recommendations of the GMPHN Directors of Public Health Group and in accordance with the 5 year GMPHN Action Plan and Investment Plan for 2027/28 to 2031/32, approved by the GMPHN Directors of Public Health Group) can secure the provision of the GMPHN Programmes and activities in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the GMPHN Services in accordance with their obligations under this Agreement.

5.3 Where the GMPHN Directors of Public Health Group wishes to amend the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 for any Financial Year, the GMPHN Directors of Public Health Group will inform the Partners as soon as possible, and ensure that there is sufficient money in the GMPHN Pooled Fund for that Financial Year to fund the Council, as Host Partner, to deliver the amended GMPHN Action Plan. Any material amendment to the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 which has a financial implication for the GMPHN Pooled Fund or either Partner shall be reviewed by the Partnership Board and approved by the Partners prior to implementation.

5.4 The Council, as the Host Partner, will work with the GMPHN Directors of Public Health Group and NHS GM to try to accommodate any proposed changes to the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 (including where the GMPHN Directors of Public Health Group wishes to request that the Council commissions a new individual GMPHN Programme Contract for any Financial Year or terminates an individual GMPHN Programme Contract). For the avoidance of doubt, where the GMPHN Directors of Public Health Group wishes to amend the 5-year GMPHN Action Plan and Investment Plan for 2027/28 to 2031/32 for any Financial Year, the Council, as Host Partner, will not be required to make any financial contribution to the GMPHN Pooled Fund to fund such amendments.

6 COMMISSIONING ARRANGEMENTS

General

6.1 For each Financial Year, the Council, as Host Partner shall seek to commission the GMPHN Programme Contracts as set out in the relevant GMPHN Programme Contract Specification detailed in the 5-year GMPHN Action Plan and Investment Plan for 2027/28 to 2031/32 which has been approved by the GMPHN Directors of Public Health Group.

6.2 To enable this, the GMPHN Directors of Public Health produce an Annual Pooled Fund Plan in Q4 of each Financial Year of this Agreement, setting out planned expenditure for the following Financial Year, to be approved by the Partnership Board.

6.3 Delivery shall be subject to oversight by the Partnership Board.

6.4 The Partners shall comply with all relevant legal duties, and guidance applicable to, both Partners in relation to the GMPHN Programmes being commissioned.

6.5 Each Partner shall keep the other Partner and the Partnership Board and the GMPHN Director of Public Health Group regularly informed of the effectiveness of this Agreement, and any Overspend or Underspend in the GMPHN Pooled Fund.

6.6 Where there are Lead Commissioning Arrangements in respect of an individual GMPHN Programme then prior to any new GMPHN Programme Contract being entered into the Partners (taking into account the recommendations of the GMPHN Directors of Public Health Group) shall agree in writing:

6.6.1 how the liability under each GMPHN Programme Contract shall be apportioned in the event of termination of the relevant individual GMPHN Programme; and

6.6.2 whether the GMPHN Programme Contract should give rights to third parties.

Appointment of Council as Lead Partner

6.7 Where there are Lead Commissioning Arrangements in respect of an individual GMPHN Programme the Council as Lead Partner shall:

6.7.1 endeavour to ensure that the individual GMPHN Programmes are funded within the parameters of the Financial Contributions of NHS GM in relation to each particular GMPHN Programme in each Financial Year;

6.7.2 commission GMPHN Programme Contracts in accordance with the relevant GMPHN Programme Contract Specification as detailed in the 5-year GMPHN Action Plan and Investment Plan for the Financial Years from 2027/28 to 2031/32 – the "**2027-2032 Financial Years GMPHN Pooled Fund Plan**" (as relevant) as approved by the GMPHN Directors of Public Health Group;

6.7.3 contract with Provider(s) for the provision of the GMPHN Programme on terms agreed with NHS GM and the GMPHN Directors of Public Health Group (provided that, for the avoidance of doubt NHS GM and the GMPHN acknowledge and agree that the Council will contract with Provider(s) in accordance with the Council's own Constitution and Financial Regulations (including the Council's Contract Procurement Rules));

6.7.4 ensure that performance management and contract monitoring of all GMPHN Programme Contracts is in place, and that appropriate action is being taken where a GMPHN Programme fails to deliver contracted requirements;

6.7.5 make payment of all sums due to a Provider pursuant to the terms of any GMPHN Programme Contract; and

6.7.6 keep the other Partner and the Partnership Board and the GMPHN Directors of Public Health Group regularly informed of the effectiveness of the arrangements including any Overspend or Underspend in the GMPHN Pooled Fund.

7 ESTABLISHMENT OF THE GMPHN POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain the GMPHN Pooled Fund for revenue expenditure as agreed by the Partners.

7.2 At the Commencement Date there shall be a single GMPHN Pooled Fund in respect of this Agreement.

7.3 The GMPHN Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.4 Subject to Clause 7.5, it is agreed that the monies held in the GMPHN Pooled Fund may only be expended on the following:

7.4.1 the Contract Price;

7.4.2 where the Council is to be the Provider, the Permitted Budget;

7.4.3 Third Party Costs where these are set out in the relevant GMPHN Programme Contract Specification or as otherwise agreed in advance in writing by the Partnership Board and the GMPHN Directors of Public Health Group;

7.4.4 the staff costs of the staff employed within the NHS GM Population Health function, (whether seconded to the Council or deployed separately by NHS GM to deliver the GMPHN Programmes and activity within the scope of this Agreement);

7.4.5 Approved Expenditure as set out in the relevant GMPHN Programme Contract Specification or as otherwise agreed in advance in writing by the Partnership Board and the GMPHN Directors of Public Health Group; and

("**Permitted Expenditure**").

7.5 All direct and indirect staff and team costs incurred by the Council in its role as the GMPHN Host LA under this Agreement, will be paid for by the Council from the GMPHN Pooled Fund. This will include pay, estates, ICT and digital equipment and licenses, telephone equipment and use, travel expenses, room bookings, training, and any other associated costs incurred by the Council in its role as the GMPHN Host LA.

7.6 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of the Partnership Board and the GMPHN Directors of Public Health Group.

7.7 For the avoidance of doubt, monies held in the GMPHN Pooled Fund may not be expended on Default Liabilities unless this is agreed by the Partners and the GMPHN Directors of Public Health Group in accordance with Clause 7.5.

7.8 Pursuant to this Agreement, the Partners agree to appoint the Council as Host Partner for the GMPHN Pooled Fund. The Host Partner shall be the Partner responsible for:

7.8.1 holding all monies contributed to the GMPHN Pooled Fund on behalf of itself and NHS GM;

7.8.2 providing the financial administrative systems for the GMPHN Pooled Fund;

7.8.3 appointing the GMPHN Pooled Fund Manager; and

7.8.4 ensuring that the GMPHN Pooled Fund Manager complies with their obligations under this Agreement.

8 GMPHN POOLED FUND MANAGEMENT

8.1 The GMPHN Pooled Fund Manager for the GMPHN Pooled Fund shall have the following duties and responsibilities:

8.1.1 the day-to-day operation and management of the GMPHN Pooled Fund;

8.1.2 ensuring that all expenditure from the GMPHN Pooled Fund is in accordance with the provisions of this Agreement and the relevant GMPHN Programme Contract Specification;

8.1.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the GMPHN Programmes and the GMPHN Pooled Fund;

8.1.4 ensuring that full and proper records for accounting purposes are kept in respect of the GMPHN Pooled Fund;

8.1.5 reporting to the GMPHN Directors of Public Health Group and the Partnership Board as required by this Agreement and by the Partnership Board and the GMPHN Directors of Public Health Group;

8.1.6 ensuring action is taken to manage any projected under or overspends relating to the GMPHN Pooled Fund in accordance with this Agreement;

8.1.7 preparing and submitting to the Partnership Board and the GMPHN Directors of Public Health Group Quarterly Reports (or more frequent reports if required by the Partnership Board and/or the GMPHN Directors of Public Health Group) and an annual return about the income and expenditure from the GMPHN Pooled Fund together with such other information as may be required by the Partners and the Partnership Board and/or the GMPHN Directors of Public Health Group to monitor the effectiveness of the GMPHN Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the GMPHN Pooled Fund Manager in time for the reporting requirements to be met.

8.2 In carrying out their responsibilities as provided under Clause 8.1, the GMPHN Pooled Fund Manager shall:

8.2.1 have regard to the recommendations of the Partnership Board and the GMPHN Directors of Public Health Group; and

8.2.2 be accountable to the Partners for delivery of those responsibilities.

8.3 The GMPHN Directors of Public Health Group may request the Partnership Board to agree to amend the allocation of the GMPHN Pooled Fund between individual GMPHN Programmes. Any such amendments shall require approval of the Partnership Board.

9 FINANCIAL CONTRIBUTIONS

9.1 The NHS GM contribution to the GMPHN Pooled Fund will cover any GMPHN Programme expenditure, and the staffing costs of NHS GM staff seconded to the Council, or deployed to the delivery of the overarching GMPHN Programmes from 1 April 2027 to 31 March 2032 to commission and manage the GMPHN Programme Contracts which are procured by the Council from the GMPHN Pooled Fund.

9.2 The Financial Contribution of NHS GM to the GMPHN Pooled Fund for each Financial Year until the End Date shall be £7,800,000 (seven million and eight hundred thousand pounds).

9.3 Financial Contributions will be paid as set out in Schedule 3.

9.4 With the exception of Clause 12, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the GMPHN Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board and GMPHN Directors of Public Health Group minutes and recorded in the budget statement as a separate item.

10 NON-FINANCIAL CONTRIBUTIONS

10.1 Unless set out in a GMPHN Programme Contract Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any GMPHN Programme for which they are Lead Partner, or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular GMPHN Programme.

10.2 Each GMPHN Programme Contract Specification shall set out non-financial contributions of each Partner including staff (including the GMPHN Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of GMPHN Programme Contracts and the GMPHN Pooled Fund).

10A STAFFING ARRANGEMENTS

10A.1 NHS GM and the Council will enter into parallel arrangements in relation to the future staffing model, commencing on 1 April 2027, including staff deployment (by secondment or other means) to the Council to commission and manage the GMPHN Programme Contracts which are to be procured by the Council from the GMPHN Pooled Fund.

10A.2 To create an integrated team, the Council will enter into separate arrangements with Tameside Council in relation to the staff employed by Tameside Council on behalf of GMPHN.

10A.3 A description of the existing workforce arrangements (made up of existing staff from NHS GM and Tameside Council) anticipated as at the Commencement Date is set out in Schedule 5 (Workforce Arrangements).

10A.4 For the avoidance of doubt, Schedule 5 is intended to be descriptive only and does not create employment obligations or confer employment rights between any Partner and any individual.

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for risk share arrangements arising within the commissioning of services from the GMPHN Pooled Fund.

Overspends in GMPHN Pooled Fund

11.2 Subject to Clause 11.3, the Council, as Host Partner for the GMPHN Pooled Fund, shall manage expenditure from the GMPHN Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

11.3 The Council as Host Partner for the GMPHN Pooled Fund shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from the GMPHN Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board and the GMPHN Directors of Public Health Group in accordance with Clause 11.4.

11.4 If the GMPHN Pooled Fund Manager identifies an actual or projected Overspend the GMPHN Pooled Fund Manager must ensure that the Partnership Board and the GMPHN Directors of Public Health Group is informed as soon as reasonably possible and the provisions of the relevant GMPHN Programme Contract Specification and Schedule 3 shall apply.

11.5 If an actual or projected Overspend is identified, including an Overspend projected to exist at the End Date the GMPHN Pooled Fund Manager shall escalate it to the Partnership Board as soon as reasonably possible. The Council shall not be responsible for funding or otherwise making good any Overspend. The Partnership Board must put in place arrangements to make good the Overspend, which may include reducing, or top-slicing, funding available in a subsequent Financial Year and/or the early termination or reduction of GMPHN Programmes.

Underspend

11.6 In the event that expenditure from the GMPHN Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, or where the expenditure in relation to an individual GMPHN Programme is less than the agreed allocation to that particular individual GMPHN Programme, the resulting Underspend shall be separately identified and accounted for from the Council's overall financial position. The Partners shall consult with the GMPHN Directors of Public Health Group to develop proposals for potential carry forward to the next Financial Year, and Schedule 3 shall apply. Any use of an Underspend carried forward from a previous Financial Year shall be subject to prior consultation with, and agreement of, the GMPHN Directors of Public Health Group. Where the carry forward of all or part of an Underspend is not agreed, the amount not approved for carry forward shall be refunded to the Partners in proportion to their respective Financial Contributions to the GMPHN Pooled Fund for the Financial Year in which the Underspend arose. Any such proposals, use and repayment shall be subject to the Law and the standing orders and standing financial instructions (or equivalent) of the Partners.

11.7 When assessing requests to carry forward underspend across financial years, consideration should be given to the general principles underpinning the NHS GM commitment to this collaboration including the recognition that this is part of a 5 year investment totalling £39,000,000 (thirty-nine million pounds), and that there is an assumption that carry forward is acceptable if there is demonstrable evidence that it can be utilised in a way which improves health outcomes and reduces health inequalities.

12 CAPITAL EXPENDITURE

12.1 The GMPHN Pooled Fund shall not normally be applied towards any one-off capital expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners.

12.2 Any request from the Council to NHS GM to advance capital expenditure would require formal approval of the GMPHN Directors of Public Health Group and the Partnership Board.

13 VAT

The Partners shall agree the treatment of the GMPHN Pooled Fund and individual programme areas of expenditure for VAT purposes in accordance with any relevant guidance from HM Revenue and Customs.

14 AUDIT AND RIGHT OF ACCESS

14.1 The Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the GMPHN Pooled Fund in accordance with the Regulations and the Local Audit and Accountability Act 2014.

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee or member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 15.2, and 15.3, if a Partner (the "Indemnified Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual GMPHN Programme) as a consequence of any act or omission of another Partner (the "Indemnifying Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any GMPHN Programme Contract then the Indemnifying Partner shall be liable to the Indemnified Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 15.1 shall only apply to the extent that the acts or omissions of the Indemnifying Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Indemnifying Partner acting in accordance with the instructions or requests of the Indemnified Partner or the Partnership Board.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Partner which may reasonably be considered as likely to give rise to liability under this Clause 15, the Indemnified Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Indemnifying Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Indemnifying Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

15.3.3 give the Indemnifying Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance.

15.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one Partner is entitled to bring a claim against the other Partner pursuant to this Agreement.

Conduct of Claims

15.6 In respect of the indemnities given in this Clause 15:

15.6.1 the Indemnified Partner shall give written notice to the Indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

15.6.2 the Indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the Indemnified Partner, the Indemnifying Partner shall consult with the Indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the Indemnified Partner informed of all material matters; and

15.6.3 the Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective standing orders and standing financial instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's

obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 NHS GM is subject to the ICB Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the GMPHN Pooled Fund are therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.

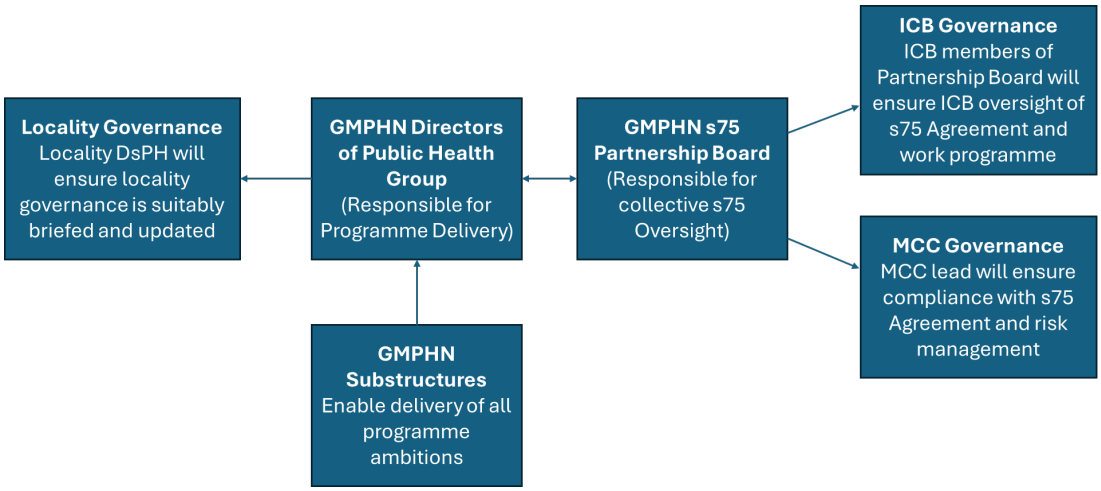
16.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the GMPHN Programme.

17 CONFLICTS OF INTEREST

17.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 4.

18 GOVERNANCE

18.1 An outline summary of the governance arrangement is as follows:



18.2 Overall strategic oversight of partnership working between the Partners is provided by the Partnership Board, taking account of the recommendations and strategic leadership provided by the GM Directors of Public Health Group.

18.3 The Partners have established a Partnership Board to oversee the joint delivery of the GMPHN Programmes and the operation of this Agreement.

18.4 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 18 and Schedule 2, Part A.

18.5 The terms of reference of the Partnership Board shall be as set out in Schedule 2, Part A as may be amended or varied by written agreed from time to time.

18.6 The GMPHN has established the GMPHN Directors of Public Health Group to provide collective GMPHN leadership and management of the delivery of the GMPHN Programmes.

18.5 The terms of reference of the GMPHN Directors of Public Health Group shall be as set out in Schedule 2, Part B and may be amended or varied by written agreed from time to time.

18.6 NHS GM will routinely oversee and review GMPHN Programme delivery from an organisational perspective through formal system governance. This will initially be through a Population Health and Neighbourhood Group, reporting into a Strategic Commissioning Committee, which in turn reports to the Integrated Care Board.

18.7 Each individual GM Local Authority who forms part of GMPHN will be responsible for ensure that their local Health and Wellbeing Board is routinely updated (at least annually) on the GMPHN work programme.

18.8 Each individual GMPHN Programme will have a named lead on behalf of GMPHN and this will be formally reviewed on a bi-annual basis.

18.9 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.10 The Partnership Board shall oversee delivery of the individual GMPHN Programmes and financial management of the GMPHN Pooled Fund, taking account of recommendations made by the GMPHN Directors of Public Health Group, as set out in Clause 11 and Schedule 2.

18.11 Each GMPHN Programme Contract Specification shall confirm the governance arrangements in respect of the individual GMPHN Programme and how that individual GMPHN Programme is reported to the Partnership Board and the GMPHN Directors of Public Health Group.

19 ESCALATION OF MATTERS

19.1 Where:

(a) the Partnership Board considers that a proposed decision presents a significant financial, legal, reputational or operational risk to either or both Partners, or to any GMPHN Programme; or

(b) a proposed decision falls outside the individual delegated authority of Partnership Board members;

the matter shall be referred to the NHS GM Board and/or the Council governance for consideration and decision.

19.2 Neither Partner shall be required to approve or implement a proposal which has not been approved in accordance with its governance arrangements.

20 REVIEW

20.1 The Council shall procure that GMPHN produces a Quarterly Report which shall be provided to the GMPHN Directors of Public Health Group and the Partnership Board.

20.2 The Council shall procure that GMPHN undertakes an annual review ("**Annual Review**") of the operation of this Agreement, the GMPHN Pooled Fund and the provision of the GMPHN Programmes within 2 Months of the end of each Financial Year.

20.3 Subject to any variations to this process agreed by the GMPHN Directors of Public Health Group and the Partnership Board, Annual Reviews shall be conducted in good faith.

20.4 The Council shall procure that GPMHN prepares an Annual Report to summarise the findings of the Annual Review and this will be completed within 3 months of the end of each Financial

Year. A copy of the Annual Report shall be provided to the GMPHN Directors of Public Health Group and the Partnership Board.

20.5 The Partners and the individual Local Authorities who form the GMPHN will be responsible for ensuring the Annual Report is taken through necessary organisational governance for information.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the GMPHN Programmes.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by either Partner giving not less than 6 Months' notice in writing to terminate this Agreement, provided that termination shall take effect on the next 31 March falling after expiry of the notice period.

22.2 Each Individual GMPHN Programme may be terminated in accordance with the terms set out in the relevant GMPHN Programme Contract Specification.

22.3 If a Partner ("**Relevant Partner**") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach.

22.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities (including the GMPHN Pooled Fund) to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to GMPHN beneficiaries, the GMPHN Programmes, the employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.5.2 where the Council has entered into a GMPHN Programme Contract which continues after the termination of this Agreement, NHS GM shall continue to contribute to the Contract Price in accordance with the agreed contribution for that GMPHN Programme prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.5.3 the Council, acting as Lead Partner, shall make reasonable endeavours to amend or terminate a GMPHN Programme Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the GMPHN Programme Contract) where NHS GM requests the same in writing Provided that the Lead Partner shall not be required to make any payments to the Provider for such amendment or termination unless NHS GM shall have agreed in advance that NHS GM shall be responsible for any such payment;

22.5.4 the Partnership Board and the GMPHN Directors of Public Health Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.5.5 termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.6 In the event of termination in relation to an individual GMPHN Programme the provisions of Clause 22.5 shall apply in relation to the individual GMPHN Programme (as though references as to this Agreement were to that individual GMPHN Programme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective chief executives or nominees with appropriate authority to act and take decisions shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable

by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause 24.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners agree to exercise their rights and obligations under this Agreement at all times in compliance with their respective obligations under the Data Protection Legislation.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; or

29.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Director of Public Health, Dr Cordelle Ofori;

Email: Cordelle.Ofori@manchester.gov.uk

and

29.3.2 if to NHS GM, addressed to the Chief Officer: Strategic People and Partnerships, Charlotte Bailey;

Email: charlotte.bailey37@nhs.net

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are agreed and recorded in writing by the Partnership Board and signed for and on behalf of each of the Partners to the Agreement.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUBCONTRACTING

The Partners shall not sub-contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any transfer to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Agreement pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

This Agreement has been entered into on the date stated at the beginning of it.

THE COMMON SEAL of
THE COUNCIL OF THE CITY OF MANCHESTER
was hereunto affixed in pursuance of
an Order of the Council of the said City:

……
Authorised Signatory

Executed on behalf of **NHS GREATER MANCHESTER INTEGRATED CARE BOARD**
by two Authorised Signatories:

……
Authorised Signatory

……
Authorised Signatory

SCHEDULE 1

PART 1

GM Public Health Network (GMPHN) s75 Deliverables 2027-2032

This document outlines the key deliverables which will sit with the Greater Manchester Public Health Network, utilising the GMPHN Pooled Budget and resources under the scope of the Section 75 Partnership Agreement.

This is split into three key areas:

- Strategic Leadership & Influence
- Public Health Priority Programmes
- Emerging Risks.

There is a broad scope of system-wide work, enablers and other business as usual, which has not been included in these deliverables, and which will form part of a more comprehensive 5-year GM Public Health Network Plan 2027-2032.

While some of this work will be system-wide across GM, it will be important to have clarity around the roles and responsibilities of the GMPHN, NHS GM and other key stakeholders involved in areas of work. The scope of work will not include meeting the existing and statutory obligations of NHS GM or other organisations within the GM system.

Strategic Leadership & Influence

- Ensuring delivery of the overarching GMPHN Programme aligns and contributing to the delivery of the NHS GM 5-year Strategic Commissioning Plan, particularly the priorities around improving healthy life expectancy, and improving the health of children.

- Providing specialist, technical public health advice and guidance to NHS GM as required including, but not exclusive to, it's role as a strategic commissioner and in satisfying its statutory responsibilities in relation to health inequalities, health protection and health care public health.

- Further shifting the focus of delivery towards prevention across the GM system.

- Working with a range of partners across the GM system to influence work on the wider, social and commercial determinants of health.

Public Health Priority Programmes

To maximise impact across GMPHN Programmes, a small number of priority programmes have been identified to focus the capacity of GMPHN. This is where the bulk of staffing and financial resource will be directed to deliver.

Three priority GMPHN Programme areas have been agreed:

1. Societal Health Harms (Tobacco, Alcohol, Food, Physical Inactivity)
2. Mental Wellbeing
3. Sexual and Reproductive Health (Including HIV)

Emerging Risks

The pooled resources of the Greater Manchester Public Health Network will also have capacity to enable it to respond to new and emerging opportunities, risks and threats in relation to public health.

In exceptional circumstances this could form part of a broader system response in partnership with other agencies to a complex or major incident or event.

Examples could include a GM-wide response to an emerging pandemic situation including flu or a novel infection as was seen with covid-19. In such circumstances, the network would re-prioritise workloads in order to redeploy expertise and resources to tackle these issues as required.

Measuring Impact

The impact of the priority programmes will be demonstrated through a contribution towards improving the following key metrics:

Tobacco

- Reduction in adult smoking prevalence
- Faster reductions in high prevalence groups (routine and manual, deprived and SMI)
- Reduction of smoking at time of delivery
- Increased uptake of smoking/tobacco cessation services
- Increased achievement of 4-week quit rate (including all forms of tobacco use)
- Increase in number of smoke free environments
- Reduction in the proportion of young people self-reporting the use of vapes (Trading Standards NW Young Persons Survey)

Alcohol

- Reduced alcohol-related hospital admissions
- Reduced alcohol-related crime, violence, and anti-social behaviour
- Increased numbers using digital interventions
- Increase numbers accessing and sustaining alcohol treatment and recovery and support (particularly in known risk groups)
- Increase the number of representations made by GM Public Health teams on alcohol licensing applications and reviews
- Increase in the number of people self-reporting that they consume no alcohol / below harmful levels of alcohol
- Reduction in young people identifying as binge drinkers (Trading Standards NW Young Persons Survey)

Food and Health

- Increase proportion of children at healthy weight in year 6 and narrow the gap in unhealthy weight between the most and least disadvantaged areas
- Decrease in food advertising exposure (esp. near schools and on public transport)
- Increase uptake of healthy start vouchers and free school meals
- Increase in the number of case-based examples of effective local policy development to tackle the impact of unhealthy food environments (including supplementary planning policies to restrict unhealthy food availability; aspects of Local Plans which tackle unhealthy food environments; bespoke localised advertising policies restricting the promotion of fast food)

Physical Inactivity

- % of adults who are inactive
- % of adults from the most deprived backgrounds who are active
- % of children and young people who are active for less than 30 minutes a day

Mental Wellbeing

- Decrease percentage of adults with common mental disorder (QOF)
- Increase life satisfaction scores (ONS)
- Increase emotional wellbeing score in children and young people (Bee Well Survey) particularly in known risk groups
- Reduce rate of suicide

Sexual Health

- Reduced under-18 conceptions
- Reduction in the rate of repeat terminations
- Increase in the uptake rate of long-acting reversible contraception (LARC)
- Increased rate of HIV testing (particularly in known risk groups)
- Reduced rate of late HIV diagnosis

PART 2

5-YEAR GMPHN ACTION PLAN FOR THE 2027-28, 2028-29, 2029-30,2030-31 and 2031-32 FINANCIAL YEARS

[*To be inserted once agreed*]

PART 3

2027-2032 FINANCIAL YEARS GMPHN POOLED FUND PLAN

[*To be inserted once agreed*]

SCHEDULE 2– GOVERNANCE

PART A

1 GMPHN s75 PARTNERSHIP BOARD

1.1 The membership of the Partnership Board will be as follows:

1.1.1 NHS GM:

- Chief Officer for Strategy, People and Partnerships
- Chief Clinical Officer

or a deputy to be notified to the Chair in advance of any meeting;

1.1.2 the Council:

- Member representative duly appointed
- Member representative duly appointed

or a deputy to be notified in writing to Chair in advance of any meeting.

[Deputies must be able to contribute and make decisions on behalf of the Partner organisation they are representing.]

1.2 The Partnership Board may agree to invite one or more individuals to attend any meeting or part of a meeting. Such attendees may participate in discussions but may not participate in decision making.

1.3 The Chair of GMPHN and the Programme Director for GMPHN shall attend meetings of the Partnership Board.

2 Role of Partnership Board

3 The Partnership Board shall:

3.1.1 provide strategic oversight of this Agreement and the delivery of the GMPHN Programmes;

3.1.2 oversee the operation of the GMPHN Pooled Fund and receive assurance from the GMPHN Pooled Fund Manager regarding financial performance, programme delivery and risk management;

3.1.3 review Quarterly Reports, Annual Reports and any other reports required under this Agreement;

3.1.4 approve Annual Pooled Fund Plans produced by the GMPHN Directors of Public Health Group;

3.1.5 review actual and forecast expenditure from the GMPHN Pooled Fund and oversee management of any Overspend or Underspend;

3.1.6 review and approve any Overspend mitigation plans prepared pursuant to this Agreement;

3.1.7 oversee delivery of the GMPHN Action Plan and any subsequent amendments to it;

3.1.8 review and make recommendations to the Partners in relation to material variations to this Agreement, Annual Pooled Fund Plans and GMPHN Programmes;

3.1.9 review strategic and operational risks associated with the arrangements and maintain oversight of risk mitigation actions;

3.1.10 consider any matter escalated to it pursuant to this Agreement;

3.1.11 make recommendations to the Partners regarding matters requiring formal approval through each Partner's governance arrangements;

3.1.12 perform such other functions as are assigned to it by this Agreement.

4 Reporting

The Partnership Board shall report directly to each of the GM ICB Board and the Council Executive Partners on a Quarterly and annual basis.

5 Partnership Board Support

The Partnership Board will be supported by officers from the Partners from time to time.

6 Meetings

6.1 The Partnership Board will meet Quarterly at a time to be agreed following receipt of each Quarterly report of the GMPHN Pooled Fund Manager.

6.2 The quorum for meetings of the Partnership Board shall be a minimum of one representative from each of the Partners. Members of the Partnership Board may participate in Partnership Board meetings by telephone or video conference and shall count towards the quorum in doing so.

6.3 The Chair of GMPHN and the GMPHN Programme Director shall be standing attendees of the Partnership Board and shall be entitled to participate in discussions and make recommendations but shall not exercise decision-making rights.

6.4 Decisions of the Partnership Board shall be made by consensus between the Partners. Each member of the Partnership Board shall make the formal decision in accordance with their own internal governance requirements. Where consensus is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no consensus is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

6.5 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

6.6 Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

7 Delegated Authority

7.1 The Partnership Board is authorised within its members' individual limits of delegated authority (which is received through their respective organisation's own financial scheme of delegation) to:

7.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of NHS GM to the aggregate contributions of NHS GM to the GMPHN Pooled Fund; and

7.1.2 authorise the Council, acting as Lead Partner, to enter into any GMPHN Programme Contracts necessary for the provision of any GMPHN Programmes.

8 Information and Reports

The GMPHN Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

9 Post-termination

The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any GMPHN Programme Contracts are received by the Partners in the same proportions as their respective contributions at that time.

10 Review

These terms of reference will be reviewed on an annual basis by the Partners.

Date of the next review: 1st October 2027

PART B

GMPHN DIRECTORS OF PUBLIC HEALTH GROUP

GM Public Health Network – Directors of Public Health Group
Core Purpose
• To provide overarching collaborative leadership of the GM Public Health Network and all its plans and responsibilities.
Key Responsibilities
1. Ensure a collaborative pan-GM approach to improving population health and tackling health inequalities. 2. Provide credible expert PH leadership to the GMPHN and the wider Greater Manchester system. 3. Influence city-regional and national strategy and policy to shape the building blocks of health and the determinants of health inequalities. 4. Agree the ambitions, delivery plans and investment strategy of the GMPHN. 5. Provide oversight of programme delivery, performance, and outcomes.
Membership
• 10 x Local Authority Directors of Public Health • GMPHN Programme Director
Chair
Chair of the GM Public Health Network
Frequency
Monthly
Quoracy
7 of 10 Local Authority Directors of Public Health must be present for a decision to be binding.

SCHEDULE 3 – FINANCIAL ARRANGEMENTS, RISK SHARE AND OVERSPENDS[1]

1.1 Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of the Agreement.

1.2 Subject to any contrary provision in the relevant GMPHN Programme Contract Specification, the Parties agree that Overspends or Underspends shall be managed in accordance with this Schedule 3.

Financial Contributions

1.3 In each of the five Financial Years from 2027/28 to 2031/32 (inclusive), NHS GM will contribute a maximum of £7,800,000 (seven million and eight hundred thousand pounds) per annum to the GMPHN Pooled Fund to fund the Council to deliver the 5-Year GMPHN Action Plan which is to be agreed following completion of this Agreement and which will be inserted at Schedule 1, Part 3 of this Agreement. A detailed 2027-2032 Financial Years GMPHN Pooled Fund Plan will be adopted by the GMPHN Directors of Public Health Group following completion of the Agreement and inserted at Schedule 1 Part 4 of this Agreement.

1.4 NHS GM contributions to the GMPHN Pooled Fund will be paid on a quarterly basis to the Council in April, July, October and January of each Financial Year.

GMPHN Pooled Fund Management

Overspend

1.5 The Partners agree to co-operate fully and apply rigorous financial management to prevent an overspend occurring.

1.6 The GMPHN Pooled Fund Manager will be responsible for identifying a potential overspend at the earliest opportunity. If the GMPHN Pooled Fund Manager identifies an actual or projected overspend the GMPHN Pooled Fund Manager must ensure that the Partnership Board and the GMPHN Directors of Public Health Group are informed as soon as reasonably possible.

1.7 Where a potential overspend is identified by the GMPHN Pooled Fund Manager, the GMPHN Directors of Public Health Group are required to prepare a plan to mitigate and make good the potential overspend and return projected expenditure to a balanced position. The Council shall not be responsible for funding, making good, or be expected to make good, any actual or projected overspend. The mitigation plan will be subject to review and approval by the Partnership Board and may include reducing expenditure in the relevant Financial Year and/or reducing or top-slicing budgets available in a subsequent Financial Year, in accordance with Clause 11.6.

1.8 Where NHS GM is the only financial contributor to the GMPHN Pooled Fund, and is asked to underwrite an overspend, the value of the overspend will be deducted from NHS GM's Financial Contribution in the following Financial Year.

Underspend

1.9 Both Partners enter into this Agreement as a multi-year commitment to delivering long-term programmes of population health improvement. As such, whilst the financial contribution made by NHS GM is identified as annual amounts and broken into quarterly payments, the intention is to create the conditions for the Council as Host Partner of the GMPHN Pooled Fund to invest in GMPHN Programmes which span Financial Years during the term of this Agreement.

1.10 In the event that expenditure from the GMPHN Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, or expenditure

on an individual GMPHN Programme is less than its agreed allocation, the resulting Underspend shall be separately identified and accounted for from the Council's overall financial position. The Partners shall consult with the GMPHN Directors of Public Health Group to develop proposals for its potential carry forward and use in the following Financial Year, consistent with Clauses 11.6 and 11.7.

1.11 Where NHS GM is the only contributor to the GMPHN Pooled Fund, any proposal to carry an Underspend forward from one Financial Year to the next, and any proposed use of that carry forward, must be submitted by the Council as Host Partner, following consultation with the GMPHN Directors of Public Health Group, to the Chief Officer and Chief Finance Officer at NHS GM for review and approval by no later than the end of Quarter 3 in the relevant Financial Year.

1.12 In considering any carry-forward proposal, the Chief Officer and Chief Finance Officer at NHS GM shall have regard to the multi-year nature of NHS GM's investment and the general principle that carry forward should be supported where there is demonstrable evidence that the Underspend is committed within an agreed delivery and financial plan and will be used to improve health outcomes and reduce health inequalities. They may approve all, part or none of the proposal and shall notify the Chair of the GMPHN and the GMPHN Pooled Fund Manager of the outcome by the end of February in the relevant Financial Year.

1.13 Any use of an Underspend carried forward from a previous Financial Year shall be limited to the purpose approved under paragraph 1.13 and shall remain subject to applicable Law and the standing orders and standing financial instructions, or equivalent, of the Partners. Where carry forward of all or part of an Underspend is not approved, NHS GM may require the Council, as Host Partner, to repay the amount not approved. If more than one Partner has contributed to the GMPHN Pooled Fund in the Financial Year in which the Underspend arose, any amount not approved for carry forward shall instead be refunded to the Partners in proportion to their respective Financial Contributions for that Financial Year.

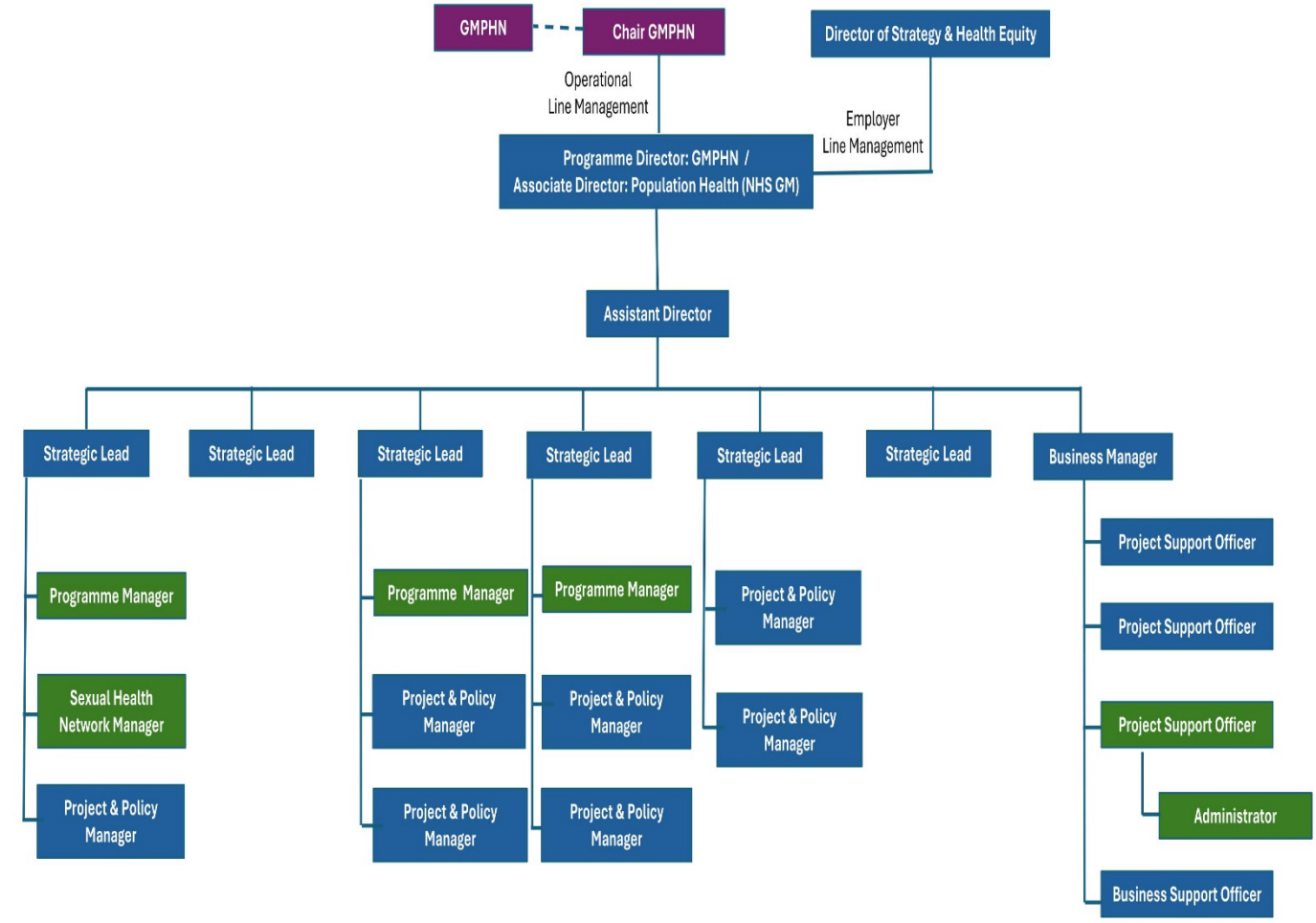
SCHEDULE 4– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

Throughout the term of this Agreement, NHS GM will act in accordance with its constitution and conflict of interest policies and processes as set out here - https://gmintegratedcare.org.uk/nhs-gm/our-principles/governance/

Any Council member and Council officer on the Partnership Board shall be bound by the principles contained in the Council's Member Code of Conduct and Employee Code of Conduct. If any Council member or Council officer has any pecuniary interest or prejudicial interest in a matter to be considered by the Partnership Board, they must not make any decision on the matter and must leave the room when discussion is taking place on the matter.

SCHEDULE 5 - WORKFORCE AND TEAM ARRANGEMENTS

Transitional Integrated GM Public Health Network Structure 2026/27



Key

NHS GM Staff	NHS GM staff remain on existing terms and conditions
GMPHN Staff (TMBC)	TMBC staff remain on existing terms and conditions, will have a TMBC organisational line manager, and NHS GM day to day supervisor where appropriate

NHS
Greater Manchester

GM HIV Strategy 2026-30

18th November 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester Integrated Care Board

Date – 18th November 2026

Required information	Details
Title of report	GM HIV Strategy 2026-30
Author	David Boulger – Associate Director of Population Health, NHS Greater Manchester.
Presented by	Dr Laura French – Consultant in Public Health, NHS Greater Manchester
Contact for further information	David Boulger – Associate Director of Population Health, NHS Greater Manchester. david.boulger@nhs.net
Executive summary	This report seeks NHS GM ICB approval of the GM HIV Strategy 2026-30.
The benefits that the population of Greater Manchester will experience.	Approximately 7300 people in GM are living with HIV. This Strategy sets out our roadmap to ending all new transmission of HIV by 2030 and eliminating HIV stigma.
How health inequalities will be reduced in Greater Manchester's communities.	HIV in GM is not a level playing field, with prevalence rates, late diagnosis and avoidable mortality all higher amongst specific population cohorts who are set out in the GM HIV Strategy. Ending new transmission of HIV and eliminating HIV stigma will have a disproportionately positive impact on those communities.
The decision to be made and/or input sought	NHS GM ICB are asked to approve the GM HIV Strategy 2026-30

How this supports the delivery of the strategy and mitigates the BAF risks	This strategy sets out proposals which contribute towards our prevention ambitions, the mobilisation of neighbourhood health and live well, and transforming health and care services in line with the 3 transformational shifts set out in the NHS 10 Year Plan.
Key milestones	Co-production: January to November 2026 GM Public Health Network Partnership Group (For Feedback) – 15/9/26 NHS GM Clinical Effectiveness Governance Group (For Feedback) – 29/9/26 NHS GM Chief Officers (For Feedback) – 7/10/26 GM Integrated Care Partnership Strategic Board (For Feedback) – 21/10/26 GM Public Health Network DPH Group (Approved) – 3/11/26 NHS GM Strategic Commissioning Committee Approved) – 4/11/26 NHS GM Integrated Care Board (For Approval) – 18/11/26 Launch to correspond with World Aids Day (1/12/26)
Leadership and governance arrangements	The strategy has been co-produced by the GM Fast Track Cities Group and the GM Public Health Network. From an ICB perspective, this is a Population Health programme and, as such, sits under the responsibilities of the Strategic Commissioning Committee which approved this Strategy on 4/11/26. The day-to-day joint SROs for NHS GM are the Associate Director of Population Health (reporting to the Chief Officer for Strategy, People and Partnerships) and the Consultant in Public Health (reporting to the Chief Clinical Officer)
Engagement* to date	

***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	This Strategy has been co-produced over a period of 12 months by key stakeholders aligned to the Fast Track Cities programme through workshops, meetings and bi-lateral discussions. This has included the GM Public Health Network, Clinicians, ICB Leads, Local Authority Sexual Health Commissioners, VCFSE Sector, and people with lived experience of HIV.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
No	Yes	No	No	No	No	Yes

1. Introduction

1.1 This report seeks NHS GM Integrated Care Board approval of the GM HIV Strategy 2026-30.

1.2 The Strategy has been subject to extensive system engagement and has been approved by the NHS GM Strategic Commissioning Committee (4/11/26) and the GM Public Health Network (3/11/26) as the co-leads for this work programme.

2. Context

2.1 As a Fast Track City-Region, GM has been a trailblazer in our collective efforts to tackle HIV in Greater Manchester.

2.2 Due to extensive collaborative efforts, over many decades, most people living with HIV in GM know their HIV status, are engaged in world class treatment and have an untransmittable viral load. This is something to be celebrated but is not a cause for complacency.

2.3 Over the past 12 months, extensive work has been undertaken to co-produce a GM HIV Strategy 2026-30, aligned to the national HIV Action Plan for England, but with an ambition to go further and faster than the national ambition.

2.4 An engagement draft was subject to significant system review during September and October 2026, including being presented to the GM Public Health Network Partnership Group, NHS GM Clinical Effectiveness and Governance Group, GM Fast Track Cities Partnership, NHS GM Chief Officers and the NHS GM Integrated Care Partnership Strategic Board. It was also shared with a wide range of stakeholders and feedback was actively sought.

2.5 Feedback from the engagement was strongly supportive of the engagement draft of the strategy, with any suggested amendments incorporated into the final version.

2.6 The final version of the Strategy has been approved by the NHS GM Strategic Commissioning Committee (4/11/26) and the GM Public Health Network (3/11/26) as the co-leads for this work programme.

3. GM HIV Strategy 2026-30

3.1 The proposed GM HIV Strategy 2026-30 is attached as **Appendix 1** of this report

3.2 The Strategy will be launched on World Aids Day (1/12/26)

3.3 The GM HIV Strategy 2026-30 sets out **3 Strategic Priorities:**

- **Prevent and Test:** We will ensure equitable access to high quality, evidence-based prevention and testing
- **Treat:** We will improve and transform treatment, care and support
- **Thrive:** We will eliminate HIV stigma and discrimination

3.4 These are underpinned by **3 cross cutting delivery principles**:

- **Inequalities**
- **Co-Production**
- **Collaboration**

4. Recommendations

4.1 NHS GM Integrated Care Board are asked to:

4.1.1 Approve the GM HIV Strategy 2026-30.

Appendix 1

GREATER MANCHESTER HIV STRATEGY 2026-2030

GREATER MANCHESTER HIV STRATEGY 2026-2030

FOREWORDS

Bev Craig – Mayor of Greater Manchester

"Greater Manchester has long been at the forefront of the fight for equality and social justice. When HIV emerged in the 1980s, it brought fear, stigma and discrimination. Many people living with HIV experienced prejudice and isolation, at a time when treatment options were limited and the future for those diagnosed was often uncertain. Yet communities, activists, voluntary organisations, clinicians and public services across Greater Manchester came together to support those affected and fight for change. From the first Manchester AIDS helpline to the amazing community and charity groups that support people living with HIV today, I'm proud of the role Greater Manchester has played. But I want us to do more.

Today, thanks to advances in treatment and prevention, we have made remarkable progress. New HIV diagnoses have fallen significantly, and as a Fast-Track City we have helped drive forward the global ambition to end the HIV epidemic. Greater Manchester has surpassed the UNAIDS 90:90:90 targets, with 94% of people living with HIV aware of their status, 95% of those diagnosed receiving treatment, and 97% of those on treatment achieving an undetectable viral load.

However, too many people still experience HIV-related stigma and discrimination, and too many people continue to receive a late diagnosis. These inequalities affect lives, health and opportunities, and this means that our work is not finished.

I want Greater Manchester to lead the way once again. This strategy sets out our shared ambition for Greater Manchester to achieve no new HIV transmissions by 2030, while ensuring that everyone living with HIV can live well, free from stigma and discrimination. Achieving this will require continued commitment from all of us, but Greater Manchester has shown time and again what is possible when we pull together in the same direction.

Together, we can create a Greater Manchester where nobody is held back by HIV, stigma, discrimination or inequality; where people can live healthy, fulfilling lives; and where everyone feels valued, respected and able to contribute. That is the ambition at the heart of this strategy, and one I am proud to champion as Mayor."

Darren Knight - Co-Chair of Greater Manchester Fast Track Cities / Chief Executive, George House Trust

"*As Co-Chair of Greater Manchester Fast Track Cities and Chief Executive of George House Trust, I have the absolute privilege of seeing first-hand the collaboration, commitment, and appetite of people across the system, working together to make sure that we lead the way on the HIV agenda. There are so many people who give their time and lived experience freely to educate and inform people about the realities of living with HIV, and I thank every one of them. We're all working towards ending new diagnoses and ensuring people have the best support to live with HIV.*

However, there's a long way to go. HIV stigma is still rife. At George House Trust we hear every single day about people's experience of HIV stigma and discrimination in places that they should feel safe. HIV stigma prevents people testing, it prevents people even offering HIV tests and it prevents people from living well. HIV stigma and discrimination hold this entire agenda back.

We all have a responsibility to do more, to do it faster and to do it better. Education is key, but so is inclusion. We need everyone to be assured that knowing their HIV status is good for their health and wellbeing, and that they'll have the support they need whatever the outcome. My hope for this Greater Manchester HIV Action Plan is that it genuinely creates a world where HIV holds no one back."

Dr Orla McQuillan - Co-Chair of Greater Manchester Fast Track Cities / Consultant in HIV and Sexual Health, Northern Sexual Health, Manchester Foundation Trust

"*The Greater Manchester HIV Strategy is critical to ensuring our region builds on the successes we have had already towards HIV Action Plan targets. The strategy provides a clear framework detailing what we need to do locally to successfully achieve our 2030 targets eliminating new transmissions and eradicating stigma enabling people living with HIV to thrive. As a proud HIV Fast-Track region, we have a legacy of unity and action-now more than ever we must come together to make this vision a reality.*"

Gillian McLauchlan - Director of Public Health at Salford City Council and GM Public Health Network Lead for Sexual and Reproductive Health

"*Greater Manchester has a proud history of coming together to tackle public health challenges facing our communities, and our response to HIV is no exception. As Lead Director of Public Health for Sexual and Reproductive Health, I am immensely proud of the progress we have made across Greater Manchester in HIV prevention, testing, treatment and care. This progress has been driven by the dedication and commitment of people and organisations across our city-region. Local authorities, the NHS, community organisations and the voluntary sector have worked tirelessly to improve access to testing, reduce late diagnoses, and ensure that people living with HIV are supported. These achievements have only been possible through partnership and a shared commitment to improving outcomes for our residents.*

While we have made significant progress, there is still more to do. This new Greater Manchester HIV Strategy sets out our collective ambition to eliminate new HIV transmissions and ensure that everyone affected by HIV can live well, free from stigma and discrimination. Behind every diagnosis are people, families and communities. We know that inequalities and stigma continue to impact the lives of people across Greater Manchester, and we must remain unwavering in addressing them. I would like to thank everyone who has contributed to the development of this Action Plan and, most importantly, those who work every day to turn its ambitions into reality."

Professor Manisha Kumar - Chief Clinical Officer at NHS Greater Manchester

"*The strategic vision of NHS Greater Manchester is to create a healthier and fairer city-region by delivering high quality, person-centred care that tackles inequalities and empowers communities.*

Nowhere is this vision more evident than in the ambitions set out in this Greater Manchester HIV Strategy. It builds on the extensive history that the GM system has spent at the forefront of HIV prevention and care and looks toward a future where the HIV prevention and service landscape is transformed. At a time of great change for the NHS and the health system at large, NHS GM is proud to be a part of the extraordinary network of colleagues working tirelessly to improve access, experience and outcomes for people living with HIV."

EXECUTIVE SUMMARY

"The difference in being told that you're HIV positive now, compared to when I was told back in 1995 is massive. The difference now is the medication works. The medication is proven. Undetectable equals untransmittable; it's a game changer in learning to deal with your self sabotage, learning to deal with how you feel towards other people and being in society. In 1995 we didn't have this luxury. I was given an AIDS diagnosis and told to get my affairs in order. There was no proven medication and there was no known effective treatment. If you were one of the unlucky ones, that didn't go to one of the charities that were offering support and advice, you never found hope and you never found a light. You never found a reason to wake up the next day, because there was no one there to give it to you. So now, meeting people living with HIV, you know you're going to live"

Anita Binns, Community Activist and Peer Navigator for George House Trust

For more than four decades, Greater Manchester has been at the forefront of the HIV response, and we are confident that we can meet, and go beyond, the ambitions of the new national HIV Action Plan. This will be achieved through collaboration, strong system alignment and by ensuring that lived experience is at the front and centre of our decision-making and delivery.

An estimated 7,300 people are living with HIV in Greater Manchester.

Due to extensive collaborative efforts, over many decades, most people living with HIV know their HIV status, are engaged in world class treatment and have an untransmittable viral load. This is something to be celebrated but is not a cause for complacency.

In Greater Manchester, we aim to go further – ending all new HIV transmissions by 2030, enabling everyone living with HIV to live well and thrive, and eliminating HIV-related stigma.

We believe this is possible if we build upon our existing strengths and use these as a platform from which to push further and faster.

This strategy sets out the steps we will take by 2030 to achieve our ambitions, and establishes 3 strategic priorities:

1. **Prevent and Test:** Ensure equitable access to prevention and improved HIV testing
2. **Treat:** Transform HIV treatment, care and support
3. **Thrive:** Eliminate HIV stigma and discrimination across Greater Manchester

It also recognises that the way we do things matters as much as the things that we do, and commits to three core principles that will underpin every action that we take:

- **Reducing Inequalities**
- **Co-Production**
- **Collaboration**

Working together we can achieve our ambitions.

THE NATIONAL CONTEXT

The national *HIV Action Plan for England 2025–2030* sets out how national, regional and local systems will work collectively to strengthen prevention, testing, treatment and support, reduce stigma, and achieve this ambition through shared accountability and partnership working.

The national plan is structured around five priority areas:

1. **Prevent:** Equitable access to prevention
2. **Test:** Scale up HIV testing
3. **Treat:** Rapid linkage and retention in care
4. **Thrive:** Address stigma and improve quality of life
5. **Collaborate:** Strengthen, and partner across, the sexual and reproductive health (SRH) and wider system

Reducing inequalities is central to the national plan and it prioritises taking additional action to support communities disproportionately affected by HIV, including people experiencing multiple forms of disadvantage. In recognising structural barriers such as stigma, racism, poverty, discrimination, and unequal access to services, the plan supports wider system ambitions to improve inclusion, reduce health inequalities, and improve outcomes for underserved populations.

Whilst acknowledging the need for a universal offer as the bedrock of HIV provision, the plan focuses on 5 key populations who are disproportionately affected by HIV:

- Ethnic minority gay and bisexual men, and all men who have sex with men.
- White gay and bisexual men, and all men who have sex with men.
- Black African heterosexual men.
- Black African heterosexual women.
- Ethnic minority heterosexual adults.

Progress is measured against the UNAIDS definition of ending HIV transmissions, including a 90% reduction in new HIV infections and AIDS-related deaths from 2010 levels by 2030, alongside ensuring the long-term sustainability of the HIV response.

OUR GREATER MANCHESTER CONTEXT

HIV in Greater Manchester

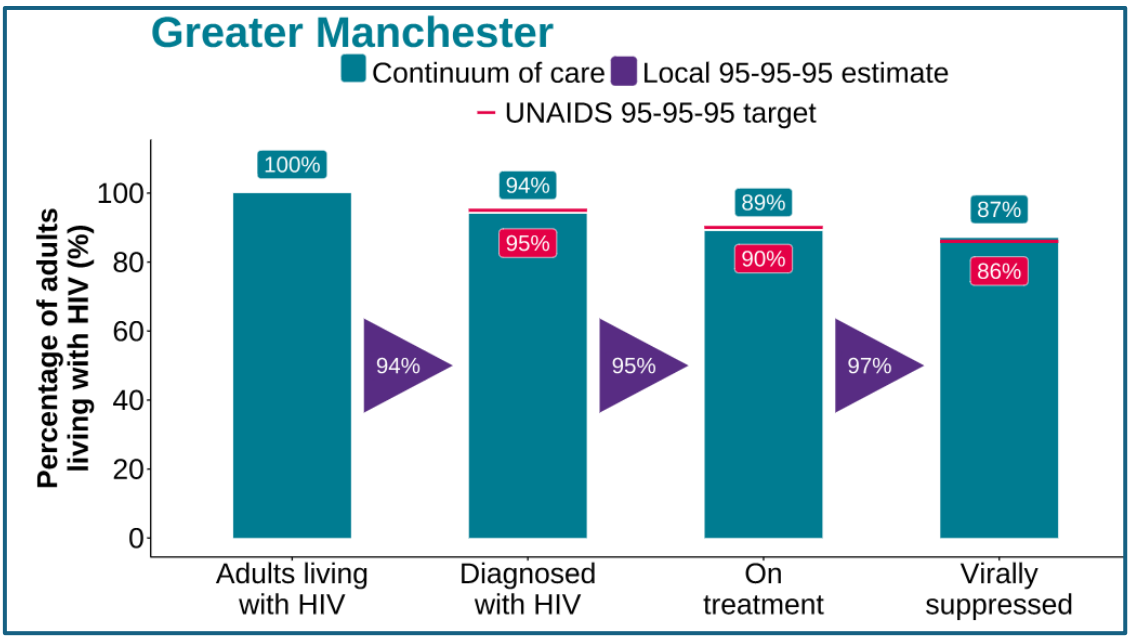
The UK Health Security Agency estimates that 7,300 people in Greater Manchester are living with HIV: 6,900 are diagnosed, 6,550 receive antiretroviral treatment and 6,380 are virally suppressed.

An estimated 254 people who had been diagnosed with HIV were not currently receiving treatment and care, and it is estimated that 400 people living with HIV remain undiagnosed – 5.5% of the total number.

UNAIDS set an ambition that by 2025 95% of people living with HIV should be diagnosed, 95% of people diagnosed should be on treatment and 95% of those on treatment to be virally suppressed.

In Greater Manchester, based on the latest data from 2024, it is estimated that:

- 94% of people living with HIV in Greater Manchester are diagnosed
- 95% of people diagnosed are on treatment
- 97% of those on treatment have a suppressed viral load



New HIV diagnoses among Greater Manchester residents have reduced by 63% since their peak in 2014.

Progress, however, has not been seen equally across all population cohorts with women and people of Black African ethnicity seeing increases in new diagnosis and Gay, Bisexual and all men who have sex with men and people of white ethnicity seeing the greatest reductions.

Our Collaborative Journey

"At the heart of our approach to ending new transmission of HIV has been a longstanding commitment to genuine collaboration and co-production. This has been a transformational journey shared by many people, from many organisations and is an exemplar of what it means to participate in a genuine partnership with our communities and our voluntary, community, faith and social enterprise sector colleagues in a way where lanyards and egos are left at the door and where we are all truly in this together."

David Boulger - Associate Director of Population health at NHS Greater Manchester / Programme Director for the Greater Manchester Public Health Network.

Greater Manchester has been at the forefront of the national effort to end new HIV transmissions and tackle HIV-related stigma, building on a strong legacy of activism and system-wide response dating back to the 1980s.

Our collective efforts over decades have driven improvements, and these have accelerated over the past 10 years and through the designation of Greater Manchester as a Fast Track City.

A timeline included as **Appendix 1** illustrates some of the key achievements and milestones over the past decade.

Highlights have included:

- Launching Greater Manchester's HIVe (Working to End HIV) programme in 2018, with the ambition of ending new HIV transmissions within a generation.

- Becoming a UNAIDS Fast-Track City in 2018, with all ten council leaders and the Mayor of Greater Manchester signing the Paris Declaration—three years ahead of the first national HIV Action Plan.

- Commissioning the Passionate about Sexual Health (PaSH) partnership, led by BHA for Equality, George House Trust, and the LGBT Foundation to drive forward community-led prevention, early intervention and support services.

- The peer-led communications campaign "HIV: Let's Sort This Together" that was instrumental in raising awareness, reducing stigma, and promoting a combination prevention approach.

- Manchester Foundation Trust (MFT) becoming the first hospital trust globally to produce and mandate a "Tackling HIV Stigma and Discrimination" eLearning module which has been completed by over 28,000 members of staff since 2024.

- The Positive Speaker programme run by George House Trust, which is led by volunteers living with HIV who use their own lived experience to educate and inspire others.

- The George House Trust intensive Support Service which provides high intensity dedicated support for people for whom adherence to HIV treatment poses significant challenges.

- BHA for Equality engagement with faith, diaspora and community groups, including the recruitment of community ambassadors and champions, which challenges HIV stigma within ethnic minoritised communities and addresses specific cultural drivers of stigma.

- Providing national leadership on the expansion of Emergency Department (ED) opt-out HIV testing, which was introduced in 2021 and is now operating across eight of Greater Manchester's ten localities, delivering more than 750,000 HIV tests to date, and identifying over 220 people newly diagnosed with HIV and over 140 people previously diagnosed but not accessing treatment and care.

Case studies and testimonies from those involved are included as **Appendix 2**.

OUR CHALLENGES

Whilst significant progress has been made in Greater Manchester, there are challenges to meeting the 2030 targets, many of which mirror those that exist nationally. These can be summarised as stigma, inequalities, late diagnoses, ensuring services are fit for the future, and engagement in treatment and care.

Stigma

> *"There was no judgment and we learnt about something that could affect any of us and now we know not to be scared of it "*
>
> **Pupil, Wright Robinson School**

Despite the existence of effective treatments which provide excellent clinical outcomes, stigma remains the most significant non-medical barrier to ending HIV, negatively affecting mental health and quality of life, reducing the offer and uptake of testing, preventing early diagnosis, creating barriers to equitable healthcare and undermining treatment engagement.

The causes of stigma are complex and multi-faceted and can include:

- Low public and professional understanding of modern HIV treatment and the realities of living with HIV today.
- Cultural shame and a lack of open discourse around issues such as sexuality

- Fear of judgement, and of what a positive result would mean for relationships, family or community standing.

- Negative previous experiences of abuse and discrimination

HIV stigma continues to have significant impact on individuals, communities and the health system in Greater Manchester.

Inequalities

> *"Greater Manchester can be proud of its record on HIV. We also need to recognise that progress has not been shared equally. Success by 2030 will mean that where someone lives, their culture, their gender or their sexuality no longer shape their chances of preventing, diagnosing and living well with HIV."*
>
> **Aydin Djemal, Chief Executive Officer, BHA for Equality**

HIV-related inequalities are stark and significant, reflecting and reinforcing wider structural inequalities, stigma and discrimination.

As an example, new HIV diagnoses among Greater Manchester residents have fallen by 63% since 2014, but these reductions are uneven. From 2019 to 2024:

- Diagnoses decreased by 41.7% among men but increased by 25.6% among women more details on the inequalities experiencing by women set out in the 2025 report, "*Systematically Excluded and Ignored: Addressing Inequalities for Women in the HIV Response*".
- Diagnoses linked to sex between men fell by 64%, compared with a 22% reduction for heterosexual exposure, although gay or bi- men remain the biggest cohort of people living with HIV.
- Among cases with recorded ethnicity, diagnoses are now higher and increasing among Black African residents than White residents where new diagnoses are falling.

One illustrative example of inequalities in access to services relates to the uptake of Pre-Exposure prophylaxis (PrEP), which is a highly effective means of preventing HIV, but whilst 74% of people assessed in GM as having a PrEP need accessed PrEP, this figure was only 23.5% for Black African heterosexual men and 35% for Black African heterosexual women.

Late diagnosis

"Despite progress in testing and work to improve awareness of HIV across the healthcare system, around 40% of people diagnosed with HIV each year in GM are diagnosed at a late stage, already with substantial immune system damage. This can lead to harm including the need for hospital admission, and sadly we still see preventable deaths from HIV. There are often missed opportunities to diagnose HIV earlier, in many areas of healthcare including primary and secondary care. Death from HIV in 2026 should be a "never event", preventable by early testing and treatment. With the changes in testing practice described in this Strategy, we aim to minimise the risk to people with undiagnosed HIV; ensure HIV testing is routine across healthcare in GM and make a real difference to people's health."

Dr Clare van Halsema, Consultant in Infectious Diseases, Manchester University Foundation Trust

Late diagnosis of HIV has significant consequences including increased mortality rates and the risk of onward transmission. Individuals diagnosed at a late stage are five times more likely to die within a year of their diagnosis compared with those diagnosed early, and very late HIV diagnosis increases the risk of early mortality 8-fold and causes significant morbidity with impacts on quality of life.

HIV testing is not consistently available across the full range of healthcare settings in Greater Manchester, as recommended by NICE guideline NG60. As a result, opportunities to diagnose HIV earlier are being missed.

Analysis of late diagnosis reviews, including coronial inquests, suggests that many people have had opportunities to be tested, including testing based on indicator conditions, missed in both primary and secondary care resulting in avoidable harm, including hospitalisation, serious illness and death.

Whilst the proportion of people diagnosed late in Greater Manchester at 39.6% is lower than the proportion in England of 43.3%, it has remained around 40% in recent years without any significant reduction.

Inequalities also exist in relation to late diagnosis:

- Late diagnosis in Greater Manchester is highest for Black African Heterosexual men at 64%, Black African women at 42% and other ethnic minority Heterosexual men at 55%
- The lowest proportion of late diagnosis in Greater Manchester is for ethnic minority gay and bisexual men at 14% and white gay and bisexual men at 31%
- Nationally people over the age of 50 are much more likely to receive a late diagnosis and have a much higher risk of dying from HIV than those diagnosed younger or diagnosed promptly.

Ensuring services are fit for the future

"Around 90% of the population contact their GP practice about their health each year making General Practice a key part of any solution for people who are at risk of, or are living with, HIV in Greater Manchester"

Dr Timothy Dalton, Chair - Greater Manchester General Practice Provider Board, Deputy Chair - Greater Manchester Primary Care Provider Collaborative

The needs of people living with HIV are evolving and changing due to many factors including an ageing population, increasing expectations of digital services and emerging innovations in HIV treatment including longer acting injectable treatments.

Across Greater Manchester there are currently disparities in the range of services and resources available, and a complex set of commissioning arrangements and service delivery arrangements.

For HIV services to be fit for the future, they must be accessible and appropriate for the communities most affected.

For ethnic minoritised communities, this means more than translation — it requires services that actively address racism, cultural bias, and the mistrust that historical and current experiences of discrimination create. Community involvement is central to this work. As HIV services in Greater Manchester are reviewed and transformed, cultural competence must be embedded as a standard, not an add-on. Services that are not accessible to Black African communities — who now account for nearly half of new diagnoses in GM — cannot be considered fit for purpose.

For children, young people and families living with HIV there is a need for tailored, person-centred and non-stigmatising support.

HIV is now a lifelong condition for most people, with effective treatment enabling individuals to lead long, healthy and fulfilling lives. This has led to a growing population of older people living with HIV, many of whom will experience other comorbidities as they age. The ageing population of people living with HIV is likely to bring challenges across the system including a rise in demand on primary care as well as other services associated with ageing like domiciliary care, care homes and housing provision for older people. Meeting the needs of this cohort requires an integrated approach to commissioning and delivery of services across health and social care.

Engagement in Treatment and Care

"Engagement and re-engagement in HIV care must be centred around the individual, understanding the barriers they face and finding solutions that work for them. Across Greater Manchester, collaboration between HIV services, primary care and community organisations enables us to think beyond traditional models of care, with nurses using approaches such as community visits to reach people who may otherwise struggle to access services."

Jen Kendrick - Clinical Nurse Specialist / Team Leader, The Northern Integrated Contraception, Sexual Health and HIV Service. Manchester University NHS Foundation Trust

The latest data indicates that, in 2024, 254 Greater Manchester residents with diagnosed HIV were not accessing treatment or care, with a further 400 people estimated to be living with undiagnosed HIV in Greater Manchester.

Untreated HIV is associated with poorer health outcomes, including an increased likelihood of costly inpatient admissions, as well as a higher risk of onward transmission.

The reasons people disengage from care are often complex and are closely linked to wider health inequalities and factors such as stigma, racism, bias, mental ill health, housing, poverty and substance misuse. For many individuals, these broader determinants are not separate from HIV care; rather, they directly influence whether prevention, treatment, and support services are accessible at all.

The Greater Manchester Emergency Department opt out testing programme has identified over 140 people who have previously been diagnosed but are not accessing treatment and care. Of these, 60% have been linked back into care. By comparison, over 230 people have been newly diagnosed through the programme, with 90% linked to care.

The George House Trust Peer Support programme links individuals to care and where needed provides Intensive Support Workers, who work alongside HIV service multi-disciplinary teams, to identify and support individuals with complex needs and barriers to accessing HIV care.

OUR PLAN: TURNING AMBITION INTO REALITY

OUR GREATER MANCHESTER VISION AND COMMITMENT

Our Greater Manchester vision is to end new HIV transmissions by 2030, enable people with HIV to live well and eliminate HIV related stigma.

Our commitment is to achieve this through the delivery of a whole system, collaborative Greater Manchester action plan, underpinned by the National HIV Action Plan.

OUR PRIORITIES FOR 2026-2030

To achieve our ambitions, we will focus on **3 strategic priorities**:

1. **Prevent and Test:** Equitable access to prevention and improved HIV testing
2. **Treat:** Transforming HIV treatment, care and support
3. **Thrive:** Eliminating HIV stigma and discrimination across Greater Manchester

These ambitions fully align with the national HIV Action Plan, whilst also recognising the relative strengths of our existing approach, our journey to date, and our enhanced level of ambition.

PRIORITY 1: PREVENT AND TEST

Our Commitment

We will act decisively to remove barriers to high-quality, evidence-based prevention and make HIV testing accessible to everyone who needs it.

We will prevent poor health and illness and HIV transmissions wherever possible by ensuring that every person at risk of HIV has equitable access to effective and evidence-based prevention, information, testing and support.

Prevention will increasingly be delivered through trusted community settings, primary care, pharmacies, digital platforms and neighbourhood services, reducing reliance on specialist sexual health services alone.

We recognise that prevention opportunities are not experienced equally. Whilst retaining a universal offer, our approach will prioritise the populations and communities currently experiencing the greatest inequalities in HIV outcomes, by ensuring that prevention is culturally competent, community-led and focused on reducing inequity.

Testing will be normalised and routinely offered across a wide range of healthcare settings, supporting earlier diagnosis and promptly linking those diagnosed to care.

Our Priorities for Action

Working together we will	
1.1	Strengthen community-led prevention with a focus on: • Reviewing the existing HIVe delivery arrangements and identifying opportunities for enhancement

	• Co-producing and delivering campaigns informed by lived experience and community insight • Expanding peer-led and voluntary sector prevention and testing approaches that reach communities less likely to engage with traditional services, including communities who are not being reached under current arrangements.
1.2	Enhance our combination prevention approach bringing together PrEP, condoms, testing, treatment as prevention, behaviour change interventions, formula milk provision, community engagement and peer-led approaches into a comprehensive and coherent prevention offer.
1.3	Complete a review of the current HIV testing offer, barriers to testing and opportunities to enhance the approach across a range of settings, including digital offers.
1.4	Diversify the locations where the delivery of HIV prevention and testing takes place, by increasing prevention and testing activity in trusted community settings and as a feature of Live Well and Neighbourhood Health and enhancing the digital prevention and testing offer.

What Success Looks Like

New HIV diagnoses continue to reduce across Greater Manchester and remain on track to meet the 2030 elimination goal, and inequalities in relation to new diagnoses no longer exist.

PRIORITY 2: TREAT

"Effective HIV Treatment and Care is core to achieving Greater Manchester's ambitions around HIV. We are committed to ensuring that GM residents living with HIV have access to safe and effective HIV care to keep them well and prevent them passing on the virus to others."

Andrew Bibby, Regional Director Specialised Commissioning (North West), NHS England

Our Commitment

We will improve and transform treatment, care and support.

Greater Manchester will be at the forefront of transforming HIV diagnosis, treatment, care and support services and create a modern, integrated and sustainable model of care that delivers outstanding outcomes, enables people to live and age well with HIV, and responds to the changing needs of our population.

We will redesign services around people rather than organisations, strengthening neighbourhood and community-based delivery, while maintaining access to specialist expertise. Through innovation, partnership working and co-production we will ensure services are high quality, equitable, person-centred and fit for the future.

While prevention remains critical to ending HIV transmissions, this action focuses on transforming the services and pathways that treat, support and retain people in care. By creating an integrated and sustainable system, we will improve outcomes, reduce unwarranted variation and ensure everyone living with HIV can access the support they need throughout their lives.

Some elements of this are achievable through short to medium term targeted transformation projects. Others will require a longer-term series of significant and complex transformational system shifts.

Our Priorities for Action

Working together we will	
2.1	Complete a holistic and independent review of the entirety of the current GM HIV model of care (diagnosis, treatment, support, care) and develop proposals to implement improvement and transformational change across the short term (within 1 year), medium term (within 5 years) and long term (5-10 years) that are fully aligned with the 3 transformational shifts included in the NHS 10 Year Plan: Hospital to Community; Treatment to Prevention; Analogue to Digital.
2.2	Work with Primary Care colleagues to review and implement a series of Primary Care "quick wins" with a focus on: • Workforce development • Primary care "HIV champions" • Availability of testing in Primary Care to meet NICE guidance • Creating system prompts for indicator conditions • Strengthening migrant health provision • Embedding HIV testing, diagnosis and treatment into neighbourhood health and everyday support in every neighbourhood.
2.3	Work with specialist HIV treatment and care colleagues to review and implement a series of "quick wins" with a focus on: • Delivering world class care and treatment across GM • Strengthening re-engagement pathways for people diagnosed but not in care • Auditing data completeness and developing actions to improve data quality. • Auditing and reviewing cases where late diagnosis occurs to identify missed opportunities and learning that can drive improvements, potential learning from the GM drug-related death panel approach.
2.4	Strengthen research, data and insight, with an initial focus on: • Working with academic and health innovation partners to establish a GM HIV Centre of Excellence. • Improving data quality, particularly in relation to protected characteristics and socio-economic disadvantage • Introducing a validated HIV-specific Patient-Reported Outcome Measure [PROM] • Producing annual HIV inequalities data profiles
2.5	Work with national government colleagues, to create the system conditions for genuine transformation with a focus on funding, national guidance, service specifications and the locus of control / decision-making.

2.6	Undertake a joint review of the future Social Care needs of people living with HIV to identify the risks and opportunities that exist in relation to an ageing population and those living with co-morbidities.

What Success Looks Like

Late diagnosis of HIV does not occur, services provide treatment and care that delivers excellent health impact, and avoidable mortality from HIV is a "never event".

PRIORITY 3: THRIVE

Our Commitment

Greater Manchester will take a system-wide approach to eliminate HIV-related stigma and discrimination, recognising it as a key driver of inequality and a barrier to prevention, early diagnosis, engagement in care, and quality of life.

Our Priorities for Action

Working together we will	
3.1	Enhance the existing HIV training offer including: • Co-producing a comprehensive HIV Stigma workforce e-learning training package and roll out to all GM NHS, local authority and social care organisations. • Creating a cultural competence training offer co-produced with minoritised and racialised communities and embed it in service standards and commissioning. • Developing a face-to-face learning and training support offer for primary care clinicians and the wider primary care workforce. • Establishing a programme of lived experience led education across Greater Manchester.
3.2	Transform the way we talk about HIV in Greater Manchester including through: • Developing an HIV / Fast Track Cities Communication and Engagement Strategy and Toolkit • Reviewing and renewing the GM PaSH website
3.3	Amplify the voice of lived experience with a focus on: • Conducting community-based research, led by people with lived experience, into the nature and drivers of HIV stigma and with a specific focus on the 5 key populations identified within the national plan. • Undertaking an annual survey of people living with HIV to measure experiences of stigma, and monitoring for improvement.
3.4	Embedding change within organisations, including: • Supporting all GM Hospital Trusts to achieve the HIV Confident Charter Mark and implement the Charter Mark to wider organisations upon a phased national roll out

	• Implementing a GM Blood Borne Virus pledge aligned with the GM Fast Track Cities BBV ambitions and the national HIV Confident Charter Mark.

What success looks like

Greater Manchester will be a place where HIV stigma is actively challenged, where care is consistently respectful, and where people living with HIV are supported to live well free from discrimination.

HOW WE WILL DO IT

THREE CORE PRINCIPLES

The way we do things matters as much as the things that we do, and three Core Principles will underpin everything that we do:

1. Reducing Inequalities

2. Co-Production

3. Collaboration

Reducing Inequalities

Reducing HIV-related inequalities is fundamental to achieving our ambition to end new HIV transmissions, eliminate HIV stigma and enable people living with HIV to live well.

All activities undertaken in service of this Strategy will consider the extent to which they impact upon inequalities, including a specific focus on those populations set out in the national plan, and other people who require additional focus and support such as inclusion health groups, people in prison, and people who face specific barriers to accessing support and treatment, such as people living with a disability.

We will work collectively to ensure that we co-produce culturally competent and inclusive interventions and services, prioritising those communities who experience the greatest barriers and poorest outcomes and recognising that stigma, discrimination, poverty and other structural barriers can lead to unequal outcomes and poor experiences of care and support.

We will use data, intelligence and research to identify priorities, monitor progress and evaluate the impact we have had on reducing inequalities.

Co-production

The Greater Manchester approach to date has been characterised by a genuine commitment to co-production and partnerships with people with lived experience.

We will sustain and amplify that approach and will ensure that all projects, services, communications and interventions are designed with and for the communities most affected by HIV.

Collaboration

Tackling HIV in Greater Manchester is a whole system endeavour, bringing together a wide range of stakeholders all working towards our common goals as a Fast Track City.

This culture of collaboration, humility and mutual trust will continue to form the bedrock of our approach to delivering upon the ambitions set out in this strategy.

CONCLUSION

Our successes to date should not be underestimated. GM has led the way in ending new transmissions and eliminating stigma and we are proud of our achievements.

However, we know we must build on these foundations and go much further if we are to end new HIV transmissions by 2030, enable people with HIV to live well and eliminate HIV related stigma.

This plan provides the roadmap for that journey. Working together we can achieve our ambitions.

APPENDIX 1 – OUR RECENT TIMELINE

- 2013: BHA and LGBT Foundation launch the first community-based HIV point of care testing service across Greater Manchester
- 2017: Passionate about Sexual Health (PaSH) Partnership launched - a unique integrated HIV and sexual health community service for key populations and people with HIV
- 2017-20: GM Sexual Health services participate in PrEP impact trial
- 2018: The NHS in Greater Manchester invested in the HIVe project with an ambition to end new transmissions of HIV in GM in a generation
- 2018: Mayor of GM signed the Paris declaration resulting in GM becoming a Fast Track City
- 2017: Peer support and mentoring commenced
- 2019: Formula milk provision commenced in Manchester
- 2019: The HIVe Programme is launched to accelerate ambitions to reach 2030 goals
- 2019: George House Trust Intensive Support Workers start working directly alongside HIV treatment providers
- 2020: Greater Manchester “HIV: Let’s Sort it Together” HIV campaign launched
- 2020: PrEP commissioned across Greater Manchester
- 2020: BHA and LGBT Foundation launch a digital testing offer for ethnic minoritised and LGBTQ communities
- 2021: Launch of Manchester Foundation Trust Stigma Training Module
- 2021: First national HIV action plan is published
- 2021: Manchester Royal Infirmary commences opt-out HIV testing in its emergency department, and national funding for opt out BBV testing in ED departments announced for areas of very high prevalence
- 2022: First long-lasting injectable treatment for HIV becomes available in Greater Manchester
- 2022: Formula milk provision expanded across Greater Manchester
- 2022: Opt-out ED testing commenced in Wythenshawe and North Manchester General Hospital
- 2023: Opt-out ED testing commenced in Salford Royal Hospital
- 2024: 30th anniversary of LGBT Foundation’s free condom and lube scheme.
- 2024: MFT stigma module made mandatory (more than 28000 staff members have now completed this training).
- 2025: Opt-out ED testing commenced in hospitals in Bolton, Bury, Rochdale, Oldham and Tameside
- 2025: National HIV action plan 2025-2030 launched
- 2025: MFT achieved HIV Confident status

APPENDIX 2 – CASE STUDIES AND TESTIMONIALS

Passionate about Sexual Health (PaSH): Community Action, System-Wide Impact

Across Greater Manchester, trusted community relationships are turning the ambition to end new HIV transmissions into action.

Since 2018, the Passionate about Sexual Health (PaSH) HIVe programme has brought together George House Trust, LGBT Foundation and BHA for Equality, working in partnership with the ten local authorities and the NHS, to deliver community-based HIV prevention where it can make the greatest difference.

Together, they connect people with HIV testing, condoms, PrEP information and wider sexual health support in settings that are convenient, welcoming and culturally responsive.

What makes this approach exceptional is its flexibility. Rather than expecting people to navigate unfamiliar services, PaSH partners take prevention into communities, trusted venues and digital spaces—meeting people where they are and responding to what they need.

High-profile campaigns, including Greater Manchester PrEP Week and Greater Manchester Testing Week, bring this work to life. Alongside national HIV testing campaigns, creative social media activity and trusted influencers help prevention messages travel further, spark conversations and encourage more people to take control of their sexual health.

Some examples of activity delivered by PaSH partners include:

LGBT Foundation: reaching people through trusted LGBTQ+ spaces.

LGBT Foundation works with LGBTQ+ communities and men who have sex with men, providing HIV and STI testing, outreach, condoms and lubricant, sexual health information, and support to access PrEP and PEP. Its venue-based, community and digital outreach connects with people in the places where they already socialise and seek support. A condom programme spanning more than 30 years has distributed millions of free condoms and lubricant, helping to normalise conversations about sexual health. Partnership with Northern Sexual Health also creates a direct community route into PrEP initiation, bridging the gap between engagement and clinical care.

In Action: Connecting People to Prevention and Community Support:

New to Manchester and without family or community connections, AB was experiencing isolation, low mood and low confidence. They contacted LGBT Foundation for a home HIV test and advice about PrEP. Alongside a postal test and PrEP guidance, staff linked AB to LGBTQ+

social groups, talking therapies and immigration advice—providing routes into both healthcare and a supportive community.

BHA for Equality: removing barriers through culturally responsive outreach.

BHA delivers targeted HIV prevention and testing with Black, Asian and other racially minoritised communities across Greater Manchester. Since introducing community HIV testing in 2013, it has supported hundreds of individuals to take their first HIV test and others who may not otherwise access sexual health services. Working through community venues, faith settings, education services, refugee and asylum support organisations and other trusted spaces, BHA tackles stigma, language barriers and limited engagement with traditional healthcare. Testing is combined with condoms, PrEP fast-track referrals, sexual health awareness and wider reproductive health support—turning trusted conversations into practical routes to prevention and care.

In Action: Removing Barriers to HIV Testing

At a British Red Cross hub, BHA supported M—who faced language and booking barriers—to take his first HIV test. Arabic-language information and clear guidance enabled access to further STI testing, condoms and home HIV tests, which he also shared with friends.

In Action: Fast-Tracking Access to PrEP

At a Salford community event, a man with multiple sexual partners who sometimes had condomless sex approached BHA's outreach stall. Unaware of PrEP, he received tailored prevention advice, condoms and an HIV test.

BHA registered him for its Fast Track PrEP pathway, linking trusted community outreach directly to clinical follow-up and widening access to HIV prevention.

"I didn't know there was anything called PrEP, now that I know I will be safe".

George House Trust: providing peer-led support tackling stigma and reducing barriers to care.

George House Trust plays a vital role in Greater Manchester's HIV response by ensuring that people living with HIV can access the information, support and services they need to live well. Through approaches including peer mentoring, counselling, advocacy, welfare support, ageing well programmes and community engagement, the organisation helps individuals navigate both their HIV diagnosis and the wider social challenges that can affect health and wellbeing. Its Peer Navigator and Intensive Support workers, embedded into HIV treatment services multi-disciplinary teams, provide personalised support for people experiencing complex barriers to care, advocating and helping them engage with treatment, access healthcare and community services, and build the confidence and skills needed to thrive. By combining lived experience, peer support and stigma reduction activity, George House Trust strengthens

retention in care, improves wellbeing and helps create the conditions needed to achieve Greater Manchester's ambition of ending new HIV transmissions and stigma while ensuring people living with HIV can lead healthy and fulfilling lives

In Action: From Isolation to Engagement: The Value of Peer Support

Living with a detectable viral load, complex trauma and a history of missing appointments and poor clinic engagement, the George House Trust peer support service was crucial for Ahesha. After years without knowing another person living with HIV, it helped reduce isolation, shame and self-stigma. Having support from someone with lived experience created trust and emotional safety, making it easier for her to talk openly, restart medication, attend appointments and stay connected to care

Together, these services show what is possible when prevention is built with communities, not simply delivered to them. By widening access to testing, increasing awareness of PrEP and creating trusted routes into care, PaSH is reducing inequalities and helping Greater Manchester move closer to its ambition of ending new HIV transmissions—one conversation, one connection and one person at a time.

Routine Testing, and Earlier Diagnosis: Emergency Department Opt-Out Testing

The nationally funded Emergency Department Opt-Out Testing Programme embeds routine HIV, hepatitis B and hepatitis C testing for adults having blood tests across nine Greater Manchester emergency departments. By normalising testing within urgent care, the programme enables earlier diagnosis and treatment, reduces onward transmission and addresses health inequalities.

Since its introduction, the programme has delivered more than 750,000 HIV tests, identified over 220 people with previously undiagnosed HIV and re-identified more than 140 people previously diagnosed but not receiving care in Greater Manchester.

A defining strength is the integration of rapid clinical linkage with peer support and community-based follow-up. George House Trust helps people newly diagnosed with HIV navigate care, access emotional and practical support and remain engaged with treatment, translating diagnosis into sustained improvements in health outcomes.

This programme demonstrates the strategic value of embedding routine testing and integrated support within mainstream clinical pathways: widening access, reaching communities underserved by traditional services and reconnecting people who have disengaged from care.

"Early diagnosis enables prompt access to life-saving treatment, improves long-term health outcomes and prevents onward transmission, while re-engagement with care helps ensure people living with HIV can remain healthy and achieve viral suppression.

The programme demonstrates how innovative, system-wide approaches to testing can reduce health inequalities, support earlier diagnosis and play a vital role in achieving Greater Manchester's ambition of ending new HIV transmissions while ensuring people living with HIV can live well and thrive".

Tom Bills, Project Manager (Blood-Borne Virus ED Opt-Out Testing Programme), Bolton NHS Foundation Trust

Safe Starts, Stronger Families: Free Infant Formula Support

With advances in HIV treatment and care, the number of babies born with HIV has dropped significantly and providing free infant formula is a key intervention which can protect newborns from the small risk of HIV transmission through breastfeeding.

Commencing in 2019 in Manchester, and now available across Greater Manchester, George House Trust's free infant formula milk service gives much-needed reassurance to families, providing free formula, bottle steriliser and feeding bottles up to their newborns 1st birthday. Families access the service through antenatal and HIV clinic referral or through George House Trust's Peer Navigators who signpost into the scheme when they meet people living with HIV in clinic during their pregnancy.

George House Trust provides person-centred support and see every intervention as an opportunity to support people living with HIV to access tools to thrive. Across Greater Manchester, 64% of families accessing the service had not received any type of support from George House Trust before, and 53% continue to engage afterwards, through peer support, groupwork or appointments with Advice and Support Case Coordinators in our Targeted Support team.

Cece's Story

"Becoming a mum is full of decisions and there's endless pressure to always make the right choice. Deciding on how to feed your baby comes with lots of questions. You spend time thinking about how it might affect your bond, their growth and the family dynamic. Becoming a mum with HIV is a whole new chapter of navigating stigma and self-stigma. Feeling like you deserve this less than others plays a huge role on the choices you feel able to make.

People assume that because the guidance now supports breastfeeding that this is automatically the right choice to make. However, growing up with HIV and thinking about the limitations on breastfeeding meant it still didn't feel like a viable choice. Monthly appointments and additional

monitoring felt like a burden. Like another reminder that HIV can often shape experiences you just want to be normal.

Being able to make the decision irrespective of the cost of feeding meant I could have a weight lifted off my shoulders. GHT provide a service that gave me a sense of dignity in my choice. All I wanted most was to be the mum I wanted to be, knowing that I could feed my baby without any worries, extra tests and appointments was the right choice for our family".

From Disengagement to Re-engagement: Manchester Foundation Trust and George House Trust Transforming Access to HIV Care

Re-engagement in HIV care requires flexible, person-centred support that addresses the practical, social and personal barriers behind disengagement.
Across Greater Manchester, HIV services, primary care and voluntary and community partners provide tailored routes back into care, including community support and home visits.

The Manchester Foundation Trust and George House Trust partnership combines clinical care, peer navigation and intensive coordination, using lived experience to build trust, reduce stigma and improve equitable re-engagement.

By bringing together clinical care, peer support and intensive coordination, we can respond to the individual rather than expecting the individual to fit around our services.

This provides and equity led, collaborative and trusted approach built on meaningful, lived experience engagement. It is has demonstrated successful re-engagement, ensuring those at greatest risk are accessing the care and supported they need.

Coordinated Support, Sustained Re-engagement: The George House Trust Intensive Support Programme

George House Trust's Intensive Support Programme provides additional support for people with complex unmet needs who are at risk of poor treatment outcomes or disengagement from HIV care.

Referrals focus on people with a detectable viral load, poor attendance or treatment adherence, risk of hospital admission or onward transmission, and reduced quality of life.

Matthew's story

Matthew, 29, had disengaged from care while experiencing homelessness, mental ill health, substance use and financial instability. He had a high HIV viral load alongside untreated syphilis and hepatitis C.

Coordinated support helped him re-engage with HIV and mental health care, secure housing and financial assistance, and access specialist substance-use services.
By case closure, Matthew had achieved an undetectable viral load, completed treatment for syphilis and hepatitis C, secured stable housing, reduced substance use and was consistently engaging with care, demonstrating the impact of coordinated, trauma-informed support.

Ageing Well with HIV: Connection, Confidence and Independence

As HIV treatment has improved, people living with HIV are living longer, healthier lives, and more than half of people living with HIV are now aged 50 or over. This changing demographic is increasingly important in Greater Manchester, where services need to respond to a growing population ageing with HIV and the additional health, care and social needs that can accompany later life. George House Trust's Ageing Well service provides one-to-one support, peer and social opportunities, health and wellbeing information, skills-based workshops and activities that help people remain connected, independent and confident as they grow older. It also provides HIV awareness training to care homes, domiciliary care providers and other organisations working with older people, helping the wider health and care system become better equipped to support people ageing with HIV.

Lydia's story

Lydia, 63, joined the Ageing Well programme two years ago. Neurodiversity made daily tasks difficult, while shyness, isolation and anxiety affected her mental health. She wanted to move closer to an African community and better cultural provision.
With encouragement from the team, Lydia began attending fortnightly craft sessions, where she formed friendships with other Zimbabwean women.

Longer one-to-one appointments supported her independence and helped her address complex needs, including finding suitable housing closer to her new friends.
Lydia now regularly attends Ageing Well events, welcomes others and says visiting George House Trust is the highlight of her week. Since February 2026, 99% of Ageing Well attendees have reported greater social connection and reduced isolation.

"*Supporting Lydia is a joy. She has gained so much confidence through engaging with Ageing Well and she's a firm favourite amongst other attendees at our skills-based and information sessions.*

Ageing Well isn't just about providing social opportunities and one to one support. It's about seeing a person as an individual, identifying barriers they may face in living a healthy life with

HIV, and through working with project partners in the community and offering person-centred care and support, ensuring we empower that person to live their best life, free from stigma and discrimination."

Anna Hughes, Ageing Well Lead at George House Trust

Changing Minds Through Lived Experience: Positive Speakers

The Positive Speakers project provides HIV Awareness training delivered by a diverse group of trained volunteers who talk about their experiences of living with HIV and answer questions.

Training is delivered to a wide range of settings including health and social care staff, schools, the voluntary sector and staff who are responsible for carrying out opt out testing in Emergency Departments.

Last year 139 Positive Speaker sessions were delivered talking to 5,440 people. 99% of participants said they had improved their knowledge and understanding of HIV

Wright Robinson School Case Study

Wright Robinson is a large secondary school in east Manchester. Each year positive speaker sessions are delivered to those in Year 10. The session includes a presentation about how HIV is transmitted, the latest developments around HIV and how to challenge HIV stigma. A short video of a group of young people born with HIV talking about their experiences is also shown alongside a Positive Speaker talking about their experiences of living with the virus and answering questions.

This has formed an excellent relationship with the staff at the school and in particular the head of PHSE who is has spoken about what a positive learning experience it is for her students, with, 99% saying their knowledge and understanding of HIV had improved.

The responses received from students are also very positive:

- *"There was no judgment and we learnt about something that could affect any of us and now we know not to be scared of it"*
- *"I liked the personal stories as you get a better insight into how people living with HIV deal with it"*
- *"Thanks so much for teaching us! I was looking forward to being educated about HIV because I have never understood it"*

Transforming the Workforce: A System-Wide Approach to Tackling HIV Stigma

As part of Greater Manchester's Fast Track City initiative, Manchester Foundation Trust (MFT) partnered with George House Trust and Dibby Theatre to develop mandatory HIV stigma training. The programme addresses stigma as a barrier to early diagnosis, equitable care and wellbeing, including within healthcare settings.

Launched in 2021 and shaped by the lived experience of people with HIV, the training became mandatory in 2024 after voluntary uptake proved limited. MFT has since trained more than 28,000 staff, embedding HIV awareness and inclusive practice across the organisation.

Evaluation showed substantial improvements: understanding of HIV stigma increased by 25%, confidence discussing HIV care by 34%, and confidence using appropriate language by 36%.

MFT's recognition as an HIV Confident organisation in 2025 demonstrates how a system-wide, mandatory approach can translate lived experience into workforce change and more inclusive care.

Embedding HIV Awareness Across Local Government

Manchester City Council is strengthening its contribution to ending new HIV transmissions and tackling HIV-related stigma. In partnership with George House Trust, it has developed an HIV awareness e-learning module for all staff, embedding accurate knowledge, inclusive practice and compassionate support across local authority services.

The interactive module covers HIV transmission and treatment, Undetectable = Untransmittable (U=U), HIV and the law, and the impact of stigma and discrimination. Video and lived-experience testimony help staff understand how their roles and everyday interactions can create more inclusive workplaces, services and communities.By equipping the whole workforce to challenge stigma and better support residents, the programme demonstrates the strategic role of local government in improving outcomes, reducing inequalities and sustaining progress towards zero new HIV transmissions.

"*For nearly four years now I have sat on Greater Manchester's Fast Track cities board, and it's been my duty to ensure the political support across our city region never wavers in the mission to end HIV stigma in the fight for zero new transmissions by 2030. The work we've undertaken to enhance our training at Manchester City Council came from someone on World Aids Day who whispered to me during a speech from Paul Fairweather that we needed to ensure the work pioneered in partnership with MFT should be taken further. This year, our Public Health team finally deliver on that conversation - and keep the urgency needed in this agenda across the Council itself.*"

Councillor Thomas F. Robinson, Deputy Leader of the Council, Manchester City Council

Learning from Delayed Diagnosis of HIV in Primary Care (Salford)

Colleagues in Salford routinely review incidents of late HIV diagnosis.

A recent review, led by primary care colleagues following a late HIV diagnosis, highlighted numerous areas for learning within General Practice, including the role of cognitive bias amongst practitioners within the assessment of HIV indicator conditions, ambiguity about where clinical responsibility lay within a shared-care framework, and pre-conceived perceptions relating to who is at a "high" or "low" risk of contracting HIV.

These findings have led to improved procedures for the follow up of patients with abnormal results, practice-wide education on HIV testing in primary care, and a focus on normalising and increasing HIV testing regardless of perceived HIV risk profile. The insights have been shared with secondary care colleagues to support wider system improvements aimed at enabling early diagnosis of HIV.

The practitioners involved reflected that they found this to be an enriching experience.

NHS
Greater Manchester

Independent CMHT Review

- Independent CMHT Review Report by CPGB Ltd
- Appendix 1 - ICB Commissioner Response

November 2026

Greater Manchester (GM) Integrated Care Board (ICB) Board

18 November 2026

Required information	Details
Title of report	Independent CMHT Review
Author	CPGB Ltd
Presented by	Professor Manisha Kumar Chief Clinical Officer Caldicott Guardian NHS Greater Manchester manisha.kumar1@nhs.net
Contact for further information	Professor Sandeep Ranote Clinical Director Mental Health & Independent CMHT Review SRO NHS Greater Manchester ICB Sandeep.ranote@gmmh.nhs.uk
Executive summary	NHS Greater Manchester commissioned CPGB Ltd to undertake an Independent CMHT Review in response to Recommendation 9 of the 2024 Shanley Review. Based on a sample of two CMHTs and multiple evidence sources, it identifies committed staff and good practice, alongside variation in access, continuity, care planning, workforce, shared care and governance. The report attached details the scope of the review, the findings and recommendations. NHS Greater Manchester accepts the recommendations following the review, which reinforce priorities already being addressed through the Community Mental Health Transformation Programme and neighbourhood-based care. As outlined in the ICB Commissioner Response to the review ***(Appendix 1),*** the current work underway with the GM Community Mental Health Service Specification *(phased implementation planned from April 2027)* will translate the recommendations into consistent commissioning expectations, minimum standards, outcomes and assurance arrangements. The Strategic System Improvement Plan will provide strategic system actions against the review recommendations, co-designed with the two mental health providers aligned to provider-led and GM-wide transformation.
The benefits that the population of Greater Manchester will experience.	The review provides a clear evidence base for improving the reliability, consistency and safety of community mental health care across Greater Manchester. Implementation of the recommendations is intended to improve access and triage, continuity and allocation, involvement of patients and carers, crisis and discharge planning, shared care and transitions, and the quality of clinical documentation. Stronger workforce support, clearer responsibilities at service interfaces and more reproducible governance information should enable risks and variation to be

	identified earlier, support more coordinated care and provide greater confidence that improvement is being delivered and sustained.
How health inequalities will be reduced in Greater Manchester's communities.	The review identifies variation in access, thresholds, allocation, communication and continuity as system issues that can contribute to an inconsistent experience of care. Its recommendations support a more consistent GM-wide minimum offer, clearer access and escalation arrangements, reliable recording of communication, cultural and learning needs, and stronger patient, carer and support-network involvement. Providers will be asked to quality assure every CMHT against the findings, helping the system identify local variation and target improvement where reliability is weakest.
The decision to be made and/or input sought	**The ICB Board is asked to:** • Receive and note the findings, recommendations and limitations of the Independent CMHT Review, recognising its sample-based scope and the need for further assurance across GM. • Endorse the ICB Commissioner Response ***(Appendix 1)***, including acceptance of the Review recommendations and the strategic approach to addressing them through the GM Community Mental Health Service Specification, existing Community Mental Health transformation programmes and the Strategic System Improvement Plan. • Support the proposed approach to implementation, oversight and assurance, with progress monitored through established system governance and reported back to the ICB Board at agreed intervals via Strategic Commissioning Committee
How this supports the delivery of the strategy and mitigates the BAF risks	This report supports delivery of the NHS Greater Manchester strategy and 5-Year Commissioning Plan by strengthening clinical oversight and improvement of community MH services, prevention, population health, quality, patient safety, safeguarding, medicines optimisation and system
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	Planned oversight of the priorities, actions and progress in relation to the Strategic System Improvement plan will be through the GM Crisis and Community Strategic Group chaired by the MH Trusts Chief Operating Officers. Regular quarterly updates will also be presented at MH Partnership Group and Strategic Commissioning Committee with a six-monthly update at ICB Board.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability,**	The review drew on care record audits, documentary review, operational and workforce information, staff feedback, stakeholder survey responses and follow-up discussions, and service user and carer feedback. Engagement included frontline staff, managers, commissioners, primary care and system partners.

financial. Comments/ approval by groups/ committees.	
Financial or Legal Implications;	The report and delivery of the strategic system actions in response to the recommendations, will inform and support future Mental Health Programme commissioning intentions. There are no direct legal implications arising from this report.

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

INDEPENDENT INVESTIGATION INTO THE GREATER MANCHESTER COMMUNITY MENTAL HEALTH TEAMS



PREPARED BY CPGB LTD

FEBRUARY 2026

Foreword

Thank you to everyone who contributed to this independent review. Patients and service users, families and carers, frontline staff, managers and system partners all shared their experiences and evidence. Many described situations that were complex or emotionally difficult. We recognise the personal effort involved in doing this, and we have approached every contribution with care and respect.

This review has been written to support learning and improvement. The findings reflect the system conditions in which Community Mental Health Teams (CMHTs) are working. They describe the pressures, the constraints, the strengths and the opportunities for improvement. We have focused on what the evidence shows, what can be inferred through triangulation, and what cannot be concluded with confidence. This approach emphasises systems thinking, transparency and learning over attribution of individual fault.

Adult community mental health services across England continue to experience sustained demand, workforce pressures and increasing clinical complexity. National evidence, including the Community Mental Health Framework and the Care Quality Commission's *State of Care* reporting, highlights similar challenges across the country. Community Mental Health Teams form only one part of wider community mental health provision, but they remain a critical component of the pathway. They support people with the most complex and enduring needs and sit at key interfaces with primary care, social care and voluntary, community and social enterprise (VCSE) partners. Strengthening how Community Mental Health Teams function is therefore central to improving continuity, confidence and outcomes across the wider system. This direction is consistent with national policy and long-term mental health transformation programmes.



Final report status

Audience

This report has been prepared for the NHS Greater Manchester Integrated Care Board (ICB) and is intended for use by ICB leadership, provider boards, system partners and, where appropriate, the wider public domain to support transparent discussion, proportionate assurance and shared learning.

Status, scope and purpose

This independent assurance report, written in line with the agreed Terms of Reference, provides a sample-based assessment of Community Mental Health Team (CMHT) functioning. The purpose is to support learning, prioritisation and improvement planning. It is also intended to inform commissioning and oversight discussions at provider, place and system levels.

This is a limited-scope review and reflects the position during the period covered by the information provided to the review team. The review has focused on understanding system conditions and the reliability of key processes rather than judging individual performance.

Reliance and limitations of use

Findings and conclusions have been drawn from the evidence available to the review team and interpreted in line with the limitations set out in the Limitations and Confidence section of the Executive Summary.

The report can reasonably be relied upon to:

- support understanding of themes, strengths, risks and assurance gaps relevant to CMHT delivery; and
- inform proportionate improvement actions and commissioning/oversight discussions consistent with the Terms of Reference.

Only the final signed and dated version of this report should be regarded as definitive.

This report should be used to inform system-level prioritisation, local improvement planning and future assurance cycles, rather than as a performance report on individual teams.

Appendices Statement

This version of the report deliberately does not have appendices and is intentionally streamlined to support board-level readability and potential publication. It therefore focuses on cross-cutting themes, patterns, variation and system implications, rather than presenting locality-by-locality analysis. A separate, more detailed version containing full locality-level findings and supporting evidence has already been provided to commissioners and providers. That detailed version is intended for operational improvement planning, provider governance and local assurance discussions, and should be used alongside this report where locality-specific action is required.

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Executive Summary

This report provides an independent, learning-focused view of how Community Mental Health Teams (CMHTs) are currently functioning across Greater Manchester. It was commissioned in response to Recommendation 9 of the Shanley review and is intended to support proportionate assurance, shared learning and practical improvement across the system. It is written for system leaders, provider boards, commissioners and partners. It reports on how consistently key CMHT processes operated across the two Community Mental Health Teams sampled.

The purpose is to provide assurance against the themes identified in the Shanley review and against the services the ICB has commissioned. To do that, the review assessed the system conditions in which CMHTs operate and the reliability of the key processes that underpin safe, person-centred care. Findings distinguish between what is evidenced in the material reviewed, what can reasonably be inferred through triangulation and what cannot be concluded with confidence because of evidence limitations. This systems-based and compassionate approach supports openness, psychological safety and improvement.

Why CMHT reliability matters

CMHTs remain a critical component of the community mental health pathway, supporting people with complex and enduring needs and operating at key interfaces with primary care, social care and voluntary, community and social enterprise (VCSE) partners. When CMHT processes are reliable, including access, allocation, communication, escalation, crisis planning and transitions, patients, families and carers experience greater continuity, clearer plans and safer care. When these processes are inconsistent, risk and demand accumulate in gaps between services, confidence erodes at interfaces and the system becomes more reactive. Strengthening CMHT reliability is therefore central to improving outcomes and system confidence across Greater Manchester. National evidence, including the Community Mental Health Framework and the Care Quality Commission's State of Care reporting, highlights similar pressures across England, particularly in access, workforce capacity, documentation quality and interface functioning.

Scope and organising framework

This review is sample-based. It examined two Community Mental Health Teams, one in each of the two provider organisations, and audited 50 care records in each. It does not provide a definitive assessment of every CMHT in Greater Manchester. Instead, it identifies system signals and recurring themes that warrant action and further assurance where needed, building on progress to date. Findings are organised using the six Shanley themes: voice of patients, families and carers; leadership; culture; workforce; governance and organisational learning; and oversight (including external and system interface). This structure is intended to support learning and system improvement rather than attributing faults.

How the review was conducted

The review used a mixed-methods approach, drawing on care-record audit, documentary review, staff voice, stakeholder feedback, interviews and available operational information. Triangulation tested whether themes aligned across independent evidence streams rather than relying on a single dataset or viewpoint. Public-domain material was used only to provide context, not to corroborate the review findings. Conclusions distinguish between what was directly evidenced, what could reasonably be inferred and what remained uncertain because of limitations in the available material.

Limitations and confidence

This section sets out the limitations that apply to the whole review. Later sections refer back to it and do not repeat it.

Scope. This phase was sample-based. It examined two Community Mental Health Teams, one in each provider organisation, and audited 50 care records in each. It does not provide a complete assessment of every CMHT in Greater Manchester, and it does not quantify leadership, workforce, governance or interface performance across all teams. The methodology was designed to support a learning-focused assurance product and was not a formal audit to external auditing standards.

Access and independent verification. In at least one setting, the review team did not have direct access to electronic records. The audit was completed through facilitated access, which limited independent verification of sampling, completeness and underlying source data. Triangulation across the other evidence sources was used to mitigate this.

Lived experience evidence. No service user responses were received through survey links distributed by the providers. The survey was then shared through an independent VCSE partner (Gaddum), which had approximately 12 days to circulate it, and six service users responded. Planned patient and carer focus groups did not take place. In the Pennine locality, provider engagement began in January 2026, which was too late to arrange focus groups safely or meaningfully. In the GMMH locality, a drop-in session was arranged at an accessible venue and an online session was offered, but no participants registered for either. Service user feedback was triangulated with the 100 care record audits, but the breadth of lived experience evidence was narrower than planned.

Documentation and practice. Where involvement, decisions or plans are not recorded, the review cannot determine whether this reflects gaps in practice or gaps in recording. This distinction matters for assurance.

Staff evidence. Staff and cultural evidence was collected anonymously to encourage candour. This strengthens openness but limits attribution to specific teams or settings.

Data maturity. In several domains, the evidence provided was descriptive and could not be reproduced to assurance grade. By assurance-grade, this report means evidence that is reproducible, traceable to its source, capable of independent verification and focused on outcomes. Evidence below that standard may still be accurate, but it cannot on its own demonstrate that a control is operating reliably. Some workforce insights relied on descriptive packs and qualitative evidence, so the report describes direction of travel and implications where precise prevalence could not be established. Contractual and KPI data was not available in a form that allowed a full comparison against commissioned expectations. Evidence on leadership diversity and inclusion was too limited to reach a conclusion on that element of the Terms of Reference.

Effect on confidence. These limitations do not invalidate the findings, but they shape the confidence that can be placed in specific conclusions. Overall confidence is moderate where cross-cutting themes recur across multiple independent sources. Confidence is lower where conclusions rely on evidence that could not be independently verified or reproduced. Each theme states its level of confidence, and the report is explicit about what is known, what is inferred through triangulation and what remains uncertain. All limitations were recorded in the evaluation tool.

The headline picture

Across the evidence base, a consistent picture emerged: committed staff and pockets of good practice operate within a system under sustained operational pressure. However, there is inconsistent reliability on key processes that underpin continuity, confidence and assurance. Recurring system signals relate to access and thresholds, communication and interface working, continuity and allocation, risk and crisis planning, documentation quality and the ability of governance to evidence “what is happening” in a way that is traceable and assurance grade. Stakeholder feedback reinforces these themes, particularly around contact routes, referral feedback and shared responsibilities at interfaces. See Figure 1a and 1b for a visual summary of the headline findings.

Table 1: Headline findings by Shanley theme

Shanley Theme	Headline Findings
1: Voice of patients, families, and carers	Involvement is present in places but is not reliably visible as a golden thread in the formal record. Audit findings showed involvement in care planning recorded in 24% and 44% of cases in two separate audit samples, which used different measures of involvement (see the note to Table 2). Where involvement and communication are inconsistent or poorly evidenced, trust is harder to sustain, carers feel excluded, and safe escalation becomes more difficult, particularly at points of deterioration, transfer or discharge.

Shanley Theme	Headline Findings
	This is a system reliability issue: even when good practice occurs, it cannot be demonstrated consistently without a dependable record.
2: Leadership	Leadership intent and governance activity are visible, but operational grip is experienced unevenly. Leadership is felt through the reliability of allocation, review cadence, escalation routes, triage consistency and responsiveness at interfaces. Where these controls are inconsistent, variation increases and people can sit outside routine oversight for longer than is safe or intended. **Recommendation link:** Standardise triage, strengthen senior clinical oversight at key decision points and record clinical rationale in the care record.
3: Culture	Staff commitment and peer support are consistently described as strengths, but the capacity for reflective practice, learning and structured wellbeing support is constrained by workload and operational pressure. Where structured supports are inconsistent, cultural resilience relies heavily on informal peer support rather than predictable organisational mechanisms. This affects sustainability, retention and the system's ability to embed learning at pace.
4: Workforce	Workforce capacity and skill mix are dominant constraints on reliability. When teams operate under sustained pressure, services predictably shift toward reactive models at the expense of proactive, recovery-focused care planning and continuity. **Recommendation link:** Stabilise the workforce and protect time for documentation and timely review.
5: Governance and Organisational Learning	Governance structures and learning activity are evident, but assurance is constrained where evidence is not consistent, traceable or reflected in the care record as a single source of truth. **Recommendation link:** Hardwire documentation to an assurance-grade minimum dataset and move from descriptive reporting to reproducible assurance.
6: Oversight and system interfaces	Interface reliability is a recurring theme. Access thresholds, referral feedback loops, contact routes and shared responsibilities are inconsistent across system boundaries. Where responsibilities are unclear or interim plans are weak, risk can inadvertently transfer between services, rework increases, and both patients and clinicians experience avoidable uncertainty. These issues reflect system functioning under pressure rather than individual intent.

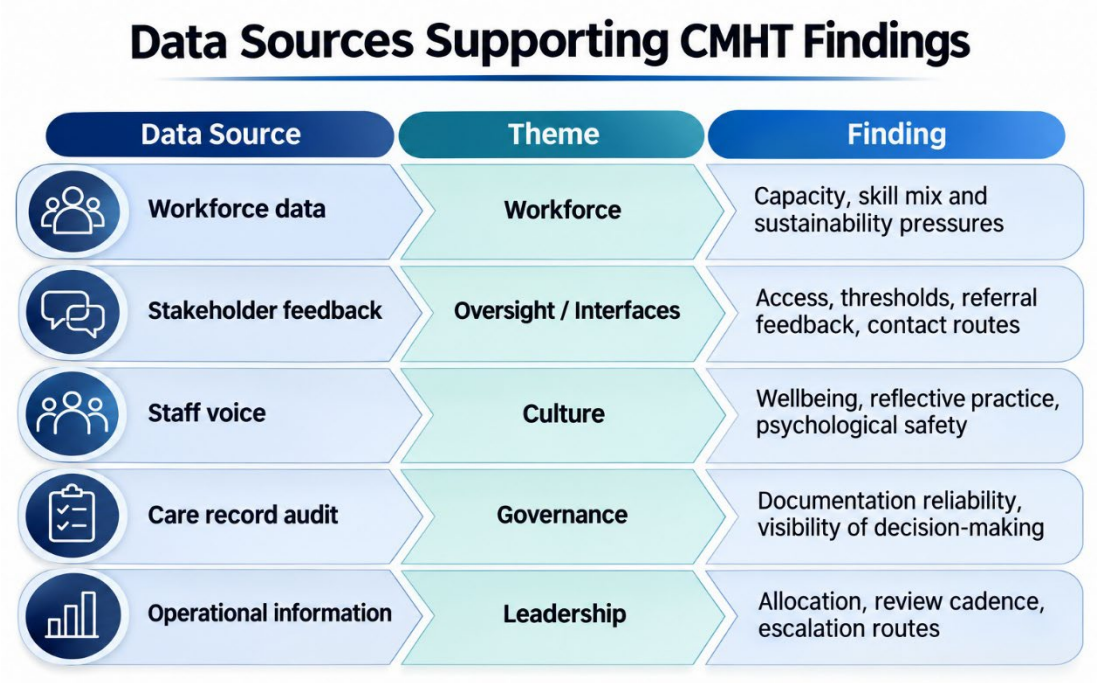
The quantitative and qualitative signals within the sample reinforce the themes set out in the headline picture. The care record audit showed wide variation in core processes across the sample. The chart below summarises the percentage of records where core processes were present across the two audit samples.

Table 2: Care record audit: range observed across the two audit samples[1]

Core Process	Lowest % Observed	Highest % Observed
Recorded involvement in care planning	**24%**	**44%**
Crisis planning present	**40%**	**52%**
Discharge planning present	**34%**	**56%**

These percentages reflect the range observed across two separate audit samples, one in each provider organisation (50 records each). The lowest and highest figures in each row do not all come from the same audit.

Figure 1a: Data Sources Supporting CMHT Findings *(This visual summarises the key evidence sources underpinning the headline findings.)*



These variations reinforce the finding that involvement, crisis planning and discharge planning are not reliably evidenced, even where good practice occurs. The observed discharge-planning range of 34% to 56% indicates inconsistent operation across the sample, affecting continuity, risk visibility and governance assurance.

Workforce data highlighted persistent cohorts of unallocated patients, and stakeholder evidence described repeated referral rejections with limited feedback and difficulty contacting teams. Staff also reported constrained capacity for reflective practice and variable structured wellbeing support, particularly for front-door roles exposed to distressing contact. These specific indicators deepen the headline findings and show that the reliability issues identified are not isolated or anomalous. They reflect system conditions seen across both localities and align closely with the patterns described in the Shanley review and in national evidence on community mental health functioning.

What needs to happen next

The recommendations in this report focus on a small set of high-leverage actions that strengthen reliability and improve assurance:

1. **Standardise triage and strengthen senior clinical oversight** for complex referrals and contested decisions, so access and thresholds are clearer and confidence improves at interfaces.

[1] The two care record audits were carried out separately, one in each provider organisation. The lowest and highest figures in each row do not all come from the same audit. The involvement figures also use different measures: one audit recorded whether the patient was fully involved in care planning (24%), and the other recorded whether any patient involvement in the care plan was documented (44%).

2. **Hardwire documentation to an assurance-grade minimum dataset** so the care record reliably functions as a single source of truth (care plan, risk formulation, crisis plan, named contacts and the reasons for transferring a person between services), enabling continuity and auditability.
3. **Clarify shared care responsibilities and safety-critical monitoring**, including clear interim plans when responsibility cannot transfer, reducing perceived risk transfer and improving patient safety at boundaries.
4. **Stabilise workforce and protect learning capacity**, including supervision, reflective practice and consistent wellbeing support — recognising that reliability cannot be sustained on goodwill alone.
5. **Move from descriptive reporting to reproducible assurance**, so oversight bodies can validate performance, risk and improvement impact over time rather than relying on narrative reassurance.

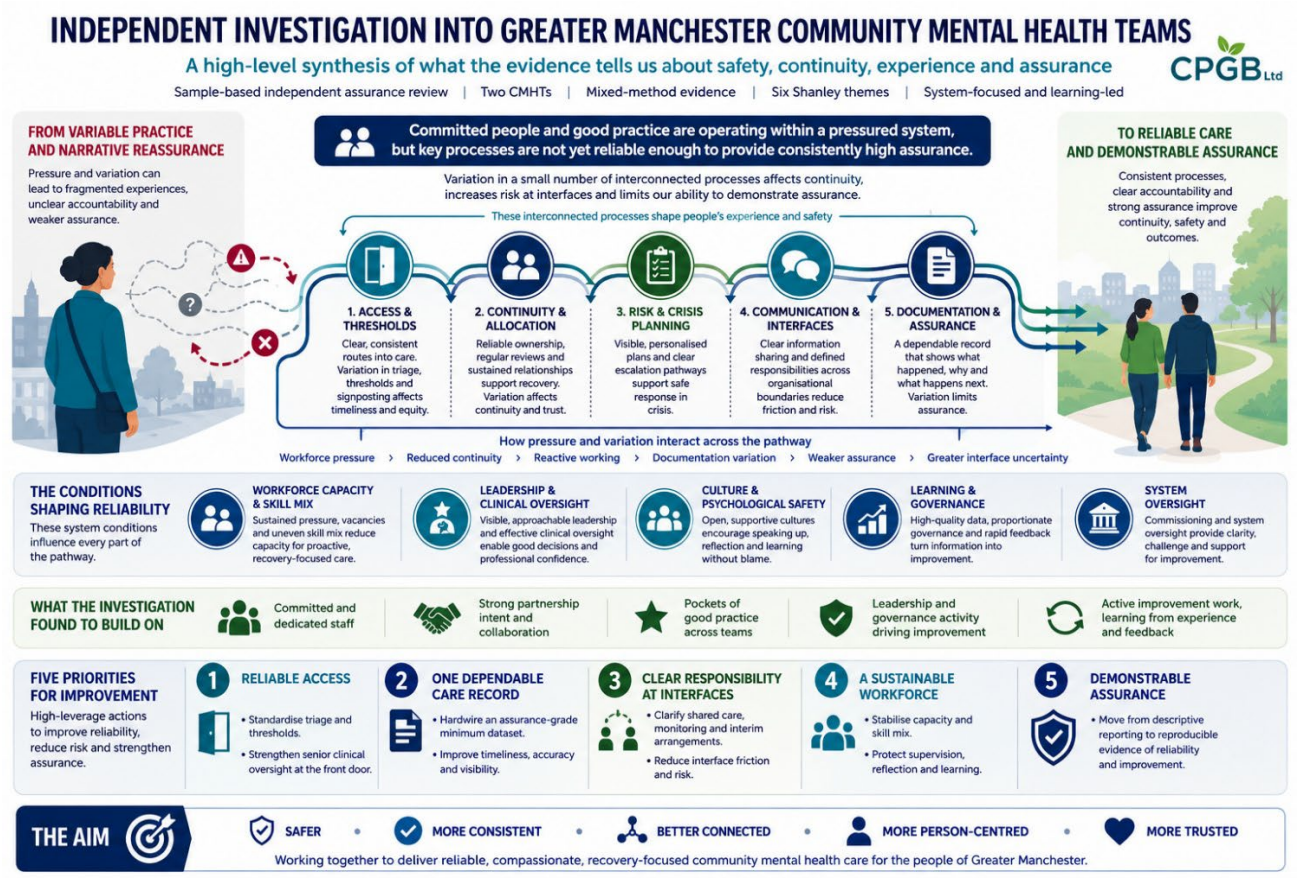
Together, these actions strengthen the core processes underpinning safety, continuity and assurance, while reducing interface friction and supporting sustainable learning and improvement across Greater Manchester.

The recommendations therefore focus on strengthening a small number of core processes that underpin safety, continuity and assurance, rather than attempting to address every issue observed.

About this version of the report

This report is intentionally streamlined for board-level readability and potential publication. It presents cross-cutting findings and system implications; the separate detailed version should be used where locality-specific evidence and action are required.

Figure 1b: Independent investigation into Greater Manchester Community Mental Health Teams: on-a-page synthesis



Introduction

1. Background

In January 2024, the independent Shanley review of Greater Manchester Mental Health NHS Foundation Trust (GMMH) highlighted a set of themes relating to quality, safety and organisational functioning that extend beyond any single service setting. Within its recommendations, Shanley called for further independent assurance where needed and explicitly recommended that community mental health services should be independently reviewed. In response, NHS GM ICB commissioned this review to assess the functioning of CMHTs in line with those themes and to provide an evidence-based view of safety, quality and effectiveness, including delivery against what is commissioned.

CMHTs sit at the centre of community mental health provision. They support people with complex and enduring needs and operate at key interfaces with primary care, social care and voluntary, community and social enterprise (VCSE) partners. As a result, their reliability shapes continuity, confidence and outcomes across the wider pathway.

Where core CMHT processes are dependable, including access, allocation, communication, escalation, risk and crisis planning and transitions, the system is better able to hold risk safely and provide consistent, person centred care. Where these processes are inconsistent, risk and demand can accumulate in gaps between services, interfaces become more fragile and both service users and partner organisations experience avoidable uncertainty. These dynamics mirror national findings in the Community Mental Health Framework and the Care Quality Commission's State of Care reporting, which highlight the importance of reliable community pathways for safe and effective mental health care.

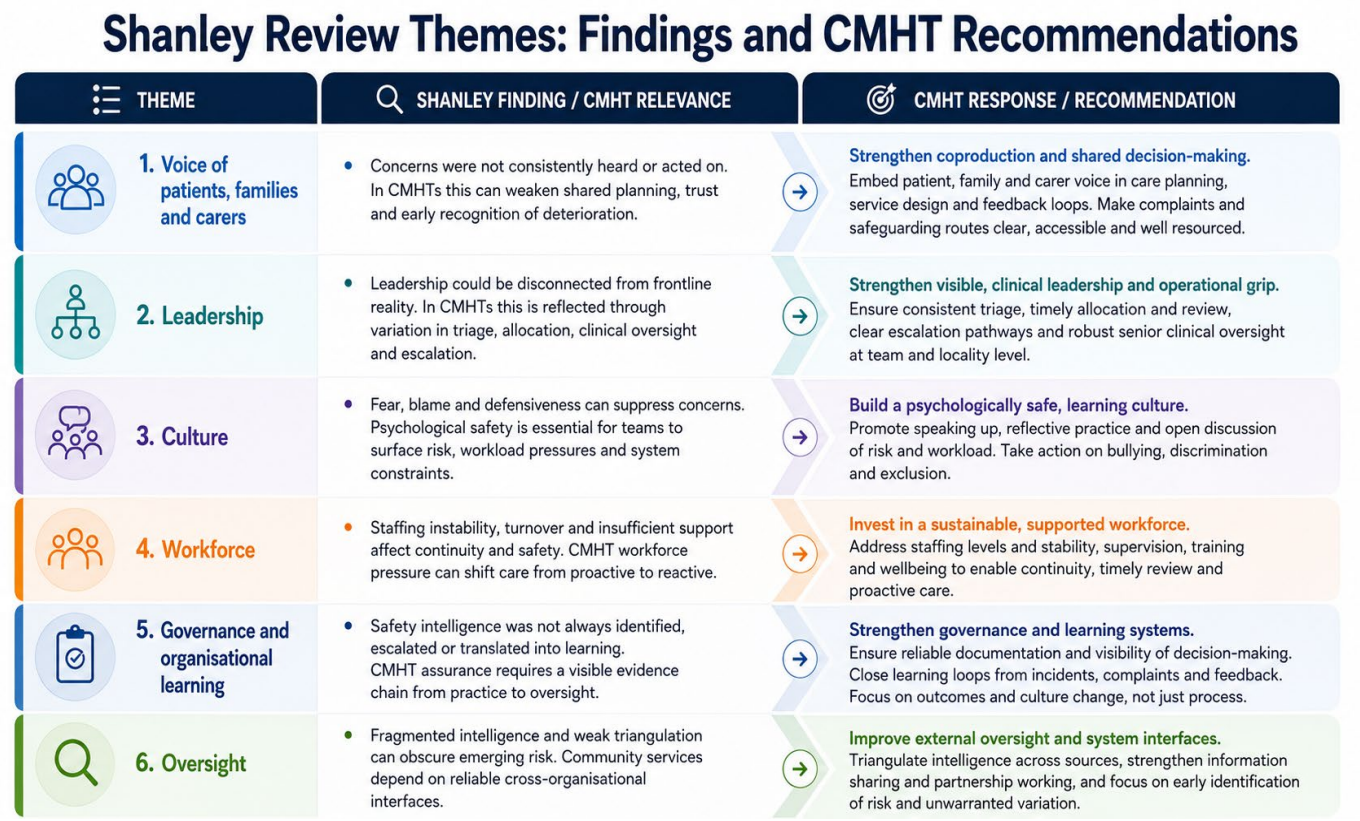
2. Key findings and recommendations in the Shanley report

The Shanley identified a set of systemic weaknesses in how mental health services listened, led, learned and assured. Although focused on a single provider, its central message was that these risks were not confined to one ward, team or site. Recommendation 9 therefore directed that community mental health services should be independently reviewed against the Shanley themes.

These themes were adopted as the organising framework for this CMHT review because they describe the system conditions that shape reliability in community pathways including access, communication, continuity, risk visibility, leadership, culture, governance and oversight.

Figure 2 summarises the Shanley themes, their relevance to CMHTs, and the corresponding recommendations for strengthening reliability and assurance.

Figure 2: Shanley Review Themes — Findings and CMHT Recommendations



What Shanley recommended

Table 3: Recommendations by Shanley theme

Shanley Theme	Recommendations
1: Voice of patients, families, and carers	Embed the voice of patients, families and carers in service design, delivery and governance, so that experience shapes decisions rather than sitting alongside them. In community settings, this means moving beyond ad-hoc engagement toward consistent involvement in care planning, clear feedback loops, and visible learning from concerns.
2: Leadership	Strengthen clinical leadership so that clinical voices are visible, valued and integral to oversight, risk management and quality improvement. For CMHTs, this is especially relevant to triage, escalation and shared risk decisions where senior clinical oversight is often pivotal.
3: Culture	Foster a compassionate, inclusive and psychologically safe culture where staff can speak up, concerns are addressed promptly, and diversity and inclusion are actively championed. This is fundamental to learning, retention and safe care under pressure.
4: Workforce	Address workforce challenges through targeted recruitment, retention, supervision and staff support, recognising that a stable and supported workforce is a prerequisite for safe, consistent care, particularly in community teams managing complexity over long periods.
5: Governance and Organisational Learning	Improve governance, data use and organisational learning by strengthening how incidents, complaints and feedback translate into measurable change, and by ensuring boards have a reliable line of sight to safety, quality and culture. This shifts the system from “activity” to demonstrable assurance.

6: Oversight and system interfaces	Enhance system oversight, information sharing and early intervention so that warning signs are identified earlier, intelligence is triangulated, and improvement support is timely and proportionate, particularly where risk is being held across organisational boundaries.

The Shanley framing highlights important real-world complexities that community services must navigate. One is the reality that carer involvement is shaped by consent, confidentiality and patient autonomy. Carers can feel excluded even when clinicians are acting appropriately within legal and ethical boundaries. Shanley's emphasis on voice therefore needs to be operationalised in a way that includes clear explanations of what can and cannot be shared, alongside meaningful signposting and support for families within those boundaries.

A second nuance is the risk of tokenism. Strengthening involvement is not only about better communication. It requires navigating the triadic relationship between patient choice, carer expectations and clinical responsibilities. If services do not explicitly acknowledge those dynamics and offer practical support within them, engagement mechanisms can feel procedural rather than genuinely collaborative.

Shanley's findings also underline the importance of balancing operational management with credible clinical leadership, including ensuring leadership diversity reflects the workforce and communities served. Where leadership becomes overly weighted toward managerial imperatives without strong, current clinical credibility, it risks drifting away from frontline realities. In community services, where complexity and uncertainty are everyday features, that balance is essential to trust, psychological safety and reliable decision-making.

In summary, the Shanley themes provide the rationale and organising framework for this review: strengthening voice, clinical leadership, psychological safety, workforce stability, evidence-based governance and system oversight to improve reliability across community pathways.

3. The Terms of Reference

The Terms of Reference (ToR) were agreed to translate Recommendation 9 of the Shanley review into a clear, testable set of questions about CMHT functioning, and to define what the review would (and would not) do. In scope, the review was asked to conduct an independent assessment of CMHT provision in line with the Shanley themes, evaluating safety, quality, effectiveness and experience, with due diligence towards human rights and consideration of any patterns suggesting unwarranted disparities. The ToR also required the review to examine four core dimensions: whether services are delivering what is commissioned; the quality and safety risks within current pathways; how incidents, complaints and feedback are used to support learning; and whether governance and oversight provide a reliable line of sight to risk, performance and improvement.

The ToR set a Greater Manchester–wide intent but defined this phase as sample-based: the purpose was to generate system learning and assurance signals rather than provide a definitive assessment of every CMHT. The ToR also required the review to consider whether services are delivering what is commissioned and to identify any gaps between expected delivery and what is evidenced in practice, recognising that the maturity of existing specifications and KPI frameworks can affect how directly contractual comparison can be made. This ensured that the review focused on system conditions and reliability rather than narrow performance management.

To ensure consistency and repeatability, the ToR anchored the review around the six Shanley themes and required these to be converted into clear Key Lines of Enquiry (KLOEs). These KLOEs set out what would be tested and how, so that the approach could be applied consistently and used again. A specific ToR requirement was the development of a structured evaluation tool to support reproducible assessment. This tool was used in this phase and is intended to be reused across other CMHTs as part of ongoing assurance and quality improvement.

The ToR specified a mixed-methods approach to evidence gathering. This included structured document review, analysis of agreed metrics where available, an audit of a sample of care records from the electronic patient record and structured feedback routes for staff and stakeholders. The ToR also envisaged direct patient and carer engagement methods, alongside surveys, recognising that lived experience is a core component of assessing "voice" and experience. This mixed-methods design aligns with the Patient Safety Incident Response Framework (PSIRF), which emphasises triangulation, systems thinking and proportionality.

Finally, the ToR set governance expectations for the work, including clear commissioner oversight and structured touchpoints through delivery, with the final output expected to present evidence-based findings and actionable recommendations aligned to the KLOEs and Shanley themes, framed at appropriate system levels to support implementation. The ToR also emphasised the importance of lived experience involvement within governance arrangements, ensuring that patient and carer perspectives informed both the design and oversight of the review. This governance structure ensured independence, transparency and a clear line of sight between evidence, analysis and recommendations. These boundaries were essential to maintain proportionality and to ensure that the review generated system-level learning rather than individual-level judgement.

4. The review team

The review was delivered by a multidisciplinary team with experience of independent assurance, patient safety learning approaches and complex system reviews. The team combined clinical, operational, analytical and report-writing capability to ensure findings were clinically credible, evidence-based and clearly presented for commissioner and board use. The team's expertise included senior clinical leadership from community and mental health services, investigation and systems-thinking capability, quantitative and qualitative analysis and programme governance experience. Consultant Psychiatrist oversight was included to support balanced clinical interpretation and ensure that conclusions were grounded in contemporary practice.

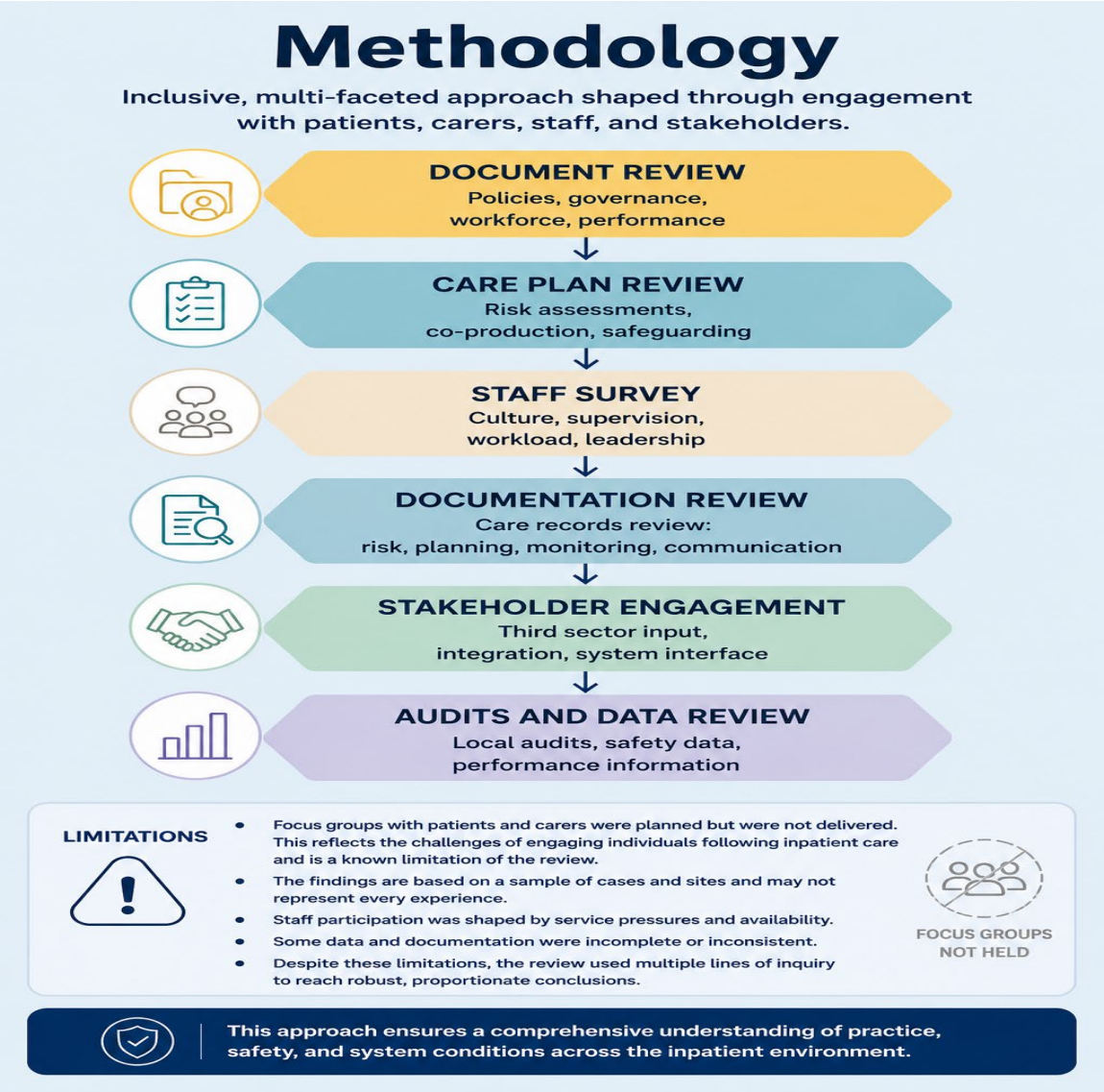
Collectively, the team has led and contributed to large-scale thematic reviews, homicide and serious incident investigations, pathway assessments and organisational learning programmes across the NHS and wider public sector. This breadth of experience enabled the team to interpret evidence from multiple sources, test the reliability of key processes and identify system conditions that influence safety, quality and experience.

The team's approach emphasised independence, proportionality and psychological safety. Engagement with staff, patients, carers and partners was undertaken with care and respect, recognising the emotional labour involved in sharing experiences of mental health care. The team applied consistent analytical methods, triangulated evidence across sources and was transparent about the strength and limitations of the material reviewed.

5. Methodology

This review used a mixed methods approach designed to produce a single, triangulated view of Community Mental Health Team (CMHT) functioning, aligned to PSIRF principles and a just culture stance. The methodology was intended to generate proportionate assurance and practical learning, recognising that community mental health services operate under sustained demand and complexity and that reliable conclusions require evidence from multiple sources rather than reliance on any single dataset or perspective.

Figure 3: Methodology: evidence sources and review flow



Evidence sources and data collection

Evidence was gathered from a blend of qualitative and quantitative sources, designed to reflect both what the system says it does and what the system appears to do in practice. A structured evaluation tool, developed in line with the ToR, was used to support consistency, reproducibility and traceability across the sample. This tool enabled evidence to be mapped systematically to the KLOEs and will be reusable for future assurance cycles. The review combined documentary evidence, care record audit findings, lived experience input, staff voice, stakeholder perspectives and available operational information. Each source contributed differently to triangulation: documentary evidence established expected standards; the care record audit tested whether these standards were reliably visible in practice; staff, service user and stakeholder feedback provided insight into day-to-day functioning; and performance/workforce information supported proportionate assurance where reproducibility was constrained. The table below summarises the evidence sources, what they covered, the volume achieved and any relevant limitations.

Evidence Table

Table 4: Evidence sources and volumes achieved

Evidence source	What it covered	Volume achieved	Notes

Care record audits	Care planning, involvement, risk/crisis planning, transitions, documentation quality	50 records per organisation (100 total)	One audit was completed through facilitated access; direct verification of sampling/completeness was constrained by the access model.
Stakeholder survey and follow-up	Interface experience (primary care, partners), access, communication, leadership confidence	52 survey respondents; 10 MS Teams meetings; 2 written submissions	Stakeholders included a broad cross-section of system roles; individual roles/localities were not listed to protect anonymity.
Staff voice survey	Workload, supervision, leadership visibility, culture/psychological safety	24 Survey Respondents (survey instrument used; responses analysed)	Survey design prioritised brevity to maximise participation under operational pressure.
Service user / carer survey	Experience of involvement, communication, understanding of plans/medication, raising concerns	6 service user responses obtained via VCSE dissemination (including Gaddum)	No responses were received via initial provider-led dissemination routes; VCSE engagement enabled additional lived-experience input.
Documentary review	Policies, SOPs, governance reports, workforce/performance packs, public domain sources	Core clinical and operational policies, Governance and assurance documents, Workforce and staffing information, Service specifications and pathway documents, public domain sources.	Included reference to public domain materials (e.g., inspection reports and board papers) to supplement evidence.
Performance and workforce information	Referral/activity measures, caseload allocation signals, workforce indicators, safeguarding/quality information	As provided by the organisation/s	In some areas, data was descriptive or not consistently reproducible, constraining commissioner-grade assurance; confidence levels were recorded in the evaluation tool.

Triangulation and analysis

Where multiple independent sources aligned, confidence increased. Where sources diverged, the report describes the variation and its implications for assurance rather than forcing a definitive conclusion. This ensured that the analysis remained proportionate, transparent and grounded in the strength of the evidence available.

To keep the analysis proportionate and transparent, the review distinguished consistently between:

- **Evidenced findings**: Directly observed in audited records or documented material reviewed.
- **Triangulated inferences:** Signals supported by alignment across multiple sources.
- **Areas of uncertainty:** Where limitations in access, engagement or reproducibility prevent confident conclusions.

This categorisation was applied consistently across themes and supports clear interpretation of confidence levels by commissioners and providers.

Deviations from plan and how these were managed

Two deviations from the planned approach were material: restricted access to electronic records in at least one setting, and planned patient and carer focus groups that did not take place. Both, and how they were mitigated, are described in the Limitations and Confidence section of the Executive Summary. They were recorded in the evaluation tool and reflected in the confidence statement for each theme.

Purpose of the approach

This methodology was designed to support a learning-focused assurance product. Its strength lies in the structured use of multiple evidence sources and triangulation, which allows recurring patterns to be identified even where exact prevalence cannot always be quantified.

Overall, this approach enables the report to provide a balanced synthesis: recognising strengths and pockets of good practice, while identifying recurring system signals that affect reliability, continuity and confidence, and translating these into practical priorities for improvement.

A structured CMHT Evaluation Tool, aligned to the Shanley themes and the tests used in this review, has been developed as a separate, reusable assurance instrument for providers, places and the ICB.

Evidence Base and Confidence Framework

Strong evidence refers to themes that recur across multiple independent sources, such as care-record audits, staff voice, stakeholder feedback and documentary review. Where findings are described as “clear and consistent”, they are grounded in this level of triangulation.

Moderate evidence refers to themes supported by more than one source, but where verification was constrained by access limitations, sampling constraints or descriptive rather than reproducible data.

Indicative evidence refers to themes drawn from single-source or low-volume data. These are treated as signals that warrant further testing rather than definitive conclusions.

This framework is applied consistently throughout the report. Unless otherwise stated, each thematic section draws on all of the evidence sources described above: care record audits, staff voice, stakeholder feedback, service user and carer feedback, documentary review and the operational information supplied by the providers. Each thematic section states what is evidenced, what is inferred through triangulation and what cannot be concluded with confidence. The limitations set out in the Limitations and confidence section of the Executive Summary apply to every theme.

Main findings and analysis

Shanley Theme 1 – Voice of Patients, Families, and Carers

A. Why this is important

Patient, family and carer voice is central to safe and effective community mental health care. It shapes shared understanding, supports meaningful planning and strengthens continuity in long-term care. When voice is reliable and visible, it anchors decision making in the realities of people's lives. When it is inconsistent or poorly evidenced, the foundations of safe practice become less secure.

Practical consequences

- **Safety:** When involvement, crisis planning or discharge intent are not clearly documented, teams have a weaker shared picture at the moments when clarity is most needed. This affects safety at points of deterioration, transfer or discharge, where the absence of a clear plan or shared understanding can delay escalation or lead to assumptions that do not reflect the person's current needs.
- **Quality and experience:** Inconsistent communication and variable involvement increase the likelihood that people feel unheard or excluded. This is particularly significant for carers who carry responsibility for day-to-day stability but may not be consistently engaged or updated. These gaps affect trust and can heighten distress during periods of change or uncertainty.
- **Assurance:** Even where good engagement occurs, it cannot be demonstrated without a reliable record. This creates a gap between practice and evidence, which limits the ability of teams, leaders and boards to understand whether involvement is happening consistently and whether it is informing care in the way that commissioned expectations require.
- **System conditions:** Workforce pressure, unallocated caseloads and delays at key interfaces reduce the time available for proactive communication and co production. These pressures contribute to a more reactive operating model where involvement is harder to sustain and less visible in the record, even when staff are working with commitment and intent.

Strengthening voice is therefore essential to demonstrating safety, continuity and person-centred care, even where individual practice is strong.

B. What was tested

This theme examined how effectively patient, family and carer voice is embedded in CMHT practice across Greater Manchester. The review considered whether people are listened to, involved and supported in ways that shape their care, and whether this involvement is clearly visible in the formal record.

The review focused on three connected areas:

- how shared decision making is reflected in care planning, risk assessment, crisis planning and review;
- whether carers' perspectives are recognised, recorded and used to inform clinical decisions; and
- whether people understand how to raise concerns and whether staff can guide them to appropriate routes for support.

The review also assessed whether reasonable adjustments for communication, cultural or learning needs are identified and recorded in a way that enables any member of the team to act on them. Taken together, these tests considered whether voice is reliably embedded in day-to-day practice as part of safe, person-centred care.

C. What the evidence shows

Strengths

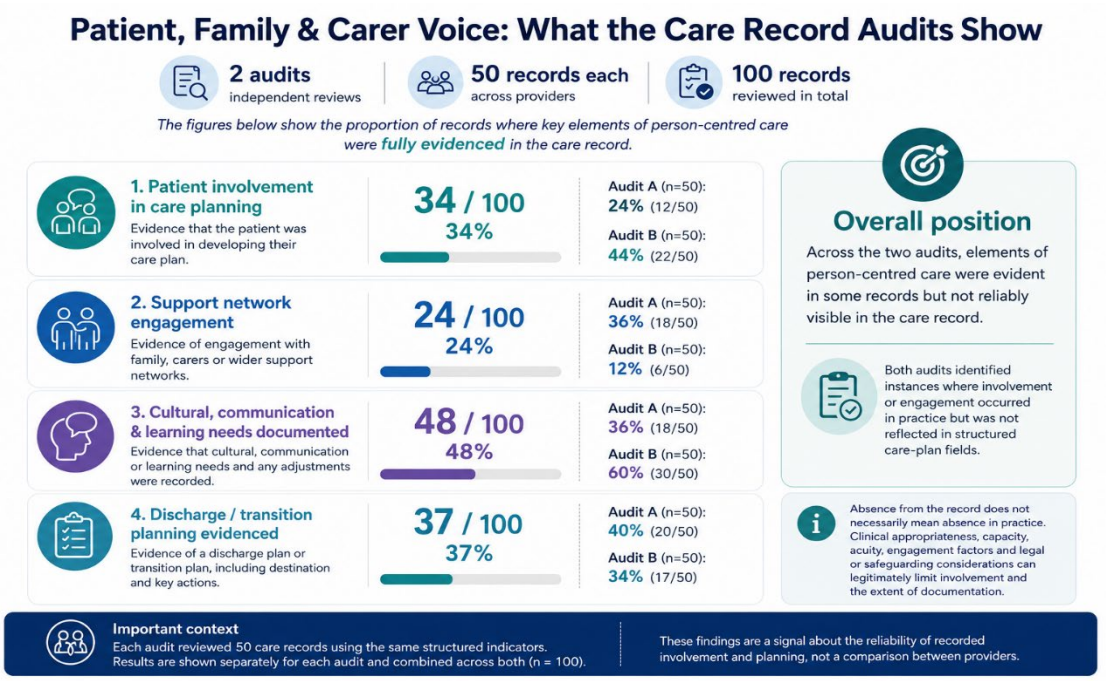
- **Compassionate individual practice is consistently described:** Service users and carers described instances of compassionate and effective care from individual clinicians.
- **Mechanisms for engagement exist:** The evidence base describes established engagement routes (for example, carer hubs/groups and feedback mechanisms), indicating intent and activity to involve carers and service users.

Gaps and variation

- **The voice is not reliably visible as a golden thread in the record:** Across the care record audits, recorded involvement in care planning was variable and often low. One audit finding recorded patient involvement in care plans in 44% of audited records. In another, only 24% of audited cases were recorded as fully involving the patient in care planning. The two audits were carried out separately and used different measures of involvement, so these figures are not directly comparable.
- **Carer and support network involvement is inconsistent and often not evidenced:** Involvement was noted as variable and often poorly evidenced. Where involvement is limited due to capacity, acuity or safeguarding constraints, this is not consistently documented, making it hard to distinguish non-engagement from non-recording.
- **Communication needs and adjustments are not consistently recorded.** In one area, cultural/communication needs were documented in 36% of audited records, indicating limited visibility of adjustments in the formal record.

These patterns are summarised in the audit indicators below, showing where involvement was visible and where shared decision making could not be fully evidenced because the corresponding audit field was absent.

Figure 4a: Audit indicators tested for patient, family and carer voice



How lived experience influenced findings:

Lived-experience feedback provided a clear and consistent signal about communication reliability. Four of the six service users described difficulty contacting CMHTs, and carers reported fear of raising concerns and lack of timely responses. These accounts reinforce the system finding that when communication is unreliable or unclear, confidence drops and continuity becomes harder to maintain. This is treated as a **system reliability issue**, not an assessment of individual staff.

Figure 4b: Lived Experience Feedback and how it influenced findings



D. Confidence

Confidence: Confidence in the overall pattern is moderate. Multiple independent sources align, including care record audit findings, stakeholder perspectives and service user and carer feedback. Together, these sources consistently indicate that involvement and communication are variable and not reliably visible in the formal record. The convergence of these signals across different evidence types strengthens confidence in the overarching theme, even though the exact scale cannot be quantified with precision.

E. Alignment with commissioned CMHT specification

The commissioned CMHT framework sets clear expectations for how patient and carer voice should be embedded in practice. It requires evidence that people are heard in care planning, that carers are offered assessments and signposted to support, that concerns can be raised through suitable routes, that advocacy is accessible when needed and that communication, cultural or learning needs are identified and recorded. These expectations are central to demonstrating that involvement is not incidental but a consistent feature of safe, person-centred care.

What the commissioned framework expects:

- Patients and carers are heard in care planning;
- Carers are offered assessments and signposted to support;
- People can raise concerns through suitable routes and staff can support this;
- Advocacy is accessible where relevant; and
- Staff adjust for communication, cultural or learning needs and this is recorded.

What the evidence indicates:

- **Partial alignment:** Mechanisms and intent for involvement are present across the system. Engagement routes exist, and examples of good involvement were described through stakeholder and lived experience feedback. These elements show that the foundations for meeting the commissioned expectations are in place.

- **Material divergence in reliability and evidence:** Care record audits show that involvement, communication needs and related planning, including crisis and discharge planning, are not consistently evidenced across the sample. This limits assurance that the commissioned expectations are being delivered in a reliable and demonstrable way, even where individual practice may be strong.

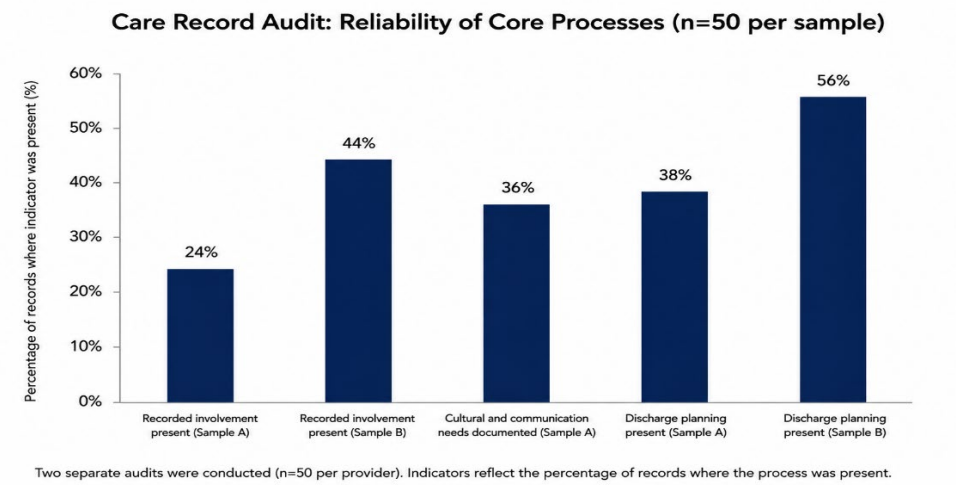
F. Theme summary

Overall finding: Patient, family and carer involvement is present but not consistently evidenced in the care record, limiting assurance about person-centred practice and continuity.

Data signal: Visibility of involvement in the record

The principal audit and lived-experience signals supporting this conclusion are presented in Figures 4a, 4b and 5.

Figure 5: Audit indicators: visibility of involvement in the care record



Two separate audits were conducted (n=50 per provider). Indicators reflect the percentage of records where the process was present.

Carer engagement routes exist across the system, including hubs, groups and wider involvement mechanisms. However, the link between engagement, care planning and review is not consistently demonstrable. Carers described difficulty accessing timely updates, and stakeholder feedback highlighted similar challenges at key interfaces. Even where staff are working with commitment and intent, the absence of a clear record creates a gap between practice and evidence.

Taken together, the evidence indicates that the system needs a more reliable and recordable approach to involvement, consent boundaries, carer engagement and reasonable adjustments. Without this, assurance remains incomplete even where individual practice is strong.

Shanley Theme 2 – Leadership

A. Why this is important

Leadership matters because it is the mechanism that turns standards into reliable practice. Where leadership grip is strong, it shows up as clear allocation, consistent review cadence, timely escalation and reliable communication routes. Where it is weaker, variation increases and patients can sit outside routine oversight for longer. Leadership effectiveness is therefore not defined by structures alone but by whether those structures translate into predictable, safe and coordinated care.

Practical consequences when leadership is inconsistent or not visible:

- **Safety:** Persistent unallocated caseloads (people accepted by the CMHT who do not yet have an allocated Care Coordinator), inconsistent senior oversight at triage and variable documentation of decision making increase the risk that deterioration is not identified promptly and that escalation thresholds are applied inconsistently.

- **Quality and Experience:** Where stakeholders perceive inconsistent senior oversight at triage, or where communication routes feel unreliable, confidence drops and relationships at the interface become more strained. This increases rework and can drive repeated referrals and escalation.
- **Assurance:** Documentation gaps and limited visibility of clinical rationale weaken the assurance chain. Even where leadership decisions occur, they are not always recorded in a way that supports continuity, auditability or board level oversight.

System conditions: Workforce fragility and vacancy pressures, set out in full under Theme 4, reduce available senior time for triage, supervision and proactive oversight. These pressures constrain leadership impact, even where intent is strong.

Taken together, the evidence shows that leadership effectiveness is not only about visibility or governance activity. It is about whether leadership creates the conditions for reliable operational control, clear clinical responsibility and consistent escalation. Strengthening leadership grip is therefore essential to improving safety, continuity and confidence across CMHT pathways.

B. What was tested

This theme examined whether leadership is visible, effective and able to support safe, consistent CMHT delivery across Greater Manchester. The review considered whether clinical leadership is clearly established through the allocation of Responsible Clinicians and Care Coordinators, and whether senior clinical oversight is reliably present in decision making, escalation and MDT processes. It also tested whether leadership behaviours create the conditions for staff to speak up, learn and improve, and whether accountability and governance arrangements translate into reliable operational grip in day-to-day practice.

The review explored how leadership influences allocation, review cadence, escalation and continuity, and whether these controls operate consistently across teams. It also assessed whether leaders have the ability to influence quality and service improvement, and whether governance structures provide a clear line of sight from frontline practice to senior oversight. Where evidence was available, the review considered whether leadership diversity and inclusion were being addressed in line with the Terms of Reference.

Finally, the review assessed whether leadership intent and governance activity are experienced consistently by staff, service users and partners. This included examining stakeholder feedback on senior visibility, triage oversight, communication reliability and interface functioning, recognising that leadership is often experienced through the reliability of operational processes rather than through formal structures alone.

C. What the evidence shows

Strengths:

- **Leadership intent and engagement** are visible across both localities. Governance forums are active, and leaders are involved in improvement activity and Trust-wide oversight structures.
- **Allocation structures exist and can function well.** In one audit sample, Care Coordinator allocation was recorded in 96% of cases and Responsible Clinician allocation in 92%, demonstrating that clear clinical responsibility can be established where processes operate reliably.
- To illustrate trust variation, crisis planning was present in 52% of audited GMMH records and 40% of audited Pennine records. This provides a clean like-for-like comparison across both providers and highlights variation in the visibility of core safety planning.
- **Governance structures** have been strengthened, with increased leadership visibility described in leadership materials and evidence of participation in locality and Trust level improvement programmes.

Gaps and variation:

- **Operational grip is variable:** In parts of the sample, a persistent cohort of unallocated cases was reported (e.g., 643 unallocated cases in one locality dataset). This suggests that leadership and oversight mechanisms are not consistently translating into timely allocation and continuity for all patients.

- **Senior clinical oversight at the front door is a recurring concern in stakeholder evidence:** Stakeholders reported that triage decisions are, at times, made without consistent senior clinical input, and described examples where decisions were "later reversed by senior psychiatrists". These accounts were not independently verified against triage records. This was described as contributing to reduced confidence and friction at the interface with primary care.
- **Leadership structures are present, but their impact is not consistently evidenced in day-to-day practice.** Documentation and risk-visibility gaps weaken board-level assurance and limit visibility of clinical rationale and MDT decision-making. Even where oversight occurs, it is not always translated into a record that supports continuity and assurance.
- **Leadership is experienced through reliability:** Stakeholders described difficulties with access, communication and clarity of escalation routes. These interface issues are experienced as leadership issues because they shape confidence that the service is reachable, responsive and accountable.

D. Confidence

Confidence is moderate in the core pattern: the evidence base consistently indicates that leadership intent and structures exist, but that translation into consistent operational grip is variable. This conclusion is supported by multiple sources, including operational indicators and stakeholder evidence about senior oversight and interface functioning.

E. Alignment with commissioned CMHT specification

The commissioned framework requires clear allocation of Responsible Clinician and Care Coordinator, visible senior clinical input in MDT processes, reliable escalation pathways with senior oversight and mechanisms for clinical leaders to influence service and quality improvement.

What the commissioned framework expects:

- Clear allocation of Responsible Clinician and Care Coordinator;
- Visible senior clinical input in MDT processes and care planning;
- Escalation pathways that provide adequate senior clinical oversight; and
- Mechanisms for clinical leaders to influence service and quality improvement.

What the evidence indicates:

- **Partial alignment:** Allocation structures and leadership mechanisms exist, with high allocation rates in one audit sample and active governance and improvement activity described.
- **Divergence in reliability/assurance:** persistent unallocated caseload indicators and stakeholder concerns about inconsistent senior oversight at triage suggest that leadership grip and senior clinical decision-making are not yet operating consistently enough to provide uniform assurance across the pathway. Documentation gaps further limit the ability to evidence leadership impact and clinical rationale reliably.

F. Theme summary

Overall theme summary: Across both localities, leadership intent, visibility and governance structures are evident, but their impact is not yet experienced consistently in day-to-day practice. This reflects variation in the conditions and controls that support reliable leadership rather than individual performance: differences in allocation, senior clinical oversight, escalation and the recording of clinical rationale can affect continuity, risk visibility and confidence at service interfaces. Improvement should focus on learning from this variation and strengthening the systems that enable leadership decisions to translate consistently into safe, coordinated care, with clear ownership, timely review and an auditable record of decision-making.

Shanley Theme 3 – Culture

A. Why this is important

Culture is a core safety mechanism. When staff feel psychologically safe, supported and able to reflect, risks are surfaced earlier, learning is embedded more reliably, and teams are better able to sustain safe practice under pressure. When these conditions are constrained, cultural resilience becomes dependent on informal peer support rather than structured systems.

Where structured support and reflective time are constrained, the likely practical consequences are:

- **Safety:** Reduced learning capacity**:** Limited reflective practice and inconsistent debriefing reduce opportunities to identify emerging risks, learn from incidents and maintain shared understanding across teams.
- **Quality and experience:** Increased risk of burnout and variation**:** Emotional burden, workload pressure and exposure to distressing contact without support increase fatigue and can affect staff confidence, communication and continuity.
- **Assurance: Higher exposure risk for some roles:** Where wellbeing support and reflective structures are inconsistent, leaders have limited visibility of cultural risks, making it harder to understand whether staff feel safe to speak up or whether concerns are escalated reliably.
- **System Condition:** Many cultural barriers reflect wider system pressures, including workload, demand and capacity constraints. These conditions limit the time available for learning and wellbeing, even where intent is strong.

B. What was tested

This theme examined the cultural conditions that shape how safely and openly staff can work and learn within CMHTs across Greater Manchester. Culture in this context refers to psychological safety, openness, fairness, inclusion and the extent to which staff feel able to speak up, raise concerns and contribute to improvement. The review considered whether staff feel safe at work, whether they experience respectful and supportive relationships and whether they have access to the structures that enable learning and reflection.

The review also tested whether day to day practice supports a learning culture, including access to debriefing, reflective practice and wellbeing support. These elements are essential for sustaining safe care under pressure, particularly in services managing complex, longstanding caseloads. The review explored whether staff experience fairness and equity, and whether there are any signals of discrimination, exclusion or inequity that may affect psychological safety or team functioning.

Finally, the review assessed whether cultural conditions support safe care for patients. This included examining whether safeguarding awareness is embedded, whether staff feel confident to escalate concerns and whether the cultural environment enables early identification of risk. The aim was to understand not only whether cultural assets exist, but whether they are reliable, consistent and experienced across different staff groups.

C. What the evidence shows

Strengths:

- **Committed, values-driven teams and strong peer support were consistently described.** Across the evidence reviewed, staff narratives include examples of supportive peer relationships and commitment to providing good care under pressure.
- **Teams demonstrate resilience**, with staff supporting one another informally when workload and emotional burden are high.

- The review approach supported candour by protecting anonymity and avoiding attribution to individuals. This provides context for interpreting the evidence but does not itself demonstrate the strength of organisational culture.

Gaps and variations:

- **Limited structured wellbeing support and limited protected reflective practice time were recurring themes:** Staff evidence describes constrained access to formal wellbeing support and reduced opportunity for structured reflection and learning within routine practice.
- **Exposure to distressing contact without consistent support was raised for some staff groups:** The evidence includes accounts of administrative/front-door staff being exposed to distressing patient contact without adequate training, debriefing or formal emotional support mechanisms, creating avoidable wellbeing and retention risks.
- **Culture is shaped by system pressures, especially workload and capacity constraints:** The evidence links day-to-day cultural experience to wider system conditions, including workload, high demand and limited time for reflective practice. In other words, some cultural barriers appear to be driven by capacity and operational pressure rather than local intent.
- **Wider Trust level culture** data from the NHS Staff Survey 2024 shows a moderate but improving safety climate, alongside high reported levels of bullying, harassment and abuse and uneven confidence in fairness and feedback loops after incidents. These indicators are consistent across both Trusts and align with cultural signals described in staff feedback. CQC well-led findings reinforce this picture, noting ongoing challenges in staff experience, psychological safety and confidence in organisational response.
- **Variation exists but is hard to disaggregate cleanly:** Culture is resilient but stretched and notes that staff feedback was collected anonymously to support openness. This means the evidence is strongest at identifying cross-cutting cultural signals, and weaker at attributing them to specific teams or settings within the sample.

Engagement patterns during the review also reflected cultural signals consistent with those identified in the Shanley review. Although Shanley examined only one organisation, similar behaviours were observed across the wider system: staff and service users often preferred anonymised or indirect routes for sharing concerns, planned focus groups did not materialise, and some contributors expressed uncertainty about confidentiality or organisational response. These patterns do not indicate reluctance to engage, but they do suggest that psychological safety, candour and confidence in organisational processes remain variable across the system. This reinforces that cultural conditions are not isolated to individual providers and require coordinated, system-wide attention.

Taken together, the evidence identifies strong peer support and values-driven commitment, but does not provide assurance that structured wellbeing support, psychological safety and protected learning time are reliable features of day-to-day practice. The small staff-voice sample means this finding should be tested across a broader group of teams.

D. Confidence

Confidence is moderate in the overall pattern. Staff feedback across both localities consistently describes committed teams with strong peer support, operating with limited structured wellbeing support and constrained reflective capacity. These signals are reinforced by Trust level culture data and by the consistency of themes across different evidence sources.

E. Alignment with commissioned CMHT specification

The commissioned framework requires evidence that staff feel safe at work, can speak up, experience fairness and equity and have access to safeguarding understanding and support mechanisms. It also expects that learning and reflective practice are embedded in routine care.

What the commissioned framework expects

- Staff feel safe and able to raise concerns
- Staff experience fairness, equity and inclusion
- Safeguarding awareness and support mechanisms are in place
- Learning and reflective practice are supported through routine structures

What the evidence indicates:

- **Partial alignment:** there is evidence of values-driven commitment and peer support, and safeguarding awareness is explicitly tested through the KLOEs and supporting evidence sources.
- **Divergence in reliability of staff support:** staff evidence describing limited structured wellbeing support, constrained reflective capacity, and variable debriefing/training (particularly for some staff groups) suggests that cultural supports are not yet operating consistently enough to provide strong assurance.

F. Theme summary

Overall theme summary: Across both localities, committed, values-driven teams and strong peer support are important cultural assets, but these strengths are carrying more weight than structured organisational support. The limited availability of protected reflective practice, consistent debriefing and accessible wellbeing support reflects wider system conditions that affect psychological safety, learning capacity and sustainable care, rather than individual or team failings. Further assurance is needed on how reliably these supports are available across CMHTs, with improvement focused on creating predictable time and mechanisms for reflection, learning and recovery under pressure.

Shanley Theme 4 – Workforce

A. Why this is important

Workforce is a primary determinant of CMHT reliability. When staffing and skill mix are fragile, services shift towards reactive operating models, with duty cover, crisis response and short contacts replacing proactive, recovery focused work. This reduces continuity and limits the ability to maintain planned interventions.

Practical consequences when workforce conditions are inconsistent or not visible:

- **Safety:** Persistent unallocated cohorts and reduced capacity for routine review increase the risk that deterioration is not identified promptly and that escalation thresholds are applied inconsistently.
- **Quality and experience:** High caseloads and stretched teams reduce the time available for proactive communication, co-produced care planning and relational work, affecting patient and carer experience.
- **Assurance:** Workforce pressure contributes to variable documentation quality, reducing visibility of clinical rationale and making it harder for governance to demonstrate safe, person-centred care.
- **System Condition:** Many workforce risks are driven by system pressures, including demand, vacancy levels, skill mix gaps and interface pressures. These conditions limit the impact of local mitigations and require system level action.

Taken together, the evidence indicates that workforce fragility and skill mix gaps are central drivers of operational pressure, continuity risk and variation in reliability. Strengthening workforce capacity and stabilising specialist roles are essential to improving safety, continuity and assurance.

B. What was tested

This theme examined whether CMHTs have the workforce capacity, stability and skill mix required to deliver safe, effective and recovery focused care. The review considered recruitment and retention, vacancy levels, reliance on temporary staffing, and the availability of specialist roles such as psychology, medical staffing and occupational

therapy. It also assessed whether caseloads are manageable, whether work is organised to maintain continuity and whether staffing conditions support consistent delivery of core CMHT functions, including proactive care planning, timely risk review and effective communication.

The review also tested whether staff have access to supervision, protected MDT time and training, and whether workforce conditions support staff wellbeing. These elements are essential for sustaining safe practice under pressure, particularly in services managing complex caseloads and high demand. The aim was to understand not only whether workforce structures exist, but whether they are sufficient, reliable and experienced consistently across teams.

Workforce Pressure Indicators

Workforce fragility is the dominant system condition affecting reliability. The table below summarises the workforce pressures consistently evidenced across the sample.

Sources: Workforce evidence was drawn from provider supplied datasets and descriptive packs. These included GMMH workforce and turnover data from Nov 2022 to Oct 2025, Pennine workforce, turnover, training and vacancy data from Aug 2022 to Jul 2025, commissioner KPI datasets from Sept 2025 and the CPN Highlight Report, which recorded 643 unallocated cases with commissioner KPI data showing more than 600 unallocated cases across much of 2025. All workforce data was provider supplied and was not independently verified.

Table 5: Workforce pressure indicators

Workforce Indicator	Evidence Source	Signal
Persistent cohorts of unallocated patients	Workforce data. Commissioner KPI data 2025: >600 unallocated cases across much of 2025	**Present**
Reliance on temporary staffing	Workforce theme	**High**
Gaps in medical roles	Workforce theme	**Present**
Gaps in psychological roles	Workforce theme	**Present**
Emotional burden on front-door roles	Staff voice	**Consistently reported**
Constrained capacity for reflective practice	Staff voice	**Consistently reported**

These indicators show how workforce pressure constrains proactive and relational work; the detailed implications are examined in the evidence section below.

C. What the evidence shows

Strengths:

- **Workforce stability is a relative strength in parts of the sample:** There is a stable core workforce and low turnover as a positive feature in one locality, which supports continuity and relationship-based care.

Gaps and variation

- **Workforce fragility is a dominant constraint in parts of the sample:** There is a vacancy position of 37.75 WTE (Oct 2025) in one locality view, alongside reliance on temporary staffing and medical staffing gaps that required mitigation.
- **Skill-mix gaps recur even where overall stability is stronger:** The evidence describes gaps in key disciplines, including psychology, medical staffing and occupational therapy capacity, which constrain timely review, formulation and proactive work.

- **Capacity constraints show up as operational pressure and reduced continuity:** The evidence links workforce conditions to a persistent cohort of unallocated cases (e.g., 643 unallocated cases (Nov 2025) in one locality dataset), and to reliance on duty systems and extraordinary MDT processes as compensatory mitigations.
- **Supervision, protected MDT time and reflective capacity are variable:** Staff evidence describes limited access to supervision and protected MDT time in some areas, and a stretched workforce with reduced space for learning and reflective practice.
- **Morale and wellbeing pressures are visible in qualitative evidence:** The evidence describes emotional burden, high demand and constrained structured wellbeing support, including concerns about some staff groups being exposed to distressing contact without consistent debriefing or support.

D. Confidence

Confidence is moderate in the central pattern. Multiple, consistent signals link workforce fragility and skill mix constraints to continuity pressure, unallocated caseloads and variable reliability in delivery and documentation. These themes are reinforced across workforce dashboards, vacancy data and staff evidence.

E. Alignment with commissioned CMHT specification

The commissioned framework requires adequate CMHT skill mix, including community psychiatric nurses, social workers, occupational therapists, clinical psychologists, medical staff, support workers and administrative staff. It also expects manageable caseloads, team-based caseload management and consistent supervision, training and wellbeing support.

What the commissioned framework expects:

- Adequate skill mixes across core and specialist roles
- Manageable caseloads and team-based caseload management
- Consistent supervision, training and wellbeing support
- Workforce conditions that support continuity and proactive care

What the evidence indicates:

- **Partial alignment:** there is evidence of stability in parts of the sample and of operational mitigations intended to manage pressure.
- **Divergence in consistency and sustainability:** reported vacancy/temporary staffing pressures and recurring skill-mix gaps indicate that the workforce platform does not consistently support reliable delivery everywhere. The downstream impacts, including unallocated cohorts, constrained proactive work, variable supervision/reflective capacity, limit assurance against the expectation of a consistently deliverable CMHT operating model.

F. Theme summary

Overall theme summary: Across the sample, committed teams continue to deliver care despite workforce pressures, but current capacity and skill mix do not yet provide a consistently reliable platform for proactive, recovery-focused practice. This reflects wider system conditions, including workforce stability, specialist capacity and the time available for supervision, MDT working and staff support, rather than individual or team effort. Improvement should focus on learning from local variation, testing the relationship between workforce conditions and operational outcomes, and developing an evidence-led stabilisation plan that strengthens specialist roles, continuity and protected time for safe, sustainable practice.

Shanley Theme 5 – Governance & Organisational Learning

A. Why this is important

Governance is the mechanism that converts learning into safer, more reliable care. When governance can describe activity but cannot evidence reliability or impact, risks remain visible but not consistently managed.

Practical consequences when assurance is not board-grade:

- **Safety:** Risks are harder to anticipate and control when they are not routinely quantified, owned and tracked through governance**.**
- **Quality and experience:** Without reproducible data and clear feedback loops, variation persists and improvement is harder to embed.
- **Assurance:** Where the care record is not a single source of truth, continuity relies on informal knowledge, increasing the risk of missed deterioration and weaker shared decision making.
- **System conditions:** Governance limitations reflect both behavioural factors (risk ownership, learning discipline) and infrastructure factors (templates, reporting, interoperability). Strengthening governance requires action on both.

B. What was tested

This theme examined whether governance and learning systems provide assurance-grade oversight in practice, not only in policy. The review tested how risks are identified, escalated and acted upon; how incidents and complaints are analysed; whether learning is translated into change; and whether boards and commissioners have a reliable line of sight to delivery and risk. It also assessed whether the system could evidence improvement through reproducible data, audit trails and feedback loops, consistent with national patient safety learning approaches and the expectations set out in the Terms of Reference.

The review considered whether governance outputs are visible in day-to-day practice, including whether MDT decisions, risk formulation and safeguarding actions are consistently captured in the care record. The aim was to understand whether governance structures are functioning as intended and whether they generate evidence that is traceable, reproducible and capable of supporting reliable assurance.

C. What the evidence shows

Strengths

- **Governance activity is present and visible:** The evidence base includes active governance forums, adoption of patient safety learning approaches, audit activity and improvement programmes. This indicates that formal governance structures and learning intent are in place across the system.
- **Audit and review mechanisms exist in high-risk areas:** There is audit activity, including care record audits and clinical audits, as part of the governance picture. This provides a foundation for identifying risks and targeting improvement.

Gaps and variations:

- **A recurring gap exists between governance formality and governance impact:** The material provided was often descriptive and reassurance-oriented rather than assurance-grade. In practical terms, processes were described, but reproducible evidence of reliability, control and impact was not consistently available.
- **Evidence traceability and reproducibility are inconsistent:** We identified fragmented data, weak traceability, limited validation, and lack of reproducible extracts or audit trails in places. This limits the ability to independently verify reported practice and makes board-level assurance harder to sustain.
- **Learning loops are not consistently evidenced as closed:** There was limited evidence of action completion; for example, training plans or recommendations listed without consistent completion evidence. There was absence, in some areas, of clear ownership, risk scoring and governance timelines that would convert issues into managed, trackable actions.

- **Risk visibility is constrained by documentation gaps:** Care record audits show that key elements needed for safe continuity, such as care planning involvement, crisis planning and discharge planning, are not consistently documented. Where MDT activity or clinical rationale is not translated into structured records, governance cannot reliably see whether standards are operating day-to-day.
- **Variation is driven by system conditions as well as local practice:** The assurance gap is linked to underlying system factors, including operational pressure and IT/data environments that are not configured to generate governance-grade outputs. This suggests that some governance weaknesses are systemic (data and operating model), not solely local.

Where evidence was descriptive rather than traceable, the review applied a lower level of confidence because reliability, control and impact could not be independently verified.

Taken together, the evidence indicates that governance structures are active, but their impact is constrained where documentation, data and learning systems do not reliably translate governance activity into assurance-grade evidence.

D. Confidence

Confidence is moderate in the central conclusion: there is consistent evidence that governance structures exist and are active, but that assurance is constrained where evidence is not reproducible, traceable or consistently reflected in the care record. This conclusion is grounded in the analysis of evidence quality and the care record audit signals.

E. Alignment with commissioned CMHT specification

The commissioned framework requires incidents to be recorded and investigated in line with policy and national patient safety learning approaches, visible oversight of safety and quality, adherence to an audit cycle and mechanisms for sharing performance and assurance with commissioners.

What the commissioned framework expects:

- Incident reporting and investigation aligned with national patient safety learning approaches
- Staff awareness of safety themes and priorities
- Visible oversight of safety, quality and workforce culture
- A functioning audit cycle
- Reliable performance and assurance reporting

What the evidence indicates:

- **Alignment (in form):** governance mechanisms, safety learning plans/structures and audit activity are present, and performance/quality reporting exists.
- **Divergence (in effectiveness):** identified gaps in traceability, validation, action closure and risk quantification, and notes that evidence is often more reassurance-oriented than assurance-grade. Documentation gaps also reduce the visibility of decision-making and risk controls. Together, these factors limit the extent to which the system can demonstrate reliable delivery and learning impact against commissioned expectations.

F. Theme summary

Overall theme summary: Governance structures, learning activity and improvement intent are evident across the sample, but they do not yet provide consistently reproducible assurance that learning is translating into reliable day-to-day practice. This reflects wider system conditions including data maturity, information systems, documentation processes and operational pressure, rather than isolated individual or team failings. Improvement should focus on strengthening traceability, ensuring key decisions and risk controls are visible in the care record, and closing learning loops through clear ownership, measurable actions and evidence of impact.

Shanley Theme 6 – Oversight (external & system interface)

A. Why this is important

Interface reliability is a core safety mechanism. When access thresholds are unclear, contact routes are inconsistent or shared responsibilities are ambiguous, risk can accumulate in the gaps between services.

These issues reflect system functioning challenges shaped by demand, capacity, fragmented pathways, information systems and variation in local agreements, rather than intent alone.

Practical consequences when interface controls are inconsistent:

- **Increased risk of unclear responsibility:** When shared care arrangements vary and monitoring responsibilities are not consistently agreed, both patients and clinicians can be exposed to avoidable uncertainty in safety-critical processes.
- **Reduced continuity and trust:** Difficulty contacting teams and inconsistent feedback loops can erode confidence for service users, carers and referrers, and can weaken the therapeutic relationship.
- **Higher rework and avoidable escalation:** Rejected referrals without clear parameters for re-referral, or unclear interim plans, increase rework in primary care and can contribute to escalation into crisis pathways.
- **Assurance gaps for commissioners and boards:** Where evidence is not reproducible and KPI definitions are under-developed, oversight tends to rely on narrative reassurance rather than measurable, comparable assurance. This limits the ability to identify variation early and target support.

B. What was tested

This theme examined how reliably CMHTs operate at key interfaces and under external and system oversight. The review tested whether access, triage and escalation routes function consistently at the interface with primary care and partners; whether responsibilities for care, risk and monitoring are clear across organisational boundaries; and whether shared care and transition arrangements support safe continuity. It also assessed whether commissioning oversight provides a reliable line of sight to variation, risk and improvement, and whether information flows such as contact routes, feedback loops, discharge handovers and record visibility enable safe decision making.

The aim was to understand not only whether interface structures exist, but whether they operate consistently enough to support continuity, shared responsibility and timely escalation across the wider system.

C. What the evidence shows

Strengths:

- **Partnership intent and engagement exist:** There is active engagement with commissioners and partners and recognises examples of improvement infrastructure and transformation work underway.
- **Some advice routes and mitigations are in place:** The evidence notes that advice routes exist in parts of the system, and that operational mitigations (e.g., oversight mechanisms for unallocated cohorts) have been established to manage demand and flow pressures.

The wider stakeholder engagement survey provides quantifiable insight into interface reliability. Fifty-two individual stakeholders responded to the survey, with seventeen requesting follow up, ten participating in Teams meetings and two providing written submissions. All respondents were Manchester-based. The detailed version of the survey grouped responses into broader categories (e.g., combining multiple negative options), but the raw dataset provides more precise figures. Analysis of the raw data shows that forty six percent reported difficulty contacting CMHTs when needed, forty four percent reported inconsistent referral feedback, forty four percent reported low confidence in CMHT leadership, forty four percent described the interface culture as difficult or siloed, and forty two percent reported that CMHTs rarely or never listened to and acted on the voices of patients, families and carers. These indicators reinforce the qualitative evidence and highlight the practical

impact of inconsistent contact routes and unclear thresholds. All stakeholder data was provider supplied and was not independently verified.

Gaps and variation:

- **Access, thresholds and referral feedback are a dominant interface issue.** Stakeholder evidence, including a GP-weighted survey, describes referral rejections, limited explanation of rationale, and uncertainty about next steps. Several respondents described this as a "referral tennis" effect, in which referrals move between services without clear ownership of the next step. This reflects how the interface was experienced by those who responded rather than a measured referral-flow analysis.
- **Communication routes are experienced as inconsistent.** Service users finding it difficult to contact care coordinators and obtain timely updates. It also reports primary care experience of inconsistent duty lines and difficulty obtaining timely advice that fits primary care workflows.
- **Shared responsibilities and shared care are not consistently reliable.** The evidence identifies tangible safety signals at the interface where responsibility for monitoring specialist medicines and high-risk prescribing is unclear. It also notes that shared care protocols exist, but implementation and acceptance vary across primary and secondary care. In addition, Greater Manchester localities operate under different shared care agreements, creating variation in expectations and processes.
- **Transitions and discharge handovers show recurring reliability issues.** There is a link to interface risk to inconsistent discharge and transition planning and to fragmentation between inpatient and community systems that reduces visibility of discharge summaries, medication changes and risk updates.
- **Commissioning assurance is constrained by data maturity and KPI definition.** Contractual/performance information was not available in a form that would enable a full assessment against contractual expectations. It also notes that the current service specification and KPI framework were limited, which restricted the review's ability to draw conclusions where measures were not clearly defined.

D. Confidence

Confidence is moderate in the overall pattern. Multiple sources align that interface reliability, including access thresholds, communication routes, shared care responsibilities and transitions, is a recurring issue and a driver of pressure and risk.

E. Alignment with commissioned CMHT specification

The commissioned framework expects robust assessment and acceptance processes, reliable discharge and transition planning, visible joint working with primary care, social care and VCSE partners, and performance information that supports commissioner oversight.

What the commissioned framework expects:

- Assessment and acceptance processes are robust
- Discharge and transition planning aligns with best practice
- There is visible joint working with primary care/social care/VCSE, and advice where required
- Performance information is shared with commissioners
- Delivery aligns with the commissioned specification.

What the evidence indicates:

- **Partial alignment:** interfaces and oversight mechanisms exist (policies, shared care protocols, advice routes, governance forums), and there is evidence of active partnership intent.

- **Divergence in reliability and assurance:** stakeholder experience of variable access thresholds, inconsistent contact routes, and unclear shared responsibilities (especially around shared care monitoring) indicates that key interface controls do not operate consistently. There are also commissioning/KPI constraints that limit robust comparison against contracted expectations, reducing assurance.

F. Theme summary

Overall theme summary: Partnership intent and interface arrangements are evident across the system, but they do not yet operate consistently enough to provide reliable continuity, shared responsibility and assurance. Variation in access, communication, shared care, transitions and oversight reflects wider system conditions, including demand, capacity, fragmented pathways, information systems and local agreements, rather than individual intent or effort. Improvement should focus on learning from variation and strengthening clear, consistent controls for triage, escalation, contact routes, shared responsibilities, information flow and commissioning oversight, so that people and professionals can navigate boundaries with greater clarity and confidence.

Cross-Cutting Themes

The six thematic findings converge on four system conditions that most affect reliability: workforce capacity and skill mix, documentation quality, interface controls and the ability of governance to demonstrate impact.

Workforce capacity and skill mix remain the most significant determinants of reliability. National evidence has long identified workforce fragility, burnout and gaps in specialist roles as key risks to service quality and sustainability (NHS Benchmarking; Royal College of Psychiatrists; NIHR). The findings in Greater Manchester align closely with this picture. High vacancy levels, reliance on temporary staffing, gaps in medical and psychological roles and the emotional burden of sustained exposure to distressing presentations all reduce capacity for proactive, relational work. Even in areas with a stable core workforce, fragility in specialist roles and the operational impact of structural changes create pressure points that require compensatory mechanisms such as duty systems and extraordinary MDT processes. These mitigations support safety in the short term but are not sustainable substitutes for a stable, skilled workforce capable of delivering consistent, recovery-focused care.

Documentation and record keeping are major cross-system assurance gaps. National investigations have repeatedly emphasised the importance of clear, current and collaborative documentation in supporting safe care, effective transitions and reliable governance (NICE transitions guidance; HSSIB suicide risk assessment investigation; PSIRF learning expectations). The care record findings in Greater Manchester reflects these national concerns. Inconsistent recording of involvement, crisis planning, discharge planning and medication reviews, combined with limited translation of MDT decisions into structured fields, weakens the care record as a single source of truth.

Figure 6: From MDT discussion to governance assurance: the documentation chain



Fragmentation between inpatient and community systems further compromises continuity, particularly around discharge summaries, medication changes and risk updates. These gaps reduce governance visibility, constrain learning and make it harder to demonstrate safe, person-centred care in a reproducible way.

Interface reliability is a recurring theme across all evidence sources. National policy emphasises integrated pathways, shared responsibility for risk and seamless transitions between services (Community Mental Health Framework; NICE

transitions guidance). The findings in Greater Manchester show that these expectations are not yet consistently met. Primary care describes difficulty contacting teams, unclear thresholds, inconsistent referral feedback and limited access to senior clinical advice. Service users report challenges obtaining timely updates and understanding their care plans. Shared care responsibilities, particularly around high-risk medicines and physical health monitoring, are experienced as ambiguous, contributing to perceived risk transfer. Discharge and transition pathways are variable, with gaps in handover information and inconsistent follow up. These interface issues are structural rather than intentional, shaped by demand, capacity, pathway fragmentation and variation in local agreements.

Figure 7a: CMHT interface reliability: pathway and breakdown points

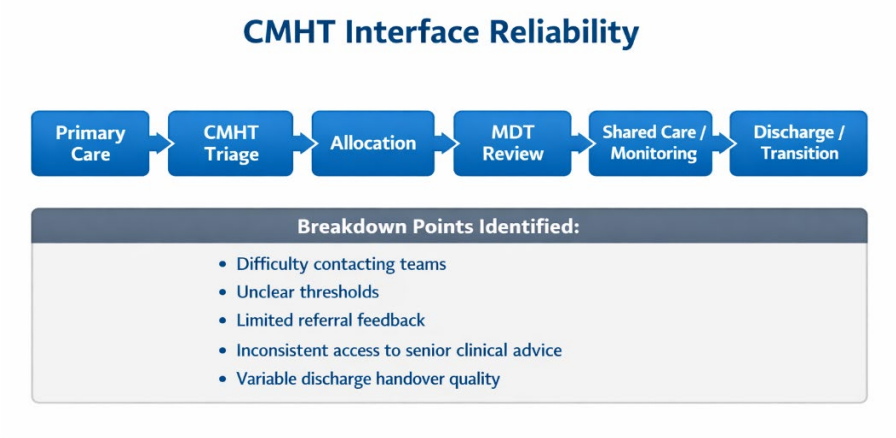


Figure 7b: Synthesis across the cross-cutting themes



Governance structures are active, with contemporary patient safety learning approaches, audit activity and improvement programmes in place. However, national reviews have shown that governance only becomes effective when learning is consistently translated into practice and when evidence is reproducible, traceable and visible (Francis; Mazars; Ockenden). The findings in Greater Manchester reflect this national learning. Much of the governance evidence was descriptive rather than assurance-grade, with limited audit trails and inconsistent closure of learning actions. Safeguarding demand is high, with repeat referrals common and delays evident in some

enquiries. These issues reduce the system's ability to identify variation early, quantify risk or demonstrate improvement over time, and they highlight the need for a more consistent, evidence-based assurance framework.

Together, these findings show that committed staff, leadership and partnership working are constrained by four connected system conditions: workforce fragility, inconsistent documentation, unreliable interfaces and limited assurance-grade evidence. The resulting risks are structural, predictable and best addressed through coordinated system-level action.

Moving from reassurance to assurance requires a coordinated, system wide response. National frameworks already set clear expectations: integrated pathways, strengthened clinical leadership, consistent risk processes, meaningful involvement and interoperable digital systems. Greater Manchester's improvement priorities align directly with these expectations. Strengthening workforce capacity and specialist skill mix is essential to stabilise allocation and create space for proactive, relational work. Documentation must be strengthened through concise, structured formats that reliably capture MDT decisions, risk formulations and transition plans, supported by progress toward interoperable digital systems. Interface controls need to be clarified and standardised, with clear triage expectations, reliable contact routes, shared care responsibilities and consistent discharge handover standards. Governance must shift from narrative reporting to reproducible evidence, with clear ownership, measurable actions and closed learning loops that demonstrate impact over time.

These changes are achievable. The foundations for improvement exist across Greater Manchester: committed leadership, active partnership working, visible transformation programmes and a workforce that continues to deliver under pressure. With coordinated action on workforce, documentation, interface reliability and governance, the system can move toward a more reliable, person centred and learning focused model of community mental health care that aligns with national expectations and provides the assurance that patients, carers and partners need.

Recommendations

The recommendations translate the six Shanley themes and four cross-cutting system conditions into high-leverage actions at provider, place and system level. They prioritise triage and thresholds, documentation, shared care and interfaces, allocation and continuity, workforce stability and learning capacity. Each recommendation includes a measure of success to support reproducible monitoring.

Shanley Theme 1: Voice of patients, families and carers

Area for Improvement	Involvement and carer engagement are variable and not consistently evidenced in records, limiting assurance that voice is embedded day-to-day.
Recommendation 1	Implement a standard involvement recording approach that captures patient involvement, consent boundaries, carer or support network involvement and planned re-engagement steps. Embed this within the care record as a routine, auditable requirement.
Level	Provider-level
Priority	High
Links to Other Themes	5: Governance and organisational learning
Risk or Assurance Gap Mitigation	Weak visibility of involvement; limited evidence of person-centred practice and shared decision making.
Measure of Success	Audit shows improved completeness of involvement fields; re-audit trajectory towards GM minimum dataset completeness.

Area for Improvement	Feedback mechanisms exist, but feedback to action is not consistently visible to patients, carers or governance.
Recommendation 2	Establish a simple You said / We did feedback loop at team level, published routinely and incorporated into governance reporting.
Level	Place-level
Priority	Medium-High
Links to Other Themes	5: Governance and organisational learning
Risk or Assurance Gap Mitigation	Reduced trust and weak demonstrability that voice shapes improvement.
Measure of Success	Quarterly publication of You said / We did outputs with evidence of action closure.

Area for Improvement	Carer identification and support are inconsistent and not reliably evidenced.
Recommendation 3	Standardise the carer offer and recording, including carer assessment offer, signposting and visibility of this information in the care record and dashboards.
Level	Provider-level
Priority	Medium
Links to Other Themes	6: Oversight
Risk or Assurance Gap Mitigation	Carers feel excluded; risk that key support needs are missed; weak assurance against commissioned expectations.
Measure of Success	Carer assessment offer ≥95% and completed assessments ≥60%.

Shanley Theme 2: Leadership

Area for Improvement	Triage and threshold decisions and senior clinical oversight are inconsistent, contributing to rework and reduced confidence at the interface.
Recommendation 4	Establish a GM wide triage and escalation model with defined senior clinical review for complex referrals and structured feedback for non-accepted referrals. Co-design with primary care to ensure operational fit.
Level	System-level
Priority	High
Links to Other Themes	1: Voice of patients, families, and carers; 6: Oversight
Risk or Assurance Gap Mitigation	Variable thresholds, unclear escalation routes, interface friction and perceived risk transfer. Improvement in system interface relationships and understanding of each other's pressures, risks and demands.
Measure of Success	Performance against proposed GM access standards; e.g., urgent ≥90% within 5 working days; routine ≥85% within 20 working days.

Area for Improvement	Operational grip on allocation and escalation is variable, with sustained unallocated cohorts in parts of the system.
Recommendation 5	Implement a consistent allocation and escalation model with defined review cadence, triggers for senior oversight and time bound management of unallocated cases.
Level	Place-level
Priority	High
Links to Other Themes	4: Workforce; 5: Governance and organisational learning
Risk or Assurance Gap Mitigation	Reduced continuity; unmanaged drift in risk or need; inequity of access to care coordination.
Measure of Success	Reduction in unallocated cohorts and sustained attainment of access and continuity measures with exception reporting.

Shanley Theme 3: Culture

Area for Improvement	Learning culture and psychological safety are stretched by workload; structured debrief and reflective practice are not consistently experienced.
Recommendation 6	Implement a minimum culture support offer including routine debrief or learning huddles, protected reflective practice time and consistent wellbeing access. Ensure inclusion of administrative and front door roles exposed to distressing contact.
Level	Provider-level
Priority	Medium
Links to Other Themes	4: Workforce; 5: Governance and organisational learning
Risk or Assurance Gap Mitigation	Reduced learning capacity, burnout, turnover and inconsistent adoption of improvement.
Measure of Success	Evidence of delivery: scheduled learning huddles/debriefs + attendance; supervision compliance (≥90% where used as a governance measure); staff feedback indicators tracked over time.

Shanley Theme 4: Workforce

Area for Improvement	Vacancy pressure and skill-mix gaps constrain continuity, timely review, proactive care and documentation reliability.
Recommendation 7	Deliver an evidence led workforce stabilisation plan focused on high impact roles such as medical, psychology and occupational therapy, and continuity critical posts, with clear retention and recruitment actions.
Level	Provider-level
Priority	High

Links to Other Themes	2: Leadership
Risk or Assurance Gap Mitigation	Reactive operating model, reduced continuity, delays in review and variable quality.
Measure of Success	Improvement in vacancy and turnover rates in priority roles, reduction in unallocated cases and improved documentation completeness on re-audit.

Area for Improvement	Variation in practice and documentation is amplified where temporary staff are used without consistent induction or supervision.
Recommendation 8	Strengthen induction and supervision for bank and agency staff, including SOP coverage and escalation routes, with monitoring through governance.
Level	Provider-level
Priority	Medium-high
Links to Other Themes	2: Leadership; 5: Governance and organisational learning
Risk or Assurance Gap Mitigation	Inconsistent practice, reduced assurance and continuity risks when staff change.
Measure of Success	Supervision compliance (≥90% where used as a governance measure); documentation quality improvements demonstrated through audit cycles.

Shanley Theme 5: Governance & organisational learning

Area for Improvement	Governance activity exists, but evidence is not consistently assurance-grade and learning loops are not always evidenced as closed.
Recommendation 9	Implement structured thematic learning cycles with named owners, time bound actions and mandatory re audit. Track progress from theme to action to completion evidence to impact check.
Level	System-level
Priority	Medium-high
Links to Other Themes	3: Culture
Risk or Assurance Gap Mitigation	Activity without impact; recurrence risk; limited demonstrability of improvement.
Measure of Success	Quarterly learning cycles with documented action closure and re-audit evidence.

Area for Improvement	The care record does not consistently function as a single source of truth, limiting continuity and board-level assurance.
Recommendation 10	Implement an EPR embedded minimum dataset including care plan, risk formulation, crisis plan, named contacts and discharge minimum fields, with routine audit and feedback.

Level	Provider-level
Priority	High
Links to Other Themes	1: Voice of patients, families and carers; 6: Oversight
Risk or Assurance Gap Mitigation	Poor continuity, weak auditability and limited assurance-grade visibility of rationale and controls.
Measure of Success	≥95% active caseload with risk formulation and crisis plan; ≥95% discharges with minimum fields.

Shanley Theme 6: Oversight (external/system interface)

Area for Improvement	Shared care responsibilities and monitoring are variable, creating uncertainty and safety risk at the interface.
Recommendation 11	Agree GM-wide shared care protocols and SLAs, supported by commissioned monitoring capacity where required. Ensure interim plans are issued when responsibility cannot transfer.
Level	System-level
Priority	High
Links to Other Themes	5: Governance and organisational learning
Risk or Assurance Gap Mitigation	Unclear responsibility, missed monitoring, risk transfer and inconsistent handovers.
Measure of Success	Shared care SLAs achieved: acknowledge within 2 working days and accept or provide feedback within 10 working days.

Area for Improvement	Commissioning oversight is constrained by limited KPI maturity and inconsistent reproducible reporting.
Recommendation 12	Adopt a concise GM wide set of core standards and a reproducible reporting specification, with routine place and team dashboards and escalation triggers for sustained under performance.
Level	System-level
Priority	Medium-high
Links to Other Themes	5: Governance and organisational learning
Risk or Assurance Gap Mitigation	Over-reliance on narrative reassurance; delayed escalation and inability to compare variation reliably.
Measure of Success	GM dashboard published monthly; quarterly deep dives and annual validation sampling.

Cross-system synthesis

Area for Improvement	A sample-based review requires a mechanism to test applicability and seek assurance across all CMHTs without assuming uniform generalisation.
Recommendation 13	Commissioners should require providers to QA each CMHT against these recommendations, identifying applicability, existing evidence, and time-bound action plans where gaps remain. Feed outputs into the existing mental health programme plan.
Level	System-level
Priority	Medium
Links to Other Themes	All themes
Risk or Assurance Gap Mitigation	Uneven adoption, blind spots beyond the sample and inconsistent assurance across GM.
Measure of Success	Completion of QA reviews across CMHTs with documented evidence, action plans and follow up audit where required.

Area for Improvement	Variation persists without a practical mutual support mechanism when teams fall below core standards.
Recommendation 14	Activate a Provider Collaborative mutual aid mechanism when core KPIs fall below threshold for sustained periods, with defined recovery trajectories and closure criteria.
Level	System-level
Priority	Medium
Links to Other Themes	4-6
Risk or Assurance Gap Mitigation	Prolonged under-performance; delayed stabilisation and continued risk exposure.
Measure of Success	Mutual aid activation record; recovery trajectories; sustained return to core standards.

Together, the recommendations provide a coordinated route to stronger reliability, continuity and assurance. Their impact depends on providers, places and system partners implementing the mutually reinforcing changes to workforce, documentation, interfaces and governance.

Evaluation Tool and Future Assurance

The CMHT Evaluation Tool has been issued to NHS Greater Manchester as a separate, reusable assurance instrument. Organised around the six Shanley themes, it combines quantitative and qualitative evidence, defined metrics, standardised scoring and a dashboard to identify variation and track improvement. Providers can use it to assess individual CMHTs, places to understand locality patterns and the ICB to support system-wide assurance. It can be refined as data maturity and the GM CMHT specification develop.

Conclusion

The evidence points to one central requirement: CMHT care must become reliably reachable, coordinated and visible in the record. Achieving that requires consistent system controls for access, allocation, communication, risk and crisis planning, shared care and transitions, supported by sustainable workforce capacity and reproducible assurance.

Leadership accountability in this context is not about blame. It is about grip and support. Leaders at provider and place level must be able to answer simple questions with confidence: Who is holding risk today? How many people are unallocated? Are escalation routes working? Can we evidence involvement, crisis planning and transitions in the record? Are we closing learning loops from incidents, complaints and feedback? Where the answer is unclear, leadership responsibility is to simplify, standardise and follow through, so that safe practice is not dependent on local workarounds. The recommendations in this report are designed to support that shift by focusing on a small number of high leverage system controls.

These challenges do not sit with one organisation alone. CMHT reliability is shaped by system interfaces and commissioning conditions. It depends on shared expectations for thresholds and triage, clear shared care responsibilities, workable discharge and transition standards and data that supports assurance rather than narrative reassurance. It also depends on realistic capacity, including workforce stabilisation and the ability to provide timely monitoring and support across boundaries. Commissioners and system partners therefore have an active role: setting consistent standards, requiring reproducible reporting and ensuring that improvement is supported and sustained across all localities, not only within the teams sampled in this phase. This reflects national learning from Francis, Mazars and Ockenden, which emphasise the importance of system-level oversight and consistent expectations.

This review has been written in a learning spirit. The aim is to help the system act with clarity and purpose. The core message is simple and compassionate: people should be able to depend on CMHT care being reachable, consistent and safe, and staff should be able to depend on systems that support good practice rather than obstruct it. The findings are intended to support honest reflection, shared ownership and practical improvement, not to attribute blame.

Overall assurance and confidence

Overall assurance is partial. The evidence base supports a clear set of cross cutting system signals, but it also shows inconsistent reliability in key processes and gaps in assurance-grade evidence. Confidence is moderate where themes recur across multiple independent sources, and lower where evidence is constrained by access, engagement or data reproducibility. In several areas, the issue is not that controls are absent, but that they are not yet operating consistently enough to provide reliable assurance.

What the findings can and cannot be relied on for

This report can be relied upon to describe the main themes affecting safety, quality, experience and assurance in the sample and to support proportionate improvement planning. Alignment across multiple evidence sources and with wider national learning strengthens confidence in the recurring system signals. It cannot support performance management or definitive conclusions about every CMHT; providers and commissioners should test applicability locally through further triangulation and quality assurance.

In short, the system now needs to move from describing activity to demonstrating reliability. If that shift is made, through clearer standards, stronger interface working and evidence that learning has been embedded, Greater Manchester can build a CMHT offer that is safer, more consistent and more trusted by the people who rely on it.

Overall assurance remains partial: the system has clear strengths and active improvement work, but key processes are not yet operating consistently enough to provide high assurance.

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Appendix 1: ICB Commissioner Response to Independent CMHT Review

November 2026

Part of Greater Manchester Integrated Care Partnership

ICB Commissioner Response to Independent CMHT Review

1. Overall position

NHS Greater Manchester welcomes the publication of the Independent Community Mental Health Team Review and accepts the recommendations set out within the report. The review provides an independent assessment of the challenges facing community mental health services and reinforces the need to reduce unwarranted variation, improve consistency, and strengthen assurance across Greater Manchester. The findings align closely with issues already recognised by the Integrated Care Board (ICB), including variation in access arrangements, triage and threshold decision-making, continuity of care, clinical oversight, shared care arrangements, risk management, and assurance.

The review validates the strategic direction already underway through the Greater Manchester Community Mental Health Transformation Programme and the wider ambition to deliver integrated neighbourhood-based models of care. It highlights the need to move beyond pockets of good practice towards a more consistent, reliable, and standardised model of community mental health care across all localities.

In response, the ICB will use the review findings to strengthen delivery of the GM Community Mental Health Service Specification, which will serve as the primary mechanism for translating the review recommendations into clear commissioning expectations, minimum standards, intended outcomes, and assurance requirements across Greater Manchester. Through the specification, the ICB will establish a consistent approach to access, continuity of care, shared care, neighbourhood delivery, outcomes measurement, and assurance, while maintaining appropriate flexibility to reflect local population needs and neighbourhood arrangements.

Alongside this, the ICB will work with providers through a programme of co-design and system improvement planning aligned to exist Community MH Transformation, to agree priorities, implementation actions, and measurable outcomes. This will ensure that review recommendations are translated into practical service improvements and embedded through commissioning, performance oversight, and continuous quality improvement arrangements.

NHS Greater Manchester has also identified the need to ensure resilient and sustainably staffed Community Mental Health Teams across Greater Manchester Mental Health NHS Foundation Trust (GMMH) and Pennine Care NHS Foundation Trust (PCFT) within its emerging commissioning intentions for 2027/28. In particular, for GMMH this will support the incorporation of requirements arising from the recent Section 29A Notice and strengthen assurance regarding workforce capacity, service quality, and delivery.

2. Standardisation through the GM Community Mental Health Service Specification

The review will directly inform the final specification so that commissioner expectations are aligned to the areas identified for improvement, and providers are clear about what must be delivered, what evidence is required and how delivery will be assured.

The specification will establish one set of expectations for community mental health services across GM. It will provide clarity and consistency across:

- access arrangements, inclusion criteria, triage and clinical decision-making;
- continuity of care, shared care responsibilities and personalised care planning;
- family and carer involvement, clinical oversight, governance and organisational learning;
- outcome measurement, assurance, partnership working and integrated neighbourhood-based delivery.

3. National policy and best practice alignment

The GM model outlined in the specification is informed by national policy and best practice. The specification supports the ambitions of the NHS 10-Year Health Plan, particularly the move from hospital to community, and aligns with the Community Mental Health Framework for Adults and Older Adults, the Mental Health Personalised Care Framework and relevant learning from GIRFT Adult Crisis and Acute Mental Health.

This means the GM model is built around place-based and neighbourhood care, whole-person and whole-population approaches, personalised care and support planning, improved re-access when needs change, stronger clinical oversight, better use of data and reduced unwarranted variation.

4. Commissioner ask, data and assurance

The commissioner ask is for providers to demonstrate delivery of the outcomes set out within the GM Community Mental Health Service Specification. These outcomes are: improved access and timeliness; improved continuity and coordination of care; personalised and neighbourhood-based care; better outcomes and experience; reduced inequalities; reduced crisis escalation; improved system flow; and reduced unwarranted variation across Greater Manchester.

Providers will be expected to evidence delivery through an agreed framework of performance, quality, outcome and experience measures, alongside assurance regarding clinical oversight, governance, care coordination, shared care, co-production, workforce sustainability and partnership working.

The Contract Review Meeting (CRM) will be the primary mechanism for commissioner oversight, assurance and performance review. Through the CRM process, providers will be expected to demonstrate progress against the service specification outcomes, review performance against agreed measures, provide assurance regarding quality and governance arrangements, identify areas of variation, and agree improvement actions where required. The CRM will also provide a formal route for monitoring delivery of recovery plans, sharing learning and evidencing continuous improvement.

Key data requirements will be aligned to the service specification outcomes and will include:

- **Access and timeliness:** referral volumes, referral outcomes, waiting times, first clinical contacts, urgent and routine access standards, and activity levels
- **Continuity and coordination of care:** allocated and unallocated caseloads, care coordinator allocation, named key worker coverage, care plan reviews, step-up and step-down activity, and transition and discharge follow-up measures.
- **Personalised and neighbourhood-based care:** co-produced care plans, DIALOG+/outcomes-based care planning, physical health checks, and referrals to community, VCSE, social care and primary care support.
- **Outcomes and experience:** patient-reported outcome measures (PROMs), patient experience measures, recovery outcomes, length of stay and wider social outcomes.
- **Reducing inequalities:** access, experience and outcome measures segmented by demographic characteristics and underserved populations.
- **System flow and integration:** transitions between services, partnership working across primary care, community mental health, social care and VCSE services, and evidence of effective neighbourhood multidisciplinary team working.
- **Workforce and delivery capacity:** workforce vacancies, turnover, workforce development and training indicators.

This will be supported through the Community Mental Health Outcomes Framework, the Community Mental Health Data Quality Improvement Plan, provider performance reporting and the planned GM Community Mental Health Dashboard. Together, these arrangements will support a consistent approach to performance monitoring, assurance and service improvement through the CRM process across Greater Manchester.

5. Linking recommendations to delivery and progress already made

It is important to also note that GM has not stood still while the review has taken place. The recommendations will build on progress already underway and strengthen consistency, scale and assurance. The table below outlines the Shanley themes and areas of progress.

Review Theme	Progress
Patient, family and carer voice	The GM Mental Health Personalised Care Framework is being implemented across services, supported by the rollout of DIALOG+ and outcomes-focused care planning. Co-production is increasingly embedded within service design, governance and improvement activity, while neighbourhood-based models are strengthening partnerships with people, families, carers and local communities to ensure support is shaped around what matters to individuals
Access, triage and clinical oversight	Localities have been testing and implementing more consistent front-door arrangements, triage models and "no wrong door" approaches to simplify access and reduce duplication. Work is also underway to improve clinical oversight, strengthen risk management processes and ensure people are directed to the most appropriate level of support earlier, including through neighbourhood mental health teams and strengthened interfaces with primary care.
Continuity of care, allocation and workforce resilience	A range of initiatives are already improving system flow and supporting more effective use of specialist community mental health capacity. This includes active management of unallocated CMHT caseloads, immediate stabilisation actions in response to identified risks, strengthened oversight of care coordination, embedding of Neighbourhood MH Teams (NHMTs) and work to ensure people can move more effectively between different levels of support. These changes are helping specialist teams focus on people with the most complex needs while improving continuity and reducing the risk of people falling between services.
Learning culture, staff support and reflective practice	Provider improvement work and staff support mechanisms, with learning from the review informing wider transformation and assurance conversations.
Governance, assurance and organisational learning	Significant work is underway to strengthen the quality and consistency of assurance arrangements. This includes development of the Community Mental Health Outcomes Framework, Data Quality Improvement Plan, routine outcome and experience measures. The new Community Mental Health Service Specification and Contract Review Meeting (CRM) process will provide a clearer and more consistent framework for ongoing performance monitoring, assurance and improvement.
System interfaces, shared care and neighbourhood integration	The Shared Care Programme, GM Live Well programme, NHMTs and improvements to specialist service interfaces are already driving closer integration across primary care, community mental health, VCSE and wider neighbourhood services. These developments are supporting earlier intervention, more joined-up care and a stronger focus on delivering support through neighbourhood-based multidisciplinary teams.

6. Immediate priorities, risks and commissioning implications

Immediate priorities include strengthening clinical oversight and decision-making, delivering greater consistency in triage and access arrangements, improving continuity and coordination of care, accelerating Shared Care implementation, embedding neighbourhood-based delivery models, and strengthening assurance, governance and organisational learning across Greater Manchester.

The mitigation approach will be anchored in the GM Community Mental Health Service Specification and the current system-wide gap analysis. The gap analysis will assess how current delivery aligns with the new specification, identify unwarranted variation, and clarify where service, pathway, workforce, capability, infrastructure or resource gaps may affect delivery of the required standards and outcomes.

Alongside the gap analysis, the ICB will work collaboratively with Mental Health Trusts, locality partners, people with lived experience and wider stakeholders to co-design a set of System Improvement Priorities arising from the review findings. This process will ensure that improvement efforts are focused on areas of greatest impact, informed by operational experience and aligned to local and Greater Manchester priorities.

The intention is not to establish a separate programme of work in response to the review. Rather, the findings will be used to strengthen, accelerate and coordinate delivery of existing Community Mental Health Transformation priorities and programmes. This includes implementation of the GM Community Mental Health Service Specification, Shared Care, neighbourhood mental health services, personalised care approaches, outcomes-based commissioning, quality improvement and strengthened assurance arrangements.

The outputs from the gap analysis and Strategic System Improvement Priority process will inform a prioritised implementation plan, provider improvement plans, future commissioning intentions and, where appropriate, investment decisions. This will provide a clear line of sight between the review recommendations, commissioner expectations, provider improvement activity and long-term transformation ambitions.

Risks will be managed through existing programme governance arrangements and monitored through commissioner assurance processes. Particular focus will be given to risks relating to patient safety, quality of care, workforce capacity, access, continuity, variation in delivery and implementation confidence. Escalation routes will be utilised where progress or assurance falls below expected standards, with a continued emphasis on shared ownership of improvement across commissioners, providers and system partners.

7. Delivery timeline and commissioning intentions

The Adult Community Mental Health Transformation Plan will set out milestones, assurance checkpoints and sequencing for implementation through the Service Specification and associated programmes. The current phase focuses on finalising the specification, completing the system-wide gap analysis process and implementation plan, confirming minimum standards, refining data requirements and aligning existing programme delivery to the review recommendations. Subsequent phases will focus on implementation at scale, evaluation, outcome and experience data, investment priorities and commissioning intentions.

8. Conclusion

The review provides an assessment of the challenges and opportunities facing community mental health services across GM. The priority is to move from variation towards consistency; from assurance based mainly on activity to assurance based on quality, outcomes and experience; and from individual transformation initiatives towards a coherent GM model aligned to national policy and best practice. Through the Service Specification, Outcomes Framework, Data Quality Improvement Plan, dashboard development and existing governance, the ICB will strengthen commissioner expectations, data, assurance and implementation to improve access, continuity, experience and outcomes for people, families and carers.

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People & Resource Committee Report

18 November 2026

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

18 November 2026

Required information	Details
Title of report	People & Resource Committee Report
Author	Ross Baxter, Governance Advisor
Presented by	Kal Kay, Non-Executive Director/ Chair of People & Resource Committee
Contact for further information	Kal Kay, Non-Executive Director/ Chair of People & Resource Committee
Executive summary	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The Board is asked to: • Note the contents of the report and provide feedback to the Committee Chair.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
Key milestones	N/A
Leadership and governance arrangements	Overview of discussions at the People & Resource Committee
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A
Financial or Legal Implications	N/A

Table 1 - core information relating to the content and creation of paper

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

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

NHS
Greater Manchester

Report from:	**People & Resource Committee**
Date of Meeting:	September 2026
Chair:	Kal Kay
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
Single Accelerated Recovery Plan - The Committee received an update from Kathy Roe regarding the organisation's financial recovery arrangements and the need for a more coordinated approach to delivering financial balance during the remainder of the financial year. Members were advised that, whilst a significant number of recovery actions were already underway across the organisation, these were currently being managed through a variety of programmes and workstreams. To strengthen oversight, accountability and transparency, it was proposed that all recovery activity should be brought together within a single accelerated recovery plan to be presented to the Board in October. The proposed plan would consolidate financial recovery actions into one framework, clearly identifying senior responsible owners, delivery timescales, dependencies, risks and expected benefits. Members noted that the intention was to provide a comprehensive view of the organisation's recovery programme, support more informed discussions regarding risk appetite and decision-making, and ensure that recovery actions remained aligned with quality, safety and operational priorities. The Committee heard that discussions with NHS England had reinforced the importance of demonstrating a credible and robust recovery plan and that whilst regulators recognised the scale of challenges facing Greater Manchester, there remained a strong expectation that the ICB should continue to pursue financial balance. Members were informed that the accelerated recovery plan would provide an opportunity for Board members to assess whether additional actions were required and to consider the level of risk that the organisation was prepared to accept in pursuit of its financial objectives. It was emphasised that recovery could not be viewed solely through a financial lens and that quality, safety and performance considerations would need to remain central to all decision-making. The Committee supported the proposal and agreed that the development of a Single Accelerated Recovery Plan represented an important next step in strengthening organisational oversight and delivery. The Committee subsequently agreed that the establishment

of the recovery plan should be highlighted to the Board as a key area of escalation and assurance.

Elective Recovery - The Committee received a detailed update on elective recovery performance as part of the wider reform, operational and financial discussions. Members were advised that elective recovery remained under significant pressure, particularly as a consequence of ongoing industrial action affecting the Northern Care Alliance. The Committee heard that extensive analysis had been undertaken to assess the impact of industrial action on activity levels and waiting lists, with officers reporting that disruption had resulted in a substantial increase in the number of patients awaiting treatment above existing recovery trajectories. Members noted that, despite extensive efforts to mitigate the impact through additional capacity and recovery initiatives, industrial action continued to present a significant challenge to achieving planned levels of elective performance.

The Committee discussed the extensive system-wide work being undertaken to support recovery, including mutual aid arrangements between provider organisations. Members were advised that Greater Manchester providers had demonstrated a strong commitment to supporting the recovery effort and that partner organisations were offering theatre capacity and treatment opportunities where available. Particular reference was made to examples of providers taking additional activity from the Northern Care Alliance to support waiting list reductions. However, members noted that the effectiveness of mutual aid arrangements was constrained by a number of factors, including uncertainty regarding future industrial action, capacity planning challenges and patient choice. The Committee heard that only a relatively small proportion of affected patients were willing to accept treatment at alternative provider organisations, with socio-economic factors, travel distances and patient preference all influencing uptake.

Members also considered the financial and operational consequences of elective underperformance. Whilst lower-than-planned elective activity was generating a short-term contract underspend for the ICB, officers stressed that this could not be regarded as a financial benefit as it directly undermined Referral to Treatment (RTT) recovery ambitions and would increase future performance risk. The Committee received assurance that providers remained expected to deliver the activity levels agreed within their contracts and noted that work was continuing with NHS England, providers and system partners to support recovery wherever possible. Members agreed that elective recovery continued to represent a significant strategic risk for the organisation and supported its inclusion within wider discussions regarding the Single Accelerated Recovery Plan and Board assurance arrangements.

Pulse Survey - The Committee received a comprehensive update from Charlotte Bailey on the findings of the first staff Pulse Survey undertaken following organisational reform. Members noted that 482 colleagues had responded to the survey, representing approximately 36% of the workforce. Whilst the response rate

was acknowledged as lower than desired, the Committee recognised that the survey provided an important baseline assessment of staff experience following a prolonged period of organisational change. Members heard that the survey followed the national NHS Pulse Survey methodology and would complement the findings of the forthcoming national NHS Staff Survey.

Whilst the committee discussed the results in detail, it was agreed that the national staff survey results expected in February would provide a fuller basis for assessing whether current actions were having an impact. Therefore, the committee agreed that this should be referenced publicly as an alert, with the fuller survey results and context brought alongside the national staff survey results to a future meeting.

Advise

Deconstructing Block Contracts – The Committee received a detailed presentation on the Deconstructing Block Contracts programme, which was described as a significant element of the organisation's strategic commissioning agenda and a key component in improving understanding of how resources are deployed across the system. Members were advised that the work formed part of a national programme aimed at increasing transparency regarding the relationship between activity, funding and outcomes following several years of block-contracting arrangements introduced during and after the COVID-19 period. The Committee noted that Greater Manchester had been exploring this agenda ahead of national requirements and was now in a position to undertake a far more detailed assessment of what services were being commissioned, how funding was being allocated, and whether resources reflected actual levels of activity and demand. This work represented a substantial step forward in developing the organisation's strategic commissioning capability and would play an important role in future planning and commissioning decisions.

The committee agreed that a Board Development Session on this area of work should be arranged.

Climate Change Adaptation Plan - The Committee received a presentation on the Greater Manchester Climate Change Adaptation Plan. Members were advised that the Adaptation Plan had previously been considered by the Strategic Commissioning Committee and was now being presented to the People and Resources Committee as the final stage of the governance and approval process. The Committee noted that the plan represented a system-wide response to the growing risks associated with climate change and was intended to support resilience across both NHS Greater Manchester and its partner organisations. Members heard that the work extended beyond responding to recent periods of extreme weather and reflected a broader recognition, both nationally and locally, that health and care systems must now

prepare for summer-related pressures with the same level of focus traditionally given to winter planning.

The Committee welcomed the work undertaken to develop the plan and recognised the increasing significance of climate resilience for NHS organisations and the populations they serve. Members noted that the Adaptation Plan provided an important framework for improving preparedness for climate-related risks and strengthening system resilience over the longer term. Subject to the inclusion of appropriate references to affordability and implementation within available resources, the Committee supported the Climate Change Adaptation Plan and endorsed its progression as the agreed system-wide framework for climate adaptation across Greater Manchester.

Committee Approvals – The Committee approved;

- **Lone Working Policy** - In response to issues raised, it was agreed to review and further refine the sections of the policy relating to home working and lone working assessments to ensure that they remained proportionate, legally compliant and practical for staff to implement. Members were advised that any revisions, together with any amendments resulting from completion of the Equality Impact Assessment process, would be circulated for final review. The Committee agreed to delegate authority to approve the final amendments, subject to consultation with the Chair, and subsequently approved the Lone Working Policy subject to those revisions being incorporated. Members welcomed the development of the policy and recognised its importance in strengthening organisational health and safety arrangements whilst ensuring that implementation remained realistic and proportionate for staff operating in a modern hybrid working environment.
- **Freedom to Speak Up Policy** - Having considered the report and received the requested assurances, the Committee agreed to approve the revised Freedom to Speak Up Policy, subject to completion of the Equality Impact Assessment process. Members further approved the delegation of authority to the Associate Director of Corporate Services, in consultation with the Chair, to make any amendments required as a consequence of the final EIA review. The Committee noted the policy and its associated implementation arrangements and welcomed the continued organisational focus on promoting an open, transparent and supportive speaking up culture.

Assure

GM Month 5 Financial Position - The Committee received the Month 5 Finance Report which outlined the organisation's financial position and forecast for the year. Members noted that the ICB remained on plan at Month 5 and was reporting a balanced position against its agreed financial plan. However, the Committee was advised that this headline position masked a significant level of underlying operational and financial risk, requiring continued and intensive management action

throughout the remainder of the financial year. Members were informed that substantial work was underway to maintain financial balance and that a significant number of recovery actions were already being implemented across the organisation.

Contract Financial Performance Report - The Committee received the Contract Financial Performance Report which provided an overview of contract activity and expenditure against plan across key service areas. Members were advised that the report was based on Month 4 activity data and demonstrated that, overall, acute expenditure remained broadly in line with plan. However, officers emphasised that a number of significant variances existed beneath the headline position and would require close monitoring throughout the remainder of the year. It was noted that contract performance and financial performance could not be considered in isolation, as any financial benefits arising from reduced activity could have wider implications for operational performance, particularly in relation to elective recovery and waiting time targets.

Chief Officers' Update Reports – The Committee continued to receive reports from the three portfolios, namely Strategy, People & Partnerships, Reform and Improvement, and Finance. These reports are undergoing continual improvement in order to best serve the committee and ensure the appropriate assurances are given. This includes Workforce Reports, Digital & IT Reports and Finance Reports that will form part of the regular Chief Officer updates.

Mersey Internal Audit Reports – The Committee received;

- **Data Quality** - The Committee received an update on progress against the recommendations arising from the MIAA Data Quality Audit. Members were advised that addressing the findings of the audit had been prioritised and that work was now progressing at pace following a period in which the issues had remained unresolved. The Committee heard that the organisation had been aware of a number of the underlying data quality challenges for more than twelve months and that significant focus had been directed over the preceding three months towards implementing the agreed management actions and accelerating delivery of the required improvements.

  Members welcomed the progress reported and emphasised the importance of demonstrating continued movement against the audit recommendations through future reporting. Members requested that subsequent updates provide clear visibility of outstanding actions, milestones and evidence of delivery, mirroring the enhanced audit-action reporting approach adopted elsewhere within Committee reports. The Committee received assurance that appropriate action was underway, acknowledged the progress that had been made in recent months, and agreed that ongoing monitoring would continue until all

recommendations had been satisfactorily implemented and the associated risks had been reduced.

- **Cyber Security -** The Committee received an update on the findings and management response to the MIAA Cyber Security Audit. Members were advised that the cyber security review had previously been considered by the Audit Committee and that the resulting audit opinion had highlighted a significant level of organisational risk. However, officers emphasised that the findings had provided a clearer understanding of the challenges facing the organisation and created an opportunity to develop a more focused and structured improvement programme.

  The Committee received assurance that appropriate management action was underway, acknowledged the importance of the risks identified through the audit, and supported the ongoing implementation of the cyber security improvement programme. Members requested continued reporting on progress and agreed that the item should remain subject to regular monitoring until sufficient assurance could be provided that the identified risks had been substantially reduced and the audit recommendations fully implemented.

Risks discussed and new risks identified

Risks will be highlighted through Chief Officer updates, and any updates provided in this section.

Learning for sharing

There were no specific points of learning from the meetings.

NHS
Greater Manchester

Report from:	**People & Resource Committee**
Date of Meeting:	28 October 2026
Chair:	Kal Kay
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
Board escalation — level of assurance: The Chair raised concerns about the level of assurance provided relating to Digital and IT. It was agreed that this should be escalated to the Board for appropriate oversight and further consideration. **Financial sustainability:** The Committee approved the Financial Recovery Plan and roadmap to financial balance for 2026/27, noting £89m of gross financial risk, £17.6m of operational recovery actions, £27.8m of identified mitigations and a further £43.6m of mitigations required. Although the plan forecasts breakeven, risks and opportunities could result in a £30m deficit or surplus. Delivery must protect safety, quality and outcomes while meeting operational performance requirements. **Efficiency delivery and funding:** Full-year delivery of the Cost Improvement Programme (CIP) remains high risk, with £23.7m reported at risk. Deficit support funding remains subject to clawback if financial balance is not achieved. Prescribing, All Age Continuing Care, mental health packages and attention deficit hyperactivity disorder (ADHD)/autism continue to create significant pressures. **Workforce capacity:** Vacancies, increased sickness absence and hard-to-fill cyber-security and IT posts continue to affect capacity and delivery, including implementation of audit recommendations. Priority recruitment and redistribution of resources remain under Chief Officer review.
Advise
Population Health transformation: The Committee approved expenditure of £39 million over five years, from 1 April 2027 to 31 March 2032, under the NHS GM Financial Scheme of Delegation. The proposed model transfers delivery of a range of population health programmes to the Greater Manchester Public Health Network, through secondment of most Population Health staff and pooling of existing resources. A Section 75 Agreement will support the arrangement, with statutory

responsibilities remaining with the ICB. Staff engagement and formal consultation will take place before implementation.

Operating model and workforce: Approximately 100 recruitments were in progress, with priority vacancies considered through business continuity arrangements. The operating-model review will continue through 2027–28, assessing resource distribution, shared capacity and gaps. Members requested clearer presentation of risk trends and mitigating actions.

Mandatory training: The reported reduction in compliance partly reflected introduction of a conflicts-of-interest module. Concerns were raised about completed training not being recorded and availability of safeguarding training. The Chair requested inclusion of non-executive directors in future Level 3 safeguarding training.

Digital and IT: Funding was confirmed for an initial replacement of end-of-life equipment, with a longer-term refresh programme still required. Following its oversight discussion, the Committee supported continued development and refinement of the Greater Manchester Health and Care Digital Strategy, further stakeholder engagement, benefits baselining and progression through the proposed approval process. Governance, resources, accessibility, national interoperability and delivery accountabilities require further development.

Contract performance: Elective expenditure was £10.2m below plan, with the underspend expected to reduce as activity increases. Urgent and emergency care expenditure was £1.2m above plan, reducing to £0.2m following contractual adjustments. Mental health expenditure was £8m above plan year to date, mainly relating to Section 117 costs and learning disability and autism placements. ADHD and autism services were £3m overspent, largely due to Right to Choose providers. Contractual options, including Activity Management Plans, were being considered.

Committee workplan: The workplan will be reviewed and rebalanced following removal of the December meeting. Confirmation is required of which subgroups are operational and how their activity will be reported, addressing gaps in visibility of subcommittee activity.

Performance: The Performance Report was noted for information.

Assure

Month 6 financial position: NHS GM remained in line with its breakeven plan, including £17.7m of deficit support funding. Efficiencies of £77.0m had been delivered, £4.6m ahead of the year-to-date target. Quarter 3 deficit support funding

had been confirmed, subject to the continuing year-end risk described above.

Financial oversight: Enhanced financial controls remain in place. Chief Officers and the Committee continue oversight of the financial position, CIP delivery and the approved Financial Recovery Plan, with monthly reporting and further work to understand and manage shared provider risks. The Committee noted the additional investment required, the proposed joint package reviews and wider benefits realisation, with safety, quality and outcomes to be protected throughout delivery.

Population Health governance: The transformation proposals had undergone due diligence and received Chief Officer support. The Section 75 Agreement is progressing through relevant NHS GM and local authority governance processes; statutory responsibilities will remain with the ICB.

Continuity and recruitment: Delayed senior appointments continue to be managed through consistent interim arrangements. Recruitment to the Emergency Preparedness, Resilience and Response (EPRR) team was progressing, with the team expected to be fully staffed the following week and one remaining post being recruited. These are actions in progress, not confirmation that the underlying risks have been resolved.

Risks discussed and new risks identified

Financial delivery: The Committee discussed the financial run rate, delivery of the full CIP, reliance on mitigations and potential clawback of deficit support funding. Shared provider pressures require continued monitoring. Cash drawdown remained above the national profile, with a closing balance of £0.72m. Capital funding of £20.1m was reported against forecast expenditure of £20.9m.

Workforce and operational resilience: Vacancies, sickness absence, delayed senior appointments and specialist recruitment difficulties remain risks to organisational capacity. Members questioned whether delayed senior leadership recruitment should be rated higher. The EPRR risk will be reframed to reflect wider system preparedness rather than team vacancies alone.

Digital resilience: End-of-life equipment and the need for a sustainable replacement programme remain concerns, alongside clarity on digital governance, resourcing and interoperability.

Risk and assurance reporting: Members sought clearer risk direction, the rationale for scores and visibility of mitigating actions. The next workforce report could include a grid showing the actions being taken to manage risks. The Committee discussed how financial assurance ratings should be interpreted.

Separately, the Chair's concerns about the level of assurance relating to Digital and IT were agreed for escalation to the Board.
Learning for sharing
Triangulating staff intelligence: Staff-away-day, survey, sickness absence and Freedom to Speak Up intelligence will be brought together around five emerging themes to inform the organisational response. **Resource allocation:** The operating-model review will assess how the model is working, identify opportunities to share resources and address gaps, and inform redistribution where required. **Risk reporting:** The discussion highlighted the value of clearly showing whether risks are improving or worsening and the actions being taken to manage them.

NHS
Greater Manchester

Month 6 Finance Report

2026/27

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

NHS GM Integrated Care Board

18 November 2026

Required information	Details
Title of report	Month 6 Finance Report
Author	Jackie Gardiner – Director of Operational Finance
Presented by	Kathy Roe – Chief Finance Officer / Acting Deputy Chief Executive
Contact for further information	Jackie Gardiner – Director of Operational Finance
Executive summary	The purpose of the report is to update the Board on the Month 6 financial position for NHS GM as at 30th September 2026.
The benefits that the population of Greater Manchester will experience.	Effective financial management will contribute to the delivery of the ICP strategy and delivery of health and social care services to the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	Effective financial management will support the delivery of the ICP strategy and the focus on commissioning decisions to reduce health inequalities.
The decision to be made and/or input sought	The Board is asked to: 1. Note the Month 6 year to date and forecast reported financial position which is in line with the balanced plan including Deficit Support Funding (DSF). 2. Note that DSF has been approved for Q3, but that the full DSF remains at risk should NHS GM not achieve a balanced position at year end and deliver the CIP target in full. 3. Note and discuss the areas of key risks and pressures. 4. Note the delivery of CIP as at Month 6 of £77.0m against a plan of £72.4m, an over delivery of £4.6m YTD, but with risk to the delivery of the full year plan. 5. Note the implementation of a Financial Recovery Plan which is required to ensure delivery of CIP, reduction in operational pressures, and identification of other mitigations to ensure an overall balanced plan is achieved. 6. Note that the forecast capital position is expected

	to deliver in line with plan including the allocation notified for GPIT. 7. Note the NHS GM cash position which continues to be closely monitored. 8. Note that enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks	The report provides an update aligned to the strategic risk to ensure financial balance for NHS GM for 2026/27.
Key milestones	Monthly reporting within 2026/27 Financial Year.
Leadership and governance arrangements	Distributed to Chief Officers on 22nd October 2026. Presented to People & Resources Committee on 28th October 2026. Presented to the NHS GM Integrated Care Board on 18th November 2026.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A, part of on-going monthly reporting.
Financial or Legal Implications	N/A as this is the monthly Finance Report.

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

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

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

1. Introduction

1.1 The purpose of the report is to update the Board on the financial position for NHS GM as at 30th September 2026.

2. Key Messages

2.1 Plan

NHS GM has submitted a breakeven plan to NHS England (NHSE) for 2026/27, which includes the receipt of deficit support funding of £17.7m.

2.2 Month 6 reported position

As at Month 6, NHS GM is reporting in line with plan.

M6 2026/27 ICB Surplus/(Deficit) £m	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
NHS GM	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0

Key messages are as follows:

- This report was produced in advance of the finalisation of the Financial Recovery Plan. The month 7 report will align with the Recovery Plan.
- YTD there continues to be pressures being reported across a number of key risk areas including Prescribing, All Age Continuing Care and Mental Health packages and ADHD/Autism, which are being offset with underspends in other areas of spend within the overall position, centrally held allocations not yet being spent and over delivery against the CIP target.
- Delivery against the efficiency target at Month 6 is £77.0m, which is £4.6m ahead of the target (a slight reduction compared to M5), with the current non-delivery risk standing at £23.7m using the NHSE risk approach. The risk of delivery has reduced again this month, but delivery of the full CIP savings is high risk and will be reflected in the Financial Recovery Plan that is being finalised.
- A Financial Recovery Plan is being finalised which will identify mitigations and actions required to ensure that operational pressures can be reduced and a balanced plan is delivered. This will be monitored through Chief Officers and the People & Resources Committee.
- Cash draw down at Month 6 is £35.6m ahead of the national straight-line profile, but with a closing balance of £0.72m, which is significantly lower when compared to last month. Future cash requests continue to be reviewed accordingly.
- NHS GM has received a total capital allocation of £20.1m, with forecast expenditure of £20.9m, which remains unchanged from last month as the additional allocation for GPIT is yet to be received. Governance continues to be reviewed to ensure all funding can be spent.
- Further to the receipt of Deficit Support Funding (DSF) for Q1 & Q2, NHSE has now confirmed that DSF will be awarded for Q3, however, there remains a risk that this and the final allocation for Q4 remain subject to clawback if a balanced position for NHS GM is not delivered.
- Enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position, CIP delivery and the Financial Recovery Plan.

2.3 Efficiencies / CIP

The overall efficiency target for NHS GM for 2026/27 is £150.0m. At Month 6 delivery is now ahead of the plan by £4.6m, which has reduced since last month. Against the overall target, £14.2m is still being identified as an opportunity whilst schemes are being scoped. The current risk adjusted forecast (based on NHSE methodology) is £23.7m, which has reduced by a further £3.3m since last month. From next month reporting will also align to the information provided in the Financial Recovery Plan.

2.4 Corporate Operating Costs

The NHS Reform Programme is nearer to being concluded and during September, ESR continued to be updated to move more staff into substantive roles. Work will continue, but the Admin/Running Costs position continues to show an underspend which is offset with an overspend in Programme Operating Costs. This is as a result of the reduction to the allocation relating to Operating Costs being taken from the Programme Allocation, when actual costs have reduced across both Admin and Programme Costs. YTD there is a slight underspend overall, due to the expected phasing of non-pay spend later in the year, with the forecast position now also reporting a level of slippage.

2.5 Cash

At M6 NHS GM has drawn down £4,738.0m of cash against a straight-line national profile of £4702.4m, reflecting an additional drawdown of £35.6m, an increase compared to M5. This reflects that in month the overall allocation was reduced by £67.5m as part of the NHSE Efficiency Adjustment. The closing cash balance was £720k, which has reduced back down to normal levels. Cash drawdown assumptions will continue to be reviewed to ensure that cash can be managed appropriately and that the ICB remains within the allowable limits.

2.6 Capital

The NHS GM annual capital plan remains at £20.1m, which is split £6.6m for BAU, £10.5m relating to the first year of the 4-year Strategic Allocation and £3.0m relating to the Utilisation and Modernisation Fund. The additional allocation of £0.8m for GPIT has still not yet been received but has been recognised in the forecast position. It is expected that all of this will be fully utilised in year.

3. Recommendations

3.1 For the NHS GM Financial position, the Board is asked to:

- Note the Month 6 year to date and forecast reported financial position which is in line with the balanced plan including Deficit Support Funding (DSF).
- Note that DSF has been approved for Q3, but that the full DSF remains at risk should NHS GM not achieve a balanced position at year end and deliver the CIP target in full.
- Note and discuss the areas of key risks and pressures.
- Note the delivery of CIP as at Month 6 of £77.0m against a plan of £72.4m, an over delivery of £4.6m YTD, but with risk to the delivery of the full year plan.
- Note the implementation of a Financial Recovery Plan which is required to ensure delivery of CIP, reduction in operational pressures, and identification of other mitigations to ensure an overall balanced plan is achieved.
- Note that the forecast capital position is expected to deliver in line with plan including the allocation notified for GPIT.
- Note the NHS GM cash position which continues to be closely monitored.

- Note that enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.

NHS Greater Manchester

NHS Greater Manchester Finance Slide Pack Month 06 – September 2026

Part of Greater Manchester Integrated Care Partnership

Presented by: Kathy Roe
Date: 18th November 2026

NHS GM Financial Position

Introduction

NHS Greater Manchester

As at Month 6 NHS GM is reporting in line with the year-to-date and annual plan, including receipt of the Deficit Support Funding (DSF).

M6 2026/27 ICB Surplus/(Deficit) £m	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
NHS GM	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0

Key points to note for Month 6 are:

- This report was produced in advance of the finalisation of the Financial Recovery Plan. The month 7 report will align with the Recovery Plan.
- YTD there continues to be pressures being reported across a number of key risk areas including Prescribing, All Age Continuing Care and Mental Health packages and ADHD/Autism, which are being offset with underspends in other areas of spend within the overall position, centrally held allocations not yet being spent and over delivery against the CIP target.
- Delivery against the efficiency target at Month 6 is £77.0m, which is £4.6m ahead of the target (a slight reduction compared to M5), with the current non-delivery risk standing at £23.7m using the NHSE risk approach. The risk of delivery has reduced again this month, but delivery of the full CIP savings is high risk and will be reflected in the Financial Recovery Plan that is being finalised.
- A Financial Recovery Plan is being finalised which will identify mitigations and actions required to ensure that operational pressures can be reduced and a balanced plan is delivered. This will be monitored through Chief Officers and the People & Resources Committee.
- Cash draw down at Month 6 is £35.6m ahead of the national straight-line profile, but with a closing balance of £0.72m, which is significantly lower when compared to last month. Future cash requests continue to be reviewed accordingly.
- NHS GM has received a total capital allocation of £20.1m, with forecast expenditure of £20.9m, which remains unchanged from last month as the additional allocation for GPIT is yet to be received. Governance continues to be reviewed to ensure all funding can be spent.
- Further to the receipt of Deficit Support Funding (DSF) for Q1 & Q2, NHSE has now confirmed that DSF will be awarded for Q3, however, there remains a risk that this and the final allocation for Q4 remain subject to clawback if a balanced position for NHS GM is not delivered.
- Enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position, CIP delivery and the Financial Recovery Plan.

Key Metrics Dashboard

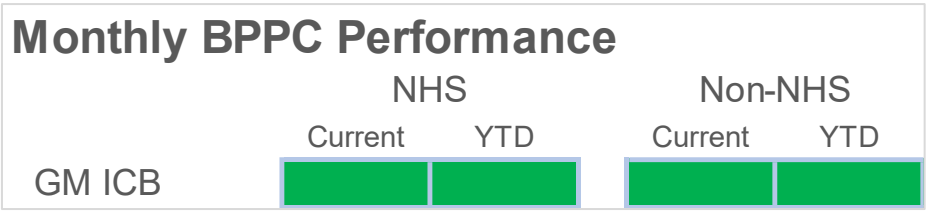
NHS Greater Manchester

2026/27 NHS GM Dashboard (£m)	YTD Budget M06	YTD Actual M06	YTD Variance M06	Full Year Budget/ Allocation	Full Year Forecast	Full Year Variance	RAG
Financial Position - Inc DSF	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	G
Financial Position - Exc DSF	-£8.8	-£8.8	£0.0	-£17.7	-£17.7	£0.0	G
CIP	£72.4	£77.0	£4.6	£150.0	£150.0	£0.0	G
Capital - NHS GM	£10.1	£10.1	£0.0	£20.1	£20.9	-£0.8	G
Key Metrics							
MHIS (Excluding LD & Dementia)	£410.1	£410.1	£0.0	£856.0	£856.0	£0.0	G
MHIS - Delegated Specialised Commissioning*	£53.1	£53.1	£0.0	£119.1	£119.1	£0.0	G
Running Costs**	£23.9	£15.5	£8.4	£47.8	£31.6	£16.2	G

- NHSE have confirmed that the target in the IFR file is the opening plan and does not yet include any additional allocations received, the budget for NHS GM does include those additional allocations.

** Running Cost underspend continues to be offset with Programme Operating Costs whilst the outcomes of the NHS Reform programme are concluded and ESR has been updated to reflect the new Operating Model and structures.

Monthly BPPC Performance

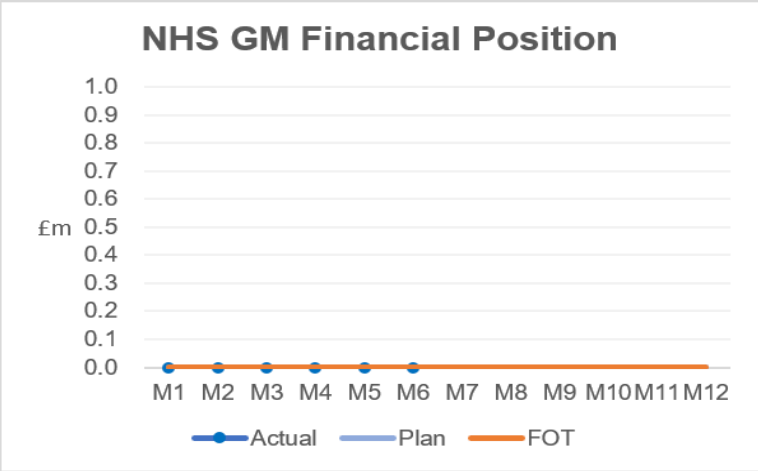


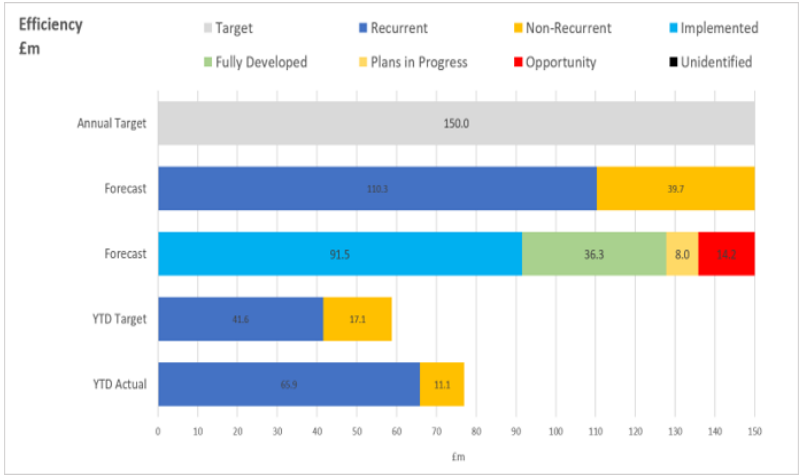
Note: *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are* calculated using precise values, before rounding is applied.

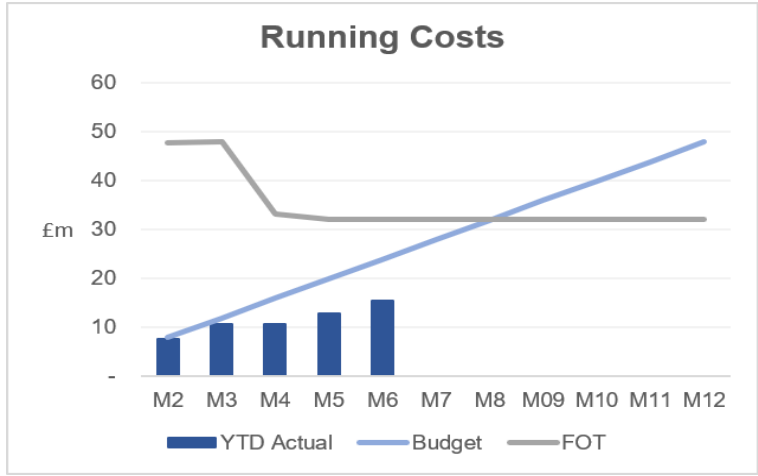
Key Metrics

Analysis

NHS Greater Manchester







NHS GM Financial Position

- As at Month 6 NHS GM is reporting in line with the year-to-date and annual plan.
- This is after Deficit Support Funding (DSF) of £17.7m has been allocated to NHS GM. To date £8.8m for Q1 and Q2 has been received and included in the M6 position.
- NHSE have confirmed that DSF for Q3 has now been awarded and should be received in M7.
- Retainment of the Q1 – Q3 DSF and achievement for Q4 will be subject to delivery of the overall plan and deliver of the full savings target of £150.0m.

NHS GM Efficiency

- The chart above details the savings delivered against an overall savings target of £150.0m.
- YTD savings of £77.0m have been delivered against the target of £72.4m, which is £4.6m ahead of plan.
- The current risk adjusted (NHSE risk approach) forecast outturn delivery is £23.7m below the target which has improved by £3.3m since last month. The Financial Recovery Plan will reflect the CIP risk.

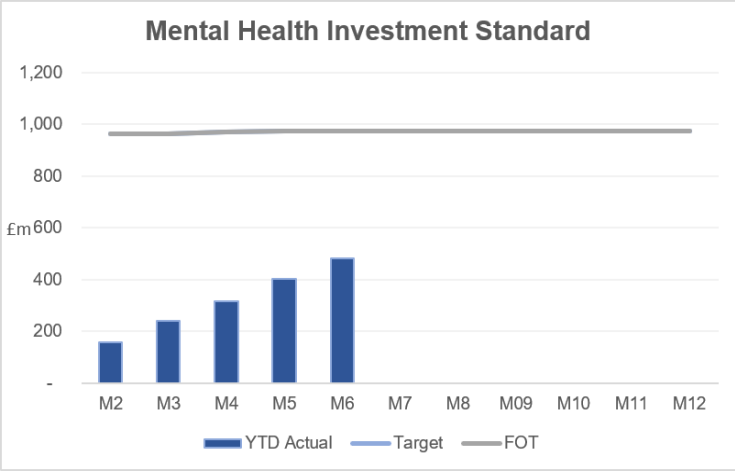
NHS GM Running Costs

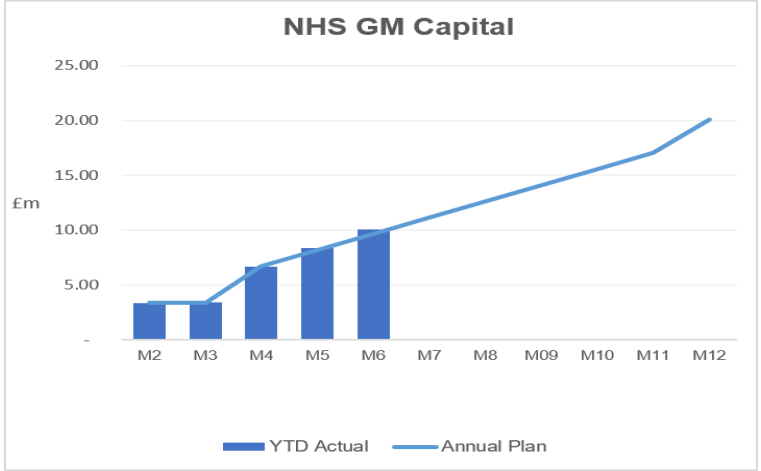
- The Running cost allowance for NHS GM for 2026/27 is £47.8m.
- At Month 6 the Running cost allowance is £23.9m with actual spend of £15.5m, a variance of £8.4m. The FOT is showing a £16.2m underspend.
- Underspends are being reported within Running costs, and these are being partially offset by overspends within Programme Operating costs. This is until the NHS Reform programme has concluded and ESR has been updated which is now expected to be by the end of November.

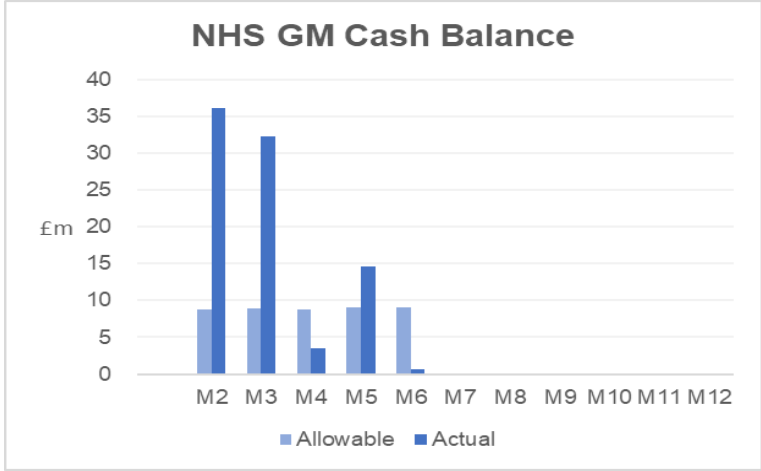
Key Metrics

Analysis

NHS Greater Manchester







Mental Health Investment Standard

- There are two targets relating to the Mental Health Investment Standard (MHIS) which are reported and monitored separately and not combined.
- The core MHIS target requires NHS GM to spend £855.9m on Mental Health provision in 2026/27.
- The Specialised Commissioning MHIS (SCMHIS) target of £115.7m target has still not been updated by NHSE to reflect the additional allocations received since the opening budgets were posted, which now totals £119.1m.
- At Month 6 NHS GM has delivered both targets.

NHS GM Capital

- The chart above shows the entirety of the NHS GM Capital plan for 2026/27 which totals £20.1m.
- This is split £6.6m for BAU, £10.5m relating to the first year of the 4-year Strategic Allocation and £3.0m relating to the Utilisation and Modernisation Fund (UMF).
- At Month 6, YTD expenditure is reported in line with plan. The forecast is showing a £0.8m overspend which is due to an anticipated allocation in relation to GPIT.
- All schemes are currently being finalised, and governance continues to be reviewed to ensure that the full allocation is spent in year.

Cash

- At M6 NHS GM has drawn down £4,738.0m of cash against a straight-line national profile of £4,702.4m, which has increased slightly compared to last month.
- The cash balance at the end of M6 is £0.72m, which is significantly lower than last month, and back in line with expected levels.
- The cash forecast for 2026/27 at M6 remains in line with the total confirmed cash limit of £9,404.8m, which will be updated as allocations are received during the financial year.

NHS GM Financial Position

Month 6

NHS Greater Manchester

The financial summary for NHS GM by expenditure type as at Month 6 is shown in the table below:

NHS GM Financial Position £m	In Month Plan	In Month Actual	In Month Variance	In Month Variance %	YTD Plan	YTD Actual	YTD Variance	YTD Variance %	Full Year Plan	Full Year Forecast	Full Year Variance	Full Year Variance %	M05 Full Year Variance	Change in Forecast M05 to M06
Allocations	£795.3	£795.3	£0.0	0.0%	£4,716.4	£4,716.4	£0.0	0.0%	£9,404.9	£9,404.9	£0.0	0.0%	£0.0	£0.0
Admin														
Running Costs	£4.0	£2.6	£1.4	35.9%	£23.9	£15.5	£8.4	35.2%	£47.8	£31.6	£16.2	33.9%	£15.8	£0.4
Total Admin	£4.0	£2.6	£1.4	35.9%	£23.9	£15.5	£8.4	35.2%	£47.8	£31.6	£16.2	33.9%	£15.8	£0.4
Programme														
Mental Health	£81.3	£84.4	-£3.1	-3.9%	£505.0	£518.3	-£13.3	-2.6%	£1,009.2	£1,022.9	-£13.7	-1.4%	-£15.9	£2.3
Acute	£357.3	£357.3	£0.0	0.0%	£2,125.0	£2,125.0	£0.0	0.0%	£4,246.8	£4,246.8	£0.0	0.0%	£0.0	-£0.0
Specialised Commissioning	£87.5	£86.9	£0.6	0.7%	£524.3	£522.8	£1.5	0.3%	£1,069.5	£1,069.5	£0.0	0.0%	-£0.1	£0.1
Primary Care	£9.8	£9.8	£0.0	-0.2%	£57.6	£57.7	-£0.1	-0.1%	£116.0	£116.0	£0.0	0.0%	£0.0	£0.0
GP Medical, Pharmacy, Dental and Optometry	£94.2	£94.4	-£0.2	-0.2%	£563.8	£563.7	£0.1	0.0%	£1,124.3	£1,123.0	£1.4	0.1%	£1.5	-£0.1
Prescribing	£54.0	£57.4	-£3.4	-6.3%	£303.6	£312.2	-£8.6	-2.8%	£611.7	£627.2	-£15.5	-2.5%	-£6.5	-£9.1
All Age Continuing Healthcare	£24.3	£27.3	-£3.0	-12.4%	£146.6	£158.1	-£11.5	-7.9%	£293.2	£306.6	-£13.3	-4.6%	-£13.8	£0.5
Community Health Services	£66.1	£66.0	£0.1	0.2%	£393.7	£395.0	-£1.3	-0.3%	£787.0	£789.5	-£2.5	-0.3%	-£2.8	£0.3
Programme Operating Costs	£6.3	£7.6	-£1.3	-20.1%	£40.0	£47.5	-£7.5	-18.7%	£80.9	£95.2	-£14.2	-17.6%	-£13.8	-£0.4
Other Expenditure	£1.5	£1.5	£0.0	-1.4%	£0.7	£0.8	-£0.1	-10.7%	£12.3	£12.4	-£0.1	-0.8%	-£0.2	£0.1
Earmarked Commitments	£8.9	£0.0	£8.9	100.0%	£32.3	£0.0	£32.3	100.0%	£6.1	-£35.7	£41.8	681.6%	£35.9	£5.9
Total Programme	£791.3	£792.7	-£1.4	-0.2%	£4,692.5	£4,700.9	-£8.4	-0.2%	£9,357.1	£9,373.3	-£16.2	-0.2%	-£15.8	-£0.4
Total Expenditure	**£795.3**	**£795.3**	**£0.0**	**0.0%**	**£4,716.4**	**£4,716.4**	**£0.0**	**0.0%**	**£9,404.9**	**£9,404.9**	**£0.0**	**0.0%**	**£0.0**	**£0.0**
Surplus / (Deficit)	**£0.0**	**£0.0**	**£0.0**		**£0.0**	**£0.0**	**£0.0**		**£0.0**	**£0.0**	**£0.0**		**£0.0**	**£0.0**

- At Month 6, there continues to be a number of pressures being reported, some of which are a continuation of those reported at the end of 2025/26:
  - Mental Health – relating to increases in ADHD spend and costs of packages of care. £0.8m of this pressure relates to costs associated with 2025/26 which were billed late by providers.
  - Prescribing – including £15.9m of estimated additional costs relating to increases in No Cheaper Stock Obtainable (NCSOs - including net impact of £0.8m from 2025/26).
  - All Age Continuing Care – a continuation of increased costs associated with additional packages and higher acuity.
  - Acute – Activity data (Month 4 Freeze and Month 5 Flex) has been received from providers, which indicates some under and over performance that broadly net off, but activity data continues to be being validated on a monthly basis.
- Running costs and Programme Operating costs – continue to be offset until the outcomes of the NHS Reform programme are concluded and ESR is updated to reflect staff moving into their substantive roles. Overall, slippage of £0.9m has been reported YTD, and a forecast underspend of £2.0m is estimated.
- Other areas of underspend are shown in the table above and these along with the over delivery of CIP of £4.6m YTD and the utilisation of non-recurrent centrally held allocations whilst investment decisions are confirmed ensure that NHS GM can report an overall balanced position.

Recommendations

Month 6

NHS Greater Manchester

For the NHS GM Financial position, the Board is asked to:

- Note the Month 6 year to date and forecast reported financial position which is in line with the balanced plan including Deficit Support Funding (DSF).
- Note that DSF has been approved for Q3, but that the full DSF remains at risk should NHS GM not achieve a balanced position at year end and deliver the CIP target in full.
- Note and discuss the areas of key risks and pressures.
- Note the delivery of CIP as at Month 6 of £77.0m against a plan of £72.4m, an over delivery of £4.6m YTD, but with risk to the delivery of the full year plan.
- Note the implementation of a Financial Recovery Plan which is required to ensure delivery of CIP, reduction in operational pressures, and identification of other mitigations to ensure an overall balanced plan is achieved.
- Note that the forecast capital position is expected to deliver in line with plan including the allocation notified for GPIT.
- Note the NHS GM cash position which continues to be closely monitored.
- Note that enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.

NHS
Greater Manchester

Strategic Commissioning Committee Report

18 November 2026

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

18 November 2026

Required information	Details
Title of report	Strategic Commissioning Committee Report
Author	Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee
Presented by	Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee
Contact for further information	Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee
Executive summary	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The Board is asked to: • Note the contents of the report and provide feedback to the Committee Chair.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
Key milestones	N/A
Leadership and governance arrangements	Overview of discussions at the Strategic Commissioning Committee
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A
Financial or Legal Implications	N/A

Table 1 - core information relating to the content and creation of paper

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

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

NHS
Greater Manchester

Report from:	**Strategic Commissioning Committee**
Date of Meeting:	7 October 2026
Chair:	Dame Sue Bailey
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert

- **Chief Clinical Officer Report:** The committee were made aware of the ongoing work that was taking place with WWL, GMMH and the Northern Care Alliance on CQC section 29A improvement requirements, while reporting progress in safeguarding recruitment and several medicines, antimicrobial and clinical-governance decisions.

Advise

- **Performance Report:** It was reported that there was continued pressure across elective care, urgent and emergency care, mental health and learning disabilities, alongside strong cancer performance. The committee noted the position as partial assurance and supported continued recovery-plan oversight.
- **Chief Commissioning Officer Report:** The committee were informed on planned changes to individual funding requests, cardiac and vascular surgery, specialist HIV services in Bolton and a Wigan joint inspection.
- **Chief Strategy, People and Partnerships Report:** It was reported that there had been progress on neighbourhood and place arrangements, including forthcoming partnership documents, returned neighbourhood plans, developing data packs and a live dashboard, while acknowledging that transition and cultural-change risks require active governance.
- **Chief Reform and Improvement Officer Report:** The committee were informed that half of the joint controller agreements have been returned, with the remaining practices receiving targeted assurance conversations before a potential cut-off for processing data from organisations that do not complete the required documentation.
- **Thirlwall Inquiry:** It was outlined how Greater Manchester will respond to the Thirlwall Inquiry through existing maternity, neonatal, quality and contractual governance rather than creating a separate process, providing the committee with a continuing line of sight on provider implementation and unresolved risks.
- **Community Mental Health Independent Review (Private meeting):** The committee were informed that NHS Greater Manchester commissioned CPGB Ltd to undertake an Independent CMHT Review in response to Recommendation 9 of the 2024 Shanley Review. The recommendations in the paper translate the six Shanley themes and four cross-cutting system conditions into high-leverage actions at provider, place and system level. They prioritise triage and thresholds, documentation, shared care and interfaces, allocation and continuity, workforce

stability and learning capacity. Each recommendation includes a measure of success to support monitoring.

Assure

- **5-Year Commissioning Plan Progress and Commissioning Intentions:** It was described that the transition from annual commissioning intentions to a broader 2027–28 commissioning framework linked to the strategic commissioning plan. Confirmation was received that there are a set out plans to strengthen children's services, mental health, neurodiversity and early intervention through renewed partnership arrangements.
- **Quality Assurance Process:** The committee were made aware of the developing quality and safety assurance framework, with support of its adoption as the ICB's standard approach for triangulating data, provider oversight, escalation and patient experience. The committee welcomed the framework and requested continued scrutiny of its thresholds and implementation.

Risks discussed and new risks identified

Risks scoring above 16 that are monitored via the Strategic Commissioning Committee:

- Risk reports included in Chief Officer Updates.
- **Chief Clinical Officer Report:** The committee were made aware of the residual risk that remained high for NCA NHS England Undertakings, as improvements are not yet embedded or evidenced as sustainable. The Trust is still unable to demonstrate reliable systems for early risk identification and mitigation. Continued exposure to patient safety harm, reputational damage and further regulatory escalation (including potential licence action) remains likely until governance structures are proven effective.

Learning for sharing

Summary of learning points to share from the Strategic Commissioning Committee October meeting.

- **Chief Commissioning Report: Primary Care Commissioning -** Five members of ICB staff, across various directorates including the Director of Primary Care and Community Healthcare Services, are taking part in the Strategic Commissioning for Neighbourhood Health Programme led by the NHS Alliance and The King's Fund. This is a six-part programme delivered between September and December 2026. The initial introductory session, with ICB colleagues across the country, took place on 9 September. Learning from the programme will be shared as available.

Achievements

NHS
Greater Manchester

Summary of the appreciation shared from the Strategic Commissioning Committee October meeting.

- **Chief Reform & Improvement Officer Report:** The Cancer 31-day standard from decision to treat, to treatment, has being ranked in the top five, nationally, each month since April. GM was ranked first in June.
- **Chief Clinical Officer Report:** The committee were informed that the Opioid Stewardship had won the HSJ Patient Safety Awards.
- **Chief Commissioning Report: Children, Young People and Maternity –** Salford SEND inspection outcome.
- **Chief Strategy, People and Partnerships Report: Population Health -** The NHS GM Population Health function, using funding provided through our involvement in the Partnership for Health Cities, has co-produced a smokefree community spaces toolkit with 8 local community organisations. The toolkit was launched on 9th September via a webinar attended from over 100 colleagues from across the country.

NHS
Greater Manchester

Report from:	**Strategic Commissioning Committee**
Date of Meeting:	4 November 2026
Chair:	Dame Sue Bailey
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert

- **Chief Clinical Officer Report – Levemir insulin:** The Committee escalated the discontinuation of Levemir insulin to the Board. At the meeting, 76% of 3,509 affected patients had been switched to alternative treatment, with 846 outstanding. Medical directors and general practice receive regular progress reports, with monthly monitoring through the Clinical Effectiveness Group. The Committee requested clearer information on outstanding patient numbers and the timescale for completing switches before supplies cease.

Advise

- **Place Outcomes Framework and oversight:** The Committee noted the developing arrangements for collective accountability at place and quarterly, outcome-based assurance. Members requested stronger measures of inequalities, greater emphasis on children, clearer ambition and early visibility of underperformance. Worked examples will support further development, with testing in quarter four, a substantive update in February 2027 and formal reporting intended from quarter one of 2027/28.
- **GM Public Health Network Transformation:** The Committee approved the proposals for progression to the November Board, following People and Resources Committee support for the financial delegation. The proposals include a Section 75 agreement setting out governance and responsibilities. Staff consultation is intended to begin following Board approval.
- **GM HIV Strategy 2026–30:** The Committee supported the strategy and endorsed its progression for formal Board approval on 18 November 2026. The strategy focuses on prevention and testing, treatment and service transformation, and helping people to thrive, with co-production and reducing inequalities underpinning delivery. Launch is intended to coincide with World AIDS Day.
- **NHS Talking Therapies expansion:** The Committee considered additional provision expected to deliver 2,900 episodes of care annually: 2,000 at Step 3 and 900 at Step 2. The expansion is intended to improve access; it does not directly assure achievement of recovery and improvement targets. The Committee supported the expansion and its expected contribution to access which was ratified by the Deputy Chair after the meeting.

Assure

- **Clinical governance and safety:** The Committee received assurance on the coordinated response to a rapid quality review, including relocation of the affected Greater Manchester patient to safer provision. It noted completion of the maternity and neonatal ten-point plan assurance exercise and approved the Clinical Effectiveness Group items requiring Committee approval. Clinical audit findings on advice and guidance will return to the Committee.
- **Performance – partial assurance:** The Committee retained partial assurance on system performance. Second-half-of-year recovery plans and the elective recovery cell are supporting delivery, with an aggregated Greater Manchester approach offering greater flexibility. Delivery risks remain, and further work with providers and the regional team is ongoing.
- **End-of-life equipment:** Funding had been identified and a delivery plan was due to be considered by executives the following week as part of second-half-of-year priorities. The Committee noted an improved position, with re-escalation to the Board if delivery concerns arise.

Risks discussed and new risks identified

- **Board Assurance Framework:** Members sought a clearer, consolidated presentation of strategic risks, their relationships, scoring and mitigations. Chief Officers were asked to discuss readiness for Board consideration with the Chief Executive and arrange further discussion. The Committee did not approve the framework or revised risk scores as currently presented but members were cognisant of and support the further work that would be undertaken at pace.
- **Quality and resilience risks:** Additional quality risks relating to Northern Care Alliance and perinatal mental health were proposed, with mitigations and updates to follow. Emergency preparedness, resilience and response, and cyber risks were being rewritten to reflect substantive organisational risks and revised accountable officer responsibilities.
- **Accountability and resource shift:** Risk NH002 highlighted unclear accountability and decision-making across system, place, provider and neighbourhood levels. Baseline and trajectory work for investment in primary care, prevention and the voluntary sector remained delayed to March; early warning of any further slippage was requested.

Learning for sharing

- **Medication safety:** The Committee supported wider sharing of seven-minute safety briefings on methotrexate and Parkinson's medication to strengthen learning from medication-related harm.
- **Outcome-based assurance:** Members emphasised measuring meaningful outcomes and narrowing inequalities gaps, rather than relying on easily measured activity. Future place assurance should combine evidence, structured professional judgement and community voices. Learning from Greater Manchester's neighbourhood approach is also being shared with national teams.

• **Forward planning:** Chief Officers were asked to prioritise substantive strategic discussions, identify potential audit topics and ensure the forward plan includes children's safeguarding annual reporting alongside adult safeguarding.
Achievements
• **Individual Funding Request service:** The team transferred on 1 November 2026 and onboarding had taken place, enabling further development of a North West model. Some TUPE matters remained outstanding. • **Commissioning and intelligence:** All local authority SEND reform plans had been agreed and nationally signed off. The Committee acknowledged progress in Oldham SEND. Live neighbourhood health dashboards had been launched and were undergoing testing to support place outcomes oversight.

NHS
Greater Manchester

Thirlwall Inquiry - Report & Recommendations

18th November 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester Integrated Care Board

18th November 2026

Report information.

Required information.	Details.
Title of report.	Thirlwall Inquiry Report & Recommendations
Author.	Sarah Owen, Associate Director of Maternity, (GM ICB/LMNS)
Presented by.	Sarah Owen, Associate Director of Maternity, (GM ICB/LMNS)
Contact for further information.	Sarah Owen, Associate Director of Maternity, (GM ICB/LMNS) Sarah.Owen61@NHS.net
Executive summary.	The Thirlwall Inquiry was published on 15 September 2026 and makes 17 recommendations following its examination of events at the Countess of Chester Hospital. NHS England subsequently issued immediate requirements for NHS Trusts and Integrated Care Boards (ICBs). This paper summarises the findings and immediate requirements, sets out the implications for NHS Greater Manchester (NHS GM), and proposes how specialist neonatal assurance will be received through the Regional Assurance Process and North West Neonatal Operational Delivery Network (ODN), with system oversight through the NHS GM Maternity & Neonatal Programme.
The benefits that the population of Greater Manchester will experience.	Supports safer neonatal care by strengthening line of sight to provider implementation, emerging safety concerns and escalation, while using specialist neonatal expertise and established NHS GM quality and contractual routes.

How health inequalities will be reduced in Greater Manchester's communities.	The report does not introduce a separate inequalities intervention. It supports consistent oversight of safety and quality across commissioned neonatal services; existing national maternity and neonatal frameworks require consideration of variation and inequalities within quality assurance and commissioning.
The decision to be made and/or input sought.	The NHS Greater Manchester Integrated Care Board is asked to: • Note the Inquiry findings and immediate NHS England requirements • Support the proposed GM assurance approach • Support quarterly reporting of the GM assurance position through the NHS GM Maternity & Neonatal Programme • Support escalation of provider-specific risks or gaps in assurance through the established NHS GM Contract Quality Mechanism where required.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Supports NHS GM strategic commissioning and Quality & Safety Management responsibilities by strengthening system oversight, provider assurance and escalation for maternity and neonatal services.
Key milestones.	• 15 September 2026 - Thirlwall Inquiry report published. • 21 September 2026 - NHS England immediate requirements issued. • 28 September 2026 - provider SUDIC communication deadline. • 30 November 2026 - interim insulin-storage CCTV deadline. • 31 March 2027 - neonatal units to meet GIRFT insulin access/storage requirements. • Further implementation requirements will develop through the National Maternity and Neonatal Taskforce and Regional Assurance Process.

Leadership and governance arrangements.	NHS GM oversight will sit within the Maternity & Neonatal Programme, with routine quarterly reporting to the Strategic Commissioning Committee. Specialist neonatal assurance is anticipated through the North West Neonatal ODN and Regional Assurance Process. Provider-specific risks or gaps in assurance will be escalated through the established NHS GM Contract Quality Mechanism where required.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The paper responds to the published statutory Inquiry and subsequent NHS England requirements. 7th November 2026 – NHS GM Strategic Commissioning Committee 12th November – GM Maternity & Neonatal System Group
Financial or Legal Implications	No new NHS GM financial decision is sought through this paper. Some national and provider implementation requirements may have financial implications as the response develops; these will need to be considered through the appropriate national, provider and commissioning routes. No separate legal advice has been sought for this paper.

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

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

1. Thirlwall Inquiry - key findings and recommendations

The Thirlwall Inquiry report was published on 15 September 2026 following an independent statutory inquiry into events at the Countess of Chester Hospital between 2015 and 2018. The Inquiry was established following the convictions of former neonatal nurse Lucy Letby and examined the circumstances surrounding the deaths and unexpected deterioration of babies on the neonatal unit, the response of the Trust and wider NHS, and the arrangements in place for raising and responding to concerns.

The Inquiry describes repeated organisational and individual failings in recognising and acting upon unusual patterns of neonatal death and deterioration, escalating clinical concerns, safeguarding babies, maintaining Board visibility of neonatal safety and ensuring effective external scrutiny. Its findings extend beyond the specific circumstances at the Countess of Chester and raise wider considerations for provider governance, neonatal safety, mortality surveillance, safeguarding, speaking up and the effectiveness of organisational assurance.

The Inquiry identifies a number of recurring findings and areas of concern, including:

Failure to recognise and connect safety signals. Neonatal deaths and unexpected collapses were repeatedly considered individually rather than as a developing pattern. The Inquiry found that an unexplained rise in neonatal mortality required active investigation until an explanation was established.

Clinical concerns were not acted upon with sufficient urgency. Consultant paediatricians repeatedly raised concerns, but organisational responses were delayed and were influenced by hierarchy, process, reputation and assumptions about what could plausibly be happening.

Neonatal safety lacked sufficient organisational visibility. The Trust Board did not receive reports about deaths of babies and children during the period examined. The Inquiry linked this to governance arrangements that had diminished the profile and voice of paediatrics and neonatology.

Assurance did not always adequately respond to unexplained safety signals. Reviews and external scrutiny did not consistently follow unexplained signals across organisational or clinical boundaries. Of particular relevance, a maternity and obstetric review concluded that maternity care had not caused the increase in neonatal deaths. The Inquiry found that this was treated as reassurance without sufficient further consideration of what was driving the unexplained mortality.

Safeguarding arrangements were not used effectively when deliberate harm by a member of staff was suspected. Thirlwall therefore recommends a national Suspicion of Deliberate Harm Protocol, strengthened safeguarding training and contractual duties.

Mortality and data intelligence require stronger real-time oversight. Recommendations include Board-level monitoring of all child and baby deaths, predetermined escalation routes for concerning trends, and a trained lead reporter for hospitals with neonatal units.

Wider system dependencies. The report identifies dependencies including neonatal monitoring, medicines security, bereavement care, digital interoperability, medical examiner

arrangements, paediatric and perinatal pathology capacity, regulation and accountability of managers, Care Quality Commission practice and whistleblowing.

Implementation and accountability are themselves a central safety issue. Recommendation 17 proposes a new National Audit Office responsibility for auditing implementation of recommendations from statutory inquiries into NHS bodies.

or NHS GM, these findings reinforce the importance of maintaining sufficient visibility of neonatal safety across commissioned services, supported by clear reporting and governance arrangements and appropriate specialist neonatal clinical oversight. The North West Neonatal Operational Delivery Network (ODN) provides an established route for oversight and interpretation of neonatal safety, mortality and performance intelligence across providers. NHS GM should therefore maintain a clear line of sight to this intelligence through the ODN, with a defined route for routine reporting and escalation into the NHS GM Maternity & Neonatal Programme where emerging trends, concerns or unexplained variation indicate potential risk, and onward escalation through established NHS GM quality and contractual routes where required.

The Inquiry makes 17 recommendations, directed to provider organisations, NHS England, the Department of Health and Social Care, the Care Quality Commission and other national bodies. None of the 17 recommendations within the Inquiry itself are assigned directly to Integrated Care Boards (ICBs). A summary of the recommendations, key requirements and assigned responsibilities is provided at Appendix 1.

The Thirlwall recommendations will not sit in isolation from the wider national maternity and neonatal improvement programme. The published objectives of the National Maternity and Neonatal Taskforce explicitly include addressing recommendations arising from the Thirlwall Inquiry, alongside the Amos National Maternity and Neonatal Investigation and the Ockenden Nottingham Review. The national response to Thirlwall will therefore form part of the wider programme of maternity and neonatal reform previously considered by the Strategic Commissioning Committee (SCC) through the Amos & Ockenden briefing.

2. NHS England response - immediate requirements

As with the NHS England 10 Point Plan issued following publication of the Amos and Ockenden reports, the full national response to Thirlwall will be developed through the National Maternity and Neonatal Taskforce. However, a number of actions require more immediate implementation and assurance and cannot wait for the wider National Taskforce action plan.

On 21 September 2026, NHS England wrote to all NHS Trust and ICB Chief Executives, Chairs and senior clinical and operational leaders setting out the immediate actions required following publication of the Inquiry. The letter provides the first stage of the national response while Government considers the 17 recommendations in full and the Taskforce develops the wider National action plan. It is explicit that Thirlwall is not solely a matter for organisations with neonatal services, stating that every Trust and ICB Board should consider the findings.

The immediate requirements are summarised below:

Area	Immediate NHS England requirement	Primary responsibility	Timeframe
Board consideration	Review Thirlwall at the next available public Board meeting; consider whether similar events could occur locally; seek assurance that sufficient measures protect babies and children; urgently discuss identified risks with the Regional Team.	Provider and ICB Boards	Next available public Board meeting
Sudden Unexpected Death in Childhood (SUDIC)	Communicate to relevant staff and Boards that SUDIC processes apply to sudden and unexpected neonatal deaths in hospital.	Providers with neonatal units	By 28 September 2026
Bereavement care	Take immediate action to improve care of the bereaved, building on requirements already set out in the NHS Medium Term Planning Framework.	ICBs and providers	Immediate; no specific completion date stated
Insulin security	Meet Getting It Right First Time (GIRFT) requirements for insulin access control and storage. Until biometric access is in place, install closed-circuit television focused on insulin storage and retain recordings for at least 28 days.	Providers with neonatal units	CCTV by 30 November 2026; GIRFT requirements by 31 March 2027
Safeguarding	Ensure staff and Board members are compliant with safeguarding training at the appropriate level, understand how to raise and escalate concerns, and assure appropriate prominence for safeguarding babies and children.	Providers and ICBs	Immediate; no specific completion date stated
Parents and staff	Consider local steps to reassure parents and families receiving neonatal care and review support mechanisms for staff working in neonatal services.	Providers with neonatal services	Immediate; no specific completion date stated

The letter therefore creates immediate requirements for both NHS GM and commissioned providers ahead of the full Taskforce response. For NHS GM, this includes direct requirements relating to Board consideration, safeguarding and bereavement care, alongside appropriate oversight of provider delivery of the neonatal-specific actions. NHS GM will utilise the newly established Regional Assurance Process to provide assurance of individual provider progress against the national immediate requirements, alongside established NHS GM quality, contractual and commissioning arrangements, ensuring that any identified gaps or areas of concern are appropriately managed and escalated where required.

3. Implications for Greater Manchester

A number of the requirements highlighted by Thirlwall build upon existing national expectations and established provider and neonatal arrangements. Providers will need to consider the immediate requirements set out by NHS England and identify any areas requiring further action. The North West Neonatal Operational Delivery Network (ODN) will have an important role in providing specialist neonatal oversight and assurance of the provider response. NHS GM understands that this assurance will be captured through the newly established Regional Assurance Process, providing the ICB with visibility of provider progress and any residual risks or concerns requiring further action or escalation.

The NHS GM Maternity & Neonatal Programme will receive quarterly updates through this process and provide a system-level position to SCC, with any provider-specific risks or gaps in assurance escalated through the established NHS GM Contract Quality Mechanism where required.

Bereavement care

Bereavement care is not a new area of national expectation. The NHS England Three-Year Delivery Plan for Maternity and Neonatal Services established expectations for compassionate, high-quality bereavement care, including access to appropriate bereavement services and facilities, and the National Bereavement Care Pathway is already established nationally. The 21st September letter now requires ICBs and providers to take immediate action to improve care of the bereaved.

This requirement should be considered alongside, but not conflated with, the post-death care requirements arising from the Fuller Inquiry and reflected within Point 10 of the Maternity and Neonatal 10 Point Plan. The Fuller work provides assurance regarding governance and respectful, safe care after death; it does not in itself provide assurance on the quality of bereavement support provided to families. The neonatal response should therefore confirm that existing provider bereavement arrangements include the National Bereavement Care Pathway for neonatal death and identify any residual gaps requiring action.

Safeguarding

Safeguarding training is already governed through the NHS England Safeguarding Accountability and Assurance Framework (SAAF), which sets out the safeguarding responsibilities and competency requirements for NHS organisations and commissioned providers. The NHS England Thirlwall letter reinforces these existing requirements, requiring both providers and ICBs to ensure that staff and Board members are compliant with safeguarding training at the appropriate level and understand how to raise and escalate concerns. For NHS GM, assurance of its own organisational compliance should continue through established safeguarding governance and reporting arrangements. As a commissioner, NHS GM must also maintain assurance that commissioned providers meet the required safeguarding standards; for the neonatal-specific response to Thirlwall, provider assurance will be supported by the North West Neonatal ODN through the Regional Assurance Process, with any areas of concern escalated through established NHS GM routes

Speaking up, professional curiosity and Board oversight

Thirlwall places particular emphasis on professional curiosity, the ability of staff to raise concerns and the responsibility of Boards to understand whether governance processes are effective in practice. These are established national expectations. The National Maternity & Neonatal Three-Year Delivery Plan required provider Boards to listen and act on staff feedback, including Freedom to Speak Up data and concerns raised, while the Maternity Incentive Scheme requires evidence of Board oversight, staff feedback, culture and escalation within maternity and neonatal services.

These existing sources of assurance are relevant and should be triangulated rather than recreated. They do not, however, provide complete assurance against the wider Thirlwall requirements. In particular, Freedom to Speak Up was not a standalone Maternity Incentive Scheme Year 7 compliance requirement. The assurance question for SCC is therefore not simply whether a process exists, but whether the available intelligence demonstrates that concerns are recognised, connected, escalated and acted upon. It is anticipated that assurance against this will be provided through the North West Neonatal ODN as part of the Regional Assurance Process, with the GM position reported through the quarterly SCC update.

Neonatal-specific requirements and specialist assurance

A significant proportion of the Thirlwall recommendations and immediate NHS England actions relate directly to neonatal clinical services, including SUDIC, insulin security, mortality surveillance, data reporting and future requirements relating to neonatal monitoring. These are provider delivery responsibilities requiring specialist neonatal interpretation and oversight. NHS GM should retain clear line of sight to implementation and risk without recreating within the ICB the specialist clinical function already available through the North West Neonatal ODN.

Recommendation 17 strengthens the emphasis on demonstrable implementation rather than self-reported compliance. NHS GM will need to maintain assurance against those requirements that apply directly to the ICB through the relevant organisational governance arrangements. For provider and neonatal requirements, it is anticipated that the North West Neonatal ODN will provide specialist assurance of implementation through the Regional Assurance Process, giving NHS GM line of sight to provider progress, any residual gaps or concerns, and areas requiring further action or escalation. This will enable the NHS GM Maternity & Neonatal Programme to maintain system oversight and ensure that any identified risks or concerns are escalated through established NHS GM routes where required.

4. Greater Manchester oversight and assurance approach

The Regional Assurance Process is underpinned by the North West Perinatal Quality Assurance & Oversight Model, which provides the framework through which implementation of national maternity and neonatal priorities will be assured. The model is supported by the Perinatal Performance & Oversight Panel (PPOP), bringing together ICB assurance with specialist clinical and network assurance, including that provided by the North West Neonatal ODN. The Regional Assurance Process is designed to remain dynamic and incorporate emerging national requirements, including the outputs of the National Maternity and Neonatal Taskforce.

PPOP will provide the regional assurance route for implementation of the National Maternity and Neonatal Taskforce action plan. As the Taskforce is explicitly required to address the Thirlwall recommendations, Thirlwall will therefore form part of the national requirements tracked through this regional assurance process.

The North West Neonatal ODN provides the specialist neonatal network function across the three North West ICBs and is represented within PPOP. It is proposed that the ODN leads the specialist neonatal element of the Thirlwall response with providers, providing professional and clinical assurance into PPOP on behalf of the North West system. NHS GM will retain commissioning and Quality & Safety Management oversight of the neonatal services it commissions and use the resulting specialist assurance to inform its wider provider oversight, escalation and commissioning responsibilities.

This approach will strengthen, rather than duplicate, existing NHS GM provider oversight and commissioning arrangements. Where assurance is obtained, this will be captured through routine oversight. Where concerns or gaps in assurance are identified, these will enter the established NHS GM Contract Quality Escalation Mechanism through provider Quality Review Meetings and, dependent upon the level of assurance and response, can escalate through Contract Review Meetings and ultimately to Provider Oversight Meetings, providing an ICB Executive-to-provider Executive route where required.

In parallel, the planned quarterly maternity and neonatal assurance update to SCC, aligned to the PPOP reporting cycle, will provide routine system-level visibility of the GM position. This will enable SCC to see areas of assurance, emerging themes, direct ICB responsibilities and any provider escalation within one joined-up assurance route, rather than receiving separate updates for each national review or requirement.

The immediate actions within the NHS England letter should progress now through the routes described in Sections 2 and 3. The wider implementation requirements will develop through the Taskforce action plan and PPOP. This provides a clear distinction between actions which cannot wait for the national response and the longer-term assurance framework through which the full Thirlwall recommendations will be tracked.

5. Recommendations

NHS Greater Manchester Integrated Care Board is asked to:

- Note the findings and recommendations of the Thirlwall Inquiry and the immediate requirements subsequently set out by NHS England.

- Support the proposed Greater Manchester approach to assurance, with requirements applying directly to NHS GM managed through the relevant organisational governance arrangements, and specialist neonatal assurance of provider implementation anticipated through the North West Neonatal Operational Delivery Network (ODN) and Regional Assurance Process.

- Support the NHS GM Maternity & Neonatal Programme receiving routine updates on the GM assurance position and reporting this to SCC through the forward planned quarterly maternity and neonatal updates.
- Support escalation of any provider-specific risks, concerns or gaps in assurance through the established NHS GM Contract Quality Mechanism where required.

Sources

Department of Health and Social Care (15 September 2026), Thirlwall Inquiry report.

The Thirlwall Inquiry, Summary Report and Chapter 45: Recommendations.

NHS England (21 September 2026) » Thirlwall Inquiry report and recommendations letter to NHS Trusts and Integrated Care Boards

Department of Health and Social Care, National Maternity and Neonatal Taskforce - published objectives.

NHS England, Perinatal Quality Oversight Model.

NHS England North West, Perinatal Quality Assurance & Oversight Model.

NHS England, Three-Year Delivery Plan for Maternity and Neonatal Services.

NHS England, Safeguarding Accountability and Assurance Framework (fifth edition, 2026).

NHS England, Maternity and Neonatal 10 Point Plan assurance process.

NHS Resolution, Maternity (Perinatal) Incentive Scheme Years 7 and 8.

Appendix 1 - Summary of Thirlwall Inquiry recommendations

The table below summarises the 17 recommendations and the responsibility explicitly assigned by the Inquiry. No recommendation within the Inquiry itself is assigned directly to an Integrated Care Board.

Recommendation	Key requirement	Inquiry-assigned responsibility
1. CCTV and monitoring	Baby monitors with livestreaming video on all neonatal cots/incubators; centrally managed, ring-fenced funding; implementation roadmap by 31 March 2027.	NHS England / national funding arrangements
2. Insulin	Digital access controls for insulin; neonatal units to meet GIRFT requirements by 31 March 2027; CCTV until biometric access is established; national laboratory guidance to become mandatory.	Providers / NHS England
3. Bereavement care	National Bereavement Care Pathway for neonatal death implemented nationally and in all providers by 31 August 2027.	Providers / national implementation
4. Safeguarding and employment contracts	Safeguarding training for all provider staff and Boards; employment, bank and agency contracts to require compliance with safeguarding guidance and the new deliberate-harm protocol.	Providers / NHS employers
5. Digital interoperability	Timed route to harmonised NHS computer systems by December 2028 and mandatory interoperability standard.	NHS England
6. Monitoring deaths	Board-level monitoring of all deaths of children and babies and predetermined escalation routes for concerning trends by 31 March 2027.	Providers
7. Data reporting	Hospitals with neonatal units to appoint a trained lead reporter; at least weekly data input/review of real-time MBRRACE neonatal and maternity data; Board reporting at least six-monthly or immediately where action is required.	Providers with neonatal units
8. SUDIC	Confirm Sudden Unexpected Death in Childhood processes apply to babies dying suddenly and unexpectedly without leaving hospital; provider briefing and revised national guidance.	NHS England / DHSC / providers
9. Suspicion of Deliberate Harm	National protocol and short guidance by 31 March 2027; immediate action on good-faith concerns; providers to embed protocol locally.	NHS England / providers
10. Independent expert panel	Consider establishment of a multidisciplinary national expert panel for rapid independent investigation of emerging concerns about patient harm.	DHSC
11. Medical examiners	Neonatal-specific guidance, stronger safeguarding questioning, interim access to neonatologists and review of the Medical Examiner system.	National Medical Examiner / DHSC
12. Paediatric/perinatal pathology	Increase training capacity to 37 doctors in paediatric/perinatal pathology posts by June 2033 and maintain incentives until achieved.	DHSC / NHS England
13. Regulation/accountability of managers	Manager barring system by September 2027; strengthened fit-and-proper arrangements, individual duty of candour and revised leadership standards.	Government / NHS England
14. Care Quality Commission	Unannounced departmental inspections using current practising specialists; greater focus on whether safety processes are effective rather than simply present.	Care Quality Commission
15. Care Quality Commission performance	Rigorous and consistent review of Care Quality Commission performance.	Health and Social Care Committee

Recommendation	Key requirement	Inquiry-assigned responsibility
16. Whistleblowing	Transfer National Guardian's Office functions to the Parliamentary and Health Service Ombudsman with expanded powers relating to mishandled whistleblowing.	National / Government action
17. Implementation	National Audit Office responsibility for auditing implementation of recommendations arising from statutory NHS inquiries.	Government / National Audit Office

NHS
Greater Manchester

Quality and Performance Board Paper
November 2026

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

NHS Greater Manchester Board – November 26

Required information.	Details.
Title of report.	Quality and Performance Report
Author.	Claire Scott – Performance Lead Anita Rolfe, Deputy Chief Clinical Officer, Nursing and Nurse Advisor to the board Amy Jeffery, Quality Manager
Presented by.	Manisha Kumar, Chief Clinical Officer
Contact for further information.	Anite Rolfe: anitarolfe@nhs.net
Executive summary.	This report provides the Board with an overview of current system performance and quality across NHS Greater Manchester, using the Assure, Alert and Advise approach. It highlights key areas of achievement, areas requiring continued oversight and escalation, and the actions being taken through provider, locality and system governance arrangements. The Board is asked to discuss and agree the levels of assurance set out in this report, noting areas rated Alert, Advise and Assure across performance and quality.
The benefits that the population of Greater Manchester will experience.	Improvement in performance and quality will support safer care, better access, reduced waits, improved outcomes and a more consistent experience for people using services across Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	The report includes oversight of variation in service performance and quality across Greater Manchester and supports targeted action to reduce unwarranted variation, improve access and strengthen outcomes for communities experiencing poorer care or longer waits.
The decision to be made and/or input sought.	The Board is asked to: 1. Discuss and agree the levels of assurance for performance and quality set out in the report. 2. Receive the ALERT section of the paper as escalations to the board

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This report supports delivery of operational priorities by providing Board oversight of system performance, quality risks and improvement actions. It also contributes to assurance against relevant Board Assurance Framework risks relating to quality, operational delivery and service resilience.
Key milestones.	The report reflects monthly and quarterly monitoring of key performance standards, quality risks, provider oversight arrangements and improvement actions across the system.
Leadership and governance arrangements.	The report is informed through established provider, locality and system governance arrangements, including quality review meetings, provider oversight processes, system boards and committees.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The report draws on information from localities, providers, system boards and committees. Specific engagement activity sits within the individual programmes and services referenced, rather than within the preparation of the report itself.
Financial or Legal Implications	There are no direct financial or legal implications arising from this report. It is provided for assurance and oversight.

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

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

1. Introduction

1.1 This paper advises the Board on the levels of assurance regarding performance and quality. It is completed using information from localities, system boards and committees within the NHS Greater Manchester (NHS GM) integrated care system. The paper highlights material issues for Board. The paper also briefs Board on provider and locality assurance arrangements.

1.2 This report uses the "Assure, Alert and Advise" approach aimed to direct members to the key issues and provide an understanding of the work that is being completed to address these issues.

ALERT: Alert to matters that require escalation for the board's attention or action
ADVISE: Advise of areas of ongoing monitoring or development
ASSURE: Inform the board where assurance has been achieved

1.3 The Board is asked to discuss and agree levels of assurance set out in this report.

2. Performance

2.1 This section highlights current performance against key deliverables. Detailed narrative commentary is provided for Alert domains, with brief updates for Advise and Assure metrics. The framework identifies nine Alert, three Advise and five Assure metrics, supporting partial assurance overall. Reporting periods vary by measure: most measures use August data, UEC uses September data, and the overall GM Talking Therapies position uses July data because Greater Manchester Mental Health NHS Foundation Trust did not publish August data for these measures.

Alert

2.2 In August, GM Acute Providers achieved 61.5% of clock stops within 18 weeks against a plan of 63.5%, while GM Registered performance was 63.0% against a plan of 64.7%. Latest forecasts indicate a widening gap against plan, driven by NCA's expected shortfall due to ongoing industrial action. NCA estimates that its performance will be 5 percentage points below plan by March 2027.

2.3 GM has established a system-wide elective recovery programme to address the growing risk to delivery of the H2 RTT trajectory, with NHS England holding GM accountable for overall system performance. The GM Elective Recovery Cell will coordinate additional provider activity and maximise NHS, Independent Sector, community and validation capacity. Providers are developing stretch plans beyond their existing H2 commitments, supported by strengthened weekly monitoring. Targeted recovery arrangements remain focused on NCA, while additional delivery across GM aims to offset system risk and increase the proportion of patients treated within 18 weeks.

2.4 Other system actions are progressing including strengthening Advice and Guidance, revised Beyond Core Contact Review scheme, consistent delivery of community pathways and Single Point of Access programmes.

2.5 The total elective waiting list remains above plan and is a material risk to the year-end trajectory. In August, the GM Acute Provider waiting list increased to 441,682 from 438,906 in July, against a plan of 412,948. The GM Registered waiting list increased to 411,464 from 405,139, against a plan of 352,213. Growth in both waiting lists widened the recovery gap despite improvement compared with the same period last year.

2.6 Both four-hour emergency care performance and 12-hour A&E waits are rated Alert. In September, four-hour performance deteriorated to 69.2% from 71.8% in August, against a plan of 74.9%. The proportion of patients attending type one and two A&E departments waiting 12 hours or more increased to 10.2% from 8.1%, against a plan of 7.5%, with 9,728 patients waiting 12 hours or more. Provider shortfalls remain widespread, reflecting continued patient flow, discharge and capacity pressures.

2.7 UEC recovery arrangements are monitoring provider H2 trajectories, delivery against forecast and actions required where providers remain off plan. Priorities include stronger system oversight and clearer individual patient escalation responsibilities, more consistent care coordination and Single Point of Access models, stronger community capacity and increased Hospital at Home utilisation. The GM OPEL Escalation, Surge and Recovery Framework is planned for launch in November. The GM Falls Lifting Service went live on 1 October and runs until 31 March 2027. Care Coordination and Hospital at Home programmes remain Amber, with delivery dependent on partner engagement, capacity and clearer accountability.

2.8 Diagnostic waits of six weeks, or more are now rated Alert. In August, 14.2% of patients at GM Acute Providers were waiting six weeks or more for a diagnostic test or procedure, against a plan of 9.8%. GM Registered performance was 14.4% against a plan of 11.5%. Both positions deteriorated from 12.0% in July, interrupting the earlier improvement, although performance remains better than the same period last year.

2.9 Diagnostic recovery actions focus on capacity, productivity and pathway improvements. These include the cardiac CT review, THRIVE productivity work, improved booking towards a maximum 5% missed-appointment rate with a focus on audiology, standardising gastroenterology pathways and validating endoscopy surveillance lists. A sonography workforce review is planned by December, with a three-to-five-year workforce plan by March 2027. Financial constraints and delays in testing enhanced diagnostic attendance data remain delivery risks.

2.10 NHS Talking Therapies reliable recovery, reliable improvement and completed courses of treatment remain rated Alert. The latest overall GM position uses July data: reliable recovery was 46.2% against a plan of 51.0%; reliable improvement was 67.8% against a plan of 69.0%; and completed courses of treatment were 3,045 against a plan of 3,846. August data was not published by Greater Manchester Mental Health NHS Foundation Trust for these measures, so a complete August GM position is not available.

2.11 Targeted improvement work continues through established mental health governance and assurance arrangements. Provider reporting indicates stronger performance for newer referrals, but internal treatment flow remains challenging, including extended waits between first and second treatment appointments. Improvement work remains focused on recovery, reliable improvement and treatment activity.

2.12 Inappropriate adult acute Out of Area Placements remained at four in August, above the plan of two. Capacity, patient flow and discharge pressures continue to require system oversight. Actions remain focused on improved discharge planning and community alternatives.

2.13 Inpatient care for autistic adults without a learning disability remains rated Alert. In August, there were 60 autistic adults in inpatient care against a plan of 48. Delivery remains constrained by insufficient community alternatives and step-down capacity, alongside barriers to timely discharge, placement and commissioning decisions. Actions focus on crisis support, admission avoidance and step-down provision to reduce reliance on inpatient care.

Advise

2.14 The 28-day Faster Diagnosis Standard remains rated Advise. In August, GM Acute Providers and GM Registered performance were both 78.5%, against plans of 80.1% and 79.8% respectively. Performance remains below plan and the 80% national standard and will continue to be monitored through Cancer Alliance governance arrangements.

2.15 The 62-day cancer treatment standard remains rated Advise. In August, GM Acute Providers achieved 76.4% against a plan of 76.9%, while GM Registered performance was 75.7% against a plan of 76.7%. Both remain below plan and will continue to be monitored through Cancer Alliance governance arrangements.

Assure

2.16 Category 2 ambulance response times remain rated Assure. In September, the average response time was 19 minutes and 57 seconds, remaining within the 2026/27 national target of 25 minutes.

2.17 The 31-day cancer treatment standard remains rated Assure and above plan. In August, GM Acute Providers achieved 96.8% against a plan of 94.6%, with GM Registered performance at 96.6% against a plan of 93.7%.

2.18 Inpatient care for adults with a learning disability, who may also be autistic, is now rated Assure. In August, there were 40 adults in inpatient care against a plan of 42, reflecting progress in reducing reliance on inpatient services. Work continues to sustain this improvement through community alternatives and discharge arrangements.

2.19 Community waiting times remain rated Assure. In August, 86.9% of people on the community services waiting list were waiting 18 weeks or less, against a plan of 82.1%, improving from 86.5% in July.

2.20 Individual Placement and Support activity remains rated Assure and above plan. In August, 4,785 people accessed support on the 12-month rolling measure, compared with a plan of 3,240, increasing from 4,740 in July.

3. Quality Update

Alert

3.1 Lancashire and South Cumbria FT (LSCFT) Peripheral Houses IPC Safeguarding Alert

A significant safeguarding and quality concern has been identified following a whistleblowing disclosure regarding Peripheral Houses IPC (Run by LSCFT) supporting individuals with learning disabilities. NHS GM has 1 patient resident in this facility. Affected patients (including the 1 NHS GM patient) have been relocated from Peripheral Houses to alternative accommodation at Water Meadow View. The concerns are being reviewed through a Rapid Quality Review process involving LSCFT, Lancashire and South Cumbria ICB (as lead NHS commissioner), Lancashire County Council and the CQC.

Regulatory Triggers

- Safeguarding concerns have been formally notified to the Care Quality Commission (CQC) and NHS England.
- A police referral and Section 42 safeguarding referral were identified as immediate actions and have been completed.
- The concerns have prompted multi-agency oversight involving the CQC, Lancashire ICB, Lancashire County Council and NHS partners.

Residual Risk Whilst immediate actions have been taken to reduce the risk of harm, a moderate residual risk remains pending the outcome of safeguarding, police and regulatory investigations. Uncertainty remains regarding the full extent and duration of the alleged concerns, the impact on affected individuals, organisational culture within the service, and the sustainability of longer-term care arrangements.

3.2 Greater Manchester Mental Health NHS Foundation Trust (GMMH)

GMMH has received a recent CQC Section 29A Warning Notices.

August 2026 notice

Following a June inspection, CQC identified ineffective systems and processes for assessing, monitoring and improving the safety of community-based mental health services for adults awaiting assessment, treatment or intervention; while a community transformation plan is in place, significant improvement was reported as required.

CQC have recently inspected older adults community and crisis services with outcomes due to be published soon

Mitigation includes the Trust‘s implementation of their community transformation plan and NHS GM requesting the Trust’s improvement plans for review at the November 2026 QRM. Discussion between NHS GM, NHSE NW regional team and NHS Specialist Commissioning

colleagues to cross reference known concerns and agree shared approach to continued monitoring and oversight.

Residual risk remains in relation to the identified safety, governance, workforce and environmental concerns pending evidence of improvement through the Trust's response and ongoing regulatory/ICB oversight. Timescales for improvement have the further potential to impact on the above for a prolonged time period.

Advise

3.3 Quality Review Meeting (QRM) Updates since last meeting

The joint Quality Review Meeting for Stockport and Tameside & Glossop considered a range of quality and safety assurance matters, including clinical documentation and record keeping, Emergency Department medical staffing, interpretation services and winter vaccination arrangements. Tameside reported completion of a Trust-wide review of clinical documentation and record keeping, with improvement actions and formal governance arrangements established through a dedicated Task and Finish Group; the inpatient audit identified overall compliance of 65.2%, with a further re-audit planned for January 2027. The meeting also reviewed ED workforce arrangements against RCEM principles, with identified gaps in consultant establishment, alongside plans for influenza vaccination of eligible long-stay patients and those being discharged to care homes. A further issue raised was critical care/HDU capacity at Tameside, which the Trust highlighted as an ongoing concern ahead of winter; this was noted by the ICB for consideration with clinical colleagues.

3.4 Maternity and Neonatal Programme – Greater Manchester

The Greater Manchester Local Maternity and Neonatal System (LMNS), on behalf of NHS Greater Manchester ICB, has completed the first provider-level assurance exercise against the NHS England Maternity and Neonatal 10 Point Plan across all six GM maternity providers. A multidisciplinary clinical expert panel was established to review and triangulate provider evidence, providing a consistent and clinically informed approach to assurance. The completed GM submission has undergone quality control by the NHS England North West Regional Maternity Team, which has confirmed satisfaction with the assurance process undertaken and incorporated the GM findings into its wider regional submission to the national team. This initial submission represents a benchmarking exercise, further detail on the GM position, emerging themes and implications for ongoing oversight will be presented to the December Strategic Commissioning Committee, in line with the agreed forward plan.

3.5 Greater Manchester Hospice Quality Visits

A programme of quality visits to Greater Manchester hospices is being undertaken as part of NHS Greater Manchester's wider approach to quality assurance and improvement. The visits will provide an opportunity to engage directly with hospice teams, understand the delivery of care and explore key aspects of patient safety, experience, workforce, culture, safeguarding and governance. Learning from the programme will help identify and share good practice, support improvement and strengthen collective assurance regarding the quality of hospice care across Greater Manchester.

Assure

3.6 Primary Care Quality Review Meeting

The first Primary Care Quality Review Meeting was held on 23 September 2026, marking an important step in strengthening the ICB's systematic approach to quality and safety oversight across general practice, community pharmacy, dentistry and optometry. The meeting established the foundations for improved triangulation of quality intelligence, identification and escalation of emerging risks and unwarranted variation, and clearer oversight of patient experience and safety. The developing arrangements will build on existing contractual and quality assurance mechanisms, strengthening connectivity between primary care commissioning and quality functions and providing a clearer line of sight through the ICB's quality governance arrangements to SCC

Achievements

3.7 Maternity & Neonatal Programme

Maternal Care Bundle Implementation Event (28 September 2026)
The Greater Manchester Local Maternity and Neonatal System (LMNS), in collaboration with the North West Maternal Medicine Network, hosted a system-wide Maternal Care Bundle (MCB) Implementation Event, bringing together colleagues from maternity, neonatal, ambulance, primary care and specialist services. The event provided an opportunity to share progress across the five MCB elements, highlight developments in regional guidance and pathways, and support consistent implementation across GM. Interactive multidisciplinary workshops focused on improving timely access to thromboprophylaxis and addressing digital and data challenges, enabling partners to identify practical solutions and agree next steps to support implementation and reduce unwarranted variation.
Maternity, Primary Care & Neighbourhood Collaborative (8 October 2026)
GM LMNS hosted the second Maternity, Primary Care and Neighbourhood Collaborative, bringing together colleagues from across maternity, primary care and neighbourhood services to strengthen integrated working and improve continuity of care for women and families. The event focused on shared priorities including implementation of the Maternal Care Bundle, early identification and management of venous thromboembolism risk, the postnatal 6–8 week GP consultation, postnatal care and contraception. Interactive workshops supported multidisciplinary discussion on improving pathways between services, strengthening postnatal

support and developing more consistent approaches to care across Greater Manchester.

3.8 Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT) - Innovation to improve access and reduce inequalities

TGICFT has introduced **video-on-demand interpretation** to improve timely access to interpreting support where increasing demand and reduced availability of face-to-face interpreters had contributed to delays, cancellations, poorer patient experience and rising costs. The technology provides **24/7 access to more than 500 languages plus British Sign Language (BSL)**, without the need to pre-book, enabling interpreting support to be accessed more readily at the point of care.



The early outcomes provide strong positive learning. The Trust reports **1,388 patient interactions**, 298 more than July 2025, delivered at a cost of **£12.6k, £5.7k less than July 2025**. Video interpretation increased from **5 sessions to 722**, while the Trust reports fewer delays and cancellations, less use of inappropriate interpretation solutions and an increased number of consultations suggestive of improved patient experience. The model is estimated to offer a **potential annualised saving of £68,400**.

4. Recommendations

4.1 The NHS GM Board is asked to discuss and agree the levels of assurance set out in this report

NHS
Greater Manchester

Audit Committee Report

18 November 2026

NHS
Greater Manchester

Integrated Care Board

18 November 2026

Required information	Details
Title of report	Audit Committee Report
Author	Jenny Noble, Board and Committee Secretary
Presented by	Richard Paver, Non-Executive Director / Audit Chair
Contact for further information	Jenny Noble
Executive summary	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The Board is asked to: • Note the contents of the verbal report including items for escalation and provide feedback to the Committee Chair.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
Key milestones	N/A
Leadership and governance arrangements	This is a summary report following the September Audit Committee meeting.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Draft report shared with the Chair for comments.
Financial or Legal Implications	N/A

Table 1 - core information relating to the content and creation of paper

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

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

NHS
Greater Manchester

Report from:	**Audit Committee**
Date of Meeting:	17 September 2026
Chair:	Richard Paver
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert

Data quality: The Committee raised concern that the limited-assurance data quality review remained outstanding. Completion of the report and action plan remained a priority, with escalation to the Chief Executive proposed and wider data quality concerns to be progressed through the Strategic Commissioning Committee. Escalation and resolution arrangements required clearer documentation before the next meeting.

Outstanding audit recommendations: Although progress was improving, some actions had remained outstanding for up to 18 months, particularly in IT. A position statement was requested following revised implementation dates at the end of September and beginning of October, with continued Chief Officer oversight.

IT, cyber security and information governance: The Data Security and Protection Toolkit review remained rated High Risk and High Confidence, with three high-risk recommendations. The Committee sought an overarching delivery plan covering outstanding audit actions, resource requirements, funding options and resulting risk levels to support Board decision-making. Infrastructure renewal remained dependent on funding, and mandatory data security training compliance required improvement.

Procurement and Provider Selection Regime (PSR): The Committee requested that Strategic Commissioning Committee take due consideration to procurement policies and processes when discharging its duties

Advise

External auditor appointment: In Part C, the committee considered the external audit arrangements when the 2026/27 contract ends and the options available.

Internal audit coverage: Changes to the audit plan included an All Age Continuing Care review and cancellation of a Continuing Healthcare review together with a

review on how quality and safety were assured with an emphasis on NCA. The Committee requested the new reviews' terms of reference, including assurance on safeguarding, provider oversight and reporting, and suggested consideration of maternity assurance within this work or separately.

Information risk oversight: The Senior Information Risk Owner (SIRO) function was transitioning to Nicola Hepburn, Acting Chief Reform and Improvement Officer. Freedom of Information reporting was to be incorporated into future SIRO reports.

Governance and development: National issues affecting declarations and conflicts of interest recording had been escalated for resolution. PSR training remained on the Board development schedule but had not yet been scheduled, so the action remained open.

External Audit Value for money recommendations: Progress was reported against four audit recommendations; one key recommendation remained ongoing and aligned to current and future planning.

Assure

Internal audit delivery and follow-up: Five final reports had been completed, four reviews were in progress and two had commenced. An overarching recommendations tracker was showing improvement. Ninety-five recommendations, including 26 high-priority recommendations, had been reviewed; seven actions had been identified as superseded and remaining open actions were confirmed as current and relevant. Monitoring would continue through Chief Officers and the Operational Leadership Group; outstanding actions remained an assurance gap.

Internal audit service quality: The Committee noted that MIAA's external quality assessment by the Chartered Institute of Public Finance and Accountancy had achieved its highest rating. A small number of improvement recommendations were being addressed.

Improvement arrangements: A Data Quality Improvement Plan and Policy were in place and being implemented. The year-end review by Grant Thornton identified continued improvements, with actions on working papers, contract variations and annual report amendments to be addressed ahead of the next audit. Procurement training, a digital waiver register and a contract register had been introduced to strengthen oversight and forward planning, although further improvement remained necessary.

Risks discussed and new risks identified

The Committee discussed risks arising from unreliable or delayed data affecting commissioning and decision-making; delayed implementation of audit recommendations; IT and cyber security, including infrastructure renewal, supplier assurance, information asset management, business continuity, backup and recovery, and training compliance; and procurement capacity, contract management and PSR compliance. Organisational change and staffing gaps had contributed to delays in progressing recommendations. Further assurance was sought through clearer delivery plans, resourcing and funding proposals, continued audit follow-up and appropriate committee escalation.
Learning for sharing
Year-end financial reporting: Learning from the 2025/26 audit would inform improvements to working papers, signed contract variations and the process for annual report amendments. The Committee emphasised organisation-wide readiness for 2026/27 and reiterated consideration of a simplified annual report.

NHS
Greater Manchester

Minutes

NHS Greater Manchester People & Resource Committee – Public

Date: Wednesday 26 August 2026

Time: 14:00 – 15:30

Venue: MS Teams

MEMBERS:		
Kal Kay	**KK**	Non-Executive Director, Chair
Richard Paver	**RP**	Non-Executive Director
Sue Bailey	**SB**	Non-Executive Director
Vish Mehra	**VM**	Partner Member - GP
Kathy Roe	**KR**	Chief Finance Officer
IN ATTENDANCE:		
Jo Street	**JS**	Programme Director – Transition (deputising for CB)
Ed Dyson	**ED**	Director of Performance, Improvement & Assurance (deputising for NH)
Stephen Downs	**SD**	Deputy Chief Finance Officer
Chris Gaffey	**CG**	Associate Director of Corporate Services
Jackie Gardiner	**JG**	Corporate Director of Operational Finance – Financial Management
Katherine Sheerin	**KS**	Chief Commissioning Officer
David Boulger	**DB**	Associate Director – Population Health
Rachael Nielsen	**RN**	Strategic Lead – Population Health
Ross Baxter	**RB**	Corporate Governance and Risk Advisor (Minutes)
Jo Harrison	**JH**	Executive Administration Officer (observing)
Jacqueline Dennis	**JD**	Executive Administration Officer (observing)
APOLOGIES:		
Colin Scales	**CS**	Acting Chief Executive Officer
Charlotte Bailey	**CB**	Chief Strategy, People and Partnerships Officer
Nicola Hepburn	**NH**	Acting Chief Reform and Improvement Officer
Owen Williams	**OW**	Partner Member - Chief Executive Officer, Northern Care Alliance

Item No	Item
	PUBLIC
1.	**Introductions and Apologies** KK welcomed everyone to the meeting and the apologies were noted. The Attendance Matrix was shared for information.
2.	**Declarations of Interest** The People & Resource Committee Conflict of Interest Register was shared for

	information. There were no additional declarations or conflicts of interest declared at the meeting.
3.	**Minutes, Action Log and Matters Arising** The minutes of the last People and Resource Committee were approved as an accurate record, subject to the correction of a year in section 6 on page 8. There were no updates to the action log to be noted. At the start of the meeting the committee were notified regarding the significant pressures being experienced across the Greater Manchester system as a result of the developing situation at the Northern Care Alliance (NCA). It was explained that the volume and seriousness of issues affecting NCA had resulted in a number of Chief Officers being unable to attend the meeting, with several apologies received. Members were advised that the absence of officers was not due to unavailability or disengagement but reflected the considerable operational demands being placed upon the executive team as they responded to events unfolding across the system. Patient safety remained the overriding priority and members were asked to be mindful of the extraordinary pressures on officers during consideration of the agenda. It was noted that while the organisation was not formally operating under business continuity arrangements, it was approaching that level of operational intensity. Providing further context, it was explained that a number of complex and challenging issues were affecting NCA simultaneously and required distinct responses. The importance of separating these issues rather than viewing them as a single matter was stressed. The most immediate concern was the industrial action affecting NCA, which was requiring intensive system-wide coordination to maintain safe services. Officers from NHS Greater Manchester and partner organisations were working closely with NCA colleagues to ensure that patient care remained safe both within NCA hospitals and across the wider Greater Manchester system. Members heard that the effects of industrial action extended beyond the strike days themselves, creating additional pressures through the management of displaced activity and subsequent backlogs. Significant effort was therefore being focused on preventing risks to patient safety and ensuring that pressures were not inadvertently transferred to other providers across the system. Despite these challenges, it was noted that the situation was demonstrating the benefits of the Integrated Care Board's role as a system convenor. Officers were seeing evidence that relationships and collaborative arrangements established across Greater Manchester were supporting an effective collective response to the operational pressures being experienced. In addition to the immediate operational issues arising from industrial action, members were advised that considerable attention was also being directed towards wider quality and safety concerns associated with NCA. A number of issues identified through independent reviews and NHS England assessments over recent months had progressed to a stage where more formal action was being required. These matters were generating substantial discussion and scrutiny across the health and care system and were attracting significant political and stakeholder interest. Officers were therefore heavily engaged in managing the organisational response, including developing stakeholder engagement arrangements and communications plans. The committee heard that particular attention was being given to managing relationships

	and communications with local partners in the four localities within the NCA footprint, namely Bury, Rochdale, Oldham and Salford. NHS Greater Manchester was working closely with local stakeholders to provide support, manage concerns and coordinate responses to developments as information emerged. Members were advised that these activities were further contributing to pressures on the executive team, with officers being required to attend numerous meetings and engage with a wide range of stakeholders throughout the week.
4.	**Terms of Reference Review** A review of the Committee's Terms of Reference was presented following the commitment made when the committee structure was established in April to undertake a three-month review. The review incorporated feedback received from committee members together with discussions that had taken place between Non-Executive Directors and Executive colleagues regarding the committee's operation and membership. Proposed amendments included the addition of responsibility for procurement and contracting strategy within the committee's finance remit, recognising that while aspects of procurement may overlap with other committees, the People and Resources Committee should act as the principal approval forum for procurement and contracting matters. Further amendments included increasing the committee quorum from three to four members, including an additional Chief Officer, reflecting the level of delegated authority held by the committee, together with changes to membership arrangements and a number of minor drafting and clarifying amendments, including greater clarity regarding items that should be considered in public and private session. Members discussed the proposed changes in detail, with concern expressed regarding the proposed alterations to committee membership, particularly the position of partner members and the wider role of Chief Officers within committee structures. He felt these were matters that should be considered corporately by the Board rather than determined independently by individual committees and indicated that some members remained uneasy about the proposed approach. In response it was noted that prior discussions had taken place with the Chair and Board Secretary regarding committee memberships and governance arrangements, recognising that the committee structure would inevitably continue to evolve over time. The inclusion of procurement and contracting responsibilities within the Terms of Reference was supported but it was suggested that the wording should extend beyond procurement strategy alone to include the procurement framework itself. It was noted that establishing an approved framework would provide a clearer basis for future procurement decisions and ensure a consistent approach to decision-making. It was further highlighted that the Terms of Reference should explicitly acknowledge that certain procurement decisions may appropriately be considered within Part 2 business, citing recent procurement discussions that had been conducted in private session due to their nature and sensitivity. Members agreed that the wording should provide greater clarity regarding the committee's role in both procurement governance and procurement decision-making. The Committee also considered how best to reflect the Socio-Economic Duty within the Terms of Reference. A request had emerged from that agenda item to strengthen the committee's reference to the duty, with a suggestion that any amendment should be mirrored within the Terms of Reference of both Board committees to ensure consistency across the governance framework. It was proposed that, rather than creating a standalone section, the duty could be incorporated within the Equality, Diversity and

	Inclusion responsibilities already contained within the Terms of Reference, and members agreed this was a sensible approach and recognised the socio-economic duty as an important consideration alongside the organisation's wider equality responsibilities. The Committee concluded that the proposed amendments should be refined to reflect the comments raised during discussion, including clarifications relating to procurement governance, membership arrangements, Part 2 decision-making and the inclusion of the Socio-Economic Duty. Subject to those amendments, the revised Terms of Reference would be progressed to the Board for formal approval and ratification. **NHS GM People & Resource Committee considered and agreed the proposed changes to the Committee's Terms of Reference before presentation to the Board for approval.**
5.	**Chief Strategy, People & Partnerships Officer Update (incl. Workforce Report)** The Committee received the update covering workforce metrics, organisational development priorities, health and safety arrangements, anti-racism activity and the emerging staff pulse survey results. The committee was advised that a number of the core workforce indicators remained outside expected standards, including mandatory training compliance, turnover, sickness absence and appraisal completion rates. However, it was acknowledged that the organisation continued to experience the effects of significant organisational change and workforce reform activity, creating instability across some teams and influencing current performance against targets. Members were directed to the supplementary workforce dashboard and workforce reports which outlined a range of improvement actions focused on organisational stabilisation, strengthening line management practice and increasing staff engagement. A key development highlighted was the rollout of new self-service workforce dashboards, providing managers and directors with direct access to workforce information at team and portfolio level. It was emphasised that these dashboards would enable more detailed analysis of workforce trends and support targeted interventions to improve performance against key workforce measures. The committee also received an update on health and safety arrangements. Members were informed that the organisation was in the process of implementing alternative arrangements due to the impending departure of the current postholder responsible for health and safety. Assurance was provided that immediate continuity arrangements had been established through an interim internal solution and that work was well advanced on developing a medium-term model. An options appraisal had been completed and procurement routes and potential delivery partners were being explored to secure a longer-term sustainable approach. Committee members were reassured that both short and medium-term arrangements were being actively managed to maintain statutory compliance and organisational safety. An update was also provided on anti-racism activity and inclusion work. Members heard that anti-racism remained a priority organisational objective and were advised that progress had been made towards establishing the Inclusion Leadership Steering Group. The committee was informed that the group would formally launch in September and would bring together staff network chairs, executive leaders, board representatives and colleagues with lived experience. It was explained that the new structure would strengthen the organisation's inclusive leadership approach by ensuring that diverse perspectives informed decision-making and organisational development activity.

	The committee discussed the results of the first staff pulse survey. It was reported that a strong response rate had been achieved, sufficient to provide meaningful results not only at organisation-wide level but also by portfolio and place partnership. Members noted that this represented an important step forward in understanding workforce experience and would enable directors and line managers to undertake targeted local action planning. Although the results had not yet been formally published, it was acknowledged that they presented a mixed picture, reflecting the challenges currently being experienced across the organisation. Nevertheless, officers considered the findings valuable because they provided detailed intelligence on staff experiences and sentiments during a period of significant change. Members were advised that the results would shortly be shared with chief officers and a detailed report would be presented to a future meeting of the committee. Committee members then scrutinised the workforce metrics in greater detail. The effectiveness of the People and Culture Subgroup was questioned, noting that the report indicated it was not yet functioning as intended due to gaps in membership from finance and commissioning teams. Assurance was sought on when the required memberships would be secured and the group would become fully operational. There was also a query on whether rising sickness absence levels were linked to colleagues affected by redundancy processes and organisational change, and whether analysis had been undertaken to distinguish between those leaving the organisation and the wider workforce. In addition, concern was expressed regarding mandatory training compliance, noting particularly low performance amongst executive leaders and stressing that senior leaders should be setting an example to the wider workforce. Clarification was requested regarding the cohorts included in the executive leadership metrics and whether non-executive directors formed part of the reported figures. It was also suggested that additional analysis would be beneficial to distinguish normal workforce turnover from turnover associated with organisational restructuring and redundancies, arguing that the current figures made it difficult to interpret true workforce trends. A query was raised on how sickness absence levels compared with other ICBs and healthcare organisations, suggesting that benchmarking information would help the committee determine whether performance represented a local concern or reflected broader national trends. It was confirmed that future reports would provide a more detailed breakdown of turnover data, separating voluntary turnover from compulsory redundancies to give a clearer picture of workforce retention. The committee's concerns regarding mandatory training were acknowledged and a commitment made to driving improvement across the executive leadership cohort, confirming that this group extended beyond the chief officer team alone and that further clarification of membership could be provided. Regarding sickness absence, it was confirmed that organisational change and redundancy processes had contributed to some long-term sickness absence cases but caution was given against attributing the increase solely to reform activity. Whilst a number of colleagues facing difficult organisational change processes had experienced periods of long-term sickness absence, evidence suggested that both long-term and short-term sickness trends were occurring across the broader workforce, with the position being driven by a combination of factors rather than any single cause. Comparative benchmarking data from other ICBs would be brought to a future meeting and actions were already in place to strengthen the effectiveness of the People and

	Culture Subgroup through revised membership arrangements and workplan development. **NHS GM People & Resource Committee noted the report.**
6.	**Chief Reform and Improvement Officer Update** The update provided an overview of the work of the Reform and Improvement portfolio, including organisational transformation, digital services and data functions. It highlighted that the digital section of the report sought to set out the scale and breadth of the Greater Manchester digital function, encompassing corporate IT, GPIT provision and a range of wider digital services delivered across the system. It also advised that the report primarily described a proposed direction of travel and that a more detailed business case would be brought forward in due course. Members were informed that the work was taking place within the context of NHS reform and reflected the need to establish a sustainable future operating model for digital services. The committee heard that the developing proposals were not focused on a straightforward outsourcing of IT functions but rather on designing a single operating model that would establish clearer workforce arrangements, clarify which services should remain core ICB functions, and identify where chargeable services might appropriately be provided. It was explained that this work was intended to support organisational transformation while also contributing to financial sustainability through a clearer understanding of service costs and responsibilities. Attention was drawn to sections of the report outlining key risks and mitigations associated with the digital service, noting that work was continuing to stabilise operational arrangements following a period of significant disruption and organisational change. Concerns were highlighted relating to the Data, Insights and Intelligence Joint Controller Agreement, describing the issue as a significant strategic risk for the organisation. Much of the analytics capability available to the ICB depended upon data-sharing agreements between GP practices, trusts, local authorities and other data controllers. It was noted that the review and renewal of those agreements had led some partners to reconsider the extent to which they were prepared to share information. Whilst some organisations were supporting direct care-related data sharing, he warned that restrictions on wider data sharing could significantly reduce the ICB's ability to undertake the population health management, planning and analytical functions necessary to support commissioning and service improvement. It was felt that the risk should be recognised and monitored closely. Clarification was requested regarding the future position of IT functions following NHS reform. Earlier national reform proposals had suggested that IT services would no longer sit directly within ICBs and there was a query regarding whether there was now greater clarity regarding ownership and accountability. The proposal to explore chargeable services was questioned, noting that if charges were ultimately levied against GP providers this could reduce resources available for frontline service delivery and so the committee should carefully consider the wider system consequences of any charging model. It was recommended that future reports include information on the feasibility of proposals, implementation timescales and costs, arguing that this would allow members to better assess whether ideas were capable of moving beyond planning into delivery. Concerns were also raised regarding broader financial pressures referred to elsewhere

	in the agenda, observing that recurring overspends in areas such as continuing healthcare and mental health appeared to be offset by underperformance in other areas rather than being fully resolved, which she felt warranted further scrutiny. Further concerns were raised regarding assurance and governance. It was noted that whilst the report presented a generally positive description of digital services, recent internal audit work had identified areas of limited assurance relating to IT supplier management. It was queried whether the report provided a sufficiently balanced picture of the service and suggested that future updates should reflect both strengths and ongoing challenges. The significance of the concerns raised regarding data-sharing agreements was acknowledged and accepted that any reduction in data availability would have consequences far beyond routine administration, potentially affecting the ICB's ability to target interventions, understand population need and support patient care. Whilst detailed answers were not available, the risk was acknowledged and a commitment made to developing a fuller understanding of the position and feeding members' concerns back to Nicola Hepburn and the team. It was also agreed that future reports would need to be clearer regarding which services might become chargeable and the implications of any such proposals. In response to concerns about assurance and audit findings, it was accepted the committee's view that future reports should provide a more balanced assessment of risks and challenges and should better reflect findings from recent internal audit reviews. Members emphasised the need for future papers to be transparent about both strengths and weaknesses in the digital function so that the committee could provide robust oversight and assurance. **NHS GM People & Resource Committee noted the AAAA report and the position as of M5.** **NHS GM People & Resource Committee noted the current scale and breadth of Digital and IT services, endorsed the proposed direction of travel towards a coordinated pan-GM operating mode, supported early Digital and IT involvement in relevant business cases and commission decisions, and requested a quantified workforce plan, financial model, technology investment plan and validated service-user baseline before final implementation.**
7.	**Chief Finance Officer Update** The committee received the Chief Finance Officer update which provided an overview of the current financial position across the Greater Manchester system and highlighted key issues requiring monitoring. Members were advised that there were no matters requiring escalation to the Board at that stage. The Chief Finance Officer reported that the system's Month 4 position was £3 million adverse to plan, representing a deterioration of £1 million from the previous month. However, it was emphasised that this should be viewed in the context of significant improvement since Month 2, when the system had been approximately £20 million off plan. Overall, therefore, the system remained broadly on trajectory and closer to plan than earlier in the financial year. Members were advised that more detailed discussion of individual provider positions would take place during the private section of the meeting. The committee was informed that significant work was underway to develop the

	medium-term financial outlook. Finance colleagues were working alongside commissioning, transformation and operational teams to assess current expenditure run rates, forecast year-end positions and model likely financial pressures for future years based on anticipated demand. Members heard that this work would support forthcoming discussions on commissioning intentions and medium-term planning and would be brought to the Board during September. It was emphasised that this represented a collaborative piece of work across several portfolios designed to strengthen long-term financial sustainability and planning arrangements. An update was also provided on the ICB's own financial position. Members were advised that the organisation remained on plan overall, although pressures continued to be experienced within All Age Continuing Care and Mental Health budgets. It was explained that the current objective was to manage and recover those pressures within the affected services wherever possible. However, it was noted that the ICB had a responsibility to deliver its overall financial target and would therefore consider all available mitigations if required, and further detail regarding the specific pressures and mitigation plans would be discussed in the private session. The committee also received an update on procurement governance and training. Referring to earlier discussions around procurement strategy and contracting responsibilities, it was advised that a formal procurement training package was being developed and would be considered by the Audit Committee. The training was intended to strengthen organisational understanding of the Provider Selection Regime (PSR) and procurement governance requirements. Members were informed that work was underway with workforce colleagues to identify the staff groups who should be required to undertake the training, with particular emphasis on ensuring that officers involved in commissioning and procurement processes fully understood the applicable governance framework. Attention was drawn to the strategic financial sustainability risk, which remained scored at 20. It was advised that, despite ongoing mitigation activity, the current financial environment and emerging pressures meant it was not yet appropriate to reduce the risk rating. Members were also informed that a substantial programme of work had recently been completed to ensure that staff affected by NHS reform and organisational change had been correctly transferred into workforce and finance systems. The committee recognised the complexity of this exercise and the significant effort required from finance, workforce and transformation teams to successfully complete the transition. During the discussion, concerns were raised regarding procurement governance arrangements. Referring to a recent urgent procurement decision that had required committee approval at short notice, it was questioned whether there were sufficient organisational controls and understanding of procurement governance routes. It was felt that the circumstances suggested weaknesses in understanding how procurement decisions should progress through governance structures and expressed the view that future training should ensure greater clarity regarding approval pathways and responsibilities. It was also questioned how the organisation intended to manage capital allocations associated with GPIT investment and sought assurance regarding accounting treatment and governance arrangements for capital expenditure. In response, clarification was given that the capital funding allocated for GPIT and digital programmes remained on NHS England's balance sheet rather than the ICB's accounts. It was explained that the ICB received an allocation and participated in decisions

	regarding how funding should be used across Greater Manchester, but the expenditure itself was formally accounted for by NHS England. Members noted this clarification. Further discussion focused on the Provider Selection Regime and organisational preparedness. It was argued that, before extensive training was rolled out, there needed to be a Board-level discussion regarding the organisation's risk appetite in relation to procurement and PSR compliance. It was observed that the committee had previously requested a Board seminar on these issues and expressed concern that the matter had not yet progressed. Whilst organisational risk appetite was a legitimate issue for Board consideration, the underlying PSR rules themselves were largely prescriptive and therefore required staff training regardless of any subsequent discussion regarding organisational interpretation or tolerance of risk. It was suggested that a better understanding of the rules would support a more informed Board debate. There were queries around whether procurement processes invariably delivered the best outcomes. He reflected on concerns that procurement exercises could sometimes favour organisations that were most effective at submitting bids rather than those best placed to deliver services. It was suggested that the increasing ease with which procurement decisions could be challenged may also be influencing organisational behaviour. Members noted that some Integrated Care Boards had sought to mitigate these risks through careful specification design and eligibility requirements, and he encouraged consideration of similar approaches where appropriate. Supporting the discussion, the importance of distinguishing between compliance with PSR requirements and the strategic choices available within the framework was emphasised. Board members needed a clear understanding not only of procurement legislation but also of choices available regarding evaluation criteria and weighting, including quality, inequalities, social value and financial considerations. Wider staff training was supported but the need for Board-level discussions regarding procurement principles, governance and risk appetite to ensure a consistent organisational approach was stressed. It was agreed that the discussion reflected a recurring theme and acknowledged that requests for a Board seminar on procurement and the Provider Selection Regime had been raised previously. Members agreed that the issue should be formally escalated so that it could be included on the Board development and assurance agenda, ensuring that members received the necessary training and strategic discussion regarding procurement governance and risk appetite. Members broadly agreed that greater clarity regarding governance routes, decision-making responsibilities and application of PSR principles would strengthen organisational assurance and reduce the likelihood of future procedural issues. **NHS GM People & Resource Committee noted the report.** **Finance Report** The discussion concluded with a short update regarding the latest financial position. It was advised that the reported Cost Improvement Programme risk had reduced to £28.5m using the NHS risk methodology and noted continuing work to reduce the risk further. Members were also informed that the system's cash position had improved and that the deficit support funding for Quarter 2 had now been received. While recognising ongoing financial pressures, the committee noted the progress being made against recovery plans and agreed that the more detailed provider-level issues would be

	explored further in the private session. **NHS GM People & Resource Committee;** • **Noted the Month 4 year to date and forecast reported financial position which is in line with the balanced plan including Deficit Support Funding.** • **Noted and discuss the areas of key risks, pressures and the requirements for early intervention and mitigations to bring spend back in line with plan, and planned presentation of the monitoring of the recovery plans which are in development.** • **Noted the delivery of CIP as at Month 4 of £50.8m against a plan of £44.9m, an over delivery of £5.9m YTD.** • **Noted that the forecast capital position is expected to deliver in line with the allocation including the additional allocation notified for GPIT.** • **Noted the NHS GM cash position which continues to be closely monitored.** • **Noted that enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.**
8.	**Socio-Economic Duty** The committee received a presentation from on progress following NHS Greater Manchester's voluntary adoption of the Socio-Economic Duty. Members were reminded that Section 1 of the Equality Act 2010 created a duty requiring public authorities to consider how their decisions affect socio-economic disadvantage, however, this provision was never enacted nationally. It was explained that NHS Greater Manchester had nevertheless chosen to adopt the duty voluntarily and remained the first Integrated Care Board in England to do so. Members heard that a number of Greater Manchester local authorities had also adopted or were progressing adoption of the duty, along with Manchester University NHS Foundation Trust, positioning Greater Manchester as a national leader in this area of work. The committee was advised that the core purpose of the duty was to ensure that socio-economic disadvantage was actively considered in decision-making and service design, reflecting the strong correlation between deprivation and health outcomes. The presentation highlighted the extent of deprivation across Greater Manchester. Members were informed that more than a quarter of the population lived within neighbourhoods ranked among the most deprived 10% nationally and that around 700,000 residents experienced significant levels of socio-economic disadvantage. The committee heard that patterns of deprivation varied considerably across the city region, with areas such as Manchester experiencing particularly high concentrations of deprivation while other localities displayed significant internal inequalities. It was stressed that socio-economic disadvantage interacted with and often intensified other forms of inequality, meaning that it was a critical determinant of health outcomes and therefore highly relevant to the work of the Integrated Care Board. The committee was also presented with findings from public engagement work undertaken with more than 1,000 residents across Greater Manchester. Members heard that concerns about personal finances were reported to affect health and wellbeing for a significant proportion of respondents, while many individuals reported difficulties accessing health and care services due to the associated costs. The engagement exercise also demonstrated that some residents were reluctant to discuss financial

	hardship with healthcare professionals because of stigma or concerns about being judged. It was emphasised that the findings provided clear evidence of the direct relationship between poverty and health outcomes and reinforced the importance of embedding consideration of disadvantage within commissioning and service delivery decisions. Progress made during the first year of implementation was summarised. Members noted that governance arrangements had been strengthened through the development of dedicated implementation and delivery groups, and that extensive engagement had been undertaken across the Greater Manchester system. More than 160 health and social care staff had received training to improve understanding of poverty and socio-economic disadvantage, with additional targeted work taking place in primary care. It was explained that health equality impact assessments had been strengthened to ensure explicit consideration of socio-economic disadvantage alongside protected characteristics and that further work was underway to improve the use of data and intelligence to support implementation of the duty. Looking ahead, priorities included strengthening collaboration across Greater Manchester organisations, further developing outcome measures, broadening engagement with people with lived experience and increasing the role of NHS Greater Manchester as an anchor institution through areas such as employment, procurement and social value. The committee was asked to consider its own role in supporting the implementation of the duty. Suggestions included embedding explicit consideration of socio-economic disadvantage within governance processes, terms of reference and committee reporting arrangements. Members were invited to provide views on how the committee could support more inclusive recruitment practices, maximise social value through procurement and ensure that decision-making consistently considered the impact of disadvantage. Officers also proposed that regular updates should be provided to enable ongoing oversight of progress. There was strong support for the principles underpinning the duty and it was felt that the committee should actively champion consideration of socio-economic disadvantage through the committee's work. It was also suggested that there may be value in incorporating a specific prompt or section within standard committee report templates to ensure that the impact on socio-economic disadvantage was routinely considered by report authors as part of decision-making processes. Members welcomed the initiative and illustrated the practical impact of deprivation through a recent patient experience, emphasising the importance of ensuring that the duty delivered tangible improvements rather than becoming a procedural exercise. There were questions around what practical changes the policy would drive and asked whether it would influence decisions such as service location, employment practices and support for lower-paid staff. It was stressed that the ultimate measure of success should be whether the approach generated visible improvements for residents rather than simply increasing organisational awareness of the issue. It was also emphasised the importance of practical application and suggested that the committee should focus on specific examples where action could make a measurable difference. Paediatric dentistry and the issue of dental decay among children was highlighted as an example of a service area where deprivation and health outcomes were closely linked. It was suggested that examining inequalities in access to and outcomes from paediatric dental services could provide a useful case study for applying the duty in practice and demonstrating its impact.

	In response to these points, it was reiterated that the intention was for the duty to lead to genuine changes in decision-making rather than becoming a compliance exercise, with the expectation established when the ICB originally adopted the duty that measurable improvements should be demonstrated over time. It was described how current work was already influencing workforce development and service design discussions and explained that a key challenge now was moving from isolated examples of good practice to systematic consideration of socio-economic disadvantage across strategic commissioning, pathway design and service development. It was highlighted opportunities to embed the approach within commissioning decisions, financial planning and procurement processes, arguing that these areas would be crucial if the duty was to drive meaningful change throughout the system. The committee also heard about emerging work to identify "missing" populations, namely groups of people who have little or no interaction with health and care services despite experiencing significant health needs. Officers explained that collaboration with the University of Glasgow and Greater Manchester research partners was exploring whether there were specific communities or clinical pathways where inequalities resulted in people being absent from routine health service activity. Members heard that the intention was to use these test areas to develop new approaches and methodologies that could then be applied more widely across the system. The dental example was endorsed and the importance of linking socio-economic data to commissioning decisions and service planning was emphasised. It was argued that understanding where need was greatest across Greater Manchester should guide future priorities and resource allocation and further added that the duty should also influence the way resources were distributed across the system. Whilst recognising the need to maintain stability across services, it was explained that NHS Greater Manchester intended increasingly to allocate resources according to need rather than relying solely on historical funding patterns. It was noted that this principle was already being reflected within medium-term financial planning and should increasingly influence commissioning, contracting and reporting arrangements. In concluding the discussion, members expressed strong support for the Socio-Economic Duty and welcomed the progress made during its first year of implementation. The committee endorsed the principle that consideration of socio-economic disadvantage should become embedded within governance arrangements, commissioning decisions, workforce policies, procurement processes and resource allocation methodologies. Members requested that further updates be provided to demonstrate how the duty was influencing decision-making in practice and to ensure that its implementation continued to produce measurable benefits for the population of Greater Manchester. **NHS GM People & Resource Committee;** • **Noted the breadth of activity that had taken place to implement the socio-economic duty over the past twelve months** • **Endorsed the proposed priorities in section 3.2** • **Confirmed it agreed with the options suggested in section 3.3.**
9.	**Mersey Internal Audit Reports** The committee considered an internal audit report from the Mersey Internal Audit Agency (MIAA) relating to data governance and digital arrangements. It was noted that the report had been presented without an accompanying cover paper, management

	response or action plan, which limited the committee's ability to undertake effective scrutiny. The discussion therefore focused primarily on governance, assurance and the process for managing limited assurance audit findings rather than the detailed content of the audit itself. The Audit Committee Chair had met with officers and auditors to discuss the report and emphasised that the committee needed to focus not only on the audit findings but also on the management response and improvement actions arising from those findings. It was felt that the committee could acknowledge the findings but was not in a position to properly discharge its governance responsibilities without sight of management actions, responsible officers, implementation dates and evidence of delivery. The discussion then broadened into consideration of data quality and assurance arrangements. The review had focused on policies, strategies and governance structures rather than the quality of information being used by the organisation. It was suggested that this left a significant gap in assurance, particularly regarding the reliability and completeness of data provided by organisations across the Greater Manchester system. Members were reminded that strategic commissioning decisions depended upon accurate and timely information, and it was argued that there needed to be greater scrutiny of whether the ICB was receiving the right data and whether sufficient assurance existed regarding its accuracy. A suggestion was made that this may require further work, potentially involving additional audit activity, to provide assurance that strategic decisions were being based on robust information. Agreed governance arrangements required all internal audit reports receiving a "limited assurance" opinion to be considered by the relevant parent committee. The purpose of this escalation was to allow the committee to monitor delivery of management responses and follow-up actions. Members were also reminded that a recent limited assurance audit concerning IT supplier management should similarly be presented to the committee. Previous IT-related audits had often gone directly to the Audit Committee because of uncertainty regarding committee ownership, but both recent audits clearly fell within the remit of the People and Resources Committee and should therefore be subject to its oversight arrangements. Clarification was sought regarding the precise scope of the audit. There was uncertainty as to whether the review was concerned with the governance and quality of operational data used within provider oversight and commissioning or whether it was intended to assess whether the organisation was collecting and utilising the right information to support its strategic commissioning role. It was advised that the review had concentrated primarily on the former, namely whether appropriate policies, strategies and governance arrangements existed, rather than whether the organisation had access to the right data or was using it effectively within strategic decision-making processes. It was reiterated that these wider questions remained important and may require separate review through governance or audit routes. It was agreed that both the data governance audit and the related limited assurance report concerning IT suppliers should be returned to a future meeting with completed management responses, action plans, named responsible officers, implementation timescales and supporting evidence. It was also agreed that the Strategic Commissioning Committee may need to consider the wider question of whether the ICB was receiving the right data and whether the quality of information was sufficient to support strategic commissioning decisions.

	In conclusion, the committee agreed that the audit findings could not be formally considered or signed off in the absence of management responses and action plans. Members requested that the limited assurance reports be returned to a future meeting with the necessary supporting documentation and agreed that further work was required both to strengthen audit follow-up arrangements and to develop assurance regarding the quality and usefulness of data underpinning strategic decision-making across NHS Greater Manchester. **NHS GM People & Resource Committee noted the report and its recommendations**
10.	**Workplan** This was provided for information.
11.	**Performance Report** This report provided an update on key performance indicators for GM. The indicators included were those considered high risk and/or form part of the undertakings process. **NHS GM People & Resources Committee noted the information provided.**
12.	**Any Other Business** There was no additional business raised. **Board Paper Escalations** There were no further specific escalations noted, and the Board Report would be drafted based on the discussions in the meeting. **Meeting Reflections** Members felt that the meeting had been effective with robust discussion and debate.

NHS
Greater Manchester

Minutes

Greater Manchester Strategic Commissioning Committee

Date: 2 September 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Rachel Egan (RE) – Non-Executive Director (Deputy Chair) Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Prof. Manisha Kumar (MK) – Chief Clinical Officer Leigh Vallance (LV) – VCSE Partner Member Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer Laura French (LF) – Public Health Consultant Chris Tyson (CT) – Assistant Director of Intelligence (Place & Strategic Intelligence) (item 6) Claire Igoe (CI) – Associate Director of Sustainability and Estates (item 8) Claire Smith (CS) - Associate Director Nursing & Quality Assurance Jo Street (JS) - Programme Director- Transition, deputising for Charlotte Bailey Stephen Downs (SD) - Deputy Chief Finance Officer, deputising for Kathy Roe Faye Vaughan (FV) – Governance Advisor (Minutes)	Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer / Acting Deputy Chief Executive

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

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3.	**Minutes from the previous meeting held on Wednesday 5 August 2026** The minutes were accepted as a true record of the previous meeting held on 5 August 2026.	
4.	**Chief Officers Update Reports:** <u>Chief Clinical Officer Report:</u> The NHS Greater Manchester Chief Clinical Officer Report provided an update on key clinical governance, quality, patient safety and system improvement matters across the region, emphasising ongoing oversight and assurance activities. It highlighted areas that required attention and approval through the Alert, Advise, and Assure framework. MK reported on the main alerts in the report: • Northern Care Alliance: It was confirmed that a further update would be provided at Octobers meeting. A detailed paper would also be provided in the private part of the meeting to assure the committee on the oversight and plans in place on how concerns in the media would be addressed. • Laureate House: It was reported that the closure of Laureate House had removed approximately 19 beds that could not be repurposed. It was confirmed that NHS Greater Manchester were working with Greater Manchester Mental Health through provider oversight to understand the effect on patients and consider a less bed-based model aligned with strategic intent. • Health Protection Planning: It was explained that local authorities had reviewed jointly owned local outbreak plans to look at how outbreaks and incidents would be managed. It was reported that NHSE had provided new commissioning guidance the previous year on how the ICB should commission outbreaks and incidents. The committee were further made aware of the work with UKHSA and local authority public health teams. It was explained that Pan GM arrangements would also be reviewed including high consequence infectious disease arrangements in partnership with UKHSA. The committee were provided with assurance that they were making sure that they had the ability to put all the elements of outbreak response in place across all localities over the winter period. • HPV Self-Sampling: The committee were made aware of the Greater Manchester rollout of HPV self-testing as an opportunity to address deprivation and ethnicity gaps in cervical screening. The approach was intended to identify people at higher risk and concentrate on follow-up support on those who test positive. • Weight Loss Medicines: It was confirmed that Tirzepatide had received financial oversight and had been considered by the Primary Care Commissioning Committee and Chief Officers. It was reported that Greater Manchester had previously used a highest-BMI-first call-in model to reduce inequity but would follow national cohorts one and two this year while commissioning clinical audit to check eligibility, NICE-aligned prescribing and whether the rollout widened health inequalities. The committee approved and supported the recommendations from the Clinical Effectiveness and Governance (CEG) report. **The Committee:** • **Noted the contents of the report.** • **Approved the items within the report that required committee**	

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	approval. • **Noted the remaining items progressed through established governance routes.** <u>Chief Commissioning Officer Report:</u> The paper set out the key issues for Alert, Advise, Assurance and Achievement from the Healthcare Commissioning Directorate. It was explained that the commissioning intentions described the material changes proposed for 2027–28 and should be presented as one component of delivering the five-year strategic commissioning plan. The four strategic goals were reported as neighbourhood delivery, improved outcomes and reduced inequalities, system transformation and fulfilment of statutory duties. The full organisational contribution would be set out in the 2027–28 operational delivery plan. KS further explained that the commissioning-intentions needed stronger emphasis on securing and improving the quality of commissioned services. It was reported that quality should be included more explicitly when assessing expected impact, alongside the changes, outcomes and metrics used to evaluate each intention. The committee were informed of the current GP Action alert concerns with awareness raised through posters and communications with patients, MPs and local politicians, without direct service-delivery impacted at present. It was confirmed that teams were monitoring cumulative effects and would intervene if earlier actions began to materially affect services. It was reported that NHS Greater Manchester were not meeting the national 28-day and 62-day cancer targets. It was confirmed that the issue would be discussed with Cancer Alliance working with providers on recovery plans, while early-diagnosis performance remained comparatively strong. **The Committee:** • **Noted the report.** <u>Chief Reform and Improvement Officer Report:</u> The report highlighted the key areas of assurance and oversight from the Reform & Improvement portfolio. NH informed the committee of the performance concerns at Bolton, Wrightington, Wigan and Leigh and the Northern Care Alliance, linked to theatre availability and the ability to complete planned activity. It was confirmed that operational teams were developing realistic recovery plans intended to return delivery to the original plan by the end of Q4. The committee were also made aware of waiting-list demand at MFT initially appeared to have increased by 20%, but joint review found that the principal issue was reporting. The verified activity increase was approximately 4%. It was confirmed that the position was improving week by week. It was reported that some providers were more than 15% below their four-hour plan after the Q2 review, while others were on or close to plan. It was confirmed that teams were working with Trusts, Primary Care, Community Services and out-of-hospital partners to reduce demand, with early improvement including a 4% year-on-year reduction in ambulance demand in the latest week.	

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	The committee were informed that Greater Manchester remained the highest-performing ICB nationally for the 31-day cancer measure. It was explained that the 28-day and 62-day results could fluctuate because mutual aid affected how activity and patients were counted, but auditable actions and continued work with ambulance and secondary-care providers were in place. It was reported that digital and IT risks remained visible in the risk report and that MIAA audit work plans were now held as a portfolio. It was confirmed that management reviews were underway, with outputs expected to return through committees in October 2026. The committee requested early warning if performance trajectories moved further off plan and noted that a Board Development Session on Data and IT was expected later on in the year. **The Committee:** • **Noted the report and the position as of M5.** <u>Chief Strategy, People and Partnerships Report:</u> The paper informed the committee of the key priorities, risks and mitigations relating to Live Well, Population Health Transformation, Place Partnerships development and Neighbourhood Health plans. There were no alerts or advise in the report. • Place Partnerships: It was explained that NHS Greater Manchester was working with Foundation Trusts and Councils that would host partnership teams and place boards. The committee were made aware that feedback on the operating-document suite closed after a six-week engagement period and a four-week sprint would take place to convert the feedback into final documents. The place-partnership documents were currently expected to complete the approval routes of each partnership in October and be taken to the NHS Greater Manchester Board in November 2026. • Neighbourhood Health Progress: It was reported that Regional NHS colleagues endorsed neighbourhood health as the organising principle for Greater Manchester's long-term transformation and strategic commissioning plan. The committee were informed that localities were updating neighbourhood health plans to reflect the approved commissioning framework. It was confirmed that the maturity self-assessments had been completed across all 10 places and partner engagement, which included a Primary-Care round table to inform the response to the national consultation on multi-neighbourhood and single-neighbourhood providers. The committee questioned when reporting would move from structural reform activity to measurable impact on population health and inequalities. It was confirmed that the next report would include more detail from the maturity assessment and that a governance, accountability and oversight framework was being developed to compare learning across the 10 places, scale effective practice and allow warranted variation according to local context. KS proposed that the 2027–28 operational delivery plan include a concise contribution plan from each place, showing how it would support strategic objectives and national outcomes-framework metrics.	

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	LV asked for a simple and efficient way to ensure that the whole workforce understood the direction of travel for place partnerships and neighbourhood health, noting uneven awareness among statutory and sector partners. **ACTION:** JS to develop a clear mechanism for keeping the wider workforce informed about the direction, purpose and operating model of place partnerships and neighbourhood health. **The Committee:** • **Noted the report.**	**JS**
5.	**Performance Report** This report provided an update on Greater Manchester's progress in achieving NHS operational planning goals and outlined significant risks faced by our providers along with key improvement actions. The committee were provided with the following updates: • Urgent & Emergency Care: Remained challenging, however, it was reported that the team were starting to see impact. • Cancer: Challenges remained from Cancer Alliance. NH explained that GM ICB remained the highest performing ICB. The committee were informed of the work that had taken place to capture patients with treatments that had continued to improve. • Ambulance Service and Secondary Care Providers: The committee were informed that they were one of the strongest in performing. MK described transformation work to address inappropriate inpatient use, inconsistent community provision and data gaps across mental health, learning disability, autism and ADHD, with members seeking clearer expectations for therapeutic care and discharge readiness. The committee were provided with partial assurance. **The Committee:** • **Noted the report.**	
6.	**Greater Manchester Health Inequalities Statement 2025/26 - Commissioning Committee update** This report presented NHS Greater Manchester's 2025/26 Health Inequalities Statement, setting out how the ICB had met its statutory duties to reduce inequalities in access, experience and outcomes. It summarised population need, key inequalities trends and performance against NHS England's Health Inequalities Improvement Metrics, aligned to CORE20PLUS5. The report showed progress in some areas, including cancer early diagnosis, SMI physical health checks and CVD prevention, while highlighting persistent inequalities linked to deprivation, ethnicity, age and wider determinants of health. It was explained that ICBs and providers must publish an annual health inequalities statement alongside their annual reports, supported by an integrated needs assessment each March. The committee approved the 2025–26 statement for publication on the NHS Greater Manchester website alongside the annual plan in September and supported continued system action to reduce inequalities in	

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	access, experience and outcomes, particularly for CORE20PLUS5 groups and deprived communities. The statement used an NHS England framework, CORE20PLUS5 measures, national and local data, ONS dashboards, statutory returns and operational information. Data was disaggregated at minimum by deprivation, ethnicity, age and sex, triangulated with programme and locality intelligence and linked to commissioning, delivery, oversight and evaluation. CT identified incomplete and inconsistent ethnicity coding across datasets, with variation across maternity, mental health and hospital data, alongside national-data delays, revisions, differing time periods, small numbers and inconsistent definitions. It was confirmed that the team were working with providers to improve completeness, linkage and shared definitions and was seeking more timely analysis from the ADSP. The information continued to show substantial deprivation-related differences in life expectancy and healthy life expectancy, with the strongest relationship among men. CT also reported mixed or concerning trends in infant mortality, overweight and obesity, diabetes prevalence, suicide and alcohol-specific mortality, indicating that service-level improvements had not yet closed the wider population-health gap. It was explained that the 2026–27 focus would be to judge both average improvement and gap reduction, apply the disparity index consistently, target prevention where gaps were widest, scale local and voluntary-sector action and embed disaggregated outcomes in commissioning and performance oversight. The committee suggested that Chief Officers check that each programme used the relevant inequality data when shaping actions, provider relationships, transformation and commissioning intentions. A suggestion was raised for teams to be required to explain what they would do about the findings and distinguish leading indicators, such as health checks, from ultimate outcomes such as improved life expectancy. JS offered to take the statement to a leadership briefing and connect it to organisational-development and commissioning-academy work. **ACTION:** JS to work with CT to include item in communications to staff, through Live Leadership Briefing, Keep Connected and a dedicated section on the Intranet focused on Health Inequalities. **The Committee:** • **Noted the 2025/26 Health Inequalities Statement and the key inequalities identified across Greater Manchester.** • **Supported continued system action to reduce inequalities in access, experience and outcomes, particularly for the most deprived communities and CORE20PLUS5 population groups.** • **Supported continued system action to reduce inequalities in access, experience and outcomes, particularly for the most deprived communities and CORE20PLUS5 population groups.** • **Approved publication of the statement on NHS GM website alongside the Annual Plan.**	**JS / CT**

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7.	**National Quality Strategy** CS informed the committee that the strategy was not a quality-team or nursing-only directive, it required an organisation-wide approach across safety, effectiveness and experience. Priorities included improving outcomes, reducing variation and inequalities, strengthening patient and population experience and trust and applying patient-safety approaches across settings. The strategy required commissioning decisions to use population-need data and make outcomes visible. It was explained that patient, carer, staff and community voice should inform decisions, contractual governance, contractual assurance and patient-safety measures. A proposed 30-, 60- and 90-day process would map current quality and safety arrangements to the three national domains, review core, contractual and system quality governance Terms of Reference and agree a coherent NHS Greater Manchester narrative for quality as an organising principle.	
8.	**Climate Change Adaptation Plan (CCAP)** This paper reported on the plan for climate change adaptation as a statutory requirement for the healthcare sector under the Health and Care Act 2022 which had been developed on behalf of the healthcare system in GM to prioritise action against the key risks for the health system. JS explained that climate adaptation was a statutory ICB responsibility and that the plan was co-produced with provider partners. It addressed mitigation of climate-change impacts on services, distinct from the Green Plan's focus on tackling climate change itself and therefore required oversight through commissioning and provider quality assurance. CI reported that Greater Manchester experienced five heatwaves and wildfires during the summer, with widespread health and public-health effects. The plan was made system-wide at the request of Trusts and was aligned with GMCA, Transport for Greater Manchester and other partners. The pragmatic plan contained eleven high-level actions for system partners. It was explained that it should be embedded throughout strategic commissioning because resilience concerns extend beyond buildings to supply chains and service continuity, with local ownership required across partners. The committee discussed what measures were funded, what was unfunded and where the gaps were. CI clarified that NHS Greater Manchester generally leased rather than owned estates, so building resilience was often the provider or landlord's responsibility, but service disruption could create indirect costs for the ICB. SD asked how cooling buildings would be reconciled with carbon-reduction objectives. CI explained that refrigerants have different global-warming potentials and that lower-impact options exist, while adaptation should also use lower-cost measures such as shading and ventilation. It was identified that universal air-conditioning was neither affordable nor necessarily feasible. MK asked for systematic learning before the next summer on which people with long-term conditions were affected by heat, why emergency-department demand changed and what advice should be provided.	

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	The Committee: • **Reviewed and approved the GM NHS Climate Change Adaptation Plan 2026 – 2031 and action plan.** • **Provided senior oversight of climate change adaptation being reflected within the SCC portfolio and associated governance.**	
9.	**SCC Forward Plan** The committee reviewed the readable SCC forward plan, identified the need to distinguish strategic from operational business and track deferred items and agreed governance changes to reduce the risk of agenda items being lost. KS explained that several items marked as monthly would only arise as needed, such as inspection outcomes, procurement pipelines and major commissioning decisions. It was agreed that many updates could be incorporated into Chief Officers' reports, with standalone papers reserved for matters that required detailed treatment. KS suggested placing the forward plan at the beginning of each committee meeting so members could agree whether items should be deferred, brought forward or otherwise adjusted. The committee requested a discussion to take place in the private part of Octobers meeting to discuss agenda prioritisation to ensure strategic items were sufficiently prioritised over operational matters.	
10.	**Any other business** The committee discussed how they could support colleagues who attend future meeting to present their items to the committee.	

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NHS
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Minutes

Greater Manchester Strategic Commissioning Committee

Date: 7 October 2026

Time: 14:45pm - 16:45pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Rachel Egan (RE) – Non-Executive Director (Deputy Chair) Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Prof. Manisha Kumar (MK) – Chief Clinical Officer Leigh Vallance (LV) – VCSE Partner Member Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer / Acting Deputy Chief Executive Claire Smith (CS) - Associate Director Nursing & Quality Assurance (item 7) Sarah Owen (SO) – Associate Director Maternity (ICB/LMNS) (item 9) Sophie Spilsbury (SS) – Acting Director Recovery and Improvement, deputising for Nicola Hepburn Sam Evans (SE) - Corporate Director of Finance – Commissioning & Financial Assurance Faye Vaughan (FV) – Governance Advisor (Minutes)	Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** SB welcomed everyone to the meeting, introductions were made, and the above apologies were noted.	
2.	**Declarations of Interest** SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	
3.	**Minutes from the previous meeting held on Wednesday 2 September 2026** The minutes were accepted as a true record of the previous meeting held on 2	

	September 2026.	
4.	**Chief Officers Update Reports:** <u>Chief Clinical Officer Report:</u> The NHS Greater Manchester Chief Clinical Officer Report provided an update on key clinical governance, quality, patient safety and system improvement matters across the region, emphasising ongoing oversight and assurance activities. MK reported on the following from the report: • Section 29a Programmes: It was explained that WWL, GMMH and the Northern Care Alliance were responding to CQC section 29A improvement programmes. Common themes included leadership, capacity, transformation, patient flow and organisational capacity. It was confirmed that the ICB were working with the providers and would use support where necessary. • Safeguarding capacity: It was reported that most vacancies in the safeguarding team had been recruited to. Work continued to take place to bring the ten teams together with staff establishing their place and portfolio responsibilities. The opioid-stewardship programme was also formally congratulated by the committee for winning an HSJ Patient Safety Award. The committee approved and supported the recommendations from the Clinical Effectiveness and Governance (CEG) report. **The Committee:** • **Noted the contents of the Chief Clinical Officer Report.** • **Approved the items within the report that require Committee approval.** • **Noted the remaining items that have progressed through established governance routes and do not require further Committee decision.** <u>Chief Commissioning Officer Report:</u> The paper set out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. KS informed the committee that the Northwest individual-funding-request arrangement hosted by NHS Greater Manchester was expected to go live on 1 November 2026. It was identified as an opportunity to create economies of scale and help manage packages that did not fit neatly within conventional IFR arrangements. It was reported that the 12-week public consultation on cardiac and vascular surgery received more than 900 responses and met the requirements for a service change of this scale. Transport, particularly for people travelling from Oldham and surrounding areas was a major theme. It was explained that the team were working with GMCA to prepare the decision-making business case for Board consideration. Bolton NHS FT had issued notice that it would stop providing its specialist HIV service at the end of the financial year after a period of fragility. It was reported that the specialised commissioning team were developing alternative	

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	arrangements, including interim resilience and long-term service continuity. The committee were informed of a joint inspection of Wigan that had been announced. It was confirmed that the locality team would receive support over the coming weeks. The committee also noted the highest possible outcome achieved in the recent joint area inspection in July 2026. **The Committee:** • **Noted the report.** <u>Chief Reform and Improvement Officer Report:</u> The report highlighted the key areas of assurance and oversight from the Reform & Improvement portfolio. The committee were informed that approximately half of the joint controller agreements had been returned, with the remaining practices receiving targeted assurance conversations before a potential cut-off for processing data from organisations that did not complete the required documentation. It was reported that digital facilitators had contacted non-signatories to establish the reasons why they had not yet been signed and provide confidence about how Greater Manchester uses the information. **The Committee:** • **Noted the report and the position as of M5.** <u>Chief Strategy, People and Partnerships Report:</u> The paper informed the committee of the key priorities, risks and mitigations relating to Live Well, Population Health Transformation, Place Partnerships development and Neighbourhood Health plans. CB informed the committee that the place outcomes framework, partnership agreement, staffing model and funding arrangements were progressing through the Executive Committee and would then go to localities for partner sign-off. The arrangements were intended to establish a practical basis for place working while allowing test-and-learn adjustments. It was reported that all localities had returned neighbourhood plans. Initial data packs had been developed and were being enhanced into a live dashboard with more granular geographical information. CB informed the committee that the HIV Strategy for 2026-30 had been written and would be shared for engagement across the system. The committee asked how risks would be mitigated while the risk log and mitigations remained under development. CB explained that mitigations included regular place leadership briefings, Executive Committee oversight involving local-government Chief Executives and Place Leads, regular review through Chief Officer meetings and partnership mobilisation meetings. CB agreed to include more explicit mitigation detail in future reporting. **The Committee:** • **Noted the report.**	

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5.	**Performance Report** This report provided an update on Greater Manchester's progress in achieving NHS operational planning goals and outlined significant risks faced by our providers along with key improvement actions. The elective waiting list remained above plan and presented a material year-end risk, while RTT performance was close to plan but required oversight. It was further reported that four-hour and twelve-hour urgent-care performance remained below plan, with recovery work focused on patient flow and discharge. Mental-health talking-therapy and learning-disability inpatient numbers also remained above plan. SS reported that both mental-health providers and most acute providers were in national oversight segment 3; The Christie was in segment 1, MFT in segment 2 and NCA in segment 4. These ratings formed part of the committees ongoing performance and recovery oversight. It was reported that Greater Manchester had remained in the national top five for the 31-day cancer standard since April and ranked first nationally in June. Diagnostic waiting times and 31-day cancer treatment performance were reported as ranking fourth nationally, while several other standards remained below plan or required continued assurance. An extended leadership session reviewed in-year recovery plans across the key metrics, with further actions established. The committee agreed to note the report, key delivery risks and areas requiring focused system oversight, retaining a partial-assurance position. **The Committee:** • **Noted the report.**	
6.	**5-Year Commissioning Plan Progress and Commissioning Intentions – From the Forward Plan** The committee were made aware that the 27/28 Commissioning Framework was the delivery vehicle for the first year of the 5 year Strategic Commissioning Strategy. The report provided described the key components of the framework and summarised the primary elements. The framework was NHS GMs mechanism to communicate to all providers what would be commissioned differently in 27/28 and what the expectations of providers were. It was explained that the framework was integral to the 27/28 Operational Planning round process and set the direction for providers, to ensure they have a framework to consider when developing their operational plans. It was further reported that the framework builds on four strategic objectives: neighbourhood health and reducing inequalities, prevention and proactive care, system transformation and delivery of statutory duties. It combined strategic direction, specific 2027–28 service changes, implications for provider planning and continued priority work. KS informed the committee that the organisation was ahead of previous planning cycles and would now undertake more detailed discussions with independent,	

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	voluntary and community-sector providers. National planning guidance may require adjustments, but the organisation intended to retain its overall direction. KS explained that a review would assess current capacity and demand for children's community health services, what the model likely required over the next five years and inform an investment strategy. The committee were made aware that the renewed Greater Manchester Children's Board would bring together local authorities, health services, schools and wider partners. MK described children's mental health as a Live Well priority, particularly at the 16–25 transition into education, employment and training. It was reported that Greater Manchester had been selected for the next phase of the Growing Up Well programme, which aimed to support children in schools before needs required specialist CAMHS intervention and national funding had been secured for the Care Together pilot in Rochdale, Stockport and Tameside. The committee supported the framework and requested that voluntary-sector organisations be included in children's mental-health planning. It was suggested that a more detailed joint report could be shared as the stocktake, service reviews and trauma-informed prevention work developed in the future. **The Committee:** • **Noted the content of the framework and supported the approach.**	
7.	**Quality Assurance Process** CS explained that quality assurance required triangulation across contracts, performance, quality, finance, safeguarding, patient safety, regulatory information and patient experience. It was reported that matrix working was intended to produce a consistent, evidence-based view rather than relying on a single metric or isolated concern. The framework placed the experience of people receiving care at its centre. Complaints, participation groups, patient-safety investigations, safeguarding information and other feedback were considered alongside targets and performance data so that commissioning decisions addressed both measurable outcomes and lived experience. Quality Review Meetings and Contract Review Meetings provided forums for provider deep dives, challenge, learning and formal action. Where evidence of improvement is insufficient, it was explained that concerns could be escalated through provider oversight, NHS England reporting and the Strategic Commissioning Committee, including contractual notices where required. It was reported that the team would complete provider dashboards, establish clear thresholds for concern and risk tolerance, continue cross-portfolio implementation and use the MIAA audit to identify gaps and positive assurance. **The Committee:** • **Noted and welcomed the quality-and-safety assurance framework.** • **Provided oversight or challenge on the next steps, including the audit, dashboards and escalation thresholds.**	
8.	**Thirlwall Inquiry**	

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	The Thirlwall Inquiry was published on 15 September 2026 and makes 17 recommendations following its examination of events at the Countess of Chester Hospital. NHS England subsequently issued immediate requirements for NHS Trusts and Integrated Care Boards (ICBs). This paper summarised the findings and immediate requirements, set out the implications for NHS Greater Manchester (NHS GM) and proposed how specialist neonatal assurance would be received through the Regional Assurance Process and Northwest Neonatal Operational Delivery Network (ODN), with system oversight through the NHS GM Maternity & Neonatal Programme. It was explained that none of the 17 recommendations were assigned directly to ICBs, but NHS England's subsequent requirements placed responsibilities on ICBs for board consideration, safeguarding, bereavement care and commissioning oversight of maternity and neonatal services. It was explained that Greater Manchester would use the Northwest Neonatal Operational Delivery Network and the regional assurance process for specialist neonatal implementation. The ICB would also monitor gaps and residual risks through existing quality and contractual mechanisms, with provider concerns moving from Quality Review Meetings to contractual review where they cannot be resolved. It was reported that Thirlwall would be combined with the response to other maternity and neonatal inquiries through the National Maternity and Neonatal Task Force and the anticipated wider improvement programme. Provider assurance would come through the perinatal performance oversight process, with quarterly maternity and neonatal updates to the committee and immediate escalations through established officer reporting. **The Committee:** • **Noted the Inquiry findings and immediate NHS England requirements.** • **Supported the proposed GM assurance approach.** • **Supported quarterly reporting of the GM assurance position through the NHS GM Maternity & Neonatal Programme.** • **Supported escalation of provider-specific risks or gaps in assurance through the established NHS GM Contract Quality Mechanism where required.**	
9.	**SCC Forward Plan** The committee agreed that the forward plan should become a clearer 12-month view showing whether requested items have been scheduled and returned.	
10.	**Any other business** LV raised a concern about reduced current-year hospice funding and the risk to palliative and end-of-life services. The committee agreed that due process must be followed. It was requested that an interim update be provided at November meeting describing the process and timelines. MK noted that LV leadership role with Bolton Hospice created a more substantial conflict-of-interest consideration than simply recording an interest. It was requested that concerns be escalated through the appropriate forum and that conflicted participants should not take part in funding decisions affecting their organisation.	

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	The committee discussed organisation-wide capacity pressures and the need to make specific service-level impacts more visible to the Board. SB identified quality-improvement skills training and trauma-informed training for all staff as priorities, arguing that both could improve patient experience and outcomes while reducing avoidable effort.	

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Minutes

Greater Manchester Audit Committee (Part A)

Date: Wednesday 17 June 2026

Time: 9:00am to 10:35am

Venue: Boardroom, The Tootal Buildings, Manchester

Present		
Members:		
Richard Paver	RP	Non-Executive Director and Audit Committee Chair, NHS GM
Sue Greenhill	SG	Independent Member
Jackie Njoroge	JN	Senior Non-Executive Director, Vice Chair
Attendees / Participants:		
Stephen Downs	SD	Deputy Chief Finance Officer, NHS GM
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer, NHS GM
Chris Gaffey	CG	Associate Director of Corporate Services, NHS GM
Izhar Chaudhary	IC	Associate Director of Finance – Financial Assurance, NHS GM
Kal Kay	KK	Non-Executive Director and Chair of the Finance Committee, NHS GM
Colin Scales	CS	Acting Chief Executive
Richard Leese		Chair, NHS Greater Manchester
Jackie Gardiner	JG	Director of Operational Finance
Kaye Abbott	KA	Associate Director of Finance – Financial Control, NHS GM
Darrell Davies	DD	Regional Assurance Director, MIAA
Perminder Sethi	PS	Senior Manager, Grant Thornton
Paul Bell	PB	Head of Anti-Crime Services, MIAA
Faye Vaughan	FV	Governance Advisor, NHS GM (minutes)
Miachel Green	MG	Director, Grant Thornton
Apologies:		
Kathy Roe	KR	Chief Finance Officer, NHS GM
Anthony Hassall	AH	Partner Member bringing the perspective of Mental Health Providers, Chief Executive of Pennine Care NHS Foundation Trust

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	Topic	Action
1.	Welcome, Introductions and Apologies The Chair welcomed members and attendees to the meeting.	
2.	Declarations of Interest (DOI) RP reminded Committee members of their obligation to declare any interest relating to items on the agenda. No interests were declared.	
3.	Minutes from the last meeting The minutes of the last Audit Committee meeting on 23 April 2026 were approved as an accurate record.	
4.	Action Log The action log was reviewed noting that updates had been provided against the open actions, with any closed actions recorded on the log.	
5.	Head of Internal Audit Opinion The committee were informed that the Head of Internal Audit (HoIA) Opinion contributed to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. It was reported that the final opinion for 2025/26 was one of Substantial Assurance. The Internal Audit Plan aimed to address all of the key risks of the ICB on a cyclical basis. The committee were made aware of the one draft report that needed to be finalised at present. It was explained that they were awaiting management responses however, the draft outcome from the report had been included in the opinion as it was not anticipated to have any material changes. **NHS GM Audit Committee noted the contents of the report.**	
6.	Anti-Fraud Annual Report 2025/26 The Anti-Fraud Annual Report offered the Audit Committee the opportunity to consider the work completed by the ICB's Anti-Fraud Specialist (AFS) during the period from April 2025 to March 2026. In completing the annual report on counter fraud, bribery and corruption work, the AFS had referred to and assessed the organisation against the Government Functional Standard 013 for Counter Fraud (which also applied to any relevant subsidiary company). The report highlighted relevant anti-fraud activities carried	

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	out and their outcomes. It was explained that the anti-fraud work plan was designed to be dynamic to enable to respond to changing requirements, ensuring the most effective use of anti-fraud resource and meeting the requirements as set out in the relevant components of the fraud standard. The committee were made aware that the 2025/26 annual self-assessment against the Government Functional Standard 013 for Counter Fraud, known in the NHS as the Counter Fraud Functional Standard Return (CFFSR), was submitted early in Q1 of 2025/26, ahead of the deadline, with the ICB receiving green ratings across 11 of the 12 assessed requirements resulting in an overall green rated self-assessment. **NHS GM Audit Committee noted the contents of the report.**	
7.	<u>Annual Report and Accounts (including Annual Governance Statement) and Letter of Representation</u> The report detailed to the Audit Committee the changes made to the draft Annual Report and Accounts submitted in April 2026. The report also included the Letter of Representation. The committee were made aware of the minor amendments that required updating in the combined papers. JN thanked all involved and acknowledged the amount of work that had taken place to complete this work. A suggestion was raised to create an easier to read Annual Report in future for the public. CG confirmed that this is something that could be considered for future years, and would check with other ICBs whether this was something they produced. **ACTION:** CG to investigate whether any other ICBs had created an easy-to-read version of their Annual Report. **The Audit Committee:** • **Approved the NHS GM Annual Report and Accounts for submission (subject to any minor, immaterial presentational amendments).** • **Confirmed the delegation to the Deputy CFO to undertake the national submissions required.** • **Approved the Letter of Representation for signature by the organisation.**	**CG**
8.	<u>External Audit Findings Report 2025/26</u> A summary of the key findings and other matters arising from the statutory audit of NHS Greater Manchester ICB and the preparation of the ICB's financial statements for the year ended 31 March 2026 for those charged with governance were shared in the paper.	

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	The number of recommendations in the report were highlighted to the committee. The committee were also made aware that the ICBs draft financial statements showed that the ICB had overspent against its revenue resource limit. As this was a breach of the statutory duty, the committee were made aware that it had been reported under the section 30(b) of the Local Audit and Accountability Act 2014 to flag the issue. It was acknowledged that this overspend had been agreed with NHS England as part of the planning process. The committee were made aware that the overall opinion on the Financial Statements was an unqualified audit opinion. Thanks were shared to the Finance Team for their support and collaborative working throughout the process. The committee were informed of the number of contract variation agreements or baseline contracts relating to specialised commissioning that had not been signed the previous year. Whilst signed agreements had been obtained or alternative confirmations received, it was explained that it would be essential to ensure all contracts and contract variations should be agreed and signed prior to payments being made. A recommendation to enforce it for the following year for best practice was raised. It was explained that compulsory redundancy and other departures reported in 2025/26 had been paid in accordance with the provisions of the redundancy scheme as agreed with NHS England. The committee were made aware that an Audit certificate could not be formally issued at present, in accordance with the requirements of the Local Audit and Accountability Act 2014 until the National Audit Office had concluded their work in respect of consolidation returns for the year ending 31 March 2026. The committee questioned whether any further progress had been made on the investment in third party company. It was confirmed that an update would be brought to the September 2026 private meeting. A discussion took place concerning the letter to the Secretary of State regarding NHS England allocated additional resource in advance of the expenditure. The committee further discussed the capacity issue in the organisation and assurance was sought on knowledge and skills retained in the organisation. It was confirmed that work would be undertaken to review the skills and capacity required across the organisation and to ensure that sufficient capability was retained to support effective delivery. The Mental Health Investment Standard was highlighted and a question was raised as to whether there was reference to meeting the Mental Health Investment Standard and the work that had taken place around it the report. It was confirmed that the disclosure was in the report which showed the target had been achieved.	

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	The Committee: • **Approved the report, the recommendations and the management responses.** • **Agreed the additional fees proposed in the report.**	
9.	<u>External Auditors Annual Report 2025/26</u> The report summarised the work undertaken by the external auditors for the 2025/26 financial year and in particular the commentary on Value for Money. It was explained that it set out the auditor's commentary on whether NHS GM had in place proper arrangements for securing Value for Money in its use of resources in respect of: • Financial Sustainability • Governance • Improving economy, efficiency and effectiveness The report reviewed the progress on implementation of recommendations made in 2024/25 and identified improvements required going forward. <u>Financial sustainability</u> It was explained that in 2025/26 the ICB delivered its agreed financial plan of a £7.5m deficit, including £175m of efficiency savings. This represented an improvement in financial delivery compared with prior years. However, a £7.5m deficit resulted in a technical breach of the ICB's statutory duty. It was explained that the key recommendation set out in the report was designed to support the ICB in strengthening arrangements to protect and deliver the medium-term strategy. It was reported that the ICB had submitted a compliant and balanced forward plan for 2026/27 to 2028/29, though this relied on significant savings. It was further explained that the ICB would need to demonstrate that prevention and transformation investment could be consistently translated into sustainable savings. <u>Governance</u> It was reported that the governance arrangements operated effectively during the year, with clear Board and Committee oversight of key risks. The committee were made aware that the ICB was now largely free from its Statutory Undertakings, with those remaining at year-end both relating to finance. As with many ICBs, it was explained that the ICB had worked to establish arrangements for consistent application of the Provider Selection Regime (PSR). However, the nature of the regime presented an ongoing risk and experience during the year which suggested that there was scope to further develop controls and governance in this area. It was reported that improvement recommendations had been raised to support assurance resilience during a time of significant transition and specifically to strengthen procurement and PSR compliance. <u>Improving economy, efficiency and effectiveness</u> The committee were informed that the ICB had maintained arrangements to oversee provider quality and performance and to support system improvement, including reporting of key performance metrics and escalation where concerns	

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	appeared. The committee discussed the interplay between prior recommendations and highlighted that management had felt that all actions had been addressed whereas the report felt there was still areas to pick up. GT recognised the significant progress made in the financial sustainability area, however, highlighted that it was still a significant weakness for the current year. It was confirmed that discussions took place with Finance colleagues who agreed it should be a key recommendation, however, the improvement was acknowledged in the ICBs performance in this area. The constraints of the reporting framework in place was also highlighted. A suggestion was raised to provide further context in the report to ensure people were aware of the detail in future. **The Committee:** • **Approved the report, the recommendations and the management responses.**	
10.	<u>SIRO Report</u> Item deferred to Part B of the meeting.	
11.	<u>Anti-Fraud, Bribery and Corruption Policy</u> The NHS GM Anti-Fraud, Bribery and Corruption Policy had been reviewed and updated. It was confirmed that the updated policy would be shared with the committee after the meeting with the minor amendments raised. **ACTION:** IC to share the updated Anti-Fraud, Bribery and Corruption Policy with the committee. **The Committee:** • **Approved and ratified the NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan policy prior to publication on the NHS GM website.**	**IC**
12.	<u>Standing Items:</u> <u>Conflicts of Interest Guardian</u> There were no updates to note. <u>Board Summary Report</u> Report to be completed noting items during the meeting. **Audit Committee noted the updates provided.**	
13.	<u>Audit Committee Workplan</u>	

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	Suggestions were raised for topics that would need including in the workplan for future meetings.	
14.	<u>Any Other Business, reflections on the meeting and items for escalation to the Board</u> There were no other items of business for consideration. <u>Reflections on the meeting</u>: Suggestion raised for a Board Development Session on PSR to understand the detail and implications. **ACTION:** Future Board Development Session to cover PSR.	**JN**
15.	<u>Date and time of next meeting:</u> 17 September 2026, 10:00 – 13:00pm, MS Teams	

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