

Agenda

Greater Manchester Strategic Commissioning Committee (Public)

Date: 3 June 2026

Time: 14:00pm to 16:00pm

Venue: MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:00	5 mins	Welcome, Introductions and Apologies received –	Verbal	Information	Rachel Egan <i>Chair</i>
2.			Attendance Matrix & Terms of Reference on a Page	Paper		
3.			Declarations of Interest	Paper	Noting	
			Minutes and matters arising from previous meeting held on 6 May 2026	Paper	Approval	
Strategic Updates						
4.	14:05	10 mins	Risk Report	Paper	Information	Nicola Hepburn, <i>Acting Chief Reform and Improvement Officer</i>
5.	14:15 14:30 14:45 14:55	50 mins	Chief Officers Update Reports: - Chief Clinical Officer Report - Chief Commissioning Officer Report - Chief Reform and Improvement Officer Report - Chief Strategy, People and Partnerships Report	Paper	Discussion	Manisha Kumar, <i>Chief Clinical Officer / Katherine Sheerin, Chief Commissioning Officer / Nicola Hepburn, Acting Chief Reform and Improvement Officer / Charlotte Bailey, Chief Strategy, People and Partnerships Officer – Population Health / Place</i>
6.	15:05	15 mins	Performance Report	Paper	Information	Nicola Hepburn, <i>Acting Chief Reform and Improvement Officer</i>
7.	15:20	15 mins	GM Prevention Demonstrator Quarterly Update	Paper	Information	Warren Heppolette, <i>Prevention Demonstrator Director, GMCA</i>

8.	15:35	15 mins	Antimicrobial Resistance Report	Paper	Information	Claire Lake, <i>Deputy Chief Medical Officer</i>
For Information						
	15:50	10 mins	Any other business	Verbal	Discussion	All
			Board Paper Escalations			
			Meeting Reflections			
Date and time of next meeting: Wednesday 1 July 2026, 14:00pm – 16:00pm MS Teams						

Key:

Present

Apologies

Attendee as per ToR

Not a member

[illegible]

Terms of Reference on a page

Purpose	Key duties	Membership
The purpose of the Strategic Commissioning Committee ('the Committee') is to obtain assurance, on behalf of the Board, that the ICB has the right <u>commissioning strategy</u> and approach, supported by intelligence, which is delivering its quality, performance, population health, and <u>oversight</u> functions in a way that secures continuous improvement, whilst ensuring that the ICB operates as a strategic commissioner. The Committee will have a strong focus on improvement, prevention, population health and the left-shift as set out in the 10-Year Health Plan. The Committee will operate within an agreed shared governance model with the People and Resources Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals.	Strategic Commissioning • Apply constructive challenge to the strategic commissioning arrangements and make recommendations to the Board or People and Resources Committee regarding procurement, and evaluation of contractual delivery. • Oversight of development and implementation of the Commissioning Strategy, ensuring this is developed within the resources available. • Ensure that opportunities for service redesign in line with the Commissioning Strategy are optimised. • Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the People and Resources Committee will scrutinise financial implications and make relevant decisions, or where appropriate, escalate recommendations to the Board. • Receive assurance on the commissioning processes and decisions across all commissioned services, including:- Primary Care, Hospital and Community Health Services, Specialised Services, Services commissioned from VSCFE providers, NHS GM Place Based Partnerships. Other key duties: - Clinical Strategy - Performance and Planning - System Oversight - Continuous improvement - Digital Strategy - Population Health - Data and Intelligence - Strategic Risks - Statutory Functions Other duties • Apply constructive challenge to the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. • Apply constructive challenge to the oversight of EPRR arrangements.	The membership of the committee shall comprise of the following members: • Non-executive Director (Chair) • Non-executive Director (Deputy Chair) • Non-executive Director • NHS GM Partner Member • NHS GM Partner Member • Chief Clinical Officer • Chief Commissioning Officer • Chief Reform and Improvement Officer • Chief Strategy, People and Partnerships Officer Only members of the Committee have the right to attend Committee meetings.

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
Bailey, Ms. Charlotte Elizabeth	Y			Nil			
Kumar, Dr Manisha	Y	Financial Interest	Outside employment	Salaried GP at the Robert Darbishire Practice - 1 session per week		2004	Ongoing
Kumar, Dr Manisha	Y	Non-financial professional interest	Loyalty interests	Honorary Professor University of Salford		01/05/2023	Ongoing
Kumar, Dr Manisha	Y	Non-financial personal interest	Loyalty interests	Husband has the following roles: • Operations Director - Primary Eye Care Services LTD • Case Examiner – General Optical Council		2021 2019	Ongoing
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son works in the finance department at Tameside and Glossop NHS Foundation Trust.		14/10/2024	Ongoing
Hepburn, Mrs. Nicola	Y	Financial interests	Clinical private practice	From 29 April 2025 I have been an associate clinical nurse assessor for MHS clinical services. MHS often complete work for MIAA. I do not complete any work on behalf of MHS across Greater Manchester or work commissioned by NHS GM. I complete all work via my own personal company outside of my contracted substantive role.		29/04/2025	Ongoing
Hepburn, Mrs. Nicola	Y	Non-financial professional interest	Outside employment	I am a volunteer Clinical Board Advisor for Now Your Talking a talking based National therapy service.		07/10/2025	Ongoing
Sheerin, Mrs. Katherine Mary (Katherine)	Y	Non-financial professional interest	Loyalty interests	Trustee and Deputy Chair of the Board of the The Whitechapel Centre, a charity which works to prevent homelessness and support people who are homeless, operating across the Liverpool City Region.	This is a voluntary role with no remuneration or expenses paid.	01/01/2025	Ongoing
Non-Executive Directors							
Non-Executive Directors	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
Bailey, Dr Susan Mary	Y	Financial Interest	Outside employment	Independent NED on the board of KOOOTH PLC, a mental health online digital platform. I am remunerated for this work. Neither any members of my family or I hold shares in this PLC.		2022	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	Chair of centre for mental health. The centre and myself advocate for better mental health outcomes for all through the delivery of evidenced based policy briefings and lobbying at a national and Regional level		2018	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Council member university of Salford		2016	
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	BEVAN commissioner - Bevan through evidence base support improved health and social care outcomes For the population of Wales.		2014	Ongoing
Egan, Rachel Mrs	Y			Nil			
Njoroge, Jackie	Y	Financial professional interest	Outside employment	Chief Strategy & Data Officer University of Salford		2016	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	First Choice Homes Oldham (FCHO) Independent Non Exec		2025	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	GMCA Independent Audit Committee member		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Transforming Access & Student Outcome (TASO) Trustee		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Deputy Chair Higher Education Strategic Planning Association (HESPA)		2015	
Partner Members							
Partner Members	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
Vallance, Leigh	Y	Financial interest	Outside employment	CEO of Bolton Hospice which is part funded by an NHS Grant		2023	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	As Chair of Bolton CVS, (a voluntary sector infrastructure body) who are in receipt of NHS funding		Ongoing	

Minutes

Greater Manchester Strategic Commissioning Committee

Date: 6 May 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present		Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Prof. Manisha Kumar (MK) – Chief Clinical Officer Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Leigh Vallance (LV) – VCSE Partner Member Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director Chris Gaffey (CG) – Associate Director of Corporate Services Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer Melissa Maguinness (MM) – Programme Director Commissioning Development (item 8) Chris Gresty (CGr) - Analytical Lead, Corporate Services, Digital Insight and Intelligence Jim Ritchie (JR) - Deputy Chief Clinical Officer Sam Evans (SE) - Corporate Director of Finance – Commissioning & Financial Assurance (deputising for Kathy Roe) Faye Vaughan (FV) – Governance Advisor (Minutes)		Rachel Egan (RE) – Non-Executive Director Kathy Roe (KR) - Chief Finance 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 1 April 2026 The minutes were accepted as a true record of the previous meeting held on 1 April 2026, subject to a minor amendment raised.	

4.	Update on Sub Groups & Draft Workplan Discussions The report provided the committee with progress on the development of Supporting Groups and Work Plans for the Strategic Commissioning Committee. CB presented the development of a new substructure for committee support, focusing on refining work plans, ensuring alignment across committees and establishing a consistent framework for thematic deep dives and reporting. It was explained that a supporting substructure of working and assurance groups would be introduced to streamline capacity. It was also confirmed that they would use existing meetings more effectively, with the aim of simplifying processes and ensure clear accountability. The committee were made aware that the work plans for the substructures were still being refined to focus on top priorities. Assurance was provided that this process was ongoing and would be coordinated to avoid duplication and ensure strategic alignment across committees. JN raised concerns regarding how issues such as health inequalities would be tracked across subgroups. The plans for deep dives and integrated reporting to provide comprehensive oversight were outlined. It was suggested that a draft piece of work could be shared at the August 2026 meeting to the committee. LV emphasised the need for timely implementation of commissioning processes ahead of April 2027. The committee agreed a timetable for reporting and further work on health inequalities, with key deliverables would be scheduled for the October 2026 meeting. The Committee: • Provided comment and views on the current proposals on Committee workplans and supporting groups.	
5.	Chief Officers Update Reports: <u>Chief Clinical Officer Report:</u> The report highlighted key areas of assurance and oversight, including the Paediatric Hearing Services Improvement Programme; maternity and neonatal safety oversight (including escalation routes through the Local Maternity and Neonatal System (LMNS) Safety Assurance Panel); learning from national patient safety event data (LFPSE) and never events; independent sector provider quality assurance and the management of commissioning risks such as Right to Choose activity and associated legal challenge. The report also set out emerging system risks and improvement activity, including the affordability and implementation position for updated National Institute for Health and Care Excellence (NICE) NG28 guidance on type 2 diabetes medicines and the use of NHS IMPACT Learning and Improvement Networks (LINS) to accelerate improvement. JR outlined the ongoing work to address paediatric audiology recalls, workforce gaps in perinatal pelvic health and the implementation of updated NICE guidance for type 2 diabetes, with holding positions and action plans in place to manage risks and ensure patient safety. The report highlighted achievements in maternity services, compliance with safety	

	actions and improvements in hypertension diagnosis, as well as the development of strong links with learning improvement networks to support shared learning across the region. The Committee: • Noted the key areas of risk and assurance highlighted within the report, including the Paediatric Hearing Services Improvement Programme, and support continued system level oversight and escalation through established governance routes. • Noted the assurance and improvement activity described, including maternity and neonatal safety oversight, system learning from national patient safety event data (LFPSE) and never events, independent sector provider quality processes, and active oversight of Right to Choose activity and associated risks. • Noted the emerging system risks and proposed approaches set out in the report, including the interim holding position for implementation of updated NICE NG28 guidance (pending a phased, affordable commissioning proposal) and the use of LINs to accelerate improvement; and advise on any areas where further deep dive reporting is requested. • Approved the addition of Azathioprine 10mg/mL suspension for inflammatory bowel disease (IBD) to the GM formulary (AMBER shared care), following Clinical Effectiveness and Governance Sub-Committee (CEG) clinical approval. • Approved the updated GM Direct Oral Anticoagulants (DOACs) Commissioning Statement, enabling switching and supporting system-wide cost savings, following CEG clinical approval. • Approved the NHS GM Independent Sector Rheumatology Service Specification, following Clinical Policy, Audit and Standards Group (CPAS) challenge/amendment and CEG clinical approval. <u>Chief Commissioning Officer Report:</u> KS reported progress towards consolidating specialist vascular surgery at MRI and cardiac services at Wythenshawe, noting positive feedback from the Clinical Senate and ongoing work to define service levels at Oldham. The committee were also made aware of the development of a single major trauma centre that had been delayed due to capacity issues and the need to appoint a Clinical Lead. It was confirmed that a new lead had since been appointed, however, the timeline will now need to be extended with a further review to take place at the upcoming Programme Board. KS highlighted the ongoing difficulties in securing a provider for adult critical care transport due to capital investment constraints, with interim arrangements in place and efforts underway to unblock capital issues following discussions at the Northwest Specialised Commissioning Committee. The committee emphasised the importance of setting clear, realistic timelines and learning from delays in trauma and cardiovascular projects, with a call for more definite dates and proactive management to avoid similar issues in future. The Committee: • Noted the report. <u>Chief Reform and Improvement Officer Report:</u>	
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	The report showed varying levels of assurance in delivery of standards. It demonstrated GM continued to show continuous improvement against standards. NH reported on the six key areas of concern in performance and patient standards, including urgent care waits, RTT pathways, diagnostics and mental health. It was confirmed that all had established recovery plans in place and were being monitored through oversight and contract meetings. NH highlighted the significant system improvements over 2025/26, including reduced waiting times and improved standards across most Trusts, with specific mention of Wigan's performance, emphasising the importance of integrated, collaborative working. The Committee: • Received and discussed the report. • Noted scrutiny of performance takes place at the Strategic Commissioning Committee and is reported to Board. <u>Chief Strategy, People and Partnerships Report:</u> CB reported that the place outcomes framework, partnership agreement, funding, staffing models and governance options were in the final draft stages, with plans for executive and locality board review and sign-off. It was further reported that efforts were underway to bring together various neighbourhood health programmes, such as Live Well and Population Health, under a unified governance structure to ensure strategic alignment and oversight while maintaining the independence of each initiative. JN questioned how consistency and local variation would be managed. It was clarified that the outcomes framework set out consistent goals, while local partnerships determined how to achieve them based on local needs, with ongoing work to refine data and dashboard capabilities. The committee discussed mechanisms for sharing best practice across localities, with CB noting that the new governance arrangements would enhance visibility and oversight, replacing current local assurance meetings with more fit-for-purpose structures. The Committee: • Noted the report.	
6.	Performance Report This report reflected a transition point between the 2025/26 year-end outturn and the early delivery position for 2026/27. Final validated positions for some 2025/26 measures were subject to national reporting timelines; therefore, where validation was not yet complete, forecast positions had been used to provide an early view of performance and delivery risk. The committee were informed that the plans were underway to combine Performance, Finance, and DII reports into a single, comprehensive report to facilitate richer committee discussions and inform future commissioning intentions, with a draft expected to be shared at the August 2026 committee. The committee discussed data access and dashboard tools. It was confirmed that	

	detailed dashboards and elevated metrics could be accessed, enabling granular analysis and more meaningful performance discussions. The Committee: • Agreed the recommended status of partial assurance and agreed the levels of assurance and delivery risks.	
7.	Oldham SEND Inspection Outcome This report supported the work of the committees responsibilities for SEND assurance and oversight and the forward plan for Children and Young People. KS summarised the SEND inspection process, noting significant reductions in waiting lists for speech and language therapy, community paediatrics and improvements in partnership working following the implementation of a priority action plan. It was explained that the team were moving towards a more proactive, system-wide approach to SEND, supporting localities in developing reform plans and exploring opportunities for commissioning services at GM level to achieve economies of scale and consistent quality. LV sought assurance on the inclusion of education and parent voice in planning. It was confirmed that strong co-production practices took place at both local and GM levels, with parent/carers forums and young people actively involved in the transformation work. The shift towards needs-led, person-centred service models, particularly in neurodevelopmental pathways was described, aiming to provide early, holistic support and reduce reliance on diagnosis-driven approaches. The Committee: • Noted the improvements made by Oldham SEND partnership and the “effective action” outcome of the Local Area SEND Monitoring visit inspection. • Noted the recommendations for system improvements to support for locality SEND systems and agree where this work can be further discussed and progressed.	
8.	Mental Health Productivity: Inpatient Reduction, Flow and Commissioning Decisions This report brought together planned activity and emerging evidence across mental health, learning disability and autism (MHLDA) services in Greater Manchester to support strategic oversight and commissioning decisions for 2026/27. It summarised system priorities for the coming year, progress and learning from the Mental Health Inpatient Quality Transformation Programme and the commissioning-led approach to inpatient bed reduction and improved flow through Clinically Ready for Discharge (CRFD) modelling. MM reported a reduction of over 80 non-commissioned beds and 30 rehab beds in 2025/26, with ongoing investment in step up/step down capacity and community alternatives to admission, aiming to end all block contracted beds by March 2027. It was explained that the transformation programme emphasised therapeutic care, purposeful admission, reduced length of stay and outcome-based service specifications, with lived experience and qualitative/quantitative metrics to monitor progress.	

	LV raised concerns about workforce fragility. It was reported that improvements in care models had positively impacted recruitment and retention, with collaborative strategies and recent successful recruitment drives, though further work remained. The need for place-level ownership of discharge planning and flow, particularly for clinically ready for discharge patients was emphasised. The importance of early intervention and community support to prevent admissions was also highlighted. The Committee: • Noted the planned commissioning priorities for 2026/27 across MHLDA services. • Noted the progress and learning from the Mental Health Inpatient Quality Transformation Programme. • Endorsed the commissioning intent and approach to inpatient bed reduction and CRFD improvement, including the planned exit from block contracted independent sector acute beds by March 2027.	
9.	Frailty Update This paper provided an update on the learning from Long Term Conditions (LTC) and Urgent and Emergency Care (UEC) work. It summarised the impact of frailty on the population, what the system was currently experiencing, what GM frailty stocktake identified and the overall direction of travel. JR described the need for a comprehensive, end-to-end approach to frailty, moving beyond front-door interventions to include prevention, community support, and end-of-life care, with a collaborative oversight group established with GMCA. It was explained that the strategy would prioritise falls and fractures, polypharmacy, dementia/delirium and severe frailty, with a planned stocktake of existing services to assess capacity, standards and alignment with strategic commissioning goals. The approach aligned with the neighbourhood health model, aiming to mobilise local resources and address system pressures such as UEC demand. LV declared a conflict of interest in the item and emphasised the role of hospices and end-of-life care. The committee also noted the importance of balancing resources across working-age adults, children, the elderly and the need for predictive analytics to plan for future demand. The Committee: • Noted the scale and importance of frailty as a system issue; the link between frailty, older people's experience, long waits and system performance; the baseline findings from the GM stocktake; and the direction of travel including alignment with neighbourhood health models and forthcoming national service expectations.	
10.	Any other business None were raised.	

Board Assurance Framework (2025/26 Year-End) and Corporate Risk Update

Strategic Commissioning Committee

3rd June 2026

3rd June 2026

Required information	Details
Title of report	Board Assurance Framework (2025/26 Year-End) and Corporate Risk Update
Author	Chris Gaffey, Associate Director of Corporate Services
Presented by	Nicola Hepburn, Acting Chief Reform and Improvement Officer
Contact for further information	Tom Conyers, Head of Risk & PMO – tom.conyers1@nhs.net
Executive summary	This report provides an update to the Strategic Commissioning Committee on the final position of the strategic (BAF) risks for the areas of responsibility for the Committee, as well as an update on Corporate Risks.
The benefits that the population of Greater Manchester will experience.	Effective risk management is essential. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation
How health inequalities will be reduced in Greater Manchester's communities.	The management of strategic risks will directly contribute to the delivery of the ICP strategy.
The decision to be made and/or input sought	The Strategic Commissioning Committee is asked to: • Reflect on the final position of the strategic (BAF) risks for 2025/26 • Consider the Corporate Risks relevant to this committee
How this supports the delivery of the strategy and mitigates the BAF risks	This report is directly focused on Risk Management which includes the BAF risks.
Key milestones	N/A
Leadership and governance arrangements	Each strategic risk has an assigned risk owner, who is a Chief Officer of NHS GM. The BAF is reported to and considered by the Board at each of its meetings, with some strategic risks also considered at the Strategic Commissioning Committee and others at the People & Resources Committee.

	The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	The BAF and Corporate Risks are considered by the relevant Committee, as well as the NHS GM Chief Officers for management oversight.
Financial or Legal Implications	None.

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

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

1.0 Introduction

- 1.1 This report provides the Committee with the final position of the relevant BAF risks for 2025/26, as well as an update on the Corporate Risks relevant to the Strategic Commissioning Committee. A formal review of NHS GM's BAF risks for the coming period is ongoing to ensure the organisation's strategic risks are aligned to its strategic objectives, and that these accurately reflect the ICB's new responsibilities as a strategic commissioner in line with the ICB Model Blueprint and new Operating Model.
- 1.2 Work is ongoing to develop a list of strategic risks for the coming year, based on the 5-Year Commissioning Plan. Proposals are planned to be presented to the Board at their informal meeting in June, before the BAF is then finalised and presented at the formal Board meeting in July for consideration and approval.

2.0 2025/26 BAF – Year End Position

- 2.1 Full detail of the final position with supporting narrative for the 2025/26 year-end position can be found starting on page 86 of the [public Board agenda](#). Key messages are presented as follows:

Comparison of the Q4 risk scores with their Year End Targets shows two areas where the Q4 score exceeds the Year End Target:

- SR1 Health of the Population (Q4 score: 15, Year End Target: 10), although this is within the agreed risk appetite (Open – range 10 to 20)
- SR10 NHS Reform (Q4 score: 16, Year End Target: 9). The Q4 is outside the agreed risk appetite (Cautious to Open – range 5 to 15)

Two Strategic Risk year-end scores are above their agreed risk appetite. These are: Q2 Health Outcomes, and SR10 NHS Reform.

- The Health Outcomes year-end risk score is outside the agreed risk tolerance range (Cautious to open 5 to 15), though the final target score for 2028 is 10.
- The NHS Reform year-end score is above the agreed risk tolerance range (Cautious to Open 5 to 15). The final target score for 2026 is 4, which is below the range.
- All other Strategic Risks year-end scores are in line with the Year End Targets.

Strategic risk Number	Strategic Risk	Year End Score	Trend	Year End Target	Final Target score	Risk Appetite	Risk Appetite Tolerance Range
SR1	Health of the Population	3 (L) x 5 (I) = 15	↔	2 (L) x 5 (I) = 10	5 (2028)	Open	10 to 20
SR2	Health Outcomes	4 (L) x 5 (I) = 20	↔	4 (L) x 5 (I) = 20	10 (2028)	Cautious to Open	5 to 15
SR3	Quality of Care	3 (L) x 5 (I) = 15	↔	3 (L) x 5 (I) = 15	10 (2028)	Cautious to Open	5 to 15
SR4	Good Employment	3 (L) x 4 (I) = 12	↓	3 (L) x 4 (I) = 12	8 (2029)	Open	10 to 20
SR5	Health Inequalities	2 (L) x 4 (I) = 12	↓	3 (L) x 4 (I) = 12	4 (2028)	Open	10 to 20
SR9	Emergency Incident	3 (L) x 3 (I) = 9	↓	3 (L) x 3 (I) = 9	6 (2028)	Cautious to Open	5 to 15
SR10	NHS Reform	4 (L) x 4 (I) = 16	↔	3 (L) x 3 (I) = 9	4 (2026)	Cautious to Open	5 to 15

2.3 All of the above will be considered within the context of the upcoming refresh of the BAF (see section three), but also within the framework of moving towards a more dynamic way of reporting risk for the organisation. Feedback from a recent deep dive on SR1 conducted by the Audit Committee (information also within the public Board pack mentioned in paragraph 2.1 above) set out a number of key areas to enhance reporting, focusing on outcomes, impact and risk movement.

2.2 Corporate Risk Update

3.1 The risks shown below are the corporate risks agreed to be considered by the Strategic Commissioning Committee.

3.2 Updates to the corporate risks have been received and are shown below. The previous committee reference has been included to ensure members are clear where the corporate risks were previously reviewed.

Strategic Commissioning Committee Corporate Risks

Risk Number	Risk Description	Score	Trend
Quality			
QUP25/07/25	There is a risk of limited assurance on the quality of interventions within paediatric audiology services which may cause delayed harm to the CYP population	16	↔
CAN0426 01	The Cancer Alliance have developed a work plan for 2026-7 which addresses the priorities in the national planning guidance for cancer. The design and delivery of this plan will require system wide working in GM across primary care, Place, VCFSE, providers and all parts of the ICB. IF the ongoing ICB reform process reduces capacity in parts of the system which the Cancer Alliance rely on to deliver the work described in the plan (i.e. commissioning, place based cancer leads, BI teams) THEN this will have a negative impact on the ability to deliver.	20	New
CAN0426 02	If there is not a sufficiently resourced, skilled, and sustainable workforce across health and social care, then the system will be unable to deliver the ambitions of the cancer plan, including early diagnosis, operational performance standards, and delivery of personalised care interventions.	16	New
CAN0426 03	The ICB reform process is ongoing and has been affected by changes in approach at a national level. If this continues without resolution in GM then there will be an impact on system partners who are fundamental to the delivery of the cancer plan in GM. Update: significant number of ICB staff working on cancer projects / programmes at a GM level and in neighbourhoods have taken VR in round 1 with others expected to go in round 2.	16	New
QUP16/11/23	IF the Cancer Alliance projects add operational and / or financial pressure to the GM system given the underlying operational and financial challenges THEN the delivery of the NHS Cancer Programme priorities and targets will be affected. This includes ongoing funding of projects to sustain services once the Cancer Alliance funding allocation to providers and partners in NHS GM ends	Closed – superseded by risks above	
QUP19/03/24	If the fragility of the dermatology service is not resolved, there will be a detrimental impact on the operational performance metrics. Furthermore there will be an impact to patient experience and potentially psychological impact.	Closed – superseded by risks above	
QUP23/05/24	If investment (non-pay) is not available to deliver improvement initiatives, then there is a significant risk to the delivery of the <u>system planning</u> requirements for cancer performance (28 day, 62 day)	Closed – superseded by risks above	

ERR 2	There is a risk of non-delivery of waiting List There are multiple causes, including insufficient system working, GM's historic waiting list position and ambitious targets versus nationally allocated levels of funding	16	↑
ERR 3	There is a risk of non-delivery of financial control (change in financial regime) in particular unfunded over-performance on contracts. Financial and contracting mechanisms have changed, which means approaches used in recent years (such as various additionality methods) cannot be utilised.	16	↑
ERR 4	There is a risk that the interaction of Elective and UEC mitigations conflict, leading to non-achievement of targets and impact on patient outcomes	12	↔
ERR 6	There is a risk that winter pressures disrupt elective capacity and performance	12	↑
ERR14	There is a risk that strategic investment decisions are taken at organisation level and unintended consequences may deteriorate Elective demand and capacity	12	↔
ERR15	There is a risk that ICB control of its provider landscape and activity is significantly limited	12	↓
GMMHPGR7	There is a recognised risk that the updated CAMHS specification and implementation of the new CYP ND clinical criteria will create commissioned gaps for CYP who meet thresholds for Autism or Attention Deficit Hyperactivity Disorder (ADHD) assessment but do not have a co-occurring mental health condition. These CYP will fall outside the scope of CAMHS, potentially leaving them without a clear referral pathway for diagnostic assessment unless alternative commissioning arrangements are made	16	↔
GMMHPGR1	There is a risk that Non Contracted Bed Usage and Local Spot Purchase (LSP) bed usage will not be eliminated if the Clinically Ready For Discharge (CRFD) and Out of Area Placements (OAPs) reduction targets are not met, and demand continues to exceed capacity	12	↔
GMMHPGR14	There is a risk that demand on GM MH Crisis and GM Urgent & Emergency Care (UEC) services will exceed capacity	12	↑
QUP21/10/24	IF the GM UEC system does not achieve the 78% 4 hour wait in Emergency Department (ED) standard of care by end March 26 THEN there may be a risk to patient safety.	20	↑
QUP09/01/23	IF the GM UEC System is overwhelmed due to capacity constraints then the possible consequence of this would be more patients attending an ED, overcrowding of EDs, less patients being seen within 4 hours, delays to hospital handover, compromising patient safety and possibly leading to patient harm.	20	↑
QUALITY AND PERFORMANCE - MEDICAL/CEG			
CCPL09A	Sustainability and resilience of the Clinical and Care Professional Leadership workforce There is a risk that NHS Greater Manchester ICB does not maintain sufficient, sustainable Clinical and Care Professional Leadership (CCPL) capacity and capability within its established clinical portfolio to fulfil its statutory functions, provide effective strategic commissioning leadership and influence safe, high-quality and clinically credible decision-	20	↔

	making across the Greater Manchester system. This may arise from prolonged workload pressure, recruitment constraints, ongoing reform and limited resilience within a lean portfolio model. If this risk materialises, the ICB's ability to lead quality, safety, transformation and clinical strategy delivery could be weakened, with consequential impact on system performance, service improvement and outcomes for the GM population.		
CCPL09B	Clinical leadership assurance, governance and statutory compliance (including Place assurance) There is a risk that clinical advice, challenge and assurance are not consistently embedded in ICB decision making, commissioning and transformation across Greater Manchester during transition to the Model ICB and ongoing financial and organisational change. As place-based arrangements evolve and legacy advisory routes fall away, assurance may vary across places and programmes, reducing clarity about where advice should be obtained, how it should be applied, and when concerns should be escalated. This could lead to poorly evidenced clinical input to key decisions, increasing the risk of sub optimal prioritisation, weaker quality and safety oversight, and inconsistent compliance with national expectations and the statutory duty to obtain appropriate clinical advice. If unmitigated, this may undermine confidence in system governance and the robustness of decisions taken at pace. This is a structural assurance risk that is likely to persist through the reform period and requires ongoing management.	20	↔
CCPL17	There is a risk that the level of quality oversight and assurance of maternity and neonatal services will reduce in NHS GM which may result in a reduction in the quality and clinical safety of care and poorer outcomes for the people of Greater Manchester.	16	New
POPULATION HEALTH			
PH1	There is a risk that the financial, operational and performance pressures facing NHS GM and the wider Population Health system lead to a reduction of funding for Population Health and Prevention, or a delay in the approval of activities resulting in disruption to planned activity. The impact of this would be to reduce the likelihood that we would not achieve our ambitions in relation to reducing health inequalities and improving health outcomes.	12	↔
PH2	There is a risk that the financial pressures and organisation change that is facing NHS GM impact on the ability to recruit staff into key roles, and to retain staff who are currently in key roles at locality and pan-GM level. The impact of this will be to delay, disrupt or scale back the delivery of key Population Health programmes which in turn will reduce their impact in terms of improving health, reducing health inequalities, and reducing avoidable demand and cost.	12	↔
PH3	There is a risk a lack of capacity, funding and prioritisation will mean that NHS GM will fail deliver the requirements of the GM Green Plan including the required carbon emissions, and failure to fully prepare for the impacts of climate change.	16	↔
PH4	There is a risk that the issues relating to financial, operational and workforce sustainability within the VCFSE sector, associated with both national and local factors, could create a level of sector fragility that could jeopardise the delivery of	16	↔

	GM's Population Health ambitions, and the wider system Live Well / Neighbourhood Health plans.	Greater Manchester	
PH5	There is a risk that largescale organisational transformation over the next 18 months, in the context of NHS reform, will cause short-term disruption to the delivery of activity focussed on improving health, reducing health inequalities, and reducing avoidable demand and cost.	12	↔
PH6	There is a risk that the NHS reform announcement will disrupt the planned formal delegation of screening and immunisations from NHSE to the ICB (planned for April 2026).	12	↔
DATA, INSIGHT & INTELLIGENCE			
DII039	Misalignment Between GM SDE and NW SDE Impacting Funding A lack of alignment between the GM SDE and NW SDE programmes could result in reduced national funding, affecting both business-as-usual activities and the SDE programme.	12	↔
DII058	Sustainability of New Commissioned Services There is a risk that ongoing maintenance of newly commissioned services via DII cannot be sustained.	16	↔
DII068	NHS Reform Threatening Continuity of CSU Support NHS reforms may lead to the dissolution or restructuring of Commissioning Support Units (CSUs), including Arden & GEM, threatening continuity of critical support services.	16	↔
DII083	There is a risk that GP Data Controllers and Local Medical Committees (LMCs) do not agree to or sign the new Joint Data Controller Agreement for the GM Care Record / ADSP, particularly for secondary use and research purposes, resulting in data being unable to legally flow across the system.	16	↔
STRATEGY			
STRP4/2/24	Delivery of the GM Sustainability Plan and Annual Plan 2025/26 Due to the extensive nature of the savings required to be delivered - there is a high probability of the levels of saving required not being achieved.	15	↓
STRP/6/8/25	Delivery of the Prevention Demonstrator fails to realise the expected outcomes Due to early stages of prevention approaches, challenges with integrated working with partners and complexities of system-wide implementation of new neighbourhood model	12	↔
STRP/7/8/25	Integrated working with VCFSE fails to realise the expected outcomes Challenges surrounding implementation of Accord Agreement within system working	9	↔
PH3	Delivery of the GM Green Plan Insufficient capacity, limited dedicated funding, and competing organisational and system priorities, leading to variable engagement and delivery across functions and partners.	16	↔
XXX	Estates delivery (to be updated following transition) Lack of capacity within GM and Place following changes to staffing and structures	16	↔

- 3.3 As part of ongoing arrangements and plans transitioning into new teams, a further, in-depth review of the organisation's corporate risks will be conducted to ensure these relate to NHS GM's responsibilities as a strategic commissioner, whilst also ensuring differentiation between risks and issues are clear.

3.0 Recommendations

- 4.1 The Strategic Commissioning Committee is asked to:

- o Reflect on the final position of the strategic (BAF) risks for 2025/26
- o Consider the Corporate Risks relevant to this committee

Chief Clinical Officer Report

June 2026

NHS Greater Manchester Strategic Commissioning Committee

June 2026

Required information	Details
Title of report	Chief Clinical Officer Report
Author	Claire Lake, Deputy Chief Medical Officer Jim Ritchie, Deputy Chief Medical Officer Kate Provan, Associate Director of Clinical Effectiveness, and Improvement
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive summary	This June 2026 Chief Clinical Officer Report provides an update on key clinical governance, quality, medicines optimisation and service improvement matters across Greater Manchester. It highlights current issues requiring attention through the Alert, Advise and Assure framework, including GP collective action linked to data sharing, work to improve the primary and secondary care interface, progress on resident doctor rotation planning, ongoing paediatric audiology risk, and the proposed CNST Year 8 assurance approach. The report also summarises items considered by the Clinical Effectiveness and Governance Committee and identifies those requiring Strategic Commissioning Committee approval.
The benefits that the population of Greater Manchester will experience.	NHS GM's statutory quality and clinical governance functions support people across Greater Manchester to experience safe, effective and continuously improving services. Through targeted quality improvement, strengthened oversight and refreshed governance pathways, the system is better able to identify risks earlier, intervene more consistently and reduce unwarranted variation. This directly supports improved experience and outcomes for patients and communities.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy, including early identification of inequality-related risks in urgent care, mental health, medicines optimisation and system improvement programmes. It supports more consistent governance and escalation, helping to reduce unwarranted variation and strengthen equitable access and outcomes across Greater Manchester.
The decision to be made and/or input sought	The Committee is asked to note the contents of the June 2026 Chief Clinical Officer Report, approve the items identified in the report that require Strategic Commissioning Committee approval, and note or endorse the remaining items progressed through established governance routes.

How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and the progress made to improve them relate to Board Assurance Framework risk SR5.
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for Strategic Commissioning Committee and has not been elsewhere but is formulated from intelligence and papers from NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group.
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	There has been no formal engagement on this paper as it is produced for Strategic Commissioning Committee and has not been presented elsewhere. The intelligence and papers used to formulate this report have been drawn from the NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group.
Financial or Legal Implications;	This report contains a combination of assurance updates, governance matters and formulary or medicines optimisation decisions. Most items do not create material new financial commitments for NHS GM and are being progressed through established governance routes. Some medicines-related items may have a local financial impact, including cost avoidance, prescribing efficiencies or rebate savings. Legal and regulatory considerations are reflected through existing statutory duties, National Institute for Health and Care Excellence (NICE) technology appraisal (TA) requirements, commissioning arrangements, medicines governance processes and data sharing obligations. No additional legal implications requiring separate Committee action have been identified beyond the approvals sought within the report.

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

Alert

General Practice (GP) Collective Action

Following a poll of members, the British Medical Association (BMA) GP committee has voted in favour of re-entering collective action due to insufficient assurance from the Government regarding concerns over the 2026/7 General Medical Services (GMS) Contract.

Whilst the previous collective action proposed a range of actions practice could take (related to interface work and inappropriate transfer of activity), the current collective action is presently focussed only on data sharing. A template letter has been provided by the BMA requesting ICBs to confirm:

- The full list of Data Sharing Agreements (DSA)s currently in effect involving the practice
- The purpose of each of these DSAs and whether under each agreement the data is shared for direct care, or for other uses
- In respect of each DSA, the legal requirement underpinning the sharing of the data, including any relevant contractual obligations (e.g. within the GMS contract, Primary Care Network (PCN) Direct Enhanced Services (DES) or activity to support local commissioning arrangements); statutory requirements (e.g. serious case reviews or safeguarding); or mandated Government data directions
-

The letter notes that, pending the above, the practice intends to stop sharing data under any DSA where:

- There is no contractual obligation on the practice to share the data, i.e. sharing the data is wholly voluntary
- There is no professional obligation upon the practice to share the data (i.e. the ICB has considered obligations under the General Medical Councils' Good Medical Practice)
- There is no statutory or mandated data Direction requiring the data flow (i.e. directions issued by the Secretary of State of the Department of Health & Care)

Risks

Although Greater Manchester has strong legal arrangements in place to allow patient information to be shared and used safely—including a national approval (known as “Section 251”) that allows certain health data to be used for planning, research, and improving services without needing consent from every individual patient—we recognise that GP practices remain responsible for their own data, we expect there will be a proportion of practices who choose to withdraw from data sharing. This will impact:

- The ability of our Digital Insight and Intelligence team to provide comprehensive data and analytics to support service planning, activity tracking and commissioning
- Our ability to track and manage local incentive schemes such as Beyond Core Contract (BeCCoR)
- The ability of the sub-regional Secure Data Environment (SDE) to provide representative data to researchers aiming to identify insights that may improve the health of our population

Mitigations

- The Primary Care team have coordinated meetings with GM Local Medical Councils (LMC) to understand the likely local approach and allow for an open dialogue
- The Information Governance (IG) team have pre-emptively begun to draft a response to questions regarding data sharing agreements between practices and NHS GM (noting that practices will also have DSAs with parties other than NHS GM)
- Health Innovation Manchester (HiNM) are evaluating the impact on delivery of the SDE programme
- The BeCCoR team are engaged with practices to offer broader support to ensure population health benefits can be delivered

Advise

10 Point Plan to improve resident doctor working lives

In August 2025 a 10 Point Plan to improve the working lives of resident doctors was published. Point 9 in this document states, "We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery".

Planning of rotation training placements is a well-recognised challenge for resident doctors. Following a successful initial single service pilot, discussions have now begun with leads from the North West School of Medicine to plan a more scaled evaluation of a digital solution that offers greater input, transparency and equity in placements whilst also reducing the burden on training leads.

Paediatric Audiology

Paediatric Audiology remains a system and regional risk as re-call clinics for children continue. The addition of an independent sector contract for supporting the waiting list in Stockport has enabled the risk of increased waiting times to be mitigated and there are ongoing conversations and planning for how the service will be reinstated. A quality assurance visit identified some areas where adjustments are required to ensure that the independent provider is reaching the standards required of all services and these measures are being put in place.

This area of delivery remains a risk for the ICB at present – particularly in relation to workforce capacity across ICB, Provider Trusts and Subject Matter Experts. This risk is articulated on the ICB risk register and a collective risk across all 3 North West ICBs has been articulated by the Regional team.

Active mitigation and oversight is being delivered through national and regional oversight arrangements, including a detailed improvement programme, NHS GM Audiology Oversight Group, and targeted quality reviews, with regular monitoring of provider improvement plans and backlog recovery initiatives; this risk is recorded on the corporate risk register and is reviewed and updated frequently to ensure continued scrutiny and assurance.

Assure

Primary / Secondary Care Interface

Reducing barriers and improving care and relationships at the primary / secondary care interface has been a longstanding national programme of work. Within GM we have recognised the importance of framing interface work more broadly and have developed a forward action plan that:

- Puts patients and patient safety at the heart of interface working
- Allows improvement at all care interfaces

This plan sets out three focus areas to focus improvement work around:

- Accountability and collaboration (recognising clear ownership and cross boundary collaboration as pre-requisites for safe care transitions)
- Embedding and sustaining best practice (scaling current progress and good practice through all system groups)
- Digital innovation (contributing to an interoperable digital ecosystem that reduces information gaps)

The forward action plan is currently in consultation with system partners to ensure shared ownership and agreement on key shared workstreams.

Summary of items considered at CEG (May 2026)

The Clinical Effectiveness and Governance (CEG) Committee met in May 2026 and considered a

wide range of statutory clinical governance and system improvement matters. The discussion reflected both substantive clinical decision-making and the evolving governance context associated with the ICB transition.

This table sets out, for each CEG item:

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

Full papers available on request

CEG paper/Item	Specific decision	Instruction to SCC
High dose semaglutide (for weight loss) In January 2026 the Summary of Product Characteristics (SmPC) for semaglutide 2.4mg for weight loss was updated to add a new licensed dose of 7.2mg weekly. A NICE TA is in progress for this new strength, but an estimated publication date is not yet available.	CEG is proposing an interim recommendation that semaglutide 7.2mg for weight management should not be prescribed until NICE guidance is published.	SCC is asked to approve the interim position not to prescribe pending NICE guidance
Loperamide 2mg capsules (used for the management of high-output stomas)	CEG acknowledged that this use of loperamide represents current best practice in the management of high-output stoma and the update to formulary is required to support the appropriate transfer of prescribing to primary care	SCC is asked to approve the amendment to formulary
Fostair NEXThaler (a dry powder inhaler, used to manage asthma and COPD by reducing inflammation and widening airways.)	CEG has approved renewal of the Fostair NEXThaler rebate agreement, which provides NHS GM with a discount on prescribing costs.	SCC is asked to approve the renewed rebate agreement for Fostair NEXThaler. The new agreement increases the discount on one strength and decreases it on the other, with an overall estimated annual saving of about £742k.
Sacubitril/valsartan heart failure information for adults in primary care	CEG has approved an update to an existing document planned to amend the RAG status as agreed by GMMMG from Green (specialist initiation) to Green (specialist advice). A full review has been undertaken and the document now includes guidance on monitoring and management of adverse effects.	No SCC decision needed Note and endorse CEG clinical approval
Shared care protocol – methylphenidate for Attention Deficit	CEG has approved a planned update to existing shared care documentation which has been	No SCC decision needed Note and endorse CEG clinical approval

Hyperactivity Disorder (ADHD) in Children and Adolescents	transferred into the new template. It aims to support safe and effective care for patients closer to home though provision of prescribing in primary care	
GM Shared Care Protocols (SCPs) – Surveillance, Prioritisation and Review Framework	CEG approved the decision to establish a structured and risk-based approach to the surveillance, prioritisation and review of Shared Care Protocols (SCPs) in Greater Manchester.	No SCC decision needed Note and endorse CEG clinical approval
Emtricitabine / tenofovir alafenamide (for pre-exposure prophylaxis (PrEP) for human immunodeficiency virus HIV-1)	CEG approved the decision to add this HIV prevention medicine to the Greater Manchester approved medicines list so sexual health services can provide it.	No SCC decision needed Note and endorse CEG clinical approval
Emerade adrenaline pens removed from use (used for the emergency treatment of severe acute allergic reactions)	CEG approved the removal of Emerade adrenaline auto-injector pens from the approved medicines list because they have been discontinued and were previously subject to a safety recall.(Alternative adrenaline auto-injectors remain available and can support the increased demand.)	No SCC decision needed Note and endorse CEG clinical approval
Asenapine tablets discontinued (an atypical antipsychotic used to treat schizophrenia and bipolar I disorder)	CEG approved removal from the formulary and noted that specialists will review any patients still using it and switch them to suitable alternatives where needed.	No SCC decision needed Note and endorse CEG clinical approval
Acoramidis (used to treat a rare heart condition)	CEG approved the addition of acoramidis to the approved medicines list for adults with this rare heart condition, in line with NICE guidance.	No SCC decision needed Note and endorse CEG clinical approval.
Natalizumab (used for adults with highly active relapsing-remitting multiple sclerosis (MS))	CEG approved the addition of new approved forms of natalizumab to the medicines list for adults with highly active MS when other suitable treatment has not worked and another option is not suitable.	No SCC decision needed Note and endorse CEG clinical approval, in line with NICE guidance.
British Pregnancy Advisory	Approve the updated PGD for	To approve the updated PGD for use by

Service (BPAS) patient group direction (PGD) for medroxyprogesterone for contraception	use by BPAS within the Manchester locality	BPAS within the Manchester locality
GM Digital Maternity Dashboard	CEG received a presentation of the GM Maternity Dashboard and noted that it gives a clear, up-to-date picture of the local population and outcomes, helping services spot inequalities, understand changing needs, and target improvements where they are most needed.	No SCC decision required
Specialist Palliative Care Discussion Paper Around Service Modelling considering the National Adult Specialist Palliative Care Service Specification	The item is primarily for noting. The Committee is asked to acknowledge the discussion paper and support the proposed follow-on actions, including further consensus work on workforce guidance, local gap analysis, collaborative locality-provider planning, workforce pathway development, improved data dashboards, future demand modelling, and consideration of the national Modern Service Framework.	No SCC decision required Note and support the proposed next steps for specialist palliative care workforce, service, and data planning.
Clinical Negligence Scheme for Trusts (CNST) Year 8 Assurance Model and System Oversight (The CNST Maternity Incentive Scheme (MIS) is designed to enhance maternity and neonatal safety within NHS Trusts. It provides financial incentives to Trusts that demonstrate they have implemented core safety actions aimed at improving outcomes for women, babies, and families)	CEG agreed to support Option B (balanced support model) for CNST Year 8, recognising it as the most pragmatic approach to maintain system oversight and mitigate risk within current resource and governance constraints. This was agreed with the expectation that additional clarity is developed on how the ICB will assure itself of maternity safety and quality within the revised national assurance framework.	SCC is asked to approve adoption of the Option B balanced support model for CNST Year 8, noting the associated risks. SCC is also asked to endorse further development of a proportionate assurance approach that enables the ICB to maintain sufficient oversight of maternity safety and quality, including agreement on the data set and escalation mechanisms required to support targeted intervention where assurance concerns arise.
Cardiovascular Disease (CVD) Prevention and Diabetes: Inequalities, performance and planning update	The item is for noting rather than approval; the Committee is asked to note the update on the GM framework for CVD prevention and diabetes, the approaches being used to assess health inequalities improvement, and current	No SCC decision required Note the update on GM's CVD prevention and diabetes framework, inequalities measurement approach, and current performance against national diabetes ambitions.

	performance against the new national ambition for diabetes care processes, including the impact of BeCCoR.	
Developing Inclusive Translational Pathways for Motor Neurone Disease (MND) across Greater Manchester.	The Committee is asked to note the progress of the Manchester MND Research Partnership and to support continued cross-system collaboration related to inclusive research pathways, genomic testing implementation, and earlier diagnosis initiatives.	Note SCC decision required Note progress of the Manchester MND Research Partnership and support ongoing cross-system collaboration on inclusive research, genomic testing, and earlier diagnosis.
CEG provided collective clinical assurance across statutory clinical governance responsibilities and supported progression of all items through established governance routes. No issues were identified that required escalation outside existing arrangements, with recommendations progressing to the Strategic Commissioning Committee where formal approval is required.		
Risk discussed and new risk identified		
The principal new risk identified relates to the potential impact of GP collective action on data sharing arrangements, which could reduce the availability of data needed for analytics, commissioning, local incentive schemes and research. The report also highlights ongoing system risks linked to the primary and secondary care interface, workforce pressures and service planning, and the need to maintain timely implementation of agreed medicines optimisation and formulary decisions. These risks are being managed through existing governance, partnership working and mitigation actions set out in the report.		
Achievements		
Greater Manchester organisations were highly successful in the inaugural NHS Excellence Awards 2026, securing multiple regional champion awards across the North West. Award-winning initiatives included system-wide transformation of mental health flow (Greater Manchester Mental Health NHS Foundation Trust, Pennine Care NHS Foundation Trust (PCFT) and NHS GM ICB), digital innovation in dialysis services (Manchester University NHS Foundation Trust), population health improvement programmes (PCFT), sustainable healthcare initiatives led by NHS GM, and partnership working through the Greater Manchester Urgent Primary Care Alliance. These awards recognise the scale of innovation, collaboration and impact being delivered across the Greater Manchester system, and position GM strongly for national recognition at NHS ConfedExpo.		

Recommendations:

The Committee is asked to:

- Note the contents of the June 2026 Chief Clinical Officer Report
- Approve the items within the report that require Strategic Commissioning Committee approval
- Note or endorse the remaining items that have progressed through established governance routes and do not require further Committee decision.

NHS Greater Manchester Strategic
Commissioning Committee
Report from Chief Commissioning Officer
3rd June 2026

Report from:	Katherine Sheerin, Chief Commissioning Officer
Date of Meeting:	3 rd June 2026
Authors	Gill Baker, Director of Healthcare Commissioning Louise Sinnott, Ben Squires, Director of Primary Care Gill Gibson,
Executive Summary	This paper sets out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. The quarterly report on the performance of All Age Continuing Care against key indicators is included at Appendix 1.

ALERT

Healthcare Commissioning

No alerts this month.

GM Specialised Commissioning Oversight Group

Cardiac and Vascular Service Changes

- **Clinical Senate and Assurance**
The NEY Clinical Senate review was supportive, identifying a small number of areas for improvement across the PCBCs. The cardiac and vascular proposals

have been shared with the NHS England North West Region as part of the Stage 2 assurance process, and the financial case is currently being finalised.

- **Oldham Vascular Provision – Key Challenge**

A significant issue remains in defining the future vascular services currently provided at Royal Oldham Hospital once the MRI centralised model is implemented. Ongoing collaboration between NCA and MFT is focused on developing a clear service specification. This specification is essential to inform activity and financial modelling and is currently delaying progress on the Financial Case.

There is a material risk to the overall programme timeline if this issue is not resolved by the end of May 2026. While the commissioning assumption remains cost neutrality, unresolved estate constraints at Oldham continue to complicate the assessment of stranded costs and future service configurations.

- **GM Vascular Network Alignment**

The group discussed progressing a parallel programme with the Greater Manchester Vascular Network to standardise spoke-site provision. This approach aims to improve equity of access to ICB-commissioned district general hospital vascular services and to ensure consistent clinical support from MFT across all spoke sites, particularly where services are clinically co-dependent.

Primary Care Commissioning

The BMA is urging GP partnerships and practices across England to take part in collective action to stay safe and sustainable in the face of the 2026/27 imposed GP contract. the first action practices take is around reviewing the GP patient data they are expected to share outside the practice, with the wider NHS and other organisations.

Data, Insight and Intelligence and Primary Care colleagues are engaging with GM LMCs around this issue and are providing clarity of arrangements and shared benefits with practices of local data sharing arrangements.

Should Collective Action escalate, NHS GM has governance arrangements established in response to previous action which can rapidly be implemented.

ADVISE

Healthcare Commissioning

Development of thematic outcome-based delivery plans – Each thematic area has developed an outcome-based delivery plan which sets out a five-year trajectory to meet their outcomes set out in the NHS GM Five Year Strategic Commissioning Plan. These plans detail the year-on-year plans and interventions to achieve the outcome(s) by year 5. During May/June, the plans will be reviewed and summarised to provide a further update

to the ICB Board in July, providing further detail of how NHS GM will deliver the ambitions set out in the Five-Year Strategic Commissioning Plan.

Development of Gynaecology and ENT services

As part of the ICB's intentions to manage demand away from acute providers and into community services, plans are underway to develop and mobilise additional community-based provision for Gynaecology and ENT. A key enabler is the development of Gynaecology and ENT Single Points of Access (SPoA) to allow for the utilisation of both existing and new service in line with GM pathways. These pathways illustrate NHS GM's commitment to the 'left shift' by enabling patients to be seen in primary and community care for a range of Gynaecology and ENT presentations that do not require Secondary Care treatment. These pathways, which will be mobilised this year, aim to deliver around 16,000 pathways which will improve referral to treatment trajectories (RTT).

Allocations are being proposed on the basis of the overall local opportunity after adjusting for existing service provision. We want to ensure funding is sufficient to stand up provision across GM and supports the SPoA workstream. However, we want to balance this with the risk that locality and trust teams will move at different speeds meaning not all teams may be able to fully realise the in-year allocation. It is therefore proposed that funding will be released in two parts (H1 and H2) allowing an opportunity to re-allocate funding based on pace of mobilisation and deepening understanding of the opportunity as evidence emerges.

Progress to develop a NW Individual Funding Request and Commissioning Policy Team / Process – Under the ICB Reforms, several areas have been identified to 'do once' on a regional footprint. The IFR and Policy Development is one of the services which has been identified and agreement that NHS GM will be the host ICB on behalf of the North West. Work continues to develop a single operating model and to harmonise commissioning policies across the North West. This will involve the transfer of staff from Midlands and Lancashire Commissioning Support Unit (MLCSU) who currently deliver the service on behalf of Cheshire & Mersey ICB and Lancashire and South Cumbria ICB. The proposed transfer date is 1 October 2026. This is dependent on the agreed operating model and appropriate due diligence being completed including staff consultation on a new structure. Work continues at pace via a representative task and finish group, chaired by the NHS GM Programme Director for Transition which meets weekly and reports into the NHS England Change and Transition Steering Group.

Oral and Maxillofacial Surgery (OMFS)

Manchester University NHS Foundation Trust (MFT) currently provides workforce for OMFS (Max Fax) through Service Level Agreements (SLA) to Stockport Foundation Trust (SFT), Salford Royal Hospital (SRH), and Wrightington, Wigan and Leigh Foundation Trust (WWL). Bolton Foundation Trust (BFT) have an SLA in place with East Lancashire Hospital Trust (ELHT) for delivery of OMFS. BFT signalled that they would like to move away from this SLA and bring activity back into Greater Manchester (GM). Due to fragilities with some of the SLA's MFT were asked to explore becoming the lead provider for GM OMFS.

In recent discussions with the ICB, MFT indicated that the engagement they require from the 3 GM remaining providers has not come forward to enable this to happen. In light of this MFT has requested that the intended direction of travel needs to be revisited. Whilst the BFT service model has a level of fragility, the MFT SLAs with WWL and the NCA are stable.

Stockport closed to new referrals in September 2023 for both Oral Surgery and OMFS. SFT have indicated in recent weeks that they wish to reopen to new referrals for Oral Surgery employing their own workforce. In response the ICB have written to SFT asking for clarification on these intentions including timescales.

GM Major Trauma Single Service Implementation

The ongoing work of the GM Major Trauma Programme continues, and progress has been made in Q1 of 26/27. A decision was previously made by the NHS GM Board to have one single GM Major Trauma Service, delivered across two sites in partnership between MFT & the NCA.

In Q1 of 26/27 there has been an identified programme lead announced and the appointment of the NHS GM clinical lead to drive forward this work. The Major Trauma Implementation Board continues to meet and has recently gained an update on the progress towards resolving previous Peer Review recommendations and from the Data & Digital, and the finance working groups. The next key milestones for the programme will be the Clinical Model Workshop, which is currently being planned to take place within the next 4-6 weeks.

A full update on this programme will be brought through NHS GM's Board in July.

GM Specialised Commissioning Oversight Group

Retinopathy of Prematurity (ROP) Screening

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

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

- Workforce resilience – outstanding recruitment to nurse screener roles, with associated risks to sustainability and cover
- IT and digital interoperability – significant variation in PACS systems, slow progress with image integration across Cheshire and Mersey, and unresolved requirements for image storage

- Cross-trust working – the absence of a unified honorary contract solution, limiting the peripatetic deployment of screening staff
- Equipment lifecycle management – a proportion of WFDRI cameras are approaching end of life, with no confirmed replacement plan in place

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

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

Specialised Mental Health Services

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

Key points from the Assurance Report:

- **St Andrews (Northampton) Closure:** The move of all patients from St Andrews in Northampton, has no immediate impact on North West patients but NW providers are offering support to affected patients.
- **Women's Secure Pathway Transformation:** Work is ongoing to transform the women's secure pathway, with Mersey Care proposing a blended low and medium secure service. National specifications are expected by June/July, and the use of the Aspen Wood unit is under consideration due to reduced Learning Disability referrals.
- **Delayed Discharges and Prison Waits:** There are persistent challenges in securing local authority placements for patients ready for discharge from secure services, particularly in Manchester, and ongoing issues with transferring patients from prison to Psychiatric Intensive Care Units (PICUs), with efforts underway to resolve these with ICBs and secure units.
- **Anderson Mother and Baby Unit Relocation:** Due to significant building issues at Laureate House, the Anderson unit has temporarily relocated patients to other units, with ongoing discussions about suitable interim locations and concerns about the impact on service users from South Manchester and Cheshire.
- **Service Updates and Capacity:** Updates were provided on the reopening of Sunflower House, pressures in adult eating disorder services, the opening of Sapphire Ward for nasogastric tube feeding, and ongoing work to restore capacity at the Cove CAMHS unit, with a continued focus on mutual aid and repatriation.

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

NW Adult Critical Care Transport (ACCT) Services

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

The Group received assurance that appropriate interim mitigations remain in place through existing interim commissioning arrangements, which continue to be closely monitored by the regional ACC Clinical Networks.

Artificial Intelligence for Mechanical Thrombectomy Identification

The group discussed the transfer of funding for AI tools supporting thrombectomy decision-making. Current deployment in GM is limited to hyper-acute (wider coverage is included in neighbouring ICBs). The Group required assurance was sought regarding pathway equity for patients presenting at non-hyper-acute sites from the ISDN

Primary Care Commissioning

In 2024 NHS GM included a review and re-procurement of Interpretation and Translation services across Primary Care as part of a Cost Improvement Program but also to improve quality of service delivery and access.

Utilising the Shared Business Services Framework, a call-off / mini-competition process has been carried out to determine the most suitable provider to deliver the expectations set out within the newly developed NHS GM Framework of Requirements for I&T services, which is in line with the actions described within the NHS Improvement Framework for Community Language Translation and Interpreting Services (Published May 2025). The outcome of this process is now progressing to contract award.

ASSURE

Healthcare Commissioning

Community Dermatology Procurement – following a challenge to the procurement process and a subsequent standstill period, the ICB made the decision to formally abandon the current Community Dermatology procurement process. Interim community provision has been commissioned for 2026/27, pending the re-start of a new procurement. Lessons have been learnt from the previous procurement, and an options appraisal has been done to propose a different approach to the new procurement. The new procurement will maintain the previously agreed funding envelope of £27.85m for a 3yr contract, however it will be advertised as 1 lot, rather than the previous 5 lots. This will simplify the

approach for bidders and will give NHS GM a broader market to ensure the security of the appropriate provider.

Wrightington Wigan & Leigh (WWL) Plastic Surgery Service Transfer to Mersey and West Lancashire Teaching Hospital (MWL)

WWL notified NHS GM in October 2025 of its intention to cease delivery of the plastic surgery service by 31 March 2026. With the service currently delivered from Wigan sites using MWL clinicians, MWL was identified as the only viable provider to take on the service. Oversight and sub-groups were established to manage the transfer, and MWL's options appraisal confirmed that a full like-for-like transfer could not be delivered within the timeframe. An interim split-site model was therefore recommended while a long-term solution is developed, supported by a further appraisal due in June 2026, including a cost-benefit assessment of returning LA clinics to Wigan.

To support long-wait reduction, WWL and MWL agreed an Inter-Provider Transfer (IPT) arrangement, enabling MWL to take responsibility for WWL's waiting list and increase capacity. Operational teams have progressed patient transfers, communications have been issued, and complaints responded to. Finance and contracting colleagues have finalised 2026/27 activity and contract values, with the transfer expected to be cost-neutral to the ICB. Equality and Quality Impact Assessments are being developed to inform longer-term decisions, and MWL has indicated it may seek a temporary non-reporting period due to potential RTT breaches.

Key risks include the compressed timeline for safe transfer, the lack of prior public engagement, and the possibility that MWL may ultimately choose not to return LA clinics to Wigan. NHS GM faces potential challenge from NHS England if statutory duties around involvement are not met. This has been escalated at executive level, and the ICB Chief Commissioning Officer has proposed that the initial contract be treated as temporary, up to six months, while proportionate engagement and the Equality Impact Assessment are completed, this will support the commissioning decision post July.

Ophthalmology Transformation Programme

The GM Ophthalmology Strategy outlined a number of key deliverables in response to several factors negatively impacting on the sustainability of NHS GM provision and subsequently contributing to the GM system financial pressures.

To date the transformation programme has delivered and implemented a GM Service Specification, Eye Care Navigation Service, Clinical Audit in our Independent Sector Providers (ISP), a GM workforce review and GM wide engagement with our service users.

The Strategy will be reviewed and refreshed in 2026 prioritising Macular Service provision and Glaucoma pathways to deliver 'left shift' in collaboration with the GM Ophthalmology Clinical Reference Group (CRG).

Paediatric Audiology

The national Paediatric Hearing Services Improvement programme was established in response to systemic issues in paediatric audiology, including cases of misdiagnosis, and has driven a full review of GM services, during which elements of the Stockport Foundation Trust (SFT) service were paused and referrals closed from February 2025, with urgent

patients supported through mutual aid. To maintain access and reduce the backlog, NHS GM commissioned an independent sector offer, appointing Health Harmonie to deliver interim paediatric audiology services from October 2025 for children over five at Stepping Hill Hospital and from February 2026 for under-fives at Woodley Health Centre using purpose-built booths; to date, 1,154 appointments have been completed across backlog and new activity pathways, supported by recall super-clinics from January 2025. Alongside these interim arrangements, NHS GM is developing a sustainable future model of care for paediatric audiology, working collaboratively with clinical and commissioning partners across GM, and an options appraisal has been completed and shared with the Paediatric Audiology Strategic Commissioning Group.

Provider Accreditation Group

The GM Provider Accreditation Group (GMPAG) continues to accredit providers to deliver Consultant Led Elective services in specialities where provision already exists.

The GMPAG subject matter experts undertake a thorough and robust review process to accredit providers against the requirements set out in the Due Diligence Questionnaire (DDQ).

Independent Sector Providers

As part of the newly formed Health Care Commissioning Directorate, team members have initiated Active Monitoring (AMP) for the Independent Sector Provider (ISP) through the contracting team, ensuring alignment with providers so the contract is managed effectively from a commissioning perspective. Activity management plans for 2026/27 have now been agreed and will be monitored through the contract meetings. Alongside this, the ISP work has included the development of standardised specifications by specialty and the establishment of a rolling programme covering Ophthalmology, Orthopaedics, General Surgery and Rheumatology. All of these specifications are now complete, incorporated into the contract for delivery, and the next phase will be to determine the new rolling programme for future ISP specification development.

GM Specialised Commissioning Oversight Group

2026–2027 Planning

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

Quality Report

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

Finance Update

The Group received an update that GM system delivered an overall surplus, supported by deficit funding in 25/26 and that specialised commissioning delivered broadly to plan. Forward planning has highlighted pressure from reduced deficit support in future years. The Group noted improved financial coherence across the system compared with the previous year.

Performance Report

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

NW Specialised Services Committee

Feedback from the March NWSSC meeting was shared that included, progress on OPIC development and emerging operating model, a review of the risk register, a focus on Mental health and neonatal issues. The Group noted anticipated future changes to governance and terms of reference.

Primary Care Commissioning Committee - INTERIM

The revised GM Dental Patient Access Quality Scheme implemented for Q1 and Q2. Consideration of extending for full year subject to ongoing review in light of national dental contract reforms and affordability. This will seek to support continued access to NHS Dental services for new patients and clinically prioritised patients.

In accordance with NHSE Planning requirements, a Primary Care Action Plan has been prepared assure delivery of required outcomes over the coming year. This has been developed to support delivery of our GM Primary Care Blueprint strategic ambitions.

ACHIEVEMENTS

Healthcare Commissioning

Neurorehabilitation Transformation

Successful transfer of Stockport NHS Foundation Trust's Devonshire Centre to the Northern Care Alliance NHS Foundation Trust (NCA). 026/27. As part of the transfer, NHS GM has increased funding to the Devonshire Centre to increase staffing and increase the bed base from 15 to 19 beds. The focus now is to transform Outpatient services during Q1 26/27.

Community Services Review

The transformation programme is progressing with an initial focus on two priority areas: **District Nursing** and **Intermediate Care**, with the aim of developing a consistent core service offer across Greater Manchester. Work has been undertaken collaboratively with system partners to align both areas to the neighbourhood model and establish a shared GM standard.

A **District Nursing task-and-finish group** has now been established to design a standardised GM-wide DN specification that can be adapted locally. This work builds on earlier engagement and is intended to bring greater consistency, clarity of offer, and alignment with the wider community transformation programme.

For **Intermediate Care**, a GM workshop is planned to sense-check progress against the agreed standards. The purpose of the session is to share good practice, test alignment across localities, and reset the collective direction of travel where required to ensure a coherent GM approach.

Musculoskeletal (MSK)

The development of a GM MSK strategy has initiated and has had early engagement with system partners to ensure the themes are right for Greater Manchester. A GM-wide Model of Care group has been established to lead the co-design and standardisation of a redesigned MSK pathway, driving consistency, quality and improved outcomes across Greater Manchester. The second multi-disciplinary workshop has now taken place and is demonstrating strong progress in shaping the pathways.

Looking ahead to 2026/27, the focus will be on establishing standardised GM-wide community MSK specifications, referral management processes and pathway redesign. This work aims to reduce unwarranted variation, improve pathway efficiency, minimise unnecessary secondary care utilisation and optimise the use of existing NHS capacity.

Ophthalmology Eye Care Navigation Service

The GM Eye Care Navigation Service was established in August 2025 to provide clinical triage and consistent, unbiased and effective CHOICE to patients. As a result, around 3700 fewer referrals have been sent to Secondary Care and NHS Market Share has increased from 49% to 58% (for Cataracts IS share has fallen from 70% to 50% since September). Across all sub-specialties there has been a 10% increase in referrals to Bolton, MFT and 12% increase to WWL, 40% reduction to SpaMedica and a 70% increase to PPG (70% decrease in Tameside). Whilst the service has delivered its objectives there are opportunities to develop and evolve the service further to support 'left shift' in line with National GIRFT Best Practice Guidance.

Primary Care Commissioning

Launch of GP BeCCoR Scheme for 2026/27, with a series of webinars for practices. This year's scheme builds on the strength and success of previous years' delivery, extending consistent pan-GM elements of:

- General Practice Quality and Sustainability
- Elective Care
- Population Health Management & Neighbourhoods
- Medicines Optimisation

with locally retained elements to ensure stability as the programme progresses.

LEARNING FOR SHARING

GM Specialised Commissioning Oversight Group

The Group discussed the potential for modelling the impact of timely ROP screening on long-term outcomes, with suggestions to share findings with local authorities and consider further analysis on prevention and cost avoidance.

APPENDIX –

All Age Continuing Health Care (AACC) update – May 2026

A/A/	Current position	Issues of concern	Improvements or mitigations in place	Link to BAF risks
Assure	Referrals completed within 28 days – target 80% or above Published data for Q4 2025/26 GM ICB achieved 89.3% against a target of 80%. Referrals exceeding 28 days by 12 weeks+ (long waits) - Target is 0 2 long waits were reported for Q4.	Reform challenges destabilising the workforce	- All 9 out of 10 localities achieved the required KPI for 28 days. - NHS GM ICB has been recognised by the NHSE national team for performing well against quality indicators and finance as nationally we are 2nd lowest spending ICB for CHC. Mitigations - Continued monitoring and oversight of KPI via monthly assurance report for early indication of any issues - Targeted meetings are set up where required with Director of Nursing Individualised Care and locality Head of Service to discuss challenges and mitigations.	Improvements in these areas significantly impact on experience of care, delivery of statutory responsibilities in respect of continuing health care, quality of service and equity of access to health and care. BAF SR2
Advise	Workforce challenges remain across GM CHC locality teams due to vacancies and sickness, but teams are maintaining good performance	- Risk of not being able to recruit to new vacancies as they arise due to reform announcements - Members of staff moving between localities, so vacancy levels remain the same at GM level. - Still some pockets of sickness within some CHC teams which is impacting on their ability to maintain business as usual.	- NHS GM ICB currently have 11 vacancies (April 26 data) 5.4wte clinical and 4.1 wte admin vacancies - NHS GM is now using NHS Professionals bank to obtain any agency staff - Authorisation to recruit to clinical vacancies is via the normal process to BCP. Recruitment to Admin vacancies is on hold currently to reform, but locality teams can utilise NHSP bank for agency as interim mitigation Mitigations - There are currently 5 agency staff from NHSP in place across 3 localities (Bury/Manchester/Stockport). Two further localities (Oldham and Wigan) are going through the process with NHSP to obtain 2 x Band 6 each. - Vacancies and sickness within localities are reported on a monthly basis to the GM Quality team in order to monitor and provide support where required. Any identified risks are escalated to Gill Gibson, Director of Nursing Individualised Commissioning. - Locality teams are encouraged to utilise mutual aid between themselves where possible as a further mitigation	
Advise	There remains a number of backlog reviews for PUPoC and COP/DOLs cases across all 10 localities	- PUPoC Reviews have built up due to not being prioritised due to several reasons within teams such as sickness and vacancies etc. - Possible risk of increase in complaints and IRPs due to backlog of PUPoC reviews - Risk of increase in finance pressures when completing PUPoC reviews due to accumulated interest and long period of time - Currently not legally compliant with the CHC Framework re; COP/DOLs due to backlog. Significant risk	Mitigations - Localities have been advised all reviews should be completed where possible and should be incorporated into BAU - This is an area under additional scrutiny due to the financial cost implications of the cases where there is a long period of time under review.	
Advise	NHS GM continue to have some localities with a number of backlog reviews for CHC, Fast Track and FNC (Bury/Manchester/Oldham/Stockport/Wigan)	Reviews have not been prioritised due to a number of reasons within teams such as sickness and vacancies etc	- Localities are completing reviews as BAU where possible and are working through cases. However high numbers remain in CHC, Fast Tracks and FNC reviews. This is due to continued workforce challenges as outlined above. Mitigations - Agency staff have commenced in all three localities as above to support this and two localities currently going through NHSP to obtain agency.	

Acting Chief Reform & Improvement Officer Report

2026

NHS Greater Manchester Strategic Commissioning Committee

June 2026

Required information	Details
Title of report	Acting Chief Reform & Improvement Officer Report
Author	Gill Baker – GM UEC Programme Director Ed Dyson – Director of performance, improvement and assurance
Presented by	Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM
Contact for further information	Nicola.Hepburn1@nhs.net
Executive summary	This report provides assurance on how NHS Greater Manchester Integrated Care Board is discharging its statutory duties for quality, safety and clinical governance across the organisation and the system as a whole. It brings together intelligence from established governance routes and demonstrates how statutory clinical governance and quality functions are being exercised to identify and manage risk, reduce unwarranted variation, and support safe, effective and equitable care across Greater Manchester. The report shows varying levels of assurance in delivery of standards. It demonstrates Greater Manchester continues to show continuous improvement against standards.
The benefits that the population of Greater Manchester will experience.	The Greater Manchester population will gain improved health outcomes and experience as the Greater Manchester system makes continuous improvement in key standards.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy,

The decision to be made and/or input sought	The Committee is asked to: • Note the report
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for Strategic Commissioning Committee and has not been elsewhere but is formulated from intelligence and papers from
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	There has been no formal engagement on this paper as this paper is produced for Strategic Commissioning Committee and has not been elsewhere. The intelligence and papers used to formulate this report have come from the
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report. Decisions with a material financial impact, including medicines optimisation and gainshare opportunities, are being progressed through the appropriate executive and financial governance routes in line with existing NHS GM policies. The report reflects continued work to improve patient standards and the ICBs delivery and improvement against the

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

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

Alert

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

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

Advise

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

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

Urgent Care focused update:

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

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

Assure

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

- Cancer – Patients receiving communication of diagnosis within 28 days
- Mental Health – Access to Children and Young People's Mental Health Services

- Prevention – Hypertension treated in line with NICE guidance
- Prevention – Cholesterol management for patients with recorded cardiovascular disease

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

Risk discussed and new risk identified
Achievements

Chief Strategy, People and Partnerships Officer - Alert Report

June 2026

NHS Greater Manchester Strategic Commissioning Committee

3 June 2026

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

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

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

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

Key Updates and Escalations

Alert
No Alerts this month
Advise
Live Well is Greater Manchester's delivery model for Public Service Reform. It aims to unite the full range of public services and support into a fully integrated, preventative system to meet need in a different way and reduces demand on public services, including the NHS. It is fundamental to the delivery of the Greater Manchester Strategy and the delivery in the city region of the 10 Year Health Plan and the Neighbourhood Health Framework. The Place Mobilisation work across Greater Manchester is the NHS Greater Manchester (NHS GM) commitment to strengthening neighbourhood delivery through our place model. The place work we have done over the last 6 months is now nearing the end of the developmental phase. More detail is given in the assure section.
Assure
<u>GM Population Health Transformation</u> Work is ongoing to establish an integrated GM Public Health Network(GMPHN), bringing together the existing GMPHN (led by the 10 LA Directors of Public Health) and the NHS GM Population Health function into a single integrated team, with a single plan, and measured against a shared outcome framework under the system leadership of the Directors of Public Health, enabled through a s75 Agreement between NHS GM and Manchester City Council (on behalf of GMPHN). The pace of transformation is now accelerating and is overseen by a Transformation Board, supported by two workstreams – s75 Development and Interim Integrated Working Arrangements. <u>Open Letter on Smoking and Mental Health</u> NHS GM has signed up to an open letter calling on Government to publish a national roadmap to a smokefree country that includes action on mental health inequalities. <u>SmokeFree Spaces</u> Building on our track recording in making smoking history, Greater Manchester is undertaking sector-leading work on smokefree spaces and smokefree hospitals helping to shift smoking out of everyday norms and tackle the biggest preventable cause of death and ill health in the city region. Through co-design with communities, a Smokefree Spaces Toolkit is being piloted across eight neighbourhood settings, with vital learning captured and shared to help all impacted GM settings prepare for and adapt to the changing legislative landscape, as well as embed smokefree environments across the city-region

Neighbourhood Health as part of Live Well

As we enter 2026/27, neighbourhood working will increasingly become our core business as a system. This is being informed by a full programme of engagement with system partners to build a clear understanding of the expectations and opportunities. This will culminate in a System Leadership workshop on 29th June.

A core slide deck and set of questions have been developed for the engagement programme. The key questions include:

- How do we work through this together to set direction and get the systemic buy-in and change that's required?
- How does this work both at a GM level and at locality, and through what partnerships?
- What should be done once at a GM level?
- What is concerning us? How would we address these concerns and risks?
- What have we already got that works - how do we strengthen these?
- What have we tried and learnt from our work so far?
- How can we remove barriers between sectors so that frontline workers can work more effectively together in neighbourhoods to support local populations?
- How can we evolve our models of commissioning, provision, accountability and investment, ahead of new national contracts and organisational forms (SNP, MNPs and IHOs) becoming clear?

During the engagement phase on Neighbourhood Health, NHS GM will receive a visit from Dr Claire Fuller – National Medical Director. A working group – with representation from place, primary care, GMCA and TPC – has been set up to plan the visit. There will be activity both pre and post the visit – the process is below:

ICB Readiness Pack

The pack is structured against the Neighbourhood Health Framework and Fit for the Future architecture, covering governance, leadership, Place-level maturity, delivery capability and enablers

Pre-visit calls

In the fortnight before the visit, two short calls: an assessment pack review call and a logistics call

Baseline visit

A full day on-site visit with the national Neighbourhood Health programme team. The visit will focus on the current position, the plan for each Place, delivery capability, risks, and a small number of priority actions for the following six weeks.

<u>Follow-up visit or call</u> A shorter session to review delivery against the priority actions agreed at the baseline visit, remaining constraints, and any escalated support requirements. <u>Place Partnership Development and Mobilisation</u> There is now an agreed coherent framework for how place-based health and care will operate across Greater Manchester, providing clarity on how strategic commissioning, place-based delivery, governance, funding, teams and outcomes align to improve population health and reduce inequalities. At its core, the Place Health and Care Partnerships (PHCP) model enables a shift towards prevention, neighbourhood-based care and system-wide collaboration, supporting delivery of NHS reform and the ambitions of the 10-Year Health Plan. It strengthens integration between NHS organisations, local authorities, VCSE partners and communities, with Place Partnerships acting as the key vehicle for translating strategy into local delivery. 2026/27 will operate as a shadow year, in line with the Strategic Financial Framework, alongside being an active development year.
Risks discussed and new risks identified <u>Place Partnership Development and Mobilisation</u> • Mobilising the place model is a complex endeavour, involving staff movement into a new structure, ways of working and the possibility of future transfers out. • Funding flows will need to shift through expanded mechanisms, creating financial, governance and assurance risks during transition. • Governance, accountability and partnership behaviours will all change simultaneously, increasing system-wide interdependency risk. • BAU delivery and ongoing transformation must continue in parallel, stretching capacity and heightening operational risk. <u>Neighbourhood Health as part of Live Well</u> • A risk register is under development <u>GM Population Health Transformation Update</u> • The risk register is routinely reviewed by the Transformation Board. There are no risks that required escalation at this stage.
Learning for sharing

- A sprint methodology has been utilised to agree the Partnership Agreement, with engagement and co-production at its heart. This methodology has been seen as a good approach to utilise in further areas of work across system partners.

Achievements

Tobacco and Vapes Act 2026

Greater Manchester, as a national and international leader in making smoking history, has worked with partners and government to help shape the [Tobacco and Vapes Act 2026](#). This landmark legislation delivers a smokefree generation by banning tobacco sales to anyone born on or after 1 January 2009, protecting future generations from ever starting smoking, alongside new powers to regulate tobacco, vaping, and nicotine products, and extend smokefree protections into more public outdoor spaces such as playgrounds and health, care, and education settings.

Greater Manchester Live Well

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

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

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

Performance Report 2026-2027

Strategic Commissioning Committee

June 2026

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

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

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

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

Performance and Quality Delivery Report Strategic Commissioning Committee

June 2026

Reporting Approach for Strategic Commissioning Committee (26/27)

Purpose of this report

This report marks a transition between the 2025/26 year-end outturn and the early delivery position for 2026/27, including updated metrics aligned to the new planning year.

Final year-end performance is available for all domains, with the exception of prevention metrics, where the latest published data reflects the most recent available position.

Key features of the reporting approach

- Performance is presented using an Alert / Advise / Assure (AAA) framework at domain level to support consistent assessment of delivery risk and assurance. In addition, we are including a section to highlight key achievements since the last report.
- Narrative commentary is provided for Alert domains only, focusing Committee attention on areas requiring system oversight
- End of year (2025/26) performance is included this month, with reporting now transitioning to 2026/27 metrics and trajectories
- Headline planning metrics for 2026/27 are set out within the report and will underpin ongoing Alert / Advise / Assure assessment
- For each domain, two slides are provided where applicable:
 - Domain Oversight Summary – current position, key issues, delivery risk and links to the Board Assurance Framework (Strategic Commissioning Committee focus)
 - System Actions & Delivery – high-level system actions, expected outcomes and delivery risks (system-level visibility)

Reporting frequency

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

Executive Summary



Overall position

Greater Manchester has delivered continued improvement at year-end 2025/26, with strengthened national performance across several core standards. As reporting transitions into 2026/27, delivery risks remain in a small number of areas, reflected in six metrics assessed as Alert. These are supported by focused system oversight.

Alert (focused system oversight)

- Urgent & Emergency Care: Four-hour performance and 12-hour waits (all types) remain above plan, reflecting ongoing system flow pressures
- Elective Care: Continued improvement in RTT performance, however 52-week waits remain behind plan, indicating further recovery required
- Diagnostics: Six-week waits remain behind plan, although performance is strong relative to peers and improving trajectory
- Mental Health: Average length of stay remains behind plan, sustaining pressure on inpatient capacity and flow
- Learning Disabilities & Autism: Autistic adult inpatient numbers (without a learning disability) remain behind plan, with continued reliance on inpatient provision

Advise (continued oversight required)

- Primary Care: Access to NHS dentistry remains behind trajectory overall, driven by underperformance in adult access, while delivery for children is on plan

Assure (on track / stable delivery)

- Cancer standards better than plan
- CAT 2 ambulance response and handovers meeting standards
- RTT 18-week and first outpatient performance improving
- CYP mental health access achieved plan
- Prevention indicators improving

Ask of the committee

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

End of Year 2025/26 Performance – Key Achievements



- System-wide improvement with stronger national position: Greater Manchester has delivered continued improvement across core NHS standards, with performance strengthening at a faster rate than peers and movement out of the 4th quartile in key areas.
- Elective recovery ahead of plan with long waits significantly reduced: RTT performance reached 63.8% (above plan) with a substantial reduction in long waits (52+ weeks down to 1.4%; 65+ week waits now amongst the best nationally). Overall waiting list reduced by ~29k.
- Urgent and Emergency Care showing sustained improvement despite pressure: A&E 4-hour performance improved to 73.4% (+3.2pp), alongside reduced 12-hour waits. CAT 2 ambulance response times consistently exceeded standards, achieving ~23-minute annual average, already meeting next year's ambition.
- Strong delivery and improvement across cancer and diagnostics: All cancer standards achieved (FDS 82.1%, 62-day 78.2%) with improved national rankings. Diagnostics performance improved to 10.2%, ranking 4th nationally.
- Progress in mental health, community and prevention priorities: Increased access to CYP mental health services (56k+), reduced length of stay, growth in GP appointments, and continued improvement in cardiovascular prevention indicators.

Performance reflects the combined contribution of GM trusts, system partners and independent sector providers, demonstrating strong collaboration in the face of ongoing demand and capacity challenges. Whilst challenges remain, the trajectory is positive, providing a strong foundation for continued improvement in 2026/27.

Building on this progress there are a number of key focus areas for the new year, these include:

- UEC performance remains sensitive to system flow, particularly bed capacity and discharge
- Further improvement required in elective pathways, with some specialty variation
- Diagnostics performance continues to improve but remains above target levels
- Mental health flow and inpatient variation,
- Reducing inpatient reliance for people with LD and autism

25/26 End of Year Performance

Area	KPI	End of Year Performance			Variance (latest published data vs same period in previous year)			ICB Benchmarking (latest published data vs same period in previous year)		
		ICB / GM Providers / NWS	Actual	Plan	Previous year	Variance	Movement	Previous year	Latest	Movement
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times	NWAS	00:20:58	<00:30:00	00:21:43	-00:00:45	↓			
	A&E % of patients managed within 4 hours	ICB	73.4%		70.2%	3.2%	↑	32/42	28/42	↑
	A&E (type 1) % waits over 12 hours		8.8%		9.5%	-0.7%	↓	16/42	18/42	↓
Elective	% of incomplete RTT pathways of 52 weeks or more		1.4%	0.9%	3.5%	-2.1%	↓	38/42	30/42	↑
	Number of incomplete RTT pathways of 52 weeks or more		5,763	3,425	15,147	-9,384	↓			
	% of incomplete RTT pathways of 18 weeks or less		63.8%	60.8%	55.0%	8.8%	↑	38/42	30/42	↑
	% of pathways waiting no longer than 18 weeks for a first appointment		68.4%	68.1%	58.0%	10.4%	↑			
	Total number of incomplete RTT pathways		402,771	377,212	432,101	-29,330	↓			
	% of incomplete RTT pathways of 65 weeks or more		0.007%		0.041%	-0.034%	↓	6/42	7/42	↓
Diagnostics	% waiting 6+ weeks		10.2%		10.5%	-0.3%	↓	7/42	4/42	↑
Cancer	% of patients receiving communication of diagnosis within 28 days		82.1%	80.2%	80.2%	1.9%	↑	18/42	12/42	↑
	% of patient with cancer receiving treatment within 62 days	78.2%	75.3%	71.5%	6.7%	↑	22/42	8/42	↑	
Mental Health	Access to CYP mental health services	56,370	55,000	55,230	1,140	↑	02/42	02/42	↔	
	Average Length of Stay in Adult Acute, Older Adult Acute and Psychiatric Intensive Care beds	68.4	57.3	73	-4.6	↓	42/42	41/42	↑	
Learning Disabilities	Inpatient care for children and young people with a learning disability and/or autism	*	9	*	*	↓				
	Inpatient care for Adults with Learning Disabilities (who may also be autistic)	**45	46	55	-10	↓				
	Inpatient care for Autistic Adults (with no learning disability)	**55	39	50	5	↑				
Primary Care	Appointments in General Practice	1,522,569	1,449,589	1,436,233	86,336	↑				
Prevention	% of patients with hypertension treated according to NICE guidance	***70.2%		67.7%	2.5%	↑		13/42		
	% of patients with GP recorded CVD, who have their cholesterol levels manage to NICE guidelines	***52.3%		49.9%	2.4%	↑		15/42		

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

** This published data is rounded to the nearest 5. For Adults with Learning Disabilities.

*** Q3 25/26 latest available data

Headline Operational Metrics – AAA Framework (25/26)



Greater Manchester

Area	Metric	Alert	Advise	Assure
Urgent and Emergency Care (UEC)	A&E % of patients managed within 4 hours (GM Providers)			
	A&E (type 1) % waits over 12 hours (GM providers)			
	CAT 2 response times			
	Average ambulance handover times			
Elective	% of incomplete RTT pathways of 52 weeks or more			
	% of incomplete RTT pathways of 18 weeks or less			
	% of pathways waiting no longer than 18 weeks for a first appointment			
Diagnostics	6 week diagnostic performance (not a planning metric but key enabler for elective and cancer delivery)			
Cancer	% of patients receiving communication of diagnosis within 28 days			
	% of patient with cancer receiving treatment within 62 days			
Mental Health	Access to CYP MH services			
	Average Length of Stay in Adult Acute Mental Health Beds			
Learning Disabilities	Inpatient care for Adults with LD			
	Inpatient care for Autistic Adults			
Primary Care	Appointments in General Practice			
	% of resident population seen by an NHS dentist			
Prevention	% of patients with hypertension treated according to NICE guidance			
	% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidelines			
Total		6	1	11

2026/27 ICB Headline Planning Metrics (SCC oversight)



ICB									
Area	KPI	April 26 Actual	April 26 plan	Variance (latest published data vs same period in previous year)			ICB Benchmarking (latest published data vs same period in previous year)		
				2025	Variance	Movement	2025	Latest	Movement
Elective	Percentage of RTT waiting list within 18 weeks	April data not yet available	61.9%						
	Total waiting list		372,212						
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over		16.9%						
Cancer	28-day cancer Faster Diagnosis Standard		79.9%						
	Percentage of patients receiving a first definitive treatment for cancer within 62 days		74.9%						
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days		93.0%						
Mental Health	Mental Health Support Team coverage of total pupils/learners (annual metric)		Annual metric						
	NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness		51.0%						
	NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment		69.0%						
	NHS Talking Therapies: No. completed courses of treatment (YTD)		3,846						
	Number of patients accessing Individual Placement Support services (12-month rolling metric)		3,109						
	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period		2						
Learning Disability and Autism	Inpatient care for Adults with Learning Disabilities (who may also be autistic)		42						
	Inpatient care for Autistic Adults (with no learning disability)		50						
Primary Care	Urgent Dental Appointments		20,500						
Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less		84.6%						

These metrics define the core measures underpinning the Alert / Advise / Assure framework and system oversight for 2026/27

2026/27 GM Provider Headline Planning Metrics (SCC oversight)



GM Providers / Ambulance Trust						
Area	KPI		April 26 plan	Variance (latest published data vs same period in previous year)		
		Actual		Previous year	Variance	Movement
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times	00:20:11	<00:25:00	00:21:08	-00:00:03	↓
	4-hour A&E performance	73.8%	73.0%	68.9%	4.9%	↑
	12-hour A&E performance	7.3%	8.8%	7.8%	-0.5%	↓
Elective	Percentage of RTT waiting list within 18 weeks	April data not yet available				
	Total waiting list					
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over					
Cancer	28-day cancer Faster Diagnosis Standard					
	Percentage of patients receiving a first definitive treatment for cancer within 62 days					
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days					

These metrics define the core measures underpinning the Alert / Advise / Assure framework and system oversight for 2026/27

Domain Performance – Elective Care & Diagnostics

Domain Performance – Elective Care & Diagnostics

Narrative provided for alerts only

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	- Continued improvement in RTT performance, with overall delivery exceeding plan and sustained reduction in long waits 52-week waits have reduced significantly year-on-year, however remain behind plan indicating further work required to fully recover long-wait backlog. - Total waiting list has reduced year-on-year, though remains behind planned trajectory, reflecting ongoing demand and pathway pressures	- Pace of 52-week wait reduction varies across providers and specialties, impacting consistency of recovery. 2 Trusts working to clear 65 week waits. - Underlying demand and pathway variation continue to influence waiting list position, particularly in high-volume specialties (e.g. ophthalmology, paediatrics) - Capacity and flow constraints across pathways continue to affect the rate of sustained improvement	- Strengthened system oversight of RTT delivery, with focused governance on <18-week and long-wait trajectories - Targeted long-wait clearance plans in place across providers, supported by clinical prioritisation - Use of Independent Sector capacity and pathway validation to support backlog reduction - Specialty-focused improvement actions for high-growth pathways driving waiting list pressures - All Trusts are working to deliver improvement in productivity and efficiency as well as working closely with ICB teams on schemes to align demand to capacity. - Maintaining or improvement access to diagnostics as a key enabler to delivering RTT standards	SR2

Elective recovery continues to progress at a system level, with sustained improvement in RTT performance and a significant reduction in long waits. The overall waiting list has reduced compared to the previous year, reflecting the impact of targeted recovery actions and increased activity. While delivery remains above planned levels for 52-week waits and total waiting list size, focused actions are in place to address variation and support continued improvement. The overall trajectory remains positive, with further gains expected as system-wide interventions continue to embed.

Elective Care system group Actions & Delivery

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Beyond Core Contact Review, Elective Quality Improvement Scheme (BeCCoR EQIS)	Elective Recovery Board	2-5% reduction in referrals from 10 high volume specialties, reducing demand by 9,000 – 22,000	Complete 25/26 appeals and Elective Board reporting; Fully embed 2026-27 EQIS; target PCNs with rising referrals and low Consultant Connect usage. Align learning and feedback loops with Advice and Guidance and SPoA communications	Green / Amber: Elective lead left during VR and lack of elective team capacity to pick up whilst posts are being filled; capacity of Place-based teams to receive routine reporting and follow-up on lines of enquiry with GP providers
Advice & Guidance	Elective Recovery Board		Stabilise reporting; begin formal service review; target promotion in low-uptake PCNs	Green / Amber: Capacity of Place-based teams to receive routine reporting and follow-up on lines of enquiry with GP providers; delay in contractual clarity for 2027-28 could undermine confidence and behaviour change
Community Services	Elective Recovery Board	ENT – incrementally avoid 5,000 pathways Gynae – incrementally avoid 10,000 pathways	ENT - Apportion funding between Trusts and issue MoUs; Agree KPIs and reporting; move ENT SPoA into initial delivery; early Wigan & Bolton phases to be implemented Gynae – Service Specification completed & approved. Additional funding earmarked for 26/27 but not yet agreed	Amber: Slippage in funding, contracting or SPoA decisions may materially delay delivery
Single Point of Access	Elective Recovery Board	In Trust Plans	Trusts developing implementation plans for Cardiology, Gastro, ENT and Gynae (for go live by end of July). GM led work underway to develop common condition pathways for each speciality which include clear diagnostic responsibilities for primary and secondary care. Work also underway to develop and agree a simple, GM-wide minimum standard for both sides of the A&G interaction to support a faster, more consistent, and more clinically meaningful triage process	Green / Amber: Trust readiness (e-RS, job planning) and specialty variation could delay implementation, GP capacity to be involved in the co-production of clinical pathways

Diagnostic group Actions & Delivery



System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Reduce waiting times for Cardiac CT	Diagnostics and Pharmacy Partnership Group	Waiting times reduction for Cardiac CT (a specific GM capacity issue) and CT generally	Comprehensive Capacity and Demand review Options appraisal for system wide solution	Amber / Green: financial considerations may reduce options
THRIVE implementation and improvement	Diagnostics and Pharmacy Partnership Group	Improvement in key productivity measures: utilisation, late starts, turnaround times, tests, reduction in IS costs	Endo network focus on increasing list capacity (10.5 pts) and patient cancellations Physiological sciences: Echo – most Trusts now online, monthly meeting set up to drive improvement Sleep and respiratory – workshops held with pilot sites (outliers) to identify network actions	Green
Did not attend improvement across all modalities	Diagnostics and Pharmacy Partnership Group	Reduction of Did not Attends (DNAs) to maximum 5% for all modalities. Increase in capacity and activity. DM01 improvement.	Regular meetings with services have driven improvements in Echo, Endoscopy and Imaging DNA rates Focus on Audiology next as a significant outlier	Green
Reduce unwarranted Endoscopy referrals	Diagnostics and Pharmacy Partnership Group	Reduce unwarranted referrals by 20% and / or % referrals returned	Improve Provider processes: Inclusion / exclusion criteria, vetting processes, Step down / redirection Development of GM wide standardised processes	Green
Review of Non Obstetric Ultrasound	Diagnostics and Pharmacy Partnership Group	Reduce acute NOU referrals Improve NOU DM01	Review existing commissioning model and options appraisal Agreement of new commissioning model to inform future Direct Access Diagnostics (DAD) contracts Sonography workshop held 14 May to address Workforce shortages	Amber / Green: financial considerations may reduce options

Domain Performance – Urgent and Emergency Care (UEC)

Domain Performance – Urgent and Emergency Care (UEC)

Narrative provided for alerts only

All Trust sare refreshing	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	- A&E four-hour performance remains below plan across GM providers, reflecting continued pressure on front-door performance 12-hour waits (all types) remain above expected levels, highlighting ongoing challenges in system flow and timely patient progression through care pathways	- System flow and limited operational headroom continue to constrain improvement in four-hour performance - Delays across the pathway (admissions, discharge and onward care) are contributing to extended waits, including 12-hour breaches across all settings - Improvement has been variable, with sustained and consistent gains yet to be fully embedded across the system - Long waits for patients in A&E with mental health conditions	- System-wide escalation and oversight through UEC governance, maintaining focus on delivery and performance improvement - Continued focus on discharge improvement and flow optimisation, including strengthening links with community and social care - Targeted provider support and resilience planning, aligned to areas of greatest pressure - Ongoing system work to reduce long waits and improve timely patient movement through urgent care pathways	SR2

Urgent and Emergency Care performance continues to experience system pressure, with A&E four-hour performance and 12-hour waits (across all types) above expected levels. These metrics reflect ongoing challenges in patient flow and operational capacity across the system. A coordinated system response remains in place through established UEC governance, with continued focus on discharge, flow optimisation and resilience. While improvement has not yet been consistently sustained across all providers, there are areas of progress, and the overall approach is supporting gradual improvement. UEC therefore remains an alert area, with continued system focus required to deliver further reductions in long waits and improvements in performance.

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

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

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

In light of the ICB's ongoing organisational change programme, there is a planned refresh and relaunch of both the UEC Reform Board and the underpinning single system oversight plan. This refresh will ensure clarity of purpose, updated membership and accountabilities, and alignment with the ICB's emerging operating model and reform portfolio. The GM UEC Reform Programme Development Session has been rescheduled to the end of June 2026 to support this work. **Despite the formal stand down of the May Board, work has continued at pace with system partners to ensure a robust, refreshed plan is in place for consideration and sign-off at the June Board.**

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

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

Domain Performance – Cancer

Domain Performance – Cancer

Narrative provided for alerts only



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

Cancer performance is currently better than plan, with all key standards, 28-day Faster Diagnosis, 62-day, and 31-day treatment, performing above plan and on trajectory to meet the end-March 2026 targets. As such, Cancer is not identified as an alert area and no immediate concerns have been raised at this time.

Cancer Alliance Actions & Delivery

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Cancer Faster Diagnosis & Waiting Times Improvement	Greater Manchester Faster Diagnosis, Operational Performance & Treatment Variation Programme Board	Improved 28-day FDS, 31-day & 62-day standards; reduced pathway delays	Targeted provider improvement plans; alliance-wide pathway actions; enhanced breach analysis	Green – GM achieved YE (March 26 published data) CWT targets
Diagnostics Modernisation – CXR AI (Artificial Intelligence Diagnostics Fund)	As above	Faster diagnosis; improved detection; reduced unnecessary CT demand	Extend AI solution; transition to business as usual commissioning; pathway refinement	Green
Multidisciplinary Team Reform & Pathway Efficiency	As above	Faster, more efficient cancer pathways.	MDT process standardisation; escalation protocols; pathway board oversight	Amber - Residual risk from variable MDT timeliness and post-MDT delays.
Cancer Workforce Capability (ACCEND)	As above	Improved workforce resilience and consistency across cancer pathways	Provider implementation plans; quarterly reporting; e-Portfolio assurance	Green
Cancer Governance & System Assurance	Cancer Alliance / ICB Performance Group	Clear accountability and earlier escalation of cancer risks	Updated terms of reference; escalation framework; alignment with ICB performance oversight	Green

Domain Performance – Mental Health & Learning Disabilities and Autism

Domain Performance – Mental Health & Learning Disabilities and Autism

Narrative provided for alerts only

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	- Average Length of Stay (ALOS) in adult acute mental health inpatient beds remains behind plan. Latest position February 2026: 64.9 bed days, compared to a plan of 57.8 bed days (and 57.0 bed days at end March). - Learning Disabilities & Autism: Autistic adult inpatient numbers remain behind trajectory, with variation across localities	- Length of stay remains behind plan, which reduced overall inpatient capacity and is contributing to pressure across acute mental health services. - Delays in discharge predominantly, combined with constraints in step-down and community provision continue to affect patient flow. - Reduction in staff and expertise in Place as a result of reform to support effective discharge.	- Ongoing system oversight through established Mental Health governance arrangements. - Continued focus on discharge planning, improved patient flow and use of step-down alternatives where available. - System priorities include developing community crisis/admission avoidance/step down services (funded through the MHIF)	SR2

Average length of stay in adult acute mental health beds remains above plan, reflecting ongoing challenges in discharge and patient flow, and continuing to place pressure on inpatient capacity. In addition, autistic adult inpatient numbers remain above trajectory, with variation across localities and continued reliance on inpatient provision. While system actions are in place across both areas, sustained improvement has not yet been demonstrated, and both domains remain alert requiring continued system focus.

Mental Health and Learning Disabilities and Autism Group

Actions & Delivery

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Inpatient care for Autistic Adults (with no learning disability)	Learning Disability & Autism Transforming Care Group	- Reduction in inpatient admissions through community alternatives - Avoidance of admission where clinically appropriate	- Development of crisis and admission avoidance pathways - Expansion of community step-down provision - Focus on improving discharge pathways and flow	Red - Delivery reliant on establishment of community alternatives and step-down capacity
Average Length of Stay in Adult Acute, Older Adult Acute and Psychiatric Intensive Care beds	GM Mental Health Partnership Group (via GM Inpatient Quality Transformation Group)	- Reduction in average length of stay from 64.9 days (Feb 2026) towards ~57 days - Improved patient flow and timely discharge	- Ongoing system oversight through MH governance arrangements - Continued focus on discharge planning and patient flow - Use of step-down and community alternatives where available - Development of crisis/admission avoidance and step-down services (MHIF funded) - Delivery of Clinically Ready For Discharge (CRFD) reduction plans and high-impact changes	Red – Length of stay remains above plan, driven by discharge delays and limited community/step-down capacity; CRFD reductions critical to improvement

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

NHS Oversight Framework (NOF) – Quarterly Update



Overall position

- NOF is reported to SCC on a quarterly basis.
- The last full update was provided in April 2026.
- There has been no material change to the NHS Oversight Framework position since that update.

Current assurance

- The NOF position continues to align with the delivery risks identified elsewhere in this report, particularly across Urgent & Emergency Care, Elective Care and Productivity.
- NOF metrics continue to be monitored internally to support preparedness ahead of future national publication.

Next steps

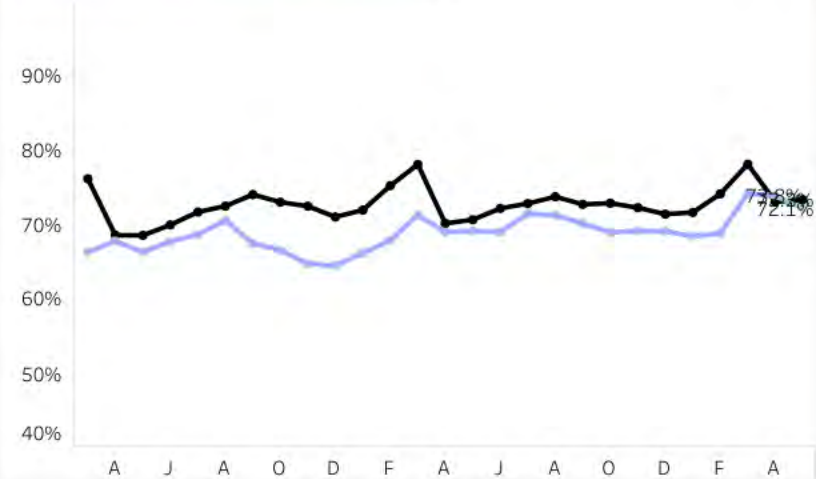
- A full NOF update, including provider segmentation and ICB metrics, will be brought back to SCC as part of the next scheduled quarterly report.

Appendices

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

2024/25/26 Performance

GM Acute Providers | Unvalidated in Month | Plan |



Regional Benchmarking

	Jan 26	Feb 26	Mar 26	Apr 26
Greater Manchester	68.3%	68.7%	74.1%	73.8%
North West	70.8%	71.1%	74.9%	74.8%
England	72.3%	73.9%	77.0%	76.8%

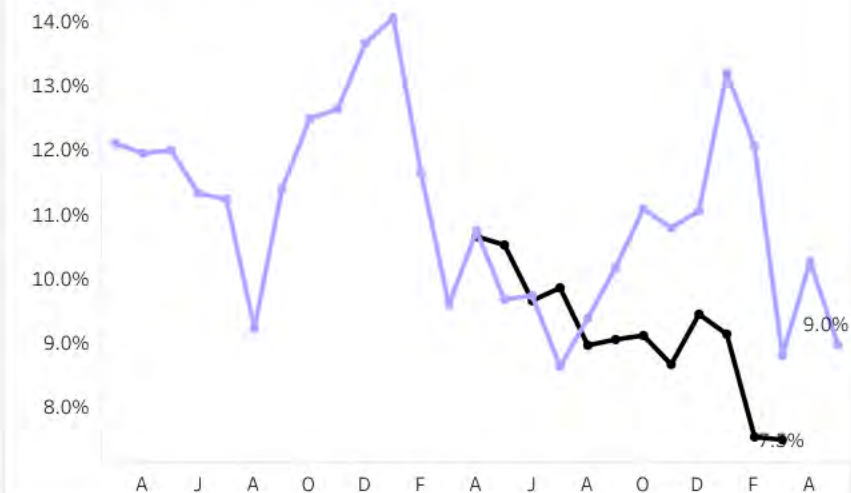
A&E 4-hour wait performance was 73.8% in April 2026, above the 73.0% target. Performance in May (1–17) has declined further to 72.1%. In March, NHS Greater Manchester Integrated Care Board ranked 28th out of 42 nationally.

		Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	17 May
Bolton FT	Actual	71.8%	66.3%	70.3%	64.9%	64.8%	64.6%	65.7%	62.1%	61.0%	60.2%	62.2%	63.8%	68.1%	72.4%	69.5%
	Plan	78.0%	72.0%	72.0%	75.0%	75.0%	76.0%	75.0%	74.0%	74.0%	73.0%	75.0%	77.0%	78.0%	68.0%	72.0%
MFT	Actual	73.9%	70.5%	71.4%	71.3%	74.3%	72.2%	70.6%	71.7%	72.4%	73.3%	71.6%	72.7%	77.2%	76.9%	74.7%
	Plan	78.0%	72.0%	72.2%	73.9%	74.6%	75.1%	72.6%	73.0%	71.2%	70.1%	70.1%	73.2%	78.1%	78.0%	78.1%
NCA	Actual	68.8%	67.9%	68.1%	68.1%	72.0%	72.2%	71.4%	69.4%	68.3%	69.1%	70.3%	69.0%	73.6%	73.1%	73.5%
	Plan	78.0%	68.2%	69.5%	70.9%	72.3%	73.7%	74.7%	75.3%	75.8%	76.1%	76.6%	76.0%	78.0%	70.0%	70.5%
Stockport FT	Actual	69.0%	68.3%	65.4%	74.0%	68.0%	69.4%	68.1%	67.1%	69.5%	69.0%	66.3%	69.2%	70.1%	69.1%	65.4%
	Plan	78.0%	66.1%	64.8%	68.5%	64.9%	68.3%	62.9%	64.9%	65.6%	65.9%	63.5%	67.0%	78.0%	71.3%	71.4%
T&G ICO FT	Actual	68.9%	66.2%	61.6%	58.8%	63.6%	66.0%	65.1%	61.0%	64.7%	63.9%	60.3%	61.0%	68.9%	65.9%	64.0%
	Plan	78.0%	69.2%	69.5%	69.3%	71.4%	71.0%	70.6%	68.2%	67.5%	65.6%	65.3%	71.0%	78.0%	67.7%	63.3%
WWL FT	Actual	71.7%	71.4%	72.2%	71.6%	75.6%	77.0%	74.6%	72.5%	70.8%	66.8%	65.7%	65.0%	78.1%	76.5%	74.6%
	Plan	78.0%	70.6%	71.4%	72.0%	72.6%	73.3%	74.0%	74.7%	74.0%	71.1%	72.3%	77.4%	78.0%	75.0%	76.0%
GM Acute Providers	Actual	71.2%	68.9%	69.1%	68.9%	71.4%	71.2%	70.1%	68.9%	69.1%	69.0%	68.3%	68.7%	74.1%	73.8%	72.1%
	Plan	78.0%	70.1%	70.6%	72.1%	72.7%	73.7%	72.6%	72.8%	72.2%	71.3%	71.6%	74.1%	78.0%	73.0%	73.3%
GM Registered	Actual	70.2%	68.0%	68.3%	68.0%	70.2%	70.0%	68.9%	67.8%	68.2%	68.1%	67.5%	68.0%	73.4%	73.2%	72.1%
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

2024/25/26 Performance

GM Acute Providers | Plan |

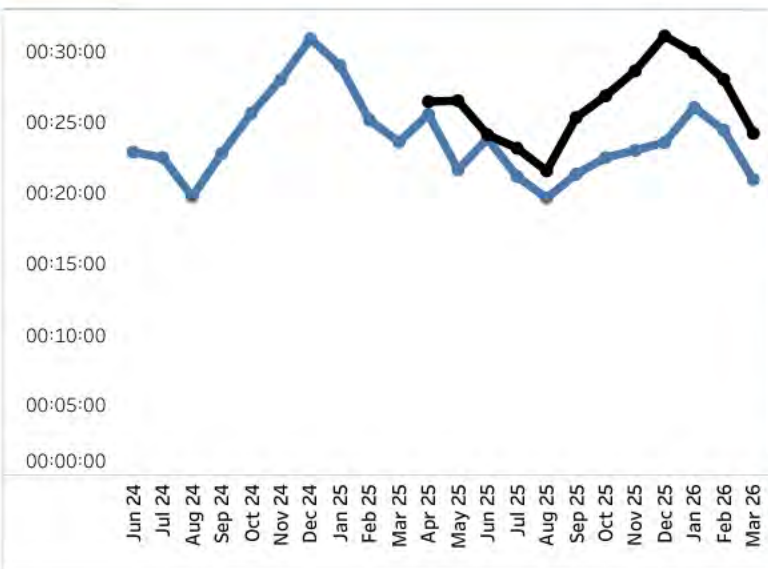


As of April 2026, 10.3% of patients attending Type 1 A&E departments waited more than 12 hours. Latest unvalidated data for May (1–17) shows an improvement to 9.0%.

From 2026/27, the metric will change to include all emergency care types, rather than Type 1 attendances only.

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Average Hospital Handover Time

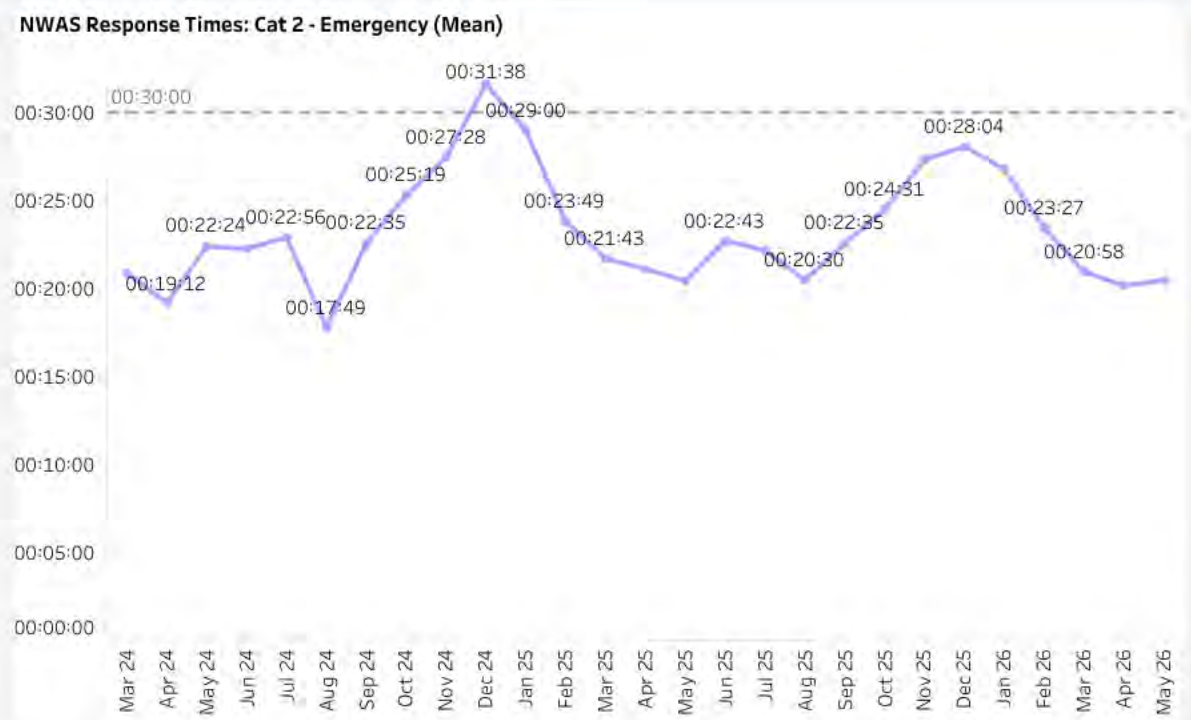


In March, the average ambulance handover time was 20 minutes and 54 seconds. The target has been achieved throughout 2025/26.

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

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

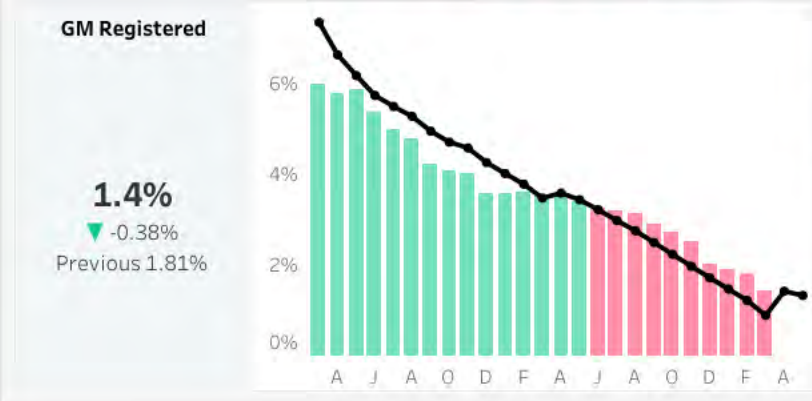
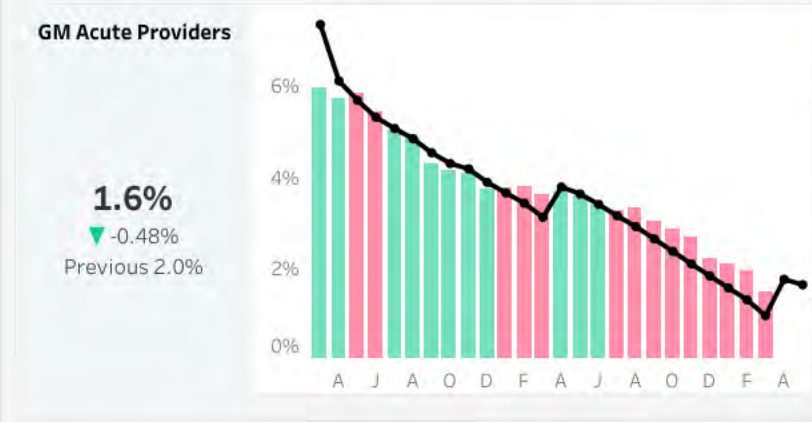
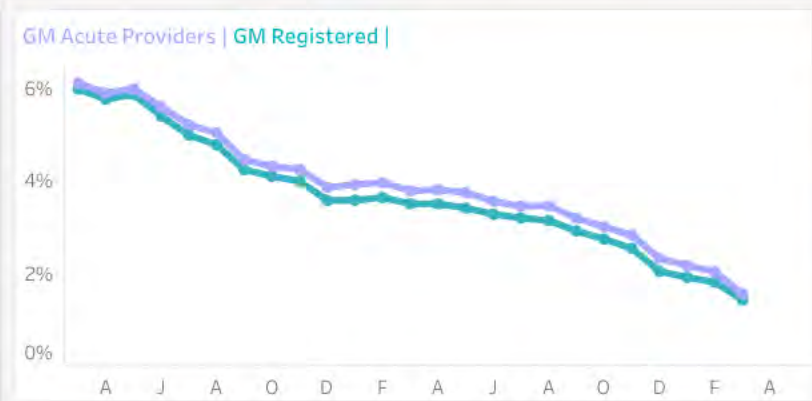
Cat 2 Ambulance Response Times



In April, average Category 2 ambulance response times across Greater Manchester were 20 minutes and 11 seconds, better than plan.

The new 26/27 target has reduced from 30 minutes to 25 minutes.

% of RTT waits over 52 weeks for incomplete pathways



Data in the purple box is weekly and unvalidated

		Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	26 Apr	10 May
Bolton FT	Actual	3.1%	3.3%	3.5%	3.1%	3.3%	3.1%	2.9%	2.8%	2.9%	2.4%	1.8%	1.5%	1.0%	1.7%	1.5%
	Plan	5.4%	3.3%	3.1%	2.9%	2.7%	2.5%	2.3%	2.1%	1.9%	1.7%	1.5%	1.3%	1.0%	0.9%	0.9%
MFT	Actual	4.4%	4.4%	4.3%	4.0%	3.8%	3.8%	3.5%	3.3%	3.0%	2.0%	1.8%	1.4%	0.9%	1.2%	1.2%
	Plan	3.2%	4.3%	4.1%	3.9%	3.6%	3.3%	3.0%	2.7%	2.3%	2.0%	1.7%	1.4%	1.0%	1.1%	1.0%
NCA	Actual	3.5%	3.6%	3.7%	3.7%	3.7%	3.7%	3.4%	3.2%	3.1%	3.1%	3.3%	3.5%	2.9%	3.2%	3.1%
	Plan	4.1%	3.5%	3.4%	3.2%	3.0%	2.8%	2.6%	2.3%	2.1%	1.8%	1.6%	1.3%	1.0%	3.2%	3.0%
Stockport FT	Actual	4.6%	4.1%	3.5%	2.9%	2.7%	2.4%	2.1%	2.1%	2.0%	1.7%	1.3%	1.0%	0.7%	0.8%	0.7%
	Plan	3.1%	4.6%	4.5%	4.1%	3.7%	3.5%	3.1%	2.7%	2.4%	2.2%	2.0%	1.8%	1.0%	0.9%	0.8%
T&G ICO FT	Actual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
WWL FT	Actual	3.8%	3.9%	3.7%	3.7%	3.7%	3.8%	3.6%	3.5%	3.1%	2.8%	2.4%	2.4%	2.0%	2.2%	2.2%
	Plan	0.0%	3.9%	3.6%	3.4%	3.1%	2.8%	2.5%	2.3%	2.0%	1.7%	1.5%	1.2%	1.0%	2.0%	1.6%
Christie	Actual	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
	Plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
GM Acute Providers	Actual	3.8%	3.8%	3.7%	3.6%	3.5%	3.5%	3.2%	3.0%	2.8%	2.3%	2.2%	2.0%	1.6%	1.8%	1.8%
	Plan	3.1%	3.8%	3.6%	3.4%	3.1%	2.9%	2.6%	2.4%	2.1%	1.8%	1.6%	1.3%	1.0%	1.8%	1.6%
GM Registered	Actual	3.5%	3.5%	3.4%	3.3%	3.2%	3.1%	2.9%	2.7%	2.5%	2.0%	1.9%	1.8%	1.4%		
	Plan	3.5%	3.6%	3.4%	3.2%	3.0%	2.8%	2.5%	2.2%	2.0%	1.7%	1.5%	1.2%	0.9%		

In line with the 2025/26 national planning guidance, a key priority is to reduce the proportion of patients waiting over 52 weeks for treatment. GM has set a target of no more than 1% by March 2026. March 26 1.6% of pathways were breaching the 52-week threshold, exceeding the end-of-year target of 1.0%.

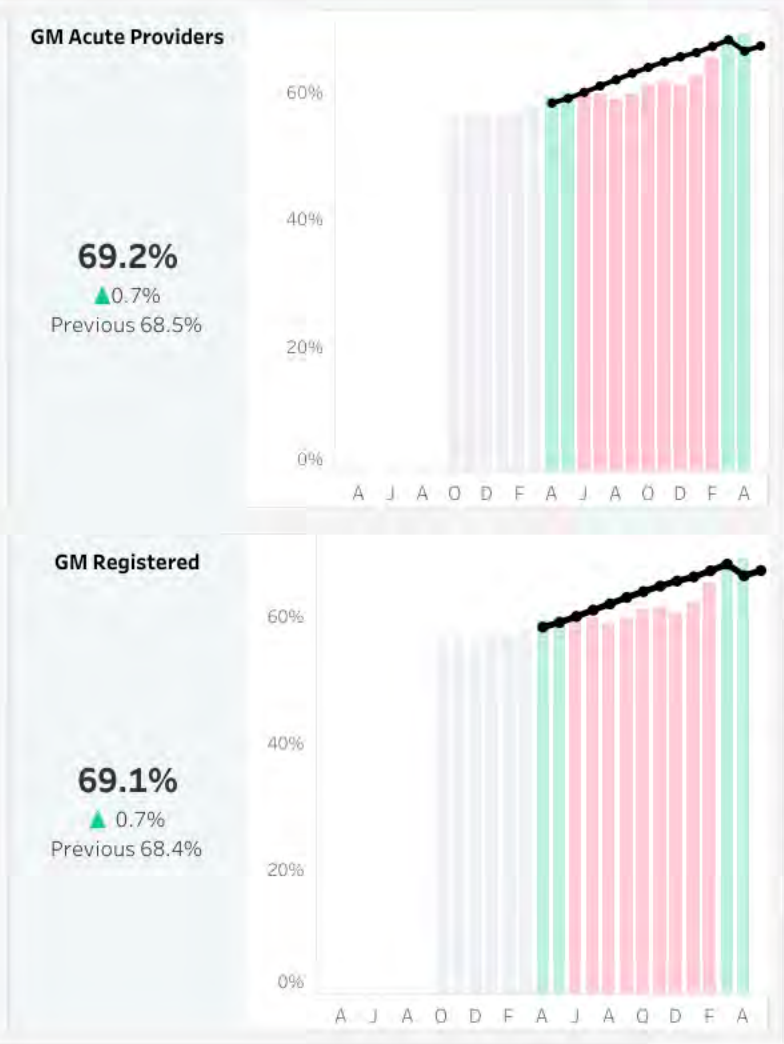
Elective – RTT Incomplete: % within 18 weeks



		Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Bolton FT	Actual	54.8%	55.4%	54.9%	55.8%	56.9%	57.2%	58.0%	59.1%	59.1%	58.6%	57.4%	57.5%	59.8%	62.1%
	Plan	N/A	N/A	55.8%	56.2%	56.7%	57.0%	57.5%	57.9%	58.4%	58.7%	59.2%	59.5%	60.0%	60.3%
MFT	Actual	50.4%	51.4%	51.0%	52.4%	53.2%	53.3%	52.7%	53.8%	53.8%	54.1%	56.1%	57.6%	60.0%	63.0%
	Plan	N/A	N/A	50.3%	50.7%	51.7%	52.7%	53.7%	54.7%	55.6%	56.6%	57.6%	58.6%	59.5%	60.5%
NCA	Actual	52.0%	52.6%	52.4%	54.0%	53.7%	53.6%	52.7%	53.6%	54.2%	53.7%	52.9%	52.4%	54.4%	59.1%
	Plan	N/A	N/A	52.6%	52.7%	53.3%	54.0%	54.7%	55.3%	56.0%	56.7%	57.3%	57.3%	58.7%	60.0%
Stockport FT	Actual	54.3%	55.2%	55.2%	56.6%	57.1%	56.8%	56.0%	57.0%	57.8%	57.1%	58.4%	59.6%	60.1%	62.1%
	Plan	N/A	N/A	54.2%	54.4%	56.1%	56.3%	55.9%	56.9%	58.5%	58.8%	58.2%	57.9%	58.9%	60.0%
T&G ICO FT	Actual	71.1%	70.3%	70.8%	71.8%	72.2%	71.6%	70.4%	72.7%	73.7%	73.6%	72.8%	73.3%	74.7%	76.4%
	Plan	N/A	N/A	68.5%	69.0%	70.1%	70.6%	71.5%	72.0%	72.4%	72.5%	71.6%	71.4%	72.5%	73.3%
WWL FT	Actual	54.6%	56.0%	56.6%	58.2%	57.9%	56.5%	56.5%	57.4%	57.7%	58.4%	57.5%	58.0%	59.0%	61.2%
	Plan	N/A	N/A	53.0%	53.6%	54.2%	54.9%	55.5%	56.2%	56.8%	57.4%	58.1%	58.7%	59.4%	60.0%
Christie	Actual	96.3%	95.1%	94.6%	94.6%	94.2%	93.6%	94.3%	95.7%	97.1%	97.1%	97.1%	97.5%	97.1%	97.1%
	Plan	N/A	N/A	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%
GM Acute Providers	Actual	53.0%	53.8%	53.6%	55.0%	55.4%	55.2%	54.7%	55.7%	56.1%	56.1%	56.5%	57.1%	59.0%	62.2%
	Plan	N/A	N/A	52.9%	53.2%	54.1%	54.8%	55.6%	56.3%	57.2%	57.9%	58.5%	59.0%	60.0%	61.0%
GM Registered	Actual	54.0%	55.0%	54.9%	56.3%	56.6%	56.2%	55.8%	57.0%	57.5%	57.4%	57.8%	58.5%	60.7%	63.8%
	Plan	N/A	N/A	52.7%	53.0%	53.9%	54.6%	55.4%	56.1%	57.0%	57.7%	58.3%	58.8%	59.8%	60.8%

Within the 25/26 national planning guidance, one of the priorities is to reduce the proportion of people waiting over 18 weeks for treatment. In March 62.2% of pathways were seen within 18 weeks, exceeding the GM plan is to deliver 61% within 18 weeks by end of year across all GM providers.

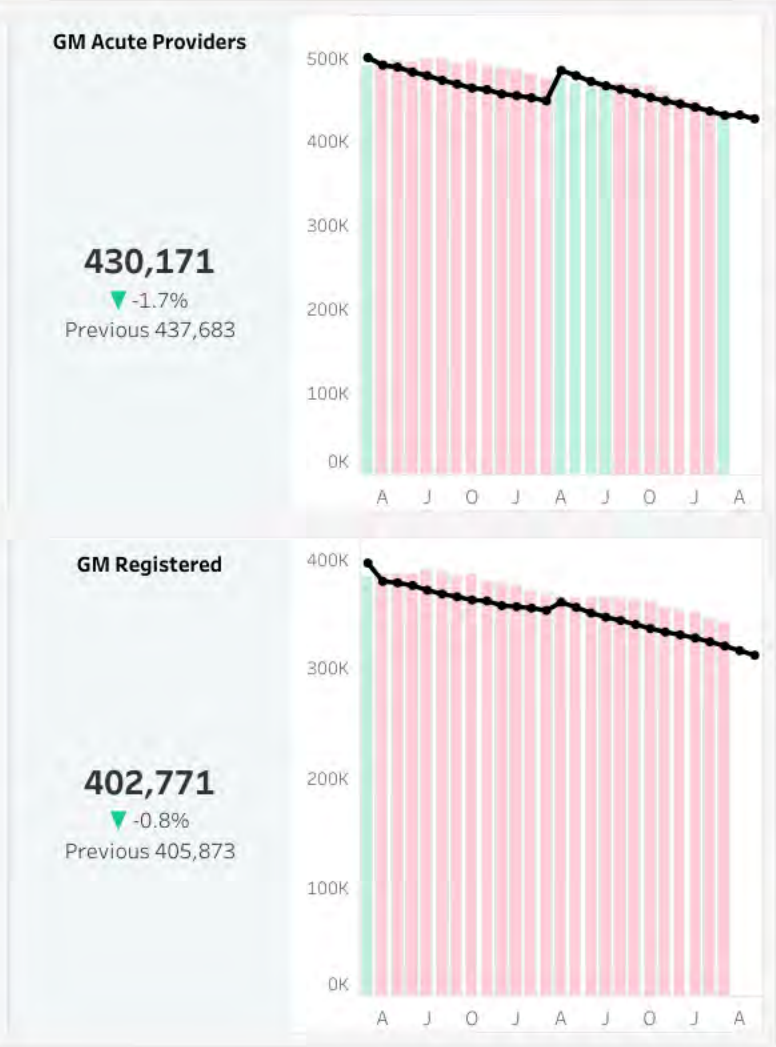
Elective – RTT Incomplete: % first appointment within 18 weeks



		Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	61.1%	61.8%	63.0%	64.0%	65.9%	66.2%	66.8%	67.6%	67.7%	64.9%	64.9%	69.8%	72.4%	70.5%	
	Plan	N/A	61.9%	62.6%	62.9%	63.6%	63.8%	64.5%	64.7%	65.4%	65.6%	66.2%	66.5%	67.1%	67.9%	68.5%
MFT	Actual	53.8%	55.2%	55.6%	56.0%	56.3%	55.8%	56.3%	57.1%	57.9%	58.4%	61.7%	64.9%	67.7%	69.1%	
	Plan	N/A	53.6%	54.8%	56.1%	57.3%	58.5%	59.7%	60.9%	62.1%	63.3%	64.6%	65.8%	67.0%	68.1%	69.2%
NCA	Actual	57.5%	58.1%	58.8%	57.1%	56.8%	55.4%	56.7%	58.9%	59.2%	56.8%	56.2%	58.7%	64.2%	65.1%	
	Plan	N/A	57.5%	57.2%	58.4%	59.7%	60.9%	62.1%	63.3%	64.1%	64.8%	64.8%	65.9%	67.0%	59.0%	60.0%
Stockport FT	Actual	61.5%	63.6%	64.8%	64.5%	64.7%	63.1%	62.1%	64.9%	64.4%	65.3%	66.3%	68.1%	69.5%	71.1%	
	Plan	N/A	62.5%	63.0%	63.5%	64.0%	64.4%	64.9%	65.4%	65.8%	66.0%	66.2%	66.5%	67.0%	67.0%	67.0%
T&G ICO FT	Actual	81.1%	81.6%	80.7%	80.1%	78.8%	77.9%	79.4%	82.3%	82.6%	81.0%	83.4%	86.4%	88.5%	88.8%	
	Plan	N/A	81.2%	82.2%	81.6%	81.8%	82.5%	82.6%	81.5%	81.5%	80.4%	80.3%	81.7%	83.4%	83.4%	83.4%
WWL FT	Actual	61.9%	63.6%	64.4%	63.0%	61.7%	61.7%	61.7%	62.4%	64.1%	62.1%	64.6%	66.6%	68.7%	68.2%	
	Plan	N/A	60.2%	60.8%	61.5%	62.1%	62.7%	63.3%	63.9%	64.6%	65.2%	65.8%	66.4%	67.0%	67.4%	67.7%
Christie	Actual	99.5%	99.1%	99.0%	99.4%	99.2%	99.1%	99.2%	99.3%	99.3%	99.2%	99.6%	99.6%	99.2%	99.3%	
	Plan	N/A	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	98.6%	98.6%
GM Acute Providers	Actual	58.1%	59.3%	59.9%	59.4%	59.5%	58.8%	59.4%	60.9%	61.5%	60.7%	62.4%	65.2%	68.5%	69.2%	
	Plan	N/A	58.2%	59.0%	59.9%	60.9%	61.9%	62.9%	63.8%	64.7%	65.5%	66.2%	67.1%	68.2%	66.4%	67.2%
GM Registered	Actual	58.0%	59.2%	59.7%	59.2%	59.4%	58.7%	59.4%	60.7%	61.3%	60.4%	62.1%	65.1%	68.4%	69.1%	
	Plan	N/A	58.1%	58.8%	59.8%	60.8%	61.8%	62.8%	63.7%	64.6%	65.4%	66.1%	67.0%	68.1%	66.2%	67.1%

Within the 25/26 national planning guidance, one of the priorities is to reduce the proportion of people waiting over 18 weeks for their first appointment. In March 68.5% of pathways were seen within 18 weeks exceeding the end of year plan.

Elective – Total Referral to Treatment pathways

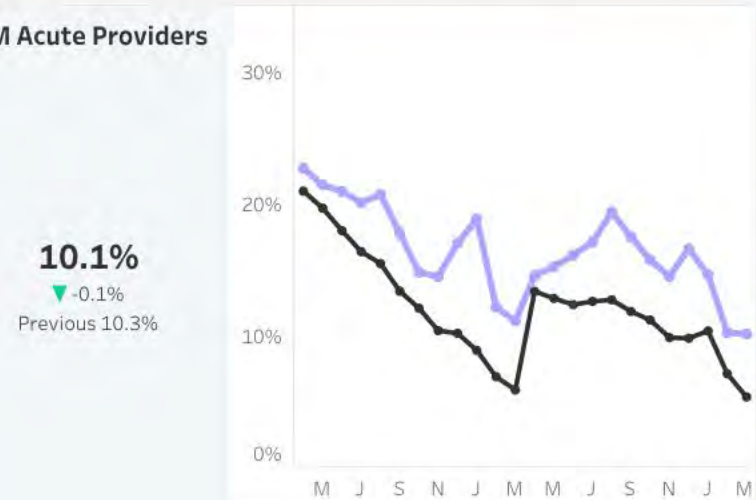


		Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Bolton FT	Actual	39,987	39,518	38,173	37,308	37,252	37,565	37,521	37,555	37,366	37,478	37,532	38,836	37,369	37,849
	Plan	45,078	45,201	39,439	39,126	38,813	38,500	38,187	37,874	37,561	37,248	36,967	36,686	36,405	36,124
MFT	Actual	197,034	192,638	192,230	190,129	186,865	186,088	187,912	185,690	183,865	179,651	178,093	174,556	171,407	165,568
	Plan	167,609	165,849	198,821	195,045	191,270	189,494	187,719	185,944	184,168	182,393	180,617	178,842	177,066	175,291
NCA	Actual	136,673	138,011	138,712	137,853	136,427	137,339	139,016	140,404	140,935	137,786	135,354	134,110	130,603	129,021
	Plan	136,196	135,639	138,022	136,394	134,766	133,138	131,510	129,882	128,254	126,626	124,998	123,370	121,742	120,110
Stockport FT	Actual	35,824	35,589	35,190	34,798	34,356	34,772	35,231	34,954	35,049	34,647	34,556	34,319	34,274	33,981
	Plan	24,648	23,316	36,229	36,046	34,795	33,570	33,361	32,164	30,992	30,452	30,510	30,569	30,029	28,932
T&G ICO FT	Actual	17,448	17,033	17,206	17,152	17,017	17,203	17,096	17,273	17,116	17,009	16,808	16,984	16,400	16,393
	Plan	19,948	19,999	17,530	17,320	17,405	17,321	17,295	17,483	17,482	17,605	17,835	17,723	17,420	17,210
WWL FT	Actual	50,098	50,122	50,409	50,200	49,368	48,840	49,337	48,473	48,514	47,410	46,450	45,540	44,382	44,346
	Plan	56,489	56,393	52,765	52,634	52,503	52,372	52,241	52,110	51,979	51,848	51,717	51,586	51,455	51,324
Christie	Actual	2,998	3,115	2,807	2,834	2,766	2,735	2,700	2,786	3,652	3,525	3,266	3,437	3,248	3,013
	Plan	2,601	2,601	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573
GM Acute Providers	Actual	480,062	476,026	474,727	470,274	464,051	464,542	468,813	467,135	466,497	457,506	452,059	447,782	437,683	430,171
	Plan	452,569	448,998	485,379	479,138	472,125	466,968	462,886	458,030	453,009	448,745	445,217	441,349	436,690	431,564
GM Registered	Actual	435,249	432,101	430,720	427,956	429,227	428,230	426,679	425,600	424,909	418,560	414,419	413,376	405,873	402,771
	Plan	417,918	415,444	424,249	418,794	412,665	408,157	404,589	400,345	395,956	392,229	389,145	385,765	381,692	377,212

In March there were a total of 430,717 referral to treatment open pathways, better than the end of year plan of 431,564.

Diagnostics: % waiting 6 weeks+

GM Acute Providers

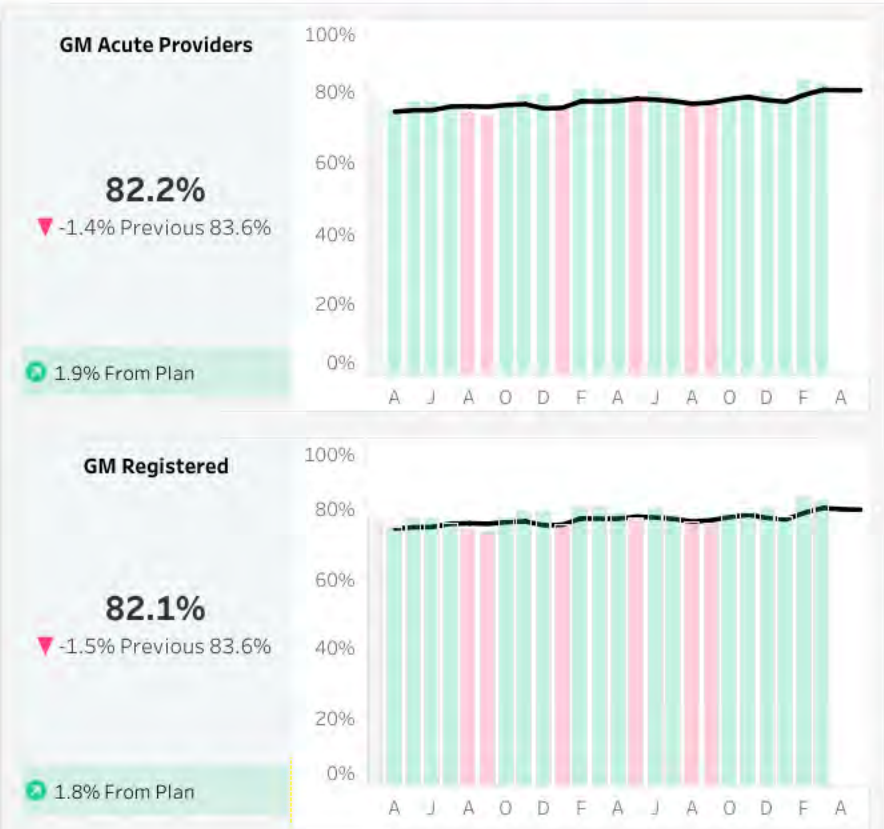


In March, the GM Acute Providers' 6-week wait (6ww) performance across all DM01 tests was 10.1%, against an end of year target of 5.4%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 4th out of 42 nationally.

	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Bolton FT	3.7%	10.8%	13.6%	14.8%	17.8%	14.3%	12.7%	6.3%	4.3%	5.0%	3.5%	2.6%	2.6%
	5.0%	7.7%	7.6%	7.7%	8.0%	8.5%	9.0%	9.5%	9.1%	9.5%	9.1%	8.4%	5.0%
MFT	11.7%	13.3%	14.2%	13.2%	12.7%	13.9%	13.0%	11.7%	11.9%	13.5%	12.5%	8.2%	7.4%
	10.0%	13.2%	12.5%	11.9%	12.9%	13.3%	11.9%	11.9%	10.3%	11.5%	13.2%	7.3%	5.5%
NCA	9.3%	12.8%	10.9%	12.3%	13.4%	17.2%	14.0%	13.2%	12.5%	15.7%	13.8%	10.0%	12.2%
	4.9%	12.9%	12.2%	11.4%	10.7%	9.9%	9.1%	8.3%	7.5%	6.7%	7.1%	6.3%	5.0%
Stockport FT	23.3%	27.4%	21.1%	22.0%	22.7%	24.2%	21.3%	18.6%	16.3%	16.1%	16.4%	16.3%	15.2%
	0.3%	25.8%	24.5%	24.2%	25.4%	27.6%	25.7%	21.6%	18.1%	15.0%	12.1%	8.9%	5.0%
T&G ICO FT	0.4%	1.6%	3.2%	2.6%	2.7%	1.6%	0.8%	0.6%	0.6%	0.0%	1.1%	0.3%	0.7%
	2.1%	1.3%	3.1%	3.9%	3.7%	4.3%	4.4%	3.9%	3.7%	4.1%	4.8%	4.6%	4.4%
WWL FT	10.1%	18.0%	25.0%	30.4%	33.5%	38.6%	37.0%	34.5%	30.6%	35.2%	30.4%	18.9%	18.6%
	4.9%	9.9%	9.7%	9.5%	9.2%	9.0%	8.8%	8.5%	8.3%	8.0%	7.8%	7.5%	7.3%
Christie	0.8%	1.7%	1.7%	2.1%	2.6%	3.1%	1.3%	0.6%	0.8%	1.4%	2.6%	3.8%	2.2%
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
GM Acute Providers	11.1%	14.6%	15.3%	16.1%	17.1%	19.4%	17.5%	15.8%	14.5%	16.6%	14.7%	10.3%	10.1%
	5.9%	13.4%	12.9%	12.4%	12.6%	12.7%	11.9%	11.2%	9.9%	9.8%	10.4%	7.1%	5.4%
GM Registered													
	11.6%	10.5%	13.9%	14.6%	15.4%	16.3%	18.5%	16.6%	14.8%	13.7%	15.7%	13.9%	10.0%

28 Day Wait from Referral to Faster Diagnosis: All Patients



In March, 28-day FDS performance was delivered at 82.2% above the end of year target of 80.3%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 12th out of 42 nationally.

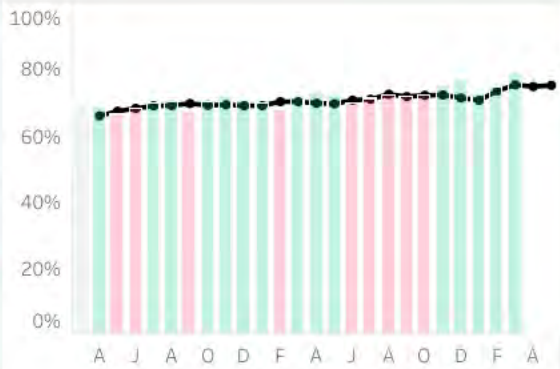
		Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Bolton FT	Actual	90.3%	88.4%	89.3%	87.7%	86.8%	84.4%	85.8%	87.0%	87.7%	86.6%	81.0%	84.5%	81.6%	
	Plan	77.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
MFT	Actual	76.0%	76.3%	75.2%	78.4%	75.3%	73.3%	72.1%	78.1%	80.8%	80.3%	78.7%	84.5%	83.4%	
	Plan	77.0%	76.3%	76.7%	76.7%	77.0%	75.8%	77.4%	78.3%	79.3%	75.4%	75.2%	78.9%	80.7%	80.0%
NCA	Actual	77.3%	74.6%	74.2%	77.7%	76.8%	74.2%	73.1%	74.2%	72.8%	75.7%	73.2%	80.7%	80.1%	
	Plan	77.0%	75.8%	75.7%	75.5%	74.1%	71.9%	71.6%	73.6%	75.6%	76.6%	74.6%	77.3%	80.0%	80.0%
Stockport FT	Actual	82.0%	79.5%	77.6%	80.3%	79.2%	82.4%	83.7%	85.3%	84.7%	82.7%	80.9%	85.1%	84.0%	
	Plan	77.1%	77.0%	77.5%	78.0%	78.0%	78.6%	78.5%	79.0%	79.0%	79.0%	79.0%	79.6%	80.0%	80.9%
T&G ICO FT	Actual	86.3%	85.8%	84.3%	85.2%	84.2%	80.8%	80.3%	80.8%	82.2%	82.5%	80.1%	85.8%	82.5%	
	Plan	77.0%	79.1%	80.0%	80.1%	80.1%	80.3%	80.1%	80.0%	79.0%	78.8%	78.9%	79.8%	80.1%	81.0%
WWL FT	Actual	85.7%	81.5%	76.2%	76.3%	76.5%	75.2%	76.2%	73.6%	71.6%	76.4%	72.8%	84.1%	81.8%	
	Plan	77.0%	78.8%	81.4%	79.7%	78.3%	79.7%	80.2%	80.4%	78.6%	80.5%	81.7%	80.0%	80.2%	80.0%
Christie	Actual	87.0%	94.7%	82.6%	89.3%	84.2%	87.5%	91.7%	94.4%	94.4%	79.5%	80.6%	90.6%	92.5%	
	Plan	78.6%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.6%
GM Acute Providers	Actual	80.3%	78.8%	77.6%	79.8%	78.2%	76.3%	75.7%	78.3%	78.7%	79.7%	77.2%	83.6%	82.2%	
	Plan	77.0%	77.2%	77.8%	77.5%	77.1%	76.4%	76.7%	77.6%	78.3%	77.4%	76.9%	78.9%	80.3%	80.2%
GM Registered	Actual	80.2%	78.7%	77.0%	79.7%	77.9%	76.1%	75.7%	78.4%	78.8%	79.8%	77.2%	83.6%	82.1%	
	Plan	77.2%	77.2%	77.8%	77.5%	77.1%	76.4%	76.7%	77.6%	78.3%	77.4%	76.9%	78.9%	80.2%	79.9%

62 Day Wait from Referral to First Treatment: All Patients

GM Acute Providers

78.8%
▲ 4.5% Previous 74.3%

3.5% From Plan



GM Registered

78.2%
▲ 4.2% Previous 74.0%

2.9% From Plan



In March performance for 62-day referral to treatment for All GM NHS Acute Providers was 78.8%, better than the end of year plan 75.3%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 8th out of 42 nationally

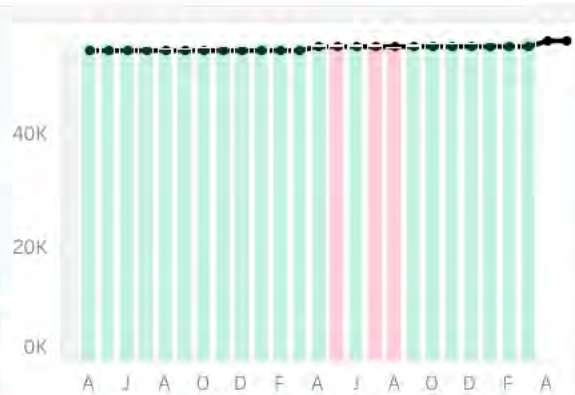
		Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Bolton FT	Actual	80.6%	87.0%	87.7%	87.3%	83.4%	81.7%	77.4%	80.4%	82.9%	85.4%	79.1%	67.8%	80.4%	
	Plan	70.6%	75.4%	75.2%	75.5%	75.2%	75.5%	75.0%	75.0%	75.0%	75.0%	75.2%	75.2%	75.2%	80.7%
MFT	Actual	63.1%	64.9%	65.5%	61.4%	61.4%	63.1%	62.7%	64.2%	66.2%	73.3%	70.1%	74.0%	76.3%	
	Plan	70.0%	62.4%	63.8%	66.1%	67.2%	68.7%	68.4%	71.8%	69.6%	66.9%	66.3%	71.0%	75.3%	75.6%
NCA	Actual	70.8%	74.0%	71.7%	69.6%	74.4%	74.0%	78.9%	72.8%	78.0%	75.3%	75.7%	73.5%	79.8%	
	Plan	70.0%	69.0%	65.6%	68.9%	68.9%	70.1%	69.4%	68.0%	68.7%	69.6%	68.6%	72.4%	75.0%	72.0%
Stockport FT	Actual	74.3%	71.1%	72.1%	62.6%	70.2%	76.7%	72.1%	83.3%	77.7%	79.6%	79.7%	81.1%	75.9%	
	Plan	70.2%	70.0%	70.2%	70.8%	71.2%	71.7%	72.1%	72.5%	72.6%	72.3%	71.8%	73.0%	75.0%	73.5%
T&G ICO FT	Actual	80.9%	76.6%	80.6%	81.6%	78.6%	79.2%	83.1%	78.9%	78.4%	78.5%	77.4%	82.6%	82.6%	
	Plan	71.1%	75.0%	75.5%	75.0%	76.7%	77.4%	77.8%	76.2%	75.0%	75.8%	75.8%	76.1%	76.3%	78.5%
WWL FT	Actual	78.1%	82.3%	77.1%	73.2%	68.8%	68.7%	66.8%	71.5%	67.2%	67.8%	61.3%	66.1%	79.2%	
	Plan	70.5%	80.3%	81.6%	76.0%	74.6%	81.0%	76.5%	74.0%	81.0%	77.3%	75.3%	78.2%	75.9%	71.2%
Christie	Actual	75.7%	72.3%	68.9%	74.3%	78.1%	77.1%	75.1%	76.5%	85.6%	83.5%	69.0%	81.2%	82.5%	
	Plan	70.4%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	76.0%
GM Acute Providers	Actual	71.7%	73.1%	72.1%	69.5%	70.9%	71.8%	71.5%	71.8%	74.7%	76.4%	72.4%	74.3%	78.8%	
	Plan	70.2%	69.8%	69.6%	70.7%	71.0%	72.5%	71.8%	72.1%	72.3%	71.4%	70.6%	73.5%	75.3%	74.8%
GM Registered	Actual	71.5%	72.6%	72.2%	69.2%	70.9%	71.8%	71.4%	71.7%	74.7%	76.6%	73.1%	74.0%	78.2%	
	Plan	70.6%	69.8%	69.6%	70.7%	71.0%	72.5%	71.8%	72.1%	72.3%	71.4%	70.6%	73.5%	75.3%	74.9%

Access to Children and Young People Mental Health Services

56,370

▲ 1.1% Previous 55,770

2.5% From Plan



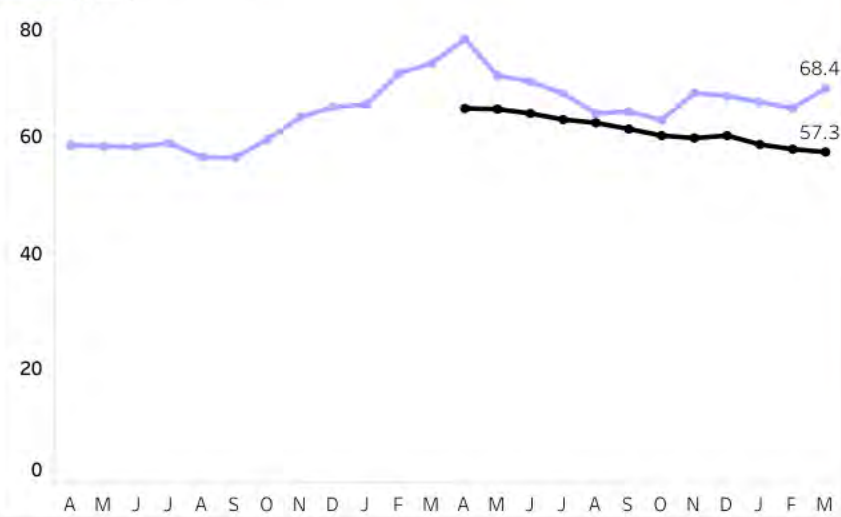
A total of 55,770 children accessed mental health services in the 12 months up to March 2026. This is better than end of year plan of 55,000.

[illegible]

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

2024/25/26 Performance

GM ICB | Plan |

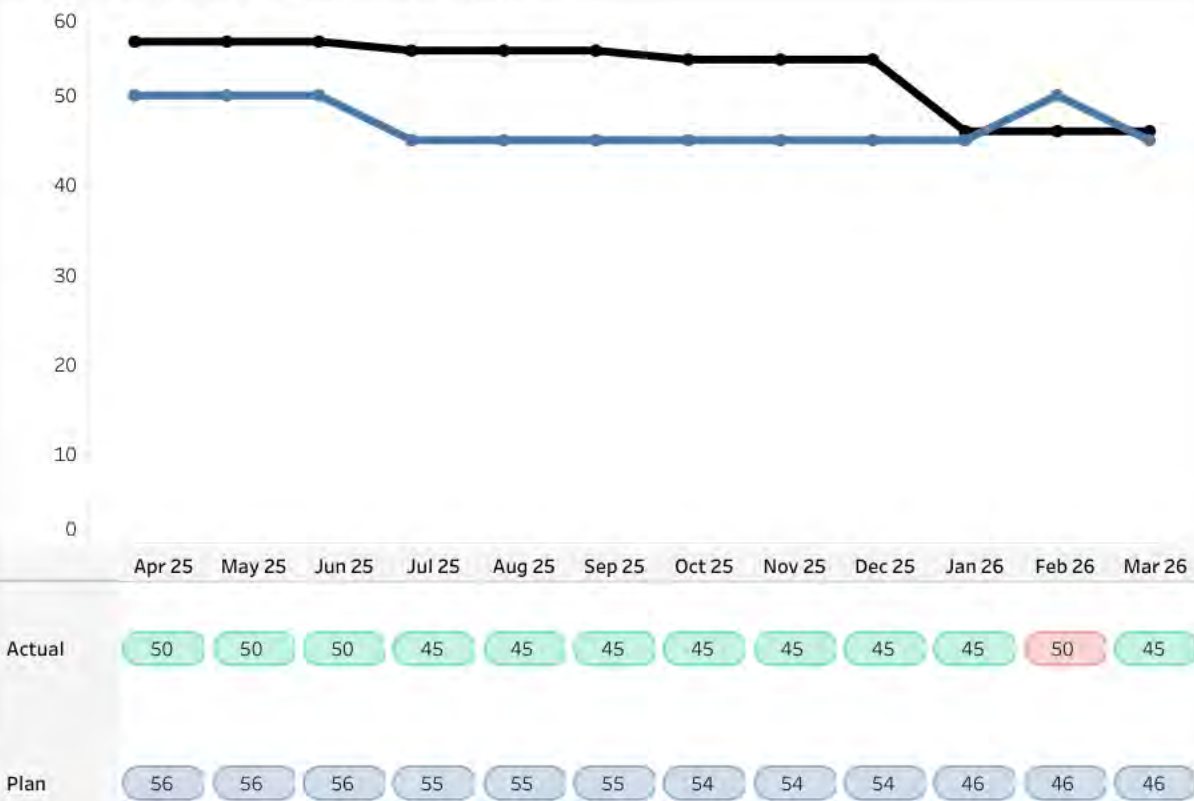


The average length of stay in adult acute, older adult acute and psychiatric intensive care unit (PICU) beds for GM registered patients discharged in the 3 months to March was 68.4 days against a target of 57.3 days.

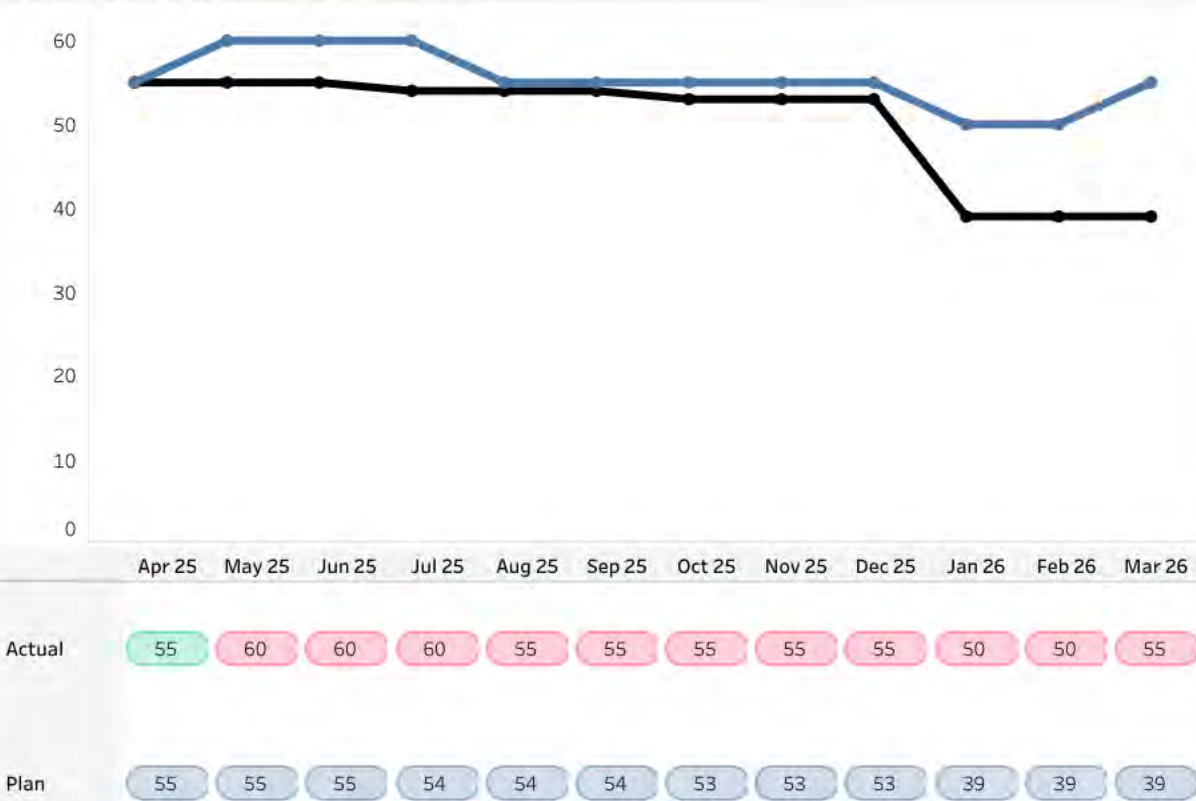
		Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
GMMH	Actual	80.9	84.1	94.1	85.9	83.9	72.7	68.8	67.1	65.1	69.7	72.6	75.1	75.4	82.1
	Plan	N/A	N/A	67.8	67.5	66.2	66.0	65.1	63.3	62.4	61.7	62.4	61.5	60.2	59.4
PCFT	Actual	67.1	64.4	63.1	64.4	64.7	73.3	70.9	70.5	68.0	70.5	67.9	63.7	60.1	60.2
	Plan	N/A	N/A	60.5	60.5	60.5	58.2	58.2	58.2	56.6	56.6	56.6	54.0	54.0	54.0
GM Providers	Actual	75.1	75.7	80.8	76.8	75.6	72.9	69.7	68.4	66.2	70.0	70.5	69.9	68.3	71.6
	Plan	N/A	N/A	64.9	64.8	64.0	63.0	62.4	61.3	60.2	59.8	60.2	58.7	57.8	57.3
GM Registered	Actual	71.0	72.7	76.9	70.6	69.5	67.5	64.0	64.4	62.9	67.6	67.0	66.0	64.9	68.4
	Plan	N/A	N/A	64.9	64.8	64.0	63.0	62.4	61.3	60.2	59.8	60.2	58.7	57.8	57.3

Inpatient Care for Adults with LD/Autism

Inpatient care for adults with LD and LD & Autism



Inpatient care for adults with autism

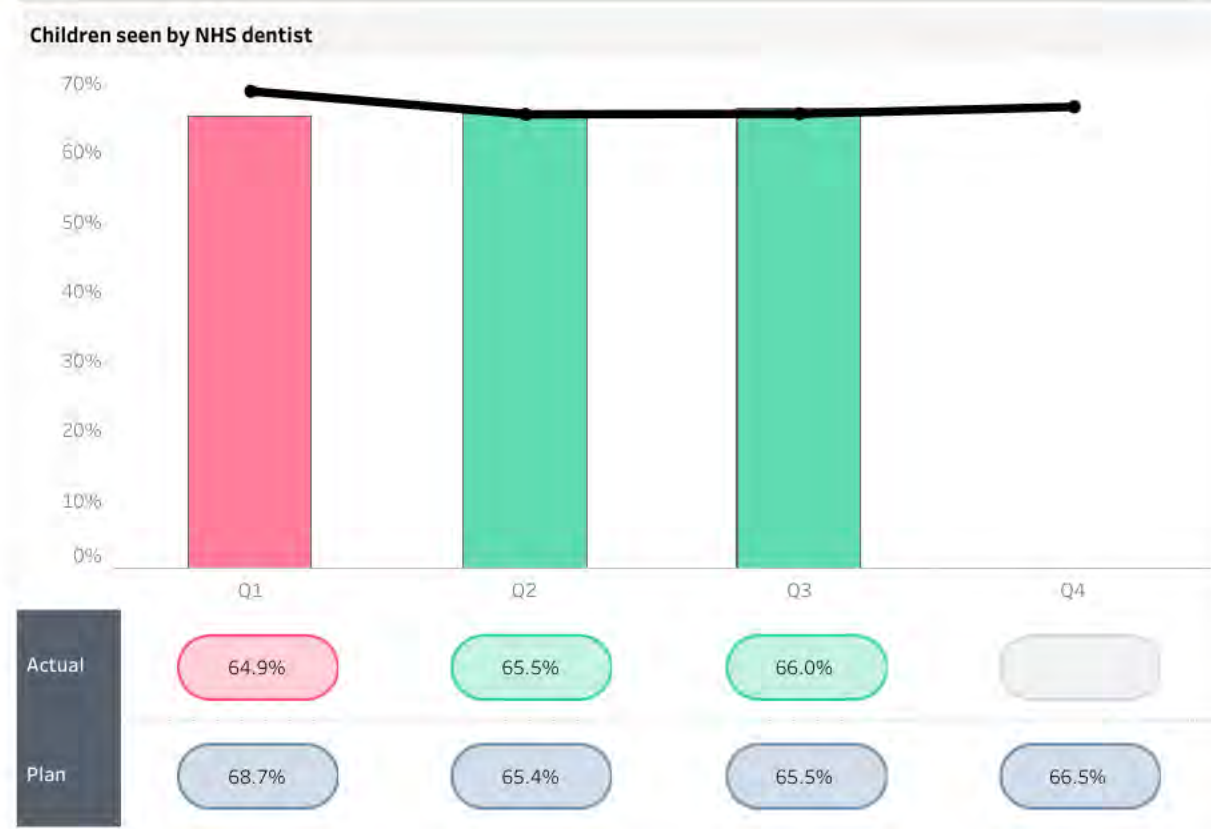
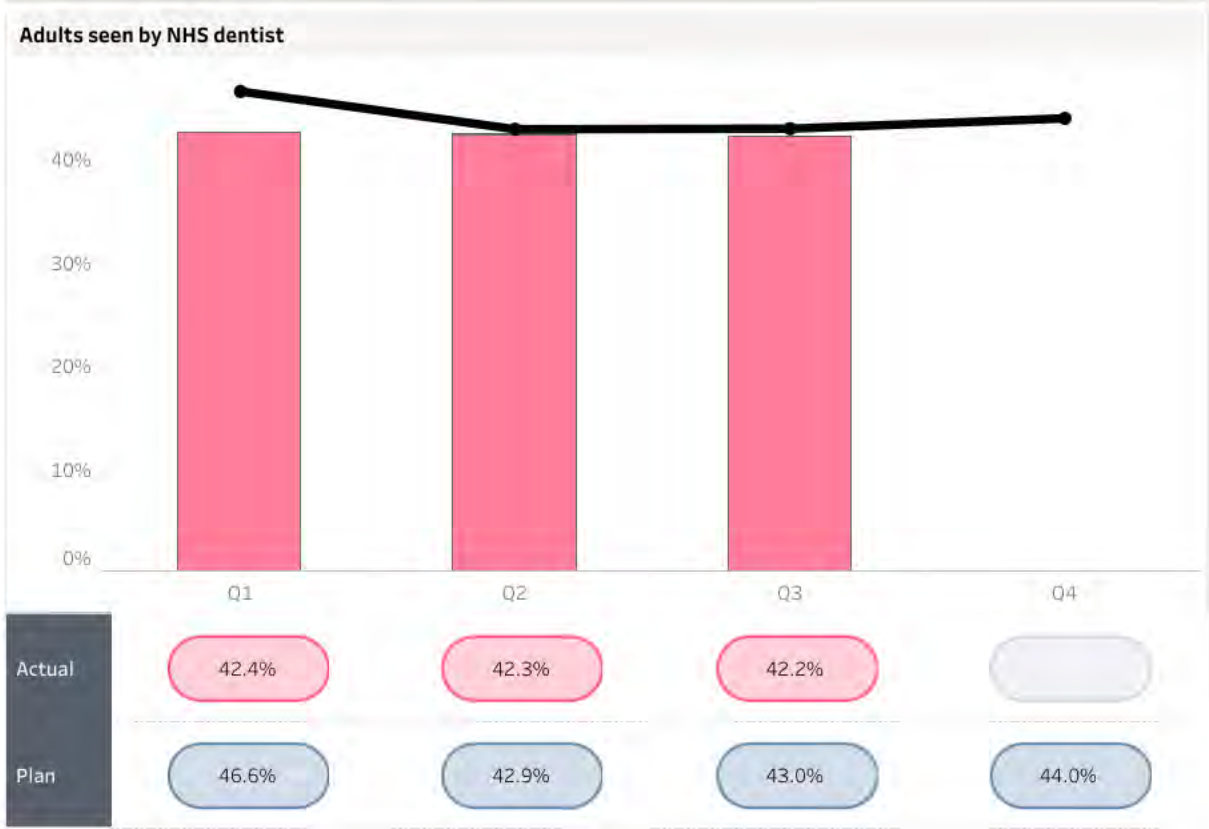


2024/25 Performance

GM ICB has set a target of 1,449,589 GP appointments per month throughout 2025/26. In March 2026, 1,522,569 appointments were delivered.

[illegible]

% of Resident Population Seen by an NHS Dentist



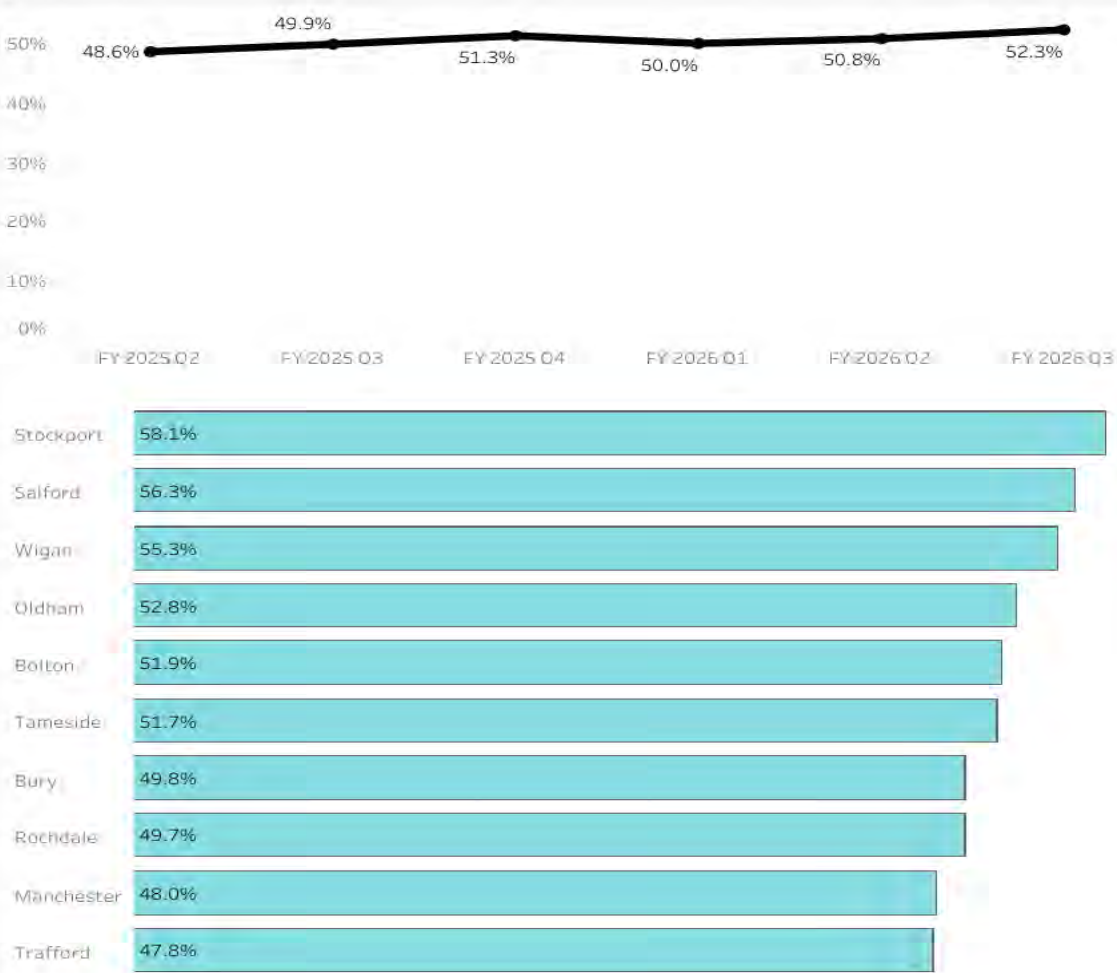
Systems are expected to monitor and improve access to NHS dental services for both children and adults. This includes tracking the percentage of the population seen by an NHS dentist within the recommended timeframes:

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

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

CVD/Hypertension

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



% of patients with hypertension treated according to NICE guidance



National priorities for 2025/26 include increasing the proportion of patients with hypertension treated in line with NICE guidance, and the proportion of patients with GP-recorded CVD whose cholesterol is managed in line with NICE guidance. Performance against both metrics has improved in Q3 2025 compared to the same period in the previous year. GM ICB ranks 13th of 42 ICBs for both hypertension and 15th out of 42 for CVD cholesterol management.

National Prevention Demonstrator - Introduction & Update

3rd June 2026

Strategic Commissioning Committee

3rd June 2026

Required information.	Details.
Title of report.	National Prevention Demonstrator – Introduction and Update
Author.	Warren Heppolette, Director, Prevention Demonstrator
Presented by.	Warren Heppolette, Director, Prevention Demonstrator
Contact for further information.	Warren.heppolette@greatermanchester-ca.gov.uk
Executive summary.	This paper provides an introduction to the National Prevention Demonstrator agreed between Greater Manchester and UK Government last year. It confirms its role in supporting implementation of the Greater Manchester Strategy, and Live Well as GM's model for public service reform and neighbourhood working. It sets out the approach to delivery and evaluation, including the contribution of 4 GM localities as 'blueprinting and evaluation partners'.
The benefits that the population of Greater Manchester will experience.	Preventative approaches will be embedded across Greater Manchester's landscape of services and support. The most impactful approaches will be tested and evaluated and the supported to spread. Existing patterns of growth in demand and costs and deterioration in outcomes will be targeted and positively affected.

How health inequalities will be reduced in Greater Manchester's communities.	The model to be tested through the Demonstrator will focus on addressing economic inactivity and poverty, disrupted education for children with SEND, pressures on families, support for people experiencing multiple disadvantage, and proactive healthcare for people with unmet needs. The model will test relational approaches which address access challenges and service fragmentation which have failed communities with multiple needs in the past.
The decision to be made and/or input sought.	The Committee is asked to: 1. Support the processes set out in this paper to mobilise delivery across the Prevention Demonstrator; and 2. Note the intent to take a formal paper to the GMCA and NHS GM in June/July to secure full system sign up and commitment to directly feed into resource planning and budget setting for 2027/28.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	
Key milestones.	Locality Engagement (May/July) Report to Board in Public (June) Cross sector planning and budget setting engagement (Sept-November) 1st Evaluation Report April 2027

Leadership and governance arrangements.	National Advisory Group chaired by GM Mayor with attendance from NHS GM Chair and CEO specifically oversees the Prevention Demonstrator. Live Well Board co-chaired by NHS GM CEO and Wigan Council CEO ensures alignment to Live Well Mobilisation. Informal governance through a design/delivery group has included participation from senior officers and clinicians from NHS GM, and Health Innovation Manchester.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	Three meetings of the Advisory Group since November 2025 have shaped the approach described here. A design/delivery group with broad system and locality engagement has supported the detailed work. For NHS GM, particular attention has been paid to aligning with Neighbourhood Health approaches, the connection to NHSE's Prevention Accelerator Programme, and the development of proactive care models through BeCCoR.
Financial or Legal Implications	NHS GM resourcing decisions supporting Live Well, Proactive Care/Population Health Management and particular population health programmes (eg Workwell, GM Moving, etc) are relevant to the initial work. As the work progresses, it will inform approaches to tracking and growing preventative spend across public services. Engagement on planning and budget setting processes therefore will be essential.

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
Yes (as part of Live Well)	Yes	No	Yes	No	No	No	No

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

1. Introduction

The Greater Manchester Strategy

- 1.1 In July 2025, partners across the city region launched the Greater Manchester Strategy, which sets out Greater Manchester's vision for a thriving city region where everyone can live a good life – and a ten-year programme to fix the foundations of life and support people to live well. The Strategy is a system wide commitment to prevention and learns from a decade of shared work to rethink the way public services are delivered - building a system that provides early help and heads off problems before they reach a crisis point.
- 1.2 This strategy reflects a collective vision for the next decade, emphasizing the importance of prevention and community participation to achieve these goals. This approach reflects the challenges facing our residents - across Greater Manchester, poverty, worklessness, poor health, trauma and insecure housing driving avoidable demand in every public service.

Live Well Implementation

- 1.3 Live Well is Greater Manchester's delivery model for Public Service Reform. Live Well will unite the full range of public services and support into a fully integrated, preventative system to meet need in a different way and reduce demand on public services – including the NHS. It is fundamental to the delivery of the Greater Manchester Strategy and the delivery in the city region of the 10 Year Health Plan.
- 1.4 Live Well is about reshaping how services and organisations work together — shifting from siloed delivery to integrated, preventative support grounded in trust, collaboration and local knowledge. Neighbourhoods, as part of thriving places in Greater Manchester, are the focal point for this.
- 1.5 Partners in all 10 localities in Greater Manchester have been developing and implementing models of neighbourhood working for several years. We need to accelerate this progress through Live Well, strengthened Place Partnership arrangements and the new national NHS framework on Neighbourhood Health.
- 1.6 In Greater Manchester, neighbourhood working has always been about more than the NHS - bringing together all the elements of community support and public service

delivery and to provide early help to residents and prevent crisis.

- 1.7 2026/27 will be a pivotal year as we embed our whole system delivery of Live Well. This will need to come together in our 10 places supported by joint working at the GM level between GMCA and NHS GM. This will focus on the following aims:
 - I. To collectively set and track clear deliverables for Live Well and accelerate implementation in all 10 localities
 - II. To integrate our approach to Neighbourhood Health as a core part of Live Well – with neighbourhood teams working across health and care, public services and the VCFSE to support residents. This provides a key opportunity to provide a distinctive additional element to the national concept of Neighbourhood Health.
 - III. To maximise the role of GMCA and NHS GM in supporting place-based delivery – including through the implementation of the new Place Partnerships for Health and Care
- 1.8 Our collective ambition is for all public services in GM to be joined up, local and built around everyday life, meaning that:
 - People will get the support they need, in their neighbourhood, at the right time without having to navigate complex systems or repeat their story. Services will work with people and communities, recognising strengths, lived experience and local leadership
 - Live Well Centres and Spaces will be visible and accessible to all residents, will be part of a fully developed neighbourhood model across all public services and support and will deliver across the full range offers – for example, Employment, Housing, Support for Families, Physical and Mental Health and Enhanced Support when needed.

The Prevention Demonstrator

- 1.9 The UK Government has recognised the commitment of the Greater Manchester system to support this shift to a more proactive and preventative public service model and designated GM as the UK's first national Prevention Demonstrator. Through this work, Government has asked GM to develop and implement public service delivery aimed at preventing poor outcomes for residents and high service costs. The Demonstrator will be

supported by increased autonomy, including exploring opportunities to pool budgets, reprofile public service spending towards prevention.

- 1.10 Through the Prevention Demonstrator, GM will show how re-wiring the state improves decisions, connects public services to community strengths and leads to more preventative action.
- 1.11 GM will accelerate the rollout of this model by testing, learning from and spreading those approaches across GM and developing an evaluation framework which will demonstrate the impacts of prevention. Devolution – including mechanisms such as the integrated settlement – will play a key role in mobilising the Demonstrator.
- 1.12 The Prevention Demonstrator will show that this way of working is the way to address the patterns of demand and cost which most seriously affect outcomes for residents and drive the demand and cost undermining the sustainability of public services. The Demonstrator will pursue the most significant outcomes supporting good lives, including economic participation, health creation, thriving families and educational attainment, reduced crisis demand.
- 1.13 GM will work with Government as part the Cabinet Office led Test, Learn and Grow process. Test, Learn and Grow is a flagship part of the government's reform programme and will work directly with affected communities to test out what works instead of trying to devise perfect solutions from Whitehall. Working in this way the GM Prevention Demonstrator will focus the first 12 to 18 months on the proof of value to capture the first phase of benefits from these approaches and roll it out across Greater Manchester. Within three years, every part of our city region will have made a more radical shift to prevention.
- 1.14 By 2030, the way GM delivers public services will look and feel very different, with the communities facing the greatest challenges feeling the biggest benefit. By 2035, our Prevention Demonstrator will have delivered an evidence-based blueprint that can be used across the UK.
- 1.15 The Prevention Demonstrator will accelerate and optimise Greater Manchester's shift to Live Well, prevention, community power, and good growth—helping people thrive,

reducing avoidable demand, and creating the blueprint for wider rollout and national replication.

- 1.16 It will show how to build a connected, proactive system that listens to residents, joins up support earlier, and tests solutions at scale. By learning from residents' experiences, it will shape new service models, define data needs for prediction and early help, and address problems before they occur.
- 1.17 The Demonstrator will also highlight the economics of prevention—showing how this approach can break down silos, unlock funding for early intervention, and deliver better and more sustainable taxpayer value. In doing so, it will enable real-time learning across Greater Manchester and provide insights to maximise impact and deepen devolution nationally.

2 Approach to Delivery

Working through the GM Localities

- 2.1 Greater Manchester will collaborate to tap into the whole system's movement to develop and embed Live Well. It will require detailed work with localities to 'blueprint' this approach to support, feed the evaluation to capture what works, and help spread proven approaches. Following discussion with all ten localities, four have offered to initiate this process. Overall therefore we will recognise and support:
- all ten localities continuing their local Live Well implementation journey to establish comprehensive, integrated neighbourhood and place based delivery models. There will be no change therefore to existing approaches to system wide proactive and preventative programmes (for example on population health programmes, or proactive care and population health management models). Where GM is asked to be a national testbed for relevant government reforms, for example, in transforming SEND provision and improving NEET prevention all ten localities would be supported to participate as part of pan-GM work.
 - Working intensively with up to 4 localities to support the process of blueprinting the change and feeding the evaluation across a 'total place approach'.
- 2.2 All ten parts of GM therefore will be part of the learning network which generates and utilises the evidence and practice of what works. We will use existing governance through the Reform Board and Live Well Board to support this practice of learning and exchange.

Delivery and Blueprinting Requirements

- 2.3 In addition to the direct contribution to the Evaluation framework, each demonstrator site

will need to support the process to blueprint the methods and processes to achieve the prevention objectives to support GM spread and national replicability. This will include:

- **Public service reform** – designing and describing the service innovation, conditions and behaviours necessary to achieve the objectives, For example, cross sector working and leadership; integrated commissioning and neighbourhood delivery; co-production and co-design with communities; partnering with business and industry; and workforce and skills development.
- **Civic Data, digital and AI developments** – spanning cross-sector data linkage, supporting real-time prevention delivery across NHS, councils, national data sources & VCFSEs; Risk stratification and case finding tools to generate near real-time insight to supports proactive delivery; AI and predictive tools that forecast need, personalise targeting, and enable earlier, smarter prevention decisions; and frontline capability to access and utilize prevention data & analysis independently. We have established a Joint Data Collaborative with UK Government to unlock barriers to data sharing and integration. At the GM system level we will be connecting partners to support the setting up of a Joint Data Unit (agreed as an objective at the GMCA in March 2026) to provide system leadership, facilitates collaboration and develops expertise on this agenda for the GM system. It would pioneer a new data management model for city regions, that puts trust and ethics at its heart and enables the GM system to exploit data to drive better outcomes for residents.
- **The economics of prevention** – developing and testing the financial frameworks and tools to support a systemic shift to prevention. For example, outcome or value based payment methods or incentives; place based budgeting; funding flexibility through the Integrated Settlement and further devolution; and national to city region gain and risk-share mechanisms.

Evaluation Requirements

2.4 It will be essential to capture the evidence and learning to respond to the Evaluation Framework. This will require both real time learning and robust impact evidence meeting

an evaluation standard accepted by Treasury and the Office of Budget Responsibility. The evidence requirements will be significant and cover five evaluation aims which must:

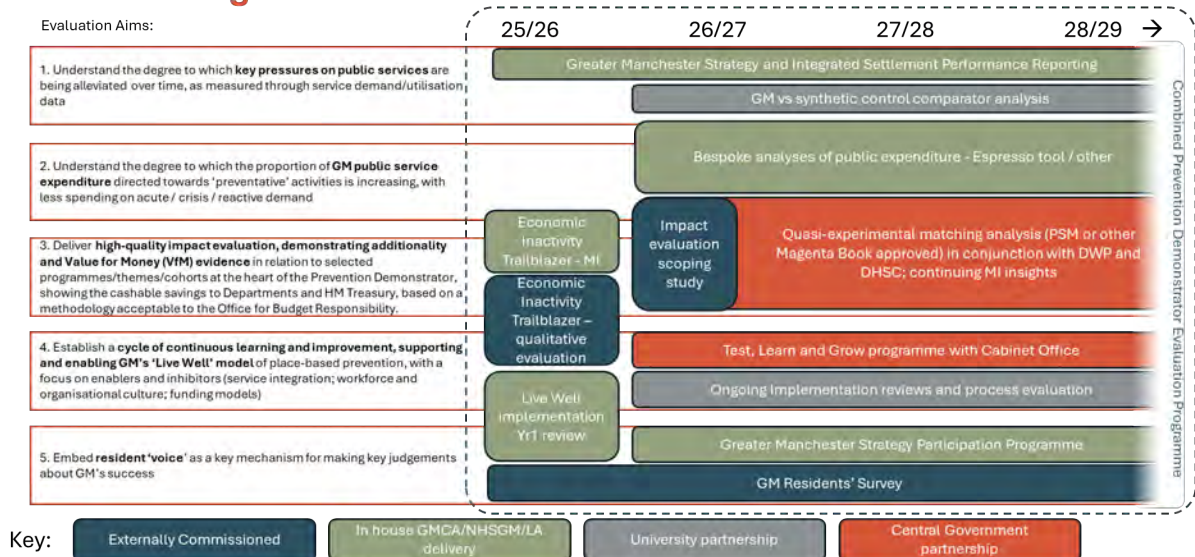
- a. Understand the degree to which key pressures on public services are being alleviated over time, as measured through service demand/utilisation data
- b. Understand the degree to which the proportion of GM public service expenditure directed towards 'preventative' activities is increasing, with less spending on acute / crisis / reactive demand
- c. Deliver high-quality impact evaluation, demonstrating additionality and Value for Money (VfM) evidence in relation to the reform of public services at the heart of the Prevention Demonstrator, showing the cashable savings to Departments and HM Treasury, based on a methodology acceptable to the Office for Budget Responsibility
- d. Establish a cycle of continuous learning and improvement, supporting and enabling GM's 'Live Well' model of place-based prevention, with a focus on enablers and inhibitors (service integration; workforce and organisational culture; funding models)
- e. Embed resident 'voice' as a key mechanism for making key judgements about GM's success.

- 2.5 The framework aims to provide data for (i) accountability to government (ii) learning to help refine the model and spread success (iii) case making for further devolution and releasing savings generated for investment in further prevention.
- 2.6 To do this it will generate data to inform national government departments, local commissioners, providers, politicians and residents and wider audiences like other combined authorities and city regions internationally and think tanks/academia.
- 2.7 The framework knits together a range of analyses that will look at activities and overall outcomes – like ongoing performance monitoring conducted by GMCA (resident's survey, GMS performance reporting), bespoke analyses by GMCA (spending analysis using espresso tool), externally commissioned research studies (synthetic control comparator analyses); and a series of studies evaluating the implementation and impact of specific programmes (Economic Inactivity Trailblazer Evaluation etc)The evaluation framework will iterate and build in line with the practical phasing and realisation of benefits. The signs of progress will emerge first in relations to specific challenges before scaling to

affect the proportion of reactive to proactive responses across the whole system. The framework is broad but brings four key elements together:

- I. High level tracking of quantitative system data for outcomes and expenditure
- II. Robust impact assessment to test the value for money and impacts of the shift to prevention
- III. Process evaluation using qualitative methods
- IV. Creative conversations with residents and practitioners to understand their experiences of accessing support and working in this way

Prevention Demonstrator and Live Well monitoring, evaluation and learning framework



Governance

- 2.8 The Prevention Demonstrator is overseen by a National Advisory Group. The Advisory Group is chaired by the GM Mayor and brings together representatives from GM's public services, Universities, and VCFSE alongside partners from national bodies and Government.
- 2.9 The GM Live Well Board, jointly chaired by the Chief Executives of Wigan Council (as the CE Portfolio Lead for Live Well) and NHS Greater Manchester, oversees the work to

ensure the clear alignment with Live Well roll out, and integrated place based working is maintained.

3 Summary and Next Steps

- 3.1 The GMS confirms Greater Manchester's ambition to reform public services in ways which head off problems before they occur and deliver better outcomes for residents. The UK Government has backed this commitment and designated GM as a National Prevention Demonstrator. GM Partners have worked intensively over recent months to hone and describe an approach to delivery and evaluation and are now ready to move to implementation.
- 3.2 The critical next step is to confirm participating localities and the overall delivery portfolio for the Demonstrator with a report to the GMCA and the NHS GM Board in June 2026.
- 3.3 Specific engagement will also be supported with the four localities who will work with GM and government colleagues and take the lead in populating the blueprint and participating in the evaluation activities to show what works and how sustainability can be secured. We will also establish effective whole system learning and sharing arrangements which connects the insights and approaches across all ten places. Finally, GM as a whole will commit to working with Government to apply the same delivery and evaluation approach to support the national reforms for NEET prevention and better meeting children's Special Education Needs.

Recommendations:

The Committee is asked to:

- I. support the processes set out in this paper to mobilise delivery across the Prevention Demonstrator; and
- II. note the intent to take a formal paper to the GMCA and NHS GM in June to secure full system sign up and commitment to directly feed into resource planning and budget setting for 2027/28.

Antimicrobial Resistance Report

Quarter 1 2026/27

NHS Greater Manchester Strategic Commissioning Committee/Group

3rd June 2026

Required information	Details
Title of report	Antimicrobial Resistance Report
Author	Claire Lake, Deputy Chief Clinical Officer, NHS GM Heather Myers, Head of Clinical Effectiveness, NHS GM Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury), NHS Greater Manchester Claire Foster, Deputy Chief Pharmacist, NHS GM Absar Bajwa, Senior Strategic Medicines Optimisation Pharmacist - GM Clinical & Quality Portfolio, NHS GM Andrew Stone, Lead Antimicrobial Stewardship Pharmacist (NCA) Rebecca Clyde, Medicine and Pharmacy Project Support, NHS GM
Presented by	Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Claire.lake@nhs.net
Executive summary	This paper provides a Quarter 1 assurance update for the GM Antimicrobial Resistance (AMR), Antimicrobial Stewardship (AMS) and Infection Prevention & Control (IPC) programme. As part of the national <i>Act Now: Protect Our Present, Secure Our Future</i> directive, NHS GM is required in Q1 2026 to benchmark performance against national AMR targets using the latest English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) and Model Health System data, complete both the IPC Board Assurance Framework and the ICB AMS Self-Assessment Toolkit, and identify three system-wide AMR improvement priorities with executive accountability. In response, this report consolidates IPC data, ESPAUR benchmarking analysis and the AMS self-assessment review into a single system-level view. It highlights areas of good progress, persistent gaps (including benchmarking updates and variation in provider assurance returns), and the key risks requiring system attention. The paper also outlines early learning, good practice, and the immediate actions needed to support delivery of both national requirements and the GM AMR/IPC Improvement Plan. The report is presented in an Alert, Advise and Assure format.
The benefits that the population of Greater Manchester will experience.	This work will improve patient outcomes by: - Reducing avoidable infections through strengthened IPC standards - Improving stewardship of antimicrobials, reducing resistance and supporting safer prescribing - Decreasing variation in sepsis recognition and management through harmonised clinical standards

	Strengthening system preparedness and outbreak response, lowering risks across all settings
How health inequalities will be reduced in Greater Manchester's communities.	This work reduces inequalities by: - Targeting improvement initiatives (e.g. urinary tract infections (UTI) work in older adults) at groups with higher infection burden - Supporting consistent stewardship and IPC practice across all GM localities, reducing postcode variation - Ensuring underserved communities benefit from better infection prevention, early identification, and appropriate antimicrobial use - Embedding equitable access to safe, high-quality, evidence-based care across clinical pathways
The decision to be made and/or input sought	The Committee/Group is asked to: - Receive and discuss the Quarter 1 AMR/IPC assurance assessment. - Endorse the proposed next-steps for Quarter 2, including data improvement work and refinement of assurance processes.
How this supports the delivery of the strategy and mitigates the BAF risks	This paper supports NHS GM strategic priorities by: - Strengthening population health outcomes through reduced infection burden - Supporting quality improvement and safety commitments across IPC and AMR - Providing assurance against applicable BAF risks, particularly: - Risks related to infection outbreaks, clinical harm, and system safety - Risks relating to variation, safety governance and data quality - Aligning with GM's statutory duties around quality, safety, and evidence-based care
Key milestones	Completed (Q1): - Compilation of IPC dashboard dataset - Initial ESPAUR benchmarking analysis - Provider assurance returns received from majority of acute trusts - AMS self-assessment review commenced Upcoming (Q2): - Integration of benchmarking outputs into a unified dashboard - Completion of AMS self-assessment analysis - Strengthened provider return process to address gaps (e.g. Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust -WWL) - Finalisation of combined AMR/IPC improvement recommendations

Leadership and governance arrangements	GM AMR Group GM Antimicrobial Stewardship / IPC oversight groups NHS GM SCC NHS GM Board (via highlight reporting)
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	GM AMR Group
Financial or Legal Implications;	N/A

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

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

Please note – we have included a Glossary of terms due to the high volume of technical language, abbreviations and programme-specific terminology that may not be familiar to all readers.

GM AMR PROGRAMME

Advise

Area - Act now: protect our present, secure our future

Act now: protect our present, secure our future was launched during Antimicrobial Resistance Awareness Week in November 2025. A letter to systems restated the national ambitions set out in the National AMR Action Plan and described actions for all NHS organisations to undertake by the end of Q1 2026/27.

The actions in the National letter are summarised as follows:

1. Schedule a joint presentation to your board from IPC and AMS teams
 - Current performance against national AMR targets
 - [ESPAUR](#) benchmarking + model health system benchmarking
 - Key concerns and immediate actions required
2. Complete:
 - [National IPC Board assurance framework](#)
 - [ICB AMS self-assessment tool](#)
3. Agree and publish 3 priority areas for AMR improvement by April 2026

This is to advise GM SCC on the progress against these actions:

1. This SCC report represents a **summary of IPC and AMS data**, contained under the umbrella of AMR. The assure section contains our current performance against NOF targets, ESPAUR and model health system benchmarking and sets out mitigating actions that are in place where targets are not being met.
2. a. The **national IPC Board Assurance Framework (BAF)** work applied to acute provider organisations. Assurance work by NHS GM is underway via Q1 Quality Assurance and Safety Meetings (QuASMs) with acute providers to assure the IPC BAF work has been undertaken with board visibility within organisations and also to collate themes and shared learning. This GM system assurance work will be completed over Quarter 1 and any escalations for individual provider organisations will be agreed and monitored via the QuASM.
b. Completion of **ICB AMS self-assessment tool**. This has been undertaken and is included as Appendix 1.
The self-assessment demonstrates GM is in a good position with regards to AMS with improving trends across all key performance areas; has an AMR action plan 2024-2026 already in place with data dashboards to measure progress and delivery underway to ensure further improvement.
The self-assessment for AMS has identified areas to develop further: a review of AMR risk to ensure sufficient visibility on ICB risk registers; a strengthened alignment with diagnostics network around infection; and system work on AMS/IPC workforce planning and training/development.
3. The AMR Programme has reviewed its **priorities** and agreed 3 priority areas based on data, evidence and discussion (presented below).

This report, therefore, advises SCC of the work that have been carried out to fulfil the requirements set out in Act now: protect our present, secure our future and advise that this work is nearly full completion.

System-wide AMR improvement priorities 2026/27

Based on our GM data and current progress in delivering our GM AMR/IPC Improvement plan, the following have been agreed as our key AMR GM improvement priorities for 26/27:

Priority 1 – Reduce avoidable antibiotic exposure in children (0–9) and improve overall primary care prescribing volume (Specific Therapeutic group Age-sex Related Prescribing Unit -STAR-PU)

Focus: Paediatric respiratory tract infection prescribing and safety-netting, and sustained reduction in overall antibiotic items/STAR-PU while maintaining appropriate access and safety.

Priority 2 – Reduce healthcare-associated infection and AMR burden

Focus: Sustained improvement in healthcare-associated GNBSI (E. coli, Klebsiella spp., P. aeruginosa) and C. difficile through integrated IPC + AMS actions across acute providers and key interfaces (admission/discharge, Outpatient Parenteral Antimicrobial Therapy- OPAT, community pathways), using Model Health System/National dashboards to track year-to-date performance against thresholds and target support where trends deteriorate.

Priority 3 – Strengthen secondary care antimicrobial stewardship: reducing Watch and Reserve antibiotic use and optimising Intravenous- IV-to-oral switch

Focus: reduce unnecessary exposure to Watch & Reserve antibiotics (higher AMR risk) and optimise IV antimicrobial use through timely IV-to-oral switch where clinically appropriate, supported by consistent provider reporting and benchmarked via Model Health System/Standard Contract metrics.

Alert

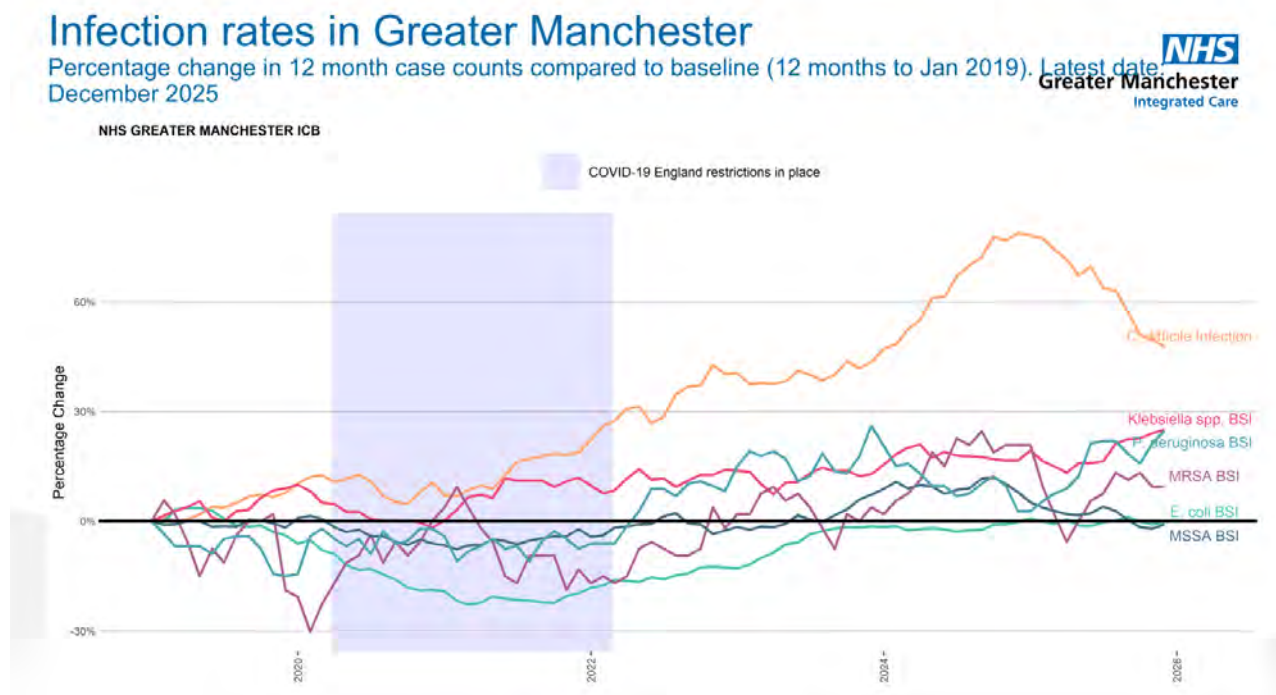
Area – HCAI (Healthcare associated infections) Figures

HCAI figures are monitored as part of National Oversight Framework performance metrics. Figure 1 presents our GM trends in HCAI rates.

In summary,

- There is an improving/stable position for E.coli reflecting UTI improvement work that began across GM in 2024 and continues through the delivery of the GM AMR/IPC Improvement Plan 2024-2026
- There is variation in MRSA infection rates across GM; with an increased incidence of MRSA blood stream infections in several sub-localities for which improvement plans have been developed and are in place
- After a steep rise in C. difficile infections post pandemic, and subsequent improvement work and quality assurance focus applied with provider organisations via Rapid Quality Review (RQR) processes, we are now seeing a steady reduction of infection rate
- There is a more recent rise in Klebsiella and Pseudomonas infections in GM, which has been included as a priority area of GM system IPC improvement work for 26/27 to work with provider colleagues to deep dive and agree mitigations/actions to address.

Figure 1



Area – GM AMR/IPC Improvement Plan 2024-26

We launched our GM AMR/IPC Improvement Plan 2024/26 in 2024. The plan has strategic Key Performance Indicators (KPIs) that are monitored regularly:

- Mortality related to sepsis in adults >65 yrs
- Rates MRSA cases
- Rates C. Diff cases
- Rates E.coli cases
- Total health care associated gram negative BSIs
- Seasonal Flu vaccination rate 65yrs older (overseen by Screening and Imms programme)

There is a deteriorating position from October 2025 to February 2026 for 3 of these KPIs; however as demonstrated in Figure 2 below the margins of deterioration for these KPIs are small. A review of actions has been undertaken with system partners to understand and address.

Figure 2

AMR Framework: Strategic Key Performance Indicators

KPI	Measure Name	Period	Latest Value	Previous Value	Direction of Travel	England Latest
KPI 3	MRSA cases	Feb 26	8.0	2.8	↑	2.8
KPI 4	C. difficile cases	Feb 26	48.7	48.7	→	42.7
KPI 5	E.coli cases	Feb 26	98.9	98.2	↑	112.3
KPI 6	Total Healthcare Associated Gram-negative bloodstream infection (HSAI) cases	Feb 26	136.9	136.1	↑	158.6
KPI 7	Seasonal Flu Vaccine Uptake: 65 years and over	Feb 26	72.0%	71.7%	↑	74.9%

Assure

Area – HCAIs Performance and Quality Oversight

Quality and performance oversight regarding HCAIs is in place.

This is firstly via GM AMR Group and GM IPC sub-group, which have a quality improvement focus. Assurance related to delivery of GM AMR/IPC Improvement Plan is via these routes.

When deterioration or outlier position is noted, then this is brought into Quality Oversight via Quality & Safety Meetings (QuASMs). Where required a RQR is established.

In addition, within the newly formed Clinical Portfolio, work is underway to review and align outbreak management and wider infection related governance (e.g. TB and other blood stream infections) with the AMR programme. This is anticipated to completed by end Q2.

Area – National AMS targets and relationship to ESPAUR

Similarly to the national HCAI metrics, the national ICB AMS (antimicrobial stewardship) targets are also set through NHS England's National Oversight Framework (NOF). These targets are aligned to the National AMR Action Plan, the WHO AMR global risk and based on evidence and causality regarding harm associated with antibiotic use, resistance and HCAIs,

ESPAUR (UKHSA) is the national surveillance report that publishes these targets, describes the metrics, and reports national trends/progress, using NHS England/NHSBSA-produced dashboards as the underlying benchmarking outputs.

NOF targets referenced in ESPAUR:

- **SO44a: ≤0.871 antibiotic items per STAR-PU.**
 - o GM position **0.879** (Mar-25 to Feb-26) vs target **≤0.871**; improved from **0.965** (Mar-24 to Feb-25).
- This means antibiotic prescribing in primary care across Greater Manchester is

improving and is now very close to the national target, although it is still slightly above the level expected.

- **SO44b ≤10% broad-spectrum items** (co-amoxiclav, cephalosporins, fluoroquinolones) as a % of total antibacterial items.
 - GM position **6.973%** (12 months Mar-25 to Feb-26); stable vs **6.945%** (Mar-24 to Feb-25).
This means Greater Manchester is meeting this target, with broad-spectrum antibiotic use staying low and stable over the last year.

This represents an improving position for GM, partially achieved via a focus on AMS in 2025/26 BeCCoR scheme.

Area – Antibiotic prescribing in children aged 0–9 (NOF patient safety metric)

- **National target: ≤27.0%** (fixed England threshold).
- **GM latest position: 29.6%** (rolling 12 months to Jan-26) – not meeting target.
- For comparison, the NW region's average is 29.5% and the NW is the 3rd best performing region in the country for this measure

This represents an area that requires ongoing improvement for GM: it has been included as an additional focus for GP practices in the AMS part of 2026/27 BeCCoR scheme with an expectation that this contributes to an improving picture.

This means too many antibiotics are still being prescribed for children aged 0–9 compared with the national standard, so this remains an area where Greater Manchester needs to improve.

Area – Optimising antibiotic duration (PrescQIPP / Model Health System)

Optimising course length reduces avoidable antimicrobial exposure and supports delivery of antimicrobial stewardship guidance and the UK 2024–2029 NAP ambition to reduce total antibiotic use by **5% by 2029**.

- **Amoxicillin 500mg capsules – 5-day courses: 82.4%** (for month of Feb 2026) and **76.12%** (12-month rolling to Feb-26).
- **Doxycycline 100mg capsules – 5-day courses: 59.35%** (for month of Feb 2026) and **46.73%** (12-month rolling to Feb-26).

We are seeing an **improving** trend in GM. Although there is no fixed national target and not reported in the ESPAUR report, we have included for assurance of duration optimisation and reduction of exposure. Course length has also been included in BeCCoR AMS scheme 2025/26 and 2026/27 so we anticipate ongoing improvement in this area over 26/27.

This means more prescriptions are now being issued for the recommended shorter treatment length, which helps reduce unnecessary antibiotic exposure.

Area – Additional GM Quality metric: coded indication for broad-spectrum antibiotics

Local (GM) target: ≥70% of broad-spectrum antibiotic prescriptions initiated in general practice

have a coded indication (GM scheme requirement).

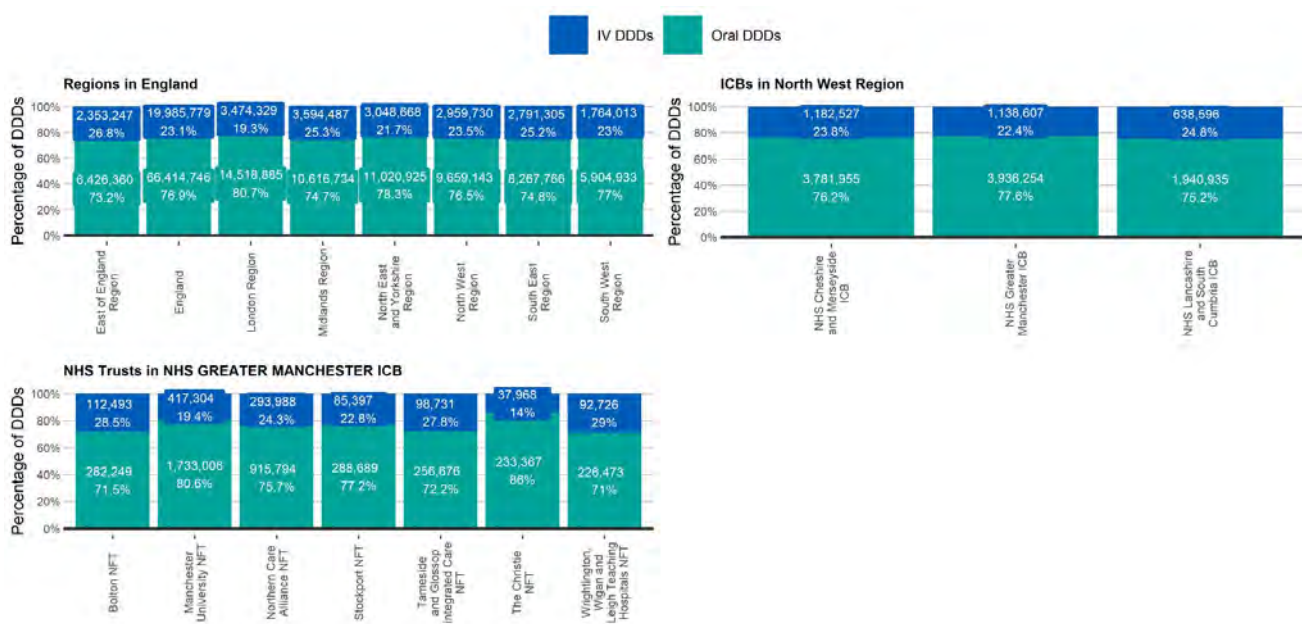
- **GM performance (Apr-25 to Mar-26):** locality range **71.87%–87.91%**, meeting target across all 10 GM localities.

This means GP practices across Greater Manchester are consistently recording why these antibiotics are being prescribed, which supports safer prescribing and better review of care.

Area – Secondary care antimicrobial stewardship and outcomes (Model Health System / Standard Contract)

Monthly reporting and benchmarking data is published across acute providers for secondary care stewardship and outcomes, including IV vs oral antibiotic defined daily dose (DDD) % and Watch & Reserve DDDs per 1,000 admissions. These targets are considered indicators of good antimicrobial stewardship within acute provider settings.

Figure 3: IV to Oral Switch ratio data – this represents a positive position for GM with a high ratio of oral:IV DDDs



This means hospitals in Greater Manchester are making good use of switching patients from antibiotics given into a vein to tablets or liquid when it is safe to do so, which is usually better for patients and can reduce unnecessary hospital-based treatment.

Figure 4: Watch and Reserve Antibiotics DDD/1000 admissions – the aim is to reduce unnecessary use of higher AMR-risk antibiotics (represented via lower DDD/1000 admissions)



This means Greater Manchester is using these higher-risk antibiotics more carefully when activity is taken into account, although there is still variation between providers.

Learning for sharing

Area - Learning Event

The Greater Manchester Health Protection Practitioner Learning Event took place at Alexandra Park, Oldham on Wednesday 15th April 2026. Over 50 delegates from partners across GM including locality IPC teams, acute providers, UKSHA and regional colleagues attended the event.

Topics discussed included:

- AMR and inequalities
- Oral health across the life course
- GM AMR Improvement Plan
- Sexual health, chem sex, and sex premise guidance
- IPC as a tool for reducing vaping harms in children and young people

Achievements

Area – AMR Research

The IPAP-UTI study is now live and running across NHS GM. It is run by the University of Bristol and GM is the 3rd ICB intervention site. It is a population based seeking to determine whether changes in prescribing patterns can impact/reduce antimicrobial resistance.

Area - GM AMR Improvement Work

There is a breadth of collaborative AMR improvement work underway across GM – summarised in the image below. The programme continues to span AMR, AMS, IPC and also sepsis/acute deterioration. This breadth of work will continue alongside the assurance and oversight described in this report.

Current Greater Manchester AMR Work



IPAP-UTI
PROGRAMME



AMR LEADERSHIP
NATIONAL GRANT



TB COMMUNITY
LED IMPROVEMENT
GROUP



IPC ADVICE FOR
SCHOOLS &
NURSERIES



GP/PCN FACE FIT
TESTING FOR FFP3
MASKS



COMMUNITY HEALTH
PROTECTION
WORKFORCE PLAN
DEVELOPMENT



CARE HOME HEALTH
PROTECTION
WEBINARS



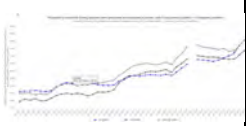
GM ICB AMR
IMPROVEMENT PLAN



CLOVER CDI
VACCINE STUDY

Appendix 1: Antimicrobial stewardship – integrated care boards (ICB) situation report/self-assessment

ICB performance against key performance indicators of antimicrobial prescribing quality and AMS					
	Key performance indicators	Performance goal	Latest position	Date	Comments
1 a	Primary care total antibiotic prescribing Source: Model Health System ** Metric: Antibacterial items per STAR-PU	Benchmarking (lower is better*)	0.879	Feb 2026	This a 12 month rolling figure for the period March 2025 to Feb 2026. Current position is just above the 0.871 target.
1 b	Primary care total antibiotic prescribing Source: Model Health System ** Metric: Antibacterial items per STAR-PU	Trend over time (decreasing is better)	0.879 (Feb 2026) reduced from 0.965 (Feb 2025)	Feb 2026	Downward (improving) trend
2 a	Primary care broad-spectrum antibiotic prescribing Source: Model Health System ** Metric: Co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of antibiotics	Benchmarking (lower is better*)	6.973%	12-month rolling figure to Feb 2026	Stable vs 6.945% 12 month rolling figure to Feb 2025; and below national target
2 b	Primary care broad-spectrum antibiotic prescribing Source: Model Health System ** Metric: Co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of antibiotics	Trend over time (decreasing is better)	Unchanged	6.973% (Feb 2026) vs 6.945% (Feb 2025)	Stable – all localities have maintained or reduced broad spectrum prescribing
3 a	Primary care antibiotic duration Source: Model Health System Metric: Proportion of amoxicillin 500mg capsules items prescribed and dispensed in primary	Benchmarking (higher is better)	82.4%	Feb 2026	

	care 5-day duration				
3 b	Primary care antibiotic duration Source: Model Health System Metric: Proportion of amoxicillin 500mg capsules items prescribed and dispensed in primary care 5-day duration	Trend over time (increasing is better)	67.2% Feb 2025 vs 82.4% Feb 2026 	Feb 2026	Upward (improving) trend
4 a	Acute hospital trusts' Watch + Reserve prescribing Source: Model Health System Metric: Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRe Index	Benchmarking (lower is better*)	Antibiotic prescribing (DDD): 593,198 (Q3 25/26) DDDs per 1,000 admissions 2397 (Q3 25/26)	Q3 2025/26	3 rd quartile nationally
4 b	Acute hospital trusts' Watch + Reserve prescribing Source: Model Health System Metric: Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRe Index	Trend over time (decreasing is better)	Antibiotic prescribing (DDD): 593,198 (Q3 25/26) vs 505,778 (Q3 24/25) DDDs per 1,000 admissions 2397 (Q3 25/26) vs 2762 (Q3 24/25)	Q3 25/26	Total DDDs increased but DDDs/1,000 admissions decreased
5 a	Acute hospital trusts' IV antibiotic prescribing Source: Model Health System Metric: Proportion of total antibiotic prescribing administered intravenously	Benchmarking (lower is better*)	Intravenous antibiotic prescribing DDDs: 98,631 Intravenous antibiotic DDDs /1,000 admissions/month: 1,245	Dec 2025	2 nd quartile nationally
5 b	Acute hospital trusts' IV antibiotic prescribing Source: Model Health System Metric: Proportion of total antibiotic prescribing	Trend over time (decreasing is better)	Intravenous antibiotic prescribing DDDs: 98,631 (Dec 2025) vs 99,845 (Dec 2024) Intravenous		DDDs and DDs/1000 admissions/month both decreased month on month

	administered intravenously		antibiotic DDDs /1,000 admissions/month: 1,245 (Dec 2025) vs 1,313 (Dec 2024)		
6 a	CQUIN performance data Source: FutureNHS webpage	Benchmarking	This indicator has been retired		
6 b	CQUIN performance data Source: FutureNHS webpage	Trend over time (four quarters)	This indicator has been retired		
7 a	Acute hospital trusts' blood culture pathway audit (tube fill and time to incubator) Source: Local data	Benchmarking	Data not held by ICB, work underway with Diagnostics Network		
7 b	Acute hospital trusts' blood culture pathway audit (tube fill and time to incubator) Source: Local data	Trend over time	Data not held by ICB, work underway with Diagnostics Network		

***Sensitive to case mix – benchmarking with peer group organisations recommended**

**To access AMR KPI data in Model Health System > [log on and open the home page](#) > select the relevant ICB (top right) > select Browse tab (top banner) > select *Antimicrobial Resistance* from Population Health menu

Documentary evidence of antimicrobial stewardship

	Source document and recommended elements	Met/not met	Evidence
1	ICB antimicrobial resistance strategic plan		
1.1	Ratification by senior leadership of ICB	Met	SRO AMR – Deputy Chief Clinical Officer SRO AMS – Deputy Chief Pharmacist GM AMR/IPC Improvement Plan 24-25 signed off by GM Quality and Performance Committee
1.2	Inclusion of antimicrobial stewardship	Met	GM AMR programme spans AMS, IPC and sepsis currently
1.3	Inclusion of monitoring and evaluation mechanisms	Met	GM dashboard developed to monitor GM AMR/IPC Improvement Plan 24-25
1.4	Inclusion of workforce strategy for antimicrobial stewardship (and infection prevention and control) with capacity plan, training and accreditation	Partially met	AMS training programmes undertaken in GM Workforce strategy capacity plan in relation to AMSIPC not yet undertaken
1.5	Inclusion of implementation plan with goals, priorities, delivery milestones and accountability	Met	Monitored via GM AMR Programme
1.6	Inclusion of programme of audit and feedback	Met	Overseen by Medicines Optimisation team
1.7	Allocation of financial and human resources	Met	Human resources – roles identified within NHS GM Clinical Portfolio to lead/deliver Financial resource via GM BeCCoR (GP Incentive Scheme) to support General Practice AMS improvement work
2	Board terms of reference		
2.1	Responsibility for oversight of antimicrobial resistance and stewardship assigned to named board member	Met	Chief Clinical Officer
2.2	Requirement for at least annual board review of performance against antimicrobial resistance key performance indicators	Met	Biannual reporting to QPC now SCC, with board visibility via highlight report
3	Board Assurance Framework		
3.1	Compliance assessed for infection prevention and control and antimicrobial stewardship domains [National infection prevention and control manual for England]	Partially met	Assurance of provider compliance underway via Q1 QuASMs
4	Board risk register		
4.1	Antimicrobial resistance included as risk or issue with evidence of mitigating actions taken or planned	Not met	Currently a programme level risk; action to review risk underway
5	Board minutes where antimicrobial stewardship report and antimicrobial prescribing data are presented		

5.1	Presentation of (annual) report of antimicrobial stewardship activities and accomplishments	Met	Via QPC report into Board
5.2	Accurate reporting of ICB performance, including underperformance	Met	Data included in AMR reports but also in wider NOF reporting
5.3	Presentation of ICB benchmarking with peers and trend over time compared to national targets for key performance indicators	Met	Data included in AMR reports but also in wider NOF reporting
5.4	Presentation of primary care key performance indicators by sub-ICB and presentation of secondary care indicators by trust(s)	Met	This is reviewed at GM AMR meetings in detail, reported by exception to QPC/SCC
5.5	Interpretation of data provided to the board with recommended actions and action plan, where required	Met	GM AMR/IPC Improvement Plan 24-25 and reporting against this to QPC and to be built into SCC forward plan
5.6	Evidence of accountability and action taken to investigate and address underperformance	Met	Escalation via quality routes, as evidenced by RQR for Bolton FT in relation to C. Diff
6	ICB antimicrobial stewardship committee terms of reference		
6.1	Appropriate multi-professional representation including: microbiology/infectious diseases, pharmacy, nursing, medical	Met	As evidenced by GM AMR group TOR
6.2	Adequate representation from key stakeholders in primary care and secondary care provider organisations	Met	As evidenced by GM AMR group TOR
6.3	Named ICB lead with responsibility for antimicrobial stewardship	Met	SRO AMR – Deputy Chief Clinical Officer SRO AMS – Deputy Chief Pharmacist
6.4	Adequate meeting frequency (minimum 6-monthly)	Met	GM AMR group meets every 2 months
6.5	Adequate committee oversight, governance, and reporting arrangements up to board level.	Met	Via GM clinical and quality governance structure
7	ICB antimicrobial stewardship committee risk register		
7.1	Risks and issues documented with evidence of mitigating actions	Partially met	Programme risk – identified as needing review
8	ICB antimicrobial stewardship committee minutes		
8.1	Attendance by core antimicrobial stewardship multi-professional team and representation from healthcare provider organisations	Met	As evidenced by TOR and minutes
8.2	Meaningful review of ICB performance, including underperformance	Met	As evidenced by wider ICB performance score card which includes AMR/AMS/IPC
8.3	Review of ICB benchmarking with peers and trend over time compared to national targets for key performance indicators	Met	Supported by regional leads in attendance at GM AMR group
8.4	Review of primary care key performance indicators by sub-ICB (and primary care network) and presentation of secondary care key performance indicators by trust(s)	Met	As evidenced through AMS group and also evidence review in BeCCoR GP AMS scheme development
8.5	Review of focussed audit or point prevalence survey reports	Partially met	Audits undertaken by meds opt team – identified as area to strengthen
8.6	Interpretation of data is documented with recommended actions and action plan where required to investigate and address any underperformance	Met	Evidenced by escalation into LAMs (previously) and QuASMs/contract meetings

9	ICB antimicrobial stewardship committee action plan		
9.1	Evidence of actions completed and underway, with milestones and accountability	Met	Programme plan in place
9.2	Local needs and inequalities considered as part of planned actions	Partially met	Ongoing work with local Directors of Public Health to strengthen this

Key informant evidence

Key informants and lines of enquiry		Evidence
1	ICB board member with nominated responsibility for antimicrobial resistance	
1.1	Awareness of ICB antimicrobial resistance and stewardship leads	
1.2	Awareness of ICB performance against antimicrobial prescribing key performance indicators	
1.3	Assurance of priority level of improving quality of antimicrobial prescribing and antimicrobial stewardship	
1.4	Knowledge of ICB antimicrobial resistance risks and actions being taken to address them	
2	ICB medical director	
2.1	Awareness of ICB antimicrobial resistance and stewardship leads	
2.2	Awareness of ICB performance against antimicrobial prescribing key performance indicators	
2.3	Assurance of priority level of improving quality of antimicrobial prescribing and antimicrobial stewardship	
2.4	Knowledge of ICB antimicrobial resistance risks and actions being taken to address them, and mechanism in place to escalate concerns to the ICB board	
3	ICB antimicrobial resistance senior responsible officer	
3.1	Assurance of sufficient capacity and capability to undertake role (protected time and training/qualifications)	
3.2	Awareness of ICB performance against antimicrobial prescribing key performance indicators	
3.3	Assurance of priority level of improving quality of antimicrobial prescribing and antimicrobial stewardship	
3.4	Knowledge of ICB antimicrobial resistance risks and actions being taken to address them, and mechanism in place to escalate concerns to the medical director	
4	ICB nominated lead for antimicrobial stewardship	
4.1	Sufficient capacity and capability to undertake role (protected time and training or qualifications)	
4.2	Awareness of ICB performance against antimicrobial prescribing key performance indicators	
4.3	Adequate senior leadership engagement and support	
4.4	Effective microbiology/infectious diseases collaboration, engagement and support	
4.5	Effective infection prevention and control collaboration, engagement and support	
4.6	Adequate healthcare provider organisation engagement and action	
4.7	Appraisal and personal development plan in place	

4.8

Knowledge of ICB antimicrobial resistance risks and actions being taken to address them, and mechanism in place to escalate to the ICB antimicrobial resistance senior responsible officer

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Appendix 2: Glossary of terms and abbreviations

This glossary explains the abbreviations and technical terms used in this report in plain English. It is intended to help readers who are not familiar with NHS, commissioning, infection prevention or antimicrobial stewardship terminology.

Abbreviation or term	Full term	What this means in plain English
AMR	Antimicrobial Resistance	This happens when bacteria, viruses, fungi or parasites no longer respond well to medicines used to treat them. In this report, the main focus is on bacteria becoming harder to treat with antibiotics.
AMS	Antimicrobial Stewardship	The work done to make sure antibiotics and other antimicrobial medicines are used only when needed, in the right way, for the right length of time.
AWaRe	Access, Watch, Reserve	A WHO classification that groups antibiotics by how they should ideally be used. “Watch” and “Reserve” antibiotics are generally higher risk for resistance and should be used more carefully.
BAF	Board Assurance Framework	A formal way for a board to understand the main risks it faces, how those risks are being managed and where more action is needed.
BeCCoR	Local incentive or improvement scheme name used in Greater Manchester	A Greater Manchester scheme used to support improvement work in general practice, including antimicrobial stewardship. The report references it as a practical lever for change.
Benchmarking	Comparison of performance	This means comparing one organisation or area with others, or with a target, to see how well it is doing.
Broad-spectrum antibiotics	Antibiotics that work against many different bacteria	These antibiotics can treat a wide range of infections but using them too often can increase the risk of resistance.
C. difficile	<i>Clostridioides difficile</i>	A bacteria that can cause severe diarrhoea and bowel problems, often linked to recent antibiotic use or healthcare contact.
Dashboard	Summary view of key information	A dashboard brings together important measures and trends in one place so performance can be reviewed quickly.
DDD	Defined Daily Dose	A standard measurement used to compare medicine use across places and time. It does not mean the exact dose given to each patient.
E. coli	<i>Escherichia coli</i>	A type of bacteria commonly found in the gut. Most types are harmless, but some can cause infections, including urinary tract infections and bloodstream infections.
ESPAUR	English Surveillance Programme for Antimicrobial Utilisation and Resistance	A national report that tracks how antibiotics are used and how resistance is changing across England. It helps systems compare their performance with national expectations.
GNBSI	Gram-negative Bloodstream Infection	A serious infection where certain types of bacteria enter the bloodstream. These infections can lead to severe illness and need urgent treatment.
GP	General Practice / General Practitioner	Primary care services delivered in the community, usually by family doctors and their teams.
HCAI	Healthcare-Associated	An infection that someone develops while receiving care

	Infection	in a hospital or other healthcare setting.
ICB	Integrated Care Board	The NHS organisation responsible for planning and funding most health services for a local area. In this document, it refers to NHS Greater Manchester.
IPC	Infection Prevention and Control	Policies and actions that prevent infections from spreading in healthcare and community settings, such as hand hygiene, cleaning and isolation arrangements.
IPAP-UTI	Improving Primary Care Antibiotic Prescribing for Urinary Tract Infection	A research study running in Greater Manchester that is testing whether changing how antibiotics are prescribed for urinary tract infections in primary care can help reduce antimicrobial resistance.
IV	Intravenous	Medicine given directly into a vein, usually through a drip or injection.
IV-to-oral switch	Changing from intravenous to oral medicine	This means changing a patient from medicine given into a vein to tablets or liquid taken by mouth when it is safe and appropriate to do so.
Klebsiella spp.	<i>Klebsiella</i> species	A group of bacteria that can cause infections, especially in people who are unwell or receiving healthcare. They can cause chest, urine or bloodstream infections and may be resistant to some antibiotics.
KPI	Key Performance Indicator	A measurable indicator used to track whether an organisation is meeting its goals or standards.
LAM	Locality Assurance Meeting	A meeting used to review assurance and performance issues at locality level. It appears in the appendix as part of earlier governance arrangements.
Model Health System	NHS benchmarking and improvement platform	A national NHS tool that shows performance data and comparisons to help organisations understand where improvement is needed.
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>	A type of bacteria that is resistant to some commonly used antibiotics, making infections harder to treat.
NAP	National Action Plan	The national plan setting out how the UK will tackle antimicrobial resistance over a defined period.
NCA	Northern Care Alliance NHS Foundation Trust	An NHS provider organisation in Greater Manchester and nearby areas, running hospital and community services.
NHS GM	NHS Greater Manchester	The NHS body serving Greater Manchester, including its commissioning and improvement responsibilities.
NHSBSA	NHS Business Services Authority	An NHS organisation that provides national business support services, including some of the prescribing data used for benchmarking.
NOF	National Oversight Framework	The NHS England framework used to monitor how organisations are performing against national standards and priorities.
OPAT	Outpatient Parenteral Antimicrobial Therapy	Giving antibiotics by injection or infusion without keeping the patient in hospital overnight, usually through outpatient or community services.
Outbreak	A sudden increase in cases of infection	An outbreak is when more people than expected develop the same infection in a place or group over a short time.
<i>P. aeruginosa</i>	<i>Pseudomonas aeruginosa</i>	A type of bacteria that can cause serious infections, particularly in people who are already ill or in hospital. It can affect the lungs, wounds, urine or bloodstream and can be difficult to treat because it is often resistant to

		antibiotics.
Q1 / Q2 / Q3	Quarter 1 / Quarter 2 / Quarter 3	Three-month periods used for planning and reporting during the financial year.
QPC	Quality and Performance Committee	A former or related committee referred to in the appendix evidence, responsible for oversight of quality and performance matters.
QuASM	Quality Assurance and Safety Meeting	A meeting used to review quality and safety issues with providers, including concerns, risks and progress on improvement actions.
RQR	Rapid Quality Review	A focused review used when there are concerns about quality or safety and a quicker, structured response is needed.
Safety-netting	Advice on what to do if symptoms change or worsen	This means giving people clear advice about when to seek more help, especially if they do not improve as expected.
SCC	Strategic Commissioning Committee	A committee that reviews and makes decisions about strategic commissioning issues. This report is being presented to that committee or group.
Sepsis	A life-threatening reaction to infection	Sepsis happens when the body's response to an infection damages its own tissues and organs. It is a medical emergency.
SRO	Senior Responsible Officer	The senior person accountable for leading a programme of work and making sure it is delivered.
STAR-PU	Specific Therapeutic group Age-sex Related Prescribing Unit	A way of adjusting prescribing data to account for differences in the age and sex of the population, so fairer comparisons can be made between areas.
Surveillance	Ongoing monitoring of data	This means regularly collecting and reviewing information to understand trends, spot risks and guide action.
TB	Tuberculosis	An infectious disease, usually affecting the lungs, caused by bacteria. It requires careful public health and clinical management.
UKHSA	UK Health Security Agency	The national public health body responsible for health protection, including surveillance and guidance on infections and antimicrobial resistance.
UTI	Urinary Tract Infection	An infection in part of the urinary system, such as the bladder. These are common and can lead to antibiotic use and, if not managed well, complications.
WHO	World Health Organization	The United Nations agency for international public health. It provides global guidance on issues such as antimicrobial resistance.
WWL	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	An NHS provider organisation mentioned in the report in relation to provider assurance returns.