NHS
Greater Manchester

Agenda

Greater Manchester Strategic Commissioning Committee (Public)

Date: 1 July 2026

Time: 14:00pm to 16:00pm

Venue: MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:00	5 mins	Welcome, Introductions and Apologies received – Attendance Matrix & Terms of Reference on a Page	Verbal Paper	Information	Dame Sue Bailey *Chair*
2.			Declarations of Interest	Paper	Noting	
3.			Minutes, matters arising and actions from previous meeting held on 3 June 2026	Paper	Approval	
Strategic Updates						
4.	14:05	10 mins	Financial Scheme of Delegation Approval & Reporting Key Financial Decisions Over £5M	Paper	Information	Kathy Roe, *Chief Finance Officer*
5.	 14:15 14:30 14:45 15:05	60 mins	Chief Officers Update Reports: • Chief Clinical Officer Report • Chief Commissioning Officer Report • Chief Reform and Improvement Officer Report • Chief Strategy, People and Partnerships Report	Paper	Discussion	Claire Lake, *Deputy Chief Medical Officer /* Katherine Sheerin, *Chief Commissioning Officer /* Nicola Hepburn, *Acting Chief Reform and Improvement Officer /* Charlotte Bailey, *Chief Strategy, People and Partnerships Officer – Population Health / Place*
6.	15:15	15 mins	Performance Report	Paper	Information	Nicola Hepburn, *Acting Chief Reform and Improvement Officer*

7.	15:30	20 mins	GM Public Health Network Transformation - Quarterly Update	Paper	Information	Charlotte Bailey, *Chief Strategy, People and Partnerships Officer – Population Health / Place*
For Information						
	15:50	10 mins	Any other business Board Paper Escalations Meeting Reflections	Verbal	Discussion	All
Date and time of next meeting: **Wednesday 5 August 2026, 14:00pm – 16:00pm** **MS Teams**						

Strategic Commissioning Committee Attendance Matrix from April 2026

Key:

Present

Apologies

No Explanation

Attendee as per ToR

Member as per ToR

Not a member

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

Terms of Reference on a page

Greater Manchester

Purpose

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

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

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

Key duties

Strategic Commissioning

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

Other key duties:

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

Other duties

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

Membership

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

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

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

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

NHS
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Minutes

Greater Manchester Strategic Commissioning Committee

Date: 3 June 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Rachel Egan (RE) – Non-Executive Director Prof. Manisha Kumar (MK) – Chief Clinical Officer Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Kathy Roe (KR) - Chief Finance Officer Leigh Vallance (LV) – VCSE Partner Member Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer Sam Evans (SE) - Corporate Director of Finance – Commissioning & Financial Assurance Warren Heppolette (WH) - Prevention Demonstrator Director, GMCA (item 7) Claire Lake (CL) - Deputy Chief Medical Officer (item 8) Faye Vaughan (FV) – Governance Advisor (Minutes)	

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** SB welcomed everyone to the meeting, introductions were made, and the above apologies were noted.	
2.	**Declarations of Interest** SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	
3.	**Minutes from the previous meeting held on Wednesday 6 May 2026** The minutes were accepted as a true record of the previous meeting held on 6 May 2026.	

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4.	**Risk Report** The report provided an update to the committee on the final position of the Board Assurance Framework (BAF) risks for the areas of responsibility for the committee, as well as an update on Corporate Risks. NH outlined the current status of the BAF risks for 2025-26 and provided an update on the corporate risks relevant to the committee, noting that two areas (**SR1** and **SR10**) exceeded year-end targets, with NHS reform risks remaining outside the agreed risk appetite. The committee requested assurance on the delivery of the new risk reporting approach. It was confirmed that the committee would see the revised report after Board approval in July 2026, emphasising the commitment to a live, action-oriented risk management process. The need for a consolidated view of workforce and clinical risks across all Chief Officer reports was highlighted. A suggestion was raised for a stocktake to take place to ensure risks were appropriately assigned under the new operating model. **ACTION:** Conduct a stocktake to clarify which workforce risks remain ICB accountabilities post-reform and update the risk register accordingly before the July 2026 Board meeting. A request for Chief Officers to take an overarching view on how risks were put together in Chief Officer reports to ensure alignment was raised. **The Committee:** • **Reflected on the final position of the strategic (BAF) risks for 2025/26.** • **Considered the Corporate Risks relevant to this committee.**	**NH**
5.	**Chief Officers Update Reports:** <u>Chief Reform and Improvement Officer Report:</u> The report highlighted the key areas of assurance and oversight from the Reform & Improvement portfolio. There were no alerts in the report. NH informed the committee that they were changing provider oversight arrangements at present. It was explained that there would be a transition from monthly Provider Oversight meetings to a risk-based approach, with meeting frequency determined by NOF ratings. The need for collaboration with regional partners and providers to ensure effective oversight and assurance was emphasised. NH reported that the digital strategy was being refreshed to align with the new 10-year plan, addressing digital exclusion and ensuring sustainability in technology investments. The committee were made aware of the revised EPRR on-call model that was now live and would be reviewed in future. NH informed the committee that NHS England now required all organisations to	

	have fully developed cost improvement plans. It was explained that failure to comply to this would impact the deficit support funding. The committee were assured that plans were being developed across the organisation. The committee acknowledged and thanked the teams involved in the GM Care Record Programme that were awarded the HSJ Digital Team of the year award. A discussion took place regarding the potential funding implications of digital transformation, particularly for reaching digitally excluded populations. A suggestion was raised for it be addressed jointly by the People and Resources Committee and Strategic Commissioning Committee. **ACTION:** Plan a discussion in the next private meeting to address digital inclusion challenges, funding implications and how to reach populations not digitally literate, involving the People and Resources Committee. **The Committee:** • **Noted the report.** Chief Strategy, People and Partnerships Report: The paper informed the committee of the key priorities, risks and mitigations relating to Live Well, Population Health Transformation, Place Partnerships development and Neighbourhood health plans. There were no alerts in the report. Key updates shared to the committee: • CB reported that the outcomes framework, partnership agreement, funding model and staffing model for place partnerships had completed their development sprint and were being circulated for local sign-off, with employment arrangements for place teams being finalised. • The committee were made aware of the national visit from Dr Claire Fuller – National Medical Director that would take place during the engagement phase on Neighbourhood Health. • CB informed the committee of the development of Health Hubs responding to the national asks around potential national tasks to support. • National Lottery Community Bid: It was confirmed that 10 GM had been awarded which would enable the VCFSE sector to grow Live Well spaces and boost everyday support across every neighbourhood. LV raised concerns around the funding cuts to the voluntary sector and the gap between strategic ambition and practical delivery, emphasising the need for effective engagement and stabilisation of the sector. KR acknowledged the funding challenges and stressed the importance of moving from planning to delivery. CB explained that each locality had a draft neighbourhood plan, with local boards and partners responsible for translating strategy into action and committed to sharing the plans and engaging further with the voluntary sector which could be shared. LV highlighted issues with contract managers understanding of system working and the need for upskilling to ensure that strategic intentions would be realised at the operational level.	

	The Committee: • **Noted the report.** <u>Chief Clinical Officer Report:</u> The report provided an update on key clinical governance, quality, medicines optimisation and service improvement matters across Greater Manchester. It highlighted current issues requiring attention through the Alert, Advise and Assure framework, including GP collective action linked to data sharing, work to improve the primary and secondary care interface, progress on resident doctor rotation planning, ongoing paediatric audiology risk and the proposed CNST Year 8 assurance approach. The report also summarised items considered by the Clinical Effectiveness and Governance Committee and identified those requiring committee approval. MK reported on GP Collective Action questioning data sharing agreements. It was confirmed that Greater Manchesters processes were robust. The ongoing risks related to national policy changes were noted. The committee were made aware that paediatric audiology remained a system and regional risk as re-call clinics for children continued. The committee were informed of the plans for further walkarounds to take place at the end of the summer. MK described efforts to refresh the approach to the primary-secondary care interface, focusing on integrated care around people rather than organisational boundaries, with ongoing assurance processes and place-based solutions. The committee approved and supported the recommendations from the Clinical Effectiveness and Governance (CEG) report. **ACTION:** SE to work with MKs team to provide financial values for new drugs to be included in future reports. The committee were made aware of the NHS Excellence Awards 2026, securing multiple regional champion awards across the Northwest. The committee were also informed of the Medicines Operations projects that had been shortlisted for HSJ award. **The Committee:** • **Noted the contents of the report.** • **Approved the items within the report that require Strategic Commissioning Committee approval.** • **Noted / endorsed the remaining items that have progressed through established governance routes and do not require further Committee decision.** <u>Chief Commissioning Officer Report:</u> The paper sets out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. KS highlighted progress on cardiac and vascular service changes, gynaecology, ENT community service models, retinopathy of prematurity screening and community dermatology procurement as well as strong performance in continuing healthcare assessments.	**SE**

	KS informed the committee that 1,154 appointments had been completed for paediatric audiology with them on track to see all patients within the year. The committee were also informed on the Neurorehabilitation Transformation and the successful transfer of Stockport NHS Foundation Trusts Devonshire Centre to the Northern Care Alliance NHS Foundation Trust (NCA). Assurance was provided to the committee that 89% referrals had been completed within 28 days for All Age Continuing Healthcare. The committee discussed the estates constraints in Oldham that were causing challenges and whether there were any other areas that may cause issues in the future. It was agreed that having the estate would be fundamental to what could be achieved over the next five years. A suggestion was raised to complete a piece of work on this area in future. **The Committee:** • **Noted the report.**	
6.	**Performance Report** The report provided an update on Greater Manchesters progress in achieving NHS operational planning goals, outlining significant risks faced by providers along with key improvement actions. NH informed the committee of a new performance report format to be introduced the following month, with a focus on Urgent and Emergency care access targets, Elective Reform, Diagnostics and Mental Health. Key updated from the report: • 12-hour waits: The committee were made aware of the significant amount of work with providers that had taken place around 12-hour waits. • RTT: Continued improvement was taking place. • Elective Reform: A focused piece of work would be taking place on this area. • Diagnostics: The committee were also made aware of the work taking place around improving diagnostics. **ACTION:** Prepare a joint deep dive report on corridor care, including breakdowns for mental health waits, elder waits and complex long-term conditions for committee review. **The Committee:** • **Agreed the recommended status of partial assurance and the levels of assurance and delivery risks.**	**NH / MK**
7.	**GM Prevention Demonstrator Quarterly Update** The paper introduced the National Prevention Demonstrator agreed between Greater Manchester and UK Government last year. WH explained that Greater Manchesters designation as the UKs first national prevention demonstrator was based on its track record in public service reform, data capability and integrated care, with the demonstrator serving as both a blueprint and a proof-of-concept for integrated, place-based models.	

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	It was explained that the demonstrator aimed to define the conditions for successful integrated care, develop financial frameworks for prevention investment and establish robust evaluation metrics, including resident and practitioner testimony and value-for-money assessments. The committee agreed that the prevention agenda would need to be system-wide, not limited to specific cohorts or pilots and should be communicated in language that resonates with residents and frontline staff, focusing on practical benefits and lived experience. CB raised the need to influence workforce transformation and balance of pay in the VCSFE sector through Prevention Demonstrator. **ACTION:** CB & WH to collaborate further on how to influence the workforce role and balance of pay in VCSFE sector. JN asked about prioritisation and psychological safety for innovation. WH explained that tactical choices would be needed to address system pressures and that the demonstrator would support a test-learn-grow approach, leveraging the applied research collaborative. **The Committee:** • **Supported the processes set out in this paper to mobilise delivery across the Prevention Demonstrator; and** • **Noted the intent to take a formal paper to the GMCA and NHS GM in June/July to secure full system sign up and commitment to directly feed into resource planning and budget setting for 2027/28.**	 **CB / WH**
8.	**AMR** This paper provided a Quarter 1 assurance update for the GM Antimicrobial Resistance (AMR), Antimicrobial Stewardship (AMS) and Infection Prevention & Control (IPC) programme. As part of the national *Act Now: Protect Our Present, Secure Our Future* directive, NHS GM was required in Q1 2026 to benchmark performance against national AMR targets using the latest English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) and Model Health System data, complete both the IPC Board Assurance Framework and the ICB AMS Self-Assessment Toolkit and identify three system-wide AMR improvement priorities with executive accountability. CL explained the structure of the AMR programme, including stewardship, infection prevention, sepsis and outlined priorities for reducing antibiotic exposure in children, healthcare-associated infections and IV/broad-spectrum antibiotic use. The report showed improvements in E. coli and C. diff rates, with ongoing challenges in MRSA and emerging infections like Klebsiella and Pseudomonas, supported by targeted improvement plans with acute providers. A robust system was in place for moving between quality assurance and improvement, with surveillance, rapid quality reviews and escalation processes, exemplified by the reduction in C. diff cases. The committee were made aware of the achievements such as the near-target antimicrobial prescribing in primary care, the launch of the IPAP UTI research trial and the successful health protection events led by locality IPC nurses.	

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	A request for more detailed data on sepsis outcomes and staff training was raised. It was confirmed that it would be provided in future reports. **The Committee:** • **Received and discussed the Quarter 1 AMR/IPC assurance assessment.** • **Endorsed the proposed next steps for Quarter 2, including data improvement work and refinement of assurance processes.**	
9.	**Any other business** The committee acknowledged the progress that had been made and shared their appreciation of the work that had taken place for the committee.	

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Actions Log: Strategic Commissioning Committee

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Completion Date	Status	Further Detail
Completed at Previous Meeting (Audit Trail)								
SCC-04	03/06/2026	6. Performance Report	Suggestion for a joint deep dive on corridor care, including breakdowns by patient group.	Prepare a joint deep dive report on corridor care, including breakdowns for mental health waits, elder waits and complex long-term conditions for committee review.	Nicola Hepburn / Manisha Kumar	01/07/2026	Closed	05/06: 12hr deepdive to be part of the new performance report.
SCC-03	03/06/2026	5. Chief Officer Updates - Chief Clinical Officer Report	Offer provided from SE to include financial values for new drugs in future reports.	SE to work with MKs team to provide financial values for new drugs to be included in future reports.	Sam Evans	19/06/2026	Closed	08/06: Finance team have been updated to work with Kenny and Nigel in meds op to include potential financial impacts on future reports but recognise these will be based upon assumptions of timing and uptake. Updates to be provided from July / August reports.
SCC-05	03/06/2026	7. GM Prevention Demonstrator Quality Update	The need to influence workforce transformation and pay structures at national level was raised.	CB & WH to collaborate further on how to influence the workforce role and balance of pay in VCSFE sector.	Charlotte Bailey / Warren Heppolette	08/07/2026	Closed	Meeting organised to take place 8th July to begin discussions.
SCC-02	03/06/2026	5. Chief Officer Updates - Chief Reform and Improvement Officer Report	Discussion around the potential funding implications of digital transformation, particularly for reaching digitally excluded populations.	Plan a discussion in the next private meeting to address digital inclusion challenges, funding implications and how to reach populations not digitally literate, involving the People and Resources Committee.	All	05/08/2026	Closed	On agenda for private meeting in August.
SCC-01	03/06/2026	4. Risk Report	Need for a consolidated view of workforce and clinical risks across all Chief Officer Reports.	Conduct a stocktake to clarify which workforce risks remain ICB accountabilities post-reform and update the risk register accordingly before the July 2026 Board meeting.	Nicola Hepburn	08/07/2026	Closed	

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Strategic Commissioning Committee - Financial Scheme of Delegation Approval & Reporting Key Financial Decisions Over £5M

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Strategic Commissioning Committee

1 July 2026

Required information.	Details.
Title of report.	Strategic Commissioning Committee - Financial Scheme of Delegation Approval & Reporting Key Financial Decisions Above £5m.
Author.	Izhar Chaudhary & Sam Evans
Presented by.	Sam Evans
Contact for further information.	Izhar Chaudhary
Executive summary.	This paper outlines the FSD to be assigned to the Strategic Commissioning Committee and the process of reporting key financial decisions above £5m.
The benefits that the population of Greater Manchester will experience.	Ensures expenditure is approved and reported in line with governance processes, reduces financial risk and improves transparency.
How health inequalities will be reduced in Greater Manchester's communities.	N/A

The decision to be made and/or input sought.	**Strategic Commissioning Committee are requested to:** 1. Endorse the proposed financial delegation to the SCC, enabling approval of healthcare-related expenditure up to £15m, subject to the conditions and caveats outlined in this paper; and 2. Endorse the proposed framework for reporting financial decisions above £5m, ensuring a consistent, transparent, and proportionate approach across all decision-making forums.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensures financial sustainability.
Key milestones.	N/A
Leadership and governance arrangements.	To be discussed and approved at: Chief Officers (27/5/26) P&R Committee (24/6/26) Strategic Commissioning Committee (1/76/26)
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Senior Finance Team (21/5/26)
Financial or Legal Implications	N/A

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

Introduction

Following the NHS Greater Manchester Board meeting held on 20 May 2026, at which the amended Financial Scheme of Delegation (FSD) was discussed and approved, the Board requested:

1. The establishment of an appropriate financial delegation threshold for the Strategic Commissioning Committee (SCC), noting that no explicit financial limit is currently defined; and
2. The implementation of a clear and consistent process for reporting key financial decisions.

This paper addresses both requirements and sets out recommendations for consideration and approval by Chief Officers.

Strategic Commissioning Committee (SCC)

It is proposed that the SCC be granted a defined financial delegation, subject to the following parameters:

- The SCC will hold delegated authority solely for healthcare-related expenditure, aligned to Table 6 of the FSD.
- This delegation will apply only where:
  - There is a continuation of an existing commissioned service with established funding; or
  - The investment has been previously identified and approved as part of the annual planning process.
- The proposed financial delegation threshold is £15m over the lifetime of the contract.

Exceptions and Escalation

- Where a proposal relates to a new service without an existing approved budget, thereby creating a financial pressure, in line with the approved FSD:
  - Proposals below £15m will require approval by three Chief Officers as per the FSD, which will take place at the Chief Officers meeting.
  - Proposals above £15m will require approval by the People and Resources Committee (PRC).
  - If significant financial pressures emerge in year, the financial approval threshold for SCC may need to be reviewed.

Governance Assurance

All proposals and business cases presented to SCC or PRC will have:

- Progressed through established internal governance processes first.
- Been scrutinised by both the Operational Leadership Group (OLG) and Chief Officers.

The governance route should be clearly stated on the front cover of all papers to evidence appropriate review and assurance.

Reporting of Key Financial Decisions Above £5m

To ensure transparency and consistency, it is proposed that all financial decisions exceeding £5m will be formally reported through the following routes:

- Decision required by three Chief Officers' (Approval threshold, £500k - £15m) → Reported to PRC monthly via the Chief Finance Officer update.
- SCC decisions (Approval threshold, £500k - £15m) → Reported via the SCC Chair's monthly update to the Board and to PRC.
- PRC decisions (Approval threshold, £15m - £100m) → Reported via the PRC Chair's monthly update to the Board.
- Board decisions (Approval threshold, Greater than £100m) (Private session) → Reported, where appropriate, within the Board's Public session via the Chair and/or Chief Executive update.

Confidentiality Considerations

- All decisions of a commercially sensitive or confidential nature will first be discussed and agreed in private session.
- Subsequent public reporting will be appropriately summarised to balance transparency with the need to protect commercial and contractual sensitivities.

Recommendations

Strategic Commissioning Committee are requested to:

1. Endorse the proposed financial delegation to the SCC, enabling approval of healthcare-related expenditure up to £15m, subject to the conditions and caveats outlined in this paper; and
2. Endorse the proposed framework for reporting financial decisions above £5m, ensuring a consistent, transparent, and proportionate approach across all decision-making forums.

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Chief Clinical Officer Report

July 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

July 2026

Required information	Details
Title of report	Chief Clinical Officer Report
Author	Claire Lake, Deputy Chief Medical Officer Jim Ritchie, Deputy Chief Medical Officer Kenny Li, Chief Pharmacist Anita Rolfe, Deputy Chief Nursing Officer Mel Maguinness, Director of Integrated Clinical Strategy and Transformation Sandeep Ranote, Clinical Director Mental Health Laura French, Public Health Consultant Claire Smith, Associate Director Nursing and Quality Assurance Kate Provan, Associate Director of Clinical Governance, and Improvement Claire Foster, Deputy Chief Pharmacist Gary Flanagan, Assistant Director – Mental Health Strategic Commissioning Heather Myers, Head of Clinical Effectiveness and Governance Boby Raja, Adult Community Mental Health Transformation Programme Manager Anthony Carter, Senior Pharmacist Professional Lead - Medicines Safety, Stewardship and Governance
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive summary	This July 2026 Chief Clinical Officer Report provides an update on key clinical governance, quality, patient safety, safeguarding, medicines optimisation and service improvement matters across Greater Manchester. It sets out issues requiring attention through the Alert, Advise and Assure framework, including GP collective action linked to data sharing, provider quality and oversight matters, safeguarding developments arising from new statutory requirements, mental health and maternity updates, health protection and outbreak management, and resident doctor industrial action. The report also summarises items considered by the Clinical Effectiveness and Governance Committee, highlighting those requiring Strategic Commissioning Committee approval and those presented for assurance or noting.
The benefits that the population of Greater Manchester will experience.	NHS GM's statutory quality and clinical governance functions support people across Greater Manchester to experience safe, effective and continuously improving services. Through targeted quality improvement, strengthened oversight and refreshed governance pathways, the system is better able to identify risks earlier, intervene more consistently and reduce unwarranted variation. This directly supports improved experience and outcomes for patients and communities.

How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy, including early identification of inequality-related risks in urgent care, mental health, medicines optimisation and system improvement programmes. It supports more consistent governance and escalation, helping to reduce unwarranted variation and strengthen equitable access and outcomes across Greater Manchester.
The decision to be made and/or input sought	The Committee is asked to note the contents of the July 2026 Chief Clinical Officer Report, approve the items identified in the report that require Strategic Commissioning Committee approval, and note or endorse the remaining items progressed through established governance routes.
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and the progress made to improve them relate to Board Assurance Framework risk SR5.
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is presented to Strategic Commissioning Committee and draws together intelligence, assurance updates and recommendations from NHS GM Clinical Effectiveness and Governance groups and related subgroups, the Greater Manchester Medicines Management Group, NHS GM Clinical Policy Audit and Standards Group, the Mental Health Partnership Group, and other established quality and clinical governance routes.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no separate formal engagement specifically on this cover report, as it brings together assurance, oversight and decision items already developed through established NHS GM governance routes. Clinical engagement has taken place through the relevant committees, subgroups and provider oversight arrangements referenced within the paper. Equality, financial, legal and sustainability considerations are reflected within the underlying work and approvals described in the report where relevant.

Financial or Legal Implications;	This report brings together assurance updates, governance matters and clinical policy or formulary decisions. Most items do not create material new financial commitments for NHS GM and are being progressed through established governance routes. Some medicines and service specification decisions may have local financial implications, including prescribing costs, cost avoidance, implementation requirements or future service impacts, which are managed through the relevant approval processes. Legal and regulatory considerations are reflected through NHS GM's statutory duties, NICE technology appraisal requirements, commissioning responsibilities, medicines governance processes, data sharing obligations and established quality oversight arrangements. No additional legal implications requiring separate Committee action have been identified beyond the approvals sought within the report.

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

Alert

General Practice (GP) Collective Action

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

The first phase of this action relates to data sharing with a template letter provided by the BMA to practices requesting the ICB to confirm:

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

The letter also reiterates concerns regarding the role of Palantir (the organisation that leads the delivery of the Federated Data Platform-FDP).

As of the 8th of June 2026, 54 letters from GM Practices have been received. In line with the requests made, a detailed response has been provided setting out a full record of processing activities; the impact of practices withdrawing from data sharing and a reiteration of NHS GM's position regarding the FDP. The full response is provided in Appendix 1. This letter was sent to practices on the 9th of June.

The letters received note that, pending the above response, the practice intends to stop sharing data under any DSA where:

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

At present no DSA have been withdrawn and the position here is being actively monitored. Engagement with LMC and GP Data Controller representatives continues to maintain an open dialogue. Health Innovation Manchester are also engaged as a key system partner to manage any potential risk to the delivery of the GM SDE programme.

Should a significant proportion of practices withdraw from data sharing this will impact the ability of our Data Insight and Intelligence (DII) team to provide comprehensive data and analytics in support of service planning, activity tracking and commissioning. In addition, our ability to track and manage local incentive schemes such as Beyond Core Contract Reviews (BeCCoR) which is a Greater Manchester system-wide primary care programme and GP incentive scheme, would be impacted. To help mitigate this risk, a detailed review of the legal and policy basis has been undertaken confirming that the use of data for case finding constitutes direct care.

As of the 1st of June, a second phase of action has been recommended by the BMA advising practices to remove or ignore any non-contractual medicines optimisation software for new prescriptions. No action has yet been taken, and this is being actively monitored by the Chief Pharmacist Network.

Supreme Court Judgement - Deprivation of Liberty
On 2 June 2026, the Supreme Court published a judgment changing the definition of Deprivation of Liberty (DoL), removing the long-standing "acid test" for identifying DoL. The previous test ("continuous supervision and not free to leave") is no longer determinative. These changes apply with immediate effect and extend across the UK. The Department of Health and Social Care (DHSC) published guidance on the 15th June 2026 to inform, support and stabilise the system: https://www.gov.uk/government/publications/changes-to-the-definition-of-deprivation-of-liberty/uk-supreme-court-2026-judgment-on-what-constitutes-a-deprivation-of-liberty The Mental Capacity Act 2005 (MCA 2005), which applies in England and Wales, defines deprivation of liberty by reference to its meaning in article 5(1) of the European Convention on Human Rights (ECHR). The Supreme Court, in P v Cheshire West and Chester Council [2014] United Kingdom Supreme Court (UKSC) 19, known as Cheshire West 2014, set out an 'acid test' to determine if someone is confined and therefore deprived of their liberty. The Cheshire West 2014 judgment concluded that someone is confined if they are under continuous supervision and control and are not free to leave. If someone lacks mental capacity to consent to their care and living arrangements under MCA 2005, they cannot give valid consent to their confinement. The Cheshire West framework underpinned: DoLS and Court of Protection (CoP) authorisations, Safeguarding application thresholds and Continuing Healthcare (CHC) oversight of restrictive care. The new ruling has replaced the 'acid test' with a multifactorial assessment of deprivation of liberty. Decisions must now consider the individual's specific circumstances, including the type, duration and impact of restrictions—no single factor is determinative. Individuals who lack capacity may still provide valid consent where they can understand and express acceptance of their situation; however, where there is doubt, consent cannot be relied upon. Greater weight must now be given to the person's wishes, feelings and level of objection, meaning that a lack of objection can be legally relevant to whether deprivation of liberty is occurring. The new definition applies to: • DoL in hospitals and care homes for people aged 18 and over where the Deprivation of Liberty Safeguards process applies (as per the DoLS code of practice) • DoL in the community for people aged 18 and over, and for children where it is authorised through the Court of Protection or the High Court's inherent jurisdiction In the long term, these changes are likely to reduce significantly the number of deprivations of liberty authorisations. In the short term, borderline cases will be referred for review. It is likely that there will be many people currently subject to DoLS authorisations who no longer fall in scope and these cases should be reviewed as soon as is practicable. Organisations should continue to ensure they meet their duties and deliver safeguards under: the MCA 2005, the Care Act 2014, continuing healthcare and common law duties of care. Local Authorities as the supervisory body will support the system and providers on the implications of the judgment. Professional experience will support a proportionate and considered approach

until further government guidance is published.
NHS GM will be required to align our organisational practice with this new legal position. The main implications for will be focused around strategic commissioning & assurance of our providers, clinical practice, Continuing Healthcare and Court of Protection (fewer CHC-funded packages may now meet DoL threshold, potential reduction in CoP applications and increase in S21* challenges to existing DoLs). A review of current practice, policies and procedures to align with the judgement.

NHS England will be publishing an updated DoLS e-learning module by 30 July 2026.

*****Section 21 of the Mental Capacity Act 2005 relates to the Deprivation of Liberty Safeguards (DoLS), which are designed to protect individuals who may lack the capacity to consent to their care and treatment. This section provides a legal framework for individuals to challenge their deprivation of liberty, ensuring that their rights are upheld and that they are not unlawfully detained

Laureate House – Service Disruption and Patient Safety Impact

Laureate House (on the Wythenshawe Hospital site, part of Manchester University NHS Foundation Trust [MFT]) provides specialist inpatient mental health services, including female adult acute wards and Psychiatric Intensive Care Unit (PICU) beds for patients requiring high levels of therapeutic support, observation, and risk management.

There remains a significant issue relating to the closure of 56 inpatient mental health beds at the site. This has required patients to be repatriated to Greater Manchester Mental Health NHS Foundation Trust (GMMH) wards, reducing overall system capacity and placing sustained pressure on inpatient services and patient flow. This has also negatively impacted the financial position through a reduction in the Mental Health Investment Fund (MHIF).

Works required to enable the wards to safely reopen have not yet commenced by Sodexo (with whom MFT holds the contract) and are anticipated to take up to 29 weeks once underway. Capacity constraints are therefore expected to continue in the medium term.

In addition, there have been two serious incidents on Griffin Ward, which has been caring for repatriated female PICU patients. These incidents have resulted in the ward being closed.

This situation continues to represent a risk to patient safety, system resilience, and service delivery, and is being actively managed through system oversight and governance arrangements.

Advise

Consultant and Specialty and Associate Specialist (SAS) doctor industrial action ballot

The BMA have announced a statutory ballot of consultants and SAS doctors regarding a mandate for industrial action. This runs to 6th July 2026. Further updates will be provided dependent on the outcome of this.

Paediatric Audiology

All of the 5-year cohort reviews have been completed with re-call clinics underway currently and over June and July. Expected completion by September 2026. This area of delivery remains a risk for the ICB at present – particularly in relation to workforce capacity across ICB, Provider Trusts and Subject Matter Experts. This risk is articulated on the ICB risk register and a collective risk

across all 3 North West ICBs has been articulated by the Regional team.

Active mitigation and oversight continues to be delivered through national and regional oversight arrangements, including a detailed improvement programme, NHS GM Audiology Oversight Group, and targeted quality reviews, with regular monitoring of provider improvement plans and backlog recovery initiatives; this risk is recorded on the corporate risk register and is reviewed and updated frequently to ensure continued scrutiny and assurance. Currently the national programme is working through the details of an ongoing assurance programme which will become business as usual once all services are through recall stages.

Pennine Care NHS Foundation Trust (PCFT)

The committee should note that two seemingly contrasting positions are both correct and reflect different aspects of organisational performance.

Firstly, under the National Oversight Framework (NOF), PCFT is currently rated in segment 4 overall. While there has been some improvement in the effectiveness and experience domain (moving from segment 4 to 3), this has been offset by deterioration in both the patient safety and people and workforce domains, which have moved from segment 3 to 4. As a result, the Trust's overall segmentation has moved to 4.

Secondly, the Trust has been rated 'Good' for Well-Led by the Care Quality Commission (CQC) following its February 2026 inspection. This reflects demonstrable improvements in leadership, culture and strategic direction, including a strong emphasis on learning, collaboration, and engagement with patients, carers and staff.

Taken together, this presents a clear narrative:

- The CQC well-led rating provides assurance that the organisational leadership, culture and governance foundations are strong and improving.
- The NOF segmentation highlights that there remain operational and outcome challenges, particularly in patient safety and workforce, which are impacting overall performance.

In essence, the Trust has strong leadership and culture in place, but this has not yet fully translated into consistent improvements in performance across all domains.

The ICB will continue to maintain oversight through established contractual and quality review mechanisms, with a focus on:

- Gaining assurance on the Trust's improvement plans
- Monitoring delivery against patient safety and workforce actions
- Ensuring compliance and sustained improvement over time

Health Harmonie/Medinet

Following a number of quality concerns / challenges emerging from a variety of services (including Dermatology and Paediatric Audiology) provided by Health Harmonie / Medinet, it was agreed that a Quality Review Meeting would be convened to gain better oversight of the provider's organisational policy and processes with particular focus on Quality and Safety governance, patient safety processes and reporting mechanisms. Some overarching assurance was provided at the meeting however it was agreed that a further meeting would be arranged to discuss some specific areas in more detail including patient safety, safeguarding and reporting of cancer performance. The next meeting is expected to take place in late June / early July and outcomes will be shared at

the next provider contract meeting.

Maternity and Neonatal

Work at Laureate House, Perinatal Mental Health Mother and Baby Unit (Greater Manchester Mental Health) is continuing as planned with expected reopening of the building by the end of this year. This includes not only the mother and baby unit but also the 3 other wards housed within Laureate House. A temporary Mother 7 Baby Unit has been opened at Lowswater ward on the Prestwich site which provides up to 6 beds.

Stockport Foundation NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust continue on enhanced surveillance for Maternity Services. Monthly Maternity Oversight meetings with the Local Maternity and Neonatal System (LMNS) continue and exit criteria have been agreed and will be progressed once the action plan is complete.

Independent Community Mental Health Team (CMHT) Review

The Independent CMHT Review has experienced delays due to the need for further development and assurance; however, the report is now progressing through an agreed recovery and publication plan. Factual accuracy checking will be completed by 19 June, followed by Trust and ICB Executive sign-off in the week commencing 13 July. System Improvement Priorities are being co-designed alongside this process and will be finalised by 10 July. Following discussion at SCC and Chief Officers; the final report and associated improvement plan are scheduled to be presented in public at the ICB Board on 19 August, with papers published the preceding week. This revised timeline reflects a strengthened and collaborative approach, ensuring the final output is robust, aligned to existing transformation, and fit for purpose.

Children Wellbeing and Schools Act 2026 – changes to ICB statutory safeguarding requirements

The Children's Wellbeing and Schools Act 2026 became law 30th April 2026 and significantly strengthens expectations of ICBs as system leaders for safeguarding, with increased accountability for outcomes, multi-agency leadership and commissioning impact. The Act strengthens the legal framework for safeguarding, child protection and outcomes for vulnerable children. For ICBs, it raises expectations rather than creating an entirely new role. Health bodies are expected to act as equal system leaders, not just as supportive partners, in protecting children and improving wellbeing outcomes. The Act:

- Reinforces ICBs as equal statutory safeguarding partners
- Embeds health within multi agency child protection teams (MACPT) in Family First Reforms
- Strengthens statutory information sharing duties
- Elevates health's statutory role in corporate parenting
- Increases expectations of ICB board level accountability and leadership

ICB will need to ensure that there clear executive oversight of children's safeguarding, ensure that health services fully commissioned and embedded in multi-agency child protection arrangements with sufficient safeguarding, paediatric and mental health expertise and we can evidence improved outcomes for vulnerable children and care experienced young people

Assure

Greater Manchester Mental Health NHS Foundation Trust (GMMH)

The Contract Performance Notice (CPN) issued by the ICB to GMMH has been closed except for areas of improvement in relation to Manchester Community Mental Health Team

NHSE has confirmed that the remaining CPNs will be closed imminently.

Manchester University NHS Foundation Trust (MFT)

MFT were delighted to be moved into segment 1 of the National Oversight Framework in the latest publication of the segmentation data. This is a testament to the work undertaken by the Trust in all areas of delivery and is a great achievement.

Return to Constitutional Standards/Left Shift Mental Health and Learning Disabilities and Autism (MHLDA) Capital Investment

NHS GM ICB was given the opportunity to bid for funding to support transformation and additional capacity in primary, community and acute settings to support the return to elective constitutional standards and improve Urgent and Emergency Care (UEC) performance through delivering a shift from hospital to community. It is intended that this investment will benefit MH planning targets and UEC recovery. NHS GM was successful in bidding for £26m capital investment for the following areas set out in the national requirements for MHLDA by March 2029.

1. Roll out of 24/7 Neighbourhood MH Centres (NMHCs)
Provide open access, integrated mental health support (including overnight beds) for those who need it, and specifically, people living with severe mental illness. Each NMHC brings together the functions of existing community mental health and crisis services, and some specialist mental health teams, into a single offer. Working in equal partnership with colleagues from primary care, Voluntary Community, Faith and Social Enterprise (VCFSE), local authority, people and families, and with strong links to wider support such as housing and employment. NMHC's operate on a neighbourhood footprint (~30-50,000 people) enabling them to deliver care close to home, tailored to local people and communities.

2. 50% Coverage of Mental Health Emergency Departments (MHEDs, also known as Crisis Assessment Centres, CACs) for Type 1 EDs
Part of the urgent and emergency mental health pathway, designed specifically for individuals experiencing a mental health emergency, who are medically fit and do not require treatment in Accident and emergency. They are co-located with Type 1 EDs, ambulance, police or referral from ED triage and provide a comprehensive mental health assessment. They offer a calm, therapeutic setting and ensure timely onward connection into mental health inpatient admission or to the wider urgent and community mental health pathways (e.g. home treatment, crisis alternatives and NMHCs). Where affordable and a relevant gap in provision exists, new MHEDs should include a Heath Based Places of Safety to provide an appropriate and safe space for Mental Health Act assessments.

3. Reducing Reliance on IP Care for LDA Populations through Crisis accommodation
Short-term accommodation-based alternatives to hospital for children, young people and adults with a learning disability, and those who are autistic, who are in crisis and at risk of admission to mental health hospital or emergency department, designed and provided in a way which is responsive to local needs. These services help people to be supported in a place which meets their needs during a crisis, for a time-limited period, without requiring inappropriate hospital admission.

4. Digitised capacity management and Mental Health Act (MHA)
Digital systems, applications, and workflow configuration which support optimised management of demand/capacity, beds, and caseloads to support improved resource management and patient flow, or digitised operation of the Mental Health Act (MHA) to reduce administrative burden and

ensure legal compliance.

A workshop was held on 12th June with MH Trust finance and operational leads to plan the next steps, with an outline proposal to be taken through GM governance. There is an expectation of Memorandum of Understandings (MoUs) and business cases for the GM schemes and this will include associated revenue implications which will need to be factored in to MHLDA planning and commissioning (from 27/28).

The model of service delivery will be jointly developed across all areas with clinical input throughout as well as lived experience. The capital funding should form part of existing programmes of work where possible (e.g. Live Well/Neighbourhood MH) - this will all be set out in an outline plan for Mental Health Partnership Group initially.

Health Protection and Outbreak Management

Health protection, or the protection of the public from infectious and non-infectious hazards, involves multiple elements and functions. These functions are the statutory responsibility of several different organisations and therefore strong collaborative working is required for an effective health protection system. Many of these responsibilities lie with the UK Health Security Agency (UKHSA) or the local authority via public health teams or environmental health. However, the NHS/ICBs retain several vital functions including:

1. Vaccinations and immunisations
2. Screening
3. Responsibilities related to infection prevention and control, and antimicrobial resistance (AMR)
4. Planning and security of health services for management of infectious disease (e.g. tuberculosis-TB, secondary care infectious diseases-ID services)
5. Mobilising NHS resource in response to outbreaks and incidents, including antibiotic or antiviral prophylaxis, vaccination, isolation and treatment facilities
6. Role in emergency planning and preparedness, including the Local Resilience Partnerships.
7. Working closely with partners at UKHSA, provider trusts, and local authority Public Health partners to coordinate planning and response

Vaccinations and screening

With the new NHS structures, responsibility for commissioning of screening and immunisation programmes will be delegated from NHSE to ICBs, via the OPIC structures (office for pan-ICB commissioning). Work on the new structures and transition is now entering the final stages of completion. Meanwhile, the teams are working to ensure that preparations for the winter seasonal vaccinations are unaffected as are the regular vaccination schedules.

A one-off vaccination campaign for Meningitis B has just been announced for an age-based cohort between July and September. This will involve two doses for those born between 01/09/2007 and 31/08/2008 (i.e. current school year 13), and for those who turn 25 after 31/12/2026 but who are entering higher education settings for the first time. This does not represent a permanent change to the schedule at the moment but rather is a response to the recent Kent outbreak in which some unexpected features were noted leading to the unusual virulence of that particular strain.

The GM maternity immunisation service has been shortlisted for a national Health Service Journal award in the ‘Maternity, Midwifery and Neonatal Safety Initiative of The Year’ category. This service

is delivered within the antenatal service at all maternity trusts in GM and vaccinates pregnant women against flu, respiratory syncytial virus (RSV) and pertussis. Since its introduction, there has been considerable improvements in uptake.

Outbreak Planning and Response

The system currently holds a Pan-GM Outbreak plan, which has within it the legionella outbreak plan and the HCID (high-consequence infectious disease) plan. This outlines the broad protocols for the management of outbreaks of infectious disease within the system. It does not detail the fine detail on process or provider at a local level however due to local variation. This detail is contained within the Local Outbreak Management Plans (LOMPs) which are held by locality partnerships. Recent events including measles, Mpox and Hantavirus incidents have highlighted the need to update and review these plans. Many localities are therefore in the process of reviewing their plans. There exists considerable variation at present across the 10 localities in what arrangements are in place for mobilisation of NHS resource in response to outbreaks, particularly out of hours. In some localities these are subject to detailed protocol and planned/commissioned response and in others, the response is management on a case-by-case basis. Following the publication of new commissioning guidance on outbreak management and also the recent communicable disease outbreaks mentioned above, a review of arrangements is required. An options appraisal is being prepared on this.

A table-top simulation exercise is planned for later in the summer to test the system response to a Meningococcal B (men B) outbreak of a similar magnitude to the one recently seen in Kent. This will then be used to inform the outbreak management plan refresh and options appraisal.

Work is ongoing on ensuring well-functioning pathways exist for managing non-sexual contacts of Mpox cases (both adult and paediatric). This is being done in close partnership with secondary care ID specialists and UKHSA colleagues. Due to low case fatality rate and increasing clinician familiarity, clade 2 Mpox is now no longer classed as an HCID in the UK. However, clade 1 infections remain so, and the recent incidents of Hantavirus on a cruise ship, and the Ebola outbreak in the Democratic Republic of the Congo (DRC) have prompted a review of our local HCID protocols to ensure they are optimised.

Deputy Delegated Safeguarding Partners

NHS GM is required to have a Chief Executive Lead Safeguarding Partner (LSP) – Colin Scales and an Executive Safeguarding Lead Delegated Safeguarding Partner (DSP) – Manisha Kumar Chief Clinical Officer for safeguarding. The model requires clear accountability, robust communication, and consistent leadership across our localities via Deputy Delegated Safeguarding Partners (DDSP) as NHS GM is an equal and joint statutory partner for the GM Safeguarding Children's Partnerships along with the Local Authority and Greater Manchester Police (GMP). Our changed Deputy Delated Safeguarding Partner model as part of NHS reform will be enacted from 1st July. Senior Clinical Nursing leads will undertake the DDSP function. System partners have been formally informed via the GM Safeguarding Alliance and transition/handover are being enacted. The named locality DDSP will also be the lead NHS GM lead for adult safeguarding and attend the Adult Safeguarding Board. Further consideration is required with regards to the statutory Community Safety Partnership senior lead representation and Family First Partnership Boards as the responsibilities matrix and neighbourhood models progress.

Summary of items considered at CEG (June 2026)

The Clinical Effectiveness and Governance (CEG) Committee met in June 2026 and considered a wide range of statutory clinical governance and system improvement matters. The discussion reflected both substantive clinical decision-making and the evolving governance context associated with the ICB transition.

This table sets out, for each CEG item:

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

Full papers available on request

Ref	CEG paper/Item	Description	Instruction to SCC
Greater Manchester Medicines Management Group Summary of Decisions of Approval			
06-1	Targeted-release budesonide (medication for treating primary IgA nephropathy- a type of kidney disease)	A new NICE-approved treatment is available for a rare kidney condition. It helps slow worsening kidney damage when used alongside existing treatments, and the NHS must make it available to eligible patients.	SCC is asked to approve adding this treatment to the local formulary
06-2	Carbidopa / entacapone / levodopa (medication for Parkinson’s treatment)	Cheaper generic versions of an existing medicine are available and work in the same way. Using these could reduce costs without affecting care.	SCC is asked to approve adding these as preferred options
06-3	Methylphenidate (medication for narcolepsy)	This medicine can now be used for adults with narcolepsy under specialist supervision, supported by a shared care agreement between hospital and GP.	SCC is asked to approve adding this use to the formulary once the care pathway is finalised
06-4	Dupilumab (medication for treating severe sinus condition with nasal polyps)	A new NICE-approved option for people whose condition has not improved with surgery or steroids. This will be provided through specialist services.	SCC is asked to approve adding this treatment to the formulary
06-5	FreeStyle Libre 3 glucose sensor (medical device used by people with diabetes to check there blood sugar levels continuously)	This device has been discontinued and replaced with a newer version that works in a similar way.	SCC is asked to approve removing this product from the formulary
06-6	Palforzia (a medication to treat Peanut allergy)	The manufacturer is stopping production worldwide. Patients currently using it will need review and alternative plans. Please note that the available secondary care prescribing data indicates there is no prescribing of this agent by GM provider trusts.	SCC is asked to approve removing this treatment from the formulary
06-7	Obinutuzumab with mycophenolate (a medication for treating lupus kidney disease)	A new NICE-approved treatment option for adults with severe lupus affecting the kidneys.	SCC is asked to approve adding this treatment to the formulary

06-8	Direct Oral Anticoagulant (DOAC) switch patient leaflet (a type of medicine that thins the blood to help prevent harmful blood clots from forming.)	A patient information leaflet has been developed to explain why some patients are being switched to different anticoagulants.	SCC is asked to approve use of the leaflet
06-9	Lisdexamfetamine shared care guideline (Lisdexamfetamine is a medication for the treatment of Attention Deficit Hyperactivity Disorder ADHD)	An updated guideline has been produced to support safe use of this ADHD medication between specialists and GPs.	SCC is asked to approve publication of the updated guideline
06-10	Patient Group Directions (PGDs) from Pennine (musculoskeletal) MSK Partnership and British Pregnancy Advisory Service (BPAS).	A PGD is a written instruction that allows specified healthcare professionals to supply and/or administer a medicine to a defined group of patients, without an individual prescription. Pennine MSK Partnership a provider in Oldham locality has updated 6 PGDs, to support the delivery of a clinic for the management of pain, inflammation, or stiffness in rheumatological or orthopaedic conditions. British Pregnancy Advisory Service (BPAS) a provider in Manchester locality has updated 3 PGDs updated, to support the delivery of contraception services.	SCC is asked to approve the updated PGDs from Pennine MSK and BPAS for re-authorisation.
06-11	Levemir discontinuation (a long-acting insulin used to treat diabetes.)	Levemir® (insulin detemir) is being discontinued by December 2026, requiring NHS GM to identify and safely switch affected patients. While many can be managed in primary care, a proportion will require specialist review and current capacity may be insufficient. A time-limited, industry-funded support offer is available to provide additional clinic capacity, with treatment decisions remaining clinically independent and based on agreed guidance.	SCC is asked to approve, in principle, the use of this time-limited additional capacity to support Levemir switching in GM, subject to information governance approval, clear non-promotional safeguards, agreed clinical governance and final operational arrangements.
06-12	COVID-19 treatments update	One medicine (sotrovimab) has been withdrawn by the manufacturer and removed from guidance.	No decision needed. SCC is asked to note this update
06-13	Blood transfusion guideline	Updated guidance recommends wider use of a medicine (tranexamic acid) to reduce bleeding during surgery, which may reduce the need for blood transfusion	No decision needed. SCC is asked to note this update

Risk			
06-14	Risks CCPL09A – capacity, resilience and sustainability CCPL09B – assurance, govern ance and statutory compliance	Risks CCPL09A and CCPL09B have been revised to provide a clearer distinction between the sustainability of clinical leadership resource and the governance arrangements through which clinical advice and challenge are obtained, applied and evidenced.	No decision needed. SCC is asked to note this update
Care of babies, children and young people in Greater Manchester with palliative and end of life care needs relating to the Kentown single point of access (SPOA) and the use of Electronic Palliative Care Coordination System-EPaCCS for this cohort.			
06-15	Palliative and end of life care for babies, children and young people – Single Point of Access (Kentown model)	A new single point of access will be introduced across Greater Manchester so all referrals for children's palliative care go through one central system. This will make access simpler, ensure consistent decision-making, and improve coordination of care for families.	SCC is asked to approve the introduction of a single point of access for all community palliative care referrals
06-16	Palliative care data collection (Kentown model)	All services will collect the same standard data about children receiving palliative care to support evaluation of the service, improve care quality, and inform future funding decisions	SCC is asked to approve consistent data collection across all 10 Greater Manchester localities
06-17	EPaCCS for babies, children and young people	A digital system (EPaCCS) will be extended to children's services so healthcare professionals can share key information (such as care plans and family wishes) across organisations, helping ensure coordinated, safe and person-centred care—especially in emergencies.	SCC is asked to approve the rollout of EPaCCS for children and young people
06-18	Kentown community palliative care model	A new community-based model will expand specialist nursing and family support so all children across Greater Manchester can access consistent palliative care closer to home, reducing variation between areas.	SCC is asked to support the continued development and implementation of the Kentown care model
06-19	System-wide collaboration and implementation requirements	Successful implementation requires all organisations to work together, including agreeing data sharing arrangements and consistently using the new systems (SPOA and EPaCCS).	SCC is asked to endorse system-wide collaboration and support local delivery arrangements
NHS GM Clinical Policy Audit and Standards Group (CPAS) Recommendations			
06-20	Clinical Commissioning Statement (CCS) in relation to the Repair of split earlobes.	Restricts commissioning to fully split earlobes from acute, direct trauma only, excluding partial tears and cosmetic causes. Clarifies definitions and aligns delivery to urgent care pathways to reduce unwarranted variation. IFR route retained for justified exceptionality.	SCC is asked to approve CCS Repair of Split Earlobes
06-21	CCS in relation to Functional electrical stimulation (FES),	This relates to the addition of previously omitted wording on implantable devices to ensure the scope is accurate and aligned to the intended position. There is no change to clinical criteria, access, or activity, with	SCC is asked to approve the CCS Functional electrical stimulation (FES).

	(minor update)	CPAS confirming it does not alter the commissioning position.	
06-22	NHS GM Community Dermatology Service Specification (SS)	The specification was previously approved by CEG in May 2024. Amendments are targeted and proportionate, focused on strengthening governance, provider requirements and overall clarity rather than changing service intent. Refinements aim to improve assurance, consistency and executability across the system.	SCC is asked to approve the NHS GM Community Dermatology Service Specification.
06-23	NHS GM Ophthalmology CSS	The specification was originally approved by CEG in September 2025. Amendments are therefore refinements to maintain alignment with evolving guidance and strengthen clarity and assurance, rather than a full redesign of the service model.	NHS GM Ophthalmology SS

CEG provided collective clinical assurance across statutory clinical governance responsibilities and supported progression of all items through established governance routes. No issues were identified that required escalation outside existing arrangements, with recommendations progressing to the Strategic Commissioning Committee where formal approval is required.

Risk discussed and new risk identified

The principal risks discussed relate to the revised corporate risks CCPL09A and CCPL09B. These have been refreshed to provide a clearer distinction between, firstly, the capacity, resilience and sustainability of clinical leadership resource and, secondly, the assurance, governance and statutory compliance arrangements through which clinical advice, challenge and oversight are obtained and evidenced. The addition of safeguarding content further reinforces the relevance of CCPL09B, given the strengthening statutory expectations on NHS GM in relation to safeguarding leadership, multi-agency working, information sharing and board-level accountability.

No wholly new corporate risk was identified through this report; however, the paper highlights a number of live operational and system risks requiring ongoing monitoring through existing governance routes, including data sharing implications arising from GP collective action, paediatric audiology delivery, provider quality concerns, maternity oversight, outbreak preparedness, industrial action resilience, and the need to ensure timely organisational readiness for strengthened safeguarding duties under the Children’s Wellbeing and Schools Act 2026.

Learning for Sharing

Getting it Right First Time (GIRFT) System Review Chronic Pain

A GIRFT system review is a clinically led NHS improvement review that uses data and expert input to identify variation, share best practice and highlight opportunities to improve outcomes, consistency and value.

The GIRFT chronic pain system review meeting, held in June 2026, recognised Greater Manchester’s strong system leadership, collaborative approach and progress in medicines optimisation- specifically around the reduction in opioid prescribing. It also highlighted variation in access, inequalities in service use and outcomes, gaps in community provision, and inconsistency in digital, neurodiversity-informed and transition arrangements.

In summary, Greater Manchester has strong foundations, but delivery is not yet consistent at scale. The main issue is uneven access, with variable local provision, unclear referral pathways and notable gaps in central Manchester and community support. Prescribing is a relative strength, but

risks remain around variation, deprescribing capability, co-prescribing and emerging gabapentinoid use. The Children's and Young Persons Model is strong at tertiary level, but gaps remain in community provision, transition and equitable access.

We will pick up any improvements needed through the work underway on MSK as chronic pain aligns well with this work. We have shared the Clinical Strategy and Outcomes Framework with GIRFT to demonstrate the wider context and work already underway.

Work will continue through the GM Pain Collaborative to improve prescribing and safety in relation to chronic pain medications.

We are also looking forward to how we can best prepare for future GIRFT System reviews in a more robust way- and having better oversight of reviews that occur in our acute Trusts.

The Greater Manchester Pain Collaborative

The Greater Manchester Pain Collaborative continues to provide strong system leadership across primary care, secondary care, community pharmacy and specialist services. Since 2022, opioid prescribing has reduced by more than 4,000 patients, with a 30% reduction in high-dose prescribing. Current priorities include refreshing the GM Pain Management Hub, addressing gabapentinoid risk, improving access to non-pharmacological support and continuing data-led improvement.

This work has also received national recognition, with opioid stewardship activity shortlisted in two HSJ Patient Safety Awards 2026 categories. Together, these achievements reflect strong system-wide collaboration to improve opioid safety across pathways and primary care.

Achievements

Mental Health Collaboration Award – Healthcare Financial Management Association (HFMA) North West awards

Greater Manchester has been recognised through the HFMA North West annual conference awards, with the system receiving Highly Commended in the Collaboration Award category. This reflects the strength of partnership working across the system, including NHS Greater Manchester Integrated Care Board, Greater Manchester Mental Health NHS Foundation Trust and Pennine Care NHS Foundation Trust.

The award recognises the system-wide approach to tackling the complex challenge of high-cost out-of-area placements in adult mental health. Partners worked collaboratively to establish a Mental Health Integrated Fund, underpinned by joint accountability, aligned incentives and transparent governance arrangements.

This approach has delivered tangible benefits, including financial efficiencies, reinvestment in local and preventative services, and improved patient experience through supporting care closer to home. It has also strengthened trust and collaboration between organisations and demonstrated a model that is considered replicable across other systems.

National Prevention Accelerator – Cardiovascular Disease (CVD)

Greater Manchester (GM) has been selected as one of five national Prevention Accelerator sites for CVD, aligned to the Prevention Demonstrator programme. This recognises GM's whole-system, inequality-focused approach to prevention and the measurable impact achieved to date. Work is ongoing with the Department of Health and Social Care (DHSC) and NHS England (NHSE) to maximise the opportunities associated with this designation.

Early impact is evident across the system. Delivery has been targeted towards those with the greatest unmet need, with around 20% of the GM population expected to receive proactive, preventative care in 2026/27. This has supported earlier diagnosis and improved management of high blood pressure, cholesterol and diabetes, including 77% of people with diagnosed hypertension now treated to target.

This approach is contributing to tangible prevention, with an estimated 180 heart attacks and 200 strokes prevented in the last year alone. Population health outcomes are improving, with reductions in hospital admissions for heart attacks and strokes. At the same time, a more proactive, coordinated model of care is helping to streamline pathways, improve access and patient experience, and reduce avoidable non-elective admissions for people with CVD.

Frailty Pathways – National Recognition of Greater Manchester's System Approach

The recently published NHS England Best Practice Guide for Frailty Pathways highlights the importance of integrated, data-enabled and community-focused models of care, with Greater Manchester cited as a leading example of how system-wide collaboration and shared records can enable more coordinated, personalised care and improved outcomes. This national recognition is further reinforced locally through the GM Care Record programme, which has received the HSJ Digital Team of the Year award. Delivered through a strong partnership between NHS Greater Manchester, Health Innovation Manchester and system partners, the programme exemplifies GM's mature, collaborative approach to digital transformation, bringing together health and care information into a single shared record to support timely clinical decision-making, reduce duplication, and enable more joined-up, neighbourhood-based care for the population.

Maternity

Greater Manchester achieved compliance with 97.3% of the national deliverables of the Maternity and Neonatal 3-year Delivery Plan. The outstanding deliverables related to:

- Bespoke digital implementations (MFT - Personalised Care and Support Plan (PCSP) and Stockport NHS Foundation Trust - Maternity Early Warning Score (MEWS)).
- Full implementation of an Electronic Patient Record (EPR) systems.

All providers have committed to a full implementation and procurement of EPR systems to support

future compliance.

Quality Review Meetings – Positive news

Quality Review Meetings are now well established with the first round of meetings with NHS Trusts almost complete with the maturity of the Terms of Reference strengthening. At recent meetings with trusts, we were able to hear several examples of improvements which we thought would be helpful to share

- Bolton NHS Foundation Trust shared positive progress made against pressure ulcers, falls and maternity services and Health Care Acquired Infections which was demonstrated by Statistical Process Control charts
- Stockport NHS Foundation Trust shared positive progress on reducing pressure ulcers at the trust last year with a 33% reduction, with plans to do some further system work with Nourish care.

Recommendations:

The Committee is asked to:

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

Dear [Name/Practice],

Subject: Re: Data Sharing Agreements (DSAs)

We are writing in response to your submission of the British Medical Association's template letter request for information on data sharing.

NHS Greater Manchester recognises that this request forms part of the collective action being undertaken by GPs. We respect the right of practices to take collective action and understand that it is being driven principally by the dispute with NHS England regarding Advice and Guidance and safe working conditions. We want to be clear that we value the contribution of General Practice to our system and remain committed to maintaining constructive working relationships throughout this period.

We recognise the concerns raised about patient confidentiality, transparency of data flows, and the need to maintain public trust. We are clear that data sharing arrangements must be lawful, proportionate, and fully understood by GP partnerships and practices in their role as data controllers.

Greater Manchester's approach to data governance, grounded in transparency, strong assurance, and public confidence, has been widely recognised, including by the national Confidentiality Advisory Group and the Department of Health and Social Care.

As requested, we have undertaken a review of data sharing arrangements between GP Practices and the ICB. The attachment to this letter includes:

1. A list of all data flows from GP Practices into the ICB describing the purpose, lawful basis and if the flow is a contractual or statutory requirement.
2. Assurance that patient opt outs are respected
3. The ICB's position on the Federated Data Platform
4. A description of the key risks associated with stopping data flows

We recognise that practices will carefully consider the implications of withdrawing from any existing data sharing arrangements, including the potential impact on patient safety, safeguarding, service continuity, and contractual obligations. In doing so, practices should continue to apply **Caldicott Principle 7**: the duty to share information for individual care is as important as the duty to protect patient confidentiality.

Kind regards,

Jim Ritchie
Chief Clinical Information Officer
NHS Greater Manchester ICB

Malcolm Whitehouse
Deputy Senior Information Risk Owner
NHS Greater Manchester ICB

NHS
Greater Manchester

GP Collective Action - Data Sharing

NHS GM response

Part of Greater Manchester Integrated Care Partnership

Graham Hayler

Associate Director of Data and Analytics
Date: 1st June 2026

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NHS Greater Manchester

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1. Introduction

NHS
Greater Manchester

In response to the GP Collective Action on data sharing, NHS GM Integrated Care Board (ICB) has conducted a review of the data-sharing arrangements between GP Practices and the ICB.

As requested, we have completed a register of GP Practice personal data flows into the ICB, capturing the following for each:

- Purpose
- Lawful basis
- Existing Data Protection Impact Assessments and Data Sharing Agreements
- Whether the flows support a contractual or statutory obligation

We also explain:

- How we process patient opt outs
- The ICB’s position on the national Federated Data Platform
- How the openSAFELY platform differs to Greater Manchester's Analytics and Data Science Platform.

2. Personal data flows into the ICB

NHS Greater Manchester

Purpose	Recipients	Flow direction	Type of Data	Identifiable	Category of use	Processor	Legal Basis under GDPR	Common Law Duty of Confidentiality basis	DPIA Completed	Contract in place	Data Sharing Agreement completed	Contractual Requirement
Individual Funding Request	NHS GM	Bidirectional	Patient health & care information	Yes	Direct Care	NHS GM	Article 6(1)(e) Article 9 (2)(h)	Implied Consent	No – IG Team to complete	Not applicable	No	Yes
GM Care Record (data extraction with multiple uses) 1) Shared Care Record	Health and Care Professionals	Bidirectional	Patient health & care information	Yes	Direct Care	Graphnet	Article 6(1)(e) Article 9 (2)(h)	Implied Consent	Yes (across all uses)	ICB holds contract	Yes (Joint Controller Agreement)	No
2) Analytics and Data Science Platform - Direct Care (Currently restricted to BeCCor)	GP Practices	Bidirectional	Patient health & care information	Yes	Direct Care	NHS GM	Article 6(1)(e) Article 9 (2)(h)	Implied Consent				
3) Analytics and Data Science Platform - secondary use and research	NHS GM, Approved Researchers	One way	Patient health & care information	No	Secondary Use and Research	NHS GM	Article 6(1)(e) Article 9 (2)(h)	S251 CAG approval				

2. Personal data flows into the ICB (continued)

NHS Greater Manchester

Purpose	Recipients	Flow direction	Type of Data	Identifiable	Category of use	Processor	Legal Basis under GDPR	Common Law Duty of Confidentiality basis	DPIA Completed	Contract in place	Data Sharing Agreement completed	Contractual Requirement
Safeguarding	NHS GM Safeguarding	Bidirectional	Patient health & care information	Yes	Safeguarding	NHS GM	Article 6(1)(e) Article 9(2)(b)	Overriding Public Interest	Individual DPIAs exist but IG Team to complete overarching DPIA	Not applicable	No	Yes
GP Practice Support Data Quality Support	NHS GM Data Quality Team	Bidirectional	Patient health & care information	Yes	Care Related	NHS GM	Article 6(1)(e) Article 9 (2)(h)	Implied Consent	Yes - needs review	Not applicable	Confidentiality Agreement	No
Medicines Optimisation - Optimise RX	NHS GM Medicines Management Team	Bidirectional	Patient health & care information	Yes	Direct Care	NHS GM	Article 6(1)(e) Article 9 (2)(h)	Implied Consent	yes	ICB holds contract	Yes - between GP Practice and Supplier	No
Medicines Optimisation	NHS GM Medicines Optimisation Team	One way	Patient health & care information	Yes	Direct Care	NHS GM	Article 6(1)(e) Article 9(2)(b)	Implied Consent	Awaiting DPO approval	Not applicable	Data Processing Agreement needs sign off	No

2. Personal data flows into the ICB (continued)

NHS Greater Manchester

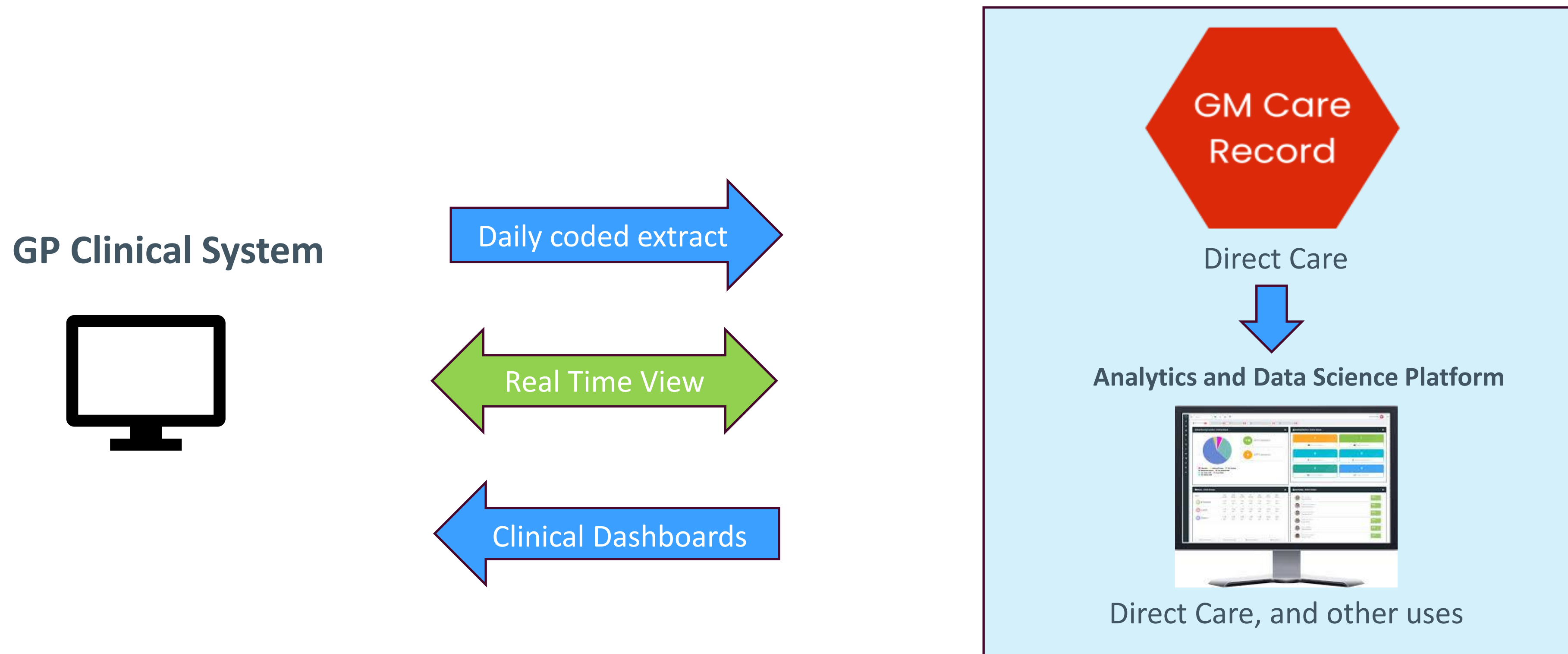
Purpose	Recipients	Flow direction	Type of Data	Identifiable	Category of use	Processor	Legal Basis under GDPR	Common Law Duty of Confidentiality basis	DPIA Completed	Contract in place	Data Sharing Agreement completed	Contractual Requirement
Additional Roles Reimbursement Scheme (ARRS)	NHS GM Primary Care	One way	Staff information	Yes	Finance	NHS GM	Article 6(1)(e) Article 9(2)(b)	Implied Consent	Yes	Not applicable	No	Yes
GP Data Quality Team - Data Extractions	NHS GM Data Quality Team	One way	Patient health & care information	No	Secondary Use	NHS GM	Article 6(1)(e) Article 9 (2)(h)	NA Anonymised Data	Yes - needs review	Not applicable	Confidentiality Agreement	No

3a. GM Care Record and Analytics and Data Science Platform Data Flows

NHS Greater Manchester

Patient identifiable data extraction from GP Practices into the GM Care Record and an onward flow into the ICBs Analytics and Data Science Platform.

The data extract into the GM Care Record supports direct care, whereas the onward flow into the Analytics and Data Science Platform supports direct care and other uses such as service planning and research.



3b. GM Care Record (GMCR) Data Extract

Greater Manchester

Purpose: Direct care

Patient opt outs: patients can opt out of having a shared care record by contacting their GP Practice.
The GP Practice can record the SNOMED code (**416409005** – Refused consent for upload to local shared electronic record). This will result in the patient's not having a shared care record.

Method of data sharing	GP data used	Other data used	Identifiable	Accessed by whom
GM Care Record – daily coded extract SNOMED coded data only, no free consultation text	Patient demographics Problems & Diagnoses Allergies & adverse reactions Medications Immunisations Observations Test results Long Term Conditions Patient Encounters	Hospital Community Health Social Care Mental Health Specialised Services Care Plans	Yes	GPs Community Pharmacy GP Out of Hours Hospital Trusts Community Health Mental Health Providers The Christie Hospices
GM Care Record – real time view A view of GP data using the GP Connect software – data is not stored within the GMCR.	Data accessible via GP Connect is predominantly coded data with limited free text contained within the encounters record from consultation notes	Same as above	Yes	Same as above

Sexual Health, fertility, termination of pregnancy data not included

3ci. Analytics and Data Science Platform (ADSP) Data Flow

Greater Manchester

Direct care use cases

Method of data sharing: daily extract - SNOMED coded data only, no consultation text
Patient opt outs: patients who have opted out of having a shared care record are excluded from direct care products developed within the ADSP.

Purpose	GP data used	Other data used	Identifiable	Accessed by whom
Beyond Core Contract Reviews (BeCCoR) – Direct care Dashboards	Patient demographics Problems & Diagnoses Allergies & adverse reactions Medications Observations Test results Long Term Conditions	Hospital Mental Health Specialised Services	Yes	GP Practices

3cii. Analytics and Data Science Platform (ADSP)

Greater Manchester

Current secondary use and research purposes – page 1

Method of data sharing: daily extract - SNOMED coded data only, no consultation text
Patient opt outs: patients who have registered a national data opt out or a type 1 opt with their GP Practice are excluded from all secondary use and research analysis.

Purpose	GP data used	Other data used	Identifiable	Accessed by whom
Beyond Core Contract Reviews (BeCCoR) – Monitoring Dashboards	Patient demographics Problems & Diagnoses Allergies & adverse reactions Medications Observations Test results Long Term Conditions	Hospital Mental Health Specialised Services	Aggregate anonymised	GP Practices NHS GM Primary Care Commissioners NHS GM Clinical Managers
Health Needs Assessment and Inequalities Analysis	Demographics LTC registers Protected Characteristics	Hospital Community Health Services Social Care Mental Health	Aggregate anonymised	NHS GM Strategic Planning Managers NHS GM Chief Officers Place Based Commissioners NHS GM Analysts
Population segmentation for financial forecasting and planning purposes	Patient demographics Problems & Diagnoses Allergies & adverse reactions Medications Observations Test results Long Term Conditions	Hospital Community Health Services Social Care Mental Health	Aggregate anonymised	NHS GM Strategic Planning Managers NHS GM Strategic Finance Managers NHS GM Chief Officers Place Based Commissioners NHS GM Analysts

3cii. Analytics and Data Science Platform (ADSP)

Greater Manchester

Current secondary use and research purposes – page 2

Method of data sharing: daily extract - SNOMED coded data only, no consultation text
Patient opt outs: patients who have registered a national data opt out or a type 1 opt with their GP Practice are excluded from all secondary use and research analysis.

Purpose	GP data used	Other data used	Identifiable	Accessed by whom
Screening and Immunisations planning and monitoring ***s251**	Demographics and protected characteristics Vaccination status	None	Aggregate anonymised	NHSE Screening and Imms Team Local Authority Public Health GP Practices NHS GM Analysts
Health Check planning and monitoring	Demographics Protected characteristics	None	Aggregate anonymised	Local Authority Public Health
Research projects approved by the Data Access Committee	Project specific requests which may require: Problems and diagnoses Allergies and adverse reactions Medications Immunisations Observations (e.g. BP, weight) Test results Long-term conditions Encounters (e.g. GP consultations)	Project specific requests which may require: Hospital Community Health Services Social Care Mental Health Ad hoc study datasets	Aggregate anonymised	Approved researchers

3d. GMCR & ADSP Joint Controller Agreement

Greater Manchester

A **Joint Controller Agreement** is a legally binding contract when two or more parties share decision-making responsibility for a data processing activity.

NHS GM has been working with the Primary Care Board’s GP Data Controller Group to refresh and strengthen the Joint Controller Agreement covering GP data flows into the GMCR and ADSP.

This group includes representatives from Local Medical Committees, GP federations, and locality GP boards. As part of this work, we have updated the indemnity and liability clause to provide greater protection for GP practices.

The refreshed agreement was due to be circulated to all practices for review and sign-off. However, due to the collective action, we have paused this and will discuss the appropriate next steps with the GP Data Controllers Group.

Please note the joint controller agreement will also be circulated to other GM Health and Care Providers who submit data into the GMCR e.g. hospitals and local authorities.

3e. GMCR – Implications of stopping the data flow

Greater Manchester

GMCR – shared care record
The shared care record is used by frontline health and care workers to provide care to patients across Greater Manchester. In March 2026, over 500K patient records were accessed by 29,610 health and care professionals. The cessation of the data flows into the GMCR would have an immediate impact on the quality of care provided to patients.

ADSP - Direct Care
NHS GM has developed several population health management tools that can be used by clinicians to identify patients with the greatest unmet need to support the delivery of the Beyond Core Contract Reviews (BeCCoR) scheme. The scheme cannot be delivered without GP data flowing into the ADSP.

ADSP - Health and Care commissioning
Data is used to support the planning and monitoring of health and care services. The analysis support needs assessment, health inequalities analysis, planning and monitoring of services such as screening and immunisations programmes, and health outcomes evaluation.

ADSP - Research
GP data has been used to support 20 research applications that benefit the Greater Manchester population. The details of these applications is published here https://healthinnovationmanchester.com/data-access-requests/

4. National Platforms

NHS
Greater Manchester

Federated Data Platform

We recognise that there are concerns about some national data initiatives, including the proposed Single Patient Record, the Federated Data Platform, and the UK Biobank data breach.

NHS Greater Manchester has taken a clear leadership position nationally on the use of health data by applying rigorous due diligence and placing public trust at the centre of decision-making. We are the only ICB in England not to have adopted the Palantir-operated Federated Data Platform, despite a national mandate, because of our commitment to these principles.

OpenSAFELY

OpenSAFELY is a national platform designed for secure, pseudonymised analysis of GP and national datasets at scale for research purposes. However, it has limitations, and it doesn't support ICBs with their statutory duty to create a longitudinal patient record that can be used for commissioning and population health management purposes.

For example, OpenSAFELY doesn't have access to the extensive range of local datasets held within the ADSP, and it can't be used to develop dashboards and tools that support GM work programmes such as the BeCCoR scheme.

The scope of the linked data held within the GM ADSP is much broader and covers local bespoke data.

5. Summary

NHS
Greater Manchester

The review **identified personal 10 data flows**:

- 5 direct care, 2 care related, 3 secondary use and research

Daily data flows into the GM Care Record (GMCR) and Analytics and Data Science Platform (ADSP):

- GMCR Record for direct care, ADSP for direct care, secondary use and research
- **Strong governance exists** – Data Access Committee, Data Protection Impact Assessment and a Joint Controller Agreement (JCA)
- The **Joint Controller Agreement has been strengthened to give greater protection to GPs** as Data Controllers
- **Patient opt out choices are respected**

GM has prioritised public trust and has **not adopted the Federated Data Platform**.

The data flows enable:

- **Direct care**: improved quality and safety of front-line care
- **Operational delivery:** successful delivery of BeCCoR and population health management tools
- **Commissioning**: stronger planning, health inequalities analysis and service monitoring
- **Research**: continuation of approved studies delivering population benefit

If you have any queries or want to cease data flows, please contact gmhscp.icpig@nhs.net

Glossary

Greater Manchester

Term	Definition
Analytics and Data Science Platform	A secure data and analytics environment containing linked health and care data to support direct care, planning, performance, and research
Anonymised data	Data where a patient cannot be identified
Aggregate data	Summary data that cannot identify an individual
Bidirectional data flow	Exchange of data between organisations
Common law duty of confidentiality	Legal obligation to keep patient information confidential unless there is a valid reason and lawful reason to share
Data Controller	Organisation that decides how and why data is used
Data Processor	Organisation that processes data on behalf of a controller
Data Protection Impact Assessment	Assessment used to identify and reduce risks when handling personal data
Data Sharing Agreement	Formal agreement setting out how data is shared between organisations
Direct Care	Activities where identifiable patient information is used to deliver, support, or improve an individual's care
GM Care Record	A shared care record giving front line health and care staff access to a patient information to provide patient care
Identifiable data	Data that can identify a patient
Joint Controller Agreement	Legal agreement where multiple organisations share responsibility for data processing
Personal data flow	Movement of identifiable information (e.g. patient data) between organisations or systems
Pseudonymised data	Data where identifying details are replaced with codes. Patients cannot be identified without the use of additional information.

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NHS Greater Manchester Strategic Commissioning Committee

Report from Chief Commissioning Officer

1 July 2026

NHS Greater Manchester

Report from:	**Katherine Sheerin, Chief Commissioning Officer**
Date of Meeting:	1st July 2026
Authors	Gill Baker, Director of Healthcare Commissioning Caroline Bradley, Associate Director of Primary Care Louise Sinnott Gill Gibson
Executive Summary	This paper sets out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate.

ALERT

Healthcare Commissioning

No alerts this month.

GM Specialised Commissioning Oversight Group

No alerts this month.

Children, Young People and Maternity

No alerts this month.

Primary Care Commissioning

Collective Action - The GPC is urging GP partnerships and practices across England to take part in collective action to stay safe and sustainable in response to the 2026/27 imposed GP contract.

The GPC will be announcing one new action per month and so far this has covered:

- May – Data sharing and reviewing the GP patient data they are expected to share outside the practice, with the wider NHS and other organisations.
- June – Medicines Optimisation and Prescribing – reviewing medicines optimisation that is utilised within the practice and removing software that is not mandated.

ICB colleagues are engaging with GM LMCs around these issues to provide clarity of arrangements and shared benefits of local data sharing arrangements and medicines optimisation software.

A weekly position statement, including risks and mitigations, is provided to NHS England North West Regional Team

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

ADVISE

Healthcare Commissioning

Community Dermatology Procurement – The NHS GM People and Resources Committee supported the recommendation to commence a new procurement for community dermatology services across Greater Manchester. The procurement timeline is being finalised, and the service specification is progressing through ICB governance. A representative task and finish group has been established with procurement expertise along with commissioning, finance and contracting to oversee the process.

The ICB has successfully mobilised a new interim community service in the Bury Locality following the Northern Care Alliance serving notice to the ICB. This ensures service continuity in Bury whilst the GM wide procurement takes place.

GM Specialised Commissioning Oversight Group

Cardiac and Vascular Surgery Service Changes

The Greater Manchester programme for specialised cardiac and arterial vascular surgery sets out a clinically led, system-wide case for change driven by rising demand, increasing patient complexity, workforce fragility, variation in current provision, and the need to meet national standards.

The pre-consultation business cases conclude that consolidating services provides the most clinically safe, resilient, and sustainable model: a single cardiac surgery centre at Wythenshawe and a single arterial vascular centre at Manchester Royal Infirmary, both supported by networked local care to maintain access. These proposals are informed by options appraisal, stakeholder engagement, and real-world service changes implemented during COVID, with no evidence of compromised safety to date.

A comprehensive communications and engagement plan underpins the consultation process, aiming to ensure transparency, meet statutory duties, and gather stakeholder and

public feedback—particularly from affected and underserved groups—to inform final decision-making, assess impacts, and identify mitigations.

Plans were supported by the GM Overview and Scrutiny Committee on 17th June 2026.

Post Meeting Note: Both schemes have been reviewed and assessed via NHSEs Stage 2 Assurance Process, with full endorsement to proceed to Public Consultation that will commence on 1 July 2026 and run for 12 weeks. During this period, targeted engagement activities (surveys, focus groups, and stakeholder outreach) will gather feedback on the proposed single-site models and their impacts. Final ICB decision making is planned for early 2027.

Neonatal Options Long-Listing and Service Review Alignment:

The Group discussed the process for developing and reviewing 18 future options for neonatal care across eight sites in Greater Manchester, emphasising the need for a clear methodology, better engagement with colleagues, and alignment with other acute service reviews.

Major Trauma Programme and Interdependencies:

The Group discussed the current status of the major trauma programme, noting its implications for vascular services and the importance of addressing interdependencies. A more in-depth discussion is planned for a future meeting

Children, Young People and Maternity

SEND Reforms - Greater Manchester is taking a coordinated approach to the significant SEND reforms published in February 2026. The reforms are ambitious and require joint working across local authorities, education and health. While local authorities are expected to lead implementation in their areas, NHS GM colleagues have worked with local authority leads and GMCA to support a GM-wide approach where appropriate. Discussions are ongoing with the Department for Education to establish Greater Manchester as an early adopter and align this work with the GM Prevention Demonstrator.

The SEND reforms include an ‘Experts at Hand’ offer in each local authority area to help mainstream settings across early years, primary, secondary and post-16 better identify and meet the needs of children and young people with SEND. The model will deploy professional expertise into education settings, with Speech and Language Therapists and Occupational Therapists identified as the health workforce. Each local authority will receive Experts at Hand funding at the end of June 2026. A working group is being established to oversee the ICB’s approach, including joint commissioning and workforce arrangements.

There is a whole system commitment to fund, in equal shares, a single Advanced Practitioner Speech and Language Therapist role with a GM wide remit, in line with the SEND reforms. This strategic role will ensure a population focused, joined up approach to SLCN across all ten localities, guiding improvement and reducing variation.

Primary Care Commissioning

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

As per previous update to SCC, this process has been progressing to contract award. Following a recent review of the process, the procurement is not in a position currently to proceed with awarding / mobilising the contract. Further considerations and due diligence are required by the ICB and whilst this in underway, actions are being taken to:

- Ensure continued delivery of interpretation and translation services
- Manage relationships and expectations of the bidders

Community Pharmacy Contractual Framework (CPCF) - The national Community Pharmacy Contractual Framework (CPCF) contract negotiations outcomes has now been published.

A high level summary of the 2026/27 funding settlement is below:

- 10.3% (£340m) funding uplift to £3,636 million for the CPCF and Pharmacy First budgets
- Write-off of net over-delivery of contract funding (margin) earned up to the end of 2025/26 – up to £239m
- The Single Activity Fee will increase by 6p to £1.52
- Independent Prescribing to be added to Pharmacy First and PCS in the Autumn
- £20m Pharmacy Quality Scheme with 80% aspiration payment payable on 1 September
- Agreement to allow late payment claims for Pharmacy First and NMS
- Pharmacies to be able to close for training for up to 4 hours a month
- A reform agenda to inform a National Community Pharmacy Strategy which will include measures intended to improve stability and predictability in the medicine margin system and support the continued supply of medicines to patients.

Overall, this is a positive direction of travel, however there are several issues outstanding that will be discussed with DHSC and Government via Community Pharmacy England (CPE) in the coming months.

ASSURE

GM Specialised Commissioning Oversight Group

Finance Update and Planning

The Group received an update on the financial position for 2025-26 and the start of the new financial year, discussing ongoing planning, variable elements, and the alignment of specialised commissioning with broader ICB financial oversight.

Quality Report

The Quality report was noted. The Group received updates on quality and safety issues, including progress on the NCA renal dialysis action plan and assurance on spinal MDT processes, with ongoing monitoring through established governance routes and continued efforts to close assurance.

Finance Update

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

Performance Report

The Group reviewed the Performance Report and noted key pressures in provider activity, waiting lists, and cancer performance across GM, highlighting overperformance in some areas, long waits in neuro and spinal pathways, and challenges in meeting cancer treatment standards. There are plans to integrate specialised performance into routine provider conversations and ICB oversight.

NW Specialised Services Committee

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

Risks discussed and new risks identified:

Specialised Commissioning Staffing and Office of Pan ICB Commissioning (OPIC) Transition:

There continues to be sustained pressure on staffing capacity within the specialised commissioning team. Since 2023/24, the compounded effects of the abolition of NHS England and delays in the delegation and transfer of specialised services staff have resulted in prolonged recruitment restrictions. In addition, the full impact of the NHS England Voluntary Redundancy Scheme on team capacity remains uncertain.

Current vacancy levels across several teams, alongside the potential for further recruitment delays, present a significant risk to the delivery of key priorities and the maintenance of business-as-usual functions. Ongoing capacity constraints are also increasing the risk of staff burnout and declining morale. The team is actively mitigating these risks through regular prioritisation of workload. OPIC structures are being finalised, with recruitment planned to commence at the earliest opportunity.

Children, Young People and Maternity

Area SEND inspection – An Area SEND monitoring inspection of Bury Local Area Partnership took place in March 2026. It concluded that the partnership had taken effective action to address the six priority areas identified during the initial inspection in May 2024. GM-wide learning opportunities will be progressed through the GM Strategic SEND Partnership.

Primary Care Commissioning Committee

Scheduled for 25 June 2026 with update provided to August SCC report

ACHIEVEMENTS

Children, Young People and Maternity

SEND Reforms – the deadline to submit Local SEND Reform Plans to the Department for Education by 19th June was met by all GM Local Authorities. The plans set out the vision, strategy and roadmap for implementing the reforms and were developed in partnership with NHS GM, including CEO sign off.

The Department for Education and NHS England will review the plans, with final recommendations expected from the Secretary of State for Education in September. Local authorities whose plans meet the required quality threshold will receive a High Needs Stability Grant to cover up to 90% of eligible historic Dedicated Schools Grant deficits accrued up to the end of the 2025-26 financial year.

Primary Care Commissioning

Relocation of Didsbury Medical Centre - on 8 June 2026, Didsbury Medical Centre relocated to a new state-of-the-art premises at Didsbury Point in West Didsbury. The practice population has grown considerably in recent years and with the current registered patients being in excess of 16,000 people, the existing building was no longer fit for purpose. The new location is on the ground floor of a new residential Southway Housing development. Providing modern and accessible facilities, the premises sees clinical capacity increasing from 8 clinical rooms to 20. This will support improved access and outcomes for patients whilst enabling future patient growth at the practice.

NHS Greater Manchester

Acting Chief Reform & Improvement Officer Report

1st July 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

1st July 2026

Required information	Details
Title of report	Acting Chief Reform & Improvement Officer Report
Author	Nicola Hepburn Acting Chief Reform & Improvement Officer, 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 thr Reform & Improvement portfolio.
The benefits that the population of Greater Manchester will experience.	
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy with the intention to deliver financial sustainability, improve our oversight arrangements with our commissioned providers and take forward our digital strategy.
The decision to be made and/or input sought	The Committee is asked to note the AAAA report and the position as of M3.
How this supports the delivery of the	The areas within this report and progress made to improve these relate to BAF risk

strategy and mitigates the BAF risks	
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for Strategic Commissioning Committee and has not been elsewhere but is formulated from intelligence and papers from
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for Strategic Commissioning Committee and has not been elsewhere. The intelligence and papers used to formulate this report have come from the functions workplans within the portfolio.
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report. Decisions with a material financial impact, including medicines optimisation and gainshare opportunities, are being progressed through the appropriate executive and financial governance routes in line with existing NHS GM policies. 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
Nil alerts for June 2026.

Advise

Data Insight and Intelligence:

DII Operating Model Transition:
DII is progressing transition to the new structure effective 1 July 2026, aligned to the ICB Blueprint and revised operating model. Expression of Interest (EoI) interviews are taking place this week to support role alignment and workforce stabilisation.

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

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

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

Federated Data Platform (FDP) Engagement:
Matt Hennessey hosted a recent parliamentary visit to demonstrate regional progress on the Federated Data Platform (FDP), with DII contributing to system positioning and showcasing Greater Manchester's approach to digital transformation and data-led service improvement.

Elective:

GIRFT ICB visit
GIRFT GM ICB virtual visit scheduled for 28 September 2026. This will need to be a joint presentation / discussion between the ICB, TPC and the GIRFT team.

Action: Elective and UEC teams to work with providers and TPC to co-develop GM presentation

Clock starts increase following end of Q4 sprint
Nationally and regionally, there has been a spike in clock starts in April following the sprint and waiting lists have increased.

Initial analysis of GM data suggests March was a large referral month (similar to July 2025 when waiting lists also increased) and the waiting list change maybe driven by a spike in delayed additions to waiting list (admin processed after 30 March) plus reduced validation compared to March (when validation period increased 80%).

April and May clock start volumes and generated e-RS referrals are below Q4 levels therefore this maybe a seasonal spike compounded by the actions taken to deliver Q4 sprint position.

Elective team are working with DII to analyse GM position and will provide an analysis in the coming week.

UEC:

The outcomes of the review of impact and value for money of all capacity and discharge schemes for 2025/26 have now been completed.
These outcomes will be presented to Chief Officers to inform decisions on funding for 2026/27 and to ensure all schemes contribute to reducing inequalities, improving outcomes, and delivering the left shift agenda.
This will support patients in our communities over the winter period**.**

Assure

Data Insight and Intelligence Update:

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

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

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

Risk discussed and new risk identified

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

- Reduced ability to deliver against statutory governance requirements
- Constraint on supporting key programmes (e.g. SDE, ICB governance assurance)

Mitigation:

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

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

Achievements

DII Updates:

The Data Insight and Intelligence team were awarded with “System Partner Award” from Health Innovation Manchester.

Recognising an organisation or group that consistently enabled delivery, opened doors, or removed barriers across the life cycle of the Programme.”

UEC
The new EPRR On-Call model went live on 1st June 26

NHS Greater Manchester

Strategic commissioning committee
A&E 12 hour waits

Presented by: Nicola Hepburn
Date: 1.7.26

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Purpose

Strategic commissioning committee asked for a deep dive into 12 hour waits in A&E. This report sets out:-

- Our current understanding of this issue
- Understanding of root causes
- Actions being taken to reduce long waits in emergency departments
- Our expectations of impact
- A case study of MFT's actions to reduce long emergency waits

Executive summary

Greater Manchester

- Long waits in A&E can significantly worsen outcomes for patients. They also represent poor experience for patients; their families and friends; and our workforce who care for them in difficult circumstances.
- Prior to Covid there were minimal 12 hour waits, these are now at significant levels.
- Whilst 12 hours is the national standard, waits can exceed 48 and 72 hours in some circumstances.
- There is variation in rates across providers in Greater Manchester; variation in the rate of improvement to date and a variation in planned reductions over the medium-term planning period.
- Delays in departments relate to needs for physical and mental health care, both admitted and non-admitted.
- There are clear patient cohorts and parts of the pathway which we can focus upon to reduce long waits.
- Levels are reducing and systems to mitigate adverse outcomes are strengthened
- There is much more to do - high rates should not be considered inevitable.

- The Royal college of emergency medicine recently reported their findings on the levels of 12 hour waits across the country and the impact on patient mortality https://rcem.ac.uk/press-release/how-many-deaths-will-it-take-before-we-see-a-meaningful-plan-to-end-the-crisis-deaths-associated-with-long-ed-waits-surge-almost-t/

Quality outcome and experience impact

NHS Greater Manchester

Pressures in UEC departments collectively increase the likelihood of avoidable harm, poor patient experience and inconsistent outcomes, particularly for those with complex needs, mental health conditions or time critical illness. A review of incidents / events shows that long waits can lead to:

1. Delayed Recognition & Escalation
2. Care being delivered in unsafe environments such as corridors
3. Non therapeutic environments for Mental Health Crisis-Related Patients
4. Missed opportunities to act on abnormal test results
5. Unsafe discharges including inconsistent follow ups
6. Diagnostic & Decision-Making Failures

ED Quality Visits (Winter 2025/26)

Greater Manchester

We carried out a number of quality visits in UEC departments during 25 / 26 with the latest visit occurring this winter. During these we identified improvements since previous visits together with challenges.

Improvements

1. Calm, Organised Departments Despite Pressure

- All sites demonstrated **professionalism, teamwork, and stability**
- Strong leadership presence (matrons, operational leads, consultants)

2. Strengthened Monitoring & Escalation Processes

- NEWS2 used consistently across all EDs, including corridor areas
- Examples of Safety checklists being embedded

3. Improved MH–ED Collaboration

- MH suites and neurodiverse rooms being developed across sites
- Weekly partnership meetings to resolve MH interface issues

4. Environmental & Patient Experience Enhancements

5. Positive Multi-Agency Working

- Strong, constructive relationships with **NWAS** across all sites
- Joint escalation and handover processes working well

6. Growing Culture of Transparency & Learning

- Staff feel empowered to raise concerns
- EDs actively engaging in **learning events**, deep dives, and redesign work
- Examples of Healthwatch engagement strengthening patient voice

Challenges

1. Sustained System Pressure & 12hr+ Waits

- EDs operating at **OPAL 3–4**, with prolonged waits for beds
- Corridor care used as a **routine mitigation**, despite known risks

2. Mental Health Long Stays & Fragmented Pathways

- MH patients waiting **8–27+ hours** for assessment or beds
- Limited MH-appropriate environments; neurodiverse/MH rooms still in development

3. Deterioration & Escalation Risks

- Delays in escalation during peak pressure
- Variation in how early deterioration is recognised and acted upon

4. Flow & Front-Door Streaming Challenges

- UTC layout and 111 referrals creating **front-door congestion**
- High Type 3 attendances adding pressure
- Streaming models inconsistent across GM

5. Environment, Dignity & Safety Concerns

- Overcrowded waiting rooms; limited space for immunocompromised patients
- Security concerns at some sites

Assurance

1. Improved Visibility & Early Detection of Risk

- GM monitored harm related to 12-hour+ waits and MH-related incidents through LFPSE/StEIS monitoring.
- Earlier identification of **themes across Trusts**, enabling faster escalation and targeted support.
- EDs increasingly using **real-time data** (flow boards, NEWS tracking, MH wait dashboards).

2. Quality Review Meetings (QRM) Providing Stronger, More Consistent Assurance

- QRM offer a **clear, structured mechanism** for oversight.
- Through SCC, themes from QRM are feeding into:
  - GM UEC Board
  - MH Collaborative
  - Winter planning

3. Growing Culture of Transparency & Reporting

- Increase in **high-quality incident reporting.**
- Trusts are more willing to **self-identify risk**, including near misses.
- This is enabling earlier intervention and **more honest system conversations**.

What the data says.

Greater Manchester

12hr waits are improving but remain materially above pre pandemic levels and show some system flow and inequality signals.

- Since the pandemic, 12hr waits have risen sharply; although performance has improved since the January 2024 peak, 2025/26 is around 10% lower than 2024/25 to date, and winter pressures remain a persistent feature.
- In 2025/26 there were around 1.06 million Type 1 ED attends across Greater Manchester, with 110,300 attendances (10.4%) waiting more than 12hrs.
- Performance varies materially across providers and sites. The GM average is 100 breaches per 1,000 attends, the 3 main MFT sites average 61 per 1,000, while RAE is at 189 per 1,000 and SRFT at 152 per 1,000.
- The strongest inequality signal is age. Breach rates rise steadily with age, from below 1% in paediatric cohorts to over 30% in patients aged 90+. Age also has the highest Index of Disparity (9.6) compared with ethnicity (3.3) and deprivation (<1).
- MH attends are disproportionately affected. 22.1% of MH related attends breached 12hrs compared with 10.4% overall, meaning MH attends are around twice as likely to breach. MH attends account for 2.3% of attends but 4.8% of breaches.
- Long waits are predominantly an admitted pathway issue, but not exclusively. 72% (79,500) of breaches were among patients later admitted, while 22.7% (25,000) were patients later discharged home or to residential / care home settings.

Performance is improving, but poor outcomes remain, high variation is a problem with the clearest risk concentrated in older people, MH attends, and certain sites within GM Trusts.

What this tells us.

Greater Manchester

Patient flow delays, especially overnight and early in the week; as well a front door demand pressure are major contributors.

- The operational pattern is highly consistent, breaches are most associated with late afternoon / evening arrivals, while discharges out of ED are concentrated the following morning / daytime, which indicates that delays are accumulating overnight.

- For patients later discharged home, the largest delays occur after triage, between treatment and discharge; this indicates that downstream process delay, not just initial assessment, is driving long waits.

- For patients later admitted, the dominant delay is between decision to admit and leaving ED for an inpatient bed, and at some sites this stage exceeds 900 minutes (15 hours).

- The relationship with discharge flow is real but only partial. Reduced discharge activity, especially in winter and over Christmas is associated with worsening breaches, but discharge volumes alone do not fully explain the volatility in 12hr performance.

- This is not mainly a repeat attender problem. 87% (92.6k) of 12hr breaches had no prior unplanned care event, attendance or admission in the 72hrs preceding the breach. Pointing to a front door demand and pathway issue rather than repeated cycling through care.

- There are some prior pathway signals. Where there is preceding contact, it is mainly through 999 and 111, and ambulance conveyance is heavily represented immediately before breach events.

- Patients experiencing extended waits show significantly higher mortality rates (6.55% within 30 days for >12hrs and 0.89% for <12hrs). While this reflects differences in patient acuity and complexity rather than direct causation, it highlights the vulnerability of this cohort and the importance of improving flow to reduce harm.

The data suggests the biggest gains will come from improving overnight flow, post decision to admit processes, front door streaming, and mental health response, rather than focusing only on headline ED demand.

Current Actions required to Reduce 12 Hour Waits

NHS Greater Manchester

Strengthening whole-system flow (primary focus on admitted cohort ~72%)

- System-wide focus on exit block reduction through daily operational grip on admission, bed management and discharge pathways
- Improvement in discharge performance and occupancy management, supporting gradual reduction in overall breaches (c.10% reduction vs 2024/25)
- Targeted focus on decision-to-admit to ward transfer delays, identified as the main constraint driving long waits

Improving operational grip and consistency of delivery

- Increased emphasis on standardised flow processes and Model ED principles across providers to reduce unwarranted variation
- Strengthening senior decision-making and operational oversight, learning from high-performing sites (e.g. MFT) where leadership focus has driven better outcomes
- Active management of performance variation across sites to scale effective practice system-wide

Aligning capacity to demand patterns (real-time operational changes)

- Early shifts in workforce and operational models to better reflect peak demand periods (afternoon/evening)
- Focus on addressing overnight flow constraints, recognising lack of 24/7 progression as a key driver of breaches

Targeted Actions on Non-Admitted & ED Flow

NHS Greater Manchester

Addressing the 30% non-admitted cohort

- Recognition that non-admitted breaches are not a consequence of system flow failure but ED congestion and front-door demand
- Actions underway to improve front-door efficiency and streaming, reducing time spent in ED for non-admitted patients

Improving ED effectiveness and same-day pathways

- Strengthening ambulatory/SDEC and streaming pathways to avoid unnecessary waits in ED
- Increased specialist in-reach into ED (e.g. frailty, specialties) to accelerate decision-making and reduce onward delays
- Improved use of alternative urgent care pathways, addressing high ambulance conveyance rates driving ED pressure

Impact on non-admitted waits

- Reduced ED congestion supports:
    - Faster clinical decision-making
    - Reduced time to discharge for non-admitted patients
    - Improved overall department flow, benefiting both cohorts

Impact to Date and Why This Now Builds Confidence

NHS Greater Manchester

Early impact (system beginning to respond, but not yet at scale)

- Reduction in 12-hour breaches (c.10% improvement year-on-year)
- Continued high volumes (e.g. ~8.5–8.9k patients per month) confirm scale of challenge remains significant
- Improvements evident in supporting metrics (flow, discharge, handovers) but not yet fully translating into sustained reduction in long waits

What could be different

- Shift from fragmented initiatives to coordinated, system-wide delivery focused on flow
- Stronger operational grip and leadership focus, reflecting learning from best-performing providers (e.g. MFT)
- Increasing focus on delivery at scale and consistency across all sites, rather than isolated improvements

Why this will deliver impact

- Directly targeting the core drivers of long waits: exit block, overnight flow, and demand-capacity mismatch
- Clear alignment of actions to end-to-end pathway redesign and high-impact cohorts
- Establishing system accountability for 12-hour waits as the primary outcome measure

Current actions and impacts – Mental health

Greater Manchester

Action	Impact
Increase in children and young people (CYP) complex case escalations for the period February to July – Options paper for a cross-sector crisis wraparound proposal has been developed which will need to be co-commissioned with Children's Services	Provide a real time person-centred response for CYP presenting in crisis to reduce long waits in EDs and prevent the need for inpatient admission
Escalation process in place with SCC for UEC MH, and proposal for non-UEC/complex case escalations developed with regular panel being established	Support safe, effective, timely care by unblocking complex system issues
S136 pathway remains pressured, however ICB-led S136/Health Based Place of Safety Improvement Plan in place and agreed multi-agency S136 GM protocol – system pressure for CYP and specific actions identified following ICB led workshop in May	Improved experience for people detained under S136 of MHA Reduced waiting time in ED for people attending as a Health Based Place of Safety/Improved access to dedicated S136 suite
Transformed GM MH First Response commissioned: MHUT established in NWAS EOC managing MH 999 Cat 3-5 calls, single GM 111 24/7 crisis line, GM crisis text service.	Improved 'hear and treat' for people in MH crisis Reduced ED attendances for people in MH crisis with earlier support Improved access to crisis alternatives including VCSE-led Dedicated professional line advice for police and ambulance crew 'at scene'
UEC MH dashboard developed as a supplementary dataset to the MH Safety Siren providing data on 111 option 2, MH Urgent Triage (MHUT), A&E MH, and S136.	Improved visibility of and responsiveness to MH system pressures
Improve patient flow to reduce length of stay with a system focus on CRFD with Trust footprint MADEs in place for escalation and identification of thematic issues.	Improved patient flow with improved bed availability for people requiring admission to a MH bed Reducing long waits in ED that result from lack of bed availability

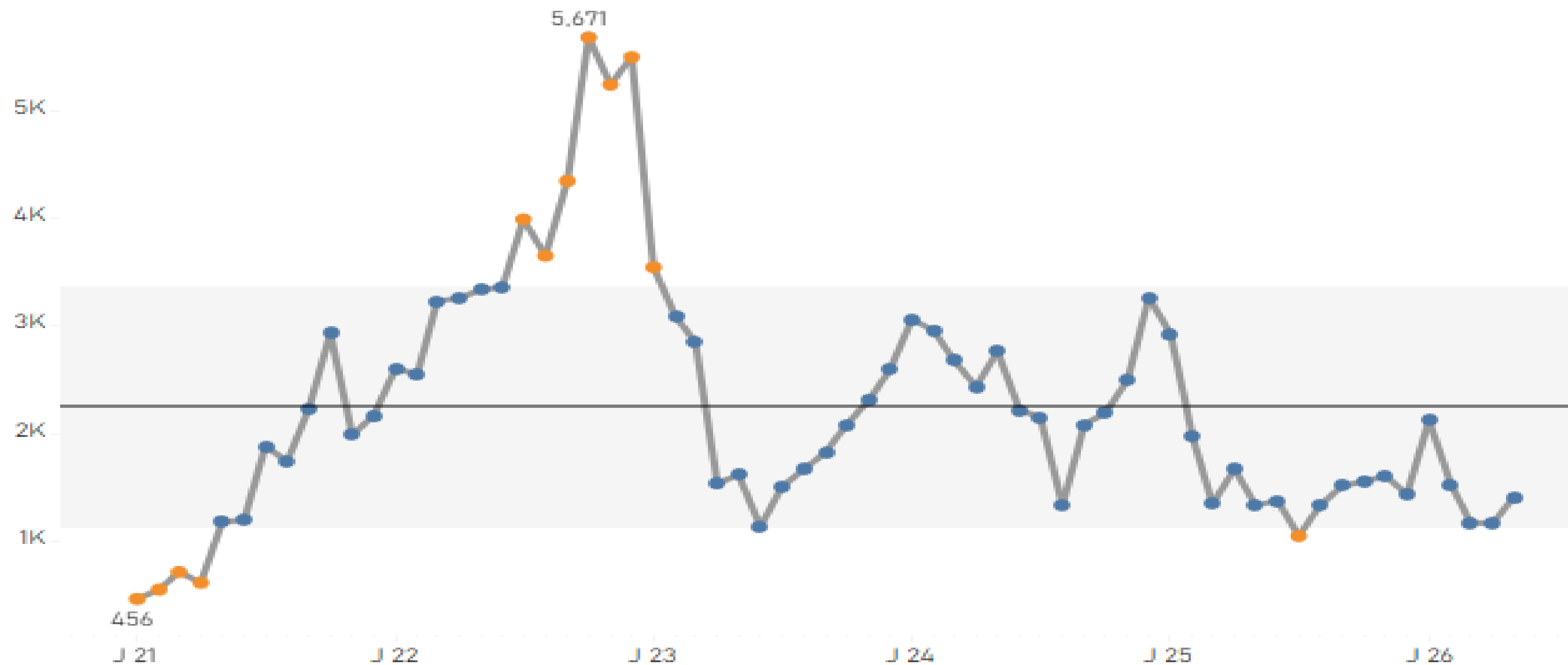
Current actions and impacts – Mental health

Greater Manchester

Action	Impact
Community crisis programme in place to support ED avoidance – GM 4 hour MH crisis response, overnight VCSE crisis space expansion, Home Treatment capacity	Improved community crisis response for people at home or place of residence reducing ED attendance Improved access to crisis alternatives including VCSE-led
ICB successfully bid to NHSE for **all** MHLDA capital schemes totalling £26m over 3 years – includes development of MH EDs and 24/7 neighbourhood MH centres – system co-design commencing	To be confirmed – dedicated ED/ Crisis Assessment Centres /purpose-built streaming areas for MH across at least 50% of type 1 EDs in GM
MRI pilot scheme in place – additional AMHP and VCSE capacity to improve people's experience in A&E when brought to hospital under S136	Improved experience for people detained under S136 of MHA Reduced waiting time in ED for people attending as a Health Based Place of Safety/Improved access to dedicated S136 suite

MFT improvement programme

In 2022 MFT made a commitment to reduce 12 hour waits in their emergency departments. This is shown in the chart below. The following slide gives a summary of the key actions they took.



Improving the 12 hour position

Manchester University
NHS Foundation Trust

Key Enablers

- Stronger clinical accountability & governance - drives ownership, reduces inappropriate validation, and ensures learning from every delay
- Daily operational grip and real-time visibility - shifts from retrospective reporting to real-time management
- Early escalation (8+ hrs) before breach point - tackles issues before they reach 12 hours
- Focus on flow and specialty responsiveness - targets the core driver of DTA delays (internal flow, not just ED processes)
- Targeted action on mental health delays - directly addressing the largest contributor to 12-hour waits
- Improved data quality and validation discipline - ensures reported improvement reflects real improvement

Takeaway messages

- 12 hour waits in our emergency departments generate poor outcomes and experience.
- They are caused by a range of factors, which are not simple to resolve.
- They should not be considered inevitable, or "normal" despite consistency in levels over several years.

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Appendix One
UEC 12 Hour Waits Review

Date: 14/11/2025

Assurance Statement

NHS Greater Manchester

The analysis is based on routinely collected Emergency Care Data Set (ECDS) records and contiguous event data for 2025/26.

Findings reflect activity and outcomes within urgent and emergency care pathways only and should be interpreted in the context of known variation in recording completeness across diagnosis, investigation and treatment fields.

The information in these slides use the Emergency Care Dataset (ECDS) for A&E data. There are significant gaps in coding in some of the fields in this data, the gaps that mainly affect this is work is the high numbers of uncoded primary diagnosis codes and primary treatment codes. At GM providers in type 1 A&E departments in 2024/25 around 35% of attendances had no primary diagnosis coded and 33% had no primary treatment coded.

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Overview and Inequalities

Introduction

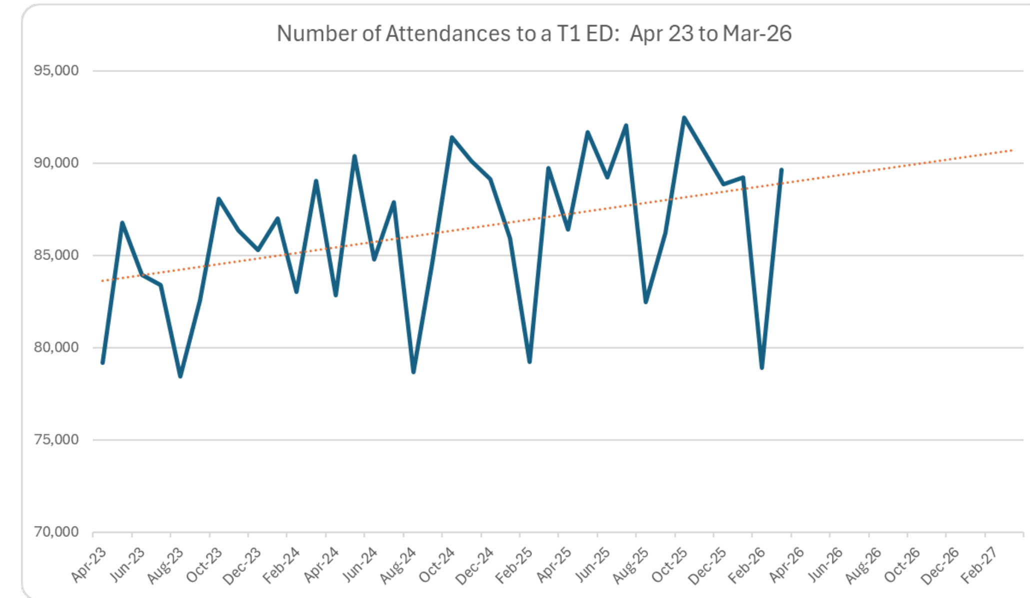
Greater Manchester

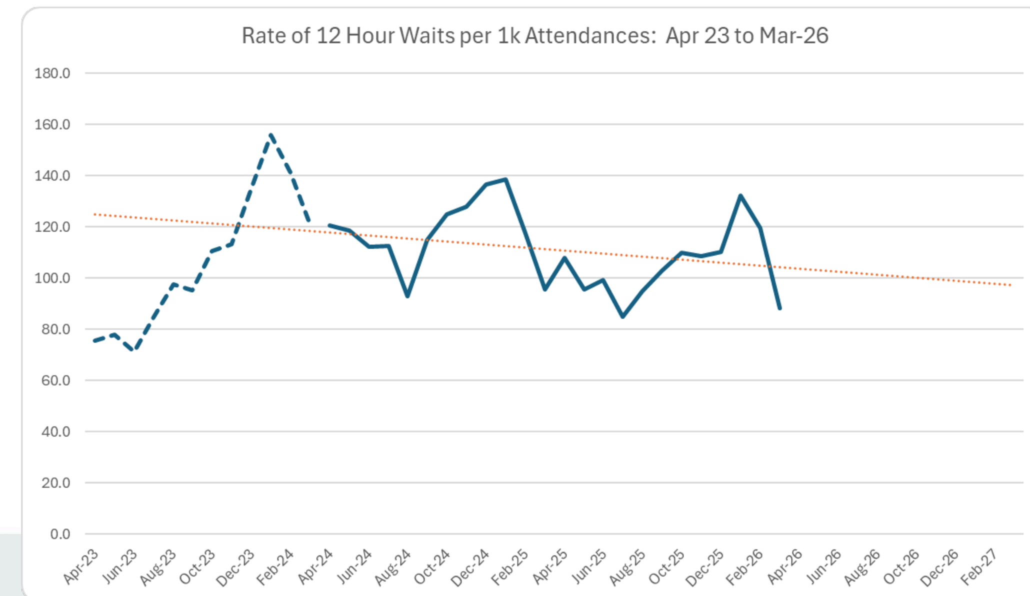
There has been a steady increase in attendances at Type 1 Emergency Departments (EDs), a trend which pre-dates the COVID-19 pandemic. Since the formation of the ICB, attendances have grown by approximately 2.1% per year, reflecting a growing, ageing, and increasingly multi-morbid population.

Since the pandemic, there has also been a significant increase in the number of patients waiting more than 12 hours in ED. The chart opposite shows the rate of 12-hour breaches as a proportion of all Type 1 attendances. This rate peaked in January 2024, when approximately 160 patients per 1,000 attendances waited longer than 12 hours.

Since April 2024, there has been a gradual reduction in the rate of 12-hour waits, with 2025/26 recording around 10% fewer breaches than 2024/25 to date. Despite this improvement, long waits continue to peak during the winter months.

Evidence shows that prolonged ED waits are associated with significant and avoidable patient harm. The following analysis explores the key drivers of long ED waits to support commissioning decisions aimed at reducing them.



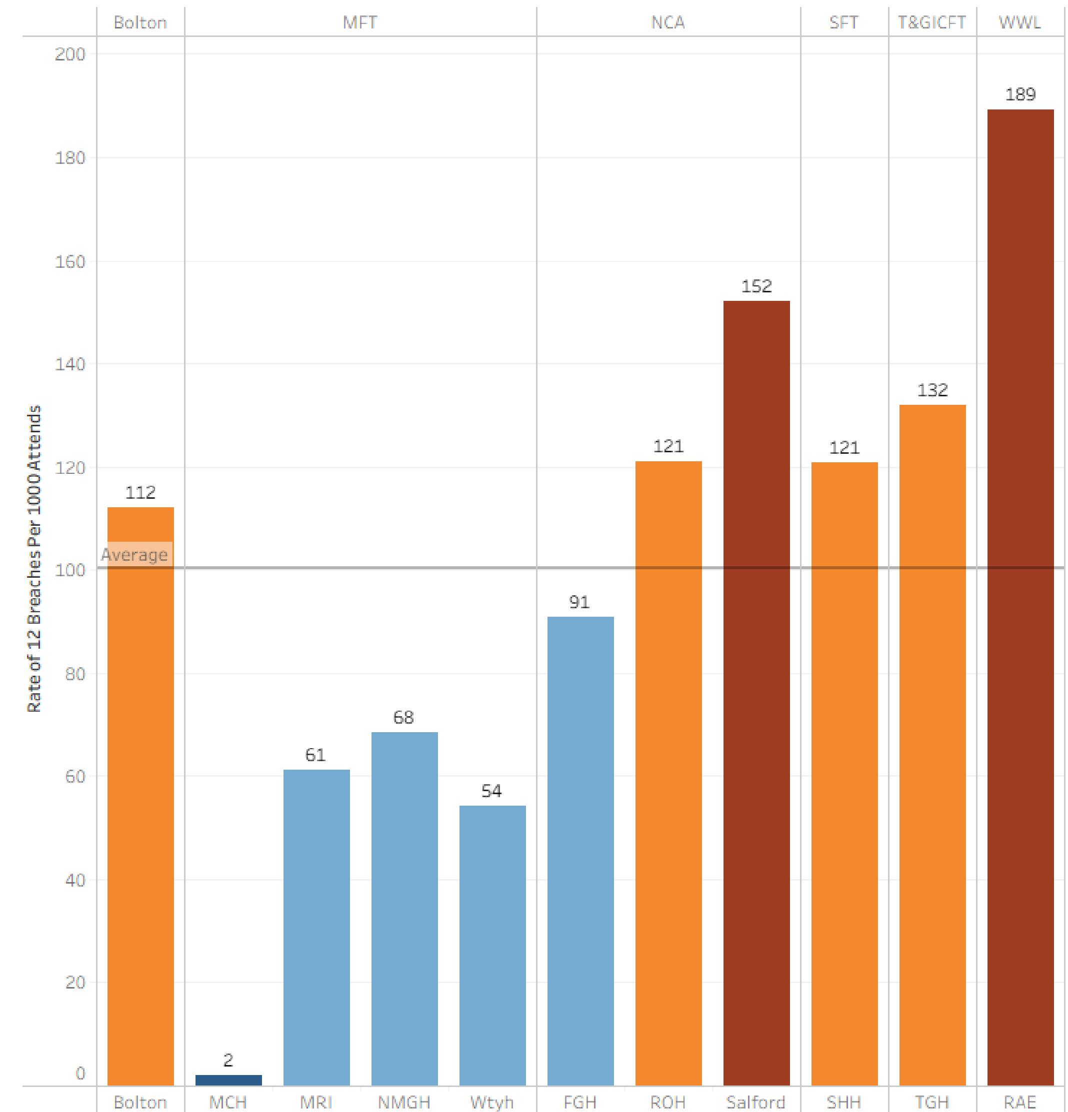


All +12 Hour Breaches in 25/26 by Site

In 25/26 across our GM providers on average 100 in a 1,000 patients waited longer than 12 hours.

This rate varied by trust and site. The three main MFT sites breaches rate averaged at 61 patients in a 1,000,

The two worst performing sites were the Royal Albert Edward 189 per 1000 and Salford Royal (152 per 1,000)

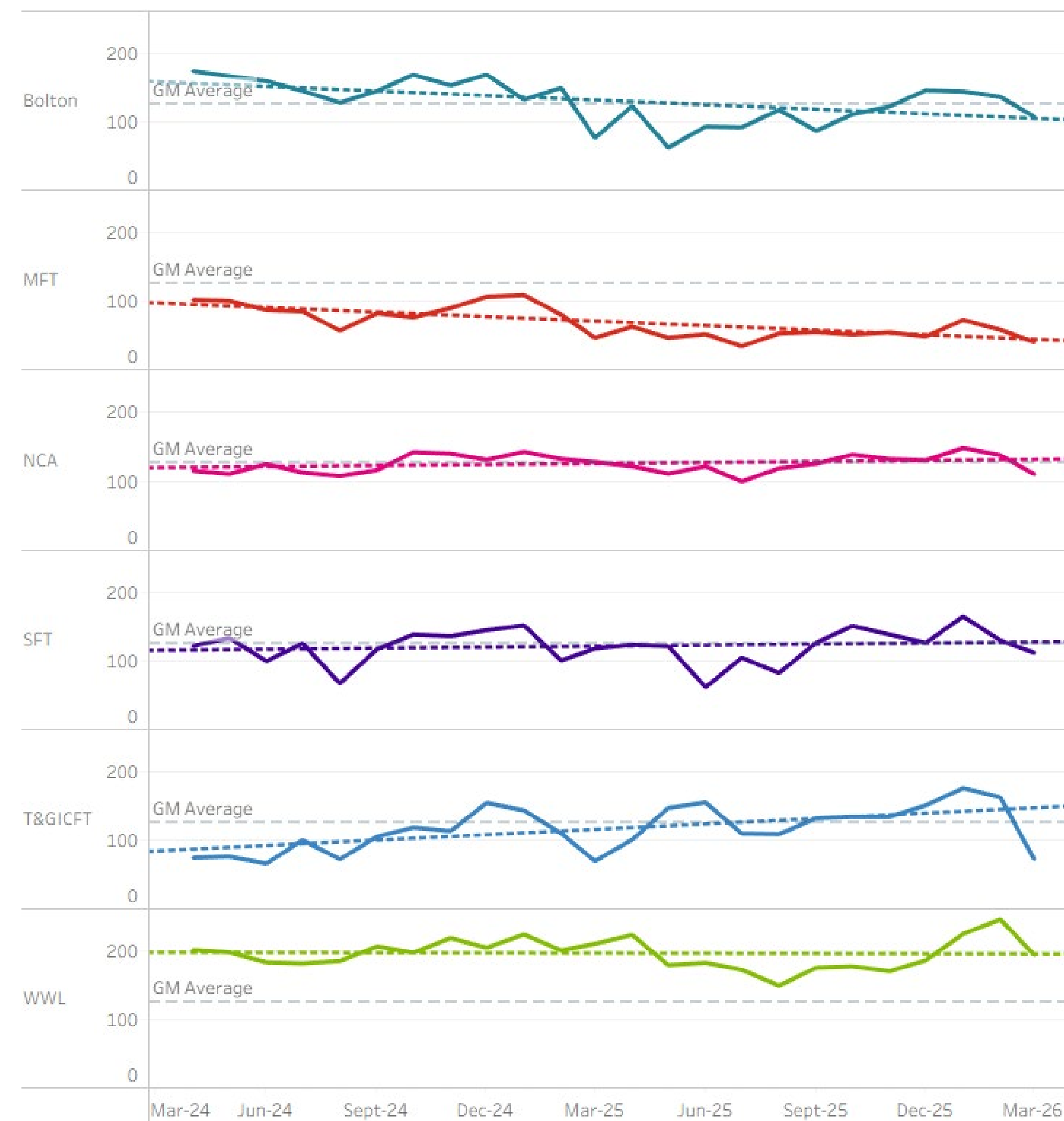


All +12 Hour Breaches Trend by Provider

Over the two-year period of Apr-24 to Mar-26 at GM providers, on average 126 in a 1,000 patients waited longer than 12 hours.

The graphs show the trend of 12 hour breaches split by site and the table below shows the rate of 12 hour breaches per year and the relative changes in those rates. MFT and Bolton have significantly reduced the number of 12 hour breaches. Whereas T&G ICFTs position has deteriorated compared to 24-25.

	FY 2025	FY 2026	Variance	Variance %
Bolton	147.6	112.2	-35.4	-24%
MFT	99.5	61	-38.5	-39%
NCA	125.6	124.3	-1.3	-1%
SFT	122.2	120.8	-1.4	-1%
T&GICFT	101	132	31	31%
WWL	201.5	189.3	-12.2	-6%
GM	**123.7**	**109.7**	**-14**	**-11%**



Inequalities – Age and Ethnicity

Greater Manchester

Reviewing the age and ethnicity breakdown of 12-hour breaches shows a strong association between age and breach rates. The proportion of attendances resulting in a 12-hour breach increases consistently with age, rising from below 1% in paediatric cohorts to over 30% in patients aged 90 and above.

Differences are also observed across ethnic groups. Overall, the White ethnic group shows a higher breach rate (12.62%) compared to other groups; however, this pattern is not consistent across all age bands, and variation is evident within individual cohorts.

Variation in older age bands, particularly in the 90+ groups, should be interpreted with caution due to smaller volumes and greater variability.

12-hour breach rate: Age (10-year) v Ethnic Group

	Asian or Asian British	Black or Black British	Mixed	Other ethnic groups	White	Grand Total
0-9	0.43%	0.22%	0.14%	0.28%	0.27%	0.29%
10-19	1.95%	2.25%	1.72%	2.35%	2.23%	2.18%
20-29	4.23%	5.73%	5.25%	4.99%	5.82%	5.41%
30-39	4.92%	5.27%	6.62%	5.78%	7.50%	6.70%
40-49	6.28%	6.80%	7.33%	7.80%	9.99%	8.82%
50-59	8.78%	7.97%	10.60%	10.91%	13.14%	12.06%
60-69	12.04%	9.77%	12.15%	15.24%	17.79%	16.77%
70-79	16.80%	13.88%	16.55%	21.94%	24.19%	23.39%
80-89	24.02%	20.28%	19.35%	27.80%	30.14%	29.58%
90-99	30.24%	17.76%	16.88%	32.63%	34.31%	33.76%
100+	12.50%	25.00%		32.81%	35.60%	34.71%
Grand Total	5.09%	4.93%	3.86%	8.32%	12.62%	10.43%

Inequalities – Age and Deprivation

Greater Manchester

Reviewing 12-hour breach rates by age and deprivation shows the same consistent association with age. Breach rates increase steadily across all deprivation quintiles as age increases, from very low levels in younger cohorts to over 30% in patients aged 90 and above.

Differences by deprivation are also observed within most age groups. In general, more deprived quintiles tend to show higher breach rates than less deprived quintiles, although the size of this difference varies between age bands.

However, the relationship between deprivation and breach rates is less consistent than that observed for age. At an aggregate level, breach rates do not follow a clear linear gradient across deprivation quintiles, indicating that deprivation alone is not a strong predictor of breaches.

12-hour breach rate: Age (10-year) v Deprivation (Quintile)

	Most Deprived 20% Quintile	2nd Quintile	3rd Quintile	4th Quintile	Least Deprived Quintile	Grand Total
0-9	0.33%	0.26%	0.26%	0.25%	0.21%	0.29%
10-19	2.19%	2.31%	2.11%	2.02%	2.11%	2.18%
20-29	5.63%	5.23%	5.39%	5.16%	4.76%	5.41%
30-39	6.75%	6.77%	6.82%	6.33%	6.23%	6.70%
40-49	9.03%	9.18%	8.95%	8.07%	7.05%	8.82%
50-59	12.86%	11.96%	11.86%	11.20%	9.25%	12.06%
60-69	18.04%	17.47%	16.48%	14.93%	12.66%	16.77%
70-79	24.90%	24.54%	23.52%	22.04%	19.21%	23.39%
80-89	31.23%	31.27%	30.65%	28.31%	25.04%	29.58%
90-99	34.57%	35.37%	35.24%	33.66%	29.57%	33.76%
100+	42.66%	35.64%	34.62%	23.40%	32.97%	34.71%
Grand Total	9.47%	10.60%	11.68%	12.07%	11.14%	10.43%

Inequalities – Index of Disparity (IoD)

NHS Greater Manchester

Index of Disparity

Index of Disparity	
Index of Disparity - Sex	0.12
Index of Disparity - Deprivation Quintile	0.86
Index of Disparity - Deprivation Decile	0.83
Index of Disparity - Ethnic Group	3.35
Index of Disparity - Age-10-year	9.63
Index of Disparity - Age-5-year	9.12
Index of Disparity - Provider	0.06
Index of Disparity - Locality	1.47

The Index of Disparity (IoD) measures the extent to which subgroup breach rates differ from the overall population rate. Higher values indicate greater variation between groups, while lower values indicate more similar rates.

The results show that age has the highest level of variation in breach rates (IoD: 9.6), indicating that breach rates differ substantially between age groups.

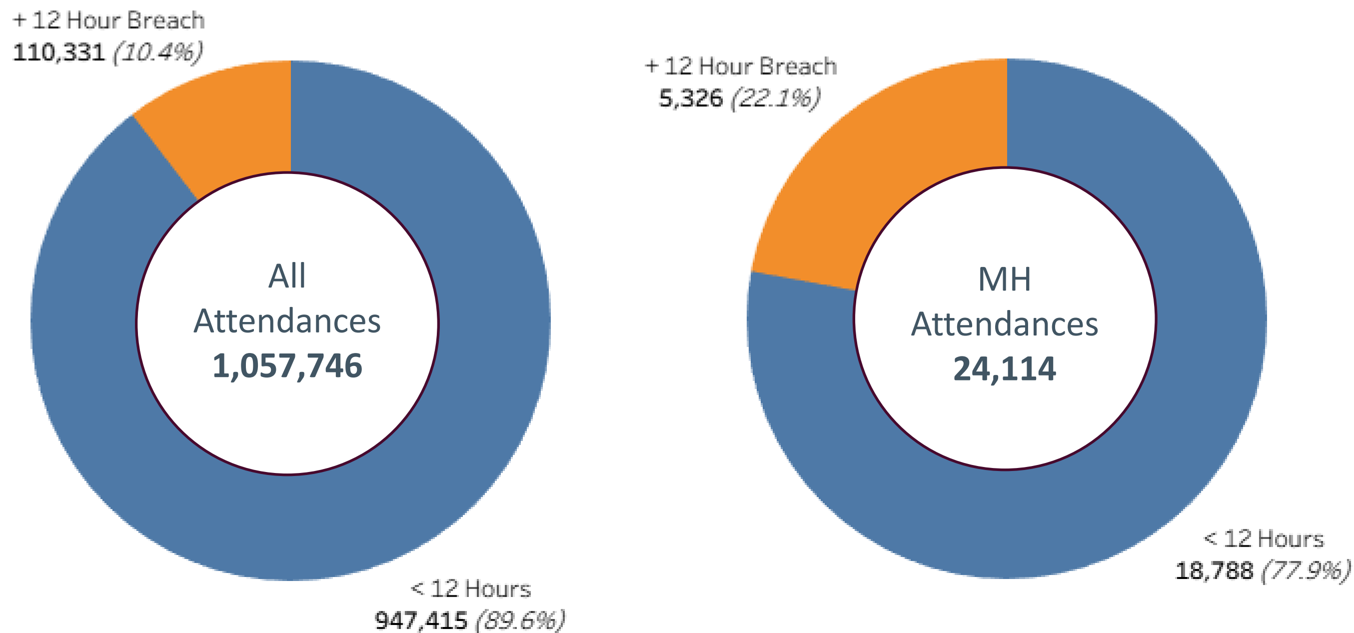
Ethnicity shows a lower level of variation (IoD: 3.3), suggesting some differences between groups, although these are considerably smaller than those observed for age.

Deprivation shows relatively low levels of variation (IoD: <1), indicating that breach rates are broadly similar across deprivation groups at an aggregate level.

Overall, age contributes the greatest variation in breach rates, whereas other factors, including ethnicity and deprivation, account for comparatively smaller differences between groups.

Mental Health

In 25/26 there were 1,060,000 type 1 attendances across Greater Manchester, of these 10.4% (110,300) waited over 12 hours.
Of the attendances flagged as Mental Health related*, 22.1% (5,300) waited over 12 hours, meaning this subsection of patients are twice as likely to breach than other conditions. Overall, Mental Health related attendances make up 4.8% of 12-hour breaches despite only contributing 2.3% (24,000) of attendances.



Patients with Long Term Conditions - General

Greater Manchester

Approximately 1.34 million people (41%) of the Greater Manchester registered population have at least one recorded long-term condition (LTC).

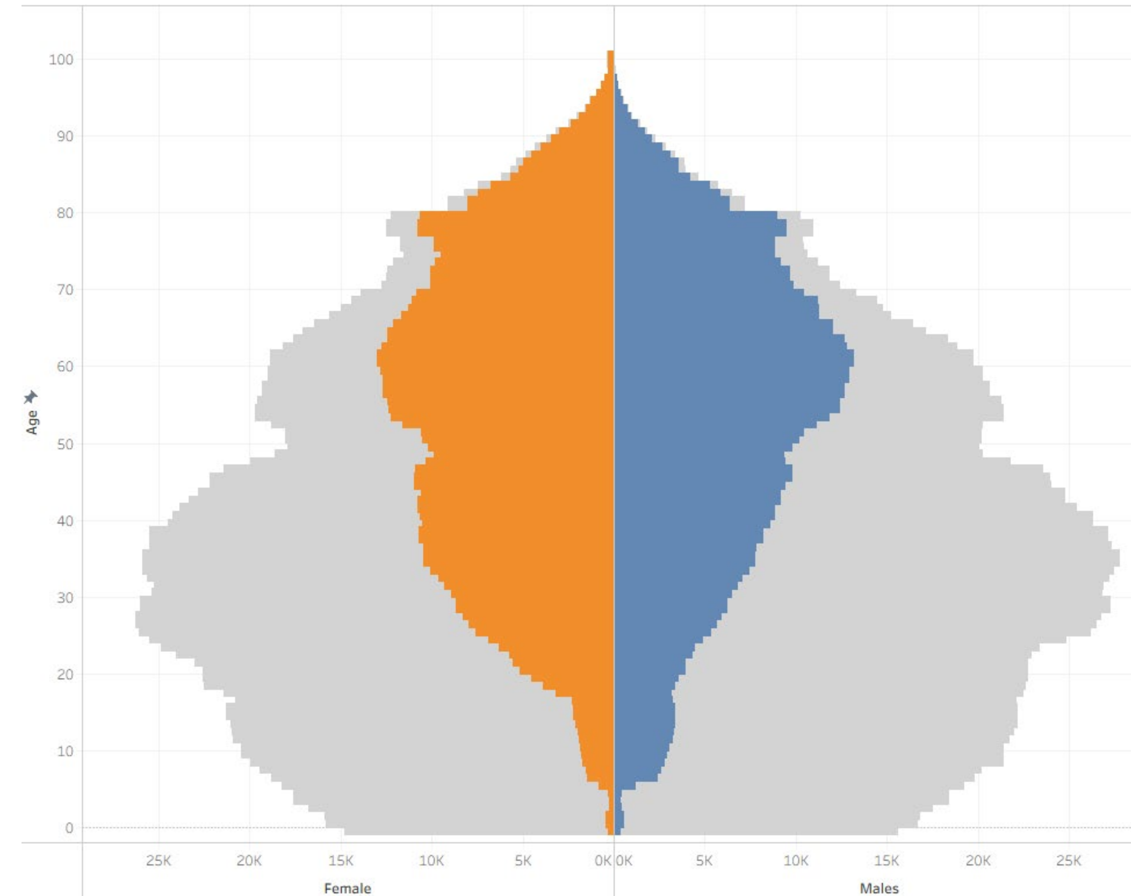
The accompanying population pyramid illustrates the distribution of the Greater Manchester population by age and sex (grey), alongside the subset of individuals with at least one recorded LTC (coloured overlay).

The prevalence of long-term conditions increases progressively with age, beginning to rise from the early 20's.

From approximately the mid-40s onwards, the proportion of individuals with at least one LTC increases markedly, forming a growing share of the population within each age cohort.

In older age groups, LTCs are near universal, with almost all individuals aged 80 and above having at least one recorded condition.

The shape of the chart also highlights the underlying population structure, with a large working-age population and an expanding older cohort, indicating continuing growth in demand associated with LTC management.



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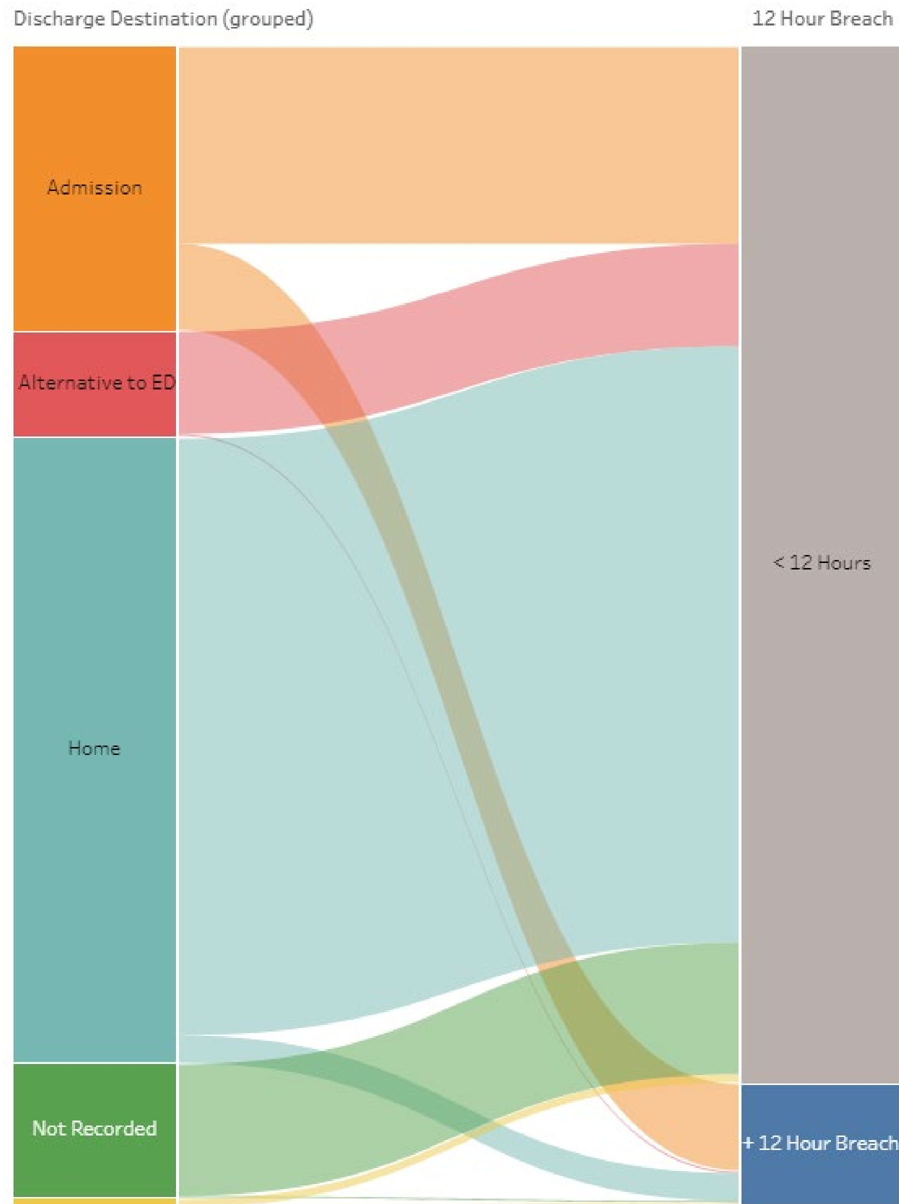
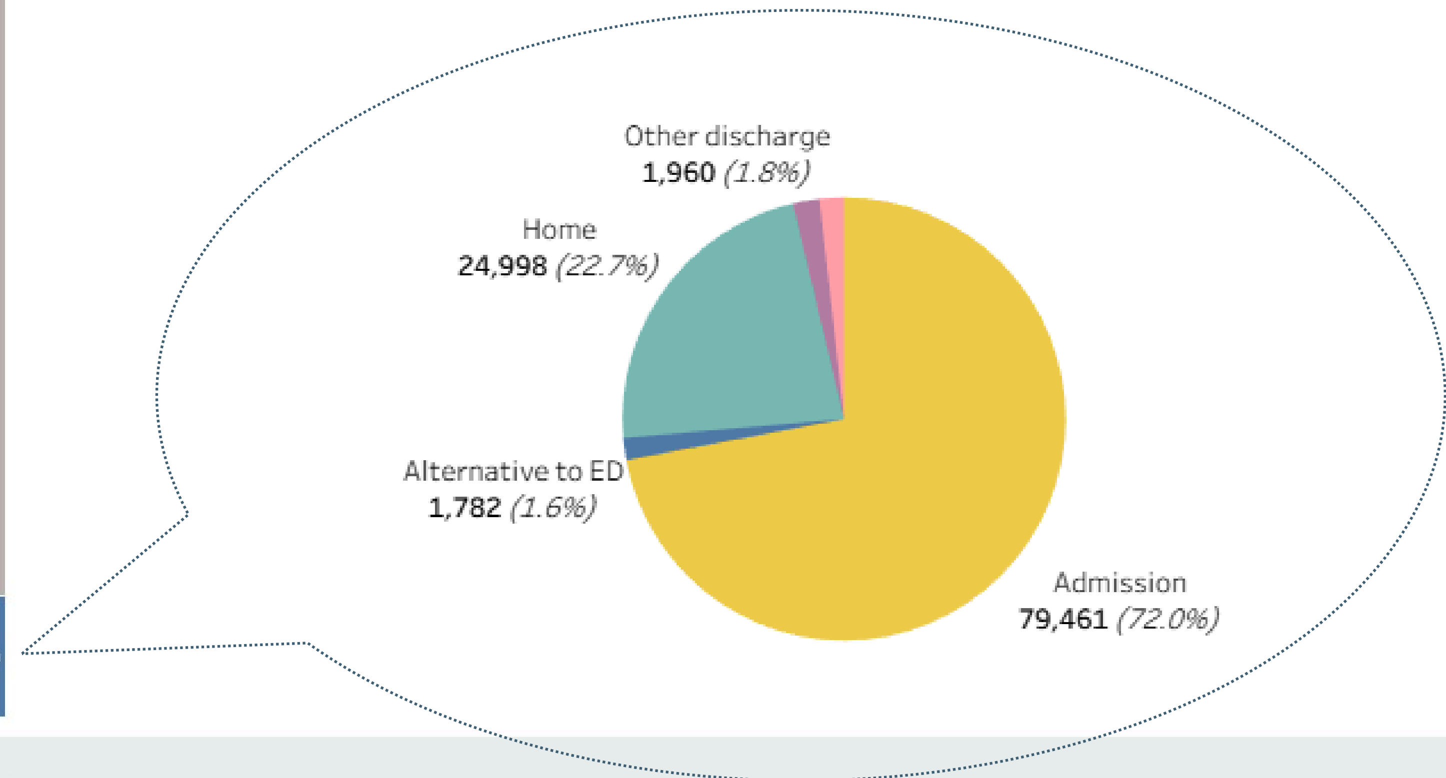


NHS Greater Manchester

The sanky chart opposite shows the patients discharge pathways and the quantities of each that breached 12 hours. Of those that breached **72% (79,500)** were **admitted** patients and **22.7% (25,000)** were **discharged home** or to a residential or care home setting.

The analysis that follows will look at these two cohorts in more detail.



NHS
Greater Manchester

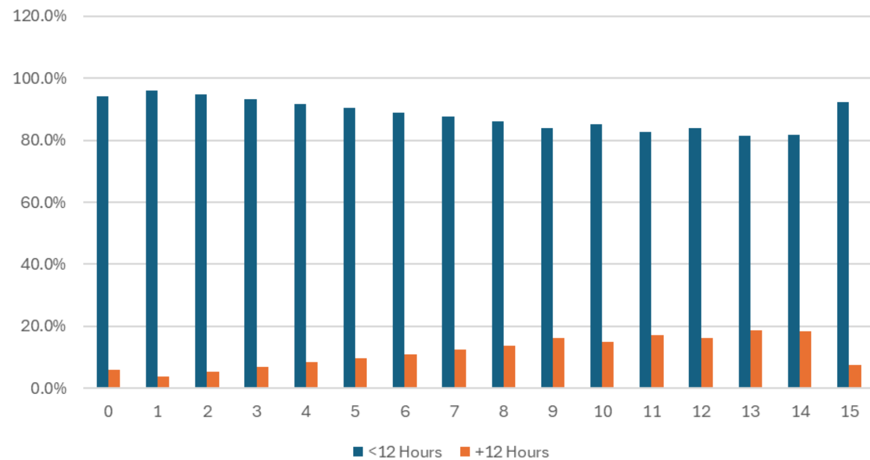
Patients Discharged Home

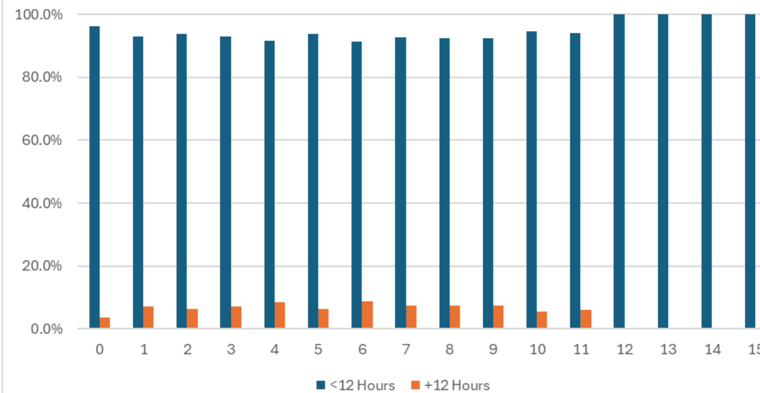
Part of Greater Manchester
Integrated Care Partnership

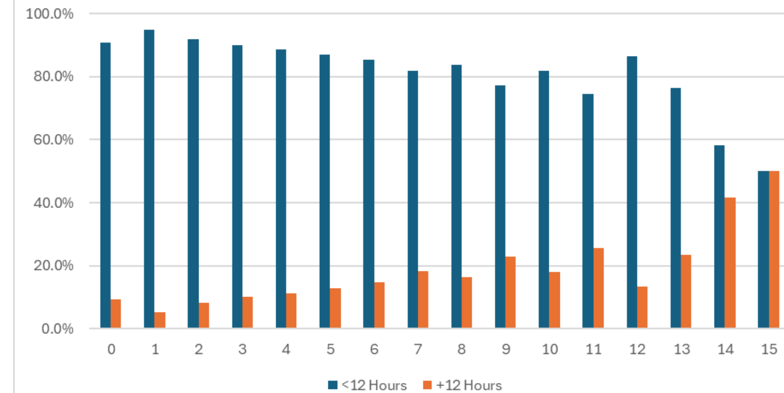
12 Hour Breaches: Discharged Home – General Ill Health

Overall there is a weak correlation between patient's general ill health and waiting times to be discharged home. The graph below shows the count of LTCs – being used as a proxy for general ill health and the % split of those that beached and those that didn't. Some of our more complex patients do wait slightly longer on average, but many more are being seen quickly, and there are patients with a low LTC count who also have longer waiting times.

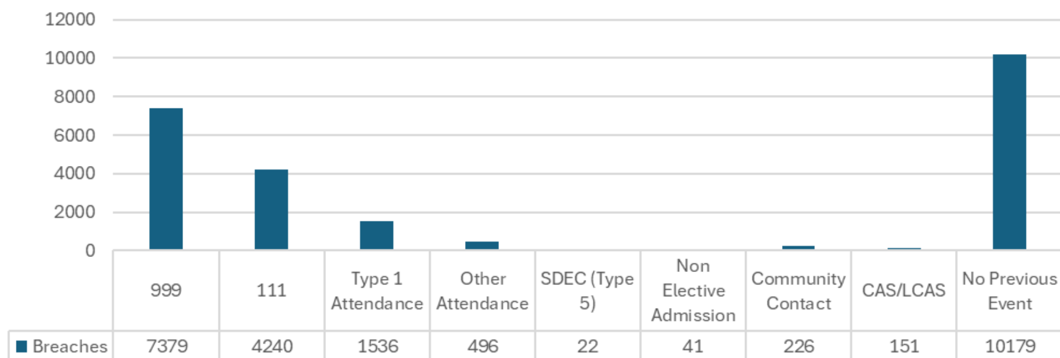
However, there are some discrepancies between sites. The two smaller graphs below show the same data but for MRI – one of the sites with a lower proportion of 12+ hour waiters, and RAE – the site with the highest proportion. At RAE the general ill health of a patient seems to have a higher impact on waiting times than at MRI.

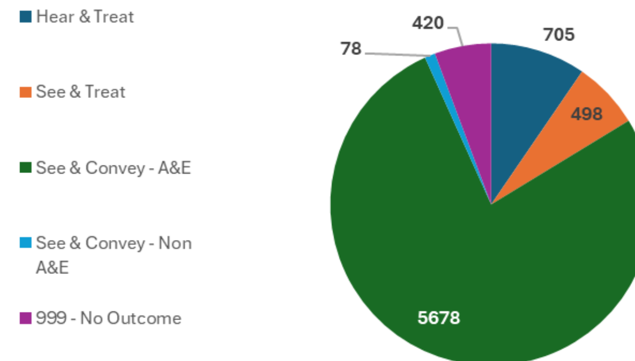


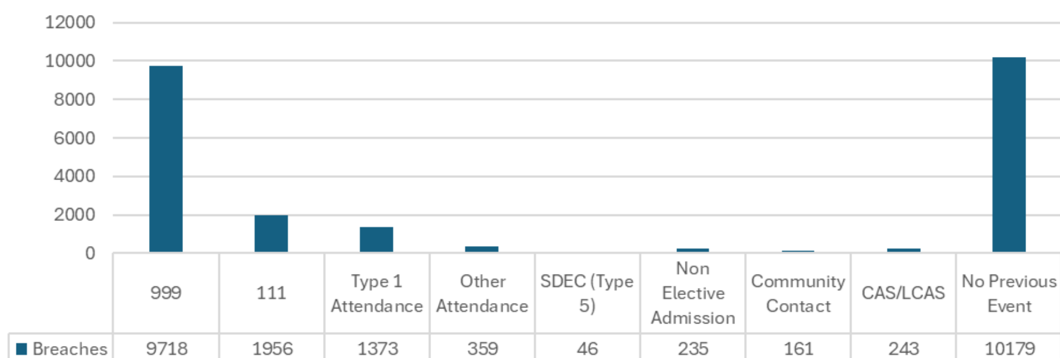


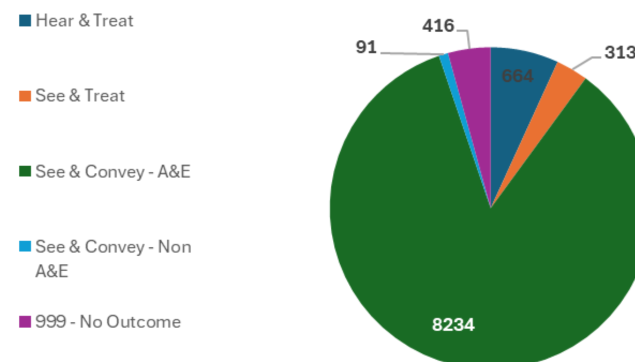


12 Hour Breaches: Discharged Home – Contiguous Events







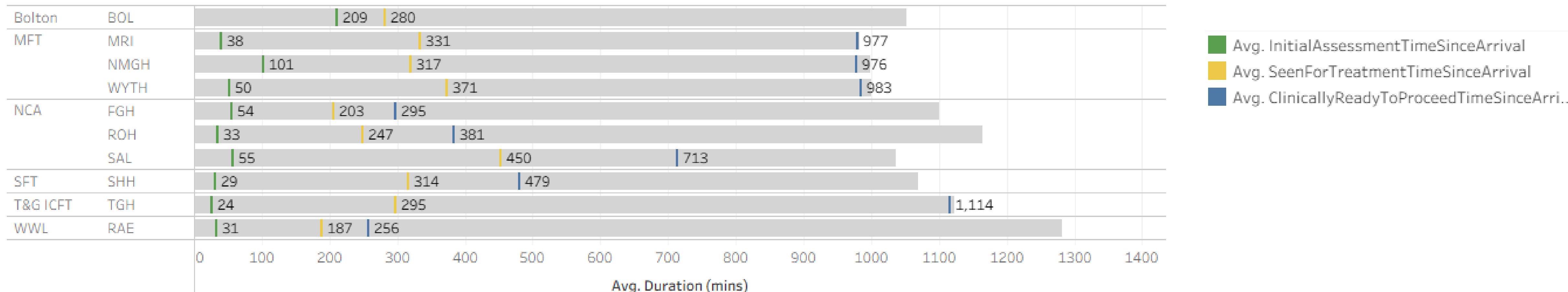


10,179 breaches for discharge home patients have no recorded prior event. For a large proportion of breaches, the initial point of contact is either 999 or 111, with all other routes contributing comparatively little. A similar pattern is observed in activity immediately preceding the breach; however this is more weighted toward 999 activity, suggesting that breaches are largely concentrated among patients with either unknown demand or limited prior interaction within the urgent and emergency care system.

For those patients that had a contact with 111 as their first activity, 13.7% of them was advised to attend an A&E, 29.2% had an outcome of an emergency/urgent ambulance, 26.3% were advised to seek primary care support, all other patients we're advised alternative care or the outcome was unknown.

Within 999 activity, pathways are heavily skewed towards hospital conveyance, with around 77% of first-contact calls resulting in A&E attendance, rising further to 85% in activity immediately before breach events. This indicates that ambulance conveyance is a key driver of system pressure.

12 Hour Breaches: Discharged Home – Bottle Necks



The chart above shows the average total duration for patients who waited over 12 hours in ED and were ultimately discharged home. It also presents the average time spent at key stages of the patient pathway. Attendances exceeding 2,880 minutes (48 hours) have been excluded to reduce the impact of data quality issues.

Across most sites, initial assessment occurs within approximately one hour of arrival. Notable exceptions include Bolton (209 minutes) and North Manchester (101 minutes), where patients wait longer before initial clinical assessment begins.
Time to treatment varies more widely between sites, ranging from 187 minutes (just over 3 hours) at Royal Albert Edward Infirmary to 450 minutes (7.5 hours) at Salford Royal.

The most significant delays occur after patients are seen for treatment. At all sites, the largest component of total waiting time is between the point patients are first treated and when they are clinically ready to proceed, and then onward to discharge. This indicates that downstream processes, rather than initial assessment or treatment initiation, are the primary drivers of extended ED stays for this cohort.

The use of the “clinically ready to proceed” milestone varies between providers, suggesting inconsistency in how this stage is defined and recorded. This limits direct comparability across sites but does not alter the overall finding that delays after treatment decision are the dominant contributor to long waits.

12 Hour Breaches: Discharged Home – Arrival Time

Greater Manchester

The heatmap shows the time and day of arrival for attendances that resulted in a 12-hour wait and were subsequently discharged home. The values represent the total number of breaches, with percentages showing the proportion relative to all attendances at each time point.

A clear pattern is observed, with breaches most concentrated among patients arriving in the late afternoon and evening. This pattern is particularly pronounced on weekdays, especially Mondays, where both the volume and proportion of breaches are highest.

In contrast, overnight and early morning arrivals are associated with substantially lower breach volumes and proportions across all days of the week.

Importantly, the periods with the highest breach volumes also correspond to the highest breach rates, indicating that the pattern is not solely driven by demand volume but reflects increased likelihood of long waits for patients arriving during these peak periods.

Patients arriving in the late afternoon and evening—particularly on weekdays—are materially more likely to experience a 12-hour wait, indicating this period represents a consistent system pressure point rather than simply higher demand.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00:00	120 *(3.0%)*	143 *(3.7%)*	133 *(3.5%)*	144 *(3.9%)*	127 *(3.3%)*	168 *(4.0%)*	151 *(3.5%)*
01:00	113 *(3.5%)*	136 *(4.3%)*	121 *(3.9%)*	116 *(3.7%)*	113 *(3.6%)*	130 *(3.7%)*	132 *(3.5%)*
02:00	55 *(2.1%)*	87 *(3.5%)*	70 *(2.9%)*	83 *(3.3%)*	69 *(2.8%)*	116 *(4.0%)*	83 *(2.7%)*
03:00	62 *(3.0%)*	66 *(3.1%)*	43 *(2.0%)*	58 *(2.7%)*	65 *(3.2%)*	63 *(2.4%)*	72 *(2.7%)*
04:00	37 *(1.8%)*	56 *(2.8%)*	53 *(2.7%)*	35 *(1.8%)*	52 *(2.7%)*	69 *(2.9%)*	59 *(2.4%)*
05:00	33 *(1.6%)*	47 *(2.3%)*	41 *(2.1%)*	38 *(1.9%)*	29 *(1.5%)*	53 *(2.4%)*	56 *(2.4%)*
06:00	40 *(1.9%)*	33 *(1.5%)*	51 *(2.5%)*	28 *(1.4%)*	31 *(1.6%)*	39 *(1.8%)*	38 *(1.7%)*
07:00	36 *(1.2%)*	32 *(1.1%)*	39 *(1.5%)*	23 *(0.9%)*	29 *(1.1%)*	35 *(1.2%)*	39 *(1.4%)*
08:00	49 *(0.9%)*	30 *(0.6%)*	30 *(0.7%)*	34 *(0.7%)*	36 *(0.8%)*	48 *(1.1%)*	62 *(1.5%)*
09:00	70 *(0.8%)*	70 *(0.8%)*	52 *(0.6%)*	68 *(0.9%)*	54 *(0.7%)*	59 *(1.0%)*	56 *(0.9%)*
10:00	111 *(1.0%)*	93 *(0.9%)*	91 *(1.0%)*	73 *(0.8%)*	74 *(0.8%)*	66 *(1.0%)*	85 *(1.2%)*
11:00	118 *(1.0%)*	142 *(1.3%)*	110 *(1.1%)*	107 *(1.1%)*	72 *(0.8%)*	94 *(1.2%)*	90 *(1.2%)*
12:00	147 *(1.3%)*	127 *(1.2%)*	149 *(1.5%)*	113 *(1.1%)*	106 *(1.1%)*	96 *(1.2%)*	105 *(1.3%)*
13:00	164 *(1.5%)*	184 *(1.8%)*	170 *(1.8%)*	134 *(1.4%)*	113 *(1.2%)*	129 *(1.6%)*	133 *(1.6%)*
14:00	193 *(1.9%)*	173 *(1.8%)*	159 *(1.7%)*	141 *(1.5%)*	137 *(1.5%)*	121 *(1.5%)*	146 *(1.8%)*
15:00	256 *(2.6%)*	212 *(2.2%)*	191 *(2.1%)*	155 *(1.8%)*	163 *(1.9%)*	160 *(2.0%)*	158 *(2.0%)*
16:00	292 *(2.8%)*	242 *(2.4%)*	225 *(2.4%)*	197 *(2.1%)*	197 *(2.1%)*	182 *(2.4%)*	189 *(2.6%)*
17:00	342 *(3.2%)*	306 *(3.0%)*	244 *(2.6%)*	250 *(2.6%)*	266 *(2.8%)*	201 *(2.8%)*	195 *(2.7%)*
18:00	366 *(3.7%)*	327 *(3.4%)*	273 *(3.0%)*	249 *(2.8%)*	274 *(3.3%)*	181 *(2.7%)*	216 *(3.0%)*
19:00	370 *(3.7%)*	346 *(3.6%)*	324 *(3.5%)*	305 *(3.4%)*	305 *(3.7%)*	216 *(3.0%)*	218 *(2.8%)*
20:00	457 *(4.9%)*	333 *(3.6%)*	325 *(3.7%)*	330 *(3.9%)*	289 *(3.5%)*	275 *(3.8%)*	249 *(3.2%)*
21:00	371 *(4.7%)*	333 *(4.3%)*	333 *(4.4%)*	264 *(3.5%)*	322 *(4.3%)*	243 *(3.5%)*	231 *(3.3%)*
22:00	283 *(4.3%)*	268 *(4.1%)*	253 *(4.0%)*	235 *(3.7%)*	281 *(4.5%)*	224 *(3.6%)*	190 *(3.2%)*
23:00	209 *(4.2%)*	176 *(3.5%)*	196 *(4.1%)*	192 *(3.9%)*	207 *(4.2%)*	193 *(3.8%)*	169 *(3.4%)*

12 Hour Breaches: Discharged Home – Departure Time

Greater Manchester

The heatmap shows the time and day of departure for attendances that resulted in a 12-hour wait and were discharged home. Values represent the total number of breaches.

There is a clear concentration of discharges occurring between approximately 08:00 and 12:00, with this period accounting for the highest volume of 12-hour breaches across all days of the week.

This reflects the typical progression of long-wait patients through the system, where individuals arriving during peak afternoon and evening periods are subsequently discharged the following morning after exceeding the 12-hour threshold.

The consistency of this pattern across all days suggests that breaches are being “resolved” in a relatively narrow discharge window, rather than being distributed more evenly throughout the day.

This indicates that system flow is constrained overnight, with limited discharge throughput occurring until the following morning, at which point a backlog of long-wait patients is released.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00:00	67	71	55	55	44	52	42
01:00	46	48	66	42	44	53	24
02:00	60	54	54	44	49	35	38
03:00	72	73	56	47	42	31	41
04:00	66	71	58	54	47	44	42
05:00	75	64	76	65	64	50	36
06:00	108	98	86	63	72	52	51
07:00	147	132	102	81	95	53	68
08:00	190	175	178	147	121	94	102
09:00	316	258	246	259	211	176	180
10:00	385	320	322	292	323	256	232
11:00	410	380	368	319	325	276	326
12:00	363	342	283	304	317	308	290
13:00	337	298	264	258	298	281	236
14:00	321	282	258	241	250	264	248
15:00	286	263	254	229	252	251	218
16:00	235	242	218	216	193	204	219
17:00	196	181	183	150	154	183	187
18:00	160	148	134	117	127	151	150
19:00	135	124	124	113	98	86	99
20:00	103	105	85	68	67	93	82
21:00	77	91	55	83	78	44	78
22:00	64	69	71	64	72	53	69
23:00	75	73	80	61	68	71	64

Taken together, these two heatmaps show that patients arriving during afternoon/evening peaks are significantly more likely to breach and are then discharged the following morning, indicating constrained overnight flow and delayed progression through the ED pathway.

NHS Greater Manchester

Patients Admitted

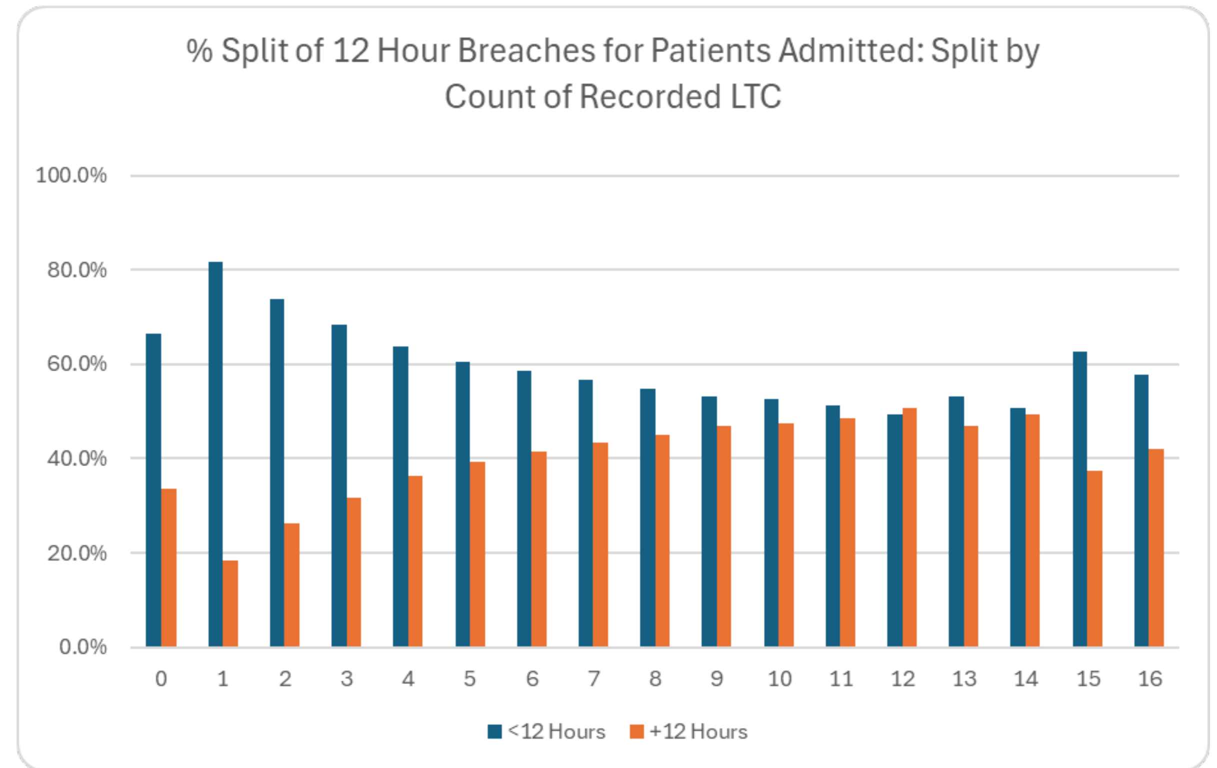
Part of Greater Manchester Integrated Care Partnership

12 Hour Breaches: Admitted – General Ill Health

Overall there is a moderate correlation between patient's general ill health and waiting times to be discharged home. The graph below shows the count of LTCs – being used as a proxy for general ill health and the % split of those that beached and those that didn't.

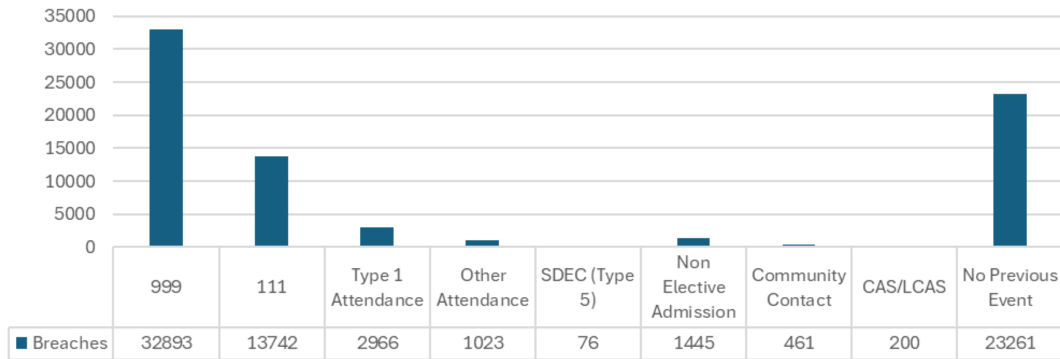
Some of our more complex patients do wait longer on average, but a higher proportion are seen quickly, and there are patients with a low LTC count who also have longer waiting times.

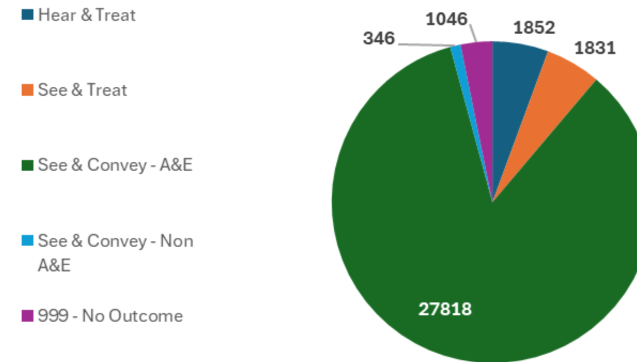
Patient complexity becomes more relevant for admitted patients as there are more likely to require diagnostics, specialist input and complex decision making. However, the relationship between general ill heath and waiting times is not strong suggesting that ill health contributes to waiting time, but does not determine it.

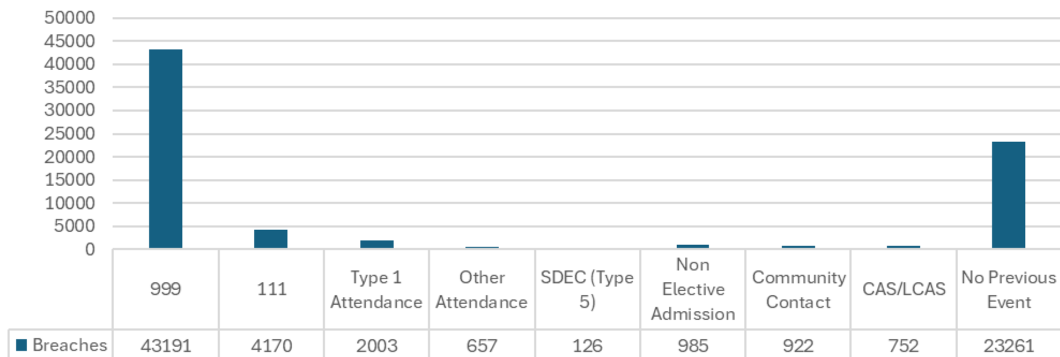


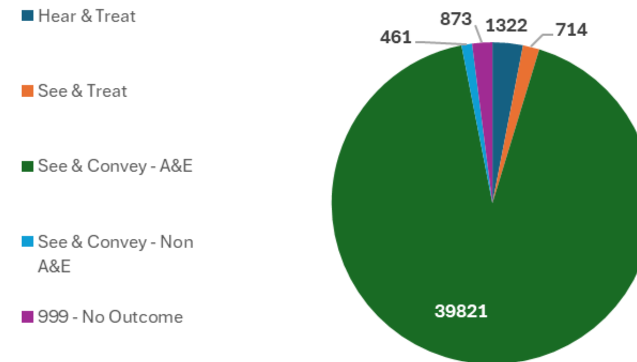
12 Hour Breaches: Admitted – Contiguous Events

Greater Manchester







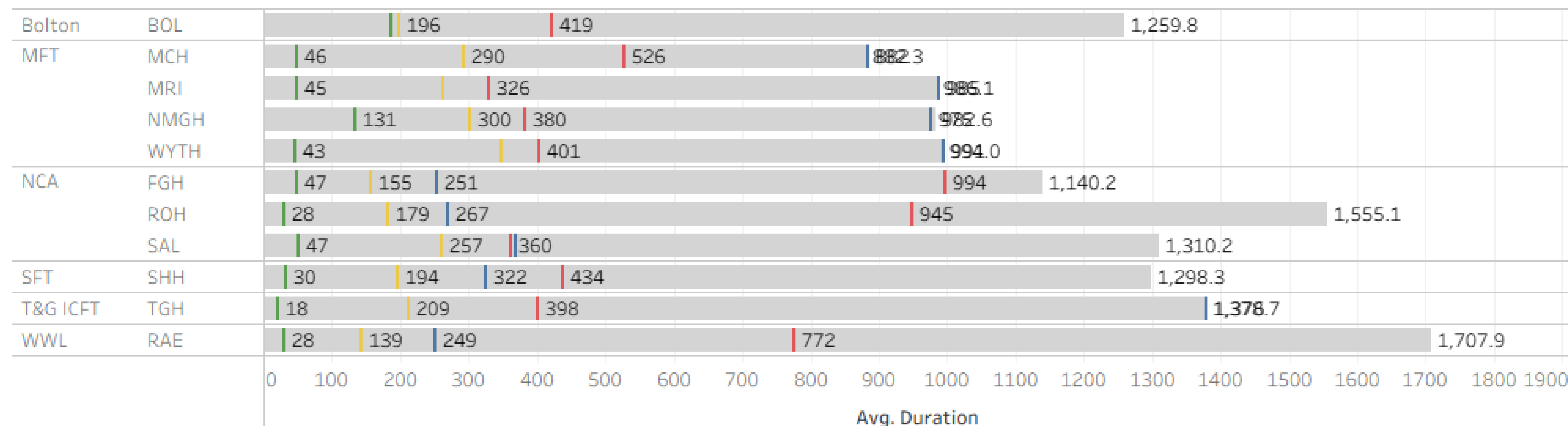


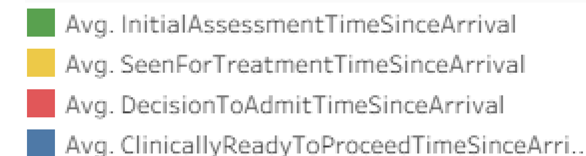
23,261 breaches for admitted patients have no recorded prior event. For the majority of breaches, the initial point of contact is either 999 or 111, with all other routes contributing comparatively little. A similar pattern is observed in activity immediately preceding the breach, suggesting that breaches are largely concentrated among patients with either unknown demand or limited prior interaction within the urgent and emergency care system.

For those patients that had a contact with 111 as their first activity, 8.7% of them was advised to attend an A&E, 40% had an outcome of an emergency/urgent ambulance, 24.5% were advised to seek primary care support, all other patients we're advised alternative care or the outcome was unknown.

Within 999 activity, pathways are heavily skewed towards hospital conveyance, with around 80% of first-contact calls resulting in A&E attendance, rising further to 92% in activity immediately before breach events. This indicates that ambulance conveyance is a key driver of system pressure.

12 Hour Breaches: Admitted – Bottle Necks





The chart above shows the average total duration for patients who waited over 12 hours in ED and were admitted to a ward, ICU or similar. It also presents the average time spent at key stages of the patient pathway. Attendances exceeding 7,200 minutes (5 day) have been excluded to reduce the impact of data quality issues.

Across most sites, initial assessment occurs within approximately one hour of arrival. Notable exceptions include Bolton (185 minutes) and North Manchester (131 minutes), where patients wait longer before initial clinical assessment begins.

Time to treatment varies more widely between sites, ranging from 139 minutes at Royal Albert Edward Infirmary to 344 minutes (~6 hours) at Salford Royal.

For most providers the time between treatment and decision to admit is shorter relative to other stages. However, a small number of sites show longer durations at this stage, including Fairfield, Royal Oldham and Royal Albert Edward Infirmary.

The time between the decision to admit and leaving ED represents the largest component of waiting time for all sites except for Fairfield. Average durations for this stage are substantial, typically several hours and exceed 900 minutes (15 hours) at some sites e.g. Tameside General Hospital. This indicates that downstream processes, rather than initial assessment or treatment initiation, are the primary drivers of extended ED stays for this cohort.

The use of the “clinically ready to proceed” milestone varies between providers, suggesting inconsistency in how this stage is defined and recorded. This limits direct comparability across sites but does not alter the overall finding that delays after treatment decision are the dominant contributor to long waits.

12 Hour Breaches: Admitted– Arrival Time

Greater Manchester

The heatmap shows the time and day of arrival for attendances that resulted in a 12-hour wait and were later admitted. The values represent the total number of breaches, with percentages showing the proportion relative to all attendances at each time point.

Breaches are most concentrated in the late afternoon and evening (approximately 14:00–21:00), where both the number and proportion of breaches are highest across most days. Peak activity is consistently observed between 17:00 and 21:00.

Weekdays, particularly Mondays, show the highest numbers of breaches. Proportions are also elevated at these times, although variation between weekdays and weekends is less pronounced when considering proportions alone.

Overnight and early morning arrivals (00:00–08:00) are associated with lower breach volumes; however, breach proportions remain comparatively high at several time points, indicating that the likelihood of a breach is not confined to peak demand periods

The relationship between attendance volume and breach proportion is not consistent across the day. While higher volumes in the late afternoon and evening coincide with higher breach counts, relatively high breach proportions are also observed at lower-volume times, particularly overnight.

Overall, the pattern indicates that while demand contributes to breach volumes, variation in breach proportions across the day suggests additional operational factors influence the risk of extended waits for admitted patients.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00:00	305 (7.7%)	369 (9.7%)	324 (8.5%)	309 (8.3%)	327 (8.6%)	315 (7.5%)	296 (6.8%)
01:00	288 (8.9%)	345 (10.9%)	280 (9.1%)	297 (9.6%)	288 (9.1%)	263 (7.4%)	301 (8.1%)
02:00	231 (9.0%)	230 (9.2%)	226 (9.2%)	219 (8.7%)	190 (7.7%)	215 (7.4%)	220 (7.1%)
03:00	177 (8.4%)	215 (10.1%)	175 (8.2%)	201 (9.5%)	168 (8.2%)	209 (7.9%)	176 (6.6%)
04:00	181 (8.7%)	209 (10.4%)	174 (8.9%)	175 (9.2%)	152 (7.9%)	167 (7.1%)	197 (8.1%)
05:00	185 (9.0%)	175 (8.6%)	165 (8.4%)	155 (7.6%)	162 (8.4%)	167 (7.5%)	176 (7.4%)
06:00	137 (6.6%)	162 (7.3%)	126 (6.2%)	133 (6.5%)	121 (6.1%)	126 (6.0%)	127 (5.8%)
07:00	157 (5.4%)	152 (5.2%)	135 (5.0%)	120 (4.6%)	101 (3.7%)	132 (4.5%)	136 (5.0%)
08:00	269 (5.2%)	235 (4.9%)	224 (4.9%)	207 (4.5%)	194 (4.2%)	192 (4.6%)	260 (6.2%)
09:00	467 (5.2%)	419 (5.0%)	371 (4.6%)	329 (4.2%)	294 (4.0%)	295 (5.1%)	359 (6.0%)
10:00	581 (5.5%)	535 (5.3%)	496 (5.2%)	418 (4.5%)	422 (4.8%)	357 (5.2%)	444 (6.2%)
11:00	707 (6.2%)	652 (6.0%)	577 (5.6%)	535 (5.3%)	456 (4.8%)	392 (5.2%)	516 (6.7%)
12:00	745 (6.6%)	687 (6.5%)	624 (6.2%)	550 (5.5%)	479 (5.1%)	436 (5.6%)	522 (6.5%)
13:00	797 (7.4%)	771 (7.6%)	654 (6.8%)	589 (6.2%)	538 (5.9%)	484 (6.1%)	633 (7.7%)
14:00	799 (7.8%)	782 (8.0%)	684 (7.3%)	679 (7.4%)	598 (6.8%)	490 (6.1%)	631 (7.9%)
15:00	899 (9.1%)	865 (9.1%)	753 (8.3%)	646 (7.4%)	570 (6.6%)	536 (6.9%)	666 (8.4%)
16:00	989 (9.3%)	875 (8.8%)	806 (8.4%)	779 (8.4%)	628 (6.7%)	531 (7.1%)	571 (7.7%)
17:00	1,092 (10.3%)	917 (9.0%)	931 (9.8%)	772 (8.1%)	743 (7.9%)	560 (7.8%)	703 (9.6%)
18:00	925 (9.3%)	803 (8.4%)	776 (8.5%)	795 (9.0%)	639 (7.7%)	535 (8.0%)	612 (8.6%)
19:00	1,022 (10.3%)	951 (10.0%)	834 (9.0%)	800 (8.9%)	689 (8.4%)	546 (7.7%)	653 (8.4%)
20:00	1,026 (10.9%)	940 (10.1%)	813 (9.3%)	847 (9.9%)	713 (8.8%)	631 (8.6%)	738 (9.6%)
21:00	805 (10.2%)	778 (10.0%)	695 (9.2%)	661 (8.8%)	719 (9.6%)	528 (7.7%)	623 (8.9%)
22:00	675 (10.3%)	605 (9.1%)	520 (8.2%)	586 (9.3%)	552 (8.8%)	461 (7.5%)	473 (8.0%)
23:00	453 (9.2%)	469 (9.3%)	383 (8.0%)	380 (7.8%)	377 (7.6%)	363 (7.1%)	396 (8.0%)

12 Hour Breaches: Admitted– Departure Time

Greater Manchester

The heatmap shows the time and day of departure for attendances that resulted in a 12-hour wait and were admitted. Values represent the total number of breaches.

Departures are concentrated during daytime hours (approximately 08:00–16:00), with the highest volumes consistently observed between 09:00 and 15:00 across all days of the week. Overnight (00:00–06:00), departure volumes are substantially lower across all sites and days

When considered alongside the arrival-time analysis, where breaches are most associated with late afternoon and evening arrivals (approximately 14:00–21:00), this pattern indicates a temporal shift between arrival and departure. The concentration of departures the following morning and early afternoon is consistent with patients breaching the 12-hour threshold overnight after arriving during peak afternoon and evening periods.

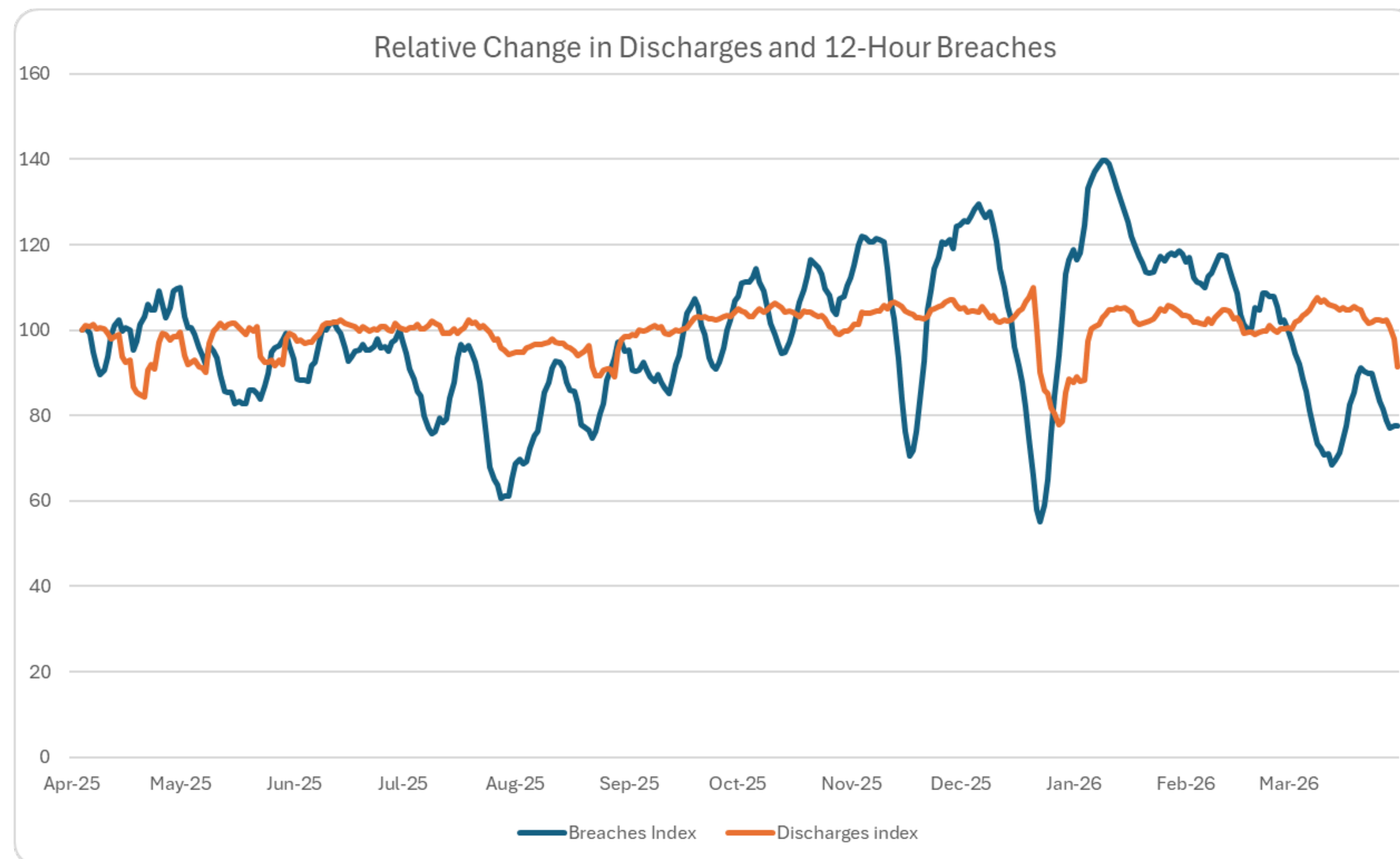
Breaches among admitted patients are most strongly associated with arrivals in the late afternoon and evening, with departures concentrated the following morning and early afternoon. This temporal pattern **suggests delays accumulate overnight**, although the underlying drivers are not directly observable from this analysis

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
00:00	502	515	435	388	421	338	370
01:00	439	382	390	361	408	280	316
02:00	353	356	312	298	322	210	223
03:00	278	302	246	253	277	166	186
04:00	254	222	229	229	268	147	139
05:00	226	211	203	201	216	130	136
06:00	194	179	170	180	176	122	122
07:00	203	208	181	158	195	124	138
08:00	610	533	508	431	278	186	374
09:00	919	865	769	730	419	342	679
10:00	860	781	768	738	461	419	607
11:00	826	739	717	680	579	469	582
12:00	690	730	687	645	616	524	540
13:00	736	725	653	651	558	550	605
14:00	896	863	736	712	709	662	667
15:00	913	862	788	712	679	678	721
16:00	835	813	703	690	678	635	709
17:00	785	690	597	520	558	564	639
18:00	653	636	484	483	458	472	550
19:00	497	483	392	402	379	407	425
20:00	515	448	413	358	315	380	407
21:00	595	532	436	445	377	412	438
22:00	549	525	439	460	384	353	412
23:00	584	541	490	457	389	361	444

12 Hour Breaches: Admitted – reviewing the relationship to discharges

The graph shows the relative change in 12-hour breaches and discharges. This is based on a 7 day rolling average which has then been indexed to 100.

The indexed trend analysis shows only a limited relationship between discharge volumes and 12-hour ED breaches across the full year. While periods of significantly reduced discharge activity — particularly during winter and the Christmas period — are associated with worsening breach performance, breaches display substantially greater volatility than discharge activity overall. This suggests that discharge flow is likely to be an important contributory factor, but insufficient on its own to explain variation in long ED waits.



Understanding indexing: both sets of data are set to a base of 100 e.g. Apr 1st = 100 and all following days show the movement in relation to that. For example a reading of 120 is a 20% increase and 60 is a 40% decrease compared to Apr 1st. This standardises both sets of data on to the same axis and makes any analysis and potential correlation easier to see.

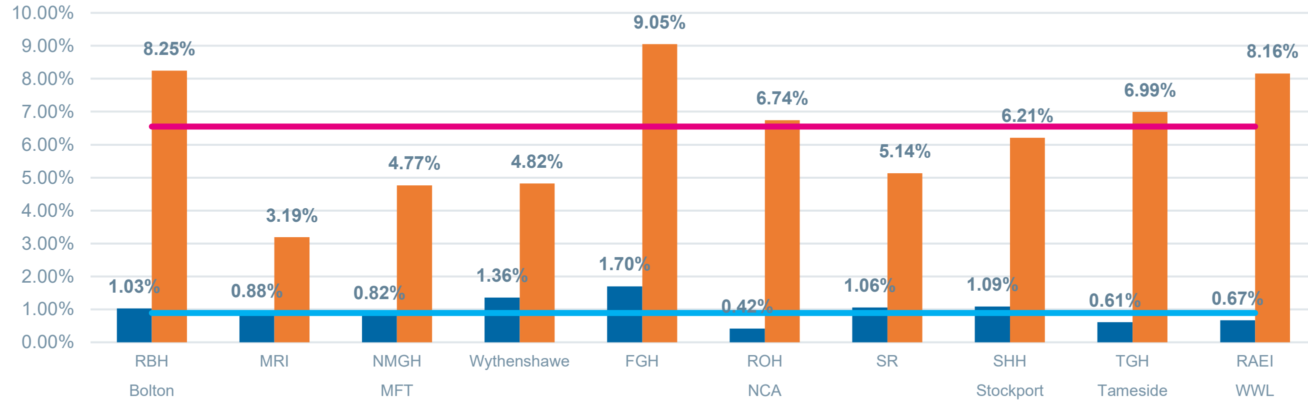
NHS Greater Manchester

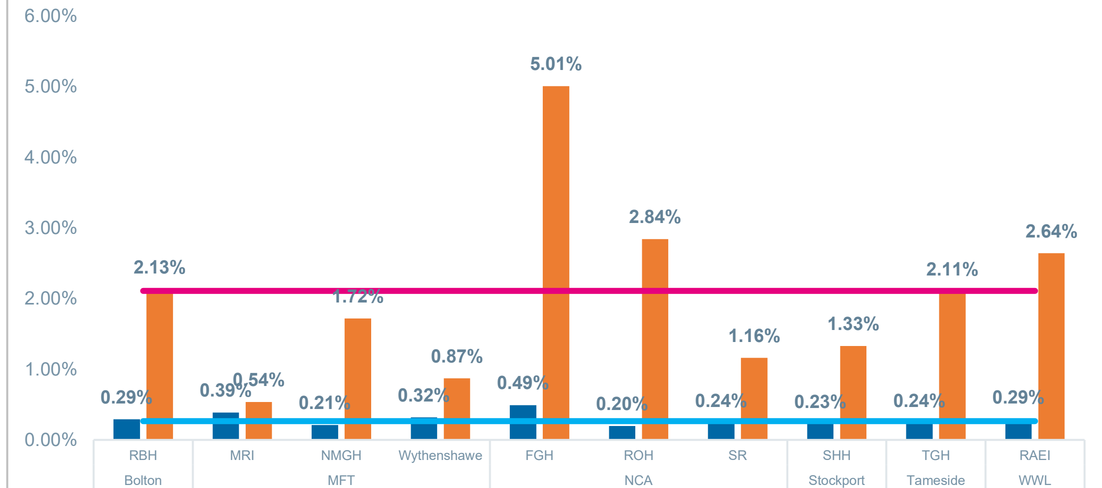
Outcomes following a 12 hour breach

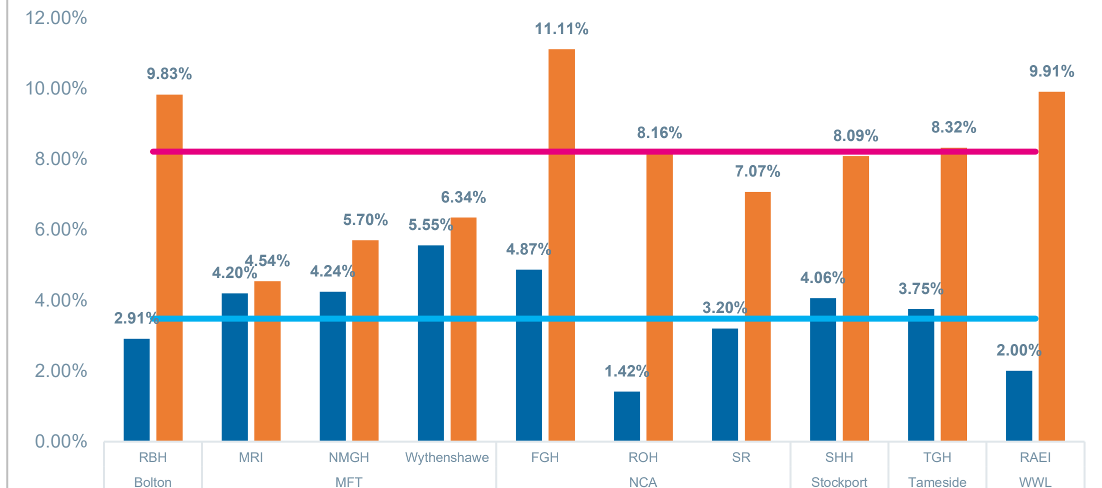
12 Hour Breaches: Deaths with in 30 Days

Under 12 Hours | Over 12 Hours | Under 12 Hours GM | Over 12 Hours GM

Greater Manchester







Patients with ED waits exceeding 12 hours show higher rates of mortality within 30 days compared to those seen within 12 hours. Across Greater Manchester, 6.55% of patients waiting over 12 hours died within 30 days, compared to 0.89% of those seen within 12 hours.

This pattern is observed across provider sites, although mortality rates vary between organisations. Several providers show mortality rates above the Greater Manchester average for patients waiting over 12 hours, while others are closer to or below the average.

Mortality rates are substantially higher among patients who are admitted compared to those discharged home. For admitted patients, 30-day mortality following waits over 12 hours is markedly higher than for those seen within 12 hours, with a similar but lower pattern observed among discharged patients.

The observed differences in mortality between patients waiting over and under **12 hours represent an association and do not, in isolation, indicate causation**. Differences in patient characteristics, including acuity and underlying health status, are likely to contribute to the variation observed.

Overall, the data shows a consistent association between extended waits in ED and higher 30-day mortality, with additional variation between providers suggesting differences in patient cohorts and operational context.

12 Hour Breaches: Points of Contact Between Breach and Death

Greater Manchester

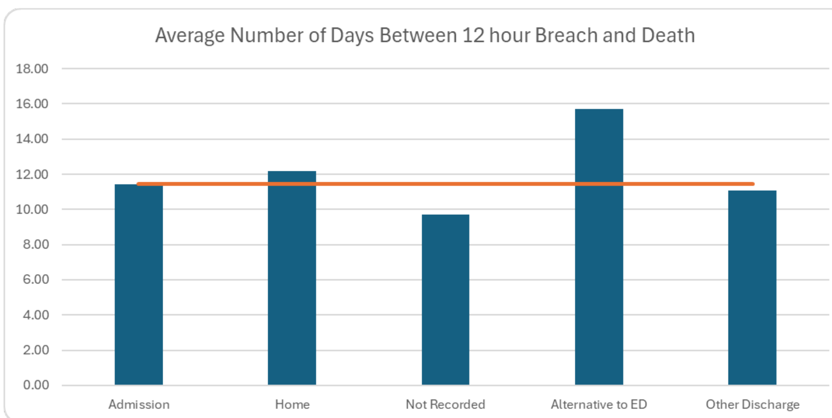
The charts show the average time, number of contacts, and contact rate between a 12-hour breach and death, segmented by discharge destination. Patients who died in the department within 12 hours have been excluded from this analysis.

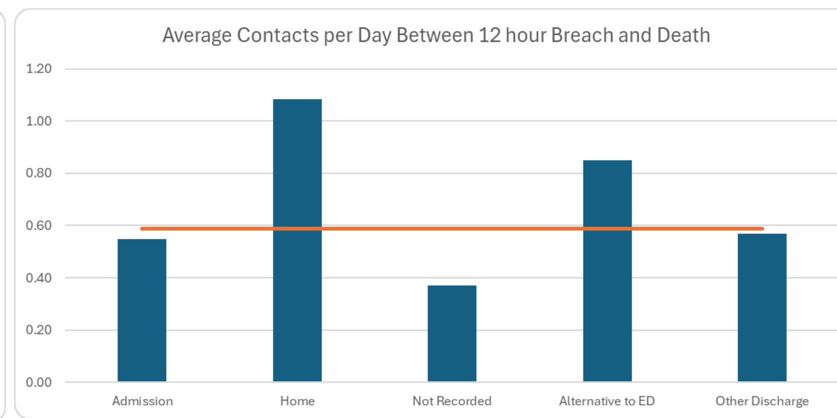
The average time from breach to death ranges from approximately 10 to 16 days across discharge groups. Patients discharged to "Alternative to ED" show the longest average duration, while those in the "Not recorded" category show the shortest.

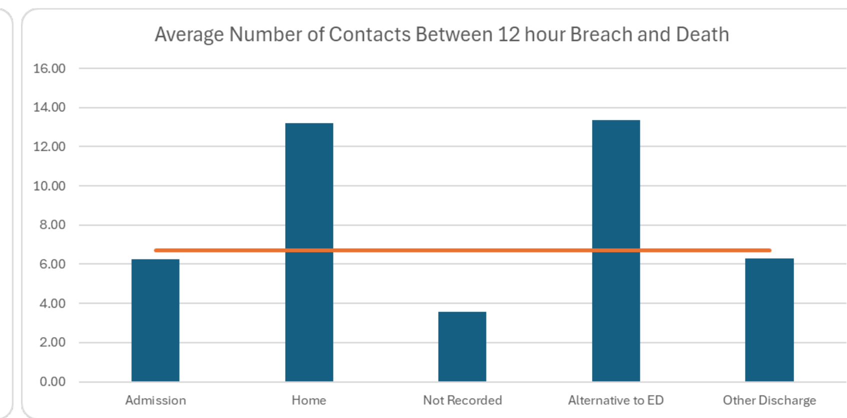
The number of contacts between breach and death varies by discharge destination. Higher average contact volumes are observed for patients discharged to "Home" and "Alternative to ED", while lower contact volumes are observed for patients who were admitted or where discharge destination was not recorded.

When adjusted for time, the rate of contacts per day remains highest for patients discharged to "Home" and lower for other groups, particularly the "Not recorded" category.

These patterns indicate variation in post-breach system interaction across discharge groups. However, the data does not provide information on the nature or purpose of these contacts, and differences should not be interpreted as reflecting quality or effectiveness of care.

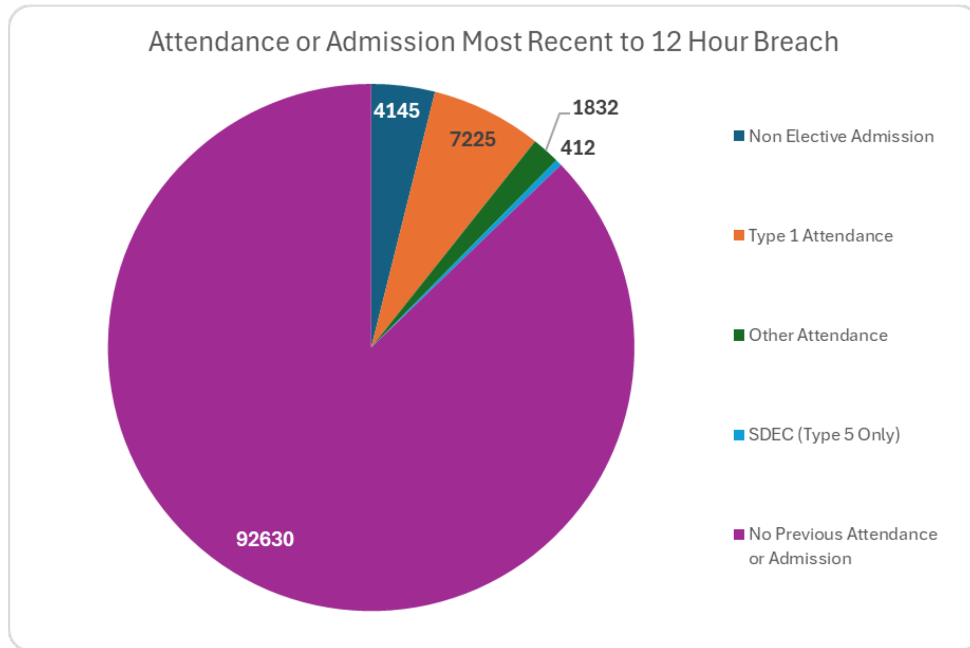






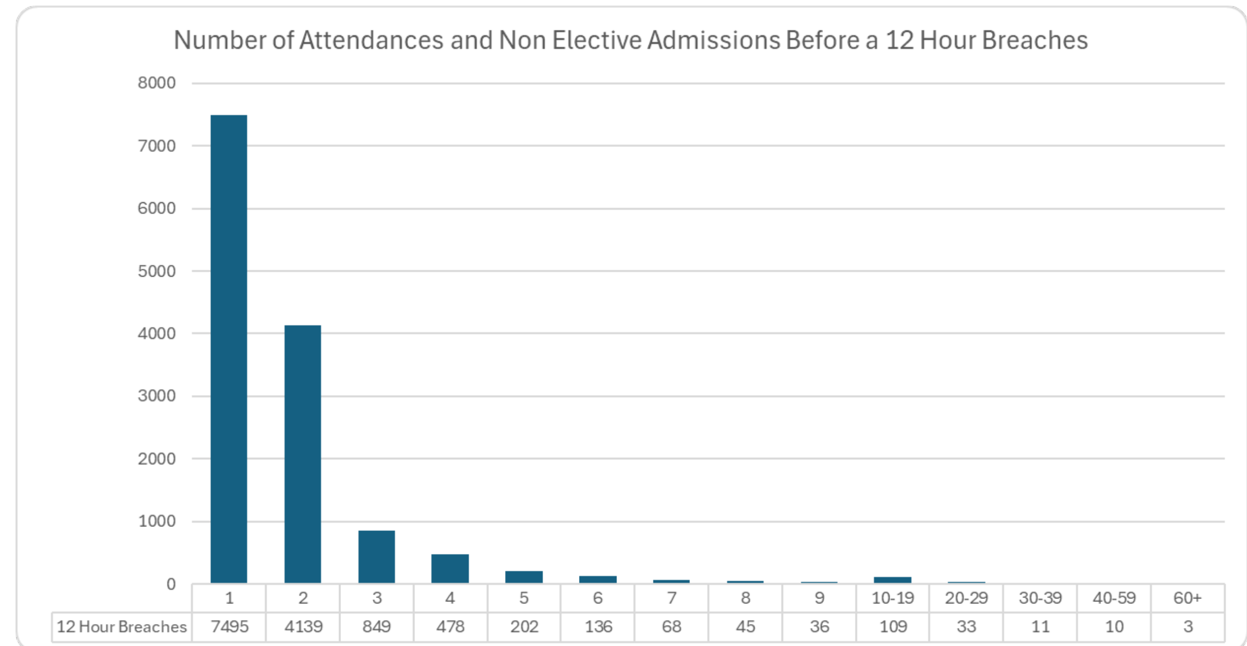
12 Hour Breaches: Breaches Following a Previous UEC Contact

Greater Manchester



12-hour breaches are largely driven by first-time attendances, with 87% (92.6k) having no prior attendance or admission, indicating a front-door demand issue rather than reattendance. Only 13% involve prior system contact, mainly Type 1 ED re-attendance (7%), while non-elective admissions (4%) and SDEC (<1%) contribute minimally. *Note: this analysis only includes attendances and non-elective admissions; patients may have had other activity types before or between the recorded event and the breach.*

The chart to the right shows that 12 hour breaches are concentrated among patients with few prior interactions, with the highest counts at one (7.5k) and two (4.1k) attendances/admissions, followed by a sharp decline thereafter. From three prior contacts onwards, numbers drop rapidly, and cases with higher repeat activity are rare. This indicates that breaches are primarily linked to early-stage system contact.



	1	2	3	4	5	6	7	8	9	10-19	20-29	30-39	40-59	60+
12 Hour Breaches	7495	4139	849	478	202	136	68	45	36	109	33	11	10	3

NHS Greater Manchester

Chief Strategy, People and Partnerships Officer - Alert Report

18th June 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

18th June 2026

Required information	Details
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report
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 Committee regarding key priorities, risks and mitigations relating to; - Live Well - Population Health Transformation - Place Partnerships development - Neighbourhood health plans All programmes are currently on track.
The benefits that the population of Greater Manchester will experience.	Develop and deliver a programme of work to improve health outcomes and enable the left shift towards prevention and care closer to home.
How health inequalities will be reduced in Greater Manchester's communities.	Develop and deliver a programme of work to improve health outcomes for all and further facilitate the left shift towards prevention and care closer to home.
The decision to be made and/or input sought	The SCC is asked to: Note the report
How this supports the delivery of the strategy and mitigates the BAF risks	SR1, SR4 and SR5 by reducing demand drivers, improving resilience in communities, and narrowing inequalities
Key milestones	New model commenced in April 2026 – priorities and associated KPIs to be reviewed.
Leadership and governance arrangements	This paper is produced for this committee and has not been elsewhere.

Engagement* to date ***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

The GM system collectively led our visit from Dr Claire Fuller – the National Lead for Neighbourhood Health – on 11th June. The visit was successful and we will carry out a full debrief to ensure we capture the key learning points. We will receive a summary report from the national team in the coming weeks.

The Population Health transformation programme is on track, and a substantive update report is on the agenda for SCC on 1.7.26.

Alert
Nothing to alert this month
Advise
Nothing to advise this month
Assure
Population Health The Population Health transformation programme is on track, and a substantive update report is on the agenda for SCC on 1.7.26. Delivery has commenced against the GM Public Health Network Action Plan 2026/27 and priority expenditure has been approved through ICB financial governance, which has been focussed on Making Smoking History, Alcohol Harm, Ending New Transmission of HIV, Tackling Poverty as a Driver of Health Inequalities, and Giving Every Child the Best Start in Life. NHS GM ICB Chief Clinical Officer, on behalf of the organisation, signed an open letter accompanying the launch of a new report by Action on Smoking in Health (ASH) focussed-on smoking cessation support for people with common mental health needs, calling for a national plan to reduce smoking that prioritises action on mental health inequalities **Neighbourhood Health** The Neighbourhood Health engagement programme is proceeding according to plan. Engagement sessions have been held with: - ICB Board Strategy Session - Live Well Board - Trust Provider Collaborative - Primary Care Board - Reform Delivery Executive - Extended Leadership Team

- Executive Committee
- Alternative Provider Collaborative
- VCFSE Leadership Group

This has been complemented by online sessions where colleagues from place and other sectors of the GM system have attended. The engagement will culminate at a System Leadership Group on 29th June.

Live Well: A collection of Live Well metrics has now been agreed via the Live Well Board and features in the Place Partnership Outcomes Framework

Place

The Place Partnership Development programme is proceeding according to plan.

The most recent focus of work has been on the Place document suite, which is a set of interrelated documents (including the partnership agreement, governance framework, outcomes framework, place fund, and place team arrangements) that together define how Place Partnerships will operate and deliver their intended outcomes across Greater Manchester.

The current iteration of the Place Partnerships Document Suite was taken to Chief Officers on 20th May and Executive Committee on 10th June for approval to progress to the next phase of development and engagement with key partners and stakeholders, and members were broadly supportive of this.

The agreed next steps are to move into an engagement phase led by Place Leads and Deputy Place Leads, who will lead structured discussions with locality partners through July and August, supported by clear lines of enquiry and feedback mechanisms. This feedback will be collated to produce a finalised version for sign-off by October.

Risks discussed and new risks identified

No risks to escalate this month

Learning for sharing

- Lessons were learnt in the organisation of the national visit and can be shared when similar events are to take place.
- New teams worked well together to pull off a well-organised, successful day.

Population Health: Colleagues at the University of Manchester have published new research focussed on "how to measure the effectiveness of healthcare providers acting as an 'anchor institution': A Case study of the NHS in Greater Manchester" and the findings

are worth considering in context of how we maximise the opportunities afforded by anchor institutions within the GM system.

Achievements

Population Health

On 12/6/26, the GM Public Health Network held the inaugural GMPHN Celebration and Learning Event which brought together the largest ever gathering of GM Public Health professionals (c.250 people) for a day focussed on shared learning and culminated in the first ever GMPHN excellence awards. This is likely to become an annual event and a key mechanism for enhancing the skills and capabilities of the GM Public Health work and strengthening the collaboration across the system.

Neighbourhood Health

Colleagues from across Greater Manchester welcomed Dr Claire Fuller, NHS England's National Medical Director for a constructive and forward-looking visit focused on strengthening neighbourhood health.
We shared our ambition for integrated, community-based care - through our long-standing partnership approach - and shared our strategic plans for delivering more preventative, equitable services.
Discussions explored how our vision for neighbourhood health is being translated into practice, including the role of place partnerships, integrated neighbourhood teams and population health approaches such as BeCCoR.
Colleagues shared real examples of progress in areas including mental health transformation, outpatient redesign and provider collaboration, alongside the challenges of workforce, consistency and scaling impact across all 10 GM places.
Roundtable discussions enabled open dialogue on local delivery, innovation and learning, with a strong emphasis on evaluation and continuous improvement.
The visit concluded with a shared commitment to accelerate progress, build on GM's strong foundations and continue working collaboratively to improve outcomes for local people.

NHS Greater Manchester

Performance Report 2026-2027

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Strategic Commissioning Committee

July 2026

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

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

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

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

NHS
Greater Manchester

Performance and Quality Delivery Report
Strategic Commissioning Committee

July 2026

Part of Greater Manchester
Integrated Care Partnership

Reporting Approach for Strategic Commissioning Committee

Greater Manchester

Purpose of this report

- This report provides a system overview of performance across key NHS standards using the Alert / Advise / Assure (AAA) framework
- Focus is on areas requiring system oversight and delivery improvement

Alert / Advise / Assure (AAA) framework

- Alert – metrics off plan requiring focused system oversight and delivery action
- Advise – metrics requiring continued oversight due to emerging risk or variation
- Assure – metrics broadly on track or stable against plan

Reporting principles

- Reporting is based on latest published data, with in-month intelligence where available
- Narrative is provided for Alert metrics only to support Committee focus
- A consistent set of core metrics is tracked across domains
- Reporting aligns to a consistent system level framework

Application of the AAA framework

- A defined set of core system metrics is used to assess delivery across Urgent & Emergency Care, Elective, Cancer, Diagnostics and Mental Health
- Metrics are categorised as Alert, Advise or Assure based on performance against plan and trajectory
- Detailed metric-level position is summarised within the Executive Summary

Data availability

- Some 26/27 metrics are early in the reporting cycle and data is not yet available for a small number of measures.

Executive Summary

Greater Manchester

Overall position

- System delivery shows early variation against plan across a small number of core metrics
- A focused set of Alert measures require system oversight, with the majority of metrics either stable or improving

Alert (focused system oversight)

- 12-hour waits remain above plan, reflecting ongoing system flow and discharge pressures
- 4-hour A&E performance remains below plan across most providers
- Total waiting list remains above trajectory despite continued reduction
- Reliable recovery and reliable improvement are below plan, indicating ongoing delivery challenge
- Inpatient care for Learning Disability (LD) and autistic adults remains above plan, reflecting continued reliance on inpatient provision

Advise (continued oversight required)

- Out of Area Placements (OAPs) require continued oversight due to ongoing pressure on inpatient capacity and flow
- Faster Diagnosis Standard (FDS) below plan with provider variation

Assure (on track / stable delivery)

- Category 2 ambulance response times within plan
- Referral to Treatment (RTT) 18-week performance is improving and better than plan
- 62-day and 31-day cancer standards remain on trajectory
- Diagnostic waiting times are better than plan, reflecting improved delivery across key modalities
- Community waits improving, though early in reporting cycle

Ask of the committee

Committee is asked to agree the recommended status of partial assurance. This reflects a small number of Alert metrics requiring focused system oversight, alongside stable or improving performance across the majority of metrics. Committee is also asked to agree levels of assurance and delivery risks.

A separate update on system performance against the NHS Oversight Framework (NOF) metrics is provided later in this report.

2026/27 ICB Headline Planning Metrics (SCC oversight)

Greater Manchester

ICB								
Area	KPI	Period	Actual	Plan	Variance (latest **published** data vs same period in previous year)			ICB Benchmarking (latest **published** data)
					2025	Variance	Movement	Apr-26
Elective	Percentage of RTT waiting list within 18 weeks	Apr-26	63.4%	61.9%	54.9%	8.5%	↑	24/36
Elective	Total waiting list	Apr-26	408,510	372,212	430,720	-22,210	↓	
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Apr-26	12.7%	16.9%	13.9%	-1.2%	↓	4/36
Cancer	28-day cancer Faster Diagnosis Standard	Apr-26	77.0%	79.9%	78.7%	-1.7%	↓	16/36
Cancer	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Apr-26	76.8%	74.9%	72.6%	4.2%	↑	6/36
Cancer	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Apr-26	96.1%	93.0%	94.9%	1.2%	↑	4/36
Mental Health	NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness	Apr-26	44.5%	51.0%	48.0%	-3.5%	↓	32/36
Mental Health	NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment	Apr-26	67.0%	69.0%	69.0%	-2.0%	↓	27/36
Mental Health	NHS Talking Therapies: No. completed courses of treatment (YTD)	Apr-26	Not yet available	3,846				
Mental Health	Number of patients accessing Individual Placement Support services (12-month rolling metric)	Apr-26	Not yet available	3,109				
Mental Health	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period	May-26	3	2	19	-16	↓	
Learning Disability and Autism	Inpatient care for Adults with Learning Disabilites (who may also be autistic)	Apr-26	45	42	50	-5	↓	
Learning Disability and Autism	Inpatient care for Autistic Adults (with no learning disability)	Apr-26	55	50	55	0	↔	
Primary Care	Urgent Dental Appointments	Apr-26	Not yet available	20,500				
Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less	Apr-26	85.0%	84.6%	82.9%	2.1%	↑	

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)

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	May-26	00:22:38	<00:25:00	00:20:27	00:02:11	↑
	4-hour A&E performance	May-26	72.3%	73.3%	69.1%	3.2%	↑
	12-hour A&E performance (type 1&2)	May-26	9.8%	7.8%			
Elective	Percentage of RTT waiting list within 18 weeks	Apr-26	61.7%	60.6%	53.6%	8.1%	↑
	Total waiting list	Apr-26	435,293	431,979	474,727	-39,434	↓
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Apr-26	12.3%	13.6%	14.6%	-2.3%	↓
Cancer	28-day cancer Faster Diagnosis Standard	Apr-26	77.0%	80.2%	78.8%	-1.8%	↓
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Apr-26	77.3%	74.8%	73.1%	4.2%	↑
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Apr-26	96.0%	94.0%	95.6%	0.4%	↑

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

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)	Annual metrics 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)	Data not yet available		
	Number of patients accessing Individual Placement Support services (12-month rolling metric)	Data not yet available		
	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			

Greater Manchester

Summary of delivery against NHS Oversight Framework (**NOF)** Metrics - **Q4**

Q4 NHS Oversight Framework (NOF) – Quarterly Update

Greater Manchester

Overall position

- NOF is reported to SCC on a quarterly basis, with this update reflecting Q4 2025/26
- Changes in provider segmentation are seen this quarter, alongside broader improvement in provider performance
- Overall system position reflects positive movement across a number of providers, with some areas requiring continued focus

Current assurance

- Manchester University NHS Foundation Trust (MFT) has improved to Segment 1, reflecting strong performance across key domains, and has moved into the top 20 trusts nationally
- Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) has improved to Segment 3, demonstrating positive progress in performance and domain scores
- Pennine Care NHS FT (PCFT) has deteriorated to Segment 4, indicating areas requiring focused improvement, with key drivers set out on slide 10-13
- Across providers:
    - 2 trusts improved (Manchester University NHS Foundation Trust; Wrightington, Wigan and Leigh NHS Foundation Trust)
    - 1 trust deteriorated (Pennine Care NHS Foundation Trust)
    - 6 trusts remain unchanged in overall segmentation (Bolton NHS Foundation Trust; The Christie NHS Foundation Trust; Northern Care Alliance NHS Foundation Trust; Stockport NHS Foundation Trust; Tameside and Glossop Integrated Care NHS Foundation Trust; Greater Manchester Mental Health NHS Foundation Trust)
- Improvements in average metric scores across the majority of providers indicate wider system progress, despite some variation in segmentation

Next steps

Continued monitoring of provider performance will take place through NOF metrics and internal assurance processes, with a targeted focus on supporting recovery in providers demonstrating deterioration, including Pennine Care NHS Foundation Trust. System oversight will also remain focused on sustaining improvement trajectories in providers demonstrating strong performance, including Manchester University NHS Foundation Trust and Wrightington, Wigan and Leigh NHS Foundation Trust, with a further NOF update to be reported to SCC as part of the next scheduled quarterly cycle.

Provider NOF segment / scores Q1-Q4

Greater Manchester

Trust		Overall Segment	Average Score	Trust Rank	Trust in financial deficit	Domain Segment Scores				
						Access to services	Effectiveness and Experience of Care	Patient Safety	People and Workforce	Finance and Productivity
Bolton NHS Foundation Trust	Q1	3	2.28	59 / 134	Yes	2	3	1	2	4
	Q2	3	2.23	55 / 134	Yes	2	3	1	2	4
	Q3	3	2.45	76 / 134	Yes	2	3	1	3	4
	Q4	3	2.23	63 / 134	Yes	2	3	2	4	2
The Christie NHS Foundation Trust	Q1	1	1.51	3 / 134	No	N/A	1	1	1	2
	Q2	1	1.59	7 / 134	No	N/A	1	1	1	3
	Q3	1	1.36	3 / 134	No	N/A	1	1	1	1
	Q4	1	1.26	2 / 134	No	N/A	1	1	1	1
Manchester University NHS Foundation Trust	Q1	3	2.41	71 / 134	No	3	2	2	4	1
	Q2	3	2.5	85 / 134	Yes	4	1	2	4	2
	Q3	3	2.36	65 / 134	No	3	2	2	4	2
	Q4	1	1.94	19 / 134	No	1	2	2	3	1
Northern Care Alliance	Q1	4	2.81	116 / 134	Yes	4	4	3	4	2
	Q2	4	2.82	112 / 134	Yes	4	3	3	4	3
	Q3	4	2.87	115 / 134	Yes	4	3	3	4	3
	Q4	4	2.72	111 / 134	Yes	4	3	3	4	3
Stockport NHS FoundationTrust	Q1	3	2.48	86 / 134	Yes	3	2	2	3	4
	Q2	3	2.33	62 / 134	Yes	2	3	2	3	2
	Q3	3	2.20	45 / 134	Yes	2	3	2	3	2
	Q4	3	2.09	48 / 134	Yes	2	3	1	3	2
Tameside and Glossop IC NHS Foundation Trust	Q1	3	2.28	59 / 134	Yes	1	3	4	3	3
	Q2	3	2.17	44 / 134	Yes	2	2	4	3	2
	Q3	3	2.09	40 / 134	Yes	2	2	4	3	2
	Q4	3	1.97	43 / 134	Yes	1	1	3	3	2
Wrightington Wigan and Leigh NHS Foundation Trust	Q1	3	2.54	92 / 134	Yes	3	2	3	4	4
	Q2	4	2.86	119 / 134	Yes	3	4	4	3	4
	Q3	4	2.89	117 / 134	Yes	4	4	3	4	4
	Q4	3	2.56	99 / 134	Yes	3	4	3	4	3
Greater Manchester Mental Health NHS FoundationTrust	Q1	5	3.02	58 / 61	Yes	4	4	4	4	2
	Q2	4	2.94	58 / 61	Yes	4	4	4	4	2
	Q3	4	2.99	58 / 61	Yes	4	3	4	4	2
	Q4	4	2.98	56 / 61	Yes	4	4	4	4	1
Pennine Care NHS Foundation Trust	Q1	3	2.41	36 / 61	No	4	3	3	3	1
	Q2	3	2.5	39 / 61	No	4	4	3	3	1
	Q3	3	2.47	40 / 61	No	4	4	3	3	1
	Q4	4	2.67	51 / 61	No	4	3	4	4	1

PCFT deterioration – key drivers (NOF Q4)

NHS Greater Manchester

Pennine Care NHS FT (PCFT) has deteriorated to Segment 4, reflecting a worsening position across key domains, particularly workforce, access and patient safety.

However, a recent CQC inspection (February 2026) has rated the Trust as Good for Well Led (previously Requires Improvement), recognising improvements in leadership, culture and strategic direction (not yet published on the CQC website).

Overall performance

- Segment worsened to 4, with average metric score deteriorating (2.47 → 2.67) and ranking falling (40/61 → 51/61)

Key areas of deterioration

- Access to services, patient safety and people & workforce domains have deteriorated
- Workforce indicators show worsening staff engagement, raising concerns and sickness absence
- Access and patient safety pressures include deterioration in CYP access and 24-hour crisis response

Offsetting movement

- Effectiveness and experience has improved, driven by improvement in long length of stay
- Recent CQC inspection (Feb 2026) rated Well Led as Good (from Requires Improvement), highlighting stronger leadership, culture and focus on improvement

Overall position: deterioration is driven by a small number of key domains, despite improvement in effectiveness and experience, indicating a need for targeted recovery focus

Pennine Care NHS Foundation Trust Specific – Q4

Greater Manchester

- Overall Segment - Changed deteriorated (4)
- Average Metric Score deteriorated from 2.47 to 2.67
- Overall Trust Ranking deteriorated from 40/61 to 51/61
- Financial deficit – remains No

Domain Segments - Movement from Q3

- Effectiveness and experience – 4 to 3
- People and workforce – 3 to 4

Domain Metric Scores – 1 Improved / 3 Deteriorated / 1 No Change

- Access to Services – 2.94 to 3.09
- Effectiveness and experience – 2.71 to 2.42
- Patient Safety – 3.66
- People and Workforce – 2.59 to 3.31
- Finance and Productivity – 1.34

- Metric score change for individual indicators – 5 Deteriorated / 1 Improved / 5 No Change
- Indicator Rankings – 6 Deteriorated / 1 Improved / 4 No Change

Significant change in indicator ranking

- % inpatients with LOS > 60 days – 38 to 24
- Variance year to date to financial plan – 18 to 35
- NHS staff survey - raising concerns sub-score – 22 to 45
- NHS staff survey engagement theme sub- score – 10 to 40

Pennine Care NHS Foundation Trust Specific – Q4

Select a trust

Pennine Care NHS Foundation Trust (RT2)

View the glossary page

Average score

2.67

Higher by 0.20 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

No

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 3

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

51 out of 61

Previous quarter's rank: 40 out of 61

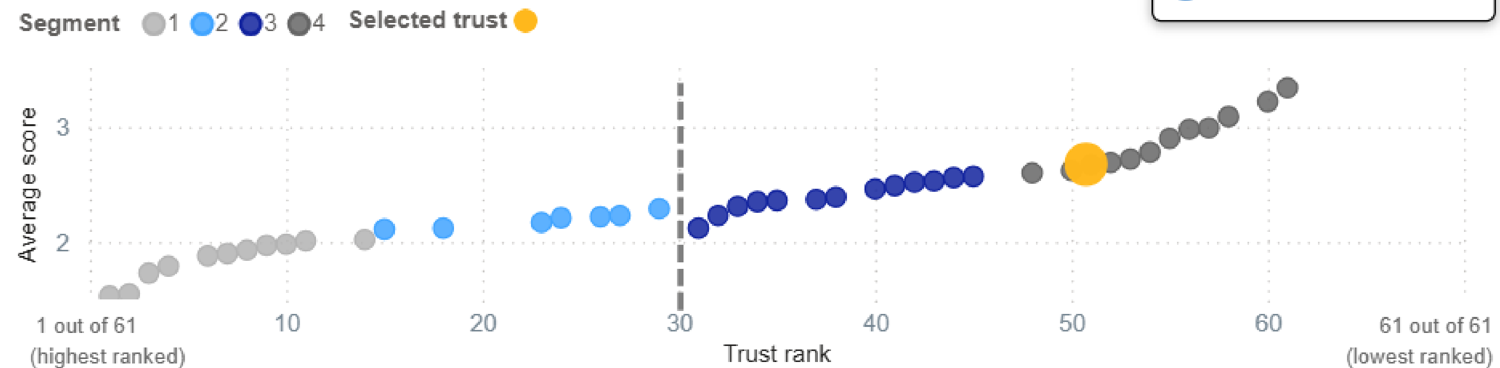
Trusts are ranked first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 61 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Domain	Segment
Access to services	4 - Low performing
Finance and productivity	1 - High performing
Effectiveness and experience	3 - Below average
Patient safety	4 - Low performing
People and workforce	4 - Low performing

Average score by trust rank placement

View full league table



PCFT Specific – Indicator Metric Score Change – Q3 to Q4

Greater Manchester

Change in Metric Score	Improved	Deteriorated	No Change / No Update
Access to services		Annual change in the number of children and young people accessing NHS-funded MH services	
Effectiveness and experience	% of inpatients with >60 day length of stay		CQC community mental health survey satisfaction rate
Finance and productivity			Combined finance
			Planned surplus / deficit
			Variance year to date to financial plan
			Relative difference in costs
Patient safety		NHS staff survey - raising concerns sub-score	
		% of patients in mental health crisis to receive face to face contact within 24 hours	
People and workforce		Sickness absence rate	
		NHS staff survey engagement theme sub- score	

NHS Greater Manchester

Domain Performance – Elective Care & Diagnostics

Domain Performance – Elective Care & Diagnostics

Narrative provided for alerts only

Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• The total waiting list has reduced year-on-year; however, remains above plan, with 4 of 7 providers above trajectory	• Delivery of total waiting list reduction is not consistent across providers, with variation in performance against plan • 4 of 7 providers remain above trajectory, impacting system delivery • Ongoing demand and pathway pressures continue to influence waiting list position • Capacity and flow constraints continue to limit the pace of sustained improvement	• Strengthened system oversight of elective performance, with focused delivery against total waits trajectories • Targeted support to providers above plan, including trajectory review and recovery actions • Continued focus on validation and demand management to improve waiting list accuracy and flow • Use of Independent Sector capacity to support backlog reduction and elective recovery • Ongoing focus on productivity and pathway optimisation across providers	SR2

Elective recovery continues at a system level; however, the total waiting list remains above plan, with variation in delivery across providers. System actions are focused on strengthening oversight, addressing provider variation and improving flow to support delivery of the planned trajectory.

Elective Care system group Actions & Delivery

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

Diagnostic group Actions & Delivery

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Reduce waiting times for Cardiac CT	Diagnostics and Pharmacy Partnership Group	Waiting times reduction for Cardiac CT (a specific GM capacity issue) and CT generally	Comprehensive Capacity and Demand review • Capacity and demand exercise started 1st June • Positive meeting with cardiology leads to improve engagement with cardiology networks	Amber / Green: financial considerations may reduce options
THRIVE implementation and improvement	Diagnostics and Pharmacy Partnership Group	Improvement in key productivity measures: utilisation, late starts, turnaround times, tests, reduction in IS costs	Endo network focus on increasing list capacity (10.5 pts) and patient cancellations Echo – most Trusts now online, monthly meeting set up to drive improvement Sleep and respiratory – workshops held with pilot sites (outliers) to identify network actions – action plans now developed, clear actions to bring greater productivity	**Green**
Did not attend improvement across all modalities	Diagnostics and Pharmacy Partnership Group	Reduction of Did not Attends (DNAs) to maximum 5% for all modalities. Increase in capacity and activity. DM01 improvement.	Meetings completed with all 14 service leads across imaging and endoscopy to review booking processes A best practice presentation and report for imaging has been completed; to be presented at June's DPPG. Meetings with 3 of the 6 audiology teams completed, meetings with the remaining teams to be scheduled. Testing of new trust submission to include additional detail such as cancellations and reasons, attendances and site being completed with NCA	**Green**
Reduce unwarranted Endoscopy referrals	Diagnostics and Pharmacy Partnership Group	Reduce unwarranted referrals by 20% and / or % referrals returned	Right test, right time: Joint working with GM Elective Single Point of Access (SPoA) implementation plan, to map current diagnostics and access and develop common conditions pathways (including triage and re-direction processes). Pathways workshop is scheduled for 24 June.	**Green**
Review of Non Obstetric Ultrasound	Diagnostics and Pharmacy Partnership Group	Reduce acute NOU referrals Improve NOU DM01	Review existing commissioning model and options appraisal Agreement of new commissioning model to inform future Direct Access Diagnostics (DAD) contracts Sonography - Governance has been established, steering group and subgroups due to commence beginning of July • Commissioning meeting taking place 16th June	Amber / Green: financial considerations may reduce options

NHS Greater Manchester

Domain Performance – Urgent and Emergency Care (UEC)

Domain Performance – Urgent and Emergency Care (UEC)

Narrative provided for alerts only

Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• 4-hour and 12-hour waits remain above plan, with 5 of 6 providers remain below plan for 4-hour performance and 2 of 6 for 12-hour waits	• 4-hour performance below plan across the system, reflecting sustained flow challenges and ED pressures • 12-hour waits remain above plan in a subset of providers, reflecting ongoing challenges in flow and timely patient progression • System flow and limited operational headroom continue to constrain improvement across the pathway • Delays in admission, discharge and onward care contribute to extended waits in urgent care pathways • Variation in provider performance is impacting overall system position	• Strengthened system oversight and escalation through UEC governance, with focus on improving ED flow and reducing 4- and 12-hour waits • Targeted support to providers above plan, aligned to areas of greatest pressure • Continued focus on discharge improvement and flow optimisation, including work with community and social care partners • Ongoing system actions to improve patient flow and reduce long waits across urgent care pathways	**SR2**

UEC performance continues to experience system pressure, with 4-hour and 12-hour waits above plan, driven by flow constraints and delays across the pathway. System actions remain focused on improving discharge, optimising flow and reducing long waits across urgent care pathways.

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

Greater Manchester

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

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

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

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

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

NHS Greater Manchester

Domain Performance – Cancer

Domain Performance – Cancer

Narrative provided for alerts only

Greater Manchester

No Alert metrics

- Cancer performance is broadly on track
- 62-day and 31-day standards are above plan and on trajectory
- 28-day Faster Diagnosis Standard (FDS) is below plan and being managed through routine oversight

Cancer Alliance Actions & Delivery

Greater Manchester

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Cancer Faster Diagnosis & Waiting Times Improvement	Greater Manchester Faster Diagnosis, Operational Performance & Treatment Variation Programme Board	Improved 28-day FDS, 31-day & 62-day standards; reduced pathway delays	Targeted provider improvement plans; alliance-wide pathway actions; enhanced breach analysis	**Green –** April published position (GM) FDS = 79.96% 31 = 96.04% 62 = 77.35% FDS under plan – driven by Skin services at NCA, Recovery plan implemented and May forecast improved.
Diagnostics Modernisation – CXR AI (Artificial Intelligence Diagnostics Fund)	As above	Faster diagnosis; improved detection; reduced unnecessary CT demand	Extend AI solution; transition to business as usual commissioning; pathway refinement	**Green**
Multidisciplinary Team Reform & Pathway Efficiency	As above	Faster, more efficient cancer pathways.	MDT process standardisation; escalation protocols; pathway board oversight	**Amber -** Residual risk from variable MDT timeliness and post-MDT delays.
Cancer Workforce Capability (ACCEND)	As above	Improved workforce resilience and consistency across cancer pathways	Provider implementation plans; quarterly reporting; e-Portfolio assurance	**Green**
Cancer Governance & System Assurance	Cancer Alliance / ICB Performance Group	Clear accountability and earlier escalation of cancer risks	Updated terms of reference; escalation framework; alignment with ICB performance oversight	**Green**

NHS Greater Manchester

Domain Performance – Mental Health & Learning Disabilities and Autism

Domain Performance – Mental Health & Learning Disabilities and Autism

Narrative provided for alerts only

Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• Talking Therapies performance is below plan for reliable recovery and reliable improvement • Out of area placements remain above plan • Learning Disability and Autism inpatient numbers remain above plan across both cohorts	• Outcomes remain below plan, indicating continued challenge in improving recovery and improvement rates • Ongoing pressure on mental health bed capacity and discharge flow • Continued reliance on inpatient provision, reflecting challenges in community alternatives and flow	• Targeted work to improve Talking Therapies outcomes and service delivery • Continued focus on reducing inappropriate out of area placements through improved discharge planning and patient flow • Continued system focus on reducing inpatient numbers through strengthened community support and alternatives to admission • Ongoing system oversight through established governance arrangements • Monitoring of emerging performance to support early intervention where delivery is off plan	**SR2**

Mental Health and Learning Disability and Autism performance shows ongoing delivery risk across outcomes, flow and inpatient reliance. Talking Therapies outcomes remain below plan, while out of area placements and inpatient numbers continue to reflect pressure on capacity and discharge pathways. System actions are focused on improving outcomes, reducing reliance on inpatient care and strengthening flow across mental health services.

Mental Health and Learning Disabilities and Autism Group Actions & Delivery

Greater Manchester

System Action / Programme	Oversight (System Board)	Expected Outcome (measurable / directional)	Actions	Delivery Risk / Status
Inpatient care for Autistic Adults (with no learning disability)	Learning Disability & Autism Transforming Care Group	• Reduction in inpatient admissions through community alternatives • Avoidance of admission where clinically appropriate • Reduction of current inpatients to achieve NHSE targets through improved discharge pathways and removal of discharge barriers	• Complete review of all autistic adults currently in inpatient settings and identify discharge barriers by Q3 2026. • Develop and agree a GM autism admission avoidance and crisis response model through the LDA Transforming Care Programme by Q4 2026. • Progress development of community step-down and housing solutions to support discharge and prevent avoidable admissions. • Ensure 100% of autistic adults in inpatient settings are reviewed through Care and Treatment Reviews (CTRs) and Dynamic Support Registers (DSRs) processes with a documented discharge trajectory.	**Red** - Delivery remains dependent on development of community alternatives, housing solutions and step-down capacity. Current inpatient numbers remain above trajectory.
Average Length of Stay in Adult Acute, Older Adult Acute and Psychiatric Intensive Care beds	GM Mental Health Partnership Group (via GM Inpatient Quality Transformation Group)	• Reduce average length of stay from 64.9 days towards the planned trajectory of approximately 57 days. • Improve patient flow and reduce delayed discharges through delivery of Clinically Ready for Discharge (CRFD) and flow improvement plans.	• Deliver locality CRFD reduction plans with a minimum 25% reduction in CRFD patients across GM during 2026/27. • Continue weekly review of long-stay patients, delayed discharges and discharge barriers through GM flow and escalation arrangements. • Deliver provider recovery trajectories to reduce reliance on independent sector placements and improve discharge flow. • Expand utilisation of step-down pathways and community alternatives to support discharge and reduce avoidable bed days. • Monitor delivery through the GM Inpatient Quality Transformation Group with monthly reporting of Length of Stay (LOS), CRFD and lost bed days.	**Red** – Length of stay remains above plan, driven by discharge delays, placement availability and community capacity constraints. Delivery of CRFD reduction plans and flow improvement actions remains critical to achieving recovery.

Appendices: Performance Charts

Note: Charts are included where April data is available.

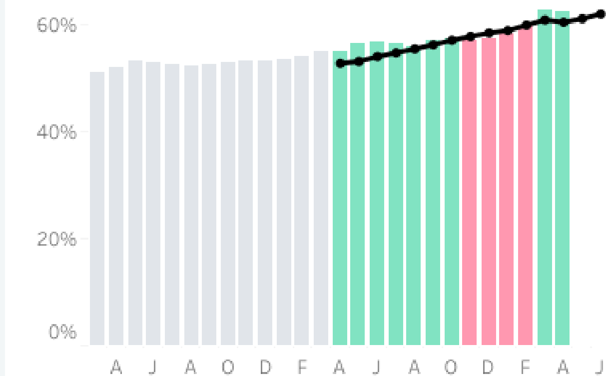
Elective – RTT Incomplete: % within 18 weeks

GM Acute Providers

61.7%

▼-0.51%

Previous 62.2%

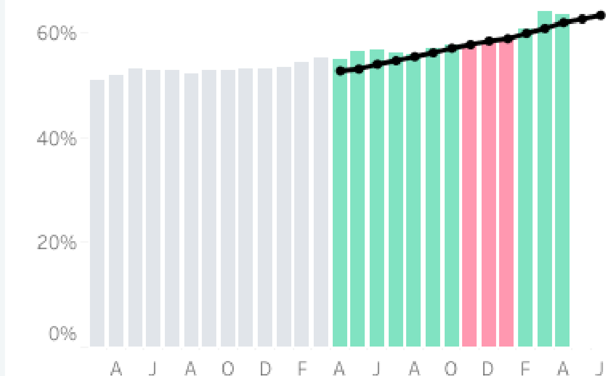


GM Registered

63.4%

▼ -0.4%

Previous 63.8%



Within the 26/27 national planning guidance, one of the priorities is to reduce the proportion of people waiting over 18 weeks for treatment. In April 61.7% of pathways were seen within 18 weeks, exceeding the April plan of 60.6%.

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	54.9%	55.8%	56.9%	57.2%	58.0%	59.1%	59.1%	58.6%	57.4%	57.5%	59.8%	62.1%	60.8%	
	Plan	55.8%	56.2%	56.7%	57.0%	57.5%	57.9%	58.4%	58.7%	59.2%	59.5%	60.0%	60.3%	61.5%	61.7%
MFT	Actual	51.0%	52.4%	53.2%	53.3%	52.7%	53.8%	53.8%	54.1%	56.1%	57.6%	60.0%	63.0%	63.0%	
	Plan	50.3%	50.7%	51.7%	52.7%	53.7%	54.7%	55.6%	56.6%	57.6%	58.6%	59.5%	60.5%	62.1%	62.7%
NCA	Actual	52.4%	54.0%	53.7%	53.6%	52.7%	53.6%	54.2%	53.7%	52.9%	52.4%	54.4%	59.1%	58.3%	
	Plan	52.6%	52.7%	53.3%	54.0%	54.7%	55.3%	56.0%	56.7%	57.3%	57.3%	58.7%	60.0%	55.5%	56.5%
Stockport FT	Actual	55.2%	56.6%	57.1%	56.8%	56.0%	57.0%	57.8%	57.1%	58.4%	59.6%	60.1%	62.1%	61.7%	
	Plan	54.2%	54.4%	56.1%	56.3%	55.9%	56.9%	58.5%	58.8%	58.2%	57.9%	58.9%	60.0%	60.6%	61.0%
T&G ICO FT	Actual	70.8%	71.8%	72.2%	71.6%	70.4%	72.7%	73.7%	73.6%	72.8%	73.3%	74.7%	76.4%	76.6%	
	Plan	68.5%	69.0%	70.1%	70.6%	71.5%	72.0%	72.4%	72.5%	71.6%	71.4%	72.5%	73.3%	77.0%	77.4%
WWL FT	Actual	56.6%	58.2%	57.9%	56.5%	56.5%	57.4%	57.7%	58.4%	57.5%	58.0%	59.0%	61.2%	60.2%	
	Plan	53.0%	53.6%	54.2%	54.9%	55.5%	56.2%	56.8%	57.4%	58.1%	58.7%	59.4%	60.0%	60.6%	61.2%
Christie	Actual	94.6%	94.6%	94.2%	93.6%	94.3%	95.7%	97.1%	97.1%	97.1%	97.5%	97.1%	97.1%	97.0%	
	Plan	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	92.0%	92.0%
GM Acute Providers	Actual	53.6%	55.0%	55.4%	55.2%	54.7%	55.7%	56.1%	56.1%	56.5%	57.1%	59.0%	62.2%	61.7%	
	Plan	52.9%	53.2%	54.1%	54.8%	55.6%	56.3%	57.2%	57.9%	58.5%	59.0%	60.0%	61.0%	60.6%	61.2%
GM Registered	Actual	54.9%	56.3%	56.6%	56.2%	55.8%	57.0%	57.5%	57.4%	57.8%	58.5%	60.7%	63.8%	63.4%	
	Plan	52.7%	53.0%	53.9%	54.6%	55.4%	56.1%	57.0%	57.7%	58.3%	58.8%	59.8%	60.8%	61.9%	62.6%

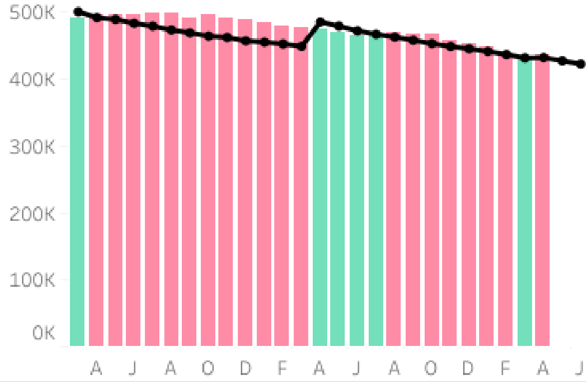
Elective – RTT Incomplete: total waiting list

GM Acute Providers

435,293

▲ 1.2%

Previous 430,171

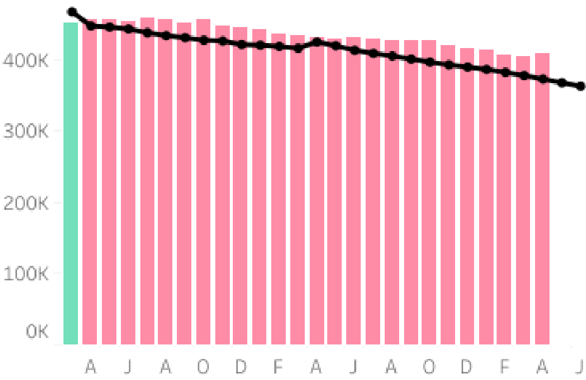


GM Acute Providers

408,510

▲ 1.4%

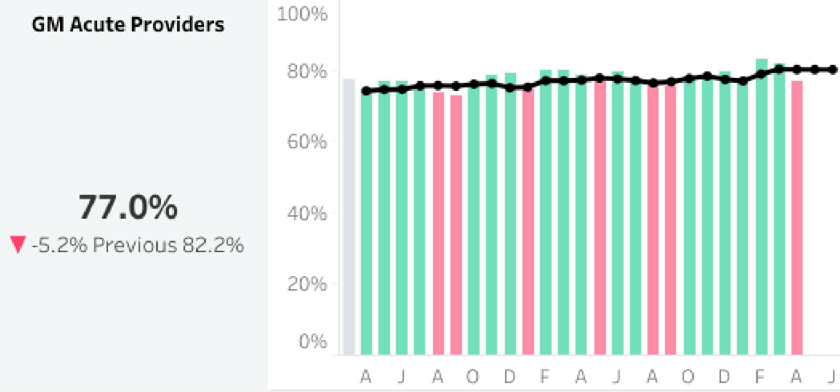
Previous 402,771

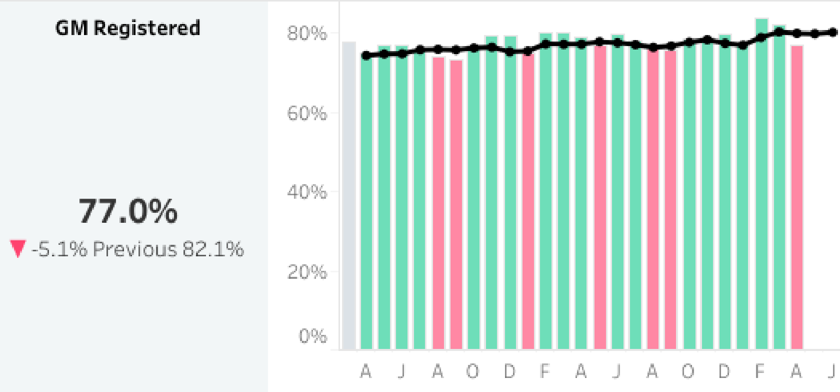


Performance against the RTT total waiting list was 435,293 in May, worse than the plan of 431,979.

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	38,173	37,308	37,252	37,565	37,521	37,555	37,366	37,478	37,532	38,836	37,369	37,849	36,779	
	Plan	39,439	39,126	38,813	38,500	38,187	37,874	37,561	37,248	36,967	36,686	36,405	36,124	36,415	35,113
MFT	Actual	192,230	190,129	186,865	186,088	187,912	185,690	183,865	179,651	178,093	174,556	171,407	165,568	167,994	
	Plan	198,821	195,045	191,270	189,494	187,719	185,944	184,168	182,393	180,617	178,842	177,066	175,291	167,292	165,703
NCA	Actual	138,712	137,853	136,427	137,339	139,016	140,404	140,935	137,786	135,354	134,110	130,603	129,021	132,806	
	Plan	138,022	136,394	134,766	133,138	131,510	129,882	128,254	126,626	124,998	123,370	121,742	120,110	133,000	131,828
Stockport FT	Actual	35,190	34,798	34,356	34,772	35,231	34,954	35,049	34,647	34,556	34,319	34,274	33,981	34,315	
	Plan	36,229	36,046	34,795	33,570	33,361	32,164	30,992	30,452	30,510	30,569	30,029	28,932	33,664	33,569
T&G ICO FT	Actual	17,206	17,152	17,017	17,203	17,096	17,273	17,116	17,009	16,808	16,984	16,400	16,393	16,283	
	Plan	17,530	17,320	17,405	17,321	17,295	17,483	17,482	17,605	17,835	17,723	17,420	17,210	16,749	16,854
WWL FT	Actual	50,409	50,200	49,368	48,840	49,337	48,473	48,514	47,410	46,450	45,540	44,382	44,346	44,088	
	Plan	52,765	52,634	52,503	52,372	52,241	52,110	51,979	51,848	51,717	51,586	51,455	51,324	41,770	41,289
Christie	Actual	2,807	2,834	2,766	2,735	2,700	2,786	3,652	3,525	3,266	3,437	3,248	3,013	3,028	
	Plan	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	3,089	3,089
GM Acute Providers	Actual	474,727	470,274	464,051	464,542	468,813	467,135	466,497	457,506	452,059	447,782	437,683	430,171	435,293	
	Plan	485,379	479,138	472,125	466,968	462,886	458,030	453,009	448,745	445,217	441,349	436,690	431,564	431,979	427,445
GM Registered	Actual	430,720	427,956	429,227	428,230	426,679	425,600	424,909	418,560	414,419	413,376	405,873	402,771	408,510	
	Plan	424,249	418,794	412,665	408,157	404,589	400,345	395,956	392,229	389,145	385,765	381,692	377,212	372,212	367,212

28 Day Wait from Referral to Faster Diagnosis: All Patients



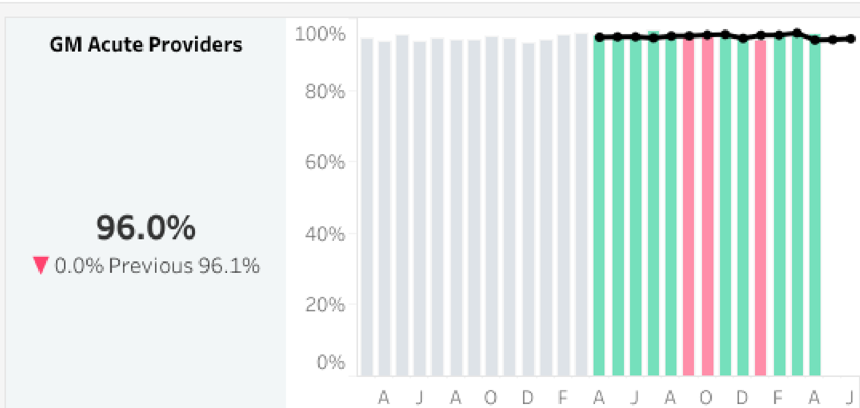


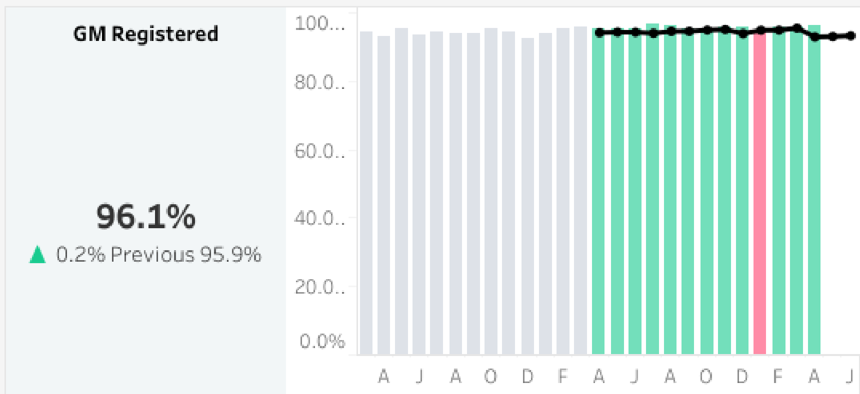
In April, 28-day FDS performance was delivered at 77.0% below the 80.2% plan

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 16th out of 36 nationally.

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	88.4%	89.3%	87.7%	86.8%	84.4%	85.8%	87.0%	87.7%	86.6%	81.0%	84.5%	81.6%	79.6%	
	Plan	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
MFT	Actual	76.3%	75.2%	78.4%	75.3%	73.3%	72.1%	78.1%	80.8%	80.3%	78.7%	84.5%	83.4%	79.1%	
	Plan	76.3%	76.7%	76.7%	77.0%	75.8%	77.4%	78.3%	79.3%	75.4%	75.2%	78.9%	80.7%	80.0%	80.0%
NCA	Actual	74.6%	74.2%	77.7%	76.8%	74.2%	73.1%	74.2%	72.8%	75.7%	73.2%	80.7%	80.1%	68.6%	
	Plan	75.8%	75.7%	75.5%	74.1%	71.9%	71.6%	73.6%	75.6%	76.6%	74.6%	77.3%	80.0%	80.0%	80.0%
Stockport FT	Actual	79.5%	77.6%	80.3%	79.2%	82.4%	83.7%	85.3%	84.7%	82.7%	80.9%	85.1%	84.0%	81.6%	
	Plan	77.0%	77.5%	78.0%	78.0%	78.6%	78.5%	79.0%	79.0%	79.0%	79.0%	79.6%	80.0%	80.9%	80.7%
T&G ICO FT	Actual	85.8%	84.3%	85.2%	84.2%	80.8%	80.3%	80.8%	82.2%	82.5%	80.1%	85.8%	82.5%	81.8%	
	Plan	79.1%	80.0%	80.1%	80.1%	80.3%	80.1%	80.0%	79.0%	78.8%	78.9%	79.8%	80.1%	81.0%	81.0%
WWL FT	Actual	81.5%	76.2%	76.3%	76.5%	75.2%	76.2%	73.6%	71.6%	76.4%	72.8%	84.1%	81.8%	80.8%	
	Plan	78.8%	81.4%	79.7%	78.3%	79.7%	80.2%	80.4%	78.6%	80.5%	81.7%	80.0%	80.2%	80.0%	80.0%
Christie	Actual	94.7%	82.6%	89.3%	84.2%	87.5%	91.7%	94.4%	94.4%	79.5%	80.6%	90.6%	92.5%	100.0%	
	Plan	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.6%	80.6%
GM Acute Providers	Actual	78.8%	77.6%	79.8%	78.2%	76.3%	75.7%	78.3%	78.7%	79.7%	77.2%	83.6%	82.2%	77.0%	
	Plan	77.2%	77.8%	77.5%	77.1%	76.4%	76.7%	77.6%	78.3%	77.4%	76.9%	78.9%	80.3%	80.2%	80.1%
GM Registered	Actual	78.7%	77.0%	79.7%	77.9%	76.1%	75.7%	78.4%	78.8%	79.8%	77.2%	83.6%	82.1%	77.0%	
	Plan	77.2%	77.8%	77.5%	77.1%	76.4%	76.7%	77.6%	78.3%	77.4%	76.9%	78.9%	80.2%	79.9%	79.8%

31 Day Wait from Decision to Treat to Treatment





In April, performance for 31 day wait from decision to treat to treatment for All GM NHS Acute Providers was 96.0%, better than the April plan 94.0%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 4th out of 36 nationally

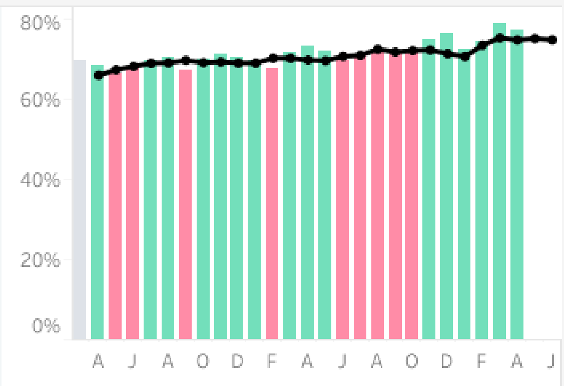
		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	99.3%	96.7%	98.6%	98.1%	96.5%	97.9%	97.4%	100.0%	97.1%	98.7%	99.1%	96.8%	97.6%	
	Plan	96.4%	96.1%	96.7%	96.1%	96.5%	96.7%	96.6%	96.5%	96.5%	96.6%	96.6%	96.7%	96.4%	96.3%
MFT	Actual	88.1%	88.0%	90.2%	89.9%	89.8%	88.3%	89.3%	90.5%	90.6%	86.4%	89.9%	91.0%	90.3%	
	Plan	86.4%	87.8%	89.0%	89.8%	89.7%	91.0%	89.6%	90.5%	87.1%	88.8%	88.6%	90.7%	91.0%	91.2%
NCA	Actual	93.2%	95.6%	92.7%	97.0%	97.6%	96.4%	95.1%	96.0%	94.2%	97.7%	96.9%	97.2%	95.4%	
	Plan	90.6%	90.7%	87.3%	88.2%	90.1%	87.4%	92.9%	93.5%	91.0%	93.6%	94.7%	96.0%	92.8%	93.4%
Stockport FT	Actual	89.2%	88.5%	86.6%	92.7%	87.5%	88.1%	89.3%	93.1%	92.1%	88.0%	90.8%	91.9%	93.2%	
	Plan	92.6%	95.1%	94.5%	92.5%	92.2%	93.9%	94.4%	90.7%	88.9%	91.6%	90.6%	91.3%	89.3%	90.3%
T&G ICO FT	Actual	97.1%	97.3%	98.4%	96.4%	100.0%	95.2%	96.9%	100.0%	97.5%	100.0%	96.4%	98.9%	98.4%	
	Plan	97.4%	97.4%	97.5%	97.3%	97.3%	97.4%	97.3%	97.4%	97.1%	97.3%	97.2%	97.2%	96.9%	94.7%
WWL FT	Actual	94.2%	91.3%	93.5%	92.9%	90.2%	83.2%	87.9%	89.2%	82.5%	75.8%	89.8%	89.2%	87.0%	
	Plan	89.1%	89.1%	89.0%	88.8%	89.1%	88.9%	88.8%	89.1%	89.0%	89.0%	89.1%	88.9%	87.0%	87.6%
Christie	Actual	99.2%	98.7%	98.7%	99.6%	99.1%	98.8%	98.9%	98.6%	99.5%	98.7%	99.1%	99.0%	99.2%	
	Plan	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	96.0%	96.0%
GM Acute Providers	Actual	95.6%	95.1%	95.5%	96.7%	95.9%	95.1%	95.3%	96.0%	95.6%	94.4%	96.0%	96.1%	96.0%	
	Plan	94.9%	95.0%	95.0%	94.6%	95.2%	95.2%	95.5%	95.6%	94.5%	95.4%	95.4%	96.0%	94.0%	94.1%
GM Registered	Actual	95.5%	95.2%	95.6%	96.6%	96.3%	95.1%	95.3%	95.6%	95.7%	94.3%	95.8%	95.9%	96.1%	
	Plan	94.3%	94.4%	94.4%	94.1%	94.7%	94.7%	95.0%	95.2%	94.0%	95.0%	95.0%	95.6%	93.0%	93.1%

62 Day Wait from Referral to First Treatment: All Patients

GM Acute Providers

77.3%

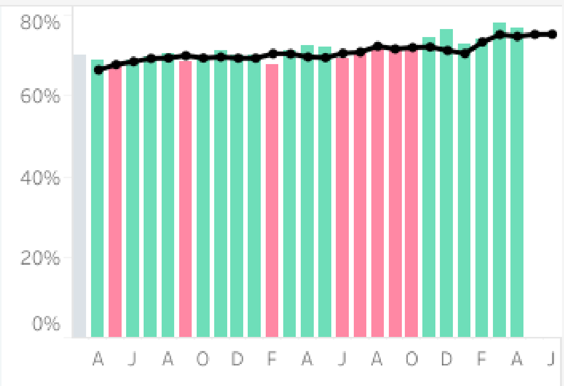
▼ -1.5% Previous 78.8%



GM Registered

76.8%

▼ -1.4% Previous 78.2%



In April, performance for 62-day referral to treatment for All GM NHS Acute Providers was 77.3%, better than the April plan 74.8%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 6th out of 36 nationally

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	87.0%	87.7%	87.3%	83.4%	81.7%	77.4%	80.4%	82.9%	85.4%	79.1%	67.8%	80.4%	83.8%	
	Plan	75.4%	75.2%	75.5%	75.2%	75.5%	75.0%	75.0%	75.0%	75.0%	75.2%	75.2%	75.2%	80.7%	80.5%
MFT	Actual	64.9%	65.5%	61.4%	61.4%	63.1%	62.7%	64.2%	66.2%	73.3%	70.1%	74.0%	76.3%	75.5%	
	Plan	62.4%	63.8%	66.1%	67.2%	68.7%	68.4%	71.8%	69.6%	66.9%	66.3%	71.0%	75.3%	75.6%	76.1%
NCA	Actual	74.0%	71.7%	69.6%	74.4%	74.0%	78.9%	72.8%	78.0%	75.3%	75.7%	73.5%	79.8%	77.9%	
	Plan	69.0%	65.6%	68.9%	68.9%	70.1%	69.4%	68.0%	68.7%	69.6%	68.6%	72.4%	75.0%	72.0%	71.9%
Stockport FT	Actual	71.1%	72.1%	62.6%	70.2%	76.7%	72.1%	83.3%	77.7%	79.6%	79.7%	81.1%	75.9%	74.0%	
	Plan	70.0%	70.2%	70.8%	71.2%	71.7%	72.1%	72.5%	72.6%	72.3%	71.8%	73.0%	75.0%	73.5%	73.0%
T&G ICO FT	Actual	76.6%	80.6%	81.6%	78.6%	79.2%	83.1%	78.9%	78.4%	78.5%	77.4%	82.6%	82.6%	80.4%	
	Plan	75.0%	75.5%	75.0%	76.7%	77.4%	77.8%	76.2%	75.0%	75.8%	75.8%	76.1%	76.3%	78.5%	80.5%
WWL FT	Actual	82.3%	77.1%	73.2%	68.8%	68.7%	66.8%	71.5%	67.2%	67.8%	61.3%	66.1%	79.2%	65.1%	
	Plan	80.3%	81.6%	76.0%	74.6%	81.0%	76.5%	74.0%	81.0%	77.3%	75.3%	78.2%	75.9%	71.2%	72.0%
Christie	Actual	72.3%	68.9%	74.3%	78.1%	77.1%	75.1%	76.5%	85.6%	83.5%	69.0%	81.2%	82.5%	86.3%	
	Plan	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	76.0%	76.0%
GM Acute Providers	Actual	73.1%	72.1%	69.5%	70.9%	71.8%	71.5%	71.8%	74.7%	76.4%	72.4%	74.3%	78.8%	77.3%	
	Plan	69.8%	69.6%	70.7%	71.0%	72.5%	71.8%	72.1%	72.3%	71.4%	70.6%	73.5%	75.3%	74.8%	75.2%
GM Registered	Actual	72.6%	72.2%	69.2%	70.9%	71.8%	71.4%	71.7%	74.7%	76.6%	73.1%	74.0%	78.2%	76.8%	
	Plan	69.8%	69.6%	70.7%	71.0%	72.5%	71.8%	72.1%	72.3%	71.4%	70.6%	73.5%	75.3%	74.9%	75.4%

Diagnostics: % waiting 6 weeks+

GM Acute Providers

12.3%

▲ 2.1% Previous 10.1%

GM Registered

12.7%

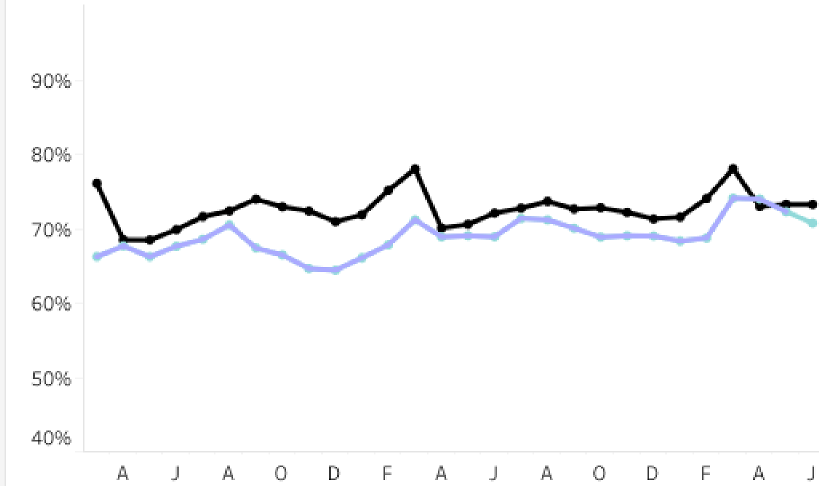
▲ 2.5% Previous 10.2%

In April, the GM Acute Providers' 6-week wait (6ww) performance across all DM01 tests was 12.3%, better than the April plan of 13.6%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 4th out of 36 nationally.

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	10.8%	13.6%	14.8%	17.8%	14.3%	12.7%	6.3%	4.3%	5.0%	3.5%	2.6%	2.6%	10.8%	
	Plan	7.7%	8.0%	8.0%	8.0%	9.0%	9.0%	10.0%	9.0%	10.0%	9.0%	8.0%	5.0%	14.0%	12.4%
MFT	Actual	13.3%	14.2%	13.2%	12.7%	13.9%	13.0%	11.7%	11.9%	13.5%	12.5%	8.2%	7.4%	8.7%	
	Plan	13.2%	12.5%	11.9%	12.9%	13.3%	11.9%	12.0%	10.0%	11.0%	13.0%	7.0%	5.0%	8.6%	8.6%
NCA	Actual	12.8%	10.9%	12.3%	13.4%	17.2%	14.0%	13.2%	12.5%	15.7%	13.8%	10.0%	12.2%	15.7%	
	Plan	1.3%	12.2%	11.4%	10.7%	9.9%	9.1%	8.0%	8.0%	7.0%	7.0%	6.0%	5.0%	17.8%	17.0%
Stockport FT	Actual	27.4%	21.1%	22.0%	22.7%	24.2%	21.3%	18.6%	16.3%	16.1%	16.4%	16.3%	15.2%	16.3%	
	Plan	25.8%	24.5%	24.2%	25.4%	27.6%	25.7%	22.0%	18.0%	15.0%	12.0%	9.0%	5.0%	11.9%	6.1%
T&G ICO FT	Actual	1.6%	3.2%	2.6%	2.7%	1.6%	0.8%	0.6%	0.6%	0.0%	1.1%	0.3%	0.7%	2.1%	
	Plan	1.3%	3.1%	3.9%	3.7%	4.3%	4.4%	4.0%	4.0%	4.0%	5.0%	5.0%	4.0%	3.4%	4.0%
WWL FT	Actual	18.0%	25.0%	30.4%	33.5%	38.6%	37.0%	34.5%	30.6%	35.2%	30.4%	18.9%	18.6%	17.9%	
	Plan	9.9%	9.7%	9.5%	9.2%	9.0%	8.8%	9.0%	8.0%	8.0%	8.0%	8.0%	7.0%	26.6%	24.6%
Christie	Actual	1.7%	1.7%	2.1%	2.6%	3.1%	1.3%	0.6%	0.8%	1.4%	2.6%	3.8%	2.2%	0.9%	
	Plan	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
GM Acute Providers	Actual	14.6%	15.3%	16.1%	17.1%	19.4%	17.5%	15.8%	14.5%	16.6%	14.7%	10.3%	10.1%	12.3%	
	Plan	13.4%	12.9%	12.4%	12.6%	12.7%	11.9%	11.2%	9.9%	9.8%	10.4%	7.1%	5.0%	13.6%	12.5%
GM Registered	Actual	13.9%	14.6%	15.4%	16.3%	18.5%	16.6%	14.8%	13.7%	15.7%	13.9%	10.0%	10.2%	12.7%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	16.9%	15.7%

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



Regional Benchmarking

	Feb 26	Mar 26	Apr 26	May 26
Greater Manchester	68.7%	74.1%	74.0%	72.3%
North West	71.1%	74.9%	74.9%	73.9%
England	73.9%	77.0%	76.9%	75.7%

A&E 4-hour wait performance was 72.3% in May 2026, below the 73.3% target. Performance in June (1–15) has declined further to 70.7%. In April, NHS Greater Manchester Integrated Care Board ranked 27th out of 36 nationally.

		May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	15 Jun
Bolton FT	Actual	70.3%	64.9%	64.8%	64.6%	65.7%	62.1%	61.0%	60.2%	62.2%	63.8%	68.1%	72.4%	68.7%	63.9%
	Plan	72.0%	75.0%	75.0%	76.0%	75.0%	74.0%	74.0%	73.0%	75.0%	77.0%	78.0%	68.0%	72.0%	72.0%
MFT	Actual	71.4%	71.3%	74.3%	72.2%	70.6%	71.7%	72.4%	73.3%	71.6%	72.7%	77.2%	76.9%	74.4%	74.1%
	Plan	72.2%	73.9%	74.6%	75.1%	72.6%	73.0%	71.2%	70.1%	70.1%	73.2%	78.1%	78.0%	78.1%	78.2%
NCA	Actual	68.1%	68.1%	72.0%	72.2%	71.4%	69.4%	68.3%	69.1%	70.3%	69.0%	73.6%	73.8%	74.3%	70.0%
	Plan	69.5%	70.9%	72.3%	73.7%	74.7%	75.3%	75.8%	76.1%	76.6%	76.0%	78.0%	70.0%	70.5%	70.6%
Stockport FT	Actual	65.4%	74.0%	68.0%	69.4%	68.1%	67.1%	69.5%	69.0%	66.3%	69.2%	70.1%	69.1%	67.6%	69.3%
	Plan	64.8%	68.5%	64.9%	68.3%	62.9%	64.9%	65.6%	65.9%	63.5%	67.0%	78.0%	71.3%	71.4%	72.6%
T&G ICO FT	Actual	61.6%	58.8%	63.6%	66.0%	65.1%	61.0%	64.7%	63.9%	60.3%	61.0%	68.9%	65.9%	62.4%	66.3%
	Plan	69.5%	69.3%	71.4%	71.0%	70.6%	68.2%	67.5%	65.6%	65.3%	71.0%	78.0%	67.7%	63.3%	60.5%
WWL FT	Actual	72.2%	71.6%	75.6%	77.0%	74.6%	72.5%	70.8%	66.8%	65.7%	65.0%	78.1%	76.5%	75.5%	72.0%
	Plan	71.4%	72.0%	72.6%	73.3%	74.0%	74.7%	74.0%	71.1%	72.3%	77.4%	78.0%	75.0%	76.0%	77.0%
GM Acute Providers	Actual	69.1%	68.9%	71.4%	71.2%	70.1%	68.9%	69.1%	69.0%	68.3%	68.7%	74.1%	74.0%	72.3%	70.7%
	Plan	70.6%	72.1%	72.7%	73.7%	72.6%	72.8%	72.2%	71.3%	71.6%	74.1%	78.0%	73.0%	73.3%	73.3%
GM Registered	Actual	68.3%	68.0%	70.2%	70.0%	68.9%	67.8%	68.2%	68.1%	67.5%	68.0%	73.4%	73.2%	71.5%	69.8%
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Data up to 1st Jun 26 is published and validated, data onwards is unvalidated.

Number of type 1 & 2 patients spending 12+ hours in an emergency department

GM Acute Providers

8,541

▼ -4.2%

Previous 8,913

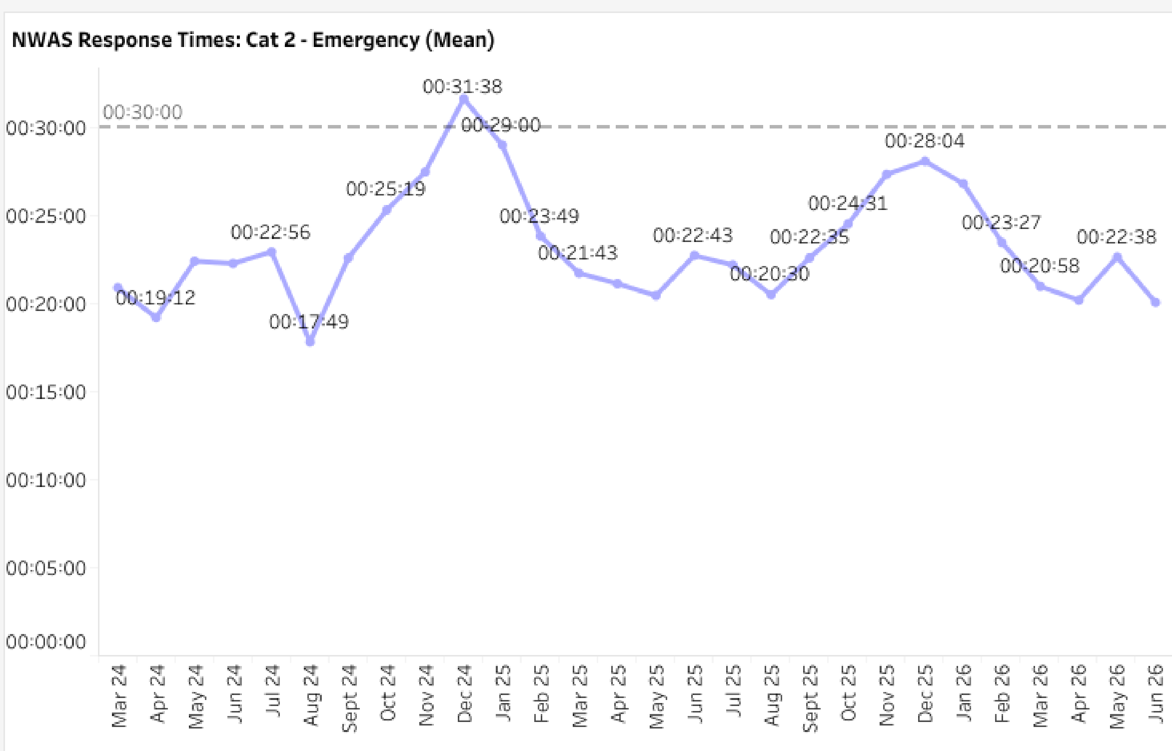
10K
5K
0K

M A M J J A S O N D J F M A M

Performance against the 12-hour emergency care standard was worse than plan in May 2026, with 8,451 Type 1 and 2 patients spending more than 12 hours in the emergency department compared with a plan of 7,216. This represents 9.8% of attendances.

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	991	532	735	779	870	706	987	1,075	1,250	1,242	1,022	919	960	1,077
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	600	250
MFT	Actual	1,815	1,455	1,477	1,106	1,441	1,625	1,675	1,733	1,549	2,267	1,672	1,277	1,232	1,478
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	558	576
NCA	Actual	3,213	3,060	3,243	2,825	2,807	2,987	3,571	3,258	3,179	3,643	2,998	2,786	2,945	2,948
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,293	3,063
Stockport FT	Actual	954	1,077	495	912	644	1,032	1,321	1,174	1,061	1,390	974	930	1,264	913
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	892	964
T&G ICO FT	Actual	863	1,420	1,387	1,061	911	1,140	1,260	1,169	1,305	1,548	1,323	643	1,222	1,095
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	813	1,107
WWL FT	Actual	1,449	1,352	1,335	1,294	1,081	1,269	1,454	1,382	1,509	1,680	1,546	1,343	1,290	1,030
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1,233	1,256
GM Acute Providers	Actual	9,285	8,896	8,672	7,977	7,754	8,759	10,268	9,791	9,853	11,770	9,535	7,898	8,913	8,541
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7,389	7,216
GM Registered	Actual	8,823	8,393	8,225	7,539	7,438	8,318	9,693	9,259	9,357	11,096	8,967	7,545	8,422	8,118
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

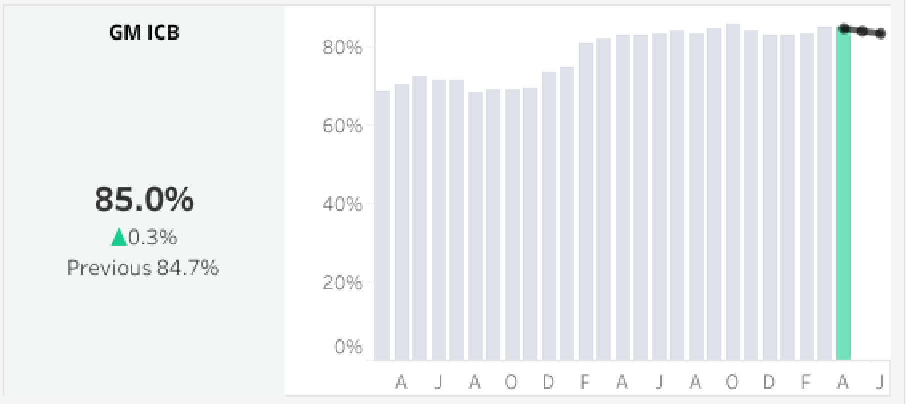
Cat 2 Ambulance Response Times



In May, average Category 2 ambulance response times across Greater Manchester were 21 minutes and 38 seconds, better than plan.

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

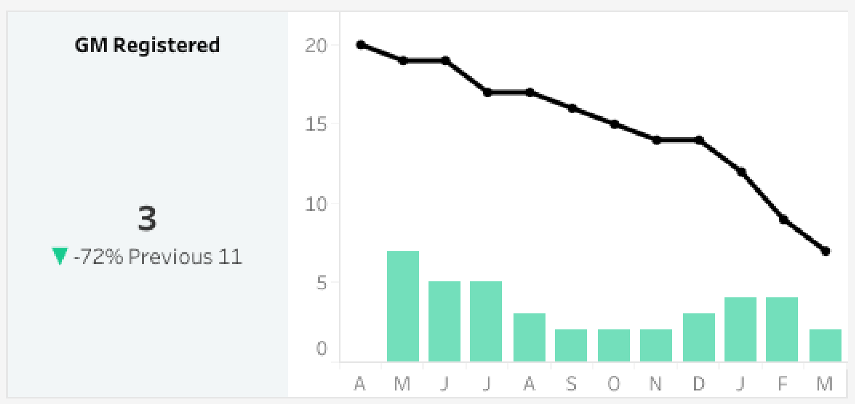
Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less



Performance against the 18-week community waiting time standard was better than plan, with 85.0% of patients waiting over 18 weeks compared with the April plan of 84.6%.

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Bolton FT	Actual	86.9%	89.6%	89.7%	87.1%	85.3%	81.7%	83.4%	81.7%	80.3%	80.6%	81.6%	84.8%	85.8%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90.2%	90.6%
MFT	Actual	80.0%	78.7%	79.7%	81.1%	82.0%	83.4%	82.9%	78.0%	76.4%	75.5%	76.4%	79.3%	79.9%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82.5%	82.6%
NCA	Actual	77.2%	76.2%	78.3%	79.3%	76.6%	79.5%	83.3%	84.0%	82.2%	82.4%	82.3%	83.1%	83.8%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	77.1%	77.2%
Stockport FT	Actual	93.6%	94.9%	95.2%	95.0%	95.1%	96.0%	96.2%	94.9%	94.4%	94.8%	95.3%	97.1%	97.4%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94.2%	94.6%
T&G ICO FT	Actual	98.0%	98.3%	97.9%	97.3%	95.8%	95.8%	96.7%	95.6%	96.1%	95.3%	92.2%	91.0%	89.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94.5%	94.8%
WWL FT	Actual	83.5%	84.3%	84.2%	86.2%	88.4%	88.2%	89.7%	90.7%	91.7%	91.7%	93.1%	92.3%	91.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89.8%	90.2%
GM Registered	Actual	82.9%	82.7%	83.2%	83.9%	83.2%	84.4%	85.8%	84.2%	82.9%	83.0%	83.2%	84.7%	85.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	84.6%	83.9%

Active inappropriate adult acute out of areas placements (OAPs) - local data



		May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
GMMH	Actual	6	3	4	2	1	1	1	2	2	1	1	4	2
	Plan	14	14	13	13	12	12	11	11	10	7	5	2	2
PCFT	Actual	1	2	1	1	1	1	1	1	2	3	1	7	1
	Plan	5	5	4	4	4	3	3	3	2	2	2	0	0
GM Registered	Actual	7	5	5	3	2	2	2	3	4	4	2	11	3
	Plan	19	19	17	17	16	15	14	14	12	9	7	2	2

Performance against active inappropriate adult acute out of area placements was 3 in May, slightly worse than the plan of 2.

Reliable recovery rate for those completing a course of treatment

GM Providers

44.5%

▲ 1.7% Previous 42.8%

GM Registered

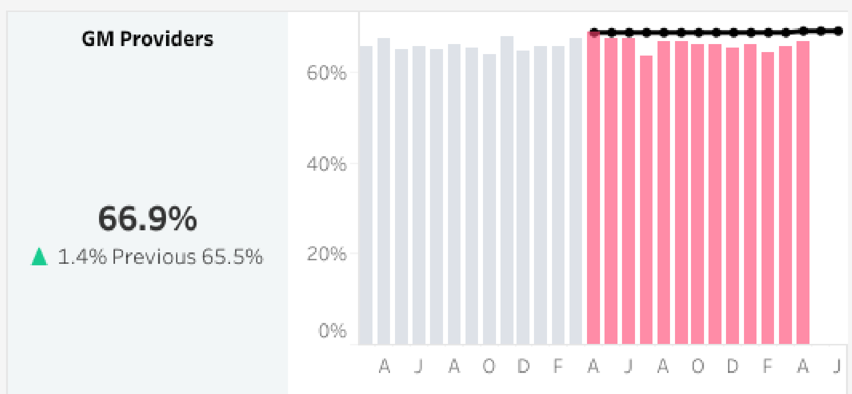
44.5%

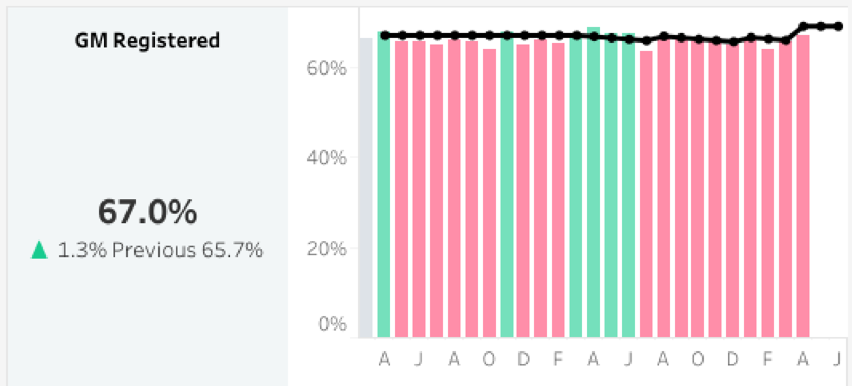
▲ 1.1% Previous 43.5%

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
GMMH	Actual	49.0%	47.0%	47.0%	46.0%	48.0%	45.0%	46.0%	46.0%	42.0%	45.0%	46.0%	43.0%	45.0%	
	Plan	47.8%	47.8%	47.8%	47.8%	47.8%	47.8%	47.8%	47.8%	47.8%	47.8%	47.8%	47.8%	51.1%	51.1%
PCFT	Actual	46.0%	47.0%	49.0%	47.0%	46.0%	47.0%	41.0%	48.0%	47.0%	48.0%	46.0%	50.0%	48.0%	
	Plan	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	51.1%	51.1%
GM Acute Providers	Actual	47.7%	46.3%	46.7%	43.3%	44.7%	43.6%	43.1%	45.3%	42.5%	43.7%	42.6%	42.8%	44.5%	
	Plan	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%	47.9%	51.1%	51.1%
GM Registered	Actual	47.8%	46.6%	46.9%	43.6%	44.9%	43.9%	43.6%	45.3%	42.7%	43.9%	42.4%	43.5%	44.5%	
	Plan	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.0%	48.1%	48.1%	48.1%	47.9%	51.0%	51.0%

Performance against the reliable **recovery** standard was worse than plan, with 44.5% of those completing courses achieving reliable recovery compared with the April plan of 51.1%.

Reliable improvement rate for those completing a course of treatment





		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
GMMH	Actual	72.0%	71.0%	71.0%	71.0%	71.0%	71.0%	70.0%	70.0%	69.0%	69.0%	68.0%	69.0%	70.0%	
	Plan	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	69.8%	69.1%	69.1%
PCFT	Actual	68.0%	66.0%	67.0%	65.0%	67.0%	68.0%	67.0%	69.0%	68.0%	71.0%	69.0%	69.0%	68.0%	
	Plan	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	67.1%	69.1%	69.1%
GM Acute Providers	Actual	68.7%	67.6%	67.4%	63.7%	66.6%	66.6%	66.0%	65.9%	65.2%	66.1%	64.2%	65.5%	66.9%	
	Plan	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	68.8%	69.1%	69.1%
GM Registered	Actual	68.7%	67.3%	67.2%	63.4%	66.3%	66.5%	65.7%	65.9%	64.9%	65.9%	63.9%	65.7%	67.0%	
	Plan	66.8%	66.5%	66.2%	65.9%	66.8%	66.5%	66.2%	65.9%	65.6%	66.6%	66.3%	65.9%	69.0%	69.0%

Performance against the reliable **improvement** standard was worse than plan, with 66.9% of those completing courses achieving reliable improvement compared with the April plan of 69.1%.

NHS Greater Manchester

Population Health Transformation: Update

1st July 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Strategic Commissioning Committee

1st July 2026

Required information.	**Details.**
Title of report.	Population Health Transformation: Update
Author.	David Boulger – Associate Director of Population Health, NHS GM Joanne Street – Transition Programme Director, NHS GM
Presented by.	Charlotte Bailey – Chief Officer: Strategic People and Partnership, NHS GM
Contact for further information.	David Boulger – Associate Director of Population Health, NHS GM. david.boulger@nhs.net
Executive summary.	This report provides an update on the Population Health transformation programme including progress to date and key next steps.
The benefits that the population of Greater Manchester will experience.	The transformation proposals aim to establish a more effective and efficient approach to the delivery of pan-GM prevention and population health programmes which will increase the impact on health outcomes and health inequalities.
How health inequalities will be reduced in Greater Manchester's communities.	The transformation proposals aim to establish a more effective and efficient approach to the delivery of pan-GM prevention and population health programmes which will increase the impact on health outcomes and health inequalities.

The decision to be made and/or input sought.	The NHS GM Strategic Commissioning Committee is asked to: 1. Note the content of the report and the progress made to date 2. Agree to receive the initial s75 for approval in September 2026
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	These proposals will directly impact on BAF Risks SR1 (Population Health Outcomes) and SR5 (Health Inequalities) and will serve as mitigation by maximising the system approach to prevention and public health.
Key milestones.	See sections (4) and (5)
Leadership and governance arrangements.	The SRO for this transformation programme is the NHS GM Chief Officer for Strategy, People and Partnerships. The governance responsibility for Population Health sits with the Strategic Commissioning Committee. The Strategic Commissioning Committee will have responsibility for overseeing the s75 agreement on behalf of the GM Integrated Care Board once it is in place. The Population Health and Neighbourhoods Subgroup will provide oversight of the delivery against the agreement to ensure it is fully aligned to Live Well, Neighbourhood Health and Place Partnership arrangements.

Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	This transformation programme has been under development and implementation for over 12 months and has been subject to extensive system engagement, including an independent review commissioned by the GMPHN which engaged a wide range of system partners. NHS GM Officers have received several updates in relation to this transformation programme
Financial or Legal Implications	This transformation involves NHS GM financial contributions into a pooled budget as described in section 3.3 of this report. NHS GM Finance colleagues are actively involved in the programme and the design of the s75 agreement. This transformation is underpinned by a s75 agreement signed by NHS GM and Manchester City Council (on behalf of the GM Public Health Network). NHS GM Corporate Governance colleagues are actively involved in the programme and the design of the s75 agreement, and appropriate independent legal due diligence will be commissioned on behalf of NHS GM before any approvals are sought. This transformation potentially involves the transfer of NHS GM staff out of the organisation to another employer. NHS GM People Services colleagues are actively involved in the programme and the design of the s75 agreement to ensure that all appropriate steps are taken to manage that process.

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

1. Introduction

1.1 As part of the NHS Greater Manchester (NHSGM) organisational change programme, and based upon a longstanding system ambition, NHSGM is entering into a formal collaborative arrangement with the Greater Manchester Public Health Network (GMPHN).

1.2 This transformational change will bring together the staffing and financial resources of the NHSGM Population Health function and the GMPHN in an integrated team with a pooled budget, working towards a single shared plan and a set of shared ambitions, under the strategic leadership of the locality Directors of Public Health.

1.3 This update report provides more detail on the transformation programme, progression to date, and key next steps.

2. Building from a Position of Strength

2.1 Greater Manchester has a long-standing and nationally recognised approach to prevention, population health and tackling inequalities, built on collaboration between the NHS, Local Authorities and the wider system. These Population Health transformation proposals seek to build on this position of strength by establishing a more integrated operating model between NHSGM and the GMPHN.

2.2 The NHS GM Population Health function has existed since 2017 and has a strong track record of leading or collaborating on high impact pan-GM Population Health programmes and system transformation, including widely recognised programmes such as Make Smoking History; Fast Track Cities: Ending New Transmission of HIV by 2030; GM Moving; Tackling Poverty; Work and Health; and Best Start in Life.

2.3 The GMPHN (https://www.gmphn.com/) is the collaborative network that bring together the 10 Local Authority Directors of Public Health and other key partners to provide system leadership and Public Health expertise across GM. It is a subscription organisation with all 10 LAs contributing annual funding into a shared fund to drive pan-GM activity as a means of supporting locality delivery.

2.4 The proposals do not to duplicate or replace individual local authority public health functions or activity led through place partnerships, but are instead focussed on:

- Strengthening pan-GM delivery of population health activity where it is agreed that scale, consistency and specialist capability add value.
- Enhancing the expert public health input provided to NHSGM (at pan-GM and place levels) to support strategic commissioning, compliance with statutory Public Health functions and the implementation of Neighbourhood Health and Live Well.
- Maximising the impact of programme delivery through collaboration.

- Optimizing the use of staff and financial resources through pooling and integration.

3. Summary of the Transformation Proposals

3.1 Under these proposals NHSGM and Manchester City Council (MCC), on behalf of the GMPHN, will enter into a Section 75 agreement which will underpin the arrangements for:

- Shared priorities, deliverables and outcomes
- Collaborative governance and decision-making arrangements
- A pooled budget
- An integrated team

3.2 The transformation has 3 core phases:

a) **Phase 1:** Interim transitional arrangements in place to enable shared planning, enhanced collaborative working, and joint governance and decision making (1 April 2026 to 30 Sept 2026)

b) **Phase 2:** An initial s75 Agreement covering the creation of a shared outcomes framework, integrated governance and a pooled budget (1 October 2026 onwards)

c) **Phase 3:** An additional s75 Agreement covering the future staffing model, including the potential for NHSGM staff to transfer to an alternative host employer (1 April 2027 onwards)

3.3 The previously agreed minimum NHSGM financial contribution to these proposals is as follows:

2026/27	2027/28	2028/29	2029/30	2030/31
£7million	£8.2million	£8.2million	£8.2million	£8.2million

3.4 This funding will cover programme delivery and the NHSGM staffing costs associated with the integrated team.

3.5 In terms of ICB governance, the Strategic Commissioning Committee will have overarching responsibility for the monitoring of the s75 agreement, with detailed oversight being provided by the emerging Population Health and Neighbourhoods sub group to ensure alignment to Live Well, Neighbourhood Health and Place Partnerships.

4. Progress to Date

4.1 The proposals have been advanced on a formal programme footing since January 2026, initially through a Task and Finish Group jointly chaired by the NHSGM

Transition Programme Director and the Chair of GMPHN, and more recently through a Transformation Programme Board and two Delivery Workstreams focussed on transitional arrangements and s75 development / approval.

4.2 Over this time there has been significant progress made with highlights including:

- Completion of initial staff consultation as part of the wider organisational change process.

- Agreement in principle by Manchester City Council to host the s75 agreement on behalf of the GM Public Health Network.

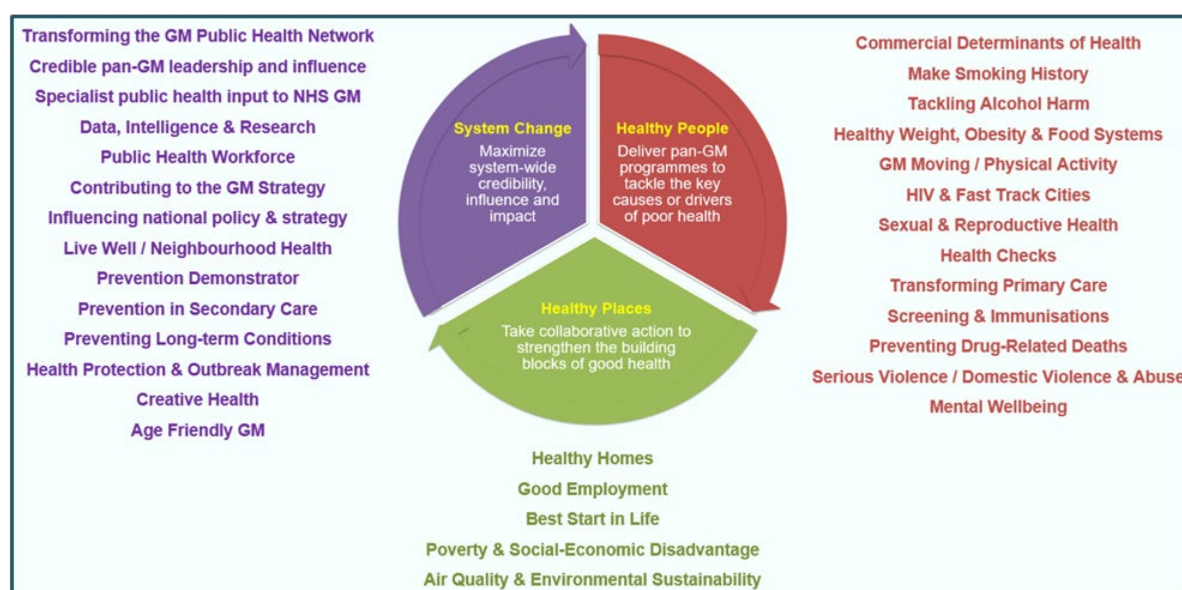
- Agreement to the NHS GM Associate Director of Population also assuming the role of the Programme Director for the GMPHN.

- Refresh of the GMPHN governance arrangements to enhance decision-making and strengthen collaborative working.

- Agreement of a GMPHN Action Plan 2026/27, co-produced by GMPHN and NHS GM and endorsed by NHS GM Chief Officers and commencement of delivery of priority actions, including approval of aligned expenditure.

- Launch of a transitional blended team bringing together the NHSGM and GMPHN staff under a single structure, whilst retaining their existing employers.

4.3 The GMPHN Action Plan for 2026/27 has 3 strategic priorities and a series of priority programmes. A high-level summary of the plan is below, and a full copy of the plan can be provided on request:



5. Key Next Steps

5.1 The two primary focus areas for the next 3 months are ensuring ongoing and impactful programme delivery during the transitional period and co-producing the initial s75 agreement for progression through system governance.

5.2 The s75 will require sign off by the Manchester City Council Executive and the GM Integrated Care Board. To achieve that in advance of 1/10/26 implementation, the following timeline for agreement within NHS GM has been established:

Forum	Paper Deadline	Meeting Date
NHS GM Chief Officers	4/8/26	12/8/26
NHS GM Strategic Commissioning Committee	19/8/26	2/9/26
NHS GM Board	2/9/26	16/9/26

5.3 Key partners and stakeholders from within and outside NHS GM are directly involved in the co-production process and others will be included in reviews and iteration in advance of the proposed final version being progressed into the governance journey set out above.

5.4 The s75 agreement will advance through MCC governance concurrently, with final sign off expected at the MCC Executive on 16/9/26.

6. Recommendations

6.1 The NHS GM Strategic Commissioning Committee is asked to:

- Note the content of the report and the progress made to date
- Agree to receive the initial s75 for approval in September 2026