NHS
Greater Manchester

# Agenda

## Greater Manchester Strategic Commissioning Committee (Public)

Date: 5 August 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 –<br><br>Attendance Matrix & Terms of Reference on a Page | Verbal<br><br>Paper | Information | Rachel Egan *Chair* |
| 2. | | | Declarations of Interest | Paper | Noting | |
| 3. | | | Minutes, matters arising and actions from previous meeting held on 1 July 2026 | Paper | Approval | |
| **Strategic Updates** | | | | | | |
| 4. | 14:05<br><br>14:25<br><br>14:45<br><br>14:55 | 60 mins | Chief Officers Update Reports:<br>• Chief Clinical Officer Report<br>• Chief Commissioning Officer Report<br>• Chief Reform and Improvement Officer Report<br>• Chief Strategy, People and Partnerships Report | Paper | Discussion | Manisha Kumar, *Chief Medical 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* |
| 5. | 15:05 | 10 mins | Performance Report | Paper | Information | Nicola Hepburn, *Acting Chief Reform and Improvement Officer* |
| 6. | 15:15 | 15 mins | Socio-economic Duty Implementation | Paper | Information | David Boulger, *Associate Director -* |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | *Population Health* / Rachael Nielsen, *Strategic Lead – Population Health* |
| 7. | 15:30 | 20 mins | A Briefing on Donna Ockenden's Review into Nottingham UHT Maternity Services & Baroness Amos's Review of Maternity & Neonatal Services in England, July 2026 | Paper | Information | Sarah Owen, *Associate Director of Maternity Assurance (ICB/LMNS)* |
| **For Information** | | | | | | |
| | 15:50 | 10 mins | Any other business<br>Board Paper Escalations<br>Meeting Reflections | Verbal | Discussion | All |
| Date and time of next meeting:<br>**Wednesday 2 September 2026, 14:00pm – 16:00pm**<br>**MS Teams** | | | | | | |

## Strategic Commissioning Committee Attendance Matrix from April 2026

**Key:**

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

| *Member* | *Title* | *Apr-26* | *May-26* | *Jun-26* | *Jul-26* | *Aug-26* |
|---|---|---|---|---|---|---|
| Dame Sue Bailey | Non Executive Director (Chair of SCC) | | | | | |
| Rachel Egan | Non Executive Director | | | | | |
| Jackie Njoroge | Deputy Chair/Senior Independent Director | | | | | |
| Leigh Vallance | NHS GM Partner Member | | | | | |
| Manisha Kumar | Chief Clinical Officer | | | | | |
| Katherine Sheerin | Chief Commissioning Officer | | | | | |
| Nicola Hepburn | Chief Reform and Improvement Officer | | | | | |
| Charlotte Bailey | Chief Strategy, People and Partnerships Officer | | | | | |
| ***Attendee*** | | | | | | |
| Chris Gaffey | Associate Director of Corporate Services | | | | | |
| Ben Squires | Director of Primary Care (deputising for Katherine Sheerin) | | | | | |
| Paul Lynch | Director of Strategy | | | | | |
| Kathy Roe | Chief Finance Officer | | | | | |
| Melissa Maguinnes | Programme Director Commissioning Development | | | | | |
| Chris Gresty | Analytical Lead, Corporate Services, Digital Insight and Intelligence | | | | | |
| Jim Ritchie | Deputy Chief Clinical Officer | | | | | |
| Sam Evans | Corporate Director of Finance – Commissioning & Financial Assurance (deputising for Kathy Roe) | | | | | |
| Warren Heppolette | Prevention Demonstrator Director, GMCA | | | | | |
| Stephen Downs | Deputy Chief Finance Officer | | | | Deputising for Kathy Roe | |
| Ed Dyson | Director of Performance, Improvement & Assurance | | | | Deputising for Nicola Hepburn | |
| David Boulger | Associate Director - Population Health | | | | | |
| Claire Lake | Deputy Chief Medical Officer | | | | Deputising for Manisha Kumar | |

# Terms of Reference on a page

NHS Greater Manchester

## Purpose

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

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

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

## Key duties

**Strategic Commissioning**

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

**Other key duties:**

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

**Other duties**

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

## Membership

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

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

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

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

NHS Greater Manchester

# Minutes

## Greater Manchester Strategic Commissioning Committee

Date: 1 July 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

## (Public)

| Present | Apologies |
|---|---|
| **In attendance:**<br>Dame Sue Bailey (SB) – Non-Executive Director (Chair)<br>Rachel Egan (RE) – Non-Executive Director<br>Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer<br>Leigh Vallance (LV) – VCSE Partner Member<br>Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer<br>Stephen Downs (SD) – Deputy Chief Finance Officer<br>Ed Dyson (ED) – Director of Performance, Improvement & Assurance, deputising for Nicola Hepburn<br>Claire Lake (CL) - Deputy Chief Medical Officer (item 5)<br>Mark Green (MG) – Director, Oka People<br>David Boulger (DB) - Associate Director - Population Health (item 7)<br>Faye Vaughan (FV) – Governance Advisor (Minutes) | Prof. Manisha Kumar (MK) – Chief Clinical Officer<br>Kathy Roe (KR) - Chief Finance Officer<br>Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer |

| Item No. | Topic | Action |
|---|---|---|
| 1. | **Welcome, Introductions and Apologies**<br><br>SB welcomed everyone to the meeting, introductions were made, and the above apologies were noted. | |
| 2. | **Declarations of Interest**<br><br>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 3 June 2026**<br><br>The minutes were accepted as a true record of the previous meeting held on 3 June 2026. | |
| 4. | **Financial Scheme of Delegation Approval & Reporting Key Financial Decisions Over £5M** | |



4th Floor, Piccadilly Place, Manchester M1 3BN
**Tel:** 0161 742 6023 **www.**gmintegratedcare.org.uk

| | | |
|---|---|---|
| | This paper outlined the Financial Scheme of Delegation to be assigned to the committee and the process of reporting key financial decisions above £5m.<br><br>The committee were made aware that the paper had been approved by the People & Resources Committee on 24 June 2026.<br><br>LV highlighted concerns around processing capacity for lower value approvals and sought assurance that sufficient resources existed to avoid delays. SD explained that the current STAR process was a transitional arrangement, with plans to update once financial stability improved.<br><br>KS raised the need to clarify the reporting and approval flow for primary care investments, particularly those that involved public health funding, noting that the current flowchart may not capture all necessary steps.<br><br>**ACTION:** KS & SD to review and amend the financial delegation process flow chart if necessary to ensure the correct route for primary care was in place.<br><br>**The Committee:**<br>• **Noted the contents of the paper.** | **KS / SD** |
| 5. | **Chief Officers Update Reports:**<br><br><u>Chief Clinical Officer Report:</u><br><br>The report provided an update on key clinical governance, quality, patient safety, safeguarding, medicines optimisation and service improvement matters across Greater Manchester. It set out issues that required attention through the Alert, Advise and Assure framework, including GP collective action linked to data sharing, provider quality and oversight matters, safeguarding developments arising from new statutory requirements, mental health and maternity updates, health protection, outbreak management and resident doctor industrial action. The report also summarised items considered by the Clinical Effectiveness and Governance Committee, highlighting those that required committee approval and those presented for assurance or noting.<br><br>CL reported on the three main alerts in the report:<br>- GP collective action: It was reported that there was no withdrawal of data sharing at present.<br>- Supreme Court Judgement: The committee were made aware that it was regarding deprivation of liberty authorisations. It was confirmed that safeguarding teams would be provided appropriate training.<br>- Closure of Laureate House Mental Health Facility: It was reported that this had reduced system bed capacity and required relocation of services.<br><br>The committee approved and supported the recommendations from the Clinical Effectiveness and Governance (CEG) report.<br><br>**The Committee:**<br>• **Noted the contents of the report.**<br>• **Approved the items within the report that require Committee approval.**<br>• **Noted / endorsed the remaining items that have progressed through established governance routes and do not require further Committee decision.** | |



4th Floor, Piccadilly Place, Manchester M1 3BN
**Tel:** 0161 742 6023 **www.**gmintegratedcare.org.uk

| | | |
|---|---|---|
| | Chief Commissioning Officer Report:<br><br>The paper set out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate.<br><br>KS outlined the approved public consultation on centralising specialist cardiac and vascular surgery, including adjustments to consultation timelines following scrutiny by the Health Overview, Scrutiny Committee and NHS England Assurance.<br><br>KS detailed the submission and approval of SEND reform plans across local authorities, the positive outcome of Bury's re-inspection and upcoming inspections in Salford and Stockport.<br><br>Progress on the Office of Pan ICB Commissioning (OPIC) was discussed, with plans to bring further updates to the committee in the future.<br><br>**The Committee:**<br>• **Noted the report.**<br><br>Chief Reform and Improvement Officer Report:<br><br>The report highlighted the key areas of assurance and oversight from the Reform & Improvement portfolio.<br><br>There were no alerts in the report.<br><br>ED presented data that showed Greater Manchester benchmarked poorly for overall 12-hour waits but better for high-acuity patients. Notably, it was reported that 22% of long-wait patients were not admitted and age was the primary demographic factor associated with long waits.<br><br>The committee highlighted the high mortality rate within 30 days for patients experiencing 12-hour waits, particularly those at end-of-life, prompting discussion on the need for better advanced care planning and system-wide targets to reduce such occurrences.<br><br>The committee further questioned the impact of senior decision-making delays and complexity of patient needs on long waits, suggesting further analysis to identify preventable factors and improve admission avoidance strategies.<br><br>LV declared an interest in the item as CEO of Bolton Hospice.<br><br>**ACTION:** ED, CL, NH, LV, DB to collaborate on a system wide action plan, including reviewing successful interventions at MFT for scalability and developing targeted quality improvement initiatives. Update to be provided at a future meeting.<br><br>**The Committee:**<br>• **Noted the report and the position as of M3.**<br><br>Chief Strategy, People and Partnerships Report:<br><br>The paper informed the committee of the key priorities, risks and mitigations relating to Live Well, Population Health Transformation, Place Partnerships development and Neighbourhood health plans. | **ED / CL / NH / LV / DB** |



4th Floor, Piccadilly Place, Manchester M1 3BN
**Tel:** 0161 742 6023 **www.**gmintegratedcare.org.uk

| | | |
|---|---|---|
| | There were no alerts or advise in the report.<br><br>The committee were made aware that the Neighbourhood Health engagement programme had closed. CB explained that they had met with 15 stakeholder groups and 150 colleagues during the online sessions. A meeting had taken place that week with the Senior Leadership Group to present the findings from the engagement and share the first draft of the Neighbourhood Health Model.<br><br>**The Committee:**<br>• **Noted the report.** | |
| 6. | **Performance Report**<br><br>The report provided an update on Greater Manchesters progress in achieving NHS operational planning goals, outlining significant risks faced by providers along with key improvement actions.<br><br>It was explained that MFT had improved from segment 3 to segment 1, indicating sustained progress, while Wrightington, Wigan and Leigh had moved from segment 4 to 3. NCA and GM remained in segment 4, facing ongoing challenges and additional regulatory oversight.<br><br>It was reported that Pennine Care had moved to segment 4 due to staff survey results and service responsiveness, despite a positive well-led CQC rating, highlighting the distinction between performance outcomes and leadership quality.<br><br>LV highlighted the correlation between financial performance and quality outcomes. It was noted that the NOF now placed greater emphasis on quality in regulatory oversight.<br><br>The committee agreed to a status of partial assurance, recognising improvements but noting that key alert metrics remained in critical areas such as A&E and UEC, and emphasised the importance of sharing learning across trusts.<br><br>**The Committee:**<br>• **Noted the report.** | |
| 7. | **GM Public Health Network Transformation - Quarterly Update**<br><br>The report provided an update on the Population Health transformation programme including progress to date and key next steps.<br><br>CB described the three-phase approach: a shadow year with a single leadership team, followed by a section 75 agreement with Manchester City Council to host the network and a final phase integrating management teams and resources. It was reported that they were in the first phase at present until September 2026.<br><br>DB highlighted Greater Manchester's track record in public health initiatives, such as reducing smoking prevalence and supporting people with HIV, but noted persistent inequalities and declining healthy life expectancy as drivers for further integration.<br><br>RE raised questions around potential vulnerabilities due to changes at Manchester City Council and GMCA. Assurance was provided that robust due diligence and legal frameworks were in place to mitigate risks. | |



4th Floor, Piccadilly Place, Manchester M1 3BN
**Tel:** 0161 742 6023 **www.**gmintegratedcare.org.uk

| | | |
|---|---|---|
| | The need for measurable metrics to track reductions in health disparities, with agreement to embed such metrics in future Chief Officer reports and the main performance dashboard was raised.<br><br>**The Committee:**<br>• **Noted the content of the report and the progress made to date.**<br>• **Agreed to receive the initial s75 for approval in September 2026.** | |
| 8. | **Any other business**<br><br>None were raised. | |



4th Floor, Piccadilly Place, Manchester M1 3BN
**Tel:** 0161 742 6023 **www.**gmintegratedcare.org.uk

**Actions Log: Strategic Commissioning Committee**

| No | Date | Section | Details of the issue | Details of action agreed | Action Lead | Completion Date | Status | Further Detail |
|---|---|---|---|---|---|---|---|---|
| SCC-07 | 02/07/2026 | 5. Chief Officers Update Reports - Chief Reform and Improvement Officer Report | Committee suggestion to collaborate on a system wide action plan. | ED, CL, NH, LV, DB to collaborate on a system wide action plan, including reviewing successful interventions at MFT for scalability and developing targeted quality improvement initiatives. Update to be provided at a future meeting. | Ed Dyson | 07/10/2026 | In progress | Claire Lake / Leigh Vallance / David Boulger supporting. |
| **Completed at Previous Meeting (Audit Trail)** | | | | | | | | |
| SCC-06 | 02/07/2026 | 4. Financial Scheme of Delegation Approval & Reporting Key Financial Decisions Over £5M | The need to clarify the reporting and approval flow for primary care investments, particularly those that involved public health funding, noting that the current flowchart may not capture all necessary steps. | KS & SD to review and amend the financial delegation process flow chart if necessary to ensure the correct route for primary care was in place. | Katherine Sheerin / Stephen Downs | 31/07/2026 | Closed | 10/07: PCC has not delegated authority and spent follows the FSOD through STAR, COs etc |

NHS
Greater Manchester

# Chief Clinical Officer Report

## August 2026

Part of Greater Manchester
Integrated Care Partnership

**NHS Greater Manchester Strategic Commissioning Committee**

**August 2026**

| Required information | Details |
|---|---|
| **Title of report** | Chief Clinical Officer Report |
| **Author** | Claire Lake, Deputy Chief Clinical Officer (Medical)<br>Jim Ritchie, Deputy Chief Clinical Officer (Medical-Secondary Care, Chief Clinical Information Officer)<br>Kenny Li, Chief Pharmacist<br>Melissa Maguinness, Director of Integrated Clinical Strategy and Transformation<br>Anita Rolfe, Deputy Chief Clinical Officer (Nursing and Nurse Advisor to the board)<br>Laura French, Public Health Consultant<br>Claire Smith, Associate Director Nursing and Quality Assurance<br>Kate Provan, Associate Director of Clinical Governance, and Improvement<br>Claire Foster, Deputy Chief Pharmacist<br>Heather Myers, Head of Clinical Effectiveness and Governance<br>Amy Ashton, Associate Director, Lead for Screening and Immunisations<br>Amy Jefferey, Quality Manager |
| **Presented by** | Professor Manisha Kumar, Chief Clinical Officer, NHS GM |
| **Contact for further information** | Kate.provan@nhs.net |
| **Executive summary** | This Chief Clinical Officer Report provides an update on key clinical governance, quality, patient safety, medicines optimisation, maternity and neonatal oversight, major trauma transformation, child health information services and wider system improvement matters across Greater Manchester. It sets out areas requiring attention through the Alert, Advise and Assure framework, including NHS England draft enforcement undertakings for Northern Care Alliance NHS Foundation Trust, continuing quality and safety oversight of Greater Manchester Mental Health NHS Foundation Trust, system pressures affecting quality and patient safety, national maternity and neonatal reviews, and Maternity Outcomes Signal System notifications. The report also provides assurance on the Child Health Information Service transition arrangements, maternity and neonatal board development work, learning from the Greater Manchester Inclusive Research Network, provider achievements reported through Quality Review Meetings, and items considered by the Clinical Effectiveness and Governance Committee requiring Strategic Commissioning Committee approval, noting or endorsement. |
| **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 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 presented to Strategic Commissioning Committee and draws together intelligence, assurance updates and recommendations from NHS GM Clinical Effectiveness and Governance groups and related subgroups, the Greater Manchester Medicines Management Group, NHS GM Clinical Policy Audit and Standards Group, the Mental Health Partnership Group, and other established quality and clinical governance routes. |
| **Engagement* to date**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | There has been no separate formal engagement specifically on this cover report, as it brings together assurance, oversight and decision items already developed through established NHS GM governance routes. Clinical engagement has taken place through the relevant committees, subgroups and provider oversight arrangements referenced within the paper. Equality, financial, legal and sustainability considerations are reflected within the underlying work and approvals described in the report where relevant. |

| | |
|---|---|
| **Financial or Legal Implications;** | The report includes a small number of items with financial implications, which are clearly set out in the relevant sections of the report. These include medicines and formulary decisions, Child Health Information Service transition arrangements, and the extension of the existing MHIPs service to support complex rehabilitation patients. Any required financial approval or oversight will be progressed through the established governance routes described in the report.<br>Legal and regulatory implications are reflected through NHS GM's statutory duties, NICE technology appraisal obligations, commissioning responsibilities, medicines governance processes, data sharing and digital information governance requirements, and quality oversight arrangements. The most significant regulatory issue relates to NHS England draft enforcement undertakings for Northern Care Alliance NHS Foundation Trust following sustained quality governance concerns. The report also notes national transition arrangements for the Child Health Information Service in response to the planned abolition of Commissioning Support Units, and emerging maternity and neonatal quality oversight risks linked to national reviews, NHS England expectations and NHS Reform. No additional legal implications requiring separate Committee action have been identified beyond the approvals, assurance and oversight routes set out in 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

### Northern Care Alliance NHS Foundation Trust (NCA) NHS England Undertakings

NHS England has determined that the Trust is experiencing a fundamental failure of quality governance, with sustained concerns over 18 months relating to spinal surgery, gynaecology, and surgical wards. The Enforcement Undertakings state that the Trust is “unable to provide assurance… that the organisation has a clear and consistent quality governance structure… that will ensure no further patients may suffer harm”.

**Regulatory Trigger**
Concerns have escalated to formal action following repeated incidents, inconsistent risk identification, slow improvement pace, and the Care Quality Commission (CQC) Section 29A* Warning Notice (October 2025) confirming significant deficits in staffing, risk management and safety oversight.
*Section 29A of the Health and Social Care Act 2008 allows the CQC to issue a written warning notice to an NHS trust when it identifies that the quality of healthcare requires significant improvement.

NCA have advised that improvements have been made in addressing historic concerns across gynaecology, spinal services, and wider governance arrangements, with evidence of strengthened multidisciplinary team (MDT) working, improved accreditation processes, and enhanced clinical leadership. Despite this progress, spinal services remain an area requiring heightened scrutiny, with ongoing external review, system-wide action planning, and continued regulatory interest. Additionally, data quality concerns in gynaecology and outstanding Health Care Associated Infection (HCAI) communication assurance actions require focused attention. Continued cross-system collaboration, robust monitoring, and transparent reporting will be critical in consolidating improvements and rebuilding confidence in these high-risk service areas.

**Mitigation**
NHS England has issued Enforcement Undertakings requiring:

- Delivery of all Good Governance Institute (GGI) quality governance recommendations (43 total).
- Full compliance with the CQC Section 29A Warning Notice within mandated timeframes.
- Completion and embedding of all Rapid Quality Review (RQR)-related actions across spinal, gynaecology and other incident areas.
- Strengthened oversight through monthly reporting, performance meetings, and provision of assurance evidence on request.

**Residual Risk**
Residual risk remains high, as improvements are not yet embedded or evidenced as sustainable. The Trust is still unable to demonstrate reliable systems for early risk identification and mitigation. Continued exposure to patient safety harm, reputational damage, and further regulatory escalation (including potential licence action) remains likely until governance structures are proven effective.

NHS England are in the process of agreeing the oversight arrangements that will oversee the progress against the undertakings which the ICB will be connected into. The ICB Quality Review Meetings will continue with a focus on delivery of the Quality schedule of the contract.

### Greater Manchester Mental Health NHS Foundation Trust (GMMH) Laureate House – Service Disruption and Patient Safety Impact

Laureate House GMMH (on the Wythenshawe Hospital site, part of Manchester University NHS Foundation Trust [MFT]) provides specialist inpatient mental health services, including adult acute wards, female Psychiatric Intensive Care Unit (PICU) beds and specialist post-natal care for new mothers experiencing mental health crisis.

Due to significant estate issues the 56 inpatient mental health beds at the site have been closed since February. This has required patients to be repatriated to Greater Manchester Mental Health NHS Foundation Trust (GMMH) wards, reducing overall system capacity and placing sustained pressure on inpatient services and patient flow. This has also negatively impacted the financial position through a reduction in the Mental Health Investment Fund (MHIF) as the use of Local Spot Placements had needed to continue and the plans to commence the phased reduction in use of the North Westy Bed Bureau beds have not been able to be enacted.

Works required to enable the wards to safely reopen have still not yet commenced by Sodexo (with whom MFT holds the contract) and are anticipated to take up to 29 weeks once underway. This situation continues to represent a risk to patient safety, system resilience, service delivery and has significant negative financial implications. This has been escalated to Chief Executive level with meetings taking place to ensure that the plans to deliver the required works are overseen at senior level.

## Advise

### Greater Manchester Mental Health NHS Foundation Trust (GMMH) Quality Review Meeting (QRM) escalations

GMMH continues to strengthen its governance, safeguarding arrangements, and incident-learning processes, with notable improvements in review timeliness and organisational openness. However, several areas require sustained oversight, including the Trust's outlier position in fatal harm incidents reported on the Learn from Patient Safety Events Service (LFPSE), ongoing safeguarding compliance gaps, and significant pressures within Psychiatric Intensive Care Unit (PICU) capacity. Continued organisational focus is noted on specific patient safety issues, with multiple investigations underway and learning still emerging. Addressing these risks will require coordinated system support, strengthened workforce and flow pathways, and continued assurance around safety, governance, and family engagement. The trust has described the plans to improve these areas and follow up conversations are planned via the Quality Review Meetings to monitor and assure progress.

### Maternity and Neonatal Programme Greater Manchester

Greater Manchester Local Maternity and Neonatal System (LMNS) on behalf of the Integrated Care Board (ICB) has received and reviewed the two significant National Reviews:

- Independent National Maternity and Neonatal Investigation led by Baroness Valerie Amos, published 30th June 2026
- Independent review into maternity services at Nottingham University Hospitals NHS Trust led by Donna Ockenden, published 24th June 2026

A briefing paper has been presented to Chief Officers highlighting the requirements of the NHS England 10 Point Plan for Maternity & Neonatal Services prior to the full action plan to address the recommendations due for publication by the National Maternity and Neonatal Taskforce in December 2026.

There is a stand-alone agenda item on the agenda this time to provide a more detailed briefing to

the committee on the National enquiries.

**Manchester University NHS Foundation Trust (MFT) (North Manchester Site) and Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT)**

Both Maternity providers received a 'Maternity Outcomes Signal System (MOSS) Signal' in July. A MOSS signal is an NHS England early warning alert that identifies a potential area of concern and triggers a structured review of the event alongside a wider assessment of intrapartum services using a standardised checklist. The findings are reported to the Trust Board and the NHS England Regional Maternity Team (including the ICB) within eight working days, providing assurance that any potential risks have been thoroughly investigated and that any necessary actions are identified and addressed.

At the time of writing this report the MFT review was fully complete and reported on, with no concerns identified. TGICFT has a further five working days to respond, however conversations with the Director of Midwifery have not highlighted any concerns.

The committee is asked to note the receipt of this safety signal and the assurance provided by the trust to both the ICB and the Regional Team of the safety of their maternity service.

**Assure**

**South, Central and West (SCW) Commissioning Support Unit (CSU) - Child Health Information Service (CHIS)**

The Child Health Information Service is a critical statutory service that supports safe and effective immunisation and screening programmes for children across Greater Manchester and provides an active, accurate care record for each child. The update is intended to provide assurance that, although national reforms will abolish Commissioning Support Units from December 2027, an interim national transition arrangement has been agreed to maintain continuity of the current SCW CHIS service while a longer-term compliant procurement route is developed.

NHS England (NHSE), through NHS Greater Manchester's embedded Section 7A Screening and Immunisation Team, commissions the South, Central and West (SCW) Commissioning Support Unit (CSU) to deliver the mandated Child Health Information Service (CHIS). CHIS provides a single, comprehensive child health record by collating statutory immunisation and screening data for all children aged 0–19 across Greater Manchester.

The NHS SCW CHIS plays a critical role in ensuring that every child has an accurate and up-to-date immunisation and screening record to 16 Integrated Care Systems (ICSs) across England, supporting approximately 4.29 million children aged 0–19. GM ICB procured the CHIS contract in 2022, awarding a six-year contract (1 December 2023 to 30 November 2029), with an optional three-year extension to 2032. The annual contract value for the Greater Manchester contract in 2026–27 is £4,724,230.

CSUs were established in April 2013 under the Health and Social Care Act 2012 as arm's length bodies of NHSE. However, under current NHS reforms, CSUs will be abolished in December 2027. Executives at the Department of Health and Social Care (DHSC) and NHSE have approved the interim national solution proposed and previously brought as an item to Chief Clinical Officers to transfer all SCW CHIS contracts into NHSE and then the DHSC (with the Business Services Authority continuing to employ the staff) until at least 2029, while a compliant procurement process is designed and implemented.

There is no immediate action required from SCC, but members should note the national transition arrangements and the importance of maintaining CHIS continuity for GM children

**Maternity and Neonatal Programme – Wrightington, Wigan and Leigh NHS Foundation Trust (WWL)**

GM LMNS were invited by the WWL Trust Board to support on a full day Board Development Session which they had dedicated to Maternity and Neonatal Services.
The Associate Director of Maternity and GM LMNS Clinical Data Lead presented and supported discussions on:

- Latest National Reports (Ockenden and Amos)
- Seeking Assurance from your Perinatal Leadership Team
- Culture within Maternity and Neonatal Services
- Horizon Scanning of expected National Reports and Recommendations
- Quality and Safety within Maternity and Neonatal Services
- Using Data to underpin Assurance

**Summary of items considered at CEG (July 2026)**

The Clinical Effectiveness and Governance (CEG) Committee met in July 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

*NICE TA stands for National Institute for Health and Care Excellence technology appraisal. Technology appraisal (TA) guidance makes recommendations on the use of new and existing medicines and other treatments within the NHS. The NHS is legally obliged to fund and resource medicines and other treatments recommended by TAs.

| Ref | CEG paper/Item | Description | Instruction to SCC |
|---|---|---|---|
| **Greater Manchester Medicines Management Group Summary of Decisions of Approval** | | | |
| 07-01 | Sulfasalzine 500mg tablets, 500mg GR tablets, and 250mg/5ml oral suspension for the management of Chron's disease and ulcerative colitis in patients over 2 years. | To be added to formulary as a shared care medicine where prescribing responsibilities shared between specialist and primary care, in line with a shared care protocol pending approval. Estimated financial impact £3K-£45K in primary care | Approve addition to the GMMMG formulary pending approval of a shared care protocol, following clinical approval by CEG |
| 07-02 | NICE TA1140: Ruxolitinib cream for treating non-segmental vitiligo | To be added to the formulary for specialist prescribing, commissioned by the ICB. Estimated financial impact for NHS GM over 3 years £7.3M. | Approve addition to the GMMMG formulary, following approval by CEG. |

| | | | |
|---|---|---|---|
| | in people 12 years and over published 17/03/26. | | |
| 07-03 | NICE TA1142: Dupilumab for maintenance treatment of uncontrolled chronic obstructive pulmonary disease with raised blood eosinophils published 26/03/26 | Already on formulary for specialist prescribing for severe asthma (NHSE-commissioned) and atopic dermatitis (ICB-commissioned). To Add to formulary as a RED drug for this condition, with links to TA1142. Estimated financial impact over 3 years £6.2M. Further work needed across NHS GM to support system readiness for implementation of NICE TA, for example work force and delivery method. | Approve addition to the GMMMG formulary, following CEG. |
| 07-04 | NICE TA1107: Delgocitinib for treating moderate to severe chronic hand eczema published 05/11/25<br><br>Commissioning: ICB, tariff included | To be added to the formulary for specialist prescribing with a link to TA1107. Deferred from March to allow further understanding of implementation issues. In the absence of this GMMMG approved for addition to formulary. Financial impact estimated to be £1.1M over 5 years | Approve addition to GMMMG formulary, following CEG approval. |
| 07-05 | GM Narcolepsy Treatment pathway for adults | All medicines already listed on GMMMG formulary. Standardisation for narcolepsy commissioning of high cost drugs currently underway. Estimated financial impact is £310K per year. | Approve publication of pathway following CEG approval. |
| 07-06 | GM Sodium oxybate commissioning statement | Currently on formulary as specialist prescribing only. Statement defines prescribing criteria for specific patient cohorts. Estimated financial impact, £74K per year. | Approve publication following CEG approval. |
| 07-07 | Relugolix for prostate cancer SCP | Developed Shared Care Protocol to enable standardised, safe and consistent prescribing across GM. No financial implications | Note CEG approval, formal approval by SCC needed. |
| 07-08 | Acarizax and Itulazax primary care guidance | Guidance for primary care prescribers on the management of these medicines for treatment of house dust mite allergic rhinitis ± conjunctivitis, and tree (birch homologous group) pollen allergic rhinitis ± conjunctivitis, respectively. Medicines are already on formulary. No financial implications. | Note CEG approval, formal approval by SCC needed. |
| 07-09 | Dapagliflozin switch programme | Process for switching SGLT2 (sodium glucose co-transporter 2 inhibitors) for managing type 2 diabetes, heart failure and chronic kidney disease, to generic dapagliflozin. A managed programme of switching using defined cohorts as a medicines value work stream. No financial impact. | Note CEG approval, formal approval by SCC needed. |
| 07-10 | HST35: Pegzilarginase for treating arginase-1 deficiency in people 2 years and over Highly specialised | Pegzilarginase can be used, within its marketing authorisation, as an option to treat arginase-1 deficiency (also called hyperargininaemia) in people 2 years and over. Commissioned by NHSE. To be added to GMMMG formulary as a drug for specialist prescribing for this condition. | Note CEG approval, formal approval by SCC needed. |

| | | | |
|---|---|---|---|
| | technologies guidance published 04/03/26 | | |
| | | **Maternity** | |
| 07-11 | Maternity and Neonatal Quality Oversight Risk: Contextual and Thematic Update | CEG considered a new corporate risk relating to maternity and neonatal quality oversight. The paper highlighted increasing national scrutiny of maternity services, implications of NHS Reform, uncertainty regarding future LMNS hosting arrangements, and potential impacts on quality oversight, commissioning support and improvement capacity. CEG supported continued executive oversight and escalation of the risk to the NHS GM Corporate Risk Register. | SCC is asked to note the emerging strategic risk relating to maternity and neonatal quality oversight and the actions being taken to maintain assurance and system oversight during NHS Reform. |
| 07-12 | Briefing on the Ockenden Review and Baroness Amos Investigation into Maternity and Neonatal Services | CEG received a strategic briefing on the findings of the Nottingham maternity review led by Donna Ockenden, the national investigation led by Baroness Valerie Amos and the subsequent NHS England 10 Point Plan. The paper outlined emerging themes relating to safety, culture, governance, workforce, inequalities and accountability, together with implications for commissioners and the programme of work already underway across Greater Manchester. | SCC is asked to note the findings, emerging national expectations and the implications for commissioning, quality assurance and maternity system leadership across Greater Manchester. |
| | | **Greater Manchester Care Record** | |
| 07-13 | Greater Manchester Care Record (GMCR) Two-Year Plan 2026–2028 (presented June 2026) | CEG reviewed the GMCR two-year transformation plan, which set out three strategic priorities: increasing frontline clinical adoption, expanding community pharmacy utilisation and rolling out Electronic Palliative Care Coordination Systems (EPaCCS). The paper identified significant quality, productivity and system benefits and sought clinical endorsement and support for adoption across Greater Manchester. | SCC is asked to note the GMCR transformation programme and support continued system-wide adoption of GMCR and EPaCCS as enablers of clinical effectiveness, integrated care and future commissioning standards. |
| Please note this month there have been no recommendations for ratification from the NHS GM Clinical Policy Audit and Standards Group (CPAS). | | | |

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 paper identifies several live and emerging risks requiring continued oversight through established NHS GM governance routes. The most significant risk discussed relates to Northern Care Alliance NHS Foundation Trust, where NHS England enforcement undertakings reflect

sustained concerns about quality governance, safety oversight and the ability to evidence reliable systems for early risk identification and mitigation. Although improvement activity is underway, the residual risk remains high until governance arrangements are demonstrably embedded and sustainable.

Additional risks discussed include continuing quality and safety pressures within Greater Manchester Mental Health NHS Foundation Trust, particularly in relation to fatal harm reporting, safeguarding compliance, Psychiatric Intensive Care Unit capacity, patient flow and serious incidents linked to Griffin Ward. Wider system pressures were also highlighted, including acute and mental health flow deterioration, high occupancy, emergency department long waits, discharge variation, environmental incidents and the potential impact of these pressures on patient safety and service resilience.

A new or emerging strategic risk was identified in relation to maternity and neonatal quality oversight. This reflects increasing national scrutiny following the Ockenden and Baroness Amos reviews, the NHS England 10 Point Plan, uncertainty linked to NHS Reform and future Local Maternity and Neonatal System hosting arrangements, and the potential impact on commissioning support, improvement capacity and assurance. CEG supported escalation of this risk to the NHS GM Corporate Risk Register, with continued executive oversight.

No additional risks requiring escalation outside existing governance arrangements were identified within the remaining items. However, the report notes that continued monitoring will be required for medicines implementation and financial impact, Child Health Information Service transition arrangements, data sharing and digital alignment, and the sustainability of provider improvement actions. These will continue to be managed through the relevant programme boards, quality review meetings, CEG and established NHS GM assurance routes.

## Learning for Sharing

**Greater Manchester Inclusive Research Network (GM IRN) publishes first evaluation demonstrating growth in research participation across underserved communities.**

The Greater Manchester Inclusive Research Network (GM IRN) was established to address inequalities in research participation by supporting primary care practices serving deprived and ethnically diverse populations to engage in research activity.

In its first year, GM IRN has expanded to 80 practices covering approximately 750,000 patients, supporting previously research-inactive practices to participate in research. The network has contributed to recruitment into National Institute for Health and Care Research (NIHR) studies, supported research funding applications exceeding £6 million, and established new collaborations across Greater Manchester's research infrastructure. A peer-reviewed publication describing the development and early implementation of the network has now been published.

The next phase of development includes establishment of the Manchester Inclusive Research Hub, working with 11 practices serving around 100,000 residents in some of Greater Manchester's most deprived and ethnically diverse communities. This aims to further embed research within frontline primary care and improve equitable access to research opportunities. A Family Wellbeing Festival involving local communities and over 50 partner organisations will support this engagement approach.

This work supports the wider ambitions to reduce health inequalities, increase inclusion in research and ensure that innovation and evidence generation better reflect the needs of Greater

Manchester's diverse population.

## Achievements

### Greater Manchester Trust Achievements reported into Quality Review Meetings

Greater Manchester providers demonstrated significant and measurable improvements in quality, safety and governance across the system. Trusts reported strengthened safeguarding arrangements, enhanced incident-learning processes, and notable reductions in investigation times. Several organisations achieved major workforce and wellbeing gains, including improved staff survey outcomes, expanded leadership programmes, and targeted wellbeing initiatives. Multiple providers delivered strong infection prevention and control performance, with some achieving leading regional positions for C. difficile reduction and successful management of complex outbreaks. End-of-life care improvements were evident across the system, supported by new education programmes, strengthened governance, and increased specialist palliative care access.

There was also substantial progress in service-specific improvement programmes, including successful completion of large-scale patient recalls, resolution of accreditation issues, and delivery of major transformation programmes in maternity, obstetrics and gynaecology, spinal services, and surgical pathways. Trusts reported significant reductions in clinical backlogs, improved diagnostic performance, and strengthened patient flow arrangements. Collaborative working across Greater Manchester continued to grow, with shared initiatives in inclusion, urgent care, Infection Prevention and Control (IPC), medicines optimisation and quality improvement. Collectively, these achievements reflect a system that is increasingly aligned, learning-focused, and committed to delivering safer, more effective and more compassionate care.

### Maternity and Neonatal Programme – Greater Manchester

Greater Manchester Maternity and Neonatal Voice Partnerships (GM MNVP) achieved national recognition at the MNVP STAR Awards, receiving eight nominations across listening and co-production categories. The GM MMVPs were awarded the National STAR Award for Co-production for its pre-term birth leaflet project, recognising exemplary co-production with women, families and communities.

**Recommendations:**

The Committee is asked to:

- Note the contents of the 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

# NHS GM Safeguarding Adult Board and Children's Partnerships Annual Reports 2025/26

July 2026

Part of Greater Manchester Integrated Care Partnership

**Strategic Commissioning Committee**

**July 2026**

| Required information | Details |
|---|---|
| **Title of report** | NHS GM Safeguarding Children Partnerships and Adult Boards Annual Reports 2025/26 |
| **Author** | Sarah Owen Associate Director of Safeguarding; Natasha Hirst, Quality Manager - Safeguarding |
| **Presented by** | Sarah Owen Associate Director of Nursing Safeguarding, NHS GM |
| **Contact for further information** | Sarah Owen Associate Director of Nursing Safeguarding, NHS GM |
| **Executive summary** | The report provides two GM Safeguarding Children Partnership and Safeguarding Adults Board Annual Reports 2025/26, within the ICB's statutory safeguarding governance arrangements. |
| **The benefits that the population of Greater Manchester will experience.** | NHS GM undertakes the Statutory Partner requirements to safeguard adults, children and families. |
| **How health inequalities will be reduced in Greater Manchester's communities.** | N/A |
| **The decision to be made and/or input sought** | The Committee is asked to approve the submitted annual reports for publication and/or submission, as applicable. |
| **How this supports the delivery of the strategy and mitigates the BAF risks** | This supports delivery of NHS GM's statutory safeguarding functions by strengthening partnership assurance, governance and oversight across Greater Manchester. |
| **Key milestones** | NHS GM Safeguarding Adult Board Annual Reports 2025/26 require ICB approval as statutory partner.<br>NHS GM Safeguarding Children Partnership Annual Reports 2025/26 require national submission to the Department for Education by the end of September 2026, in line with Working Together requirements. |
| **Leadership and governance arrangements** | This paper will form part of the SCC update to the ICB Board and System Improvement Board, following the formal governance route. |
| **Engagement* to date**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | NHS GM Deputy Delegated Safeguarding Partners<br>NHS GM Designated Safeguarding teams |

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

## 1. GM Safeguarding Adult Board and Safeguarding Children Partnerships Annual Reports 2025/26

1.1. This report presents the 2025/26 Annual Report for one Greater Manchester (GM) Safeguarding Adult Board and one GM Safeguarding Children Partnership to the NHS GM Strategic Commissioning Committee (SCC) for formal approval.

1.2. Under Working Together to Safeguard Children, safeguarding partners — local authorities, Integrated Care Boards and Chief Officers of Police — are jointly accountable for publishing annual reports that evidence the effectiveness of multi-agency safeguarding arrangements. This includes collaborative working, impact on outcomes, learning from safeguarding reviews and future priorities. Under the Care Act 2014, Safeguarding Adults Boards are also required to publish annual reports setting out how partners have worked together to safeguard adults with care and support needs, including learning from Safeguarding Adult Reviews (SARs) and implementation of board priorities.

1.3. Within NHS Greater Manchester, the GM ICB Chief Officer acts as the Lead Safeguarding Partner (LSP), with the Chief Clinical Officer acting as the Delegated Safeguarding Partner (DSP). As a statutory partner across all ten localities, NHS GM contributes safeguarding health statements to both Safeguarding Children Partnership and Safeguarding Adults Board annual reports, providing assurance on health system engagement, statutory compliance and the impact of multi-agency safeguarding activity across GM.

1.4. Further full draft reports for the remaining partnerships and boards will be received later in the year for formal review and sign-off through NHS GM governance. Variation in locality timelines is expected and reflects differing

partnership governance processes; progress will continue to be monitored to ensure timely completion.

1.5. The GM Safeguarding Adult Board annual report for approval is provided in **Table 1** below.

1.6. The GM Safeguarding Children Partnership annual report for approval is provided in **Table 2** below.

*Table 1 – GM Safeguarding Adult Board Annual Reports 2025/26 for Approval*

| Safeguarding Adult Board | Annual Report 2025/26 |
|---|---|
| Salford | Final Version SSAB Annual Report 2025 |

*Table 2 – GM Safeguarding Children Partnership Annual Reports 2025/26 for Approval*

| Safeguarding Children Partnership | Annual Report 2025/26 |
|---|---|
| Stockport | 02ei. SSCP Yearly Report 2025 to 2026 |

## Recommendations

- Note the completion of the submitted GM Safeguarding Adult Board Annual Reports 2025/26 and approve NHS GM sign-off for Safeguarding Adult Board publication.
- Note the completion of the submitted GM locality Safeguarding Children Partnership Annual Report 2025/26 and approve submission to the Department for Education.
- Note that the remaining GM Safeguarding Adult Board and Safeguarding Children Partnership Annual Reports 2025/26 will be submitted to a later meeting in 2026.
- Current governance arrangements for the sign off for Safeguarding annual reports are under review with a commitment to share the outcome at the next meeting.

NHS
Greater Manchester

NHS
Greater Manchester

# NHS Greater Manchester Strategic Commissioning Committee

## Report from Chief Commissioning Officer

August 2026

NHS Greater Manchester

| | |
|---|---|
| **Report from:** | **Katherine Sheerin, Chief Commissioning Officer** |
| **Date of Meeting:** | 5th August 2026 |
| **Authors** | **Gill Baker**, Director of Healthcare Commissioning<br>**Caroline Bradley**, Director of Primary Care<br>**Louise Sinnott,** Head of Acute Strategy & Transformation / Place Based Lead for Greater Manchester<br>**Emma Storer**, Senior Project Manager Children & SEND |
| **Executive Summary** | This paper sets out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. |

## ALERT

### Healthcare Commissioning

No alerts this month.

### GM Specialised Commissioning Oversight Group

**Performance and Quality Risks Across Specialised Services**

The Specialised Commissioning Oversight Group received a readout from the North West Specialised Services Committee highlighting a number of areas requiring continued oversight. Ongoing performance concerns remain at Blackpool Teaching Hospital, whilst significant waiting list pressures continue within specialised spinal services at Northern Care Alliance. National renal dialysis capacity constraints remain a concern and neonatal services continue to present a high-risk area due to challenges in meeting service specifications and ongoing service review work.

Specialised elective performance remains a key challenge across neurosurgery, spinal services and specialised gynaecology pathways. The Group noted continuing difficulties in

securing mutual aid arrangements and concerns regarding the impact on patient access and prioritisation.

**SEND**

No alerts this month.

**Primary Care Commissioning –**

Following a poll of members, the British Medical Association (BMA) GP Committee voted in favour of re-entering collective action due to insufficient assurance from the Government regarding concerns over the 2026/27 General Medical Services (GMS) Contract. This is an escalating situation, with one new collective action being announced each month commencing May 2026.

The first action relates to data sharing and reviewing the GP patient data they are expected to share outside the practice, with the wider NHS and other organisations. A template letter has been shared with the ICB requesting details of all Data Sharing Agreements with the suggestion that these may be withdrawn if there is no contractual, professional or statutory obligation to share. NHS GM has received 62 letters, with the last of these on the 19 June. All practices have received a detailed response with no further steps taken at this time. A constructive dialogue is being maintained with GP Data Controllers through Primary Care Board and with the GM LMCs through the Primary Care Team.

The second action Medicines Optimisation and Prescribing – reviewing medicines optimisation that is utilised within the practice and removing software that is not mandated. NHS GM is aware that 5 GP practices across three localities have switched off Medicines Optimisation software (OptimiseRx) since June 2026. The Medicines Optimisation Team is actively monitoring the prescribing software, reassuring remaining practices and working to mitigate risks to patient safety together with understanding the impact on financial planning.

The third action is to decline any new Shared Care Arrangements that are not supported by a locally commissioned formal agreement, adequate resourcing and clear clinical responsibilities and to review existing Shared Care Arrangements to ensure they remain safe and appropriately commissioned. Both of these actions are being tracked by the Medicines Optimisation Team with mitigations considered at a national level.

A weekly position statement, including all risks and mitigations, is shared with NHS England Northwest Regional Team.

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) at by year. These plans will feed in to the Annual Planning Round process, which has now started and will help to shape the commissioning intentions for 27/28.

**Progress to develop a NW Individual Funding Request and Commissioning Policy Team / Process** – Work continues across the three North West ICBs to develop a NW Individual Funding Request and Commissioning Policy Process as part of the 'do once' programme under ICB Reforms. A proposed single operating model and single governance framework is currently being considered and will progress through the respective ICB governance in early August. A draft Host ICB Agreement has been developed which sets out the roles and responsibilities of NHS GM as the host ICB but also the participating ICBs. The development of the NW service 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. There is also an established IFR / Policy Development Team employed by NHS GM. The proposed transfer date is 1 October 2026, and work continues to achieve this date however it is acknowledged that this may be pushed back slightly whilst the single operating model is agreed and further due diligence is undertaken on the funding of the NW service.

**GM Major Trauma Single Service Implementation**

A clinical workshop was held on 8 July 2026 to support the transformation of major trauma services across Greater Manchester. The session reviewed current patient pathways and explored how future services could be designed to deliver more integrated and effective care. Participants demonstrated strong engagement and broad support for change.

A key theme was the need to shift focus from moving patients to specific locations towards ensuring patients receive the right expertise and care when needed. Opportunities were identified to improve rehabilitation pathways, discharge support and community-based rehabilitation services.

There was strong support for greater collaboration across provider organisations, including shared workforce development, joint education, integrated multidisciplinary working and aligned leadership arrangements. Existing examples of successful collaborative practice were recognised as foundations on which future arrangements can be built. Participants also highlighted the importance of developing a shared culture and identity to support delivery of a single service model.

The workshop identified several enablers, including shared digital systems and opportunities for future technological integration. Participants acknowledged that digital alignment would require longer-term system development.

Several risks and challenges were also recognised, including limitations within pre-hospital pathways, the geographical distribution of services, information-sharing barriers and differing digital systems. Historical organisational competition was also identified as a cultural challenge requiring continued attention.

Overall, the workshop provides assurance that clinical leaders are actively engaged in the transformation programme, there is emerging consensus around the direction of travel, and key opportunities, risks and dependencies are being identified early to inform future service design.

The next steps with the programme are to gather recent data from across the pathway to inform the future development discussions and to hold a follow-up workshop on the 3rd August to continue the positive engagement and clinical discussions. The outputs of the next phase of work will allow a revision of the original timescales to take place, this will be brought to the Major Trauma Implementation Board on the 10Th August.

In addition to the above, NHS GM have worked with MFT & the NCA to agree the extension of the existing Major Trauma Advanced Rehabilitation service, which supports complex rehabilitation patients. This agreement has been made until the end of the 26/27 financial year. The longer-term sustainable model for this will be worked into the overall project and pathway re-design for the Major Trauma Single Service.

**Development of Gynaecology and ENT services**

The ENT and Gynaecology Business Cases have been approved and £4.6m of funding is now available to support the establishment of community ENT and Gynaecology services across localities.

This will see 5,000 ENT and 11,300 Gynaecology pathways to be moved out of hospital during 2026/27.

The approach in 2026/27 will be to move beyond short-term waiting list initiatives/subcontracting and move towards integrated models with consultants and primary care working together.

There is a proposed two-stage release of funding (H1 and H2) to enable mid-year stocktake and potential reallocation based on pace of delivery. Funding to be issued with an MOU setting out left-shift principles and expectations.

NHS Trusts and Localities are working collaboratively to develop a model following which the Memorandum of Understands (MOU) will be signed. Further updates on the progress of this will come to SCC in in the future.

## GM Specialised Commissioning Oversight Group

**Cardiac and Vascular Service Change Programme**

The Group received an update on the Greater Manchester Cardiac and Vascular Surgery Programme. Preparations for public consultation are progressing following assurance and scrutiny processes, alongside development of the decision-making business case. The Group noted:

- Planned public consultation activity and stakeholder engagement.
- The requirement to maintain momentum against programme timelines.

- Financial and resource implications associated with delivery.
- The importance of maintaining clear communication and engagement throughout the consultation period.

The Group recognised the complexity of the programme and supported the enhancement of programme management and analytical support from the NHS Transformation Unit to assist in concluding the Decision-Making Business Case and maintaining delivery against agreed programme timescales.

The Group noted the requirement to maintain momentum against programme timelines whilst ensuring robust clinical, financial and quality assessment of the preferred service models.

**Commissioning Prioritisation Framework**

The Group reviewed a proposed commissioning prioritisation matrix for specialised services. The framework is intended to support transparent, evidence-based decision making and provide a consistent approach to prioritisation across commissioning programmes.

Feedback focused on:

- Alignment with existing strategic priorities.
- Transparency of decision making.
- Practical application within resource-constrained environments.
- Consistency across programmes and commissioning responsibilities.

**OPIC Development and Governance Arrangements**

The Group discussed ongoing development of the Office of Pan-ICB Commissioning (OPIC) model and associated transfer arrangements for specialised commissioning teams. Discussions highlighted the need to finalise:

- Hosting arrangements.
- Responsibilities for non-core commissioning functions.
- Governance and oversight structures.
- Consistent North West-wide reporting and decision-making arrangements.

## Children, Young People and Maternity

**SEND Reforms**

Local authorities have received funding from the Department for Education for Year 1 delivery of their ‘Experts at Hand’ offer, totalling £25m across Greater Manchester. Experts

at Hand aims to deploy Education Psychologists, Specialist Teachers, Speech and Language Therapists (SALTs) and Occupational Therapists (OTs) into mainstream education settings to support education staff in identifying and meeting the needs of children and young people with SEND. Year 1 areas of focus are establishing a shared vision, understanding local starting points, developing the delivery model and strengthening commissioning and workforce arrangements. Local areas are expected to deliver elements of the offer from September 2026.
NHS GM Executive Committee recently considered recruitment challenges affecting the SALT and OT workforce and supported a coordinated approach to workforce development across all 10 local authorities. Further discussions have taken place through the GM SEND Strategic Partnership and with GM SEND leads on developing a GM-wide approach to joint commissioning of the health workforce, to reduce the risk of destabilising Trusts and creating unwarranted variation in SALT and OT models.
A working group is being established to oversee the GM approach, including joint commissioning and workforce arrangements.

**Area SEND inspection** – Salford Local Area Partnership has recently undergone an Area SEND inspection. Jointly conducted by Ofsted and the CQC, the inspection assesses how effectively the local area partnership supports children and young people with SEND and, where appropriate, identifies areas for improvement. The inspection concluded on 17th July, with the outcome to be confirmed when the full report is published.

### Primary Care Commissioning

No update this month

**ASSURE**

### Healthcare Commissioning

Community Dermatology Procurement – NHS GM agreed to abandon the original procurement following a challenge to the process and commence a new procurement for a standardised NHS GM community Dermatology service. The original service specification has been reviewed and updated and has been formally agreed via the ICB Clinical Governance. Work continues in preparation to publish the Invitation to Tender (ITT) in August 2026.

**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).

There are currently 6 providers requesting accreditation to deliver Consultant Led service in Greater Manchester. One of these providers is going through the final governance for

accreditation to deliver Gynaecology Services and the remaining 5 are going through due process at this stage.

## GM Specialised Commissioning Oversight Group

**Risk Management and Assurance Activity**

The Group received updates regarding the continued integration of specialised commissioning risks into Integrated Care Board assurance and risk management processes.

Several assurance actions have now been completed and closed, demonstrating continued progress in strengthening governance and oversight arrangements.

**Mental Health Services**

The Group received an update on specialised mental health commissioning activity, including:

- Workforce developments within Pennine Care services.
- Expansion of specialist community forensic teams.
- Progress in transferring patients from St Andrew's Hospital.
- Ongoing management of operational pressures and recent incidents.
- Continued monitoring of service resilience and quality.

The Group received assurance that established governance processes remain in place and that providers continue to manage risks appropriately.

**Finance and Contract Management**

The year-to-date financial position was review and an update on block deconstruction activity was received.

The group noted:

- Continued oversight of specialised commissioning budgets.
- Progress in improving financial transparency.
- Contract management developments across specialised services.
- Ongoing monitoring of elective and non-acute service pressures.

**Quality Oversight and Highly Specialised Services**

The Group received assurance regarding quality oversight arrangements across specialised services. National and regional work continues with Directors of Nursing and quality teams to strengthen governance arrangements for highly specialised services.

The recently published Quality Strategy provides a framework for ongoing assurance, with continued emphasis on local oversight, risk assessment and escalation arrangements where required.

### Children, Young People and Maternity

None

### Primary Care Commissioning Committee

Confirmation of the **National Vaccines and Immunisations Catch-up Campaign for 2026-27** was noted**.** The NHS England letter, which has been shared with General Practice and PCNs, confirms details of the national MMR/V catch-up campaign. The campaign runs June 2026 to March 2027 and focuses on:

- General Practices are required to undertake local call and recall for eligible individuals aged 12 months to less than 6 years who are missing 1 or 2 doses of MMR/V
- Practices are asked to support requests for vaccination of individuals aged 6 years up to and including 11 years.

Further information will follow via the Primary Care Bulletin and Regional cascade, to provide advanced notice of the phased national invites, including the invite communications schedule.

The **Delegated Commissioning Self-Assessment report** provides assurance, against NHSE's Primary Care Commissioning Framework, on an annual basis in relation to our delegated primary care functions. These functions include General, Pharmaceutical

Services, Primary Ophthalmic Services, Dental Services and Primary Medical services. The self-declaration is accompanied by 'evidence of compliance' and an ICB RAG rating to all areas. The NHS GM self-declaration for 2025/26 demonstrates a green RAG rating against all areas with the exception of an amber rating for Primary Medical Services in relation to Contractor / Provider compliance & performance. Actions have been identified, and are being undertaken, to strengthen this area and discussions are on-going with NHSE regional colleagues to provide necessary assurance.

The PCCG considered an update on the **PCN Capacity and Access Improvement Plan 2024/25 post payment verification process (CAIP PPV).** The update provided progress on the process, the challenges encountered and proposed next steps to resolve outstanding issues in a timely manner. The PCCG agreed several actions including that the process will continue as planned, underpinned by available data, with a clear timeline and process for appeals including any financial reconciliation. The learning from the process will also be applied to future processes.

## ACHIEVEMENTS

### Primary Care Commissioning

### 2026 GP Patient Survey

The 2026 GP Patient Survey results, which include information on patient experience of General Practice, NHS Dentistry and Community Pharmacy, were published on 9 July.

Patient confidence in NHS GM clinicians remains exceptionally strong, with 93% of patients reporting confidence and trust in the healthcare professional they saw or spoke to.

**Key findings include:**

1. 79% of patients had a good overall experience of their GP practice, an increase of 2% from 2025, and 2% above the England average.
2. More than 50% of patients reported they had used online GP services, including booking appointments online, and over half of patients reported it was easy to contact their practice using the NHS App.
3. Across all three contact methods that patients were asked about (phone, practice website, and NHS App), between 58% and 63% of patients reported they found it 'easy' to contact their general practice.
4. 74% of patients had a good overall experience of NHS dental services, an increase of 1% from 2025.
5. 89% of patients had a good overall experience of using pharmacy services, an increase of 1% from 2025.

Information on the Patient Survey website includes National, Integrated Care System (ICS), Primary Care Network (PCN) and GP practice level data in different formats. It shows NHS GM is performing above the national average on most General Practice headline measures, with continued improvement since 2024 in patient experience, access, communications and appointment satisfaction. However, there remains variation between PCNs, particularly in access and patient experience measures.

The results are a positive reflection of the hard work of teams in rolling out improvement measures such as digital telephony and triage systems in General Practice, Pharmacy

First, which is providing more convenient access to care for patients with minor illnesses, and focusing on patients needing urgent dental care, which are all making it easier for patients to access primary care.

Through the Primary Care Action Plan and NHS GM Primary Care Blueprint, we are working with localities and the Primary Care Provider Board (PCB) to reduce unwarranted variation in access, quality and patient experience, particularly in General Practice. This includes support through the Primary Care Excellence Programme, which provides training and improvement support to practices on areas including quality, demand and capacity management, CQC preparedness and patient experience.

A GP Quality Dashboard, introduced in 2025, is helping to identify variation and target support where it is most needed, including through the GP Peer Ambassador Programme, which provides peer-to-peer support to practices facing challenges with access and patient

experience. Over the past year, 40 practices have also participated in the national Practice Level Support programme to implement Modern General Practice approaches.

We will continue working with PCB, localities and Place Partnerships to use data, shared learning and quality improvement approaches to reduce variation and improve access and experience for patients across NHS GM.

The response rate was 18% - 41,549 completed surveys from 228,556 questionnaires sent out.

NHS
Greater Manchester

# Acting Chief Reform & Improvement Officer Report

5th August 2026

Part of Greater Manchester Integrated Care Partnership

**NHS Greater Manchester People & Resources Committee**

**August 2026**

| Required information | Details |
|---|---|
| **Title of report** | Acting Chief Reform & Improvement Officer Report |
| **Author** | Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM<br>Malcolm Whitehouse CDIO NHS GM, Dan Gordon Director Elective Care, NHS GM |
| **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.<br><br>The report highlights key areas of assurance and oversight from the Reform & Improvement portfolio. |
| **The benefits that the population of Greater Manchester will experience.** | |
| **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 with the intention to deliver financial sustainability, improve our oversight arrangements with our commissioned providers and take forward our digital strategy. |
| **The decision to be made and/or input sought** | The Committee is asked to note the AAAA report and the position as of M4 |
| **How this supports the** | The areas within this report and progress made to improve these |

| | |
|---|---|
| **delivery of the strategy and mitigates the BAF risks** | 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**<br><br>***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 functions workplans within the portfolio. |
| **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.<br><br>The report reflects continued work to improve patient standards and the ICBs delivery and improvement against the agreed strategic priorities. |

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

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

## Alert

**Elective**
Elective waiting list has seen an increase in Q1, reducing c50% of the improvement seen in the Q4 sprint. This is not limited to GM providers but has been seen regionally and nationally. Our assessment is that reduced levels of activity (following end of Q4 sprint), significantly reduced levels of waiting list validation and a historically high month for referral numbers in March have combined to drive this partial reversal in the waiting list reduction. Trusts have been asked to focus on validation and stepping up activity to contractual levels, referrals appear to have reduced in April and May in line with normal variation.

**Urgent and Emergency Care**
Delivery of 12 and 4 hour ED standards are behind plan. There is continued focus on improving discharge, optimising flow and reducing long waits across urgent care pathways. A deep dive into 12-hour waits was presented to the Strategic Commissioning Committee in July.

**Mental Health**
The proportion of patients reporting reliable recovery and improvement after talking therapies is lower than planned. To improve rates there is a focus on strengthening pathway delivery and treatment completion. Core actions include driving progress against System Maturity Tool plans with clear local ownership and oversight and improving efficiency across pathways by reducing 'Do not Attends', minimising administrative waste, and addressing variation in attrition and re-referral rates

**Learning Disabilities**
Too many people with learning disabilities and autism are reliant on inpatient care. Work is ongoing to reduce inpatient admissions, ensuring all patients are reviewed through Care and Treatment Reviews (CTRs) with a documents discharge trajectory, escalating individual discharge barriers through Multi Agency Discharge Events (MADEs), developing plans for an autism crisis and admission avoidance service and developing community step-down and housing solutions. Delivery remains dependent on effective system-wide collaboration and securing appropriate invest-to-save funding to expand crisis and admission avoidance provision.

## Advise

**Data Insight and Intelligence:**

DII Operating Model Transition:
DII is progressing transition to the new structure effective 1 July 2026, aligned to the ICB Blueprint and revised operating model. Expression of Interest (EoI) interviews have taken place and further activity is underway to fill other vacancies in the agreed structure

Digital Enablement & Governance (TaskFlow):
DII has developed TaskFlow, a new workflow management tool which will:

- Track all requests, risks, issues and Data Quality (DQ) items
- Provide end-to-end visibility of demand and delivery
- Strengthen governance reporting and escalation routes

This will underpin improved prioritisation and oversight as part of the new operating model.

Federated Data Platform (FDP) Engagement and ADSP:

Matt Hennessey and the DII team continues to support the GM approach to the use of the Federated Data Platform (FDP), with DII contributing to system positioning and showcasing Greater Manchester's approach to digital transformation and data-led service improvement through the use of our ADSP (Advanced Data Science Platform)

**Digital and IT Services**

Digital and IT Operating Model Transition
D&IT is progressing transition to the new structure with a plan for managing through the "business continuity" phase during transition.

There are still 27 vacancies with the structure the next steps are to advertise these internally and then externally – the first of these will go though internal post filling processes during July. It is likely that the majority of posts will need to be filled externally due to the technical nature of the roles.

Work has started on the development of a refreshed digital strategy (2027 – 2032) for the GM Integrated Care Partnership/System – this is in alignment with the Strategic Commissioning Plan which is due to be signed off in July. This is being done in partnership with all parts of the system, with round table activities being set up and the initial meeting of a steering group taking place on the 30th June.

Procurement of a replacement for the main supplier (Graphnet) for our GM Shared Care Record is underway. The existing contract ends on the 31st March 2028.

**Mental Health**
There were four out of area placements which was worse than the plan of no more than two throughout the year. This means four adults requiring acute mental health inpatient care were admitted to hospital outside of GM because a suitable bed was not available inside GM. Reducing the number of patients clinically ready for discharge remains a key priority as well as a continued system focus admission avoidance.

**Cancer**
The proportion of patients receiving a cancer diagnosis within 28 days is behind plan. The focus is on speeding up access to diagnostics, implementing best timed pathways and targeted support from the Cancer Alliance for underperforming Trusts.

**Financial Recovery & Improvement**

There is a c.£22m unidentified gap against the £150m CIP. There is ongoing work to fully identify schemes to the £150m plan via a sprint team who are reviewing all existing plans in place to

ensure delivery of the agree targets as well as new opportunities.

We have been successful in securing Q2 deficit support funding (DSF) following discussions with NHSE regional colleagues and assurances given we have plans in place to mitigate risk, identify opportunities and continue delivery to achieve the plan.

**Assure**

**Data Insight and Intelligence Update:**

A DII position statement has been presented to OLG, outlining:

- Priority areas aligned to the new ICB Blueprint
- Workforce requirements and current gaps
- Proposed areas to stop or reduce activity to enable new demand

Next step: Chief Officers to review and provide feedback to confirm direction and prioritisation.

**Digital and IT Services**:

Two papers are being prepared for Chief Officers to provide assurance regarding:

1. The current position and sustainability of the GMCR and the SDE to agree our future approach to the funding and support of these key GM assets.
2. The outcome of the DSPT (Data Security Protection Toolkit) and a briefing in response to some new requirements from NHSE with regards to Cyber assurance

At the current time, services are operating to agreed service levels and we are seeking to open the service desk to ICB staff for longer hours during each working day.

A Digital and IT Services operating model is ready for discussion which identifies how services will be delivered and governed. In future, the outcome from the IT and Digital Assurance group will form the basis for updates to this committee. A digital and IT Services strategy to identify how services will be delivered over the next 5 years has commenced and will involve gathering input from the ICB, Neighbourhoods and general practices – this is to help manage the risk of change as NHSE transitions to DHSC and CSUs are closed by 2027/28.

**Headline planning metrics on track include**

- Category 2 response times
- RTT 18 weeks
- 62 day and 31 day cancer treatment standards
- Access to diagnostics within 6 weeks
- Waiting times for community services.

**Risk discussed and new risk identified**

**DII Update:**
Known corporate risk: insufficient Data Governance capacity. External recruitment unsuccessful to the Data Governance Manager role.
Impact:

- Reduced ability to deliver against statutory governance requirements

- Constraint on supporting key programmes (e.g. SDE, ICB governance assurance)

Mitigation:

- Role re-advertised
- Prioritisation of demand through TaskFlow
- Resource discussions underway with the GMCA

**Demand vs Capacity Pressure:**
The need to stop or pause lower-priority activities (as outlined in the position statement) introduces risk of stakeholder dissatisfaction or delays in non-priority areas.

**Digital and IT Services Update:**

Known corporate risks are

1. Capacity to deliver services effectively while we transition to new structure and continue to recruit to the 27 vacancies
2. A critical vacancy needs to be filled to lead our Cyber Security strategy and effective delivery of cyber defences – this is being covered in the interim (we have a mature capability and set of tools, but this will become weaker without the specific skills and knowledge needed in this post) – we are seeking to mitigate this risk through working with others across the GM system
3. Continued deprecation of devices across the system – we have increasing numbers of devices that are end of life and as a consequence these represent a risk as they are unpatched. We have funds to replace some of them but still have a funding gap that we need to fill during 26/27 along with additional people resources to configure and install them – the financial gap spread between 26/27 and 27/28 is over £1.5M – a case for employing agency staff urgently is in progress speed up the delivery of existing devices. A detailed paper is being prepared for Chief Officers

**Elective**
Trusts and localities working together to develop plans for implementing community service provision in ENT and Gynaecology, in line with the Commissioning Intentions. Speed of mobilisation varies across each locality. Advice and Guidance (A&G) activity continues to be strong and growing despite withdrawal of the national GP payment for usage of A&G. Pan-GM Advice and Guidance service been running since October 2025, extended to the end of March 2027, will be subject to a contract review and recommendation for Commissioning Intentions to follow for 27/28.

**Achievements**

**Digital and IT Services**
All key service levels have been met during June 2026

**Elective**
June was a record month for Advice and Guidance requests in Greater Manchester with c11,000 requests for A&G compared to monthly baseline of 4,500 in 24/25 and 7,500 in 25/26.

NHS
Greater Manchester

# Chief Strategy, People and Partnerships Officer - Alert Report

18th June 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

**NHS Greater Manchester Strategic Commissioning Committee**

**18th June 2026**

| Required information | Details |
|---|---|
| **Title of report** | Chief Strategy, People and Partnerships Officer - Alert Report |
| **Author** | Emma John, Senior Delivery Manager |
| **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;<br>- Live Well<br>- Population Health Transformation<br>- Place Partnerships development<br>- Neighbourhood health plans<br>All programmes are currently on track. |
| **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:<br>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** | The Neighbourhood Health engagement programme has concluded, including the successful delivery of the System Leadership Summit. A draft engagement report was presented to the Population Health and Neighbourhoods Supporting Group on 15 July. |

| | |
|---|---|
| **Leadership and governance arrangements** | This paper is produced for this committee and has not been elsewhere. |
| **Engagement* to date**<br><br>***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 The Committee and has not been elsewhere. |
| **Financial or Legal Implications;** | n/a. |

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

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

## Key Updates and Escalations

| Alert |
| --- |
| Nothing to alert this month |
| **Advise** |
| **Place Partnership**<br><br>The Place Partnership Development Programme continues to progress to plan, with a strong focus over July and August on socialising the final draft of the Place Partnership Document Suite across localities, provider collaboratives and wider sector partners. This phase is designed to test the coherence of the full suite, including the partnership agreement, governance framework, outcomes framework, place fund arrangements and place team model, and ensure it reflects both local realities and GM-wide intent.<br><br>Structured engagement is now underway, led by Place Leads and Deputy Place Leads, who are facilitating locality-based discussions supported by clear lines of enquiry and consistent feedback mechanisms. In parallel, the programme team is leading a coordinated engagement process with provider collaboratives and sector-specific groups to ensure their perspectives are fully captured, particularly around operational interfaces, accountability flows and the practicalities of implementation. This dual approach ensures that both locality and provider/sector voices shape the final iteration.<br><br>We are working closely with Mills & Reeve to ensure the document suite fits together as a single, purposeful framework and does not stray beyond its intended scope. Their input is helping to refine the clarity of roles, accountabilities and the relationship between Place and GM-wide functions.<br><br>Simultaneously with work on the document suite, work is progressing with regards to the future hosted employment model for PHCP teams. All Places have responded to a request to identify their preferred host employer. A robust approach to due diligence as we prepare for transfer between now and 1st January 2026 is being developed at pace. The document suite being signed up to in all 10 Places forms a key part of that due diligence.<br><br>The overall timetable remains on track. Engagement and refinement activity will continue through July and August, enabling final amendments to be completed in August. The full suite will then move through organisational and partnership governance routes in September, with the aim of establishing the agreements formally in October. |
| **Assure** |
| |

**Neighbourhood Health**

The Neighbourhood Health engagement programme has now concluded. The final event of the programme was a System Leadership Summit on 29th January – which proceeded successfully. A draft engagement report was presented to the Population Health and Neighbourhoods Supporting on 15th July.

The key output from the engagement is the GM Strategic Commissioning Framework for Neighbourhood Health – which describes a consistent offer to be delivered across all neighbourhoods. This was approved by the Executive Committee on 15th July. Place Leads have been asked to lead the process of updating Neighbourhood Health Plans to reflect the new Commissioning Framework by September.

**Live Well:** An update on the Strategic Commissioning Framework for Neighbourhood Health will be provided to the July Live Well Board.

**Population Health:**
The Population Health transformation programme remains on track. The draft section 75 agreement has been produced and is currently being reviewed and progressed through legal due diligence. It is still proposed that this will be brought to Strategic Commissioning Committee on 2/9/26.

Delivery has continued against the Greater Manchester Public Health Network (GMPHN) Action Plan 2026/27, and a Quarter 1 (April to June) update report was taken to the GMPHN Directors of Public Health meeting on 14/7/26 where the progress made was acknowledged. A copy of this report is available upon request. Quarter 2 priority proposals have been endorsed by the GMPHN and will now progress through ICB financial governance during July / August. These focus on Make Smoking History, Alcohol Harm, Food and Health, Commercial Determinants of Health, Fast Track Cities / HIV, Tackling Poverty, Research / Intelligence and Health Checks.

**Risks discussed and new risks identified**

Risk are currently under development, and will be discussed at the next Supporting Group meeting.

**Learning for sharing**

- Early engagement with localities, providers and sector partners improves the quality and deliverability of programme outputs.
- Bringing together health, care, local government and wider partners strengthens decision-making and supports shared accountability.

- Sustained partnership approaches can deliver significant improvements in population health outcomes, as demonstrated through the Make Smoking History programme.
- Structured leadership engagement is an effective mechanism for building consensus and driving large-scale transformation.

## Achievements

**Population Health**

Enabled by the **Make Smoking History** programme, the latest data for Smoking Status at Time of Delivery (SATOD) for GM showed that Greater Manchester had a Q4 2025/26 SATOD rate of 3.7%, our lowest quarterly rate on record, whilst the annual 2025/26 SATOD rate was 4.2%. This represents a significant improvement from 7.8% in 2024/25, equating to a reduction of 3.6 percentage points in a single year or a 46% relative reduction in SATOD across Greater Manchester. The scale of progress is even more significant when we consider that in 2018, at the point we commenced our system-wide Smokefree Pregnancy programme, Greater Manchester's SATOD rate was 12.6%. Since then, we have reduced SATOD by 8.4 percentage points, representing a two-thirds reduction (67%) over eight years. We have now effectively met our original ambition, which was an annual rate of 4% by 2028, two years ahead of schedule and we are now working towards the new ambition we have included in the GMS that no child in GM will be born to a parent (mother or father) who smokes by 2035.

**Neighbourhood Health**

Between May and June 2026 NHS GM and the GMCA undertook a leadership conversation across system partners to gather insights and perspectives to inform the leadership and development of Neighbourhood Health across Greater Manchester.

The engagement involved discussions across fifteen system Boards and Committees, interactive workshops involving over 150 leaders, targeted sessions with programme and commissioning leads, written submissions, and a dedicated System Leadership Group event. Collectively, this provided perspectives from health and care organisations, local government, the voluntary, community, faith and social enterprise (VCFSE) sector, and wider system partners not least housing, police and justice, and innovation/improvement partners.

The purpose of the engagement was to understand what leadership, commissioning, accountability and system changes will be required to successfully deliver on the ambition through our Live Well model.

NHS
Greater Manchester

# Performance Report 2026-2027

Part of Greater Manchester Integrated Care Partnership

# Strategic Commissioning Committee

# August 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<br><br>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.**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | Engagement is undertaken within various programmes contributing to performance delivery. |
| **Financial or Legal Implications** | |

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

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

NHS
Greater Manchester

# Performance Report
# Strategic Commissioning Committee

August 2026

Part of Greater Manchester
Integrated Care Partnership

# Executive Summary

**Overall position**

- System delivery shows variation against plan across a small number of core metrics.
- Alert measures are concentrated within Urgent and Emergency Care, Elective Care and Mental Health, whilst the majority of metrics remain on track or better than plan.
- Delivery of the elective waiting list trajectory remains a significant system performance risk.

**Alert (focused system oversight)**

- 4-hour emergency care performance remains below plan, with four of six providers below plan.
- 12-hour waits remain above plan, with four of six providers worse than plan.
- Total waiting list remains above plan, with six of seven providers worse than plan. The Integrated Care Board waiting list trajectory also remains off track, presenting a material risk to delivery of the year-end target.
- Reliable recovery and reliable improvement remain below plan, indicating continued challenge in delivering Talking Therapies outcomes.
- Out of Area Placements remain above plan, reflecting ongoing pressure on mental health capacity and discharge pathways.
- Learning Disability and Autism inpatient numbers remain above plan, reflecting continued reliance on inpatient provision and challenges in supporting timely discharge.

**Assure (on track / stable delivery)**

- Category 2 ambulance response times are better than plan.
- Referral to Treatment 18-week performance is better than plan.
- Cancer and diagnostic standards remain better than plan.
- Community waiting times remain better than plan

**Key achievements**

Greater Manchester continues to deliver strong performance across a number of national standards. Cancer performance remains a particular area of strength, with all three standards above plan and national rankings of 11th for Faster Diagnosis, 2nd for 31-day performance and 4th for 62-day performance. Diagnostic waiting times also remain amongst the strongest nationally, ranking 4th overall. Category 2 ambulance response times are achieving the revised national standard, whilst Individual Placement and Support activity continues to significantly exceed plan, demonstrating sustained delivery across key priority areas.

**Ask of the committee**

Committee is asked to note the current performance position, key delivery risks and areas requiring focused system oversight, and agree the recommended position of partial assurance.

# 2026/27 ICB Headline Planning Metrics (SCC oversight)

NHS Greater Manchester

| ICB | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Area | KPI | Period | Actual | Plan | Variance (latest **published** data vs same period in previous year) | | | ICB Benchmarking (**published** data) | | |
| | | | | | 2025 | Variance | Movement | Apr-26 | May-26 | Movement |
| Elective | Percentage of RTT waiting list within 18 weeks | May-26 | 63.7% | 62.6% | 56.3% | 7.4% | ↑ | 26/36 | 27/36 | ↓ |
| | Total waiting list | May-26 | 407,664 | 367,212 | 427,956 | -20,292 | ↓ | | | |
| Diagnostics | Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over | May-26 | 11.8% | 15.7% | 14.6% | -2.8% | ↓ | 4/36 | 4/36 | ↔ |
| Cancer | 28-day cancer Faster Diagnosis Standard | May-26 | 81.9% | 79.8% | 77.0% | 4.9% | ↑ | 16/36 | 11/36 | ↑ |
| | Percentage of patients receiving a first definitive treatment for cancer within 62 days | May-26 | 75.4% | 75.4% | 72.2% | 3.2% | ↑ | 6/36 | 4/36 | ↑ |
| | Percentage of people treated beginning first or subsequent treatment of cancer within 31 days | May-26 | 97.3% | 93.1% | 95.2% | 2.1% | ↑ | 4/36 | 2/36 | ↑ |
| Mental Health | NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness | May-26 | 45.4% | 51.0% | 46.0% | -0.6% | ↓ | 32/36 | 32/36 | ↔ |
| | NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment | May-26 | 66.8% | 69.0% | 67.0% | -0.2% | ↓ | 27/36 | 29/36 | ↓ |
| | NHS Talking Therapies: No. completed courses of treatment (YTD) | May-26 | 2,440 | 3,846 | 2,650 | -210 | ↓ | | | |
| | Number of patients accessing Individual Placement Support services (12-month rolling metric) | May-26 | 4,580 | 3,142 | 1,555 | 3,025 | ↑ | | | |
| | Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period (local data) | Jun-26 | 8 | 2 | 5 | 3 | ↑ | | | |
| Learning Disability and Autism | Inpatient care for Adults with Learning Disabilites (who may also be autistic) | May-26 | 45 | 42 | 50 | -5 | ↓ | | | |
| | Inpatient care for Autistic Adults (with no learning disability) | May-26 | 55 | 50 | 60 | -5 | ↓ | | | |
| Primary Care | Urgent Dental Appointments | Data not yet available | | | | | | | | |
| Community Health Services | Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less | May-26 | 86.0% | 82.9% | 82.7% | 3.3% | ↑ | Benchmarking not yet available | | |

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

Benchmarking against the previous year not included due to change in ICB cohort (42 to 36), preventing direct comparison

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

NHS Greater Manchester

| GM Providers / Ambulance Trust | | | | | | | |
|---|---|---|---|---|---|---|---|
| Area | KPI | Period | Actual | Plan | Variance (latest **published** data vs same period in previous year) | | |
| | | | | | 2025 | Variance | Movement |
| Urgent and Emergency Care (UEC) | CAT 2 ambulance response times | Jun-26 | 00:23:41 | <00:25:00 | 00:22:43 | 00:00:58 | ↑ |
| | 4-hour A&E performance | Jun-26 | 70.9% | 73.3% | 68.9% | 2.0% | ↑ |
| | 12-hour A&E performance (type 1&2) | Jun-26 | 9.2% | 7.8% | | | |
| Elective | Percentage of RTT waiting list within 18 weeks | May-26 | 62.0% | 61.2% | 55.0% | 7.0% | ↑ |
| | Total waiting list | May-26 | 438,882 | 427,445 | 470,274 | -31,392 | ↓ |
| Diagnostics | Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over | May-26 | 11.4% | 12.5% | 15.3% | -3.9% | ↓ |
| Cancer | 28-day cancer Faster Diagnosis Standard | May-26 | 82.0% | 80.1% | 77.6% | 4.4% | ↑ |
| | Percentage of patients receiving a first definitive treatment for cancer within 62 days | May-26 | 76.1% | 75.2% | 72.1% | 4.0% | ↑ |
| | Percentage of people treated beginning first or subsequent treatment of cancer within 31 days | May-26 | 97.2% | 94.1% | 95.1% | 2.1% | ↑ |

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

# 26/27 Alert, Assure and Advise framework

NHS Greater Manchester

| Area | Metric | Alert | Advise | Assure |
|---|---|---|---|---|
| Urgent and Emergency Care (UEC) | CAT 2 ambulance response times | | | |
| | 4-hour A&E performance | | | |
| | 12-hour A&E performance | | | |
| Elective | Percentage of RTT waiting list within 18 weeks | | | |
| | 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 | | | |
| Mental Health | Mental Health Support Team coverage of total pupils/learners (annual metric) | Data not yet available | | |
| | NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness | | | |
| | NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment | | | |
| | NHS Talking Therapies: No. completed courses of treatment (YTD) | | | |
| | Number of patients accessing Individual Placement Support services (12-month rolling metric) | | | |
| | Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period | | | |
| Learning Disability and Autism | Inpatient care for Adults with Learning Disabilites (who may also be autistic) | | | |
| | Inpatient care for Autistic Adults (with no learning disability) | | | |
| Primary Care | Urgent Dental Appointments | Data not yet available | | |
| Community Health Services | Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less | | | |

NHS
Greater Manchester

# Appendices

# 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 | • The total waiting list remains above plan, with 6 of 7 providers reporting a higher waiting list than planned at the end of May.<br><br>• While the waiting list remains below the prior year position, performance has deteriorated since March and the system is not currently delivering the trajectory required to achieve the year-end ICB plan. | • Delivery of the GM ICB year-end waiting list target remains a significant risk, with current provider trajectories below the level required to achieve the planned position.<br><br>• 6 of 7 providers were above plan in May, demonstrating variation in delivery across the system.<br><br>• Increased demand, lower levels of activity and reduced validation have contributed to recent waiting list growth and deterioration in performance.<br><br>• The anticipated benefits from demand management schemes have not yet been fully realised, increasing pressure on delivery of the planned trajectory. | • Strengthened oversight through the Elective Recovery Board, with continued monitoring of total waiting list trajectories and provider recovery actions.<br>• Demand management actions are being progressed through the Beyond Core Contact Review / Elective Quality Improvement Scheme, Advice and Guidance, Community Services and Single Point of Access programmes, with a focus on reducing avoidable referrals and supporting pathway optimisation.<br>• Targeted support and challenge continues with providers above plan, including review of delivery risks, productivity, waiting list validation and recovery trajectories.<br>• Independent Sector activity and treatment provided outside Greater Manchester continue to be maximised to support elective recovery and delivery of year-end plans.<br>• Diagnostics remains better than plan, with improvement actions continuing through capacity and demand review, productivity improvement and Did Not Attend reduction programmes. | SR2 |

Elective Care & Diagnostics has one Alert metric: total waiting list. In May, GM provider total waits were 438,882 against a plan of 427,455, with six of seven providers worse than plan. The ICB waiting list also remains above trajectory and there is a significant delivery risk to achievement of the year-end target. Whilst RTT 18-week performance and diagnostic 6-week waits remain better than plan, delivery of the total waiting list trajectory is dependent upon the successful implementation of demand management schemes, alongside continued productivity improvements, waiting list validation, Independent Sector activity and treatment provided outside Greater Manchester.

# Domain Performance – Urgent and Emergency Care (UEC)

Narrative provided for alerts only

NHS Greater Manchester

| | Current position / performance | Issues of concern | Key actions taken/improvement programmes and impact | Links to BAF risks |
|---|---|---|---|---|
| Alert | • 4-hour and 12-hour waits are the two Urgent and Emergency Care Alert metrics.<br>• In June, 4-hour performance was 70.9% against a plan of 73.3%, with four of six providers below plan.<br>• 12-hour waits were 9.2% against a plan of 7.8%, with four of six providers worse than plan. | • 4-hour performance remains below plan across the majority of providers, reflecting ongoing pressure on patient flow and emergency care pathways.<br>• 12-hour waits remain above plan, indicating continued challenges in timely admission, discharge and onward care.<br>• System flow, discharge delays and limited operational headroom continue to constrain improvement.<br>• Variation in provider performance is impacting overall system delivery.<br>• Sustained improvement will require continued whole-system action across acute, community, social care and ambulance services. | • Strengthened oversight through UEC governance, with focused monitoring of 4-hour and 12-hour performance.<br>• Increased focus on measurable improvement in patient flow, discharge and operational performance rather than activity alone.<br>• Targeted support and challenge aligned to provider and Place ownership of recovery actions.<br>• Priority work focused on cohorts with the greatest impact on demand and flow, including frailty, children and young people, and high-intensity service users.<br>• Trust-by-trust performance assessment, with stronger use of analytics and shared learning to reduce variation and spread effective practice across Greater Manchester. | SR2 |

Urgent and Emergency Care has two Alert metrics: 4-hour and 12-hour waits. In June, 4-hour performance was 70.9% against a plan of 73.3%, with four of six providers below plan, whilst 12-hour waits were 9.2% against a plan of 7.8%, with four of six providers worse than plan. Performance remains challenged by ongoing flow pressures, discharge delays and limited operational headroom across the system. Actions remain focused on improving discharge, strengthening patient flow, reducing long waits and supporting providers with the greatest delivery challenges.

# Domain Performance – Cancer

Narrative provided for alerts only

NHS Greater Manchester

**No Alert metrics**

- All cancer standards remain above plan and on trajectory.
- Greater Manchester ranked 11th nationally for Faster Diagnosis, 2nd for 31-day performance and 4th for 62-day performance in May.
- Performance continues to compare favourably nationally across key cancer standards.

# Domain Performance – Mental Health & Learning Disabilities and Autism

Narrative provided for alerts only

NHS Greater Manchester

| | Current position / performance | Issues of concern | Key actions taken/improvement programmes and impact | Links to BAF risks |
|---|---|---|---|---|
| Alert | • Reliable recovery and reliable improvement remain below plan, indicating ongoing challenge in improving Talking Therapies outcomes.<br><br>• Out of Area Placements remain above plan, reflecting continued pressure on mental health capacity and patient flow.<br><br>• Learning Disability and Autism inpatient numbers remain above plan across both cohorts. | **Mental Health**<br>• Talking Therapies outcomes remain below plan despite continued focus on service improvement.<br><br>• Delivery remains constrained by workforce capacity, with workforce levels below those required to deliver the full NHS Talking Therapies model.<br><br>• Additional workforce investment is expected to support future capacity growth; however, benefits are unlikely to have a material impact on performance during the current year.<br><br>• Ongoing pressure on mental health bed capacity and discharge pathways continues to contribute to Out of Area Placements.<br><br>**Learning Disability and Autism**<br>• Continued reliance on inpatient provision reflects challenges in developing community alternatives and supporting timely discharge.<br><br>• Patient flow and discharge delays remain a key constraint to reducing inpatient numbers. | • Targeted work to improve Talking Therapies outcomes and service delivery, with continued focus on reliable recovery and reliable improvement measures.<br><br>• Continued focus on reducing inappropriate Out of Area Placements through improved discharge planning, patient flow and community alternatives.<br><br>• Development of crisis and admission avoidance pathways to reduce reliance on inpatient care where clinically appropriate.<br><br>• Expansion of community step-down provision and strengthened discharge arrangements to support timely movement through inpatient pathways.<br><br>• Ongoing system oversight through established governance arrangements, including regular reviews of length of stay, discharge barriers and delayed discharges. | SR2 |

Mental Health and Learning Disability and Autism performance continues to present delivery risk across outcomes, patient flow and inpatient reliance. Reliable recovery and reliable improvement remain below plan, reflecting ongoing workforce and capacity challenges within Talking Therapies services, whilst Out of Area Placements and Learning Disability and Autism inpatient numbers continue to reflect pressure on capacity and discharge pathways. System actions remain focused on improving outcomes, reducing reliance on inpatient care, strengthening community alternatives and improving patient flow across mental health services.

NHS
Greater Manchester

# An Update on the Voluntary Adoption of the Socio-Economic Duty by NHS Greater Manchester

## August 5th 2026

**Part of** Greater Manchester
Integrated Care Partnership

# Strategic Commissioning Committee

## 5th August 2026

| Required information. | Details. |
|---|---|
| **Title of report.** | An update on the voluntary adoption of the Socio-Economic Duty by NHS Greater Manchester |
| **Author.** | Rachael Nielsen, Strategic Lead - Population Health |
| **Presented by.** | Dave Boulger, Associate Director – Population Health |
| **Contact for further information.** | Rachael Nielsen, Strategic Lead - Population Health *Rachael.neislen@nhs.net* |
| **Executive summary.** | In July 2025 NHS Greater Manchester became the first ICB in England to voluntarily adopt The Socio-Economic Duty. This report provides an update on the work that has taken place over the last twelve months and asks The Committee to consider how the duty can be embedded further in the new operating model. |

| | |
|---|---|
| **The benefits that the population of Greater Manchester will experience.** | Poverty is the primary driver of poor health and health inequalities. Addressing socio-economic disadvantage is therefore fundamental to improving population health and reducing avoidable inequalities across Greater Manchester.<br><br>The voluntary adoption of the Socio-Economic Duty embeds consideration of socio-economic disadvantage into strategic decision-making across the Greater Manchester health and care system. Its full implementation will support a system-wide culture shift, strengthening collective action to reduce inequalities in access, experience and outcomes. |
| **How health inequalities will be reduced in Greater Manchester's communities.** | Poverty is the primary driver of ill health and inequalities.<br><br>The voluntary adoption of the Socio-Economic Duty puts tackling socio-economic disadvantage at the core of the GM health and care system and strengthens activity to reduce variation and inequalities in access, experience and outcomes and reduce health inequalities. |
| **The decision to be made and/or input sought.** | The Committee is asked to:<br><br>1. Note the breadth of activity that has taken place to implement the socio-economic duty over the past twelve months.<br><br>2. Endorse the proposed priorities in section 3.2.<br><br>3. Confirm if it agrees with the options suggested in section 3.3 and give a view on any further opportunities to strengthen SED adoption across NHS GM. |

| | |
|---|---|
| **How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.** | This report includes content that is relevant to the mitigation of the new BAF risk relating population health outcomes and health inequalities. |
| **Key milestones.** | • 16th July 2025: The Greater Manchester Integrated Care Board formally approved voluntary adoption of the duty<br>• 5th August: 2026 Update to Strategic Commissiong Committee<br>• 26th August 2026: Update to People and Resources Committee<br>• 16th September 2026: Update to Integrated Care Board |
| **Leadership and governance arrangements.** | Strengthening the implementation of the SED to mitigate the impact of poverty and socio-economic disadvantage is a key deliverable set out in the integrated Greater Manchester Public Health Network 2026/27 Action Plan.<br><br>The Associate Director of Population Health is the Senior Responsible Officer for this work programme on behalf of the Greater Manchester Public Health Network<br><br>ICB Chief Officer responsibility sits with the Chief Officer for Strategy, People and Partnerships.<br><br>From a governance perspective, the work programme most clearly aligns with the responsibilities of the Strategic Commissioning Committee but is of relevance to all Committees and the Integrated Care Board. |

| | |
|---|---|
| **Engagement* to date.**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | The NHS GM Tackling Poverty Delivery Group has provided strategic oversight.<br><br>This also aligns to the priorities of the Greater Manchester Live Well Financial Resilience Group. |
| **Financial or Legal Implications** | This report has no financial or legal implications for NHS GM |

| **Public engagement** | **Clinical engagement** | **Sustainability impact** | **Financial advice** | **Legal advice** | **Conflicts of interest** | **Report accessibility** | **EHIA** |
|---|---|---|---|---|---|---|---|
| *No* | *No* | *No* | *No* | *No* | *No* | *No* | *No* |

# 1 Introduction

1.1. Poverty is the single biggest driver of ill health and inequalities, and NHS Greater Manchester has been at the forefront of ICB responses to tackling the impact of poverty on health service access and experience, and on health outcomes.

1.2. The Socio-Economic Duty (SED) places a duty on public bodies to consider how their decisions and policies could increase or decrease the inequalities that arise from socio-economic disadvantage. Although contained within Section 1 of the Equality Act 2010, SED has never been commenced in England but was in Scotland in 2018 and in Wales in 2021. Across England many public authorities have voluntarily adopted the duty including all 10 of Greater Manchester Local Authorities.

1.3. In July 2025, following extensive preparatory work led by the Population Health Tackling Poverty Programme, the Greater Manchester Integrated Care Board supported a formal proposal for NHS GM to voluntarily adopt the Socio-Economic Duty. In joining system partners such as local authorities and Manchester Foundation Trust, NHS GM became the only ICB in England to adopt the duty, reinforcing the GM system response to tackling inequalities and put socio-economic disadvantage as a central focus of the GM health and care system. The board made the specific commitment to:

> *Ensure that meeting the needs of those who experience socio-economic disadvantage is a key consideration of the model(s) of care developed within the ICB transformation programme, specifically within the Strategic Commissioning and Integrated Delivery elements.*

1.4. This report provides:

a) An update on the implementation of the duty over the past 12 months.

b) Next steps to embed SED in the new operating model.

c) An ask to The Committee for a view on additional opportunities to strengthen implementation of SED and demonstrate due regard to socio-economic disadvantage.

# 2 The NHS GM Implementation of the SED

2.1. The existing comprehensive programme of work led by the Population Health Tackling Poverty programme provided strong foundations to advance the organisational changes required to implement the duty. In the past twelve months progress has been made in the following areas:

2.2. **Visible leadership** – NHS GM has an established Tackling Poverty Delivery Group, that convenes system partners in responding to socio-economic disadvantage. This acts as a space to share learning and good practice and to hear from partner organisations and people with lived experience.

Following the voluntary adoption of the SED a complimentary NHS GM SED Implementation Group was established with the purpose of providing leadership and accountability for successful implementation.

2.3. **System Engagement** – a range of activity has taken place to engage and support NHS GM to adopt the duty. This includes individual meetings with system leads ranging from commissioning to communications and facilitating an SED development session for system leaders in partnership with Resolve Poverty. As a result of this activity, SED is increasingly a consideration in key meetings such as the Commissioning Oversight Group where it is regularly considered when reviewing papers and taking decisions. Due to the NHS Reform, much of the planned system engagement activity did not take place and this requires a refreshed approach for 2026/27.

2.4. **A poverty literate workforce** – Since SED adoption the ICP workforce development offer has been strengthened through bespoke training offers delivered by strategic partners Resolve Poverty and the Shared Health Foundation.

- **Resolve Poverty:** Since commissioning the first wave of 'Poverty Awareness Training' in 2023, Resolve Poverty has trained a total of **1,689** individuals from across the diverse ICP workforce. This training is highly evaluated with 100% of attendees stating the training met their expectations, and 98.6% reporting feeling more confident in supporting people experiencing financial difficulty following the training. The 2026/27 commission for this training includes an increased focus on the SED adoption and an enhanced evaluation approach to capture impact beyond the immediate training sessions.

- **The Shared Health Foundation:** In November 2025**,** utilising grant funding provided by the programme, the Shared Health Foundation (SHF) held a 3 day conference bringing together practitioners academics, politicians and those with lived experience to celebrate best practice in addressing poverty in our most deprived communities. Two of the days had a specific focus on the role of health and care looking at the role of GPs and NHS managers. In addition, the SHF continue to equip GM GPs to work in areas of deprivation through the 'In the Deep End' training.

2.5. **Meaningful Equality Health Impact Assessments (EHIA)** - NHS GM have long included socio-economic disadvantage in EHIAs, alongside the nine protected characteristics defined in the Equality Act 2010. In the 12 months since SED adoption actions have been taken to add rigour to the EHIA process and to ensure due regard and provide oversight. This includes establishing an EHIA Rigour Panel to review all assessments and the development of a digital EHIA form.

2.6. **Utilising Data and Insights -** An SED data task and finish group has been established to explore and agree a monitoring framework and set of metrics to demonstrate due diligence and measure impact of the SED adoption. Furthermore, SED is specifically referenced in the NHS GM Integrated Health Needs Assessment Plan ensuring a

strong focus on the impact of socio-economic disadvantage, deprivation and poverty on health outcomes.

# 3 Next steps for SED implementation in GM

3.1. As we progress into the second year of SED adoption and a new organisational operating model, we have greater opportunity to use the implementation of the duty to drive a culture shift, further advancing efforts to reduce variation in access, experience and outcomes.

3.2. The priority next steps for implementation of SED include:

- **Create a GM-Wide Socio-economic Duty Network –** bringing together all 10 LAs and strategic partners Resolve Poverty and The Shared Health Foundation to share good practice and coordinate policy development.
- **Prepare for England SED enactment in April 2027** - work with local and national colleagues to prepare for the expected enactment including the potential opportunity to test the national statutory guidance.
- **Strengthen the evidence base** - finalise the SED outcome monitoring framework within the NHS GM Intelligence Hub and establish a data subgroup to collectively oversee the Health Inequalities Statement, SED and Integrated Health Needs Assessment Plan.
- **Maximise the role of health and care providers as anchor institutions** by embedding the principles of the SED through social value and procurement frameworks, inclusive employment policies and practices, and stronger partnerships with local communities.
- **Enhance SED awareness and compliance** across NHS GM though a refreshed workforce training offer and robust comms and engagement plan.
- **Broaden the membership of the SED Implementation Group** and adopt a sprint-based approach to accelerate delivery, drive progress, and support effective implementation.
- **Strengthen engagement with people who experience socio-economic disadvantage** in services design, decision making and consultation.

3.3. Committee members are encouraged to consider the role NHS GM Committees can play in bringing rigour to SED adoption. Proposed options include:

- The Committee chair to champion best practice and encourage regular attendees to consider socio-economic disadvantage in all discussions and decision-making.
- Amending Committee cover sheets so that the health inequalities box includes a specific ask about the extent to which the report has considered the impact of socio-economic disadvantage and deprivation.

- In the next refresh of The Committee's Terms of Reference, include a specific role of The Committee to ensure due regard to the SED.

- The Committee to ensure any strategic commissioning activity gives due regard to socio-economic disadvantage.

## 4 Recommendations

The NHS GM Committee is asked to:

- Note the breadth of activity that has taken place to implement the SED over the past twelve months.

- Endorse the proposed priorities to strengthen the voluntary adoption of the duty.

- Confirm if The Committee agrees with the options suggested in section 3.3 and give a view on any further opportunities to strengthen SED adoption across NHS GM.

NHS
Greater Manchester

# A Briefing on Donna Ockenden's Review into Nottingham UHT Maternity Services & Baroness Amos's Review of Maternity & Neonatal Services in England,

5th August 2026

Sarah Owen, Associate Director of Maternity

**Part of** Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

# NHS Greater Manchester Strategic Commissioning Committee

| Required information | Details |
|---|---|
| **Title of report** | A Briefing on Donna Ockenden's Review into Nottingham UHT Maternity Services & Baroness Amos's Review of Maternity & Neonatal Services in England, July 2026 |
| **Author** | Sarah Owen, Associate Director of Maternity |
| **Presented by** | Sarah Owen, Associate Director of Maternity |
| **Contact for further information** | Sarah.owen61@nhs.net |
| **Executive summary** | This paper provides a strategic briefing on the findings and implications of the Nottingham Maternity Review led by Donna Ockenden, the Independent National Maternity and Neonatal Investigation led by Baroness Valerie Amos, and the subsequent NHS England 10 Point Plan for Maternity and Neonatal Services.<br>It summarises the emerging national themes, highlights the implications for Greater Manchester, and outlines the work already underway through the GM Local Maternity & Neonatal System (LMNS) to support implementation of national priorities. The paper is intended to provide assurance that GM LMNS is well positioned to respond to the evolving national maternity agenda and to support informed discussion at the Strategic Commissioning Committee. |
| **The benefits that the population of Greater Manchester will experience.** | By supporting early understanding of emerging national recommendations, this briefing will help Greater Manchester continue to strengthen maternity and neonatal services through proactive planning, considered commissioning and timely implementation of national priorities.<br>Supporting GM to continue to deliver safe, high-quality and equitable care for women, babies and families, while helping to reduce unwarranted variation and improve patient experience and outcomes |
| **How health inequalities will be reduced in Greater Manchester's communities.** | This paper supports Greater Manchester's commitment to reducing inequalities in maternity and neonatal care by reinforcing implementation of national recommendations relating to equity, anti-discrimination and population health. It supports the continued delivery of the Greater Manchester Maternity & Neonatal Equity and Equality Action Plan and reinforces ongoing work to reduce unwarranted variation in outcomes and improve the experiences of women, babies and |

| | |
|---|---|
| | families from underserved and disadvantaged communities |
| **The decision to be made and/or input sought** | The Strategic Commissioning Committee is asked to note the contents of this briefing and the emerging implications for maternity and neonatal services in Greater Manchester, recognising the importance of continued system-wide collaboration to support implementation of the resulting national priorities, including the NHS England 10 Point Plan for Maternity and Neonatal Services |
| **How this supports the delivery of the strategy and mitigates the BAF risks** | This paper supports NHS Greater Manchester's strategic objectives by informing system-wide planning and implementation of emerging national maternity and neonatal priorities. It contributes to mitigating the Board Assurance Framework risk relating to the ICB's statutory responsibilities for quality assurance and patient safety through strengthened commissioning, governance and quality oversight. |
| **Key milestones** | Key milestones include<br>• Implementation of the NHS England 10 Point Plan for Maternity and Neonatal Services throughout 2026/27<br>• Publication of the National Maternity & Neonatal Action Plan by the National Maternity & Neonatal Taskforce in December 2026.<br>Greater Manchester will continue to align its commissioning and improvement programmes with these national priorities. |
| **Leadership and governance arrangements** | • Chief Officers Briefing 08/07/2026<br>Planned for:<br>• GM Local Maternity & Neonatal System Group 14/07/2026<br>• Clinical Effectiveness Group 30/07/2026 |
| **Engagement* to date**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | • Chief Officers Briefing 08/07/2026<br>Planned for:<br>• GM Local Maternity & Neonatal System Group 14/07/2026<br>• Clinical Effectiveness Group 30/07/2026 |

| Quality and Clinical Governance Framework – tick applicable pillars of the framework √ | |
|---|---|
| √ | Clinical Governance (The use of clinical audit, standards and policies; risk processes; and compliance with legal frameworks to improve quality of care) |
| √ | Clinical Effectiveness (Tackling unwarranted variation; horizon scanning; sharing learning and best practice; |

| | |
|---|---|
| | assuring evidenced based care; and innovation and research) |
| | Quality Improvement (Through adoption of formal Quality Improvement (QI) methodologies, using QI to drive system improvement) |
| | Clinical Transformation (Clinical strategy and transformation via pathway and service redesign and new models of care) |
| √ | Clinical Leadership (Embedding the clinical voice at every level across the GM health system; supporting the development of clinical leaders and developing future clinical leaders). |
| ICS/Q&P Objective – Tick applicable objectives | |
| √ | Improve outcomes in population health |
| √ | Tackle inequalities in health and health care |
| | Enhance productivity and value for money |
| | Help the NHS support broader social and economic development |
| Associated risk – high alert | |
| Quality & Performance | |
| Clinical | |
| Governance | |
| Other | |
| Ask of system partners | |
| Please outline the requirement of ICB Locality team functions or system partners | |

*Table 3 -alignment to quality and Clinical Governance Framework, and ICS/Q&P Objectives*

GREATER MANCHESTER
LOCAL MATERNITY AND
NEONATAL SYSTEM

# GM ICB Briefing on: Ockenden's Review into Nottingham UHT Maternity Services & Baroness Amos's Review of Maternity & Neonatal Services in England

## 5th August 2026

Sarah Owen

Associate Director of Maternity

Greater Manchester Integrated Care Partnership

GREATER MANCHESTER LOCAL MATERNITY AND NEONATAL SYSTEM

Greater Manchester Integrated Care Partnership

Ockenden Review of Maternity Services at Nottingham UHT

# The Independent Maternity Review into Maternity Services at Nottingham University Hospital Trust

## Led by Donna Ockenden – Published Wednesday 24th June

# The picture so far . . . . .

Background

Culture within Maternity & Neonatal services remains at the forefront of the NHS agenda, with numerous external reviews of individual maternity providers resulting in overarching themes including:

- **Failing to listen to patients**
- **Not learning from investigations**
- **Poor behaviour and a corrosive blame culture**
- **Lack of effective leadership for patient safety**
- **Absence of an effective regulatory framework**

These themes were identified in specific reports from independent investigations:

- 2015 Kirkup's report into maternity services at Morecambe Bay Kirkup Review of Maternity Services at Morecambe Bay
- 2022 Ockenden's report into maternity services at Shrewsbury & Telford (Ockenden 1 & 2) OCKENDEN REPORT - FINAL
- 2022 Kirkup's report into maternity services at East Kent Kirkup Review of Maternity Services at East Kent

Additionally, the NHS England Maternity & Neonatal 3-Year Delivery Plan , a robust action plan to improve maternity services in England concluded in March 2026

Baroness Amos was commissioned in August 2025 by the then Secretary of State for Health & Social Care to chair a rapid Investigation to understand why avoidable deaths and harm to women, birthing people and babies continue to occur, despite multiple reviews, inquiries and hundreds of previous recommendations across maternity and neonatal care. About - National Maternity and Neonatal Investigation

# Baroness Amos', Reflections & Initial Impressions (December 2025)

*"Since 2015, there have been a significant number of independent investigations and reviews of maternity and neonatal services in NHS Trusts across England.*

*This is in addition to national reviews looking at patient safety and care, which impact on maternity and neonatal services, as well as reviews by regulatory bodies in England, such as the Care Quality Commission (CQC).*

*At the time of writing, the NHS has recorded a staggering 748 recommendations relating to maternity and neonatal care, the majority of which have been made since 2015"*

Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation

"Women and babies were failed by a system that did not listen, did not learn, and did not act.“

Ockenden Review into Maternity Services at Nottingham UHT, June 2026

# Ockenden Review of Services at Nottingham UHT, June 2026

The Nottingham Review is now the largest maternity & neonatal review in NHS history.

- 3007 cases reviewed, with over 2,500 families included.
- Care episodes reviewed spanned 2012–2025 (maternal deaths from 2006 onwards).
- More than 830 current and former staff contributed evidence.
- The Review concluded that approximately 520 mothers and babies died or suffered serious harm which was considered potentially avoidable.
- The review identified longstanding failures across antenatal, intrapartum, postnatal and neonatal care.
- A toxic organisational culture was found to have prevented learning, improvement and openness for over a decade.

Some Interesting Scrutiny of the data provided in the report:

- Ockenden's Review of Shrewsbury & Telford, Final Report March 2022 with 22 IEA's
  If you consider any case from 1/1/2023 as being 'Post Ockenden's National Recommendations'
  - In Nottingham 3007 cases were reviewed
    - 2641 (87.8%) of these were prior to 2023
  - Of the 3007 cases, in 520 of these the death or harm was considered 'Avoidable'
    - 466 (89.6%) of these were prior to 2023

# Ockenden's Immediate & Essential Actions

There are **8 key** headings & themes for the Immediate and Essential Actions
These headings include: 18 IEAs in total and a total of 72 actions:

- **Theme 1: Listening to Women & Families** (7 underpinning actions)
  - IEA 1: Strengthening women-centred communication and informed choice
- **Theme 2: Workforce Planning & Safe Staffing** (10 underpinning actions)
  - IEA 2: Support a nationally agreed perinatal workforce planning methodology as a critical enabler of perinatal improvement at pace and scale
- **Theme 3: Training & Multi-Professional Learning** (6 underpinning actions)
  - IEA 3: National IEA for Labour Ward Coordinator Role
  - IEA 4: All trusts must support Training for Midwives in the use of Speculum Examination
  - IEA 5: Enhanced Maternal Care
- **Theme 4: Risk Assessment Throughout Pregnancy** (30+ underpinning actions)
  - IEA 6: Delivering Safe, Personalised and Equitable Maternity Care Through Early Risk Recognition, Coordinated Care and Responsive Services
  - IEA 7: National standard for standardisation and recording of fetal growth risk assessment
  - IEA 8: There must be a national standard and documentation for maternity triage and record keeping in maternity care provision
  - IEA 9: Support the development and implementation of a structured assessment framework for the latent phase of labour, ensuring clarity when the 'latent phase of labour' becomes abnormal requiring escalation
  - IEA 10: All Trusts must define criteria for the safe use of telephone postnatal follow-up, indicating when telephone follow-up is acceptable or when face-to-face follow-up is mandatory
  - IEA 11: National standard for obstetric anaesthetic record-keeping
  - IEA 12: Safe, accessible and comprehensive maternity anaesthetic documentation
  - IEA 13: DHSC/NHSE should introduce and support access to coordinated multidisciplinary debrief and psychological support
- **Theme 5: Incident Investigation & Family Involvement** (10 underpinning actions)
  - IEA 14: Funding for implementation of Maternity Patient Safety Incident Reporting Framework (PSIRF)
- **Theme 6. Governance & Board Accountability**
  - IEA 15: Strengthened multidisciplinary governance and learning

# Ockenden's Immediate & Essential Actions

- **Theme 7: Culture, Teamwork & Psychological Safety** (2 underpinning actions)
  IEA 16: Foster a compassionate, psychologically safe, and learning culture
  IEA 17: DHSC/NHSE should recommend and support recruitment processes and implement a consistent onboarding package for new starters
- **Theme 8: Mothers Who Have Died and Post Death Care**
  IEA 18: All Trusts to ensure compliance, audited annually, with the NHS Records Management Code of Practice (2023).

**Post-Death Care :**

1. Cease the practice of conducting postmortem examinations anywhere except the mortuary.
2. Ensure all deceased patients are fully – or if there is a valid technical reason, temporarily – reconstructed to a high standard immediately after their postmortem examination. If reconstruction must be delayed, the rationale for this decision should be recorded and referenced in subsequent condition checks of the deceased person, so there is a clear audit trail and timeline prior to final reconstruction.
3. Ensure all investigations or reviews into after-death care include an independent post-death care specialist
4. Formally review all staff roles involved in the delivery of post-death care to:
   a. Map post-death care roles, responsibilities and scope of practice for each staff group.
   b. Identify points of crossover or duplication between each staff group.
   c. Define robust communication pathways for each staff group, for each post-death care process.

**National Action:**

1. Introduce statutory regulation of Anatomical Pathology Technologists.
2. Ensure that paediatric postmortems of babies >12 weeks gestation are only undertaken by qualified Anatomical Pathology Technologists, specifically trained and competent in paediatric evisceration and reconstruction techniques

GREATER MANCHESTER LOCAL MATERNITY AND NEONATAL SYSTEM

Greater Manchester Integrated Care Partnership

Amos Review of Maternity & Neonatal Services in England

# Independent Investigation into Maternity and Neonatal Services in England

## Led by Baroness Valerie Amos – Published Tuesday 30th June

# Amos Review into Maternity and Neonatal Services in England, June 2026

## Background

The Independent National Maternity & Neonatal Investigation, chaired by Baroness Valerie Amos, was commissioned by the Secretary of State following repeated failures in maternity and neonatal services despite numerous previous national reviews and inquiries. Rather than focusing on a single NHS Trust, the investigation examined the maternity and neonatal system across England, drawing on evidence from affected families, frontline staff, NHS organisations, regulators and previous inquiries. Its purpose was to identify why avoidable harm continues to occur and to recommend whole-system reform.

## Overall conclusion

The report concludes that England's maternity and neonatal system is not currently designed to consistently deliver safe, equitable, high-quality and compassionate care.

The investigation identifies that failures are systemic rather than isolated, with recurring issues found across multiple organisations despite more than a decade of reviews and recommendations.

Baroness Amos concludes that incremental improvement is no longer sufficient, and that fundamental redesign of the national maternity and neonatal system is required.

## Key Themes

- The report identifies eight overarching areas requiring national reform:
- Improving the experience of women, babies and families by ensuring they are listened to and involved in decision-making.
- Delivering consistently safe, high-quality maternity and neonatal care.
- Improving how incidents are investigated, responded to and learnt from.
- Developing a new national **Modern Service Framework** with consistent standards across England.
- Tackling racism, discrimination and health inequalities.
- Strengthening governance, accountability and regulatory oversight.
- Improving leadership, organisational culture and multidisciplinary team working.
- Modernising estates, equipment and digital infrastructure to support safe care.

## Principle Recommendations

The report proposes significant structural reform, including:

- Creation of a new statutory Maternity and Neonatal Commissioner, accountable directly to Parliament.
- Development of a national Modern Service Framework setting minimum standards for maternity and neonatal care.
- Simplification of national governance and accountability arrangements.
- Strengthened regulatory oversight, including improvements to inspection and assurance processes.
- Greater emphasis on listening to women and families, with their experiences informing improvement.
- A system-wide focus on eliminating racism and discrimination.
- National improvements in workforce culture, leadership and multidisciplinary working.
- Investment in digital systems, estates and infrastructure to support safer care.

## Immediate Priorities

Whilst recognising that structural reform will take time, Baroness Amos identifies several actions that should begin immediately, including:

- Urgent review of maternity triage arrangements within NHS Trusts.
- Early legislation to establish the proposed Maternity and Neonatal Commissioner.
- Accelerated work to strengthen governance, accountability and learning following adverse events.

**Potential Implications for Integrated Care Boards:**

The report reinforces the expectation that ICBs will continue to play a key role in:

- Commissioning high-quality maternity and neonatal services
- Quality surveillance and early identification of deteriorating performance
- Ensuring effective governance and system oversight
- Reducing unwarranted variation and health inequalities
- Supporting collaborative improvement across providers
- Ensuring the voices of women and families are central to service improvement

Although the report recommends national structural change, it is likely to increase expectations on ICBs to provide stronger assurance and system leadership whilst implementation is undertaken nationally.

The Amos Review marks a shift from previous maternity reviews. Rather than making further recommendations aimed primarily at individual providers, it concludes that the architecture of the maternity and neonatal system itself requires redesign.

The report calls for a nationally coordinated programme of reform focused on safety, equity, accountability and compassionate care, underpinned by clearer national leadership, stronger governance and greater accountability to women, families and Parliament

# 10 Point Plan for Maternity and Neonatal Services

On the 1st July Jim Mackey wrote a letter to all NHS Trust's & ICB's describing the **10 Immediate Actions** required to address Baroness Amos' National Investigation and Donna Ockenden's Nottingham Review.
These urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December 2026.

| Urgent Action | Description | GM LMNS Comments |
|---|---|---|
| Listening to women and their families by rolling out Martha's Rule | Commence roll out of **Martha's Rule** across all maternity and neonatal services in 2026/27.<br>Implementation will be led by the national Martha's Rule programme team who will contact provider organisations in the coming weeks | MFT was a pilot site for Martha's Rule, NCA have started to consider plans for this. Health Innovation Manchester will support the roll out across GM |
| Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level | All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards, using locally meaningful measures like the friends and family test, selected elements of '**Patient Reported Experience Measure**' (when available) and insights from maternity and neonatal voices partnerships (**MNVP**s). | GM LMNS MNVP service model is considered the Gold Standard and is used as an exemplar across England |
| Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care | All trusts must establish clear joint accountability at board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership. | GM LMNS continues to prioritise 'system working' as it focuses for the future with all 2026/27 workstreams prioritising collaboration with for example; Primary Care, PNMH, Place Partnerships & Secondary Care<br><br>Does the new Chief Clinical Officer Model put GM ICB in a excellent position to eliminate siloed working |

# 10 Point Plan for Maternity and Neonatal Services

| Urgent Action | Description | GM LMNS Comments |
|---|---|---|
| 'Amos into action' staff listening exercise | NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it | All GM Providers have fully engaged with the 'Perinatal Culture & Leadership Programme' which focuses on listening to staff and improving staff culture |
| Addressing inequalities in maternity and neonatal outcomes | National rollout of the **Perinatal Equity and Anti-discrimination Programme**, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism.<br>Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital<br>All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle (MCB) by March 2027. | GM LMNS has led the way with the development & implementation of the 'Greater Manchester Equity and Equality Action Plan' and continues to support this programme<br><br>GM LMNS is leading regional discussions to develop a much more in depth 'North West Inequalities Dashboard'<br>GM LMNS has a full programme to support the implementation of the MCB in GM |
| Ensuring 24/7 safety and responsiveness of maternity and neonatal services | All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups<br>Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families. | Significant work has been supported in GM to align to PSIRF & Safer Staffing Requirements. |

| Year | Maternity Services Vacancy Rate | Turnover Rate |
|---|---|---|
| 2024 | 102.6wte | 13.7% |
| 2025 | 84.7wte | 11.8% |
| Current | 18.5wte | 7.1% |

GREATER MANCHESTER LOCAL MATERNITY AND NEONATAL SYSTEM

# 10 Point Plan for Maternity and Neonatal Services

Greater Manchester Integrated Care Partnership

| Urgent Action | Description | GM LMNS Comments |
|---|---|---|
| Trusts to review their homebirth services | Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer (CMO) for England asked trusts to urgently review the safety and quality of their homebirth services. | GM LMNS undertook a review of all services following a serious incident at MFT. All GM providers have completed the CMO instructed review. MFT are supporting the National work |
| Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach | Trust boards should review how they are responding to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour. NHSE will work with trusts, in alignment with the work of the national taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care. | NHSE led work |
| Deliver safe and effective triage in maternity services | All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week. | All GM providers submit quarterly data (moving to monthly from August 2026), aligned to the RCOG Maternity Triage Good Practice Paper & the National Triage Standards. Annual assurance visits have assessed these standards |
| Post death care | All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years. | NHSE led work |

GREATER MANCHESTER
LOCAL MATERNITY AND
NEONATAL SYSTEM

Greater
Manchester
Integrated Care
Partnership

# Questions & Discussion