NHS
Greater Manchester

Agenda

Greater Manchester People & Resource Committee (Public)

Date: 26 August 2026

Time: 14:00pm to 15:30pm

Venue: Microsoft Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:00	5 mins	Welcome, Introductions and Apologies Attendance Matrix	Verbal Paper	Information	Kal Kay *Chair*
2.			Declarations of Interest	Paper	Noting	
3.			Minutes, Action Log and Matters Arising	Paper	Approval	
Strategic Updates						
4.	14.05	5 mins	Terms of Reference Review	Paper	Discussion	Chris Gaffey *Associate Director of Corporate Services*
5.	14:10	15 mins	Chief Strategy, People and Partnerships Officer Update Workforce Report	Paper Paper	Discussion Discussion	Charlotte Bailey, *Chief Strategy, People and Partnerships Officer*
6.	14:25	15 mins	Chief Reform and Improvement Officer Update Digital and IT Report	Paper Paper	Discussion Discussion	Nicola Hepburn *Acting Chief Reform and Improvement Officer*
7.	14:40	15 mins	Chief Finance Officer Update Finance Report	Paper Paper	Discussion Discussion	Kathy Roe *Chief Finance Officer/* Jackie Gardiner, *Director of Operational Finance*
8.	14:55	10 mins	Socio-Economic Duty	Paper	Discussion	David Boulger *Associate Director – Population Health*
9.	15:15	10 mins	Mersey Internal Audit Reports	Paper	Discussion	Nicola Hepburn *Chief Officer, Reform and System Improvement*
10.	15:25	5 mins	Workplan	Paper	Discussion	Kal Kay *Chair*
For Information						

11.	15:30	0 mins	Performance Report	Paper	Information	N/A
12.	15:30	0 mins	Any other business Board Paper Escalations Meeting Reflections	Verbal	Discussion / Noting	All
Date and time of next meeting: **Wednesday 23 September 2026, 14:00pm – 16:00pm - MS Teams**						

Item A - People & Resource Committee (Public) Attendance Matrix 2026/27

Key:

Present	
Apologies	
Attendance Not Required	
No Explanation	
Member as per Terms of Reference	
Apologies provided but Substitute attended on behalf	
No longer a member	

Member:	*Title*	*April*	*May*	*June*	*July*	*August*	*September*	*October*	*November*	*December*	*January*	*February*	*March*
Kal Kay	Non Executive Director- Chair Finance Committee												
Jackie Njoroge	Non Executive Director- Vice Chair												
Richard Paver	Non Executive Director												
Vish Mehra	NHS GM Partner Member												
Owen Williams	NHS GM Partner Member												
Colin Scales	Acting Chief Executive Officer												
Kathy Roe	Chief Finance Officer												
Charlotte Bailey	Chief Strategy, People and Partnerships Officer												
Nicola Hepburn	Acting Chief Reform and Improvement Officer												

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Bailey, Ms. Charlotte Elizabeth	Y			Nil			
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
Scales, Mr. Colin	Y	I have no interests to declare		Honorary Professor at UCLan		2024	
Scales, Mr. Colin	Y	Indirect interests	Outside employment	Wife works at NCA as a nurse		19/09/2024	Ongoing
Non-Executive Directors	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Outside employment	Interim FD Derian House Childrens Hospice		06/10/2025	
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Shareholdings and other ownership interests	Director and Shareholder of GSD Financial Consulting Ltd	Set up my own consultancy firm	01/04/2025	
Kay, Mrs. Khalida (Kal)	Y	Non-financial personal interests	Outside employment	Great Academies Education Trust	Trustee (non remunerated)	20/04/2020	
Kay, Mrs. Khalida (Kal)	Y	Non-financial professional interest	Shareholdings and other ownership interests	Association of Camerados	Non Exec, non remunerated director	22/10/2018	
Paver, Mr. Richard	Y	I have no interests to declare					
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**
Williams, Dr Owen	Y	Non-financial professional interest	Loyalty interests	Co-Chair of the Chairs and CEO NHS Ethnic Minority Network		2021	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Loyalty interests	Acute Partner Member of the NHS Greater Manchester Integrated Care Board (ICB)		2022	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Loyalty interests	Chair - Yorkshire and Hmber PSRC Strategic Advisory Board		Jan-24	Ongoing
Williams, Dr Owen	Y	Financial interests	Loyalty interests	Chief Executive Officer – Northern Care Alliance NHS Foundation Trust		Nov-21	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Chief Medical Officer for Health Innovation Manchester	Ongoing	Dec-25	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Clinical Director, Gorton and Levenshulme Primary Care Network	Ongoing	Apr-19	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Executive Committee Member, Manchester Local medical Committee	Ongoing	Jan-26	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Salaried GP, West Point Medical Centre	Ongoing	Apr-23	Ongoing

NHS
Greater Manchester

Terms of Reference Review

August 2026

Part of Greater Manchester
Integrated Care Partnership

People and Resources Committee

26 August 2026

Report information.

Required information.	Details.
Title of report.	Terms of Reference (TOR) Review
Author.	Jenny Noble, Board Secretary
Presented by.	Chris Gaffey, Associate Director of Corporate Services
Contact for further information.	Jenny Noble, Board Secretary jennynoble@nhs.net
Executive summary.	This paper sets out the People and Resources Committee Terms of Reference for consideration following the 3-month review. There are minor changes proposed, including to the membership and quorum following comments received from members. Any changes to the TOR must be submitted to the Board for approval before being formally implemented by the Committee in line with the process prescribed in the NHS GM Constitution. The Terms of Reference will remain under review as further work on strengthening governance arrangements (as part of the Governance Improvement Plan) continues.

The benefits that the population of Greater Manchester will experience.	Good governance arrangements will facilitate effective decision making which will benefit the population of GM.
How health inequalities will be reduced in Greater Manchester's communities.	Effective and efficient decision making will help to reduce health inequalities.
The decision to be made and/or input sought.	Consider and agree the proposed changes to the Committee's Terms of Reference before presentation to the Board for approval.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring the TOR are reviewed annually will ensure these areas are considered as part of any discussion in relation to NHS GM BAF risks, supporting the delivery of the ICP strategy.
Key milestones.	The proposal is for the TOR of the People and Resources Committee to be submitted to the September 2026 Board.
Leadership and governance arrangements.	Kal Kay, Non-Executive Director as Chair of the People and Resources Committee Kathy Roe, Chief Finance Officer, and Charlotte Bailey, Chief Strategy, People and Partnerships Officer, are the Lead Execs for the People and Resources Committee.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Feedback survey completed as part of 3-month governance review. Virtual engagement with Committee members requesting additional views and feedback.
Financial or Legal Implications	N/A

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

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

Table 2: Assurance needed about the document.

Introduction

1.1. This paper sets out the People and Resources Committee Terms of Reference for consideration following the 3-month review.

Background

1.2. The current TOR requires that these will be reviewed on at least an annual basis and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

1.3. The TOR were last reviewed and recommended for approval by the Transition Committee and approved by Board in March 2026.

1.4. The TOR have been reviewed as part of the ongoing review of Committee arrangements following their establishment in April 2026, providing further clarity for Committees regarding their remit, whilst also ensuring that all TORs were fully aligned with the delegations prescribed within the Scheme of Delegation and Reservation (SORD) as well as the Operating Model.

Proposed Changes and Further Considerations

1.5. For the People and Resources Committee, the following changes are proposed:

- Adding the Procurement and Contracting Strategy to the duties under finance
- Including all Chief Officers as members of the Committee and reducing the number of Partner Members noting that potential conflicts of interest will need to be managed
- Increasing the quorum from 3 to 4, including one other Chief Officer to reflect the level of delegated authority to the committee
- Minor typographical amendments throughout.

1.6. As arrangements continue to be review in line with the ongoing Governance Improvement Plan, additional changes to the People and Resources Committee ToR may be required as arrangements develop.

1.7. Any potential changes will be discussed with the People and Resources Committee Chair ahead of their presentation to the People and Resources Committee for consideration.

Recommendations

1.8. The NHS GM People and Resources Committee is asked to:

- Consider and agree the proposed changes to the Committee's Terms of Reference before presentation to the Board for approval.

NHS Greater Manchester

People and Resources Committee

Terms of Reference

Purpose	The purpose of the People and Resources Committee ('the Committee') is to obtain assurance, on behalf of the Board, that the ICB will achieve its statutory financial duties, and that the system is financially sustainable, by having the right financial strategy that results in the ICB meeting its financial targets and sustainability. The Committee will also provide strategic oversight, assurance, and guidance on behalf of the Board on all matters relating to workforce, organisational culture, and staff experience across NHS GM. The Committee will ensure that through the delivery of our organisation's People Plan, NHS GM fosters an inclusive, compassionate, and high-performing culture that supports the recruitment, retention, wellbeing, and development of its people. The Committee will also provide strategic oversight and assurance on matters relating to estates and environmental sustainability across NHS GM, as well as receiving assurance and constructively challenging the operational resourcing and delivery in the areas of digital and IT infrastructure, and data and intelligence. The Committee will operate within an agreed shared governance model with the Strategic Commissioning Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals and ensure delivery of investment standards. The People and Resources and Strategic Commissioning Committees will collectively provide Board assurance across the end-to-end strategic commissioning cycle, from assessment of population need and outcomes, through prioritisation and design, to resource enablement, implementation, performance, value and learning. Specifically, the People and Resources Committee leads on enabling delivery of agreed commissioning intent through workforce, finance, estates, IT, data and infrastructure, ensuring affordability, sustainability and value. The Committees will share information, risks, and escalations in a systematic and timely way to support effective Board oversight.
Duties	The Committee will: <u>Finance</u> **Financial strategy and planning** - Ensure delivery of the ICB financial plan / strategy and make recommendations to the Board

- Have oversight of the ICS financial position
- Where delivery of the financial plan is not assured, ensure the necessary actions are being taken to recover the position wherever possible
- Apply constructive challenge to medium and long-term ICB financial plans and monitor their implementation.
- Approve and receive assurance on the delivery of the Procurement and Contracting Strategy.

Financial resource allocation

- Apply constructive challenge to proposals in line with Financial Scheme of Delegation.
- Apply constructive challenge to business cases for major investments / disinvestments for material service change or efficiency schemes.
- 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.

Financial performance

- Provide assurance in relation to the ICB achieving its statutory duties.

People

Strategy and planning

- Review the NHS GM People, Culture and Organisational Development Plan and monitor progress with its implementation, through regular highlight reports.
- Review delivery of the ICB workforce elements of the 10 Year Health Plan, with a focus on sustainability and effectiveness.
- Oversee workforce planning, transformation and change programmes on behalf of the organisation.
- Oversee our performance against CQC standards, with a focus on the 'well led' measure.

Statutory duties

	- The approval of disciplinary process and arrangements for employees, including the accountable officer (where he/she is an employee of NHS GM) and for other persons working on behalf of NHS GM. - Making recommendations regarding the approval of arrangements for discharging NHS GM's statutory duties as an Employer and for staff appointments. - Making recommendations to the Remuneration Committee on items relating to the terms and conditions, remuneration and allowances for non-AfC employees. - Reviewing national policy and implementing accordingly, to ensure the organisation follows core employment legislation changes etc. - Provide system oversight of workforce efficiencies. **Workforce performance and experience** - To monitor and review workforce key performance indicators for the organisation, including sickness absence, training, appraisal, bank and agency usage and escalate any issues to the NHS GM Board. - Review the results of the annual staff survey and any other staff surveys and proposed organisation action plans. - Review reports from the Freedom to Speak Up Guardian regarding activity within the organisation, reflecting the updated national and regional models. - Review and approve partnership agreements with staff side. **Equality, diversity and inclusion** - Review workforce elements of the organisation's Equality, Diversity and Inclusion Implementation Plan prior to its submission to the Board, and monitor progress with delivery, including review of WRES, WDES, PSED, Gender, Disability and Ethnicity Pay Gap reports. - Oversee progress to act on the Anti-Racism Framework and the Sexual Safety Charter. Estates **Strategy** - To monitor implementation of the Infrastructure Strategy ensuring outcomes are achieved in line with required timescales - Apply constructive challenge whilst working collaboratively with Strategic Partners and Stakeholders to drive the development of a flexible, greener and cost-efficient estate, aligned with service transformation priorities

	Utilisation - Provide strategic direction and support in achieving realistic cost efficiencies and effective use of accommodation whilst ensuring optimum utilisation of retained estate - Ensure Department of Health Property Companies work in partnership with NHS GM to increase levels of utilisation; reduce void and subsidy costs; increase capital investment in the retained estate and to consider options at the end of the Local Improvement Finance Trust (LIFT) lease concessionary periods Primary Care - Review GP non mandatory occupational subsidies to reduce reimbursement costs and achieve an equitable outcome for all NHS GM practices - Ensure adherence to statutory requirements under the provisions of the Premises Cost Directions in relation to GP Practice new leases and lease renewals in order to achieve value for money in terms of rent reimbursement - Provide strategic advice and support to ensure primary care capital and revenue business case governance and approvals processes are followed **Corporate** - Review the corporate estate to establish strategic need and drive best practice in terms of provision and utilisation - Promote flexible access to accommodation throughout the corporate estate - Promote a robust Health & Safety culture ensuring compliance with statutory regulations and business policies <u>Environmental Sustainability</u> - Assurance of appropriate oversight for the implementation of the NHS Greater Manchester Green Plan - Assurance of appropriate oversight for NHS Greater Manchester's statutory responsibilities on environmental sustainability <u>IT and Digital</u> - Apply constructive challenge to the operational resourcing and delivery of digital and IT infrastructure. - Oversee and obtain assurance on resource planning and allocation for

	digital/IT. - Apply constructive challenge to evidence of deliverability, value creation integration with estates/workforce functions. Data - Manage corporate risks in relation to the maintenance and development of the ICB's data assets. This will involve recognising the centrality of the asset to the wider system, including the provision of a secure data environment to support Research and innovation. - Oversee and obtain assurance on data assets in respect of data governance, infrastructure investment, recognising that data costs are naturally inflationary and that the commercial value of data is being realised through partnership reimbursement (data is not a free good) - Oversee and obtain assurance that data and analytical skills are being developed and supported in accordance with professionalisation and the future requirements of the organisation and ~~it's~~its role in the system **Enabling strategies** - Provide assurance around any enabling strategies, e.g. capital, and monitor their implementation. **Strategic risks** - Monitor and provide assurance to the Board on BAF risks assigned to the committee, as well as relevant Corporate Risks. **Other Duties** - Review and recommend the ICB's Standing Financial Instructions to the ICB Board. - Apply constructive challenge to action taken in response to changes in relevant national policy. - Approve any business cases, procurements, non-healthcare contracts and expenditure and also be notified of any Individualised Commissioning healthcare placements or packages in line with the financial scheme of delegation.
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 Executive Officer • Chief Finance Officer • Chief Strategy, People and Partnerships Officer • Chief Reform and Improvement Officer • Chief Clinical Officer • Chief Commissioning Officer * partner members will be excluded from the Private section of the People and Resources Committee meetings due to potential and perceived conflicts of interests
Attendees	Where any conflicts of interest arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting. Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter. The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.
Delegated authority	The Committee is established by the Board as a Committee of the Board in accordance with its constitution. The Committee has delegated responsibility by the Board to: • Investigate any activity within its terms of reference • Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference • Commission any reports it deems necessary to help fulfil its obligations • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • The Committee may establish a sub-committee and arrange for the functions exercisable by the Committee to be exercised by the sub-committee. For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. Members will be expected to conduct business in line with NHS GM values and behaviours, including demonstrably considering the equality and diversity implications of decisions they make.

Meeting management	**Frequency** The Committee shall meet monthly a minimum of 10 times per year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. Meetings will be held in public, however there may be occasions where items will need to be considered in private. Anyd decisions to consider items in private will be evidenced, and be by agreement with the Chair. Contract monitoring and oversight will be considered in Private due to the commercial sensitivity of the data included within those reports. **Agenda and papers** The agenda and papers for meetings will be distributed five working days in advance of the meeting. **Attendance and Quorum** A quorum shall consist of 43 Committee members, including the Chair or Vice Chair, one other Non-Executive Director, and the Chief Finance Officer (or Deputy Chief Finance Officer) and one other Chief Officer. Members should attend at least 75% of meetings within any calendar year. Members are expected to nominate a deputy to attend in their absence. Attendance will be monitored and addressed by the Chair, who will be responsible for discussing regular non-attendance with the relevant member. The Chair of the Committee will also be required to bring to the attention of the Chair of NHS GM if they feel that lack of attendance has not enabled adequate discussion or decision making. **Support** The Corporate Governance team will support the Ccommittee and the Chair of the Committee. **Conflict of interest** Conflicts of interest should be disclosed and managed in line with the NHS GM Conflict of Interest Policy. The Cchair is responsible for the management of all conflict of interest matters. **Reporting** The Committee Chair shall report to the Board on the Committee's activities by: • Providing a written update report following each meeting • The presentation of an annual report • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board. The Chair of the Committee

	shall draw to the attention of the Board of any issues that require disclosure to the full Board of Directors, or require action. **Annual self-assessment** The Committee shall undertake an annual self-assessment. It will report thereon to the Board. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
Date agreed by the People and Resources Committee:	
Date approved by the Board:	
Review date:	

Appendix: Constructive challenge

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

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

NHS
Greater Manchester

Chief Strategy, People and Partnerships Officer - Alert Report P&C

24th August 2026

NHS Greater Manchester

NHS Greater Manchester People and Resources Committee

24th August 2026

Required information	Details
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report P&C
Author	Rachel Watkin, Strategy & Partnerships Delivery Lead
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 People and Resources Committee regarding key people and culture priorities, risks and mitigations as overseen by the People and Culture Sub-Group. All programmes are currently on track.
The benefits that the population of Greater Manchester will experience.	To support our staff to be their best in order to deliver our ambitions for GM.
How health inequalities will be reduced in Greater Manchester's communities.	To support our staff to be their best in order to deliver our ambitions, including tackling health inequalities for GM and leading by example.
The decision to be made and/or input sought	The PRC is asked to: Note the report
How this supports the delivery of the strategy and mitigates the BAF risks	Relates to the ability of our workforce to perform at their best and supports the organisation's ability to manage all BAF risks.
Key milestones	New model commenced in April 2026 – priorities and associated KPIs to be reviewed.
Leadership and governance arrangements	Development of this report is done in line with the workplan for the People and Resources Committee and as supported by the People and Culture supporting group. The Director or People, Communications and Engagement is the responsible officer for this report and has approved its content. The Chief Strategy, People and Partnerships Officer is the accountable officer for this report and has approved its content.

Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as it is produced for 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

Mandatory training (MT)

Workforce training compliance is at 94% as of M04, which is below the national target of 95%. This has been the case since Nov 2025 and is likely to be a result of staff de-prioritising the completion of outstanding modules through the uncertainty of Reform and with busy workloads.

Dedicated engagement is ongoing with the Extended Leadership Team to improve compliance as that team is significantly below the rest of the organisation, showing a 22.6% variance from target - which has been the case now for lengthy period.

There is particular concern with the Information Governance (IG) and Data Security module, where compliance stands at 84.7%, which is 10.3 % points below the national target - representing a significant risk to the ICB in relation to information security, regulatory compliance and organisational reputation.

It is expected that the introduction of the Mandatory Training & Learning Oversight Group (MLOG) over the next few months will ensure a more targeted and proportionate approach towards Mandatory Training moving forward, where subject matter experts will assess which members of staff should undertake which level of course depending on their role and compliance monitoring will become the responsibility of the subject matter experts - rather than being centralised.

(Further details can be found in the Workforce Report)

Sickness absence

The absence rate for July M04 is 3.72% which is 0.33% above the organisation target. This comprises of 0.86% of short term absences and 2.86% of long term absences, which are being predominantly being reported as being caused by mental health / stress / anxiety related issues. This again is likely to be a

causal result of the stress and anxiety being caused by the reform.

All sickness absence continues to be actively managed through HR case management processes, with appropriate support and interventions in place to promote wellbeing and attendance. The upcoming launch of the new self-service digital workforce dashboards will provide leaders with increased visibility of absence trends, enabling earlier identification of issues and more proactive management of attendance.

Advise

People & Culture (P&C) Sub-group

The People and Culture Subgroup is not yet operating in its intended form because representation from the Commissioning and Finance portfolios have still not been identified. It is however expected that these will be given imminently. The sub-group's purpose is not to only review the work of the People and Culture team, but to create a two-way process where information, assurance, concerns and feedback flow between the business and the people function.

P&C Sub-group terms of reference and governance architecture need to be established to ensure clear responsibilities, reporting lines and assurance routes.

There are also collaborative discussions involving local government, transport, fire services and health organisations. These partnerships are aiming to deliver anti-racism initiatives collectively rather than duplicating effort across organisations.
There are plans for an Inclusive Leadership Steering Group which will be used to understand how policies and initiatives are experienced in practice by staff from across the organisation. There is a workshop planned to define membership, scope and practical operation of the steering group. Staff networks will play a central role in the establishment of the steering group as many of the concerns raised originated from these groups. The steering groups purpose would not only be to gather evidence but also to evaluate whether actions already taken have made a measurable difference for staff. Trade Union and Freedom to Speak up representation is already included in the membership considerations for the steering group.

Health and Safety

Work on establishing alternative arrangements for delivery of Health and Safety functions remains ongoing. An options appraisal and service level agreement have been drafted, with the viability of options now being considered. Conversations with procurement team on potential tendering process are also ongoing. The Health, Safety and Security Lead post has been removed from the structure as part of organisational reform, with the postholder due to leave the organisation at the end of September. Steps are being taken to mitigate any risks with the departure of this person to ensure business continuity in the short term ahead of more formal arrangements coming into place. Work is also ongoing with addressing the outstanding internal audit recommendations relating to Health and Safety – it is anticipated that the new incident reporting system will be operational from early September, and the draft Lone Worker Policy has now been considered by the Policy Review Group. Further engagement is taking place on the policy,

which will be presented to the People and Resources Committee for consideration in line with the Scheme of Reservation and Delegation (likely to be the September meeting).

Organisational Change

Organisational Stability Observations: The organisation's current position is still unsettled due to ongoing change activity. Many people have adjusted successfully, but unresolved issues affecting a smaller group continue to influence organisational stability and morale.

Anti-Racism

Additional programme management support has been secured, increasing capacity for both internal organisational work and for wider system wide collaboration. The video and engagement campaign has received substantial public attention.

Work is underway to launch both the NW Anti Racism Programme Board and the Inclusive Leadership Steering Group (ILSG) in September.

The NW Anti-Racism Board is bring together system partners to look at how we can start to tackle racism and embed anti-racism within health and care, GMCA, local authorities and other key stakeholders and organisations. The group will be supported by Danielle and chaired by Evelyn Asante-Mendah and Claudette Elliott

The ILSG is an internal GM ICB group which will be bringing together peer support network chairs, leaders from across the organisation and those with lived experience to strengthen inclusive leadership, promote equity, improve staff experience and ensure lived experience is embedded within organisational decision-making. The Steering Group will focus on creating a culture where all colleagues feel heard, valued, safe and supported to thrive and progress. It will also seek to address inequalities identified through workforce data, staff feedback and lived experience.

Wider work is also being done with our executive leadership and chief officers as they are on a 6 month programme facilitated by BRAP in which they are learning and seeking to understand how they can be better leaders from an anti-racism perspective. The first session was last week and this will continue over the next 6 months.

NHS Staff Standards and NHS Leadership and Management Framework

The newly launched NHS Leadership and Management Framework was accompanied by the launch of a national Leadership and Management College and new staff standards. It is expected that leaders and managers will complete self-assessments and create personal development plans that align to the framework over the coming year.

The Framework is being championed to support appraisal completion and promote organisational development resources. Organisational pressures and reform-related disruption is acknowledged but the

importance of maintaining development conversations and workforce support is essential. From a broader organisational challenge, the organisation is rich in data and insight but often less effective at converting this information into meaningful action and improvement – so this needs further consideration. There are several organisational development initiatives in the planning.

Freedom to Speak Up

The Quarter 1 (Q1) Freedom to Speak Up (FTSU) Report was presented directly to the Board on 15 July 2026, setting out the refreshed approach to FTSU arrangements, Q1 FTSU data, associated risks and next steps for further development. The report was well received and, and two of our Guardians (Selina Margan and Sophie Porter) were in attendance to present the report and to provide visibility for our Guardians. Other Guardians will be in attendance at future meetings to ensure the Board have met them all. Work is ongoing to refresh the FTSU Policy, which is due for review, and is scheduled to be considered by the Policy Review Group in early September ahead of consideration by the People and Resources Committee for approval. The number of open FTSU cases remains relatively low (one active case). The Associate Director of Corporate Governance and the FTSU Guardians are working on additional communications to ensure staff are aware of arrangements, and will have a stand at the upcoming all staff event in September to raise awareness and answer any questions that staff might have.

Assure

Appraisals and Development Planning:

Timelines had been adjusted following changes to organisational reform schedules. Completion of appraisals by the end of August where possible is being encouraged, because the revised process includes improved mechanisms for identifying and commissioning development opportunities. Practical challenges such as annual leave and workforce pressures have been considered. Managers are being reminded of the importance of logging the date of any appraisal discussions they hold onto ESR so we can monitor overall compliance.

People and Culture Work Plan:

There is now a structured work plan covering future P&C sub-committee meetings. Standing items will include: People and Culture highlight report, workforce reporting, organisational reform updates, anti-racism progress, partnership updates and policy development reports with named leads being accountable for regular reporting. The meetings will also include themed presentations on major programmes such as leadership development, organisational development and operating model changes. The work plan will provide consistency whilst remaining flexible enough to accommodate emerging priorities.

Workforce Reporting and Dashboard Development:

The organisation is about to launch a more interactive workforce dashboard model, enabling managers to self-serve and explore their workforce data directly – and be more proactive in identifying issues and mitigating against them.

People Pulse Survey

There has been strong engagement with the pulse survey, with nearly 500 responses and 300 free text comments which have been themed. Response thresholds (>10 responses) were met across all places and portfolios, allowing reporting to be produced for each area whilst maintaining anonymity protections. A results pack is being prepared for Chief Officers and will be distributed to Extended Leadership Team and the workforce thereafter; this can be expected by Wednesday 26th August.

The National Staff Survey (NSS) will be live between September-November, with data released in tranches from late December. Results will be available by Place & Portfolio if the minimum response rate (>10 responses) is met, and comms are supporting in maximising engagement.

Risks discussed and new risks identified

Current People & Culture Risks

Key workforce risks remain centred on post-reform workforce sustainability, continued high turnover impact, and ongoing wellbeing pressures reflected in long-term absence trend

- **Risk 001:** Loss of talent and organisational knowledge due to voluntary redundancies, restructures and staff departures.
- **Risk 002:** People and culture Teams Lack of Capacity to Deliver BAU
- **Risk 003:** Uncertainty in P&C Responsibilities and impact on system commitments
- **Risk 004:** Workforce wellbeing and leadership capacity, including interim leadership arrangements, wellbeing communications and sustaining the network of wellbeing champions.
- **Risk 005:** Widening inequalities due to reduced organisational focus
- **Risk 006:** Inaccurate Workforce Data. Data becomes inaccurate or misleading due to high turnover and limited capacity for ESR maintenance.
- **Risk 007:** Mandatory training Compliance, particularly around IG and safeguarding, where compliance may fall due to inaccurate ESR data and reduced capacity.

Please note these risks have not been scored due to quoracy at the meeting. These will be updated for the report following the next meeting.

These dynamic risks will be monitored on an ongoing basis to ensure they remain responsive to the organisation and emerging people and culture risks.
Learning for sharing
Achievements

NHS
Greater Manchester

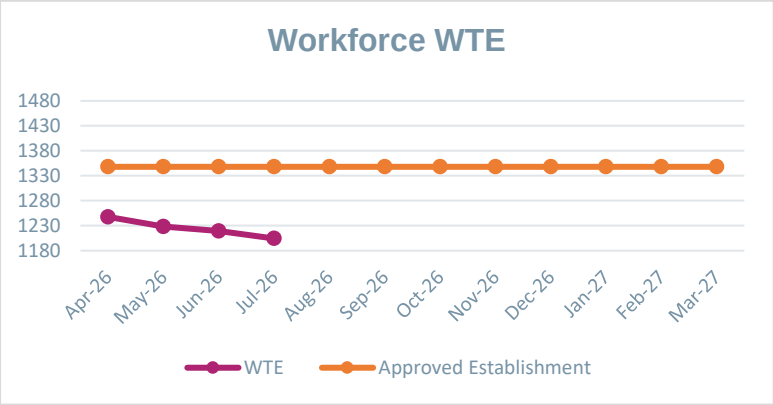
NHS GM People & Culture Workforce Metrics – M4 July

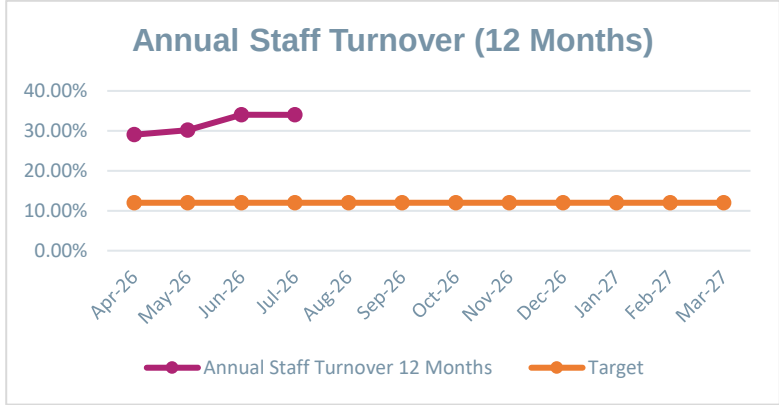
Part of Greater Manchester Integrated Care Partnership

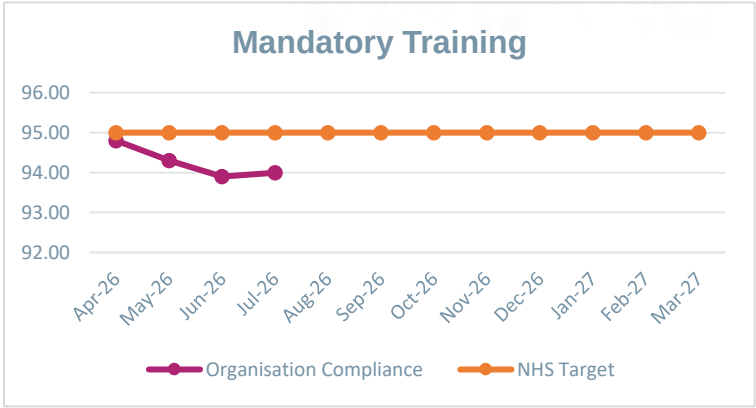
Workforce Key Metrics

Analysis

NHS Greater Manchester







WTE /Headcount

- Workforce levels remain stable with a headcount of **1,330 employees (1,204.40 WTE),** with ongoing activity focused on vacancy management and the completion of staff transition into the new organisational structure.
- Organisational vacancies have been assessed for the purposes of organisational change SAE Suitable Alternative Employment and identified displaced colleagues. Vacancies will be managed utilising the assurance and governance of the NHS GM Business Critical Panel.
- Note to committee: The organisation is now working within the **1348** WTE approved establishment plan.

Staff Turnover (12 Months)

DATA/ INSIGHT:

- Annual Staff turnover for the 12 Months remains high at **34.01%** which is above the NHS target of **12.00%**
- 2 New starters in July M4/ 4 Recorded leavers in July M4

RISK: The rolling annual turnover rate is expected to remain elevated in the short term as further voluntary redundancy (VR) and compulsory redundancy (CR) leavers exit the organisation and workforce transition activity continues.

ACTION: Vacancies will continue to be reviewed through the NHS GM Business Critical Panel, with recruitment activity aligned to organisational priorities and service requirements. Workforce turnover trends will be monitored to identify any emerging risks to service delivery and organisational stability.

ASSURANCE: Monthly turnover monitoring, establishment controls and Business Critical Panel oversight provide ongoing assurance that workforce risks are actively managed, and recruitment activity remains aligned to organisational priorities.

Mandatory Training

DATA/ INSIGHT:

- Mandatory Training (MT) compliance in M4 is 94.00% (-1.00% below national target)

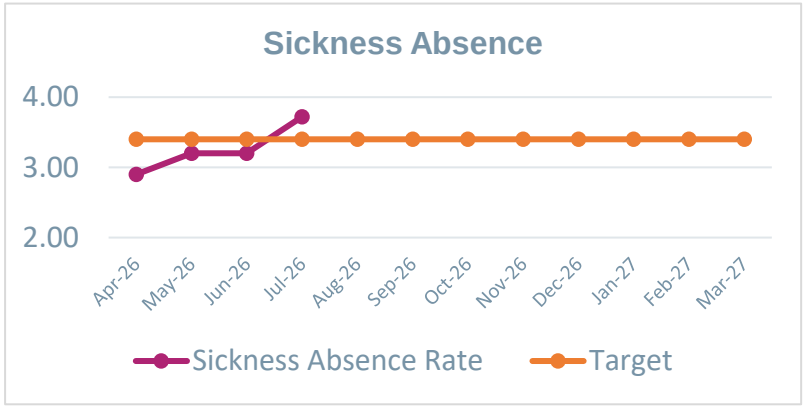
RISK: Information Governance (IG) and Data Security compliance stands at **84.7%,** 10.3 % points below the national target, presenting a significant risk in relation to information security, regulatory compliance and organisational reputation.

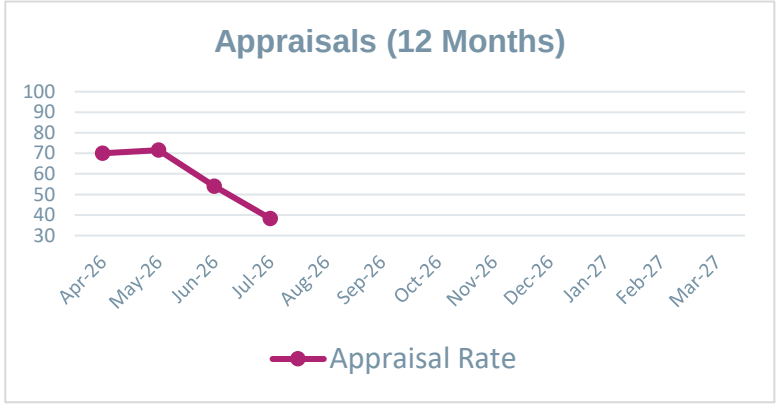
ACTION: Dedicated engagement is ongoing with the Executive Leadership Team to improve compliance as that team is significantly below the rest of the organisation and this has been the case for lengthy period.

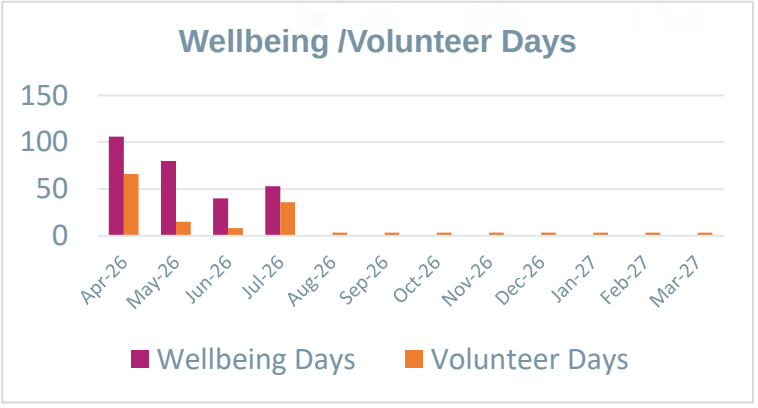
ASSURANCE: It is expected that the introduction of the Mandatory Training & Learning Oversight Group (MLOG) will ensure a more targeted and proportionate approach towards MT moving forward, where compliance monitoring will become the responsibility of the subject matter experts, rather than being centralised.

Workforce Key Metrics Analysis

NHS Greater Manchester







Sickness Absence

DATA/ INSIGHT:

- Absence Rate for July M4 is **3.72%,** +0.33% **above** the organisation target
- Short term absence 0.86% / Long term absence 2.86% (predominantly caused by mental health / stress / anxiety related issues which are potentially being caused by uncertainty associated to Reform.)

RISK: Identified risks to the organisation include a reduction on wellbeing, morale, productivity and service capacity; increased pressure on colleagues, leading to stress and burnout; and financial impact on days lost.

ACTION: Sickness absence continues to be actively managed through HR case management processes, with appropriate support and interventions in place to promote wellbeing and attendance. The launch of the **new self-service digital workforce dashboards** will provide leaders with increased visibility of absence trends, enabling earlier identification of issues and more proactive management of attendance.

ASSURANCE: Monthly monitoring, HR case management processes and enhanced leader access to workforce data through self-service dashboards provide assurance that sickness absence is being actively monitored by the People & Culture sub-group and managed across the organisation.

Appraisals (12 Months)

DATA/INSIGHT:

- The Appraisal rate in July M4 is **38.26%, our organisational** target is **100%.**
- Current organisational guidance is that all Personal Development Plans (PDPs) are required to be completed by the **end of August 2026.**

RISK: Low appraisal compliance may limit organisational oversight of staff development, workforce capability and training needs. Failure to accurately record appraisal activity in ESR may also result in under-reporting of compliance and reduced assurance regarding staff engagement and development.

ACTION: Targeted communications are being issued to managers and staff to reinforce the importance of completing development conversations and Personal Development Plans (PDPs),including the importance of **ensuring appraisal dates are recorded correctly in ESR.** Compliance continues to be monitored through regular workforce reporting.

ASSURANCE: Regular monitoring, organisational communications and ESR reporting provide assurance that appraisal activity remains a priority during the transition period, supporting staff development and maintaining an accurate organisational record of appraisal completion.

Wellbeing / Volunteer Days

DATA / INSIGHT:

- **53 wellbeing days** were recorded in July (M4).
- **36 volunteer days** were recorded in July (M4).
- Between April and July, **279 wellbeing days and 125 volunteer days** have been recorded.

Staff continue to be encouraged to make use of wellbeing days and volunteer leave to support their health, wellbeing, work-life balance and community engagement.

ACTION/UPDATE: The Strategy, People and Partnership Portfolio is piloting a dedicated volunteering week commencing 12 October 2026 to promote the benefits of volunteering, support community engagement and encourage team development. Feedback will be provided as to this approach and how it may be expanded across other portfolios.

ASSURANCE: Organisational communications continue to promote the staff benefits package, including wellbeing days and volunteer leave. Uptake is monitored through workforce reporting to support staff wellbeing, engagement and community contribution.

Workforce Key Metrics

Month 4

NHS Greater Manchester

NHS GM Organisation Workforce Metrics	JULY-25	AUG-25	SEPT-25	OCT-25	NOV-25	DEC-25	JAN-26	FEB-26	MAR-26	APR-26	MAY-26	JUNE-26	JULY-26
	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4
Approved Establishment Plan WTE	1557.7	1557.7	1557.7	1557.7	1557.7	1557.7	1557.7	1557.7	1557.7	-	-	-	1348
Substantive WTE In Post Actual	1525	1514	1516	1516	1504	1502	1501	1385	1371.8	1247.7	1228.5	1219.4	1204.4
Budget Establishment Variance	-32.7	-43.7	-41	-41	-53.7	-55.7	-56.7	-172.7	-185.9	-	-	-	-143.6
Substantive Headcount Actual	1693	1680	1684	1682	1673	1671	1670	1542	1528	1379	1357	1344	1330
Staff Turnover (In Month)	0.53%	0.83%	0.41%	0.53%	1.02%	0.36%	7.92%	0.97%	10.01%	1.52%	1.55%	3.95%	0.30%
NHS GM Organisational Turnover Target	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%
Staff Turnover (12 Months)	6.36%	6.71%	6.45%	6.35%	7.12%	6.89%	14.39%	16.11%	25.33%	29.03%	30.16%	34.03%	34.01%
New Starters	3	4	10	4	4	4	9	3	2	3	0	6	2
Leavers	9	14	7	9	17	6	132	15	153	21	21	5	4
NHS GM Organisational Target Sickness Absence %	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%	3.40%
NHS GM Sickness Absence %	2.80%	2.93%	3.25%	3.72%	3.52%	3.83%	3.40%	3.40%	3.40%	3.21%	3.48%	3.30%	3.72%
Short Term Absence %	0.99%	0.71%	0.74%	1.09%	1.18%	0.86%	0.72%	0.88%	0.84%	0.69%	0.60%	0.79%	0.86%
Long Term Absence %	1.77%	2.19%	2.49%	2.61%	2.34%	2.96%	2.68%	2.51%	2.56%	2.52%	2.88%	2.51%	2.86%
National NHSE Learning Compliance Target %	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
NHS GM Mandatory Learning Compliance %	96.50%	96.20%	96.00%	95.90%	94.80%	94.90%	94.30%	94.60%	94.30%	94.80%	94.30%	93.90%	94.00%
Mandatory Learning Compliance Variance	1.50%	1.20%	1.00%	0.90%	-0.20%	-0.10%	-0.70%	-0.40%	-0.70%	-0.20%	-0.70%	-1.10%	-1.00%
NHS GM Appraisal Rates	62.21%	65.91%	71%	72.25%	73.97%	74.53%	76.13%	76.86%	77.83%	70.00%	71.55%	54.00%	38.26%
NHS GM Annual Leave Utilisation	27.19%	32.34%	42.96%	47.87%	51.01%	61.19%	67.09%	70.31%	75.51%	6.29%	11.82%	16.14%	26.70%
Wellbeing Day Utilisation	53	26	40	54	69	142	41	67	184	106	80	40	53
Volunteering Utilisation	5	9	6	3	12	5	2	38	79	66	15	8	36

NHS
Greater Manchester

Supplementary Workforce Information

NHS Greater Manchester Mandatory Learning Compliance: July 2026

Structure

NHS Greater Manchester

YTD Mandatory Training Compliance compared to national target

		Compliance July 2026	Variance to Target	Variance to Prev Mo..
Locality	Place Partnership Portfolio	92.7%	-2.3%	
Portfolio	Strategic Finance Portfolio	97.9%	2.9%	
	Reform & Improvement Portfolio	96.3%	1.3%	
	Strategy, People & Partnership Portfolio	95.8%	0.8%	
	Commissioning Portfolio	92.8%	-2.2%	
	Clinical Portfolio	91.1%	-3.9%	
	GM Reform	87.4%	-7.6%	
	Executive Leadership	72.4%	-22.6%	

NHS Greater Manchester Mandatory Learning Compliance: July 2026

NHS Greater Manchester

		Locality / Directorate Total Compliance	Equality, Diversity and Human Rights - 3 Years	Fire Safety - 2 Years	Fraud Awareness - 3 Years	Health, Safety and Welfare - 3 Years	Infection Prevention and Control - Level 1 - 3 Years	Information Governance and Data Security - 1 Year	Moving and Handling - Level 1 - 3 Years	NHS Conflict Resolution (England) - 3 Years	Preventing Radicalisation - Basic Prevent Awarenes..	Preventing Radicalisation - Basic Prevent Awarenes..	Resuscitation - Level 1 - No Specified Renewal	Safeguarding Adults (Version 2) - Level 1 - 3 Ye..	Safeguarding Adults (Version 2) - Level 1 - No ..	Safeguarding Adults (Version 2) - Level 2 - 3 Ye..	Safeguarding Adults (Version 2) - Level 2 - No ..	Safeguarding Children (Version 2) - Level 1 - 3 Ye..	Safeguarding Children (Version 2) - Level 1 - No ..	Safeguarding Children (Version 2) - Level 2 - 3 Ye..	Safeguarding Children (Version 2) - Level 2 - No ..	The Oliver McGowan Mandatory Training on Le..
Locality	Bolton - Place Team	93.9%	83.3%	100.0%	91.7%	100.0%	100.0%	83.3%	100.0%	91.7%	81.8%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	90.9%	100.0%	90.9%	100.0%	100.0%
	Bury - Place Team	95.3%	88.2%	94.1%	94.1%	88.2%	100.0%	82.4%	100.0%	100.0%	100.0%	100.0%	100.0%	93.8%	100.0%	93.8%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	HMR - Place Team	90.6%	88.2%	88.2%	94.1%	82.4%	82.4%	58.8%	82.4%	88.2%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Manchester - Place Team	97.9%	100.0%	100.0%	96.2%	100.0%	96.2%	88.5%	100.0%	96.2%	92.3%		100.0%	100.0%		100.0%		100.0%		100.0%		100.0%
	Oldham - Place Team	92.6%	88.9%	88.9%	77.8%	100.0%	100.0%	88.9%	100.0%	88.9%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	87.5%	100.0%	87.5%	100.0%	100.0%
	Salford - Place Team	95.8%	89.5%	100.0%	100.0%	94.7%	94.7%	94.7%	94.7%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	88.9%	100.0%	94.4%	100.0%	88.9%	100.0%	100.0%
	Stockport - Place Team	99.1%	100.0%	100.0%	93.3%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%		100.0%		100.0%		100.0%
	Tameside - Place Team	77.0%	90.9%	90.9%	90.9%	72.7%	72.7%	54.5%	81.8%	63.6%	77.8%	100.0%	90.9%	77.8%	50.0%	77.8%	50.0%	60.0%	0.0%	80.0%	0.0%	90.9%
	Trafford - Place Team	79.3%	90.0%	90.0%	90.0%	80.0%	70.0%	60.0%	90.0%	70.0%	77.8%	100.0%	100.0%	66.7%	100.0%	55.6%	100.0%	77.8%	100.0%	55.6%	100.0%	100.0%
	Wigan - Place Team	92.3%	92.3%	100.0%	84.6%	100.0%	100.0%	84.6%	92.3%	100.0%	92.3%		100.0%	92.3%		76.9%		84.6%		84.6%		100.0%
Portfolio	Clinical Portfolio	91.1%	96.9%	94.7%	92.5%	96.5%	94.7%	85.4%	96.0%	93.4%	85.9%	95.2%	99.6%	78.8%	92.9%	77.2%	97.6%	82.1%	92.9%	81.0%	97.6%	99.1%
	Commissioning Portfolio	92.8%	97.0%	94.3%	90.9%	95.5%	93.2%	79.9%	95.1%	95.1%	92.9%	99.3%	99.6%	91.8%	99.2%	88.1%	98.4%	85.5%	100.0%	80.5%	100.0%	99.2%
	Executive Leadership	72.4%	85.7%	85.7%	42.9%	85.7%	71.4%	42.9%	85.7%	71.4%	80.0%	50.0%	85.7%	80.0%	50.0%	60.0%	50.0%	80.0%	50.0%	80.0%	50.0%	85.7%
	GM Reform	87.4%	77.8%	88.9%	77.8%	88.9%	88.9%	88.9%	77.8%	88.9%	88.9%		100.0%	88.9%		88.9%		88.9%		88.9%		88.9%
	Reform & Improvement Portfolio	96.3%	97.3%	92.0%	93.6%	98.1%	96.6%	86.7%	98.5%	98.9%	97.3%		99.6%	97.3%		96.2%		97.3%		95.1%		99.2%
	Strategic Finance Portfolio	97.9%	98.6%	97.2%	96.6%	98.6%	98.6%	93.1%	97.9%	96.6%	98.6%		100.0%	99.3%		98.6%		98.6%		96.6%		99.3%
	Strategy, People & Partnership ..	95.8%	96.9%	93.8%	92.8%	97.9%	99.0%	86.6%	96.9%	97.9%	99.0%		100.0%	96.9%		92.8%		95.9%		90.7%		100.0%
Total Organisation Compliance		94.0%	96.4%	94.3%	92.5%	96.4%	95.2%	84.7%	96.3%	95.4%	94.0%	97.9%	99.6%	92.6%	96.7%	90.6%	96.1%	91.3%	91.4%	88.6%	94.8%	99.1%

NHS Greater Manchester Organisation Workforce Metrics: July 2026

Filters

Chosen Comparator
- (●) vs Previous month
- ( ) vs Target

Organisation and Portfolios
All

Choose Fiscal Year
- ( ) FY 2023/24
- ( ) FY 2024/25
- ( ) FY 2025/26
- (●) FY 2026/27

Time Series Choice
Headcount

Growing and Developing our Workforce Organisational Profile

Headcount or FTE
- ( ) Headcount
- (●) FTE

Good Employment Organisational Movement
(level 3 filter doesn't apply)

Bank
0
0 ()
vs Previous month (0)

Fixed Term
16
-15 (-48.8%)
vs Previous month (30)

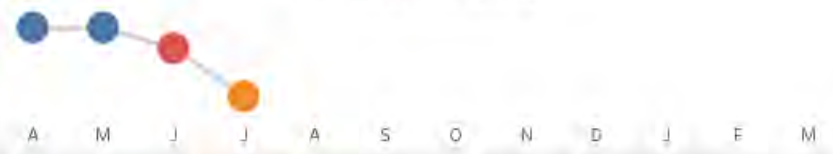
Permanent
1,189
+3 (0.3%)
vs Previous month (1,186)

All
1,204
-12 (-1.0%)
vs Previous month (1,216)

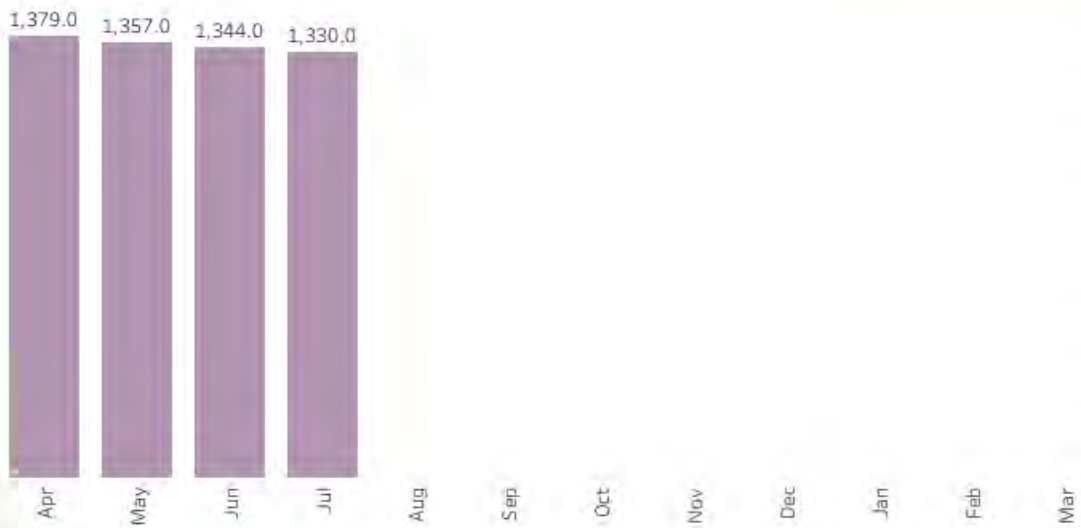
Starters Headcount
2
-2 (-50%)
vs Previous month (4)

Leavers Headcount
4
-11 (-73%)
vs Previous month (15)

Turnover Rate
0.3%
-0.8% (-73%)
vs Previous month (1.1%)



Headcount over time



Headcount and FTE by Portfolios for July 2026

Portfolio View
All

Org Level 3	Distinct count of Emp No	FTE
Commissioning Portfolio	286	263.1
Reform & Improvement Portfolio	266	261.4
Clinical Portfolio	236	204.7
Place Partnership Portfolio	156	144.2
Strategic Finance Portfolio	149	141.2
GM Reform	123	85.4
Strategy, People & Partnership Portfolio	101	97.3
Executive Leadership	13	7.3

NHS Greater Manchester Organisation Workforce Metrics: July 2026

NHS Greater Manchester

Filters

Organisation and Portfolios

All

Fiscal Year filter

- FY 2023/24
- FY 2024/25
- FY 2025/26
- (●) FY 2026/27

Workforce Wellbeing

KPI Choice

- (●) Latest month vs previous month
- ( ) Latest FY vs previous FY
- ( ) Last 12m vs previous to last 12m

Absence Rate

3.7%

+0.4%

Latest month vs previous month (3.3%)

Cost

£209,297

-£1,791 (-1%)

Latest month vs previous month (£211,088)

Short Term FTE hrs

2,092.9

+270.4 (15%)

Latest month vs previous month (1,822.5)

Long Term FTE hrs

4,730.1

+385.3 (9%)

Latest month vs previous month (4,344.8)

Absence over time

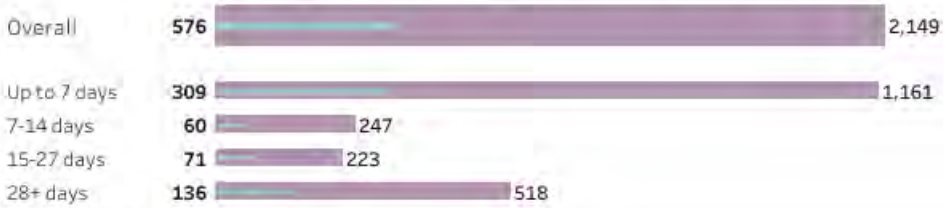
Time Series Choice

Absence occurrenc..

Number of absence episodes during this month and this year

Choose month (for portfolios chart)

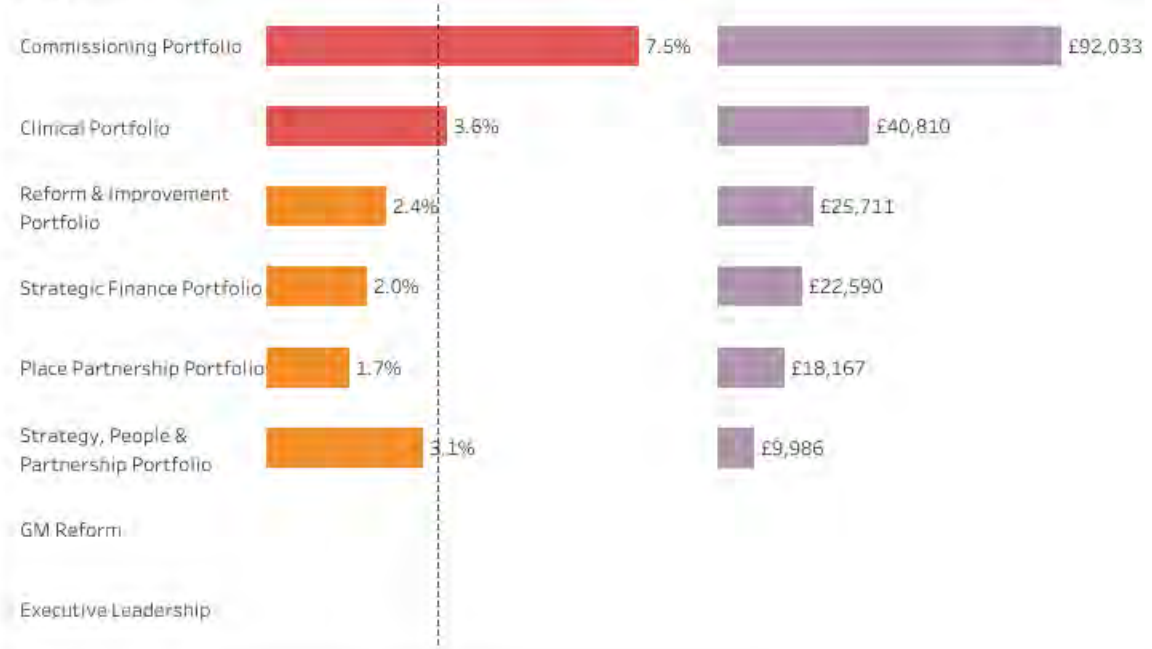
- March 2024
- April 2024
- May 2024
- June 2024
- July 2024
- August 2024
- September 2024
- October 2024
- November 2024
- December 2024
- January 2025
- February 2025
- March 2025
- April 2025
- May 2025
- June 2025



Absence rate & cost by Portfolios for July 2026

Porfolio View

All



NHS Greater Manchester Reasons for Absence

NHS Greater Manchester

Filters

Organisation and Portfolios

All

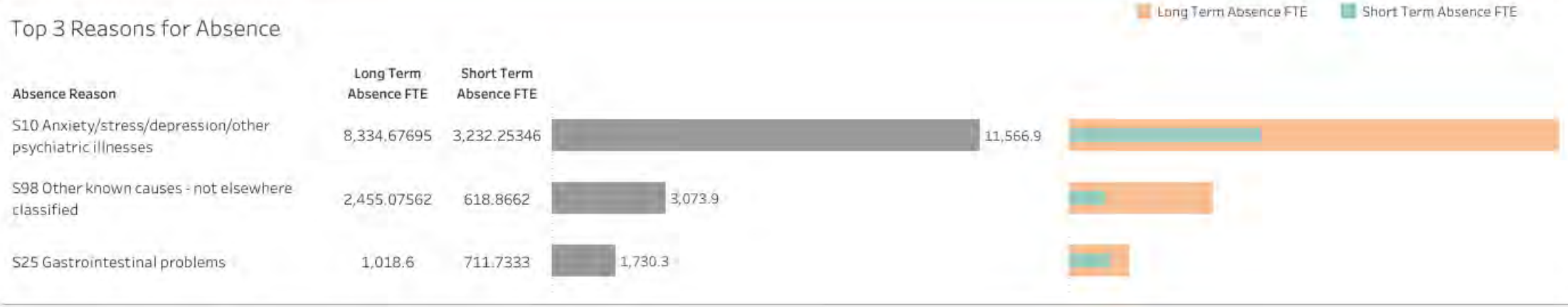
Fiscal Year filter

- FY 2023/24
- FY 2024/25
- FY 2025/26
- FY 2026/27

Choose Month

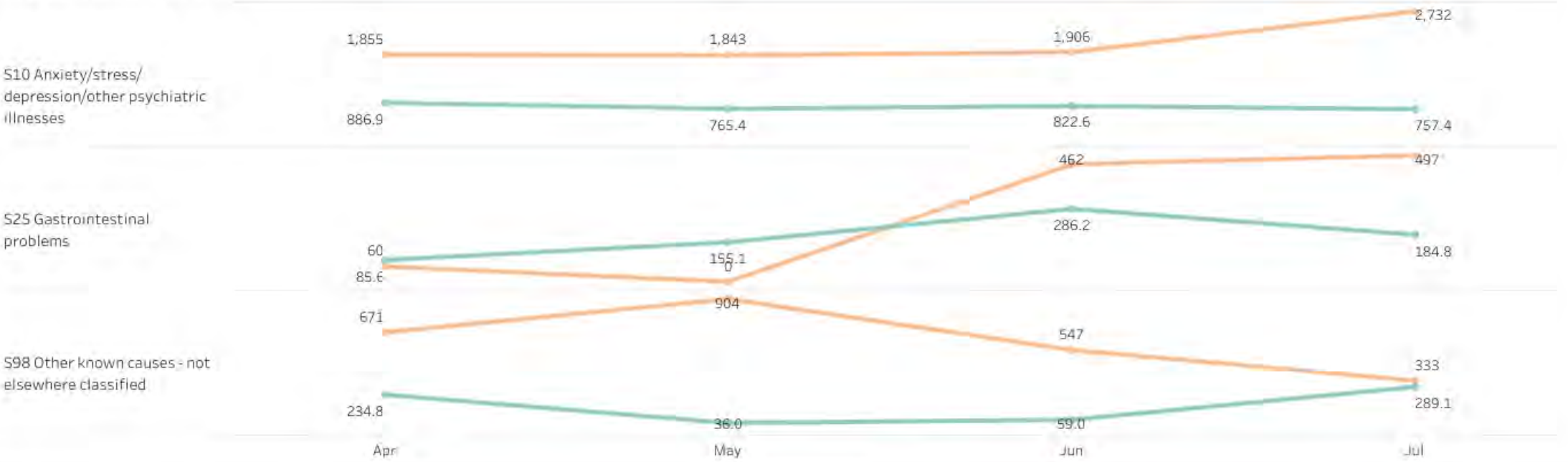
- April 2026
- May 2026
- June 2026
- July 2026

Top 3 Reasons for Absence



Absence Reason	Long Term Absence FTE	Short Term Absence FTE
S10 Anxiety/stress/depression/other psychiatric illnesses	8,334.67695	3,232.25346
S98 Other known causes - not elsewhere classified	2,455.07562	618.8662
S25 Gastrointestinal problems	1,018.6	711.7333

Top 3 Reasons by Month



NHS Greater Manchester Reasons for Absence

NHS Greater Manchester

Filters

Organisation and Portfolios

All

Fiscal Year filter

- ○ FY 2023/24
- ○ FY 2024/25
- ○ FY 2025/26
- ◉ FY 2026/27

Select Month

- ☑ July 2026

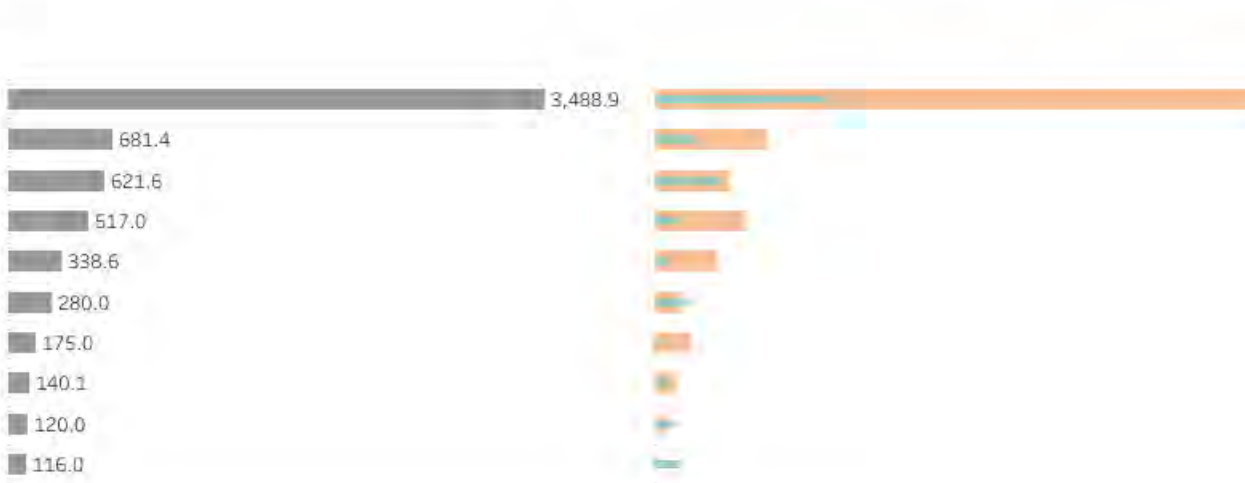
Select Organisation or Portfolio

Multiple values

Top 10 Reasons for Absence

Click on reason to filter dashboard

Absence Reason	Long Term Absence FTE	Short Term Absence FTE
S10 Anxiety/stress/depression/other psychiatric illnesses	2,731.5323	757.38711
S25 Gastrointestinal problems	496.6	184.8
S98 Other known causes - not elsewhere classified	332.53876	289.0666
S28 Injury, fracture	403	114
S16 Headache / migraine	279	59.6
S26 Genitourinary & gynaecological disorders	130	150
S17 Benign and malignant tumours, cancers	155	20
S12 Other musculoskeletal problems	93	47.0667
S11 Back Problems	35	85
S21 Ear, nose, throat (ENT)	0	116



Absence by Portfolio for **All**

Green bars show rate of absence (FTE hrs lost / count of employees)

Click on locality to filter dashboard

Org level 3	Long Term Absence FTE	Short Term Absence FTE
Commissioning Portfolio	2,063.40491	1,019.05371
Clinical Portfolio	1,116.66615	183.8
Reform & Improvement Portfolio	440	598.0667
Place Partnership Portfolio	432.4	12
Strategic Finance Portfolio	367.6	88
Strategy, People & Partnership P..	310	192

Absence by Month

filters from other charts apply

NHS
Greater Manchester

Acting Chief Reform & Improvement Officer Report

26th August 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester People and 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 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. The report highlights key areas of assurance and oversight from the Reform & Improvement portfolio.
The benefits that the population of Greater Manchester will experience.	Continued support for performance oversight of health and care services, digital and data services delivery which enables effective healthcare delivery across the ICS
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 M5
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for the People and Resources Committee and has not been elsewhere but is formulated from intelligence and papers from existing governance routes
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability,**	There has been no formal engagement on this paper as this paper is produced for the People and Resources Committee. The intelligence and papers used to formulate this report have come from the functions workplans within the portfolio.

financial. Comments/ approval by groups/ committees.	
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report. Decisions with a material financial impact, including medicines optimisation and gainshare opportunities, are being progressed through the appropriate executive and financial governance routes in line with existing NHS GM policies. The report reflects continued work to improve patient standards and the ICBs delivery and improvement against the 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 Care

Total waiting list size has stabilised after increasing in Q1. It remains at February 2026 levels but has not decreased in line with plan. MFT, NCA, Bolton and WWL are all driving this variance to plan. All Trusts have validation opportunities and NHSE have extended the validation period for July's submitted data. Reduced levels of activity due to theatre issues at NCA, WWL and Bolton are also contributing, and investigation is underway into MFT's demand growth in Q1.

The volume of 65-week waiters has continued to grow, driven by NCA and WWL, linked to reduced theatre capacity. Mutual aid discussions are taking place between GM COOs each week, with patients from NCA being seen in Whiston for spines, Tameside and Wrightington. Independent sector activity is being increased to support recovery through Trust subcontract arrangements.

Urgent and Emergency Care

Delivery of 12 and 4 hour ED standards are behind plan. In July 72.5% of patients attending ED were seen and treated within 4 hours compared to a plan of 74.8%, although behind plan this is 1.1% better than July 2025. 8.4% of patients in ED waited in excess of 12 hours (type 1 and 2) against a plan of 7.4%, 3 of our 6 trusts are behind plan. There is continued focus on improving discharge, optimising flow and reducing long waits across urgent care pathways.

Data Insight and Intelligence

The new Joint Controller Agreement has been distributed for circulation to all data controller partners. Some data controllers have yet to sign and a cut-off date may be required to stop processing data from practices that have not signed. Discussions are ongoing with some LMCs to provide reassurance. Some controllers have signed the agreement but requested a reduction in the current use of their data. If sign-up rates remain where they are and processing must stop for those who have not signed or have requested limited use, there will be a significant risk to delivery capability. See table below for status

Sign up status	Bolton	Bury	HMR	Manchester	Oldham	Salford	Stockport	Tameside	Trafford	Wigan	Grand Total	%
Yes to all data sharing	33	11	15	48	29	6	7	30	9	37	225	55.4%
No response	16	14	21	32	4	28	24	1	7	19	166	40.9%
Direct Care Only	0	0	0	2	0	0	0	0	6	0	8	2.0%
Direct Care minus BeCCoR	0	0	0	0	0	2	0	0	0	0	2	0.5%
Other	0	0	0	0	0	0	0	0	1	0	1	0.2%
No for all data sharing	0	0	0	0	0	0	1	0	1	0	2	0.5%
Wants more information	0	0	0	0	0	0	0	0	2	0	2	0.5%
Total	49	25	36	82	33	36	32	31	24	56	406	
% fully signed	67%	44%	42%	59%	88%	17%	22%	97%	38%	66%	55%	

Organisation Type	Fully Signed	Total	% Signed
Primary Care (GM)	225	406	55%
Primary Care (Derbyshire)	3	4	75%
Secondary Care	2	8	25%
Tertiary Care	1	1	100%
Local Authorities	4	10	40%
UEC	3	6	50%
Hospice	7	7	100%
All	245	442	55%

Digital and IT Services

- End-of-life devices remain the principal assurance concern. The current risk score is 4 x 4 and the risk should be escalated to the corporate risk register, supported by clearer definitions of exploitability, consequence and mitigating controls, which can reduce the risk score to 3 x 4.
- Workforce capacity continues to affect resilience, with specialist cyber security recruitment expected to remain particularly challenging.
- Programme governance requires continued oversight, with 16 projects planned for closure in July moving into August, primarily because of outstanding DPIA approvals, closure reports and SRO sign-off.
- Financial sustainability remains a key area requiring further modelling for GMCR and related digital assets, with Finance input needed to establish a sustainable operating approach.

Advise

Data Insight and Intelligence:
GM Health Scrutiny Committee held a focused session on maternity at which poor data availability and quality were noted. A data quality improvement plan has been drawn up by DII, but this requires action at provider level. Provider Chief Data Officers have indicated that this is not currently a priority for them as they meet their existing obligations to send data by provider rather than at other geospatial levels.

Digital and IT Services
- Endorse a risk-based desktop refresh approach, prioritising devices according to actual exposure, usage and available controls rather than age alone.
- Support development of a formal ISO 27001-aligned risk treatment plan, including an 18-month, month-by-month device profile and consideration of proportionate controls such as physical port restrictions.
- Maintain close oversight of recruitment and consider wider professional channels for hard-to-fill roles, particularly cyber security.
- Require clear Finance partnership for GMCR sustainability, desktop refresh investment and the consolidated Digital and IT financial pressure position.

Elective Care
All Trusts and localities are working with the team to implement Tier 2 services in ENT and Gynaecology. Pace is variable at present, with different approaches being taken.
There is a risk in ENT around available workforce in primary care. Consideration is needed on how workforce capacity is built alongside procurement and commissioning strategy.
There is a separate issue with NCA around its ability to engage with service development while challenged on clinical and operational capacity. Four localities are now taking a lead, with existing local provision in place and development of new capacity where not available.

Financial Recovery & Improvement Financial Recovery & Improvement
There is a c.£17.1m unidentified gap against the £150m CIP, which has reduced from c.22m as reported in the previous month. There is ongoing work to fully identify remaining schemes required to meet the £150m plan. Current schemes are under continual scrutiny to ensure their full delivery and to ensure that appropriate measures are in place to mitigate against any potential risks.

We were successful in securing Q2 deficit support funding (DSF) following discussions with NHSE regional colleagues, and we are continuing to work on ensuring continued delivery of the CIP programme to further secure Q3 DSF allocation.

A new Acting Director or Recovery and Improvement has been recruited to, who will provide operational leadership and support to the recovery programme and ensure a clear plan and system for monitoring assurance to meet the financial recovery plan.

Assure

Digital and IT Services:
- Service Desk performance met all reported SLA targets in July. Capacity remained stable and the extension of Corporate telephone support from 14:00 to 11:00 has been managed operationally.

- Cyber security assurance improved, with software patching compliance for updates released over 28 days ago reported at 91% and GP laptop compliance improving to 82.49%.
- Five high-severity cyber alerts were received in July and none were applicable to NHS Greater Manchester.
- DSPT feedback from MIAA covered 12 of 47 outcomes which will each have improvement plans, meaning 35 outcomes were successfully concluded. IT Security and Information Governance are working jointly on the resulting improvement actions.

No unresolved critical GMCR incidents were reported. One July service interruption affecting three trusts was noted as resolved.

UEC

- In July, the average response time was 19 minutes and 56 seconds, better than the 25 minute plan. This is 2 minutes 15 seconds better than the same period last year. GM providers are working to reduce ambulance handover times in ED to support faster response times.

Risk discussed and new risk identified

DII Update:

Demand vs Capacity Pressure: The need to stop or pause lower-priority activities, as outlined in the position statement, introduces a risk of stakeholder dissatisfaction or delays in non-priority areas. Requirements to support contracting and organisational transformation, including digitising records and automating processes, were explicitly excluded from the function's operating model capacity and design. These requirements are now building up.

Digital and IT Services Update:

- End-of-life device risk requires corporate escalation and a clearer evidence-based risk treatment plan, including exploitability, consequence and existing mitigating controls.
- Digital and IT vacancies remain a risk to resilience, with multiple posts in authorisation, advert or interview stages and specialist cyber roles expected to be difficult to fill.
- Financial pressures and sustainability remain material, including GMCR, SDE, desktop refresh costs and the wider consolidated Digital and IT financial pressure position.
- The project closure backlog requires continued PMO and SRO focus, with 16 July closures moving into August due to DPIAs, closure reports and SRO approvals.
- Asset inventory and recovery require strengthened reporting, particularly in relation to reassigned or unreturned equipment.
- Third-party SLA debt and offboarding exceptions remain under active management, including outstanding debt reported at approximately £350k-£360k.

Achievements

Digital and IT Services

- Laura Hosey-Davies and Matt Dearden were appointed as Associate Directors for Digital Services and Operational IT respectively, effective from the beginning of August.
- OneDrive Sync enablement for Corporate ICB users was approved for phased progression through the formal change process.
- Bolton locality onboarding was approved for 22 users and associated devices/data, with completion targeted by the end of October 2026.
- Fourteen projects were closed by the PMO in July.
- A Copilot business case is under development.
- The IM1 Data Feed project moved into testing after the supplier issue was resolved following escalation to NHSE.
- The use of two agency engineers for four months has been agreed to improve the rate of delivery for end-of-life device replacement.

Elective:

As of the end of July, NCA, Stockport, Tameside and MFT have all launched Single Point of Access in several services.

Consultant Connect exceeded 3,000 requests in July for the first time, demonstrating a six-fold increase in

usage since launching to the rest of Greater Manchester in October.

NHS
Greater Manchester

GM Digital and IT Services People and Resources Committee Briefing

August 2026

NHS Greater Manchester People & Resources Committee

28 August 2026

Required information	Details
Title of report	Digital and IT Service Offering and Operating Model
Author	Malcolm Chief Digital and Information Officer, NHS Greater Manchester Nicola Hepburn, Acting Chief Reform and Improvement Officer, NHS Greater Manchester
Presented by	Malcolm Whitehouse, Chief Digital and Information Officer, NHS Greater Manchester
Contact for further information	Malcolm.Whitehouse@nhs.net
Executive summary	This report provides the Committee with an executive briefing on the proposed Digital and IT service offering and operating model for NHS Greater Manchester. It sets out the current scale of provision, the case for a more coordinated pan-Greater Manchester model, and the workforce, financial, commercial, governance and risk implications that need to be resolved before full implementation. The proposed model would create a clearer single front door, common standards, stronger prioritisation, improved accountability and more transparent cost recovery arrangements. The Committee is asked to endorse the direction of travel, subject to completion of a quantified business case, confirmed workforce requirements, an authoritative service-user baseline, clear service boundaries and an affordable technology lifecycle plan.
The benefits that the population of Greater Manchester will experience.	Residents, patients and staff will benefit from more reliable digital services, safer access to shared information, improved service responsiveness, stronger cyber resilience and better support for neighbourhood working, primary care and integrated care delivery across Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	The model supports reduction of health inequalities by enabling consistent digital access, standardised service quality and improved use of shared information across localities. Implementation will need to ensure accessible services, digital inclusion support, assistive technology where required, and monitoring of differential impacts across communities and workforce groups.

The decision to be made and/or input sought	The Committee is asked to note the current scale and breadth of Digital and IT services; endorse the proposed direction of travel towards a coordinated pan-GM operating model; support early Digital and IT involvement in relevant business cases and commissioning decisions; and request a quantified workforce plan, financial model, technology investment plan and validated service-user baseline before final implementation.
How this supports the delivery of the strategy and mitigates the BAF risks	The operating model supports delivery of the ICB Blueprint, the Greater Manchester digital strategy and wider system priorities by strengthening the digital foundations required for strategic commissioning, primary care, neighbourhood working, prevention and population health. It also mitigates Board Assurance Framework risks linked to digital resilience, cyber security, service continuity, workforce capacity, financial sustainability and delivery of strategic transformation.
Key milestones	Key milestones include confirmation of the service-user and workforce baseline, development of the service catalogue, agreement of the commercial policy and rate card, completion of workforce and financial plans, introduction of performance reporting, launch of the Digital Hub and champions network, and progression of the GM Digital Strategy and GM Care Record re-procurement.
Leadership and governance arrangements	This paper is presented to the People and Resources Committee for discussion and endorsement. The report draws on existing operational, programme, service-management and digital governance intelligence and should inform further executive oversight through the appropriate NHS GM governance routes.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	No formal public engagement has been undertaken specifically on this briefing. The content has been informed by existing operational intelligence, service-management reporting, programme workplans and engagement with digital, clinical, operational and corporate stakeholders through established NHS GM governance routes.
Financial or Legal Implications;	There are no direct new financial or legal decisions arising from this report. However, implementation of the proposed model will require a quantified financial model, clear commercial policy,

	agreed rate card, and confirmation of any legal or contractual implications associated with third-party services, supplier arrangements, information governance and cost recovery. Any decisions with material financial, contractual or legal consequences should be progressed through the appropriate executive, finance, procurement and information governance routes in line with NHS GM policies.

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

Digital and IT Service Offering and future Operating Model

1. Purpose of the report

This paper provides an overview of the current services provided by the Digital and IT Services function and the approach being planned for a future proposed Greater Manchester Digital and IT services strategy to define a resilient and financially sustainable operating model, the scale and scope of services currently provided, and the associated workforce, financial, organisational and governance implications.

2. Recommendations

The Committee is asked to:

1. Note the current scale and breadth of Digital and IT services.
2. Endorse the proposed direction towards a coordinated GM Digital and IT Services operating model based on shared infrastructure, common standards and transparent governance.
3. Support early Digital and IT involvement in business cases, commissioning decisions, organisational changes and third-party arrangements.
4. Support development of a formal service catalogue, commercial policy, rate card and standard service agreements.
5. Request a quantified workforce plan, financial model and technology investment plan before final implementation.
6. Request confirmation of the remaining ICB workforce and service-user baseline as a priority.
7. Receive regular performance reporting covering service quality, workforce capacity, financial sustainability, cyber risk and strategic delivery.

3. Executive summary

Digital and technology services are essential to the delivery of strategic commissioning, modern primary care and integrated neighbourhood working across Greater Manchester. Their importance will continue to increase as the NHS moves care from hospitals into communities, replaces analogue processes with digital services and places greater emphasis on prevention and population health.

The proposed operating model would establish a more consistent and coordinated service across the ICB, primary care, Place, Integrated Neighbourhood Teams and partner organisations. It would provide a single front door through ServiceNow, common infrastructure and standards, clearer governance, transparent prioritisation and greater reuse of GM-wide products and services.

The wider delivery model currently supports 16,699 service users. This comprises:
- 14,302 users supported directly by GM IT and Digital;
- 1,033 users supported through commissioned services from Tameside; and
- 1,364 users supported through commissioned services from Bolton.

The user base includes 12,764 GP service users, 1,677 ICB service users and 2,258 third-party service users.

The GM IT and Digital figure includes 80 Trafford locality users transferred in December 2025. Although 201 locality staff have transferred to NHS trusts, a confirmed count of people remaining within the ICB is not yet available. This limits effective planning for software licences, devices, physical assets, support capacity and future costs.

The service also has a substantial operational and strategic footprint. In June 2026, the operational report recorded 13,421 GP and ICB end-user devices supported. The Service Desk handled an average of 255 calls per working day, with 94.3% resolved within target and customer satisfaction of 4.7 out of 5.

The Greater Manchester Care Record serves approximately 3.2 million residents and connects more than 600 health and care organisations, including over 400 GP practices. It averages approximately 27,040 distinct users each month.

Implementation of the operating model will require a robust workforce and financial plan. Current pressures include specialist vacancies, limited engineering capacity, ageing infrastructure, technology inflation and increasing cyber threats.

The proposed commercial model would recover appropriate costs from third parties and other beneficiaries while protecting statutory duties and valuable public-sector collaboration. Clear definitions will be required for core, enhanced and chargeable services.

The strategic direction is credible and aligned with wider Greater Manchester priorities. Final implementation should be conditional upon a quantified business case, confirmed workforce requirements, clear service boundaries, validated performance baselines and an affordable technology lifecycle plan.

4. Strategic context

The ICB Blueprint and NHS 10-Year Plan require three significant shifts:
- from hospital-based care to community and neighbourhood provision;
- from analogue processes to digital services; and
- from treating illness to prevention.

Digital and IT capabilities underpin each of these shifts. Integrated working requires secure access to shared information, reliable devices and connectivity, appropriate identity controls, resilient infrastructure and digital tools that operate across organisational boundaries.

The function must deliver these strategic capabilities while maintaining safe and reliable day-to-day

services. It must also respond to financial constraints, growing stakeholder expectations, technology cost inflation and heightened cybersecurity risks.

5. Current scale of service

5.1 Service users supported

Delivery route	GP users	ICB users	Third-party users	Total
GM IT and Digital	10,516	1,528	2,258	**14,302**
Tameside commissioned service	928	105	—	**1,033**
Bolton commissioned service	1,320	44	—	**1,364**
Total	**12,764**	**1,677**	**2,258**	**16,699**

The GM IT and Digital figure includes 80 Trafford locality users transferred in December 2025.

The figures should be treated as the current operational service-user baseline rather than a validated workforce establishment. Confirmation of the number of people remaining within the ICB is required to improve:

- software licensing and contract management;
- device allocation and recovery;
- physical and information-asset management;
- support-demand forecasting;
- workforce and service-capacity planning; and
- financial forecasting and cost recovery

5.2 Wider operational scale

Measure	Current position
Total service users supported	**16,699**
GP and ICB end-user devices supported in June 2026	**13,421**
Localities directly supported by GM IT and Digital	**8 of 10**
Average Service Desk demand	**255 calls per working day**
Calls resolved within target in June 2026	**94.3%**
First-time fix rate	**73.7%**
Customer satisfaction	**4.7 out of 5**
Population covered by the GM Care Record	**Approximately 3.2 million**
Organisations connected through GMCR	**More than 600**
Average distinct GMCR users per month	**Approximately 27,040**
Patient records accessed through GMCR annually	**Approximately 5.2 million**

The GM Care Record connects nine NHS trusts, ten local authorities, more than 400 GP practices, more than 200 community pharmacies, eight hospices and other specialist and out-of-hours services.

6. Summary of key services

6.1 Service management and customer support

Services include:

- The Service Now portal and single point of contact;
- Service Desk and user support;
- incident, request, problem and change management;
- major-incident coordination;

- service-level reporting;
- customer communications; and
- continual service improvement.

6.2 Technical services and infrastructure

Services include:
- desktop, laptop and mobile-device support;
- field engineering and device deployment;
- network connectivity and management;
- data-centre, cloud, compute and storage services;
- infrastructure monitoring; and
- technical resilience.

6.3 Asset and lifecycle management

Services include:
- hardware and software asset management;
- device standards and secure builds;
- software licensing and compliance;
- device refresh and end-of-life management; and
- joiner, mover and leaver processes.

6.4 Cybersecurity, information governance and access - Services include:

- Cyber security strategy and threat protection;
- vulnerability and patch management;
- cyber-incident response;
- Data Security and Protection Toolkit assurance;
- data protection and information governance;
- Registration Authority and smartcard services;
- identity and privileged-access management; and
- business continuity and disaster recovery.

6.5 Primary care and neighbourhood services - Services include:

- GP clinical and corporate system support;
- NHSmail and national-service support;
- NHS App, online consultation and digital telephony;
- practice-level digital facilitation and technology adoption;
- digital inclusion and accessibility;
- Integrated Neighbourhood Team enablement; and
- delivery of national primary care digital requirements.

6.6 Greater Manchester Care Record - Services include:

- operational and technical support;
- product and supplier management;
- interoperability with clinical and care systems;
- user training and adoption;
- incident escalation and communications; and

- development and re-procurement of future capability.

6.7 Strategy, transformation and innovation - Services include:

- development of the 2027–2032 GM Digital Strategy;
- development of the five-year IT and Digital Services Strategy;
- population health and analytical capabilities;
- Microsoft 365, SharePoint and Copilot adoption;
- artificial intelligence governance and automation;
- workforce digital-skills development; and
- regional and national programme engagement including co-ordination and prioritisation of expressions of interest and bids for National Digital Funding

6.8 Programme and commercial services including:

- project and portfolio management;
- demand assessment and prioritisation;
- project mandates and Statements of Work;
- supplier and contract management;
- third-party onboarding; and
- rate-card and cost-recovery arrangements.

7. Proposed operating model

The proposed operating model is based on the following principles:

- One coordinated service: teams operate as a single function rather than separate service silos.
- A single front door: incidents, requests and project demand are managed through ServiceNow.
- Common infrastructure and standards: shared platforms, controls and products are used wherever possible.
- Build once and reuse: improvements are designed for adoption across Greater Manchester.
- Transparent prioritisation: work is assessed against statutory need, risk, strategic value and system impact.
- Formal accountability: projects are supported by agreed mandates, Statements of Work and named owners.
- Early involvement: Digital and IT implications are considered during business-case and commissioning development.
- Proportionate cost recovery: beneficiaries fund enhanced or third-party services where appropriate.

The intention is not to eliminate all local flexibility. Local variation would remain possible where there is a demonstrated need, agreed funding and appropriate governance.

8. People and organisational implications

The operating model requires sufficient workforce capacity to maintain operational services while supporting strategic change.

A detailed workforce is being prepared to:

- confirm the future organisational structure and funded establishment;
- clarify responsibilities across GM, Place, primary care and partners;

- quantify operational and project capacity;
- identify vacancies, critical skills and succession risks;
- define the balance between permanent staff, contingent labour and suppliers;
- support career development and professional capability;
- identify recruitment and retention priorities; and
- set out the required organisational-development programme.

Particular attention is required in:

- cybersecurity;
- technical engineering and infrastructure;
- information governance;
- clinical safety;
- service management;
- data and analytics;
- artificial intelligence;
- commercial management; and
- programme and project delivery.

The proposed Digital Hub and champions network should support wider workforce capability in Microsoft 365, Copilot, cyber awareness and effective use of standard digital tools.

Confirmation of the remaining ICB workforce and service-user population is a priority. Without this information, software, device and support requirements cannot be planned with sufficient accuracy.

9. Financial and commercial implications

A sustainable operating model requires clarity about what is funded as a core service and what should be treated as enhanced or chargeable provision.

The development of the Service strategy for 2027-2032 will define:

- the total cost of the proposed operating model;
- cost-to-serve by service and customer group;
- core, enhanced and chargeable service boundaries;
- charging principles, rates and exemptions;
- technology lifecycle and infrastructure investment;
- anticipated efficiencies and avoided costs;
- affordability within the ICB financial envelope; and
- arrangements for monitoring financial and operational benefits.

Potential rate-card areas include:

- organisation and user onboarding;
- user and device support;
- project and change resources;
- information-governance services;
- compute, storage and hosting;
- premium or out-of-hours support; and
- digital training.

Cost recovery should not prevent the ICB from fulfilling statutory duties or participating in beneficial

public-sector collaboration.

10. Principal risks and required responses

Risk	Required response
Unconfirmed ICB workforce baseline	Obtain an authoritative workforce and service-user count.
Insufficient operational capacity	Develop a quantified workforce plan and apply transparent prioritisation.
Specialist skills shortages	Target recruitment, workforce development and managed supplier support.
Ageing devices and infrastructure	Prepare a costed lifecycle and capital investment plan.
Unfunded third-party demand	Agree a commercial policy, rate card and standard agreements.
Cybersecurity and information risk	Maintain pan-GM controls, investment and regular assurance.
Unclear service responsibilities	Agree a RACI model and service catalogue.
Resistance to common standards	Use stakeholder engagement and controlled exception routes.
Excessive project demand	Strengthen portfolio governance and sequencing.
Benefits not demonstrated	Agree baselines, accountable owners and benefits reporting.

11. Implementation priorities

The immediate priorities are to:

1. confirm the organisational design, governance and accountability arrangements;
2. validate the workforce and service-user baseline;
3. define the service catalogue and service boundaries;
4. complete the workforce, financial and technology plans;
5. establish common portfolio and prioritisation arrangements;
6. agree the commercial policy and initial rate card;
7. introduce a balanced performance scorecard;
8. launch the Digital Hub and champions network; and
9. progress the GM Digital Strategy and GMCR re-procurement.

12. Performance and assurance

Historically performance reporting has not been in place, a monthly report is now being developed which will cover:

- financial sustainability and cost recovery;
- customer and stakeholder experience;
- service availability and resolution performance;
- workforce capacity, vacancies and critical skills;
- cybersecurity, information governance and resilience;
- delivery of strategic projects;
- digital adoption and maturity; and
- quantified benefits and productivity improvements.

Targets currently contained within the operating-model material are illustrative. Baselines, definitions and accountable owners will be formally agreed before routine reporting begins.

13. Equality and inclusion considerations

Digital-by-default services must not create barriers for citizens or staff – we focus services on supporting all aspects of accessibility:

- use of accessible and supportive technology and communications;
- hybrid digital and non-digital access;
- support for digital inclusion;
- appropriate assistive technology;
- monitoring of differential impacts across communities and workforce groups;
- and our future strategy will incorporate more workforce and citizen co-design – which we currently support in partnership with General Practices through our Digital Facilitators.

14. Conclusion

The proposed operating model provides a sound basis for a more consistent, sustainable and accountable Digital and IT service across Greater Manchester.

The wider delivery model currently supports 16,699 service users, alongside a substantial device, infrastructure and shared-care-record estate. Its success is fundamental to day-to-day service delivery and to the ICB's wider strategic ambitions.

The Committee is asked to endorse the direction of travel, subject to completion of:

- a quantified business case;
- confirmed workforce requirements;
- an authoritative ICB service-user baseline;
- clear service boundaries and accountability;
- validated performance baselines; and
- an affordable technology investment plan.

NHS
Greater Manchester

Chief Finance Officer Report

August 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester People and Resources Committee

26th August 2026

Required information	Details
Title of report	Chief Finance Officer Report
Author	Stephen Downs, Deputy Chief Finance Office, NHS GM
Presented by	Kathy Roe, Chief Finance Officer, NHS GM
Contact for further information	Stephen.Downs1@nhs.net
Executive summary	This report provides assurance on how NHS Greater Manchester Integrated Care Board is discharging its statutory duties for finance across the organisation and the system as a whole. It brings together intelligence from a number of resources to provide the Committee with an update on current pertinent issues and updates. <u>Alerts</u> • None to raise this month <u>Advise</u> • Month 4 – system position • 2027/28 Financial Planning <u>Assure</u> • Month 4 – ICB • Procurement Training <u>Risks</u> • Strategic Risk 3 - Inability to Delivery Financial Sustainability <u>Achievements</u> • ESR and Ledger Update
The benefits that the population of Greater Manchester will experience.	The ICB will operate within the resources available for the Greater Manchester population and deliver the best value possible.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy.
The decision to be made and/or input sought	No decisions are required
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk SR3
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for the People and Resources Committee and covers the finance aspects of the Committee business. It has not been elsewhere but is formulated from intelligence gathered

	from various senior managers within the ICB.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper.
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report.

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

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

Alert

None noted this month.

Advise

Month 4 System Financial Position

As reported to NHS England at Month 4, the Greater Manchester system reported a year to date adverse variance of £3.0m, which is a deterioration of £1.1m from Month 3; noting that the ICB reported a balanced position.

2027/28 Financial Planning

Planning for 2027/28 has commenced, starting with a review of the 2027/28 exit run rate. In addition, the finance team are working with business intelligence colleagues to model the counterfactual financial impact of activity demand in 2027/28. This work will form the baseline onto which the anticipated impact on commissioning intentions can be modelled.

Assure

2026/27 Month 4 – ICB

The ICB is on plan at Month 4 but there continues to be pressures being reported across a number of key risk areas including Prescribing, All Age Continuing Care and Mental Health packages, and ADHD, which are being offset with underspends in other areas of spend within the overall position. Further detail is provided in the separate finance report on the agenda.

Procurement Training

The Procurement Team has designed a training programme for ICB staff to increase awareness on procurement rules and processes. The logistical roll out of this programme is currently being finalised with the Organisational Development Team.

Risk discussed and new risk identified

Strategic Risk 3 – Inability to Delivery Financial Sustainability

There is only one strategic finance risk that has been identified to date, and this is outlined below:

Risk Number	Risk Description	Current Score	Direction	Date Last Reviewed
1	The ICB does not deliver the in-year financial plan and deliver medium-term financial sustainability. It should be noted that whilst the ICB is no longer directly responsible for managing the overall GM system financial position, as the strategic commissioner: • The ICB will work closely with NHSE to ensure the delivery of individual provider positions and the overall system position; • Financial viability of providers is critical to ensuring delivery of operational performance and quality of care; • The overall system position demonstrates credibility with NHSE which influences the ability to access national capital and revenue funding;	20	↔	17 August 2026

A summary of the position and controls included in the detailed risk register are:

- The ICB has submitted a balanced plan for the period 2026/27 to 2028/29
- Medium- and long-term financial plans were approved by the Board on 11/02/2026.
- Currently on plan at month 4
- The enhanced levels of grip and control and financial assurance established during 2025/26 continue across NHS GM, including Cost Improvement Plan (CIP) governance.
- ICB has revised the reporting pack with a focus on run rate to allow identification of potential issues and mitigation plans have been implemented to address the risks on in year delivery.
- Recovery plans are in progress for areas of expenditure that are forecast to overspend.
- An intensive review of all current CIP schemes has been undertaken to validate the planned values and to confirm their delivery status. Where planned values in year have been reduced alternative schemes have been identified to maintain the current trajectory of delivery. During this time in addition to the fortnightly Core Delivery Group meetings attended by scheme SROs and operational and finance leads, a fortnightly dedicated CO meeting was stepped-up to maintain focus and scrutiny.

Achievements

ESR and Ledger Update

Joint work between the Workforce Planning Team, Transformation Team and Operating Costs Finance Team has meant that over 1,200 staff moves as part of the NHS Reform Programme have been actioned in ESR, Payroll and the Ledger over a short period of time. A fantastic achievement, recognising reduced staffing levels in those teams, whilst still meeting normal month end and other reporting deadlines.

Chief Officer Approvals between £5-15m

There are no approvals to report.

NHS
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NHS Greater Manchester Finance Slide Pack Month 04 – July 2026

Part of Greater Manchester Integrated Care Partnership

Presented by: Jackie Gardiner
Date: 26th August 2026

NHS GM Financial Position

Introduction

NHS Greater Manchester

As at Month 4 NHS GM is reporting in line with the year-to-date and annual plan, including receipt of the Deficit Support Funding (DSF).

M4 2026/27 ICB Surplus/(Deficit) £m	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Actual	Full Year Variance
NHS GM	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
ICS Total	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**

Key points to note for Month 4 are:

- There continues to be pressures being reported across a number of key risk areas including Prescribing, All Age Continuing Care and Mental Health packages, which are being offset with underspends in other areas of spend within the overall position and over delivery against the CIP target YTD.
- Delivery against the efficiency target at Month 4 is £50.8m, which is £5.9m ahead of the target, with the current non-delivery risk standing at £28.5m using the NHSE risk approach. The position has improved again this month, and the risk of delivery has reduced but delivery of CIP savings and reducing CIP delivery risk at pace, remains a high priority for NHS GM.
- Cash draw down at Month 4 is £15.2m ahead of the national straight-line profile, but with a closing balance of £3.4m, which is a significant reduction when compared to last month, as cash requests have been adjusted accordingly.
- NHS GM has received a total capital allocation of £20.1m, with a forecast expenditure of £20.9m, which remains unchanged from last month as the additional allocation for GPIT is yet to be received. Governance continues to be reviewed to ensure all funding can be appropriately spent.
- Deficit Support Funding (DSF) has now been received for Q2, but there remains a risk that this and future allocations are subject to clawback if a balanced position for NHS GM is not delivered.
- Enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.

Key Metrics Dashboard

NHS Greater Manchester

2026/27 NHS GM Dashboard (£m)	YTD Budget M04	YTD Actual M04	YTD Variance M04	Full Year Budget/ Allocation	Full Year Forecast	Full Year Variance	RAG
Financial Position - Inc DSF	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	G
Financial Position - Exc DSF	-£5.9	-£5.9	£0.0	-£17.7	-£17.7	£0.0	G
CIP	£44.9	£50.8	£5.9	£150.0	£150.0	£0.0	G
Capital - NHS GM	£6.7	£6.7	£0.0	£20.1	£20.9	-£0.8	G
Key metrics							
MHIS (Excluding LD & Dementia)	£282.0	£282.0	£0.0	£855.6	£855.6	£0.0	G
MHIS - Delegated Specialised Commissioning*	£35.5	£35.5	£0.0	£118.0	£118.0	£0.0	G
Running Costs**	£16.0	£10.8	£5.2	£47.8	£33.2	£14.6	G

- NHSE have confirmed that the target in the IFR file is the opening plan and does not yet include any additional allocations received, the budget for NHS GM does include those additional allocations.

** Running Cost underspend is currently offset with Programme Operating Costs until ESR has been updated to reflect the new Operating Model and structures.

Monthly BPPC Performance

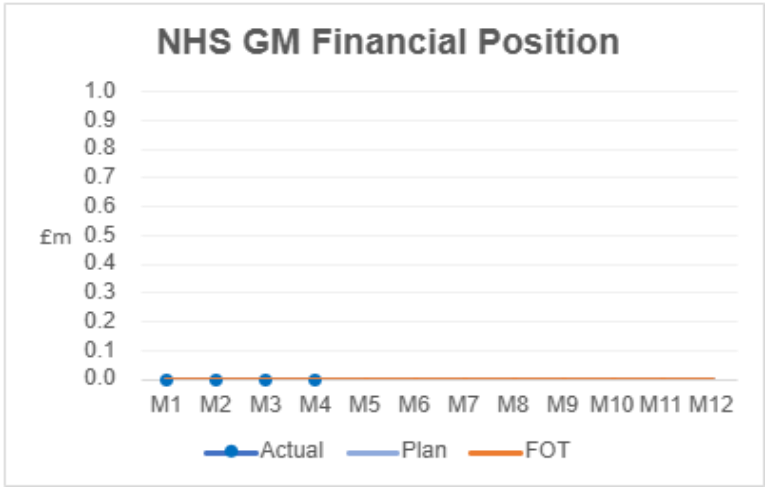
	NHS		Non-NHS	
	Current	YTD	Current	YTD
GM ICB				

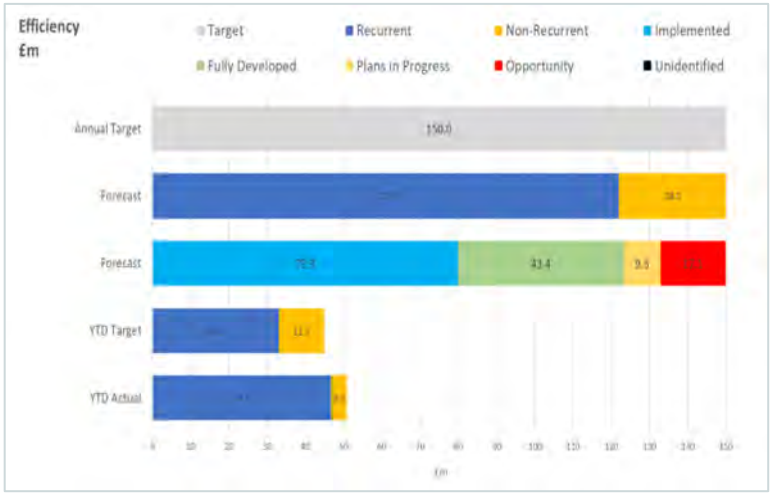
Note: *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are* calculated using precise values, before rounding is applied.

Key Metrics

Analysis

NHS Greater Manchester





NHS GM Financial Position

- As at Month 4 NHS GM is reporting in line with the year-to-date and annual plan.
- This is after Deficit Support Funding (DSF) of £17.7m has been allocated to NHS GM. To date £8.9m for Q1 and Q2 has been received, of which £5.9m is profiled to Month 4.
- DSF for the remainder of the year will be subject to delivery of the overall plan and identification of all schemes to deliver the savings target of £150.0m.

NHS GM Efficiency

- The chart above details the savings delivered against an overall savings target of £150.0m.
- YTD savings of £50.8m have been delivered against the target of £44.9m, of which 92.0% has been delivered recurrently.
- NHS GM is expected to deliver savings of £150.0m in full, albeit that at Month 4, £17.1m are flagged as an opportunity, where schemes are still being scoped. The current risk adjusted (NHSE risk approach) forecast outturn delivery is £28.5m which has reduced by £5.9m since last month.

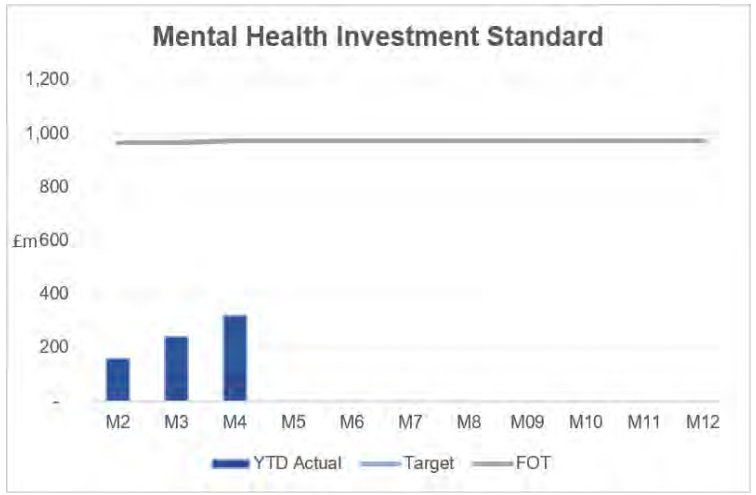
NHS GM Running Costs

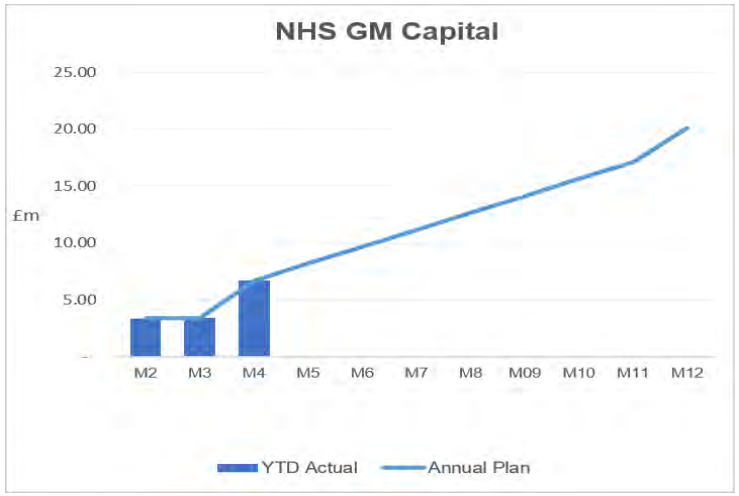
- The Running cost allowance for NHS GM for 2026/27 is £47.8m.
- At Month 4 the Running cost allowance is £16.0m with actual spend of £10.8m, a variance of £5.2m.
- Underspends are currently being reported within Running costs, and these are being partially offset by overspends within Programme Operating costs. This is until the NHS Reform programme has concluded and ESR has been updated which is expected to now be by the end of September.
- The FOT is showing a £14.6m underspend.

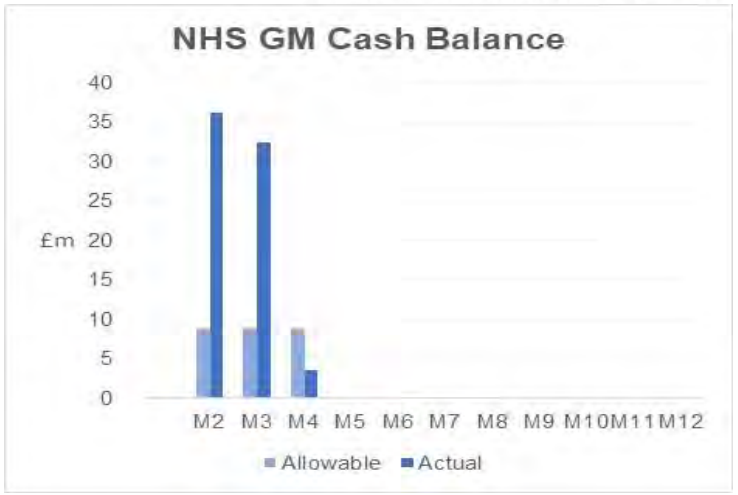
Key Metrics

Analysis

NHS Greater Manchester







Mental Health Investment Standard

- There are two targets relating to the Mental Health Investment Standard (MHIS) which are reported and monitored separately and not combined.
- The core MHIS target requires NHS GM to spend £855.6m on mental health provision in 2026/27, which now includes a Cost Uplift Factor (CUF) from M4.
- The Specialised Commissioning MHIS (SCMHIS) target of £115.7m target has still not been updated by NHSE to reflect the additional allocations received since the opening budgets were posted, which now totals £118.0m.
- At Month 4 NHS GM has delivered both targets.

NHS GM Capital

- The chart above shows the entirety of the NHS GM Capital plan for 2026/27 which totals £20.1m.
- This is split £6.6m for BAU, £10.5m relating to the first year of the 4-year Strategic Allocation and £3.0m relating to the Utilisation and Modernisation Fund (UMF).
- At Month 4, YTD expenditure is reported in line with plan. Forecast is showing £0.8m overspend which is due to an anticipated allocation in relation to GPIT. All schemes are currently being finalised to ensure that the full allocation is utilised in year. Governance continues to be reviewed to ensure all funding can be appropriately spent.

Cash

- At M4 NHS GM has drawn down £3,169.9m of cash against a straight-line national profile of £3,154.6m, which has reduced compared to last month.
- The cash balance at the end of M4 is £3.5m, which is also significantly lower than last month, and which is as a result of reducing the cash draw down required in July.
- The cash forecast for 2026/27 at M4 remains in line with the total confirmed cash limit of £9,463.8m, which will be updated as allocations are received during the financial year.

NHS GM Financial Position

Month 4

NHS Greater Manchester

The financial summary for NHS GM by expenditure type as at Month 4 is shown in the table below:

NHS GM Financial Position £m	In Month Plan	In Month Actual	In Month Variance	In Month Variance %	YTD Plan	YTD Actual	YTD Variance	YTD Variance %	Full Year Plan	Full Year Forecast	Full Year Variance	Full Year Variance %	M03 Full Year Variance	Change in Forecast M03 to M04	Change in Var - M03 vs M04 FOT var
Allocations	£782.4	£782.4	£0.0	0.0%	£3,130.1	£3,130.1	£0.0	0.0%	£9,463.9	£9,463.9	£0.0	0.0%	£0.0	£0.0	£0.0
Admin															
Running Costs	£4.0	£0.1	£3.8	96.3%	£16.0	£10.8	£5.1	32.2%	£47.8	£33.2	£14.6	30.6%	£0.0	£14.6	£14.6
Total Admin	£4.0	£0.1	£3.8	96.3%	£16.0	£10.8	£5.1	32.2%	£47.8	£33.2	£14.6	30.6%	£0.0	£14.6	£14.6
Programme															
Mental Health	£85.6	£87.3	-£1.8	-2.1%	£338.5	£343.5	-£5.0	-1.5%	£1,014.2	£1,027.3	-£13.1	-1.3%	-£7.5	-£5.6	-£5.6
Acute	£355.9	£355.9	£0.0	0.0%	£1,410.5	£1,410.5	£0.0	0.0%	£4,232.4	£4,232.4	£0.0	0.0%	£0.0	-£0.0	-£0.0
Specialised Commissioning	£86.6	£86.2	£0.4	0.4%	£349.3	£348.4	£0.9	0.3%	£1,068.9	£1,068.9	£0.0	0.0%	£0.0	£0.0	£0.0
Primary Care	£9.5	£9.5	£0.0	-0.3%	£38.1	£38.2	-£0.1	-0.2%	£114.4	£114.5	-£0.1	-0.1%	-£0.1	£0.0	£0.0
GP Medical, Pharmacy, Dental and Optometry	£92.8	£92.8	£0.0	0.0%	£375.7	£375.5	£0.2	0.1%	£1,125.5	£1,124.0	£1.4	0.1%	£1.3	£0.1	£0.1
Prescribing	£51.3	£50.3	£1.0	2.0%	£201.7	£204.7	-£3.0	-1.5%	£603.0	£607.7	-£4.8	-0.8%	-£0.9	-£3.9	-£3.9
All Age Continuing Healthcare	£24.5	£25.2	-£0.7	-3.0%	£97.9	£103.0	-£5.1	-5.2%	£293.6	£304.9	-£11.3	-3.8%	-£9.2	-£2.0	-£2.0
Community Health Services	£66.0	£67.7	-£1.7	-2.6%	£264.4	£265.5	-£1.1	-0.4%	£792.6	£795.4	-£2.8	-0.4%	£0.2	-£3.0	-£3.0
Programme Operating Costs	£6.9	£10.4	-£3.5	-51.4%	£27.0	£31.6	-£4.6	-16.9%	£82.3	£96.9	-£14.6	-17.7%	£0.0	-£14.6	-£14.6
Other Expenditure	-£3.2	-£3.1	-£0.1	2.4%	-£1.7	-£1.6	-£0.1	4.5%	£13.8	£14.1	-£0.2	-1.5%	-£0.1	-£0.1	-£0.1
Earmarked Commitments	£2.7	£0.0	£2.7	100.0%	£12.7	£0.0	£12.7	100.0%	£75.4	£44.7	£30.7	40.8%	£16.3	£14.5	£14.5
Total Programme	£778.4	£782.2	-£3.8	-0.5%	£3,114.1	£3,119.2	-£5.1	-0.2%	£9,416.1	£9,430.7	-£14.6	-0.2%	-£0.0	-£14.6	-£14.6
Total Expenditure	**£782.4**	**£782.4**	**£0.0**	**0.0%**	**£3,130.1**	**£3,130.1**	**£0.0**	**0.0%**	**£9,463.9**	**£9,463.9**	**£0.0**	**0.0%**	**£0.0**	**£0.0**	**-£0.0**
Surplus / (Deficit)	**£0.0**	**£0.0**	**£0.0**		**£0.0**	**£0.0**	**£0.0**		**£0.0**	**£0.0**	**£0.0**		**£0.0**	**£0.0**	**-£0.0**

- At Month 4, there continues to be a number of pressures being reported, some of which are a continuation of those reported at the end of 2025/26:
  - Mental Health – relating to increases in ADHD and costs of packages of care. £0.8m of this pressure relates to costs associated with 2025/26 which were billed late by providers.
  - Prescribing – including £4.8m of estimated additional costs relating to increases in No Cheaper Stock Obtainable (NCSOs – including net impact of £0.8m from 2025/26).
  - All Age Continuing Care – a continuation of increased costs associated with additional packages and higher acuity.
  - Acute – Activity data (Month 2 Freeze and Month 3 Flex) has now been received from providers, which indicates some under and over performance that broadly net off, but this continues to be being validated.
- Running costs and Programme Operating costs – continue to be offset until the outcomes of the NHS Reform programme are concluded and ESR is updated to reflect staff moving into their substantive roles. Overall, some slippage has been reported YTD, but the overall forecast position is in balance.
- Offset with other areas of underspend in the overall position, over delivery of CIP of £5.9m YTD and the utilisation of centrally held allocations whilst investment decisions are confirmed.

Recommendations

Month 4

NHS Greater Manchester

For the NHS GM Financial position, the People & Resources Committee is asked to:

- Note the Month 4 year to date and forecast reported financial position which is in line with the balanced plan including Deficit Support Funding.
- Note and discuss the areas of key risks, pressures and the requirements for early intervention and mitigations to bring spend back in line with plan, and planned presentation of the monitoring of the recovery plans which are in development.
- Note the delivery of CIP as at Month 4 of £50.8m against a plan of £44.9m, an over delivery of £5.9m YTD.
- Note that the forecast capital position is expected to deliver in line with the allocation including the additional allocation notified for GPIT.
- Note the NHS GM cash position which continues to be closely monitored.
- Note that enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.

NHS
Greater Manchester

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

August 26th 2026

Part of Greater Manchester
Integrated Care Partnership

People & Resources Committee

26th August 2026

Report information.

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. 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. 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: 1. Note the breadth of activity that has taken place to implement the socio-economic duty over the past twelve months. 2. Endorse the proposed priorities in section 3.2. 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 • 5th August: 2026 Update to Strategic Commissiong Committee • 26th August 2026: Update to People and Resources Committee • 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. The Associate Director of Population Health is the Senior Responsible Officer for this work programme on behalf of the Greater Manchester Public Health Network ICB Chief Officer responsibility sits with the Chief Officer for Strategy, People and Partnerships. 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. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The NHS GM Tackling Poverty Delivery Group has provided strategic oversight. This also aligns to the priorities of the Greater Manchester Live Well Financial Resilience Group. On August 6th 2026 The Strategic Commissioning Committee supported a number of recommendations to strengthen the Committee's role in SED implementation.
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** – broad engagement activity has taken place to 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.
- **Seize the opportunity** to embed the duty in all commissioning decisions with The Strategic Commissioning Committee and governance processes ensuring all strategic commissioning activity gives due regard to socio-economic disadvantage.
- **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 The People and Resources Committee can play in bringing assurance, challenge influence and leadership to SED adoption. Proposed options include:

- The Chair will champion the consideration of socio-economic disadvantage, fostering constructive challenge and ensuring it remains a key consideration in committee discussions and decision-making.

- Amend Committee governance documentation to include a specific ask about the extent to which the proposal has considered the impact of socio-economic disadvantage and deprivation.

- The next refresh of The Committee's Terms of Reference to describe specific Committee duties supporting SED compliance.

- The Committee to receive and annual Socio-Economic Duty Progress Report

4 Recommendations

4.1. The People and Resources 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.

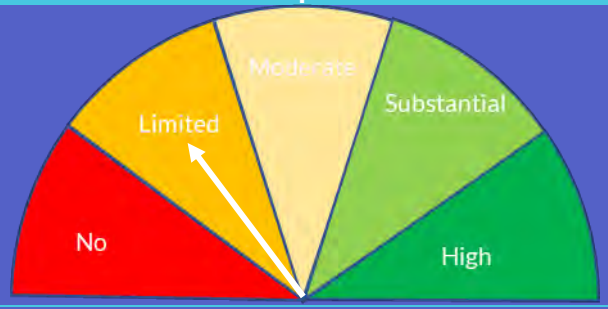
- Confirm if The Committee agrees with the options suggested in section 3.3 and give a view on any further opportunities to strengthen SED implimentation across NHS GM.

Data Quality Review
Assignment Report 2025/26 (Final)

Greater Manchester Integrated Care Board

560GMICB_2526_022

Overall Assurance Opinion



There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.

Contents

MIAA would like to thank all staff for their co-operation and assistance in completing this review.

This report has been prepared as commissioned by the organisation and is for your sole use. If you have any queries regarding this review, please contact the Engagement Manager. To discuss any other issues then please contact the Director.

1 Executive Summary

Overall Audit Objective The overall objective of this audit was to review and assess the extent to which the ICB has adopted and embedded its Data Quality Policy as part of gaining assurance over data quality.

Scope Limitation The review did not include any deep dives of data quality into individual areas or an assessment of the systems in place to capture data at source.

Key Findings/Conclusion

This audit was conducted as a follow up review to two reviews by Internal and External auditors in 2024/25 which recommended that Data Quality processes be developed and embedded in the GMICB's everyday business and governance related reporting. However, it has been identified that limited progress had been made at the time of the audit. Management advised that the "Reform Programme" has been a distraction to all internal teams which could have fully implemented the recommendations. Data quality assessments are conducted mainly as a matter of course at performance monitoring forums such as the Contract Review Meetings (CRM) and the Provider Oversight Subcommittee meetings as required by their terms of reference. Our key findings include:

- The GMICB does not have an approved and in date Data Quality Policy / Strategy in place. There is a draft which is dated April 2024, with a review date of April 26 which was not formally approved or ratified. **High Risk**
- The GMICB has not conducted a data quality gap analysis from their sources of business information such as from General Practitioners and Trusts so that they can develop a Data Quality Improvement Plan with providers and embed the processes. **High Risk**
- The GMICB has not developed a forward-looking programme of assessment and assurance to monitor the quality of the data generated in support of their everyday business and reporting requirements across all commissioned areas on an ongoing basis. **High Risk**
- The GMICB does not have Data Quality as a standing agenda item on the CRM meetings so that the Data Insight & Intelligence (DII) function can hold providers to account on the accuracy, validity, completeness, consistency and relevance of the information they share at that forum. **Medium Risk**

Objectives Reviewed	RAG Rating
Policy and Strategy	Red
Data Quality Improvement Plan	Red
Programme of Assessment and Assurance	Red
Performance Management and Governance Arrangements	Green
Data Quality Functions and Contract Management	Amber
Overall Assurance Rating	**Limited**

Recommendations		
Risk Rating	Control Design	Operating Effectiveness
Critical	0	0
High	1	2
Medium	0	1
Low	0	0
Total	**1**	**3**

Areas of Good Practice

- The GMICB has established a Data Insight & Intelligent function dedicated to improving data quality within the organisation.
- The GMICB has developed a governance structure such as the Provider Oversight Subcommittee and Provider Oversight Meetings which are staffed by senior officers and has the responsibility of overseeing provider performance, including data quality.
- The GMICB has established Contract Review Meetings (CRM) which are held regularly with providers to monitor the contractual key performance indicators and challenge data if the KPIs are not as expected. If the data coming through is unreliable for decision making, this will be discussed and data quality improvement strategies agreed. This oversight arrangement covers all areas of the ICB business - Mental Health; Provider Trust; Primary Care and Community.

Key Findings – Issues Identified	
	1.1 The GMICB does not have a formally approved and ratified policy / strategy for Data Quality that should guide staff and providers on how to produce reliable, accurate and timely information to support effective delivery of care and the decision-making capability of the ICB Board and its supporting committees. The approved policy should be published on the ICB website and intranet as appropriate. 1.2 The GMICB has not conducted a data quality gap analysis from their sources of business information such as from General Practitioners, which is largely managed through the 'GM Care Record' and the assortment of local data flows which come in from Providers/ Trusts and specified under schedule 6 of their contracts, in addition to the Community Services data which is work-in-progress. From this analysis, they should identify gaps of data quality which require improvement plans to be developed and agreed with the providers. In addition, they should also identify ongoing assurance mechanisms that should be provided to confirm that data quality is embedding moving forward. 1.3 The GMICB has not developed a programme of assessment and assurance to monitor the quality of the data generated in support of their everyday business and reporting requirements across all commissioned areas. Where areas of improvement have been identified, corrective action should be taken and lessons learned shared with other functions and providers.
Medium	2.1 The GMICB does not have Data Quality as a standing agenda item on the CRM meeting so that the DII can hold providers to account on the accuracy, validity, completeness, consistency and relevance of the information they share at that forum.

2 Findings, Recommendations and Management Action

1. Data Quality policy and / or strategy Approval		Risk Rating: High
Control Design		
Key Finding – Our review identified that the GMICB does not have an approved data quality policy in place. The policy made available to audit was not formally considered and approved / ratified by an appropriate governance arrangement of the ICB. It is clearly marked as first draft. The policy is dated April 2024 with a review date of April 2026, which was already out of date at the time of the audit in June 2026. The absence of an approved in-date policy was against a background of two earlier critical audit reports - a more in-depth review by MIAA of Data Quality – Community Services in 2024/25 which provided 'limited assurance' and a 24/25 review by the external auditors Grant Thornton which had made a recommendation that "The ICB needs to ensure its data quality strategy and associated governance has the necessary positive impact on data quality. It should consider developing a related programme of assessment and assurance to test the impact of the policy and embed data quality in its everyday business and reporting." A further review of the draft policy confirmed that it states that the policy will be made available to all staff via "Keep Connected" and published on NHS Greater	**Specific Risk** – Inaccurate, incomplete or untimely data may be provided to management and the Board/Sub-Committees, potentially compromising their ability to make appropriate decisions	**Recommendation** - The ICB management must formally develop, and have ratified, a fit for purpose policy / strategy for Data Quality that should guide staff and providers on how to produce reliable, accurate and timely information to support effective delivery of care and the decision-making capability of the ICB Board and its supporting committees. The approved policy should be published on the ICB website and intranet as appropriate.

Manchester Integrated Care website and on the intranet for staff. Because the policy had never been formally approved, it was not on the ICB website or intranet, therefore staff are not positively aware of their roles and responsibilities in relation to data quality policy.		
Management Response - **Responsible Officer** -		**Implementation Date** - **Evidence to Confirm Implementation** -

2. Development of Data Quality Improvement Plans		**Risk Rating: High**
Operating Effectiveness		
Key Finding – In discussion with management, it was noted that the development of Data Quality Improvement Plans was still an on-going exercise. They had identified and provided to audit an extract of the DQIPs that are going into the 2026/27 contracts with Bolton FT, Manchester Foundation Trust FT, and Northern Care Alliance FT. These relate to Community Health Services. It was noted that for each Data Quality indicator identified for the 3 Trusts, the Method of Measurement has not been discussed with any of the Trusts as they all contained the phrase "Method of Measurement and Monitoring to be agreed during 2026/27 via Data Quality meetings; frequency TBD". At the time of the	**Specific Risk** – Failure to improve data quality will result in poor patient care and lack of delivery of value for money by the Trust.	**Recommendation** - The GMICB should conduct a data quality gap analysis from their sources of business information such as from General Practitioners, which is largely managed through the 'GM Care Record', and the assortment of local data flows which come in via Providers/ Trusts and specified under schedule 6 of their contracts, in addition to the Community Services data which is work-in-progress. From this analysis, they should identify gaps of data quality which require improvement plans to be developed and agreed with the providers. In addition, they should also identify ongoing assurance mechanisms that should be provided to confirm that data quality is embedding moving forward

audit in June 26, the improvement plans for other commissioned areas of the ICB had not been developed. Even though management advised that they only enter a formal contractual DQIP where they have identified a need to do so, there was no formal assessment conducted and approved by the ICB across the commissioned services to identify areas with data quality gaps and therefore requiring an improvement plan.		
Management Response - **Responsible Officer** -		**Implementation Date** - **Evidence to Confirm Implementation** -

3. Develop a Comprehensive Programme of Assessment to Embed Data Quality in Everyday Business and Reporting		**Risk Rating: High**
Operating Effectiveness		
Key Finding – It was noted that the Data Quality policy has not been formally adopted by the GMICB. Therefore, a comprehensive programme of assessment to test the impact of the policy and embed data quality in its everyday business and reporting has not been fully developed as recommended by External Audit Grant Thornton in 2024/25. However, the Data Insight and Intelligent function of the ICB had developed a Data Quality (DQ) Assurance	**Specific Risk** – Failure to have processes to identify areas to enhance data quality and embed good practice may lead to wrong or costly business decisions.	**Recommendation** – The ICB should develop a programme of assessment and assurance to monitor the quality of the data generated in support of their everyday business and reporting requirements across all commissioned areas. Where areas of improvement have been identified, corrective action should be taken and lessons learned shared with other functions and providers.

Standard Operating Procedure (SOP), including the associated roles and responsibilities within the Data, Insight & Intelligence function. This procedure outlines the key operating processes of recording and escalating key data issues in line with NHS GM's Data Quality Policy, ensuring there is a consistent way of managing the quality of the data used for decision making across the organisation. The requirements, roles and responsibilities for Data Quality issues are outlined within this document. It was noted that the SOP stated that DQ issues should be logged onto a "DQ Issues Log". A review of the log identified that the users stopped using the spreadsheet in September 2025, sighting it as not user friendly. It was further noted that the SOP has not been approved by any governance arrangement within the ICB to be widely used across the organisation.		
Management Response - **Responsible Officer** -		**Implementation Date** - **Evidence to Confirm Implementation** -

4. Enhance Visibility of Data Quality Assessment on the Contract Monitoring Meetings (CRM) Agenda		**Risk Rating: Medium**
Operating Effectiveness		
Key Finding The review noted that the GMICB has established the Data Insight & Intelligent (DII) function	**Specific Risk** – If data quality is not on the CRM agenda, inaccurate	**Recommendation** - The GMICB should ensure that there is a standing agenda item on the CRM meeting so that the

to drive data quality agenda within the organisation. DII management advised IA that there is a standard agenda item on the contract monitoring meeting on Information, where it picks up all information issues including data quality. There was no evidence provided to the audit to assess the level of discussion on information / data quality at the meetings. The CRM terms of reference (ToR) does not refer to Data Quality issues specifically. Management advised internal audit that this ToR was being reviewed so that they will have Data Quality added specifically to ensure clarity.	data may lead to wrong decisions by the ICB.	DII can hold providers to account on the accuracy, validity, completeness, consistency and relevance of the information they share at that forum.
Management Response - **Responsible Officer** -		**Implementation Date** - **Evidence to Confirm Implementation** -

Appendix A: Engagement Scope

Scope

The overall objective of this audit was to review and assess the extent to which the ICB has adopted and embedded its Data Quality Policy as part of gaining assurance over data quality.

The following sub-objectives have been identified:

Sub Objective	Risk
The ICB have a data quality strategy and policy in place and staff are aware of their roles and responsibilities in relation to data quality.	Inaccurate, incomplete or untimely data may be provided to management and the Board/Sub-Committees, potentially compromising their ability to make appropriate decisions.
A data quality improvement plan is in place which clearly identifies the gaps in data quality across key areas and sets out actions for improvement.	Gaps in data quality have not been identified, and actions are not taken to make improvements leading to poor data quality and no strategic oversight.
The ICB have developed a programme of assessment and assurance to test the impact of the policy and embed data quality in its everyday business and reporting.	The data quality policy is not embedded within routine structures and processes.
Performance management and governance arrangements include data quality as part of routine monitoring, to hold providers/ trusts to account. Where data quality is identified as being poor in areas, to ensure that these issues are being addressed with reference to contractual levers over ensuring improvements are delivered.	Lack of adequate processes to monitor data quality and hold providers/ trust to account.
The process between the central Data Quality functions and contract management functions provides a consistent structure and suite of information to support data quality improvements and contract management routines.	Lack of cohesion and joint working between functions. Lack of structured reporting routines to monitor data quality.

Scope Limitations

The limitations to scope are as follows:

- Our review will not provide any deep dives of data quality into individual areas.
- Our review will not involve an assessment of the systems in place to capture data at source.

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system

Appendix B: Assurance Definitions and Risk Classifications

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non- compliance with controls could/has resulted in failure to achieve the system objectives.

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significantimpact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives; • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control.

Appendix C: Report Distribution

Name	Title
Nicola Hepburn	Acting Chief Reform and Improvement Officer
Matt Hennessey	Chief Intelligence and Analytics Officer
Kathy Roe	Chief Finance Officer
Chris Gaffey	Associate Director of Corporate Services
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Limitations

Internal Audit and shall not have any rights under the Contracts (Rights of Third Parties) Act 1999.

Global Internal Audit Standards (UK Sector)

Our work was completed in accordance with Global Internal Audit Standards (UK Sector) and conforms with the International Standards for the Professional Practice of Internal Auditing.

Forward Plan Public Meeting	August	September	October	November	December	January	February
Standing Items							
Apologies for Absence and Quoracy	X	X	X	X	X	X	X
Declarations of Interest	X	X	X	X	X	X	X
Matters Arising, Action Log & Minutes of Last Meeting	X	X	X	X	X	X	X
Forward Plan Review (at end of meeting in preparation for the next one)	X	X	X	X	X	X	X
Committee Effectiveness							
Terms of Reference Review	X						X
Agree Committee Priorities							
Committee Review of Effectiveness			X				
Thematic Areas - Strategic							
Workforce Transformation Plan		X					X
Anti-Racism Framework Implementation Deep Dive				X			
Estates and Infrastructrue Strategy							X
Public Health Investment Standard feasibility assessment							
Socio-Economic Duty: Work to date and next steps	X						
Procurement and Contracting Strategy							
Place Partnership Agreements - Place Fund							X
Financial Strategy & Planning Deep Dive					X		
Financial Planning & Efficiency Review						X	
Digital Strategy Approval					X		
Strategy, People and Partnerships							
Workforce Report	X	X	X	X	X	X	X
Organsiational Development and Design Plan			X				
NHS Staff Survey Initial Findings						X	
Green Plan			X				
Freedom to Speak Up				X			
Health & Safety					X		
Strategic Finance							
Finance Performance Update (including Jigsaw)	X	X	X	X	X	X	X
Standing Financial Instructions Annual Review							X
Estates and Environmental Sustainability Review							
Chief Finance Officers Report (including investment decisions £5-£15m)	X	X	X	X	X	X	X
Contract Financial Performance	X	X	X	X	X	X	X
Capital Programme Review		X			X		
Financial Scheme of Delegation							X

Deconstructing Block Contracts		X					
System Reform							
Performance Report	X	X	X	X	X	X	X
Digital & Data Annual Review			X				
Digital and IT (Reources) Assurance Briefing	X						
Data Assurance Briefing		X					
Digital & IT Oversight Session			X				
Data-Driven Decision Making Deep Dive		X					
Digital Workforce Capability Deep Dive				X			
Other							
BAF and Risks (As Part of Regular COs' Reports)	X		X		X		X
Mersey Internal Audit Internal Audit Reports	X	X	X	X	X	X	X

NHS
Greater Manchester

Performance Report
Strategic Commissioning Committee

August 2026

Part of Greater Manchester
Integrated Care Partnership

Executive Summary

NHS Greater Manchester

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

NHS Greater Manchester

	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. • 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. • 6 of 7 providers were above plan in May, demonstrating variation in delivery across the system. • Increased demand, lower levels of activity and reduced validation have contributed to recent waiting list growth and deterioration in performance. • 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. • 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. • Targeted support and challenge continues with providers above plan, including review of delivery risks, productivity, waiting list validation and recovery trajectories. • Independent Sector activity and treatment provided outside Greater Manchester continue to be maximised to support elective recovery and delivery of year-end plans. • 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. • In June, 4-hour performance was 70.9% against a plan of 73.3%, with four of six providers below plan. • 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. • 12-hour waits remain above plan, indicating continued challenges in timely admission, discharge and onward care. • System flow, discharge delays and limited operational headroom continue to constrain improvement. • Variation in provider performance is impacting overall system delivery. • 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. • Increased focus on measurable improvement in patient flow, discharge and operational performance rather than activity alone. • Targeted support and challenge aligned to provider and Place ownership of recovery actions. • Priority work focused on cohorts with the greatest impact on demand and flow, including frailty, children and young people, and high-intensity service users. • 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. • Out of Area Placements remain above plan, reflecting continued pressure on mental health capacity and patient flow. • Learning Disability and Autism inpatient numbers remain above plan across both cohorts.	**Mental Health** • Talking Therapies outcomes remain below plan despite continued focus on service improvement. • Delivery remains constrained by workforce capacity, with workforce levels below those required to deliver the full NHS Talking Therapies model. • 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. • Ongoing pressure on mental health bed capacity and discharge pathways continues to contribute to Out of Area Placements. **Learning Disability and Autism** • Continued reliance on inpatient provision reflects challenges in developing community alternatives and supporting timely discharge. • 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. • Continued focus on reducing inappropriate Out of Area Placements through improved discharge planning, patient flow and community alternatives. • Development of crisis and admission avoidance pathways to reduce reliance on inpatient care where clinically appropriate. • Expansion of community step-down provision and strengthened discharge arrangements to support timely movement through inpatient pathways. • 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.