NHS
Greater Manchester

Agenda

Greater Manchester Strategic Commissioning Committee (Public)

Date: 2 September 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 5 August 2026	Paper	Approval	
Strategic Updates						
4.	14:05 14:15 14:25 14:35	40 mins	Chief Officers Update Reports: • Chief Clinical Officer Report • Chief Commissioning Officer Report • Chief Reform and Improvement Officer Report • Chief Strategy, People and Partnerships Report	Paper	Discussion	Manisha Kumar, *Chief Medical Officer /* Katherine Sheerin, *Chief Commissioning Officer /* Nicola Hepburn, *Acting Chief Reform and Improvement Officer /* Jo Street, *Programme Director-Transition*
5.	14:45	10 mins	Performance Report	Paper	Information	Nicola Hepburn, *Acting Chief Reform and Improvement Officer*
6.	14:55	15 mins	Greater Manchester Health Inequalities Statement 2025/26 - Commissioning Committee update	Paper	Approval	Chris Tyson, *Assistant Director of Intelligence (Place & Strategic Intelligence)*

7.	15:10	10 mins	National Quality Strategy	Verbal	Information	Manisha Kumar, *Chief Medical Officer*
8.	15:30	10 mins	Climate Change Adaptation Plan (CCAP)	Paper	Information	Claire Igoe, *Associate Director of Sustainability and Estates*
9.	15:40	10 mins	SCC Forward Plan	Paper	Information	Dame Sue Bailey *Chair*
For Information						
	15:50	10 mins	Any other business Board Paper Escalations Meeting Reflections	Verbal	Discussion	All
Date and time of next meeting: **Wednesday 7 October 2026, 14:00pm – 16:00pm** **MS Teams**						

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.

Attendees

Where any conflicts arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting.

Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

The Chief Executive should be invited to attend the meeting at least annually.

The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

Quorum

A quorum shall consist of 3 committee members, including The Chair or Vice Chair, and the Chief Clinical Officer or Chief Commissioning Officer (or nominated Clinical Deputy as agreed by the Chair).

Members should attend at least 75% of meetings within any calendar year. Members are expected to nominate a deputy to attend in their absence. Attendance will be monitored and addressed by the Chair, who will be responsible for discussing regular non-attendance with the relevant member. The Chair of the Committee will also be required to bring to the attention of the Chair of NHS GM if they feel that lack of attendance has not enabled adequate discussion or decision making.

Strategic Commissioning Committee Attendance Matrix from April 2026

Key:

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

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

Terms of Reference on a page

NHS Greater Manchester

Purpose

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

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

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

Key duties

Strategic Commissioning

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

Other key duties:

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

Other duties

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

Membership

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

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

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

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

Partner Members	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Vallance, Leigh	Y	Financial interest	Outside employment	CEO of Bolton Hospice which is part funded by an NHS Grant		2023	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	As Chair of Bolton CVS, (a voluntary sector infrastructure body) who are in receipt of NHS funding		Ongoing	

NHS
Greater Manchester

Minutes

Greater Manchester Strategic Commissioning Committee

Date: 5 August 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Rachel Egan (RE) – Non-Executive Director (Deputy Chair) Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Leigh Vallance (LV) – VCSE Partner Member Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Prof. Manisha Kumar (MK) – Chief Clinical Officer Kathy Roe (KR) - Chief Finance Officer Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer Sarah Owen (SOw) - Associate Director of Nursing Safeguarding (item 4) David Boulger (DB) - Associate Director - Population Health (item 6) Rachael Nielsen (RN) - Strategic Lead – Population Health (item 6) Sarah Owen (SO) - Associate Director of Maternity Assurance (ICB/LMNS) (item 7) Sam Evans (SE) - Corporate Director of Finance – Commissioning & Financial Assurance Adam Shipp (AS) – Clinical Director for Womens and Children Faye Vaughan (FV) – Governance Advisor (Minutes)	Dame Sue Bailey (SB) – Non-Executive Director (Chair)

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

	The minutes were accepted as a true record of the previous meeting held on 1 July 2026, subject to a minor amendment raised.	
4.	**Chief Officers Update Reports:** <u>Chief Clinical Officer Report:</u> The Chief Clinical Officer Report provided an update on key clinical governance, quality, patient safety, medicines optimisation, maternity & neonatal oversight, major trauma transformation, child health information services and wider system improvement matters across Greater Manchester. It set out areas that required attention through the Alert, Advise and Assure framework, including NHS England draft enforcement undertakings for Northern Care Alliance NHS Foundation Trust, continued quality and safety oversight of Greater Manchester Mental Health NHS Foundation Trust, system pressures affecting quality & patient safety, national maternity & neonatal reviews and Maternity Outcomes Signal System notifications. The report also provided assurance on the Child Health Information Service transition arrangements, maternity & neonatal board development work, learning from the Greater Manchester Inclusive Research Network, provider achievements reported through Quality Review Meetings and items considered by the Clinical Effectiveness & Governance Committee that required committee approval, noting or endorsement. MK reported on the main alerts in the report: - Northern Care Alliance Legal Undertakings: It was explained that there were daily conversations with the Northern Care Alliance through nursing and medical leads, as well as with NHS England, to ensure safety, quality oversight and improvement was in line with the new provider oversight framework. Further details would be brought back to the committee. - Laureate House Service Disruption and Patient Safety Impact: MK reported progress on repairs at Laureate House, with a planned rebuild and phased opening of units by December 2026. The committee noted the recent change in leadership at GMMH. - Impact on Mental Health Bed Provision: It was reported that 56 beds were closed, leading to increased local spot placements and higher costs. It was stated that out-of-area placements had not increased. Assurance was provided that the team were working to ensure alternative provision was safe and suitable, with daily oversight of delayed patients. The committee approved and supported the recommendations from the Clinical Effectiveness and Governance (CEG) report. **The Committee:** • **Noted the contents of the report.** • **Approved the items within the report that require Committee approval.** • **Noted the remaining items progressed through established governance routes.** <u>NHS GM Safeguarding Adult Board and Childrens Partnership Annual Reports 2025/26</u> The report provided two GM Safeguarding Children Partnership and Safeguarding Adults Board Annual Reports 2025/26, within the ICB's statutory safeguarding governance arrangements.	

	SO presented the first iteration of the annual safeguarding reports. It was explained that one adult and one children's report were submitted, with recommendations to note and approve the childrens report for Department of Education submission. MK highlighted the establishment of a new Safeguarding Accountability Group post-reform, providing clear statutory oversight. It was explained that the following year, guidance would be issued to align report deadlines and ensure earlier committee sign-off. **The Committee:** • **Approved the submitted annual reports for publication and/or submission, as applicable.** <u>Chief Commissioning Officer Report:</u> The paper set out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. KS reported ongoing quality issues in specialised services, with active work on mutual aid across the Northwest to manage patient care and performance, especially in gynaecology, neurosurgery and spinal services. It was noted that it was the third month of primary care collective action. KS explained a new shared care arrangements and weekly position statements that had been introduced, with oversight and risk mitigation fed to NHS Northwest. MK informed the committee of a clinical workshop that had taken place which involved over 35 clinicians, including air ambulance and pre-hospital pathway teams which had resulted in an agreement on revised pre-hospital and supplementary pathways. It was confirmed that there were plans for further collaboration in research, innovation and quality assurance. KS updated on the cardiac and vascular service change programme, noting a 12-week consultation period. The committee were also made aware of the positive GP patient survey results for Greater Manchester. MK explained the importance of data sharing for quality improvement in primary care, with some practices expressing discomfort. It was confirmed that digital facilitators were working with these practices to address concerns. **The Committee:** • **Noted the report.** <u>Chief Reform and Improvement Officer Report:</u> The report highlighted the key areas of assurance and oversight from the Reform & Improvement portfolio. NH described ongoing work with Trusts to validate elective waiting lists, resulting in positive improvements to be demonstrated in future Provider Oversight meetings. NH reported challenges in UEC performance, leading to accelerated recovery	

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	plans with Trusts and Regional colleagues to meet 4 and 12-hour standards. The committee were made aware of the collaborative work taking place to improve reporting and outcomes for vulnerable populations, with increased oversight and risk management. The committee were further informed that all key service levels for digital and IT had been met. Risks related to operational workforce recruitment and ongoing efforts to close financial gaps were noted. The committee accepted the digital and cyber risk mitigations outlined. **The Committee:** • **Noted the report and the position as of M4.** <u>Chief Strategy, People and Partnerships Report:</u> The paper informed the committee of the key priorities, risks and mitigations relating to Live Well, Population Health Transformation, Place Partnerships development and Neighbourhood Health plans. There were no alerts or advise in the report. The Place Partnership Development Programme continued to progress to plan, with a strong focus over July and August 2026 on socialising the final draft of the Place Partnership Document Suite across localities, provider collaboratives and wider sector partners. Neighbourhood Health Plans were being updated by Place Leads. It was reported that they had been asked to lead the process of updating Neighbourhood Health Plans to reflect the new Commissioning Framework by September 2026. Population Health programmes were on track, with the draft Section 75 due for committee review in September 2026. CB highlighted record-low smoking rates. The committee encouraged greater visibility and celebration of population health achievements. **The Committee:** • **Noted the report.**	
5.	**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. MK suggested providing an update on learning disability and autism standards at a future meeting. NH identified validation of elective standards, recovery and mitigation for urgent & emergency care and proactive winter planning as the three main actions to improve performance. The committee agreed on partial assurance for performance.	

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	The Committee: • **Noted the report.**	
6.	**Socio-economic Duty Implementation** This report provided an update on the work that had taken place over the last twelve months and asked that the committee considered how the duty could be embedded further in the new operating model. DB explained the voluntary adoption of the Socio-Economic Duty by NHS GM, its legal context and the unique position of GM as the first ICB in England to adopt the duty, emphasising its importance for tackling inequalities. The committee were made aware of a survey of 1,000 GM residents that revealed significant financial barriers to health access, with 67% reporting health impacts from finances and 42% not accessing services due to cost, highlighting the need for NHS consideration of cost implications. RN described leadership structures, workforce training, strengthened Equality Impact Assessments and the establishment of a Data Task Group to monitor outcomes and embed the duty in decision-making. The need to approach it as a whole system, with VCSE involvement was raised. **The Committee:** • **Noted the breadth of activity that has taken place to implement the socioeconomic duty over the past twelve months.** • **Endorsed the proposed priorities in section 3.2.** • **Confirmed it agreed with the options suggested in section 3.3 and give a view on any further opportunities to strengthen SED adoption across NHS GM.**	
7.	**A Briefing on Donna Ockenden's Review into Nottingham UHT Maternity Services & Baroness Amos's Review of Maternity & Neonatal Services in England, July 2026** This paper provided a strategic briefing on the findings and implications of the Nottingham Maternity Review led by Donna Ockenden, the Independent National Maternity and Neonatal Investigation led by Baroness Valerie Amos and the subsequent NHS England 10 Point Plan for Maternity and Neonatal Services. It summarised the emerging national themes, highlighted the implications for Greater Manchester and outlined the work already underway through the GM Local Maternity & Neonatal System (LMNS) to support implementation of national priorities. SO explained that the Nottingham Review was now the largest maternity and neonatal review in NHS history. SO identified gaps in perinatal mental health services, particularly for cases involving parent-infant separation and requested committee support for prioritisation and improved data to inform commissioning intentions. The committee discussed assurance timelines, impact measurement and plans to bring perinatal mental health and pathway reviews to future meetings, with support for continuous improvement and cross-team collaboration.	

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	The Committee: • **Noted the contents of this briefing and the emerging implications for maternity and neonatal services in Greater Manchester, recognising the importance of continued system-wide collaboration to support implementation of the resulting national priorities, including the NHS England 10 Point Plan for Maternity and Neonatal Services.**	
8.	**Any other business** None were raised.	

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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
SCC-07	02/07/2026	5. Chief Officers Update Reports - Chief Reform and Improvement Officer Report	Committee suggestion to collaborate on a system wide action plan.	ED, CL, NH, LV, DB to collaborate on a system wide action plan, including reviewing successful interventions at MFT for scalability and developing targeted quality improvement initiatives. Update to be provided at a future meeting.	Ed Dyson	07/10/2026	In progress	Claire Lake / Leigh Vallance / David Boulger supporting.
Completed at Previous Meeting (Audit Trail)								

Actions Log: Strategic Commissioning Committee

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Completion Date	Status	Further Detail
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	
SCC-06	02/07/2026	4. Financial Scheme of Delegation Approval & Reporting Key Financial Decisions Over £5M	The need to clarify the reporting and approval flow for primary care investments, particularly those that involved public health funding, noting that the current flowchart may not capture all necessary steps.	KS & SD to review and amend the financial delegation process flow chart if necessary to ensure the correct route for primary care was in place.	Katherine Sheerin / Stephen Downs	31/07/2026	Closed	10/07: PCC has not delegated authority and spent follows the FSOD through STAR, COs etc

NHS
Greater Manchester

Chief Clinical Officer Report

September 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

September 2026

Required information	Details
Title of report	Chief Clinical Officer Report
Author	Claire Lake, Deputy Chief Clinical Officer (Medical) Jim Ritchie, Deputy Chief Clinical Officer (Medical-Secondary Care, Chief Clinical Information Officer) Kenny Li, Chief Pharmacist Melissa Maguinness, Director of Integrated Clinical Strategy and Transformation Anita Rolfe, Deputy Chief Clinical Officer (Nursing and Nurse Advisor to the board) Laura French, Public Health Consultant Claire Smith, Associate Director Nursing and Quality Assurance Claire Foster, Deputy Chief Pharmacist Kate Provan, Associate Director Clinical Governance and Improvement Amy Ashton, Associate Director, Lead for Screening and Immunisations Amy Jefferey, Quality Manager
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Laura.french16@nhs.net
Executive summary	The NHS Greater Manchester Chief Clinical Officer Report provides an update on key clinical governance, quality, patient safety, and system improvement matters across the region, emphasizing ongoing oversight and assurance activities. It highlights areas requiring attention and approval through the Alert, Advise, and Assure framework. • Alert items include regulatory undertakings for Northern Care Alliance, disruption from Laureate House closure impacting mental health services, and concerns about homebirth services at Wigan, Wrightington & Leigh. • Advise section covers the NHS England Quality Strategy, ongoing quality oversight of Greater Manchester Trusts, and workforce and infection control challenges. • Assure updates include maternity programme progress in Stockport, a health protection and outbreak management review, and tuberculosis collaborative efforts. • The report also details clinical governance committee decisions requiring Strategic Commissioning Committee approval, including medicines formulary updates and service specifications.
The benefits that the population of Greater Manchester will	NHS GM's statutory quality and clinical governance functions support people across Greater Manchester to experience safe, effective and continuously improving services. Through targeted

experience.	quality improvement, strengthened oversight and refreshed governance pathways, the system is better able to identify risks earlier, intervene more consistently and reduce unwarranted variation. This directly supports improved experience and outcomes for patients and communities.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy, including early identification of inequality-related risks in urgent care, mental health, medicines optimisation and system improvement programmes. It supports more consistent governance and escalation, helping to reduce unwarranted variation and strengthen equitable access and outcomes across Greater Manchester.
The decision to be made and/or input sought	The Committee is asked to note the contents of the Chief Clinical Officer Report, approve the items identified in the report that require Strategic Commissioning Committee approval, and note or endorse the remaining items progressed through established governance routes.
How this supports the delivery of the strategy and mitigates the BAF risks	This report supports delivery of the NHS Greater Manchester strategy and 5-Year Commissioning Plan by strengthening clinical oversight of prevention, population health, quality, patient safety, safeguarding, medicines optimisation and system improvement priorities.
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;	The report includes a small number of items with financial implications, which are clearly set out in the relevant sections of the report. In this report, this mainly includes medicines and formulary decisions, of particular note is the Tirzepatide commissioning statement. Any required financial approval or oversight will be progressed through the established governance routes described in the report. Legal and regulatory implications are reflected through NHS GM's statutory duties, NICE technology appraisal obligations, commissioning responsibilities, medicines governance processes, data sharing and digital information governance requirements, and quality oversight arrangements. The most significant regulatory issue relates to NHS England enforcement undertakings for Northern Care Alliance NHS. Foundation Trust following sustained quality governance concerns. No additional legal implications requiring separate Committee action have been identified beyond the approvals, assurance and oversight routes set out in the report.

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

Alert

Northern Care Alliance (NCA)

The Northern Care Alliance continue under enhanced scrutiny following the issuing of the NHS England (NHSE) regulatory undertakings and the regulatory activity carried out by the Care Quality Commission (CQC). There is a system approach that has been enacted with the ICB working closely with CQC and NHSE colleagues in the North West Regional Tier and the Trust to develop and assure the necessary improvement plan and determine the immediate and ongoing oversight mechanisms required.

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

The ongoing closure of Laureate House remains a significant quality, safety and operational risk across the Greater Manchester mental health system, resulting in reduced older adult, acute and PICU bed capacity, increased pressure on patient flow, increased use of Local Spot Placement (LSP) and Out of Area (OOA) placements (which has also had a significant negative impact on the Mental health Integrated Fund [MHIF]), instability and impacts on patient experience and planned service transformation. There have been no direct StEIS-reportable incidents arising from the ongoing closure of Laureate House; however, patient safety and impact have remained central considerations in the management of the incident. The closure has been recognised as a contributing factor in other patient safety events within the replacement provision. Whilst assurance has been requested regarding the learning and outcomes from these events evidence that this learning has been embedded more widely across the Trust is still being sought and will be addressed through established contract quality mechanisms (Quality Review Meetings Recovery Plans etc).

The loss of capacity continues to impact key performance measures, including patient flow, clinically ready for discharge (CRFD) performance, use of external and independent sector beds, delivery of external bed reduction trajectories and wider system pressures, whilst also affecting delivery of the Trust's financial recovery programme. Mitigations remain in place through redistribution of clinical services across the Trust estate, mutual aid arrangements, enhanced clinical oversight, active management of patient flow and discharge pathways, rehabilitation and repatriation programmes, a reimbursement to GMMH from MFT of 50% of the cost of the estate whilst vacant, and robust provider, commissioner and executive oversight arrangements of the interim arrangements and the refurbishment programme. Construction and remediation works remain on track for completion in December 2026, with a phased reopening programme running through October to December and full-service restoration planned from January 2027.

CQC Inspection Feedback – GMMH Acute Wards & PICU

The Care Quality Commission (CQC) undertook an inspection of Greater Manchester Mental Health NHS Foundation Trust's adult acute wards and Psychiatric Intensive Care Units (PICUs) across North View, Atherleigh Park, Rivington Unit, Meadowbrook Unit and Moorside Unit in July 2026. The preliminary feedback highlighted several areas requiring improvement that have potential implications for patient safety, patient experience and regulatory assurance. These are monitored through the ICB contractual quality oversight mechanism.

The inspection team also acknowledges a number of positive improvements since previous inspections, including a developing culture of quality improvement, least restrictive practice work, multidisciplinary team input, generally positive patient feedback, and achievement of planned safer staffing levels.

Blue Ribbon / Cade Care / Forevermore Care – A North West Regional Provider of Independent Care and Supported Living

All Greater Manchester patients in Blue Ribbon facilities have had safe and well checks and joint reviews of their care needs and plans by health and social care. The reviews were undertaken following serious quality and safeguarding allegations relating to Blue Ribbon Healthcare, and associated providers Cade Care and Forever More Care, and subsequent media coverage.

Lancashire County Council are leading the assurance work with the Placing/Host commissioners supporting this. The process enacted brings together all the relevant local authorities along with the 3 ICBs, North West Association of Directors of Adult Social Services (NWADASS) and CQC with an emphasis on a joined-up approach to ensure oversight and improvement whilst reducing duplication and impact on the care provision for service users and their families. Assurance will feed back into the ICB through this committee as the work progresses.

Advise

NHS England Quality Strategy for NHS-funded Care in England

NHS England has recently published the *Quality Strategy for NHS-funded Care in England*, setting out a national approach to improving quality across the three domains of safety, effectiveness and experience over the next decade. The strategy will inform the future direction of quality oversight, assurance and improvement across the NHS.

A separate paper on this agenda provides a detailed summary of the strategy and its implications for NHS Greater Manchester. The Committee is therefore asked to note the publication of the strategy and consider the accompanying report

HPV (Human Papilloma Virus) Self-Testing Roll-out

The UK National Screening Committee has now recommended the roll out of HPV self-testing as part of the NHS Cervical Screening Programme. This does not replace the primary screening programme, but aims to run alongside to support the screening of people who have previously not attended.

Initially, this will become available via invitation to an eligible population of women and people with a cervix aged between 30 and 65 who have not attended for screening following previous invitations. It allows a self-sample to be taken and tested for HPV in the first instance, rather than needing to attend for an appointment. If the test for high-risk HPV via the self-test sample is positive, then that individual will still need to attend for a clinician-taken sample so that the cervical cells can be examined for changes (cytology) and appropriate follow-up arranged.

After an initial test period (likely to be around 1 year), the service will then be extended so that any non-responders to an invite for a cervical smear will be offered a self-test option. It is hoped that introducing the self-test will encourage those who have previously felt reluctant or unable to come forwards to access cervical screening. Cervical screening is an important tool for early identification and treatment of cervical cancer and pre-cancerous changes, and therefore for improving outcomes. Some groups are known to access screening at lower rates than others, leading to poorer outcomes and increasing inequalities. It is hoped that a self-test option for HPV will widen access to those who have not previously taken up their screening offer and in doing so begin to tackle these inequalities.

Self-test invites will be sent by the programme team and this will be undertaken nationally. Primary care colleagues are not required to invite non-responders at this stage.

Assure

Maternity & Neonatal Programme

Stockport Foundation Trust and Tameside & Glossop Foundation Trust are both progressing well through their action plans associated with the Maternity Enhanced Surveillance Program, they are aiming to enter the exit period where they will provide regular evidence of sustained improvement over 2 quarters before being recommended to the ICB for step down back into Routine Surveillance.

Health Protection and outbreak management quarterly update

Outbreaks and Incidents

The 2025 commissioning guidance for ICBs gives a comprehensive framework for the required elements of response to infectious disease outbreaks and incidents. The guidance is based around three principles:

- A flexible system to respond to threats
- Advance planning to mitigate impacts
- System resilience to ensure the system can safely deliver a response whilst other services remain unaffected

It also outlines a number of elements which are ICB responsibility including pathways for assessment and diagnostics as well as treatment and prevention/post-exposure prophylaxis.

Largely, the elements of a robust response are all present in the GM system, along with significant experience and knowledge, however, given recent changes to both NHS structures and staffing, and national guidance changes, there is a need to review and take stock of these arrangements to provide assurance and a central repository of information.

A detailed paper describing the current situation and progress across partners on this guidance has recently been presented to the GM Health Protection Confederation. Key health protection updates for this quarter are as follows:

- Locality teams are reviewing their individual local area management plans (LOMPs) with NHS GM input. When complete, these will be co-signed by the local authority Director of Public Health (DPH), the relevant place partnership lead and the consultant in healthcare public health from the clinical directorate. This will ensure system visibility.
- The Pan-GM Outbreak Plan and accompanying high-consequence infectious disease (HCID) pathway is also being reviewed to ensure alignment with the LOMPs. This includes a review and vaccination pathway for Mpox, the more common type of which is no longer classed as an HCID by UKHSA, however, still requires specific management and expertise.
- An information resource on providers and pathways for out of hours access for medications such as antibiotics and antivirals for post-exposure prophylaxis is being collated so that ICB on call teams will always be able to access this information should the need arise out of hours. Simultaneously, the contracting arrangements for these services are being reviewed to ensure they are fit for purpose.
- A table-top/workshop-style exercise is planned for late September to explore and test the system response to a Men B outbreak similar to the one that recently occurred in Kent. This will be more of a collaborative/workshop type exercise in the first instance to explore the arrangements in the light of reform and guidance changes, and lessons learned by colleagues in the South, and then will be followed up by a more ‘formal’ style real time exercise in due course.

Tuberculosis (TB)

TB is an infectious disease that usually affects the lungs (though can affect many other parts of the body) and is serious if untreated. It can be more complex to treat than some other infections given that it requires a longer course of antibiotics, and it can also present late and some strains are resistant to commonly used medications. It is more likely to affect some groups, including those with weakened immune systems, those who were born or have lived in areas the world where TB is more common, or those who live with complex disadvantage, such as people who are homeless or rough sleep and those who use drugs or alcohol.

Because of this complexity, diagnosis, treatment and vaccination for TB are undertaken by specialist teams. Holistic management of TB as a condition however requires system collaboration and an approach which takes into account the wider determinants of health.

All TB services and systems nationally are experiencing challenges due to increasing demand and complexity of cases. Locally, the GM TB Collaborative has been re-established to provide a forum for system discussion and collaborative problem-solving. The chair role has recently been taken over by the new consultant in public health at NHS GM, who will be seeking a co-chair from a partner organisation within the group. Together, the group will review the national action plan (which is due a refresh this year) and using this and local intelligence, create a local system action plan to address and improve TB case rates.

As part of this work, there is a public-health-led system group which focusses on community-led TB prevention and the wider determinants, to compliment the more healthcare and pathway focus of the TB collaborative.

There will also be a follow-up visit from the TB GIRFT team in November, an update on which can be brought in a later report.

Summary of items considered at CEG (July 2026)

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

This table sets out, for each CEG item:

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

Full papers available on request

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

Ref	CEG paper/Item	Description	Instruction to SCC
Greater Manchester Medicines Management Group (GMMG) Summary of Decisions of Approval			
09-01	NICE TA1148: Sodium zirconium cyclosilicate for treating hyperkalaemia published 29/4/26.	Already on the GMMMG formulary as amber with a shared care protocol in place, but in line with updated NICE TA can now be used as an option for treating hyperkalaemia in adults for an expanded cohort of population. Estimated financial is expected to be £357K per 100,000 population by year 3, not accounted for in horizon scanning, therefore represents a financial risk to the system.	Approve addition to the formulary following approval by CEG and note additional financial impact.
09-02	NICE TA1143: Fezolinetant for treating moderate to severe vasomotor symptoms associated with menopause published 31/3/26.	Fezolinetant can be used as an option to treat moderate to severe vasomotor symptoms associated with menopause when hormone replacement therapy is unsuitable. Add to GMMMG formulary as green drug with links to NICE TA and safety advice. Additional guidance being developed to support this. Additional estimated financial impact £1.1M per year from year 2. .	Approve addition to the GMMMG formulary, ad publication of guidance following approval by CEG.
09-03	NHS Greater Manchester Malnutrition Prescriber Guidance for Adults	GM guide to support review and management of malnourished patients and provide appropriate advice on food first information which is suitable for patients with several dietary requirements. Fully implemented estimated £900K per year savings in primary care.	Approve addition to the GMMMG formulary, following CEG approval.
09-04	Orobalin Primary Care Rebate Scheme	Already on formulary as a green medicine for managing vitamin B12 deficiency. Scheme enables ICB to claim back money back when Orobalin (cyanocobalamin) is prescribed and dispensed.	Approve scheme for use in the ICB following CEG approval.
09-05	GM gainshare Policy and current opportunities	Policy for collaborative arrangements between NHS GM and Providers of NHS services for the best use of tariff-excluded biologic medicines.	Approve policy for use following CEG approval.

09-06	Shared care protocol (SCP) for Dexamphetamine for the treatment of attention deficit hyperactivity disorder (ADHD) in children and adolescents	Currently amber drug on formulary. This is an update to an existing document to adopt the new template for GM SCPs and incorporate changes to NICE guidance, and current best practice in GM	Approve publication following CEG approval.
09-07	Rivastigmine twice-weekly patches for management of Alzheimer's dementia.	Update to formulary entry to provide clarity on interchangeability of brands following a prescribing incident.	Formal approval by SCC needed, following CEG approval.
09-08	Trixeo Aerosphere inhaler (budesonide 160mcg, formoterol 5mcg, glycopyrronium 7.2mcg)	Assign green rag status for COPD management.	Formal approval by SCC needed following CEG approval.
09-09	GM sodium valproate guidance	The guidance provides a comprehensive GM-wide framework for the safe initiation, prescribing, monitoring, and review of valproate medicines which can be used to treat epilepsy and bipolar disorder.	Formal approval by SCC needed for publication and adoption in GM following CEG approval.
09-10	GM Tariff-excluded High-Cost Drugs list 26-27	A list of the agreed tariff-excluded medicines for the 2026-27 financial year which MO teams and provider organisations use for reference purposes.	Formal approval needed for publication following CEG approval.
09-11	Tirzepatide for weight management commissioning statement	Revised interim commissioning statement. The revised statement makes clear that NHS-funded incretin-based treatment for weight management is not commissioned for patients outside Cohorts 1 and 2. Estimated financial impact of £9.5M, creating risk to the prescribing budget. For	Formal approval by SCC needed of the commissioning statement following CEG approval.

		escalation through financial governance.	
Clinical Policy, Audit and Standards (CPAS) Group Recommendations			
09-12	GM Cardiac Acute Transfer Service (CATS) service specification	The specification supports the timely transfer of patients requiring specialist cardiac intervention across organisational boundaries. CPAS considered the need for clearer governance, accountability, operational arrangements, performance oversight, and assurance measures to support a consistent and equitable patient experience across Greater Manchester.	SCC are asked to approve the GM Cardiac Acute Transfer Service (CATS) service specification following approval at CEG
09-13	NHS GM Children and Young People Neurodevelopmental (ND) Triage Service Specification	The specification responds to increased demand, long waits, and variation in access to Autism and Attention Deficit Hyperactivity Disorder (ADHD) assessment and support. CPAS considered the introduction of a consistent, needs-led, multidisciplinary triage model to improve transparency, prioritisation, early support, and equitable access across localities.	SCC are asked to approve the NHS GM Children and Young People Neurodevelopmental (ND) Triage Service Specification following approval at CEG
09-14	NHS GM Standards for Heart Valve Clinics	The standards address variation in heart valve referral pathways, diagnostics, waiting times, clinic provision, workforce capability, and multidisciplinary review. CPAS considered the need for a consistent framework to support equitable access, earlier diagnosis, improved outcomes and stronger governance across Greater Manchester.	SCC are asked to approve the NHS GM Standards for Heart Valve Clinics following approval at CEG
09-15	Adult Attention Deficit Hyperactivity Disorder (ADHD) Assessment Clinical Criteria	The clinical criteria respond to increasing demand for Adult ADHD assessment, pressure on diagnostic capacity and variation in referral management. CPAS considered the need for a consistent, transparent and clinically robust approach to prioritisation, supported by equality monitoring, governance oversight, clinician training and regular review.	SCC are asked to approve the Adult ADHD Assessment Clinical Criteria following approval at CEG
CEG focus on Clinical Audit			
As part of its continued focus on clinical audit following Clinical Audit Awareness Week 2026, CEG dedicated its August meeting to showcasing examples of high-quality clinical audit and quality improvement activity from across Greater Manchester. Presentations highlighted the use of audit to drive improvements in patient safety, clinical effectiveness and value-based care, including work to streamline the pre-operative referral pathway for upper limb surgery patients suitable for block-only procedures, an integrated pharmacy initiative in Stockport that improved Direct Oral Anticoagulant (DOAC) prescribing in line with the Greater Manchester formulary and enhanced medication safety, and a Greater Manchester-wide optometry audit examining primary eye care services. Collectively, these examples demonstrated how clinical audit continues to support learning, reduce unwarranted variation and improve outcomes for patients across the system.			

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 report discusses a range of existing quality, safety and financial risks across Greater Manchester, including regulatory concerns at Northern Care Alliance, the ongoing impact of Laureate House closure on mental health services, maternity safety concerns at WWL, safeguarding concerns relating to independent care providers, and continuing workforce and capacity pressures across provider organisations. Financial pressures from medication and prescribing, particularly potential Tirzepatide-associated costs, are also highlighted. No new risks are explicitly identified within the report.

Achievements

GM Mental Health Integrated Fund has been successfully shortlisted for a 2026 HSJ Award, representing significant national recognition of the partnership approach taken across the NHS Greater Manchester ICB, Greater Manchester Mental Health NHS Foundation Trust (GMMH), Pennine Care NHS Foundation Trust (PCFT), and wider system partners.

The award recognises the innovative use of the Integrated Fund to improve patient outcomes, reduce out of area placements, support community alternatives, and strengthen collaborative commissioning arrangements across Greater Manchester.GM Mental Health Integrated Fund Planning and Oversight Group

The next stage of the awards process requires a formal judging presentation, and the awards ceremony is scheduled for 19 November 2026 in London

Recommendations:

The Committee is asked to:

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

NHS Greater Manchester

NHS Greater Manchester Strategic Commissioning Committee

Report from Chief Commissioning Officer

September 2026

Report from:	**Katherine Sheerin, Chief Commissioning Officer**
Date of Meeting:	2nd September 2026
Authors	**Sara Roscoe,** Associate Director – Healthcare Commissioning Operations **Gill Gibson**, Director of Nursing & Personalised Care **Caroline Bradley**, Director of Primary Care **Oliver Butterworth,** Senior Programme Manager, GM Cancer Alliance
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. **All Age Continuing Health Care (AACC) update** No alerts this month. **Primary Care Commissioning** **GP Collective Action**

Detailed updates have been provided regularly to SCC on GP Collective Action. Since 1 May 2026, GPC England has announced one new action each month. For July, June and May 2026, these have covered the following:

- No new shared care unless an adequately resourced locally commissioned pathway already exists
- Medicines optimisation software and acute prescribing choices
- Advising ICBs against new data sharing agreements and addressing existing data flow governance standards

For August 2026, the fourth action focuses on raising public awareness of the pressures facing General Practice by displaying and sharing patient-facing materials to encourage public support by:

- Displaying and sharing campaign materials in reception areas, waiting room screens, practice websites and through standard patient communications.
- Directing patients to the GPs on your side webpage and to sign the public petition.
- Contacting local MPs using the BMA's online tool
- Encouraging practice teams, family and friends to sign the petition and share the campaign more widely.

Until recently, weekly assurance reports have been requested by the NHS England North West Regional Team. However, given the relatively low levels of confirmed action being reported across the North West, coupled with assurance from ICB teams of mitigation against current risks, the reporting cadence has been revised to monthly.

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

GM Cancer Alliance

No alerts this month.

ADVISE

Healthcare Commissioning

Approach to the development of the Commissioning Intentions 27/28

Greater Manchester completed the 2026/27 planning process in March 2026. Subsequent analysis, thematic review and lessons learnt activity have provided a significantly richer understanding of the system position than has been available in previous planning cycles. In addition, for the first time, NHS Greater Manchester has access to provider-submitted

activity and performance trajectories for subsequent years, creating an opportunity to analyse future delivery risk, understand the system position and begin planning earlier.

The proposed approach is to commence 2027/28 planning through a structured four-phase planning cycle covering planning intent, contracting and refinement, submission and transition to delivery, and evaluation and reset.

Commissioning intentions will be developed in parallel with the analytical work. The aim is to produce a small number of focused, evidence-based commissioning intentions that can influence provider planning and support delivery of strategic, operational and financial objectives.

Each commissioning intention should answer the following questions:

Requirement	**Description**
Strategic alignment	Which strategic priority or objective does this support?
Planning metric	Which commissioning strategy. operational planning, NOF or performance metric will it affect?
Baseline	What is the current, quantified position?
Target population or service	Who or what is affected?
Proposed intervention	What change is being commissioned or requested?
Expected impact	What numerical improvement is expected in activity, performance, outcomes, capacity or cost?
Financial impact	What is the expected quantified financial benefit, cost avoidance, investment requirement or risk?
Delivery route	How will this be enacted through planning, contracts, performance, transformation or provider collaboration?
Executive owner	Which Chief Officer owns delivery?
Timescale	When should the impact be seen?

A commissioning intention should be data-led. Where a narrative commissioning intention is required, it should still be grounded in evidence, aligned to GM priorities and capable of further development into a measurable proposition.

The default position should be that a commissioning intention demonstrates a credible link to at least one of the following:

- improving performance against a key planning metric;
- reducing cost or avoiding future cost growth;

- improving productivity or capacity;
- supporting financial sustainability;
- enabling left shift;
- reducing unwarranted variation;
- improving outcomes for a defined population.

If a commissioning intention cannot demonstrate likely impact, it should not proceed at this stage.

Timeline

The timeline for developing the commissioning intentions is set out below

Date	Activity
27 July	Commissioning Intentions Framework issued to Planning Leadership Team
29 July	Commissioning Intentions Framework issued to Chief Officers
30 July	Live Leadership discussion – Planning and Commissioning Intentions
30 July	Framework issued across Chief Officer portfolios
31 July	Commissioning Intentions Assessment Framework finalised
24 August	Deadline for completed Commissioning Intentions Frameworks (CoP)
26 August	Panel review against the Commissioning Intentions Assessment Framework
27 August	Commissioning Intentions Panel
3 September	Recommended Commissioning Intentions submitted to NHS GM Commissioning Delivery Group
9 September	Chief Officer approval of recommended Commissioning Intentions
16 September	Board

Next Steps

Following finalisation and ratification of the commissioning intentions at the ICB Board in September, these will then be formally issue to Providers.

GM Specialised Commissioning Oversight Group

No updates this month.

All Age Continuing Health Care (AACC) update

Please refer to appendix 1

Primary Care Commissioning

No updates this month.

GM Cancer Alliance

No updates this month.

ASSURE

Healthcare Commissioning

No updates this month.

GM Specialised Commissioning Oversight Group

No updates this month

All Age Continuing Health Care (AACC) update

Please refer to appendix 1

Primary Care Commissioning

The August PCCG considered four substantive items that considered the following:

- Revised PCCG Terms of Reference (ToR) – The discussion acknowledged the work undertaken to revise the ToR and highlighted the need for further revisions to ensure alignment with revised NHS GM governance arrangements.
- Dental Patient Access Quality Scheme (PAQS) – an extension to the PAQS scheme agreed in principle subject to NHS GM processes. There will also be a review of the available data to mitigate financial risk. The scheme will also be reviewed in line with the development of an NHS GM BeCCoR dental scheme.
- NHS GM Orthodontic Service Commissioning Plan – PCCG supported the actions outlined, to undertake procurement in line with PSR in relation to the current Orthodontic PDS contracts across Greater Manchester and for the commission of additional orthodontic PDS activity in order to increase capacity in line with need.

- PCN DES Capacity Access Improvement Payment (CAIP) 2025/26 post payment verification (PPV) – support given to current process and to the appeals process outlined. PCCG agreed that the appeals process will complete, with outputs reviewed before further actions are agreed.

GM Cancer Alliance

Cancer Waiting Times Standards
Whilst the 62D and 28D metric are not meeting target within GM, the performance of GM is above the national average. Variation exists at provider and pathway level within the metrics. For further detail, Trust Standards Performance | GM ADSP

Metric	Target	GM Jun 26	Eng Jun 26
28 Day Wait from Referral to Faster Diagnosis	80%	79.6%	79.0%
62 Day Wait from Referral to First Treatment	85%	73.9%	69.9%
31 Day Wait from Decision To Treat to Treatment	96%	97.2%	92.2%

Early Diagnosis of Cancer
In the 12-month rolling period April 2025 – March 2026, 60.5% of stageable cancers were diagnosed at an early-stage (I/II). GM ranked 8th of the 20 cancer alliances and was the highest performing across NW. Improvements achieved over recent years have been sustained with GM consistently outperforming the England average since mid-2024.

ACHIEVEMENTS

GM Cancer Alliance

Cancer Alliance Quarterly Assurance Meeting Feedback
GM Cancer Alliance received positive feedback from the NHS NW regional team and the NHSE national cancer programme on the progress that is being made in the delivery of the annual cancer plan for GM.

Implementation of AI in prostate cancer pathway
GM Cancer Alliance has begun rolling out Lucida Medical's Prostate Intelligence (Pi™) across four provider trusts: Salford Royal (NCA), Stepping Hill (Stockport), Royal Bolton, and WWL (Royal Albert Edward Infirmary, Wrightington, Leigh CDC). This is funded through the NHS Cancer Programme with SBRI Healthcare support. The tool flags prostate MRI scans most likely to show cancer, allowing radiologists to prioritise the highest-risk patients and rule out disease more quickly for others.

National Cancer Patient Experience Survey
The latest National Cancer Patient Experience Survey results highlight the positive experiences of people receiving cancer care across Greater Manchester. In GM, 1,906 patients responded representing a response rate of 44%. Greater Manchester Cancer Alliance recorded no scores below the expected range, with 10 areas performing above expectations nationally, and patients rated their overall care 9 out of 10 on average, above the national average of 8.9.

Particular strengths were identified around diagnosis, including being given the opportunity to have a family member or friend present and being told sensitively and in an appropriate setting. Patients reported high levels of confidence and trust in their teams, with 91% saying they were always treated with respect and dignity in hospital, and nine in ten saying their care team worked well together, reflecting the strength of collaboration across GM's cancer services.

The survey also identifies opportunities to improve support for people living with and beyond cancer, particularly around emotional support, information about long-term side effects, and support available through community and primary care. The Alliance will use the findings to continue improving services and outcomes, and thanks everyone who took part alongside the staff delivering high-quality, compassionate cancer care every day.

LEARNING FOR SHARING

GM Cancer Alliance

Employer Engagement in the Cancer Programme
The Get Cancer Clever programme is due to be expanded to employers and businesses across Greater Manchester with an event at the People's History Museum on Tuesday 22nd September, 8:30 - 10:30, delivered in partnership with The Growth Company. As part of this programme, GM Cancer Alliance commissioned a survey of 1,000 working age adults from across which showed:

- 72% of respondents agreed it would be easier to recognise early cancer symptoms if their workplace regularly shared resources about what these were.
- Only 56% of people feel confident that their employer would know how to support them.
- 54% of respondents weren't aware of any cancer support available to them through their workplace.

If other programmes of work regularly engage with employers, please share the event details Get Cancer Clever: Breakfast Briefing Tickets, Tuesday, September 22 • 8:30 AM - 10:30 AM | Eventbrite

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APPENDIX 1 – All Age Continuing Health Care (AACC) update

A/A / A	Current position	Issues of concern	Improvements or mitigations in place	Link to BAF risks
Assure	**Referrals completed within 28 days – target 80% or above** Published data for Q1 2026/27 GM ICB achieved 87% against a target of 80%. **Referrals exceeding 28 days by 12 weeks+ (long waits) - Target is 0** 8 long waits were reported for Q1.	• Workforce issues such as sickness and vacancies • Vacancies were put on hold for a number of weeks due to SAE process as part of the reform • Social Worker allocation • Inter agency disputes	• 9 out of 10 localities achieved the required KPI for 28 days • Since Q1 data has been published Long waits have reduced down to 2, it is anticipated they will be resolved by Q2 **Mitigations** • Continued monitoring and oversight of KPI via monthly assurance report for early indication of any issues • Mutual aid is enacted where required/possible to support neighbouring localities	Improvements in these areas significantly impact on experience of care, delivery of statutory responsibilities in respect of continuing health care, quality of service and equity of access to health and care. **BAF SR2**
Advise	Workforce challenges remain across GM CHC locality teams due to vacancies and sickness, teams working hard to maintain good performance	• Delay in recruitment processes due to vacancies having to go through internal advertisement initially before going external • Members of staff moving between localities, so vacancy levels remain the same at GM level. • Still some pockets of sickness within some CHC teams which is impacting on their ability to maintain business as usual.	• July's data shows that NHS GM ICB currently have 14 vacancies 6.84wte clinical and 4.3wte admin vacancies • NHS GM is now using NHS Professionals bank to obtain any agency staff **Mitigations** • There are currently 5 agency staff from NHSP in place across 3 localities (Manchester/Oldham/Stockport). • Vacancies and sickness within localities are reported on a monthly basis to the GM IC Hub team in order to monitor and provide support where required. Any identified risks are escalated to Gill Gibson, Director of Nursing Individualised Commissioning. • Locality teams are encouraged to utilise mutual aid between themselves where possible as a further mitigation	
Advise	There remains a number of backlog reviews for PUPoC and COP/DOLs cases across all 10 localities	• PUPoC Reviews have built up due to not being prioritised due to several reasons within teams due to workforce capacity • Possible risk of increase in complaints and IRPs due to backlog of PUPoC reviews • Risk of increase in finance pressures when completing PUPoC reviews due to accumulated interest and long period of time • Currently not legally complaint with the CHC Framework re; COP/DOLs due to backlog. Significant risk	**Mitigations** • Localities have been advised all reviews should be completed where possible and should be incorporated into BAU • PUPoC - This is an area under additional scrutiny due to the financial cost implications of the cases where there is a long period of time under review. • COP/DOLs - Discussion in place between Associate Directors and legal team, a tool will be developed by legal to support the ICB with addressing the backlog. Anticipated Implementation will be throughout September 2026	
Advise	NHS GM continue to have some localities with a number of backlog reviews for CHC, Fast Track and FNC (Bury/Manchester/Oldham/Stockport/ Wigan)	• FNC Reviews have not been prioritised due to a number of reasons within teams such as sickness and vacancies etc	• Localities are completing reviews as BAU where possible and are working through cases. However high numbers remain in CHC, Fast Tracks and FNC reviews. This is due to continued workforce challenges as outlined above. **Mitigations** • NHSP bank staff have commenced in all three localities as above to support this. • A GM Fast Track SOP and standardised letters have been developed and in implementation stage across all localities. This is to reduce reviews from 12 to 8 weeks.	

A/A / A	Current position	Issues of concern	Improvements or mitigations in place
Advise	Working with BI and finance colleagues to develop a GM Individualised Commissioning Dashboard (via Tableau) for Assurance and finance data.	• Difficulties with obtaining access to some locality finance reports/data	• A project group has been established and meets fortnightly • A demo of the dashboard progress to date has been presented to the GM IPOC Programme group
Advise	Procurement and set up of one NW EPR digital data system for Individualised Commissioning – Anticipated roll out July 2027	• Possibility Roll out could be delayed due to 3 ICB's coming together and doing at scale.	• A NW AACC project group has been established and meets monthly • Business case has been developed and currently with ICB Executives for sign off, next stage is procurement once all ICB's have sign off confirmed. • More consistent reporting across all NW ICB's • Mutual aid will be easier to enact once in place as all teams will be on same digital system

NHS
Greater Manchester

Acting Chief Reform & Improvement Officer Report

2nd September 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Strategic Commissioning Committee

September 2026

Required information	Details
Title of report	Acting Chief Reform & Improvement Officer Report
Author	Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM Malcolm Whitehouse CDIO NHS GM, Dan Gordon Director Elective Care, NHS GM
Presented by	Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM
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Executive summary	This report provides assurance on how NHS Greater Manchester Integrated Care Board is discharging its statutory duties for quality, safety and clinical governance across the organisation and the system as a whole. It brings together intelligence from established governance routes and demonstrates how statutory clinical governance and quality functions are being exercised to identify and manage risk, reduce unwarranted variation, and support safe, effective and equitable care across Greater Manchester. The report highlights key areas of assurance and oversight from the Reform & Improvement portfolio.
The benefits that the population of Greater Manchester will experience.	Continued support for performance oversight of health and care services, digital and data services delivery which enables effective healthcare delivery across the ICS
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy with the intention to deliver financial sustainability, improve our oversight arrangements with our commissioned providers and take forward our digital strategy.
The decision to be made and/or input sought	The Committee is asked to note the AAAA report and the position as of M5
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for the People and Resources Committee and has not been elsewhere but is formulated from intelligence and papers from existing governance routes
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability,**	There has been no formal engagement on this paper as this paper is produced for the People and Resources Committee. The intelligence and papers used to formulate this report have come from the functions workplans within the portfolio.

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

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

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

Alert

Elective Care

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

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

Urgent and Emergency Care

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

Data Insight and Intelligence

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

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

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

Digital and IT Services

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

Advise

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

Digital and IT Services

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

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

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

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

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

Assure

Digital and IT Services:

- Service Desk performance met all reported SLA targets in July. Capacity remained stable and the

extension of Corporate telephone support from 14:00 to 11:00 has been managed operationally.
- Cyber security assurance improved, with software patching compliance for updates released over 28 days ago reported at 91% and GP laptop compliance improving to 82.49%.
- Five high-severity cyber alerts were received in July and none were applicable to NHS Greater Manchester.
- DSPT feedback from MIAA covered 12 of 47 outcomes which will each have improvement plans, meaning 35 outcomes were successfully concluded. IT Security and Information Governance are working jointly on the resulting improvement actions.

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

UEC

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

Risk discussed and new risk identified

DII Update:

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

Digital and IT Services Update:

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

Achievements

Digital and IT Services

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

Elective:

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

Consultant Connect exceeded 3,000 requests in July for the first time, demonstrating a six-fold increase in usage since launching to the rest of Greater Manchester in October.

NHS
Greater Manchester

Chief Strategy, People and Partnerships Officer - Alert Report

August 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester Strategic Commissioning Committee

August 2026

Required information	Details
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report
Author	Emma John, Senior Delivery Manager
Presented by	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Contact for further information	Charlotte.bailey37@nhs.net
Executive summary	This paper alerts, assures and advises the Committee regarding key priorities, risks and mitigations relating to; - 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	• Three-month Neighbourhood Health engagement programme concluded at end of June

	• Full engagement report drafted and shared with participants • Key action from engagement was to develop a Strategic Commissioning Framework for Neighbourhood Health setting out core standards. This was approved at Executive Committee and ICB in July. • Successful Live Well Board held on 23rd July • Follow up meeting to Dr Claire Fuller (National Lead for Neighbourhood Health) visit completed on 5th August • Process underway to respond to national pre-consultation on Neighbourhood Contracts – to conclude by 10th September • Localities to update their Neighbourhood Health plans by end of September • 21 August - engagement on Place Partnerships documentation closes and all feedback is reviewed during a 'sprint month'. • Approval of Place Partnership Agreement and associate documentation by Chief Officers and Place Leads in September, followed by Place Boards in October.
Leadership and governance arrangements	This paper is produced for this committee and has not been elsewhere.
Engagement to date	There has been no formal engagement on this specific paper – however, it reflects

***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	broader system engagement – including on Neighbourhood Health and Live Well and on Place Partnership documentation as referenced above.
Financial or Legal Implications;	n/a.

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

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

Key Updates and Escalations

Alert
Nothing to alert this month
Advise
Place Partnership Update: Significant progress has been made in preparing for Place Partnership mobilisation following a joint sprint session on 12 August 2026 involving NHS GM's Business and Delivery and People and Culture teams. Key mobilisation documentation and approval routes have been mapped, programme timelines have been refreshed, and engagement activity remains on track to conclude on 21 August. A focused four-week sprint period will commence from the week beginning 24 August to review stakeholder feedback, finalise documentation, including the Partnership Agreement and supporting documents, and support progression towards Chief Officer and Place Lead approval in September. Mobilisation arrangements continue to develop, including the establishment of an oversight function at pan-GM level and local Place mobilisation groups, supported by workstreams covering key enabling functions such as Finance, People and Culture, Digital and IT, and Estates. Engagement continues with local and regional trade unions through the NHS GM Partnership Forum, as well as with our workforce; with a Place Staff Briefing held on 20 August. Priority activity over the coming weeks includes: • Place Staff briefing on 20 August as part of ongoing workforce engagement • Assurance workshop on 27 August to support development of the assurance framework for Place Partnerships • Establish local Place mobilisation groups and implement associated governance arrangements • Preparation of all documentation for formal approval. Fortnightly programme updates are provided to Chief Officers and shared with Place Leads and Place Directors to support timely oversight, decision making and escalation.
Assure
<u>Neighbourhood Health</u>

The Neighbourhood Health engagement programme concluded at the end of June. A draft engagement report was presented to the Population Health and Neighbourhoods Supporting Group on 15 July and has been shared with all participants in the engagement process.

The draft GM Strategic Commissioning Framework for Neighbourhood Health was identified as a priority action from the engagement. This was approved by the Executive Committee on 8 July and Board on 15 July. Localities have been asked to lead the process of updating Neighbourhood Health Plans to reflect the new Commissioning Framework by September.

Following the Claire Fuller, Medical Director, NHS England national visit in June, a follow up call took place on 5 August. There was positive assurance that the actions from the national visit were on track.

A consultation on new, proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models to support neighbourhood health was launched in July. The link to the relevant documents is here: https://www.england.nhs.uk/long-read/a-consultation-on-proposed-mnp-and-snp-contracting-models-high-level-summary/ . Discussion on the responses to the consultation will take place with key partners – including through a Primary Care Roundtable, our 10 localities and Trust Provider Collaborative. The responses are due by 10th September.

Live Well

An update on the Neighbourhood Health engagement was given to the Live Well Board in July.

Risks discussed and new risks identified

Ongoing changes to governance arrangements continue to create uncertainty regarding programme timelines and approval processes.

In relation to Place Partnerships, risks have been raised with Chief Officers regarding mobilisation of supporting functions, and capacity pressures without significant dedicated resource to support the breadth of the programme. The risks continue to be monitored, with mitigations in place.

A full risk log is being prepared for Neighbourhood Health and will be reviewed by the Population Health and Neighbourhoods Supporting Group on 11 September.

Learning for sharing

Population Heath

The NHS GM Population Health function co-authored a blog for the GM Public Health Network on the lessons learned for the development of a comprehensive Alcohol Harm Strategy in Greater Manchester. This was published by the Institute for Alcohol Studies -

Alcohol harm is not inevitable. But reducing it requires us to act differently - Institute of Alcohol Studies

Achievements

Neighbourhood Health

Positive feedback was received from NHS England Region on the Neighbourhoods approach via the Quarterly Executive Strategic Review meeting on 22 July. See feedback below:

What came through most strongly was the clarity of the system's long-term ambition. Neighbourhood health is clearly becoming the organising principle for transformation, underpinned by a strategic commissioning plan, a neighbourhood commissioning framework and a strong commitment to place-based delivery. We were particularly struck by the focus on outcomes, prevention and proactive care, and by the determination to work alongside local government, public health, social care and the voluntary sector to improve population health in a different way.

The draft Strategic Commissioning Framework for Neighbourhood Health was approved by Board in July.

NHS
Greater Manchester

Performance Report 2026-2027

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Strategic Commissioning Committee

September 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

Strategic Commissioning Committee (SCC) Performance Report

September 2026

Part of Greater Manchester Integrated Care Partnership

Executive Summary

NHS Greater Manchester

Overall position

- System delivery remains broadly on track, with the majority of core metrics rated Assure.
- Alert measures are concentrated within Elective Care, Mental Health & Learning Disabilities and Autism, and Urgent & Emergency Care, whilst Cancer includes a small number of Advise metrics.
- Delivery of the elective waiting list trajectory remains a significant system performance risk.

Alert (focused system oversight)

- Total waiting list remains above plan, with five of seven providers above plan. The ICB waiting list trajectory also remains off track, presenting a material risk to delivery of the year-end target.
- Reliable recovery, reliable improvement and completed courses of treatment remain below plan, indicating continued challenges in delivering NHS Talking Therapies outcomes.
- Out of Area Placements remain above plan, reflecting ongoing pressure on mental health capacity and discharge pathways.
- Learning Disability and Autism inpatient numbers remain above plan across both cohorts, reflecting continued reliance on inpatient provision and challenges supporting timely discharge.
- 12-hour waits remain above plan, reflecting continued challenges in patient flow, discharge and system capacity.

Advise (continued oversight)

- 4-hour emergency care performance remains below plan and will continue to be monitored through established UEC governance arrangements.
- 28-day Faster Diagnosis and 62-day cancer standards are rated Advise and remain under routine monitoring through Cancer Alliance governance arrangements.

Assure (on track / stable delivery)

- Category 2 ambulance response times remain better than plan.
- Referral to Treatment (RTT) 18-week performance remains broadly on plan.
- 31-day cancer performance remains rated Assure and is the highest performing ICB nationally.
- Diagnostic waiting times remain better than plan.
- Community waiting times remain better than plan.
- Individual Placement and Support activity continues to exceed plan.

Key achievements

Greater Manchester continues to deliver strong performance across a number of national standards. Cancer remains a particular area of strength, with no Alert metrics and 31-day treatment performance ranked first nationally. Diagnostic waiting times remain amongst the strongest nationally, whilst Category 2 ambulance response times continue to achieve the revised national standard and Individual Placement and Support activity remains above plan.

Ask of the committee

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

2026/27 ICB Headline Planning Metrics (SCC oversight)

NHS Greater Manchester

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

ICB										
Area	KPI	Period	Actual	Plan	Variance (latest **published** data vs same period in previous year)			ICB Benchmarking (**published** data)		
					2025	Variance	Movement	Jun-25	Jun-26	Movement
Elective	Percentage of RTT waiting list within 18 weeks	Jun-26	63.5%	63.3%	56.6%	6.9%	↑	32/36	29/36	↑
	Total waiting list	Jun-26	407,375	362,212	429,227	-21,852	↓			
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Jun-26	12.2%	14.3%	15.4%	-3.2%	↓	9/36	5/36	↑
Cancer	28-day cancer Faster Diagnosis Standard	Jun-26	79.3%	80.2%	79.7%	-0.4%	↓	8/36	18/36	↓
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Jun-26	73.1%	75.4%	69.2%	3.9%	↑	15/36	9/36	↑
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Jun-26	96.9%	93.4%	95.6%	1.3%	↑	5/36	1/36	↑
Mental Health	NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness	Jun-26	45.5%	51.0%	46.9%	-1.4%	↓	20/36	30/36	↓
	NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment	Jun-26	68.7%	69.0%	67.2%	1.5%	↑	25/36	24/36	↑
	NHS Talking Therapies: No. completed courses of treatment (YTD)	Jun-26	2,755	3,846	2,845	-90	↓			
	Number of patients accessing Individual Placement Support services (12-month rolling metric)	Jun-26	4,740	3,175	2,280	2,460	↑			
	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period (local data)	Jul-26	4	2	5	-1	↓			
Learning Disability and Autism	Inpatient care for Adults with Learning Disabilites (who may also be autistic)	Jun-26	45	42	50	-5	↓			
	Inpatient care for Autistic Adults (with no learning disability)	Jun-26	60	50	60	0	↔			
Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less	Jun-26	86.9%	83.3%	83.2%	3.7%	↑	Benchmarking not yet available		

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

NHS Greater Manchester

GM Providers / Ambulance Trust							
Area	KPI	Period	Actual	Plan	Variance (latest **published** data vs same period in previous year)		
					2025	Variance	Movement
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times	Jul-26	00:19:56	<00:25:00	00:22:11	-00:02:15	↓
	4-hour A&E performance	Jul-26	72.5%	74.8%	71.4%	1.1%	↑
	12-hour A&E performance (type 1&2)	Jul-26	8.4%	7.4%			
Elective	Percentage of RTT waiting list within 18 weeks	Jun-26	61.9%	62.1%	55.4%	6.5%	↑
	Total waiting list	Jun-26	437,332	422,439	464,051	-26,719	↓
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Jun-26	11.8%	11.5%	16.1%	-4.3%	↓
Cancer	28-day cancer Faster Diagnosis Standard	Jun-26	79.6%	80.1%	79.8%	-0.2%	↓
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Jun-26	73.9%	74.8%	69.5%	4.4%	↑
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Jun-26	97.2%	94.4%	95.5%	1.7%	↑

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

26/27 Alert, Assure and Advise framework

NHS Greater Manchester

Area	Metric	Alert	Advise	Assure
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times			
	4-hour A&E performance			
	12-hour A&E performance			
Elective	Percentage of RTT waiting list within 18 weeks			
	Total waiting list			
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over			
Cancer	28-day cancer Faster Diagnosis Standard			
	Percentage of patients receiving a first definitive treatment for cancer within 62 days			
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days			
Mental Health	Mental Health Support Team coverage of total pupils/learners (annual metric)	Data not yet available		
	NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness			
	NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment			
	NHS Talking Therapies: No. completed courses of treatment (YTD)			
	Number of patients accessing Individual Placement Support services (12-month rolling metric)			
	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period			
Learning Disability and Autism	Inpatient care for Adults with Learning Disabilites (who may also be autistic)			
	Inpatient care for Autistic Adults (with no learning disability)			
Primary Care	Urgent Dental Appointments	Data not yet available		
Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less			

NHS
Greater Manchester

NHS Oversight Framework 2026/27: ICB metrics and assurance approach

ICB approach to monitoring NHS Oversight Framework metrics

NHS Greater Manchester

The 2026/27 NHS Oversight Framework introduces a formal national oversight regime for Integrated Care Boards, including delivery segmentation based on 43 ICB applicable metrics. Performance will be assessed and published quarterly by NHS England, increasing the importance of routine oversight, early identification of risk and timely intervention.

Each metric has been allocated to:
- A nominated operational lead responsible for delivery and improvement.
- A DII team responsible for interpreting national guidance and building the metric and supporting data.
- A Performance Team lead responsible for monitoring, analysis and assurance.

Performance will be reviewed monthly through existing governance arrangements, supported by national, regional and local intelligence. This will enable emerging risks, deteriorating performance and delivery challenges to be identified ahead of quarterly NHS England publications.

Monthly monitoring
- Review available performance data and local intelligence.
- Monitor trajectories, deterioration and emerging risks.
- Discuss performance with relevant operational leads.
- Identify actions, mitigations and recovery plans where required.

Quarterly reporting to SCC
- Review published NHS Oversight Framework results.
- Assess implications for ICB performance and segmentation.
- Report findings through the existing Alert, Advise and Assure framework.
- Provide detailed narrative, risks, mitigations and recovery actions for Alert metrics.
- Advise and Assure metrics will be reported at a summary level, with further detail provided only where material risk or deterioration is identified.

Key principle
The approach is designed to maintain ongoing oversight of all 43 ICB applicable metrics whilst ensuring SCC receives focused, proportionate reporting on the areas of greatest delivery risk and potential impact on future NHS Oversight Framework performance.

NHS Oversight Framework 2026/27: ICB applicable metrics

NHS Greater Manchester

Domain 1: Population health, prevention and reducing inequalities
- U75 cancer mortality
- U75 CVD mortality
- Cervical screening
- Bowel screening
- Breast screening
- MMRV uptake
- Obesity prevention programmes
- Smoking in pregnancy quit rate
- Deprivation gap in early cancer diagnosis
- Deprivation and ethnicity gap in pre-term births
- Deprivation gap in lipid management
- Deprivation gap in hypertension management

Domain 2A: Allocating resources
- Overall waiting list change versus previous year
- Growth in community care contacts
- Cancers diagnosed at stage 1 or 2
- Acute MH admissions with no previous community MH contact
- Occupied bed days per 100,000 population
- Same-day clinically urgent appointments
- Dental activity as % commissioned

Domain 2B: Access to services
- Longest length of stay for people with a learning disability or autistic people in a mental health hospital

Domain 3: Experience of care
- GP access rated good
- Ability to see preferred general practice professional
- Complaints open beyond 6 months
- Adult admission rate for people with learning disability or autism
- ICB-commissioned inappropriate OAP bed days
- Average delay between discharge ready and actual discharge

Domain 4: Effectiveness of care
- Talking Therapies reliable recovery
- 3+ emergency admissions in last 90 days of life
- Over 65s bed days per 100,000 population
- Diabetes 8 care processes
- CVD cholesterol managed to NICE guidance
- Hypertension managed to NICE guidance
- SMI physical health checks
- Learning disability health checks and action plans

Domain 5: Patient safety
- Antibiotics prescribed to children aged 9 and under
- Neonatal deaths and stillbirths per 1,000 total births

Domain 6: Finance, productivity and innovation
- Planned surplus or deficit
- Variance to plan year-to-date
- Implied productivity growth
- Clinical trials set up within 90 days

Domain 7: People
- Sickness absence
- NHS staff survey engagement score
- GP headcount per capita

Full metric list shown for completeness. All 43 metrics will be monitored internally, with SCC receiving exception-based reporting through the AAA framework.

NHS
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Appendices

Domain Performance – Elective Care & Diagnostics

Narrative provided for alerts only

NHS Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• Total waiting list remains above plan and is the Elective Care Alert metric for this report. • Five of seven providers are above plan, indicating continued system-wide delivery pressure. • Following validation, RTT 18-week performance is broadly on plan and 52-week waits remain relatively stable • The ICB waiting list trajectory remains a material risk to delivery of the year-end planned position.	• Delivery of the GM ICB year-end waiting list target remains a significant risk, with the current position not yet delivering the level of reduction required. • Although RTT 18-week performance is broadly on plan after validation, total waiting list size continues to be the key area of concern. • Waiting list variation is being seen across the system, with some areas increasing and others decreasing. • Sustained delivery will be dependent on continued validation, productivity improvement, delivery of provider trajectories, demand management and use of available system capacity.	• Continued oversight through the Elective Recovery Board, with routine monitoring of total waiting list trajectories and provider recovery actions. • Performance, recovery trajectories and delivery risks are routinely reviewed through contract management and assurance meetings, with targeted support and challenge provided where performance is off trajectory. • Demand management actions continue through BeCCoR/EQIS, Advice and Guidance, Community Services and Single Point of Access programmes. • Provider support remains focused on productivity improvement, waiting list validation and delivery of elective recovery trajectories. • Independent Sector activity and treatment provided outside Greater Manchester continue to be maximised to support elective recovery and delivery of year-end plans. • Diagnostics remains better than plan, with improvement actions continuing through capacity and demand review, productivity improvement and DNA reduction programmes.	SR2

Elective Care & Diagnostics has one Alert metric: total waiting list. The latest position shows that five of seven providers are above plan, and the ICB waiting list trajectory remains off track. Following validation, RTT 18-week performance is broadly on plan and 52-week remaining relatively stable; however, total waiting list size remains the key delivery risk. Recovery is dependent on sustained delivery of provider trajectories, waiting list validation, productivity improvement, demand management schemes, Independent Sector activity and treatment provided outside Greater Manchester.

Domain Performance – Urgent and Emergency Care (UEC)

Narrative provided for alerts only

NHS Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• 12-hour waits are the Urgent and Emergency Care Alert metric. • In July, 12-hour performance was 8.4% against a plan of 7.4%, with four of six providers above plan.	• 12-hour waits remain above plan, indicating continued challenges in patient flow, discharge and onward care. • System flow, discharge delays and limited operational headroom continue to constrain improvement. • Variation in provider performance continues to impact overall system delivery. • Sustained improvement will require continued whole-system action across acute, community, social care and ambulance services.	• Strengthened oversight through UEC governance, with focused monitoring of 12-hour performance. • Increased focus on measurable improvement in patient flow, discharge and operational performance rather than activity alone. • Targeted support and challenge aligned to provider and Place ownership of recovery actions. • Priority work focused on cohorts with the greatest impact on demand and flow, including frailty, children and young people, and high-intensity service users. • Trust-by-trust performance assessment, with stronger use of analytics and shared learning to reduce variation and spread effective practice across Greater Manchester.	SR2

Urgent and Emergency Care has one Alert metric: 12-hour waits. In July, performance was 8.4% against a plan of 7.4%, with four of six providers above plan. Whilst performance improved from 9.2% in June, challenges relating to patient flow, discharge delays and operational capacity continue to impact delivery. Actions remain focused on improving discharge, strengthening patient flow and reducing long waits across the system.

Domain Performance – Cancer

Narrative provided for alerts only

NHS
Greater Manchester

No Alert metrics

- Cancer continues to be one of Greater Manchester's strongest performing domains, with no metrics rated Alert.
- Two cancer metrics (28-day Faster Diagnosis Standard and 62-day treatment standard) are rated Advise and will continue to be monitored through established Cancer Alliance governance arrangements.
- 31-day treatment performance remains rated Assure and is currently the best performing Integrated Care Board nationally.
- Overall cancer performance continues to compare favourably against national benchmarks and delivery trajectories.

Domain Performance – Mental Health & Learning Disabilities and Autism

Narrative provided for alerts only

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	• Six Mental Health and Learning Disability & Autism metrics are rated Alert. • Reliable recovery, reliable improvement and completed courses of treatment remain below plan, reflecting ongoing challenges in delivering NHS Talking Therapies outcomes. • Inappropriate Out of Area Placements remain above plan, reflecting continued pressure on mental health bed capacity, patient flow and discharge pathways. • Inpatient numbers for adults with Learning Disabilities and autistic adults remain above plan, indicating continued reliance on inpatient provision across both cohorts.	**Mental Health** • Talking Therapies performance remains below plan across outcome and activity measures, with workforce and capacity pressures continuing to affect delivery. • Delivery of planned improvement trajectories remains challenging and benefits from workforce investment are unlikely to have a material impact during the current year. • Ongoing pressure on mental health bed capacity and discharge pathways continues to contribute to Out of Area Placements. **Learning Disability & Autism** • Continued reliance on inpatient provision reflects challenges in developing community alternatives and supporting timely discharge. • Delays in patient flow, discharge arrangements and access to appropriate community support remain significant constraints to reducing inpatient numbers.	• Targeted improvement work continues to support delivery of NHS Talking Therapies outcomes, with ongoing oversight of reliable recovery, reliable improvement and completed courses of treatment. • Performance, recovery trajectories, risks and mitigating actions are routinely monitored through established mental health governance, contract management and assurance arrangements. • Continued focus on reducing inappropriate Out of Area Placements through improved discharge planning, patient flow and community alternatives. • Development and expansion of admission avoidance, crisis support and community step-down provision to reduce reliance on inpatient care where clinically appropriate. • Regular review of length of stay, discharge barriers and delayed discharges to support reductions in inpatient numbers and improve patient flow. • A business case to address the commissioning gap in provision for people with LD and Autism has been developed but as yet, no funding identified.	SR2

Mental Health and Learning Disability & Autism has six Alert metrics relating to Talking Therapies outcomes and activity, Out of Area Placements, and Learning Disability & Autism inpatient care. Performance continues to present delivery risk across outcomes, capacity, patient flow and inpatient reliance. Workforce challenges, bed capacity pressures and discharge delays continue to impact delivery, whilst reducing inpatient numbers remains dependent on the availability of community alternatives and timely discharge arrangements. System actions remain focused on improving outcomes, strengthening community provision, reducing inappropriate inpatient care and supporting patient flow through ongoing oversight, assurance and targeted improvement programmes

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Health Inequalities Statement 2025-2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Commissiong Committee

2nd Sept 2026

Report information.

Required information.	Details.
Title of report.	Health Inequalities Statement 2025/26
Author.	Chris Tyson – Assistant Director of Intelligence (Place & Strategic Intelligence) Khalada Abdullah – Strategic Lead Population Health and Strategy & Equity Zoé Neilson – Project and Policy Manager Population Health and Strategy & Equity Paul Langton - Head of Strategic Intelligence Bolanle Odebiyi -Senior Intelligence Analyst Fatamah Shah - Intelligence Manager (In addition to the above-mentioned, system leads across GM have contributed to HI statement narrative)
Presented by.	Chris Tyson
Contact for further information.	Christyson@nhs.net

Executive summary.	This report presents NHS Greater Manchester's 2025/26 Health Inequalities Statement, setting out how the ICB is meeting its statutory duties to reduce inequalities in access, experience and outcomes. It summarises population need, key inequalities trends and performance against NHS England's Health Inequalities Improvement Metrics, aligned to CORE20PLUS5. The report shows progress in some areas, including cancer early diagnosis, SMI physical health checks and CVD prevention, while highlighting persistent inequalities linked to deprivation, ethnicity, age and wider determinants of health.
The benefits that the population of Greater Manchester will experience.	Residents will benefit from a clearer, evidence-led understanding of where inequalities are greatest and where targeted action is needed. The report supports more equitable commissioning, prevention, early intervention and service improvement across Greater Manchester, with a particular focus on communities experiencing the poorest health outcomes.
How health inequalities will be reduced in Greater Manchester's communities.	The report supports action to reduce inequalities by using disaggregated data on deprivation, ethnicity, age and sex to identify unwarranted variation and target improvement. Priorities include prevention and early intervention, improving data quality, strengthening community-based approaches such as Live Well and Neighbourhood Health, and working with VCSFE partners to improve reach into underserved communities.

The decision to be made and/or input sought.	The Committee is asked to: 1. Note the 2025/26 Health Inequalities Statement and the key inequalities identified across Greater Manchester. 2. Support continued system action to reduce inequalities in access, experience and outcomes, particularly for the most deprived communities and CORE20PLUS5 population groups. 3. Support continued system action to reduce inequalities in access, experience and outcomes, particularly for the most deprived communities and CORE20PLUS5 population groups. 4. Approve publication of the statement on NGS GM website alongside the Annual Plan.		Support continued system action to reduce inequalities in access, experience and outcomes, particularly for the most deprived communities and CORE20PLUS5 population groups. Endorse the ongoing focus on improving data quality, transparency and routine reporting of health inequalities.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The report supports NHS GM's strategy by strengthening population health improvement, prevention, neighbourhood working and fairer access to care. It provides evidence to support oversight of risks relating to health inequalities, unequal access, service variation, population health outcomes and data quality.		

How this aligns to the new strategic objectives.	The statement aligns with strategic objectives focused on improving population health, reducing unwarranted variation, shifting care towards prevention and early intervention, and working with communities and partners to address the wider determinants of health. This also meets statutory reporting requirements.
Key milestones.	Publication of the 2025/26 Health Inequalities Statement -September 2026
Leadership and governance arrangements.	Strategic commissioning Committee. Decision to be agreed to set up a Health Inequalities Governance Group from September 2026 with representatives from ICB Programme Teams to support the annual update of the report.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Extensive engagement with System leads to analyse and develop narrative. Drop-in sessions were set up throughout the development of metrics and report narrative. Data Task group was also set up to ensure all metrics of the reporting framework were developed and reviewed where data was available.

Financial or Legal Implications	No direct financial decision is sought through this report. Any financial implications associated with individual programmes or improvement actions will be managed through the relevant programme governance and existing NHS GM financial processes. The report supports NHS GM's statutory responsibilities to have due regard to reducing inequalities in access to healthcare and outcomes for patients. No separate legal decision is sought through this cover report.

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*	*No*	*No*

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

NHS Greater Manchester

NHS Greater Manchester Health Inequalities Statement 2025-2026

V1.0 (20 August 2026)

Part of Greater Manchester Integrated Care Partnership

Contents

Purpose

This Annual Health Inequalities statement is a statutory requirement for NHS Bodies including NHS Greater Manchester ICB to demonstrate how we are fulfilling our legal duties and taking an evidence-led improvement approach to tackling health inequalities, aligned with Core20PLUS5 for adults and children and young people. The statement will demonstrate how health inequalities information is used to inform local action.

Health inequalities are systemic, unfair and avoidable differences in health across the population, and between different groups within society. Healthcare inequalities relate to inequalities between groups in the population in the access they have to health services, and in their experiences of and outcomes from healthcare. Tackling inequalities in health outcomes, experience and access is one of the 4 core purposes of integrated care systems (ICSs).
This 25/26 updated statement sets out how NHS GM collects and analyses data to:

- Understand population health need by drawing on local analysis, demographic insight and population health outcomes data to identify the risk factors for health inequalities and Core20PLUS population groups.
- Disaggregate data (at a minimum by deprivation, ethnicity, age, and sex) and analyse performance data and local service insight to identify unwarranted variation in access and outcomes across population groups and geographies.
- Improve data quality, collection and analysis by identifying gaps in datasets (including where key demographic data is recorded as unknown or not stated) and identifying

practical steps to make improvements.

- Use information on health inequalities to take action across commissioning and service delivery, and evaluate impact on reducing health inequalities.
- Publish information on health inequalities as part of annual reports, for example Public Sector Equality Duty (PSED) and embed health inequalities data into other data publications throughout the financial year, such as public board papers.

Executive Summary

This Health Inequalities Statement is structured around the NHS England Health Inequalities Improvement Metrics framework, with the formal response to the metrics presented in Sections 6-15. The preceding sections provide contextual information on the Greater Manchester population, demographic characteristics, deprivation and wider determinants of health to support interpretation of the findings.

For ease of reference, a copy of the NHS England Health Inequalities Improvement Metrics framework is included in the Appendix. This enables readers to cross-reference the metrics with the corresponding narrative, analysis and actions presented throughout the report.

Building on this framework, this Health Inequalities Statement sets out how NHS Greater Manchester (GM) is meeting its statutory duties to reduce inequalities in access, experience and outcomes of healthcare. It reflects NHS England's requirements for 2025/26 and is aligned to the CORE20PLUS5 framework, with a strong emphasis on measurable improvement across priority clinical areas and underserved population groups.

Greater Manchester is home to over 3.3 million residents and continues to experience higher levels of deprivation and poorer health outcomes than the national average. Around a quarter of residents live in the most deprived areas in England, and this underpins persistent inequalities in life expectancy, long-term conditions and access to care.

Overall Position and Direction of Travel

Analysis of over 60 health inequalities indicators shows a mixed but concerning picture. While

improvements are evident in some service areas, there are signs of worsening outcomes and widening gaps compared to England across several key metrics.

Key population health indicators demonstrate:

- Lower life expectancy than the England average, with a gap of 9.5 years for men and 7.5 years for women between the most and least deprived communities.
- Declining healthy life expectancy, with residents spending fewer years in good health.
- Worsening outcomes in priority areas including:
    - Infant mortality (above national average)
    - Obesity and diabetes prevalence (increasing and above England levels)
    - Suicide rates and alcohol-related mortality (both rising)

These trends reinforce that health inequalities in GM remain deep-rooted, systemic and closely linked to deprivation.

Performance against NHS England Health Inequalities Metrics

The NHS England framework requires systems to demonstrate progress across CORE20PLUS5 priorities and key lines of enquiry, including access, experience and outcomes. This report highlights the following system-level performance:

1. Access to Services

- Elective recovery has improved overall, including reductions in long waits; however:
    - Persistent inequalities remain for children and young people, deprived communities and some ethnic groups.
- Urgent and emergency care has seen shorter average waiting times, but:
    - Older people experience significantly longer waits, reflecting inequalities in frailty and system flow.
- Vaccination uptake shows a strong deprivation gradient:
    - 32.2% uptake in the most deprived areas compared to 63.9% in the least

deprived.

2. Clinical Priority Areas (CORE5)

Progress is variable across NHS England's clinical priorities:

- Cardiovascular disease (CVD):
  - Hypertension control has improved to over 75%, alongside reductions in inequality (measured using the Index of Disparity).
  - However, emergency admissions for myocardial infarction remain 78% higher in the most deprived communities, demonstrating persistent inequity.
- Respiratory disease:
  - High levels of emergency admissions and hospital bed use continue, particularly in deprived populations.
  - Pulmonary rehabilitation uptake and completion remain unequal.
- Cancer:
  - Early diagnosis rates have improved to 60.7% and are now above the England average.
  - A deprivation gap remains in early diagnosis and survival outcomes.
- Mental health:
  - Severe Mental Illness (SMI) health check uptake has exceeded the national target (62.7%).
  - Significant inequalities persist, including:
    - Higher detention rates under the Mental Health Act in deprived communities (up to four times higher).
- Maternity and early years:
  - Persistent inequalities in early antenatal booking and outcomes by ethnicity, age and deprivation.
  - Smoking in pregnancy remains higher among more deprived women.

3. Wider Priority Metrics

Across additional NHS England priority indicators:

- Learning disability annual health checks are high (over 85%), though uptake is lower in more deprived areas.
- Smoking cessation programmes are successfully engaging high-risk populations, with early signs of improvement in smoking at time of delivery (3.7%, below national average).
- Children and young people (CYP):
    - Emergency attendance and oral health outcomes show strong deprivation-related inequalities.

Data, Measurement and Improvement

A significant development for 2025/26 is the introduction and expansion of the Index of Disparity, enabling more consistent and transparent measurement of inequalities across key programmes, particularly in cardiovascular prevention.

However, data quality remains a challenge, particularly in the recording of ethnicity and other protected characteristics. This limits the ability to fully understand and address inequalities and is a key area for improvement.

System Response and Priorities

NHS Greater Manchester is responding through a whole-system, population health approach, including:

- Strengthening community-based prevention through programmes such as Live Well and Neighbourhood Health.
- Expanding targeted interventions for CORE20PLUS populations.
- Working with voluntary, community, social and faith enterprise (VCSFE) partners to improve reach.
- Embedding health inequalities into commissioning, service design and performance

oversight.

Priorities for 2025/26 and beyond are to:

- Reduce gaps in access, experience and outcomes, particularly for the most deprived communities.
- Improve data quality and intelligence to support targeted action.
- Focus on prevention and early intervention, especially in cardiovascular, respiratory and mental health services.
- Ensure equitable recovery across all services, not only overall performance improvement.

Conclusion

While there has been progress in several areas, this report demonstrates that health inequalities in Greater Manchester remain significant and, in some cases, are widening.

Sustained, targeted and coordinated action aligned with NHS England's expectations is required to ensure that improvements in healthcare delivery lead to fairer outcomes for all residents, particularly those in the most disadvantaged communities.

1. Introduction

1.1 Understanding Health Inequalities

Health inequalities are unfair, avoidable and systematic differences in health outcomes, life expectancy and access to healthcare experienced by different population groups. These inequalities are shaped by wider social, economic and environmental determinants, including deprivation, housing, employment, education and access to opportunities. Health inequalities can affect people throughout their lives and contribute to differences in both physical and mental health outcomes across communities.

1.2 Legislative and System Context

Integrated Care Boards (ICBs) and NHS organisations have a statutory responsibility to consider and address health inequalities in the planning and delivery of services.

The NHS has a legal duty to reduce inequalities in both access to healthcare and health outcomes experienced by different population groups. This includes reducing inequalities in access, experience and outcomes for communities experiencing the poorest health.

This report provides an overview of health inequalities across Greater Manchester and highlights key areas where inequalities continue to impact population health outcomes.

1.3 Greater Manchester Context

Greater Manchester is a diverse city-region with significant variation in population health outcomes across localities and population groups. Inequalities remain substantial between the most and least deprived populations.

People living in more deprived areas experience poorer health outcomes, earlier onset of long-term conditions and lower life-expectancy compared with those living in less deprived communities.

Reducing health inequalities remains a key priority across Greater Manchester and requires a coordinated, place-based approach focused on prevention, early intervention and addressing the wider determinants of health.

1.4 Greater Manchester Population Profile

Greater Manchester has a population of over 3.3 million residents and is one of the most deprived urban areas in England, with over 42% of residents living in the most deprived national quintile. The population is ethnically diverse and includes a large working-age population alongside growing numbers of older residents.

These demographic and socioeconomic characteristics influence patterns of health behaviours, long-term conditions and health outcomes across Greater Manchester.

Figure 1: Overview of Population Characteristics and Demographics in Greater Manchester

Source: NHS Greater Manchester Health Profiles: Population Characteristics – GM ADSP

1.5 Types of Health Inequalities

Health inequalities can be observed across a range of areas including:

- Differences in life expectancy and healthy life expectancy.
- Variation in access to healthcare services.
- Differences in quality and experience of care.
- Behavioural risk factors including smoking, alcohol use, unhealthy diet and physical inactivity.
- Wider determinants of health such as income, housing, education, employment and environmental conditions.

Inequalities may occur between different population groups and communities, including:

- People living in areas of higher deprivation.
- Different geographical areas and localities.
- Ethnic minority populations.
- Different age groups and genders.
- Inclusion health groups including homeless populations, people with substance misuse needs and socially excluded groups.

2. Data Quality, Completeness and Limitations

2.1 Overview

This report draws upon a range of national, regional and local data sources, including NHS England datasets, Office for National Statistics (ONS) publications, Greater Manchester intelligence products, programme dashboards, statutory returns and locally collected operational data.

Whilst every effort has been made to ensure the accuracy and consistency of the information presented, readers should be aware of several limitations relating to data quality, completeness and timeliness.

2.2 Data Completeness

The completeness of information varies between datasets and local systems. Information relating to protected characteristics such as ethnicity, disability, sexual orientation and religion is not consistently recorded across all datasets.

In particular, ethnicity data quality varies substantially between source systems and may be affected by the presence of blank or null values, as well as residual ethnicity categories such as “Not Stated” and “Not Known”. The availability of valid, non-residual ethnicity codes is essential to support robust inequalities analysis and accurate identification of variation between population groups.

Analysis of ethnicity recording across key NHS datasets demonstrates considerable variation in completeness. Ethnicity completion is highest within the National Cancer Registration dataset (99%) and Alcohol Dependence Records (98%), indicating near-complete recording. In contrast, ethnicity completeness is substantially lower within Continuing Healthcare datasets (37%) and All Age Continuing Care datasets (39%), limiting the ability to undertake robust inequalities analysis within these services. Community Services also demonstrate relatively low completeness (51%), whilst several other datasets, including maternity services (93%), inpatient admissions (92%), tobacco dependence records (90%) and emergency care (89%), achieve

comparatively high levels of recording. A detailed breakdown is provided in **Appendix 2, Table A2.1.**

Trend analysis of Greater Manchester's population segmentation dataset demonstrates that missing ethnicity recording reduced gradually between 2018 and 2024 before increasing during 2024 and 2025. The proportion of records with missing ethnicity has risen from approximately 11% to over 13% during the most recent period, suggesting a deterioration in recording completeness. Whilst overall ethnicity completeness remains approximately 87%, the recent increase in missing data highlights the need for continued improvement in demographic data collection and recording practices across partner organisations. Further detail is provided in **Appendix 2, Figure A2.2**.

Variation also exists in the identification and recording of learning disability and autism, meaning recorded prevalence may not fully reflect population need. Where data completeness is known to be limited, findings should be interpreted with caution.

2.3 Data Quality

Data quality is dependent upon accurate recording within source systems. Variations in clinical coding, registration practices, data entry processes and extraction methodologies may affect the quality and consistency of reported measures.

Where possible, validated national datasets have been used; however, some locally collected operational data may be subject to ongoing quality assurance processes.

2.4 Timeliness of Data

Many national datasets are published with a reporting lag and may not reflect the most recent position. Some indicators included within this report represent the latest available data at the time of publication and may subsequently be revised following validation by national bodies or local providers.

2.5 Snapshot Measures

Several indicators presented within this report represent point-in-time snapshots rather than

continuous measures. This is particularly relevant for operational datasets such as Assuring Transformation data, Dynamic Support Registers, programme monitoring returns, waiting list data and service utilisation measures.

These figures may fluctuate throughout the year and should therefore be interpreted as reflecting the position at the time of data extraction.

2.6 Ongoing Improvement

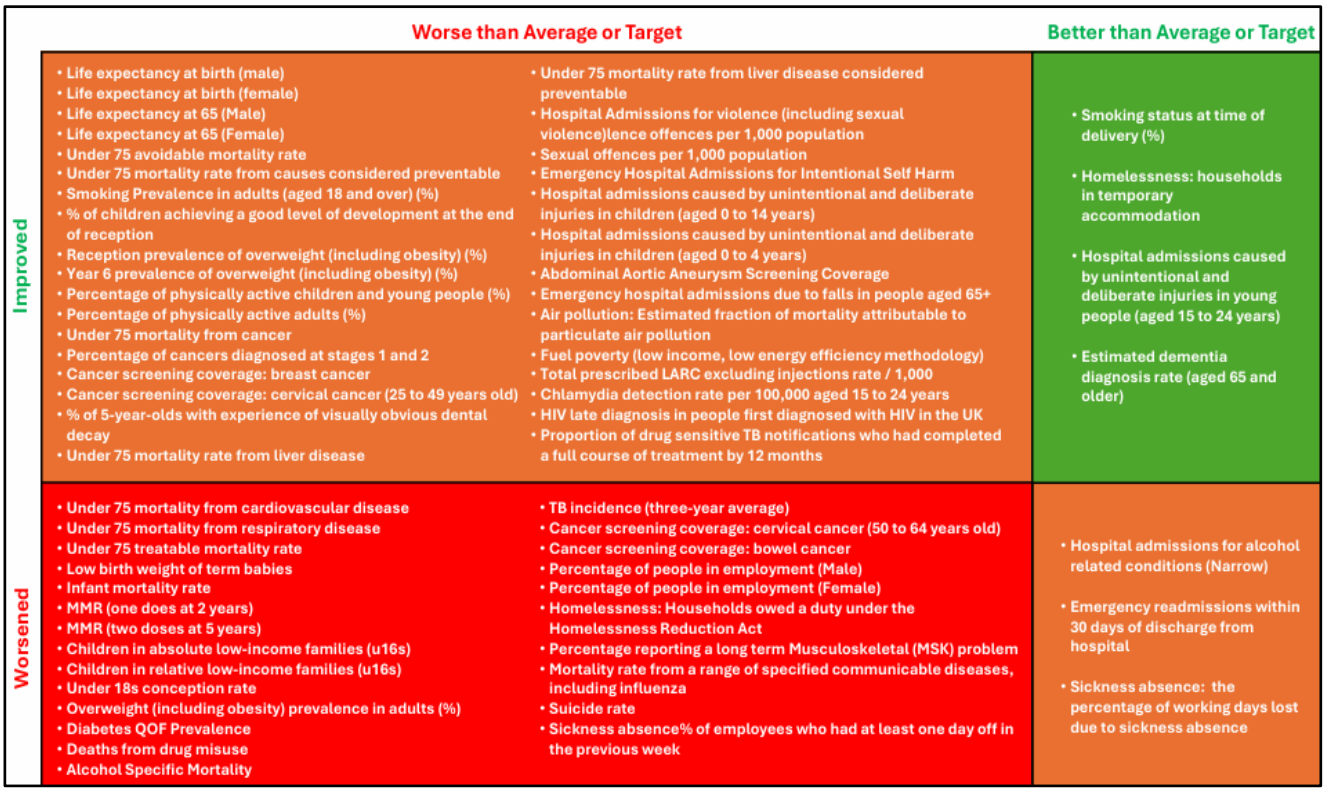
Improving the quality, completeness and consistency of data remains a key priority across Greater Manchester. Work continues across health and care partners to strengthen recording of protected characteristics, improve data quality and enhance intelligence capabilities to better understand and address health inequalities.

Despite these limitations, the data presented provides a robust overview of health inequalities across Greater Manchester and supports evidence-based decision making to improve outcomes for residents.

3. Health Inequalities Overview and Key Trends

3.1 Health Inequalities Indicators: Performance and Direction of Travel

Figure 2: Highlights Health Inequalities Indicators by Performance and Direction of Travel



Source: NHS Greater Manchester Population Health Analysis – GM ADSP

A quadrant analysis carried out in September 2025 has shown that while GM has shown improvement in multiple metrics, there are areas of worsening performance and widening gaps to the national average. Of the metrics shown in greater detail in this briefing:

- **Infant mortality** in GM rose from 4.9 per 1,000 births in 2020–2022 to 5.3 per 1,000 in 2021–2023, this is above the national average of 4.1 per 1,000. This increase is despite lower levels of births.

- The **percentage of adults who are classified as overweight (including obesity)**

increased from 65.9% to 67.1%, above the national average of 64.5%. The gap between GM and England has increased from 1.9% to 2.6%.

- The **prevalence of diabetes** (Quality and Outcomes Framework definition) has increased from 7.7% in 2022/23 to 8% 2023/24, above the national average of 7.7%. The gap between GM and England has increased from 0.2% to 0.3%.

- The **suicide rate** in GM has increased from 10.9 per 100,000 in the 2020 – 2022 period to 12.5 per 100,000 in the 2021 – 2023 period. This is above the national rate of 10.7 per 100,000. For males the rate is 19.3 per 100,000 in GM.

- **Alcohol specific mortality** from the 2017–2019 period to the 2020–2022 period there was a 22.8% increase. Females saw a steeper relative increase compared to males, as females saw a 26% increase by the 2020 to 2022 period while males peaked at 23.7% in the 2021-2023 period.

See the Integrated Care Board (ICB) Annual report for a summary of locality and system wide action on prevention and proactive care programmes in 2024/25 to reduce inequalities and the Academy website for a range of examples of Fairer Health for All in Action happening across our neighbourhoods and localities and 'stories of change' on *how* we are enabling:

- Best Start.
- Community-led health and well-being.
- Prevention and proactive care.
- Health creating places.
- Reduced variation in access, experience and outcomes of care.

We know that NHS bodies can influence the social determinants of health (such as employment, education, housing and the environment)– in their role as anchor institutions and know how these factors also provide important context for understanding healthcare needs and

inequalities in access, experience and outcomes.

NHS GM's commitment to strengthen the role of communities and the Voluntary Community Faith Social Enterprise (VCFSE) sector as a strategic partner in our prevention programmes is enabling community-led health and wellbeing. This is shifting resource and power to communities and expanding access to well-being support, screening and proactive care in non-traditional settings.

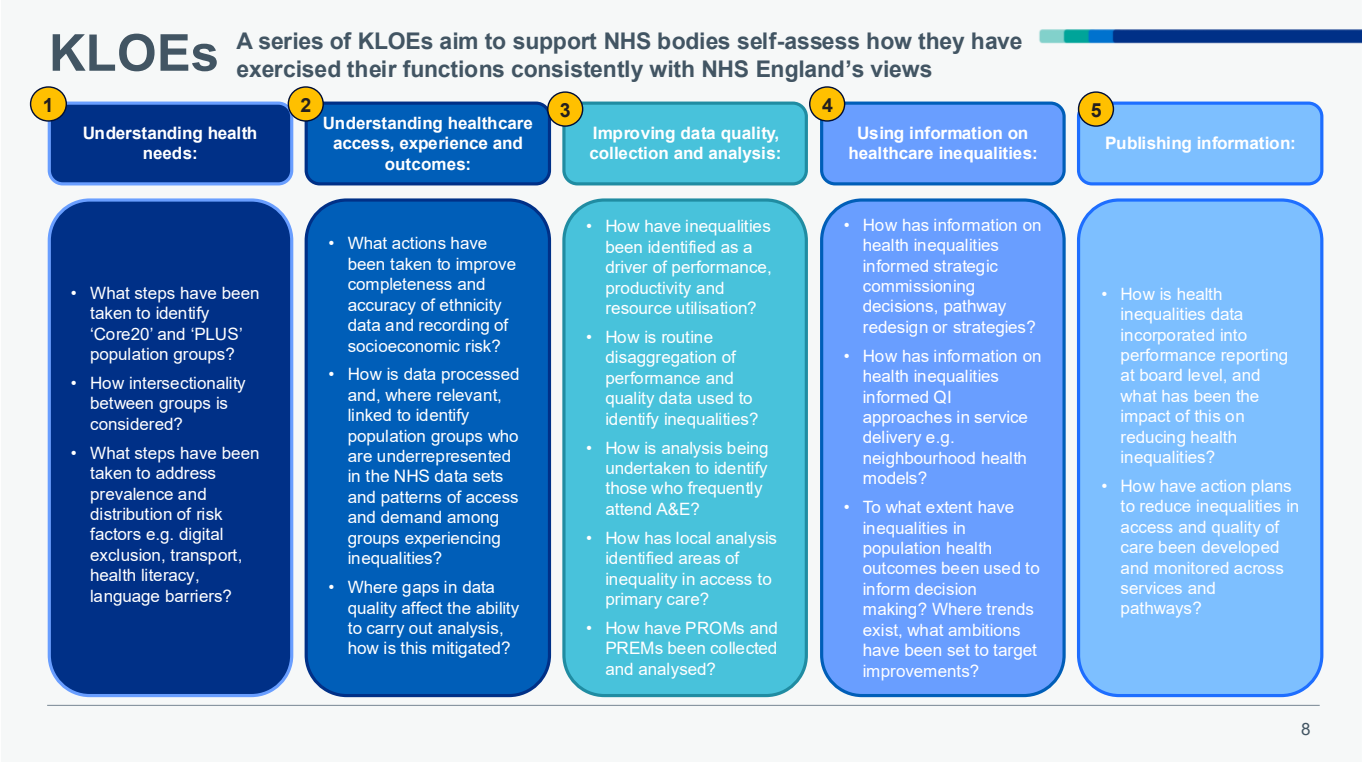
There is work that has taken place 2025-2026 on a range of key programmes that relate to reducing health inequalities and improving outcomes for all, including the workforce. Some examples of this include; Public Sector Equality Duty, anti-racism work, health equality quarterly impact updates, health literacy, creative health and not forgetting all the work happening around GM Live Well.

GM Live Well is Greater Manchester's commitment to ensure everyone can access great everyday support in every neighbourhood. It aims to tackle health, social and economic inequalities by changing how we work with people and communities, and in public services. Live Well is nationally recognised as part of Greater Manchester's status as a 'Prevention Demonstrator', as outlined in the 10-year Plan for Health, attracting significant interest from various government departments.

Over the last 12 months, GM Live Well has transformed from an ambitious manifesto pledge into our collective programme for public service reform. Live Well is now the main mechanism for embedding prevention, integration, and community empowerment across GM's neighbourhoods. The GM programme has also introduced the "Live Well Hallmarks" – a developing, collaboratively designed framework for Live Well centres, spaces, and offers, co-created with localities and community groups to ensure consistent, values-driven delivery.

3.2 NHS England Framework for Assessing and Reducing Health Inequalities

Figure 3: Illustrates NHS England Framework for Assessing and Reducing Health Inequalities.



Source: NHS England.

NHS England's Key Lines of Enquiry (KLOEs) provide the overarching framework for assessing how effectively organisations identify, understand and address health inequalities. The framework considers five interconnected domains:

1. Understanding the health needs of populations, including CORE20PLUS5 and other underserved groups.
2. Assessing inequalities in access to healthcare, patient experience and health outcomes.
3. Improving the quality, completeness and use of health inequalities data.

4. Using intelligence and evidence to inform commissioning decisions, pathway redesign and targeted interventions.
5. Demonstrating accountability through transparent reporting, monitoring and publication of health inequalities information.

Throughout this statement, evidence and analysis have been presented in a way that supports these domains, highlighting areas of good practice, emerging challenges and opportunities for improvement across Greater Manchester.

4. Population Demographics and Population Health Need

4.1 Population Demographics

Greater Manchester Integrated Care Board is the largest in England out of 42 such organisations. The number of people registered with a GP practice in Greater Manchester is just over 3.3 million (September 2025), with the number of people estimated to reside within the Greater Manchester area being slightly over 3 million (Source: ONS Mid-Year Estimates, 2024). Since 2014, the resident population of Greater Manchester has increased by 10.1% over the 10-year period. In the same timeframe, the population in England increased at a slower rate, 7.8%.

It is estimated that the main driver for the increase in the Greater Manchester population, particularly in the most recent years, is due to net international migration with the population increasing by more than 40,000 people per year in 2022, 2023 and 2024.

Greater Manchester is comprised of 10 local authorities ranging in population size from 198,921 in Bury, to 589,670 in Manchester. The average (median) age of residents in Greater Manchester is 36 years, below the national average of 40 years. The proportion of people aged under 16 in Greater Manchester is 20.2%, higher than England (18.4%); whilst there are also a higher proportion of people of working age (16-64) in Greater Manchester than England – 64.2% vs 62.9% respectively. Conversely, the proportion of people aged 65 and over in Greater Manchester is 3% lower than England – 15.7% vs 18.7% respectively.

Greater Manchester is an urban area with 2,359 people per square kilometre living there, compared to 450 people per square kilometre in England (5.2 times more densely populated). However, there is variation amongst local authorities in GM ranging from 1,490 people per square kilometre in Rochdale, to 5,099 people per square kilometre in the City of Manchester – all more densely populated than England.

Given the size of Greater Manchester, the make-up of the population is diverse in terms of socio-economic deprivation and ethnicity, as well as the age profile. Almost 40% of areas in Greater Manchester are within the most deprived 20% of areas nationally (Source: English

Indices of Deprivation 2019). In general, people living in the most deprived areas of the country are more likely to have health issues or develop health issues at an earlier age.

The 2021 Census estimated that there were 821,801 Greater Manchester residents from an ethnic minority. This equated to 28.7% of Greater Manchester's population, slightly above the England average of 26.5%. Asian residents were the most numerous high-level ethnic group (389,283), accounting for nearly half (47.4%) of the overall ethnic minority population, followed by White people who were not White British (144,887) and Black people (134,113). Between 2011 and 2021, the ethnic minority population of Greater Manchester increased by 280,960. This represented growth of 51.9%, significantly above the national increase of 39.3%, and largely driven by new arrivals – more than three quarters (77.4%) of the increase was accounted for by people who had settled in the UK since 2011.

In 2021, Greater Manchester had residents from all the 189 countries listed in the Census. The country of origin accounting for the highest number of Greater Manchester residents who were born overseas was Pakistan (89,331), followed by India (31,030) and Poland (29,859). At least 90 different languages were spoken as a main language in Greater Manchester, and 42 of these languages were spoken by at least a thousand speakers.

4.2 Projected Population Change

The 2022-based sub-national population projections were released by the Office for National Statistics during 2025. Population projections are calculated for geographical areas of the country using trends in recent years for births, deaths and migration. These projections are not forecasts, so do not consider proposed policy changes or planning for housing development for example.

By 2030, the Greater Manchester population is projected to increase by 3.1%. Increasing the latest mid-year estimate by this amount would increase the population by 92,500 people which would put the Greater Manchester population in excess of 3.1 million residents. All 10 local authority areas are expected to show an increase in the period between 2024 and 2030;

however these increases vary from 0.8% in Bury to 7.4% in Salford.

It is estimated that most age groups will see an increase in their population by 2030, with the largest increases being observed in the 80-89 and 90 and over age groups, 21.7% and 17.4% respectively. However, small decreases in the population are predicted across Greater Manchester in the 0-9 age group (-5.4%), 50-59 age group (-6.0%) and the 70-79 age group (-0.4%).

Salford is the only local authority area where the 0-9 age group is predicted to increase (1.5%). Bury, Manchester and Oldham are expected to see decreases in the 10-19 age group also. The largest increase in the older age groups (80-89 and 90 & over) are expected to occur in Wigan, 27.9% and 29.3% respectively.

International net migration is expected to contribute the largest change in seven Greater Manchester local authorities (as well as the whole of Greater Manchester) with net internal migration (that is migration within England) contributing the largest change for Stockport, Tameside and Wigan.

For further useful information regarding the population of Greater Manchester please see the links below to useful tools/briefings from national publications and GMCA briefings.

- ONS - ONS population projections and Greater Manchester (E47000001) - ONS.

We also have two useful visualisation dashboards developed on the Intelligence Hub for registered and resident population of Greater Manchester.

- GM Resident Population Overview
- GM Registered Population by GP Practice

5. Life Expectancy, Healthy Life Expectancy and Deprivation

5.1 Life expectancy in Greater Manchester

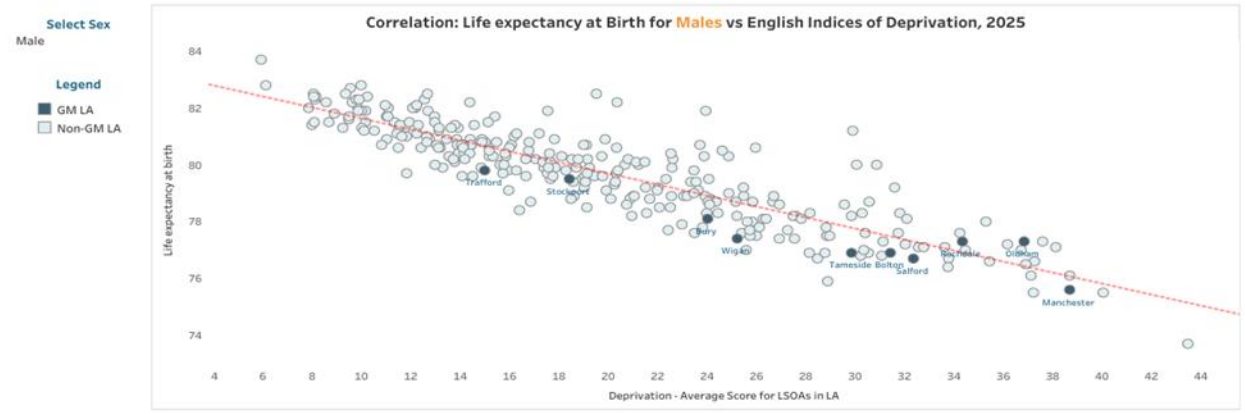
Figure 4: Illustrates life expectancy at birth for males and females across the local authorities of Greater Manchester between 2022 and 2024, with Comparison to England

Source: Life Expectancy Correlation, 2022-24 – GM ADSP

Life expectancy in Greater Manchester remained below the England average for both males and females between 2022 and 2024. Marked variation was observed across local authorities, with Trafford and Stockport reporting the highest life expectancy estimates and Manchester reporting the lowest.

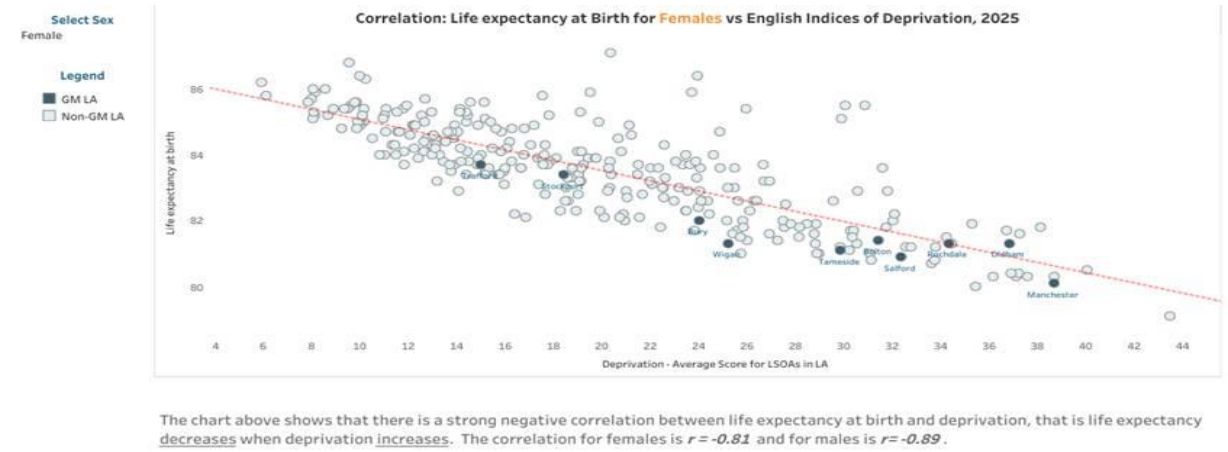
These findings demonstrate substantial inequalities in health outcomes across Greater Manchester.

Figure 5: Analysis of the Relationship Between Deprivation and Life Expectancy at Birth in Males, 2025



Source: Life Expectancy Correlation, 2022-24 – GM ADSP

Figure 6: Analysis of the Relationship Between Deprivation and Life Expectancy at Birth in Females, 2025



Source: Life Expectancy Correlation, 2022-24 – GM ADSP

Figures 5 and 6 demonstrate a strong negative correlation between deprivation and life expectancy for both males and females across England, with Greater Manchester local authorities generally clustering within the more deprived range of the distribution.

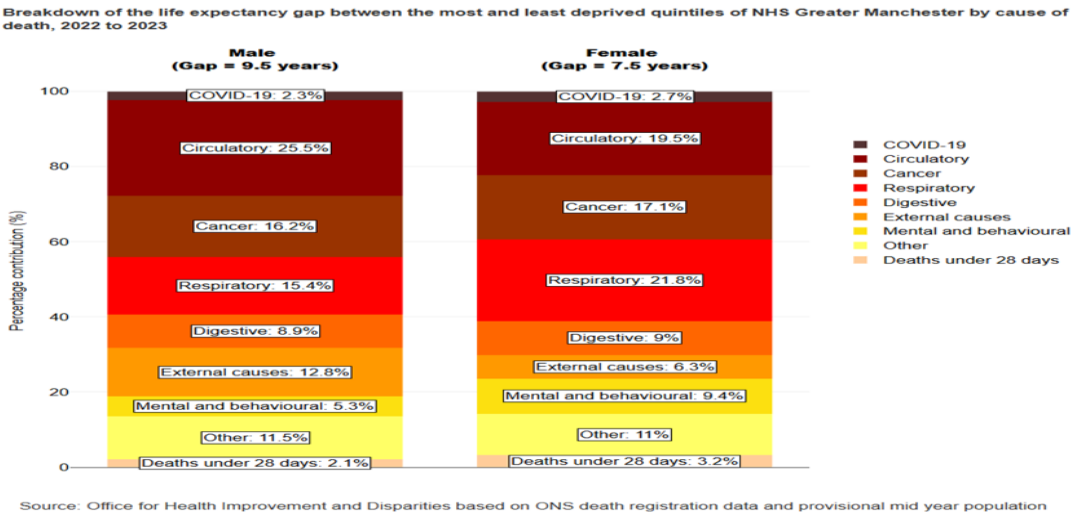
Areas with higher deprivation scores tended to report lower life expectancy outcomes. Manchester, Rochdale, Oldham and Salford were positioned towards the more deprived end of the distribution and also reported comparatively lower life expectancy. In contrast, Trafford and Stockport were associated with lower deprivation levels and higher life expectancy outcomes.

The correlation was stronger for males (r = -0.89) than for females (r = -0.81), indicating that increasing deprivation is strongly associated with reductions in life expectancy, particularly among men. These findings highlight the close relationship between socioeconomic deprivation and inequalities in life expectancy outcomes across Greater Manchester.

5.2 Life expectancy Gap in Greater Manchester

The latest available data for Greater Manchester shows a difference in life expectancy between populations living in the most deprived and least deprived areas. For males, the gap in life expectancy between the most and least deprived populations is 9.5 years. For females, the gap is 7.5 years.

Figure 7: Contribution of Causes of Death to the Life Expectancy Gap between the most and least deprived quintiles in Greater Manchester, 2022–2023, by Sex



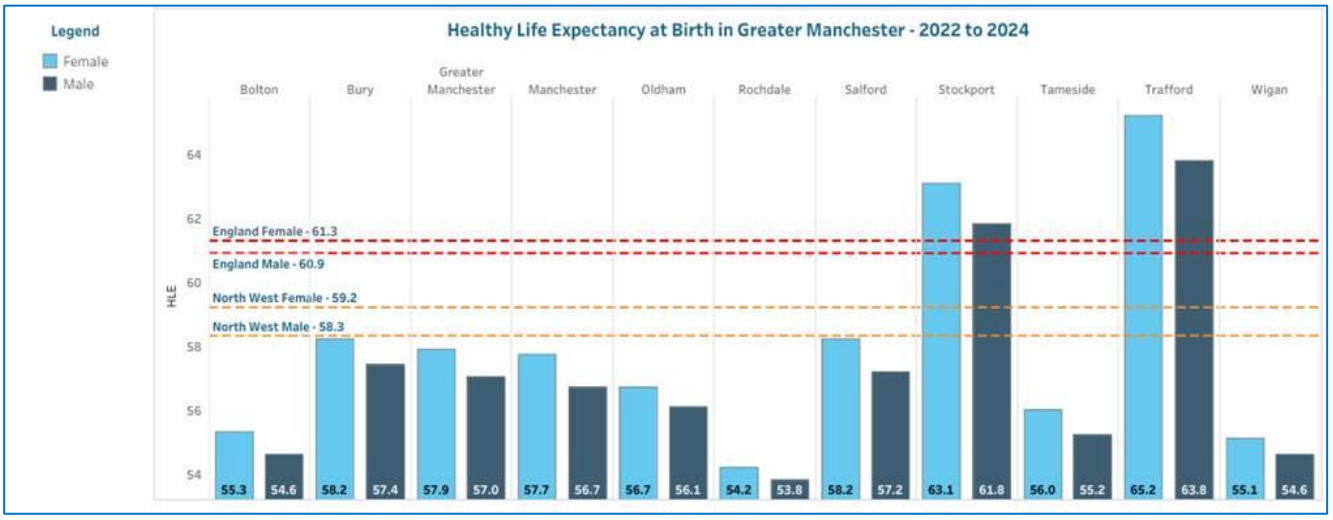
Source: Office for Health Improvement and Disparities Segment Tool

For males, circulatory disease accounted for the largest proportion of the gap (25.5%), followed by cancer (16.2%) and respiratory disease (15.4%). For females, respiratory disease accounted for the largest proportion (21.8%), followed by circulatory disease (19.5%) and cancer (17.1%).

5.3 Healthy Life Expectancy in Greater Manchester

Healthy life expectancy in Greater Manchester is lower than both the Northwest and England averages for males and females.

Figure 8: Variation in Healthy Life Expectancy Across Greater Manchester Localities, 2022–2024, with Comparison to England and the North West

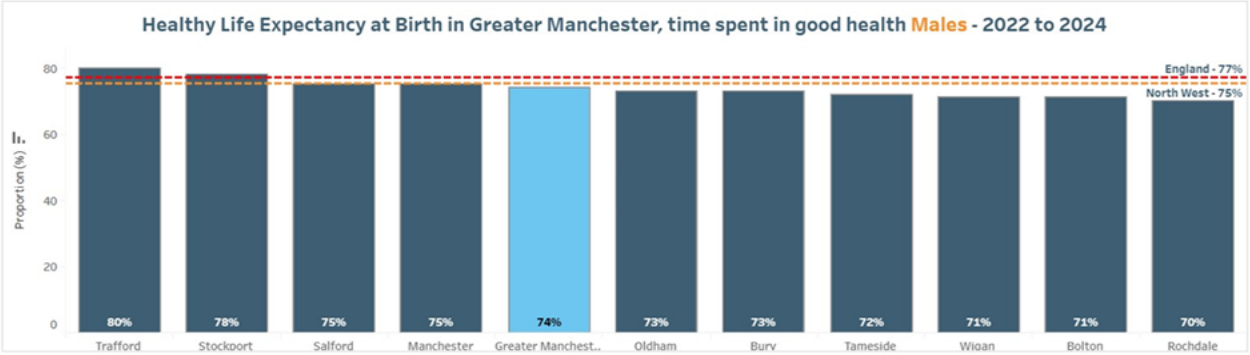


Source: NHS Greater Manchester Life Expectancy Correlation, 2022-24 – GM ADSP

For males, healthy life expectancy in Greater Manchester is 57 years, which is 3.9 years lower than the England average. Male healthy life expectancy has decreased from 59.7 years in 2012–14 and from a peak of 60.7 years in 2017–19.

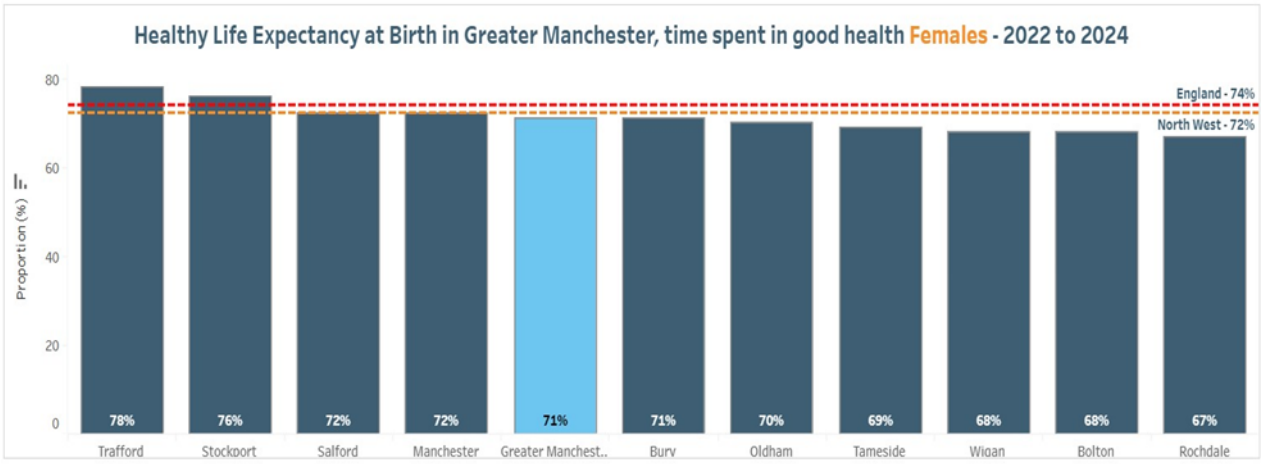
For females, healthy life expectancy in Greater Manchester is 57.9 years, which is 3.4 years lower than the England average. Female healthy life expectancy has decreased from 60.3 years in 2012–14 and from a peak of 61.2 years in 2018–20. Healthy life expectancy varied across Greater Manchester localities for both males and females.

Figure 9: Proportion of Life Spent in Good Health Among Males Across Greater Manchester Localities, 2022–2024, with Comparison to England and the North West



Source: NHS Greater Manchester Life Expectancy Correlation, 2022-24 – GM ADSP

Figure 10: Proportion of Life Spent in Good Health Among Females Across Greater Manchester Localities, 2022–2024, with Comparison to England and the North West



Source: NHS Greater Manchester Life Expectancy Correlation, 2022-24 – GM ADSP

Residents in Greater Manchester spend a lower proportion of their lives in good health compared with England averages. For males, the proportion ranged from 70% in Rochdale to 80% in Trafford. For females, the proportion ranged from 67% in Rochdale to 78% in Trafford. While life expectancy reflects length of life, healthy life expectancy estimates the number of years lived in good health.

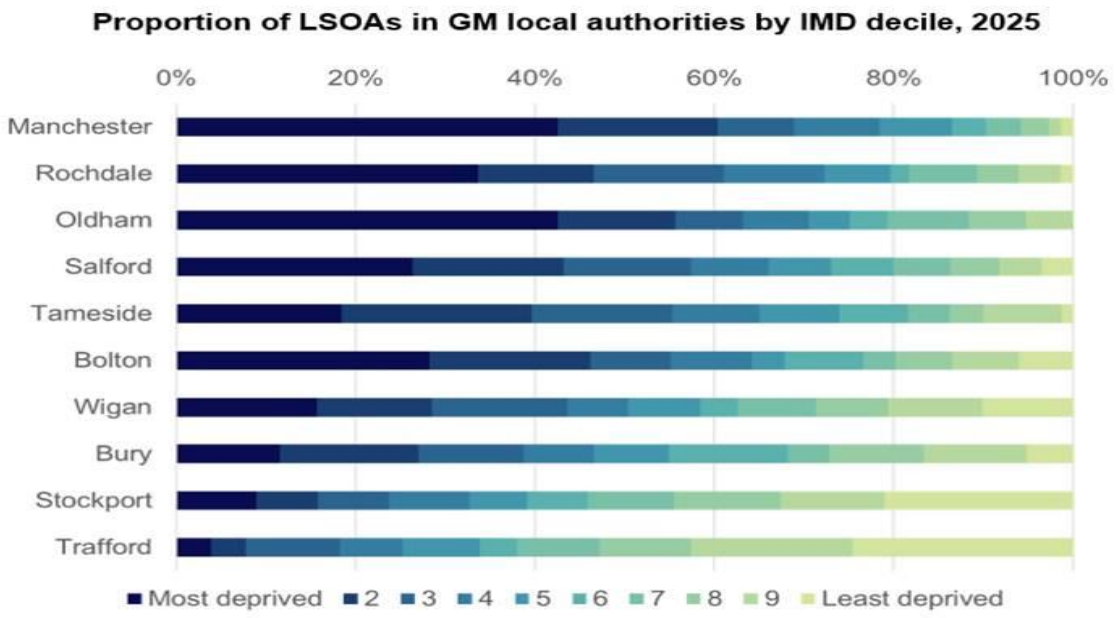
5.4 Deprivation Across Greater Manchester

5.4.1 Greater Manchester's overall deprivation profile

Greater Manchester experiences high levels of deprivation relative to national averages, with marked variation across local authorities and neighbourhoods.

According to the Index of Multiple Deprivation (IMD) 2025, 392 Lower Super Output Areas (LSOAs) in Greater Manchester fall within the 10% most deprived areas nationally. These neighbourhoods contain more than 733,000 residents. Overall, 23% of LSOAs and 25.0% of residents in Greater Manchester are living within the most deprived areas in England.

Figure 11: Inequalities in Neighbourhood Deprivation Across Greater Manchester Local Authorities



Source: Index of Multiple Deprivation (IMD) 2025

5.4.2 Distribution of deprivation across GM local authorities

Figure 11 demonstrates substantial variation in deprivation across Greater Manchester local

authorities. The distribution of deprivation across GM is uneven, with substantial variation both between and within local authorities.

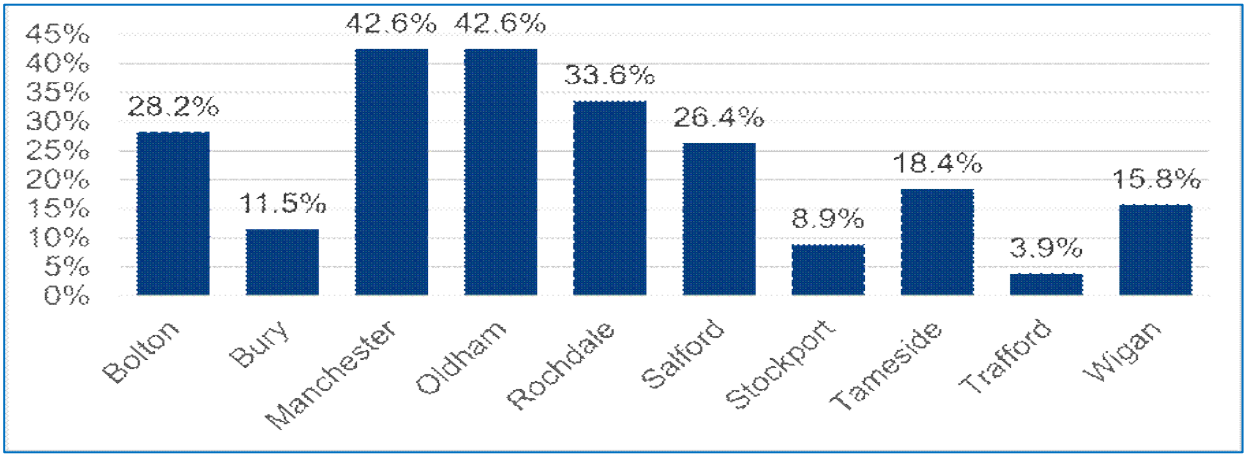
Manchester, Oldham, Rochdale and Salford had the largest concentrations of neighbourhoods within the more deprived national deciles. In contrast, Trafford and Stockport have greater proportions of neighbourhoods within the least deprived national deciles.

The distribution also highlights variation within local authorities themselves. For example, Stockport contains neighbourhoods within both the most deprived and least deprived national deciles, demonstrating inequalities within the locality.

Across Greater Manchester, more deprived neighbourhoods were more commonly concentrated within urban centres, while less deprived neighbourhoods were more frequently located within suburban and peripheral areas.

5.4.3 Population living within the most deprived national decile

Figure 12: Proportion (%) of Residents Living in the Most Deprived Neighbourhoods by Greater Manchester Local Authority



Source: Index of Multiple Deprivation (IMD) 2025

Manchester and Oldham had the highest proportions of residents living within the most deprived areas nationally, with both local authorities recording 42.6% of their populations within the 10%

most deprived national decile.

Rochdale also had a high proportion at 33.6%, followed by Bolton at 28.2% and Salford at 26.4%.In contrast, Trafford had the lowest proportion at 3.9%, followed by Stockport at 8.9% and Bury at 11.5%.

These findings demonstrate substantial inequalities across Greater Manchester local authorities.

5.4.4 Change in deprivation ranking across Greater Manchester

Table 1 shows changes in the relative deprivation ranking of Greater Manchester local authorities between 2019 and 2025, based on rank of average score (ROAS). A lower ranking indicates a higher level of deprivation relative to other local authorities in England.

Table 1: Change in IMD Rank (Based on Rank of Average Score) for Greater Manchester Local Authorities, 2019–2025

Local authority	ROAS 2019	ROAS 2025	Change in ranking
Bolton	34	30	4
Bury	95	90	5
Manchester	6	4	2
Oldham	19	11	8
Rochdale	15	17	-2
Salford	18	24	-6
Stockport	130	158	-28
Tameside	28	44	-16
Trafford	191	201	-10
Wigan	75	78	-3

Source: Index of Multiple Deprivation (IMD) 2025

NOTE: *Negative values indicate a reduction in relative deprivation ranking, while positive values*

indicate an increase in relative deprivation ranking.

For context, the Index of Multiple Deprivation (IMD) rankings are based on 317 lower-tier local authorities in England (382 across the UK), with a rank 1 representing the most deprived local authority.

The findings indicate widening variation across Greater Manchester local authorities between 2019 and 2025. Oldham experienced the greatest increase in deprivation ranking, moving from 19th to 11th nationally, followed by Bury (95th to 90th), Bolton (34th to 30th), and Manchester (6th to 4th nationally). Overall, four Greater Manchester local authorities became relatively more deprived over the period.

Manchester remained the most deprived local authority in Greater Manchester and ranked as the fourth most deprived local authority nationally in 2025. Oldham also remained among the most deprived local authorities nationally, ranking 11th in England. In contrast, several local authorities experienced the largest reduction in relative deprivation ranking between 2019 and 2025. Stockport experienced the largest reduction in relative deprivation ranking, moving from 130th to 158th nationally. Tameside also showed a notable reduction, moving from 28th to 44th. Trafford remained the least deprived local authority in Greater Manchester, ranking 201st nationally in 2025.

Table 2: IMD Rank, Proportion of LSOAs in the Most Deprived 10% Nationally, and Proportion of Population Living in the Most Deprived 10% of LSOAs, 2025

Local authority	IMD Rank 2025	Proportion of LSOAs in 10% most deprived nationally	Proportion of population in 10% most deprived LSOAs nationally
Bolton	30	26.00%	28.20%
Bury	90	10.80%	11.50%
Manchester	4	40.70%	42.60%
Oldham	11	37.30%	42.60%
Rochdale	17	31.10%	33.60%
Salford	24	25.50%	26.40%
Stockport	158	7.90%	8.90%
Tameside	44	17.60%	18.40%
Trafford	201	4.30%	3.90%
Wigan	78	15.50%	15.80%
Greater Manchester	-	23.00%	25.20%

Source: Greater Manchester Combined Authority analysis of the Index of Multiple Deprivation (IMD) 2025

Table 2 further highlights substantial inequalities across Greater Manchester local authorities in the proportion of neighbourhoods and residents living within the 10% most deprived areas nationally. Across Greater Manchester as a whole, 23.0% of LSOAs and 25.2% of the population were within the 10% most deprived areas nationally in 2025.

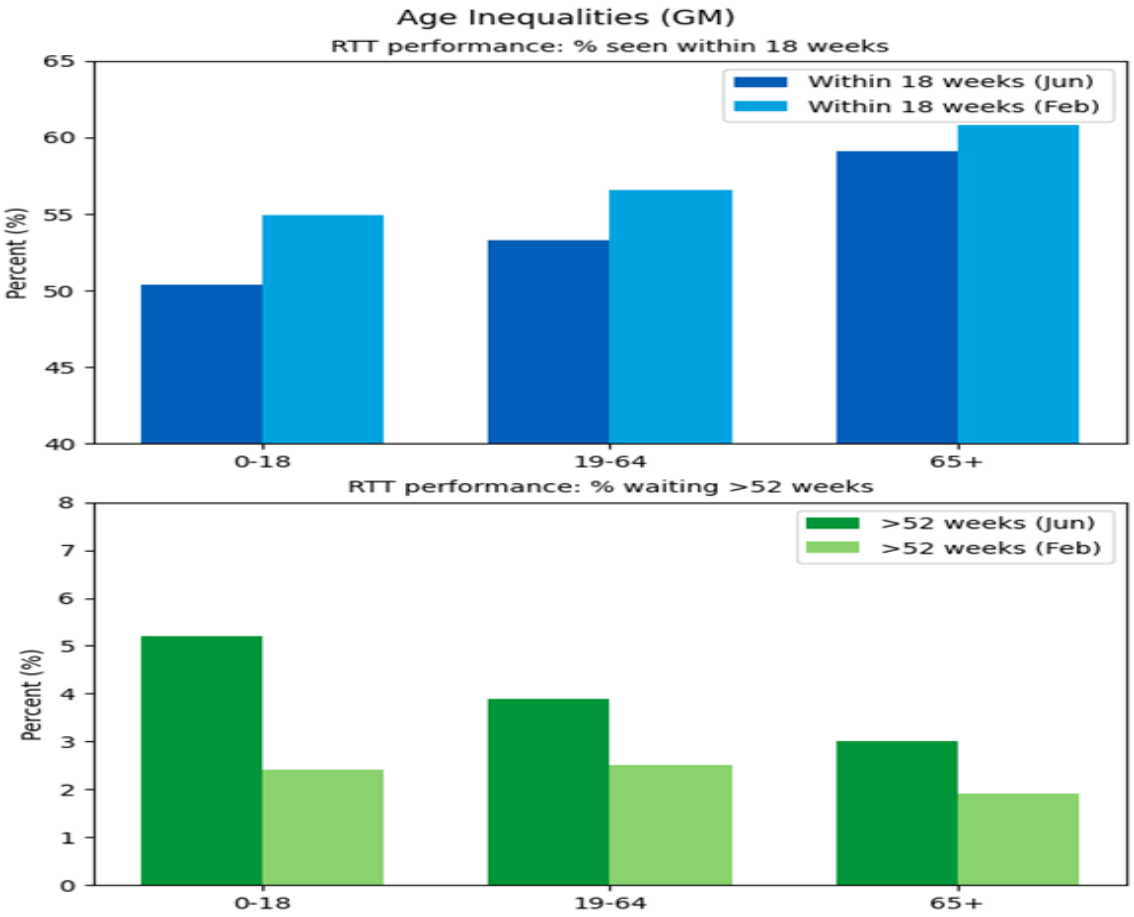
Manchester and Oldham had the highest proportions of residents living within the 10% most deprived areas nationally, with both local authorities reporting 42.6% of their population within the most deprived decile. Rochdale also reported a high proportion at 33.6%, followed by Bolton at 28.2% and Salford at 26.4%.In comparison, Trafford had the lowest proportion of residents living within the 10% most deprived areas nationally at 3.9%, followed by Stockport at 8.9% and Bury at 11.5%. These findings demonstrate the considerable variation in deprivation levels across Greater Manchester local authorities.

NHS England Health Inequalities Metrics Response (Sections 6-15)

6. Elective Care and Recovery

This analysis uses newly published national elective data disaggregated by age, sex, deprivation and ethnicity to benchmark Greater Manchester (GM) performance against the England average over the most recent nine-month period (June 2025 to February 2026). It considers Referral to Treatment (RTT) performance, waiting list size and recent Did Not Attend (DNA) rates to provide a rounded view of equity of recovery.

Figure 13: Referral to Treatment (RTT): Percentage Seen Within 18 Weeks and Percentage Waiting Over 52 Weeks by Age Group, Highlighting Age Inequalities

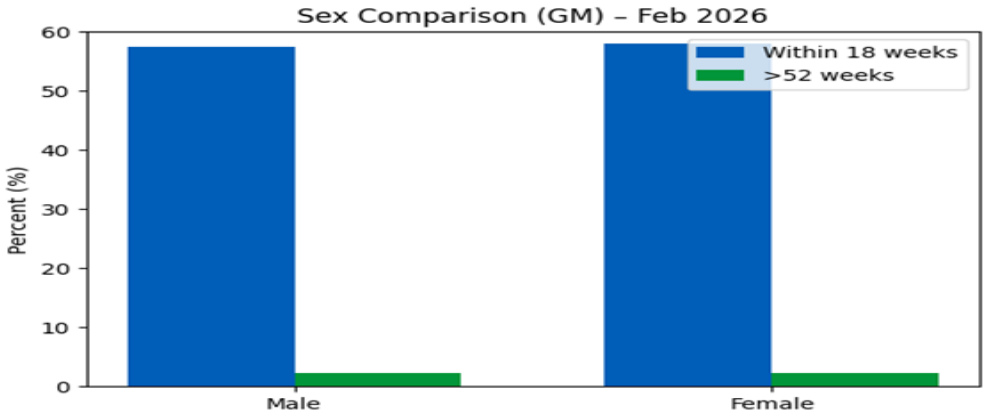


Source: NHSE Published statistics

Children and young people (0–18) remain the most disadvantaged age group but have also seen the greatest improvement. The proportion waiting over 52 weeks reduced from 5.2% to 2.4%, compared with 3.9% to 2.5% for those aged 19–64 and 3.0% to 1.9% for those aged 65+.

The proportion treated within 18 weeks increased from 50.4% to 54.9%, narrowing age gaps and reducing the distance to England. The waiting list reduced most for children (-14.9%), compared with -10.1% for 19–64s and -6.0% for 65+. DNA rates show a strong age gradient, with young adults aged 20–29 recording the highest non-attendance (12.0%), above the England average, while rates fall steadily with age.

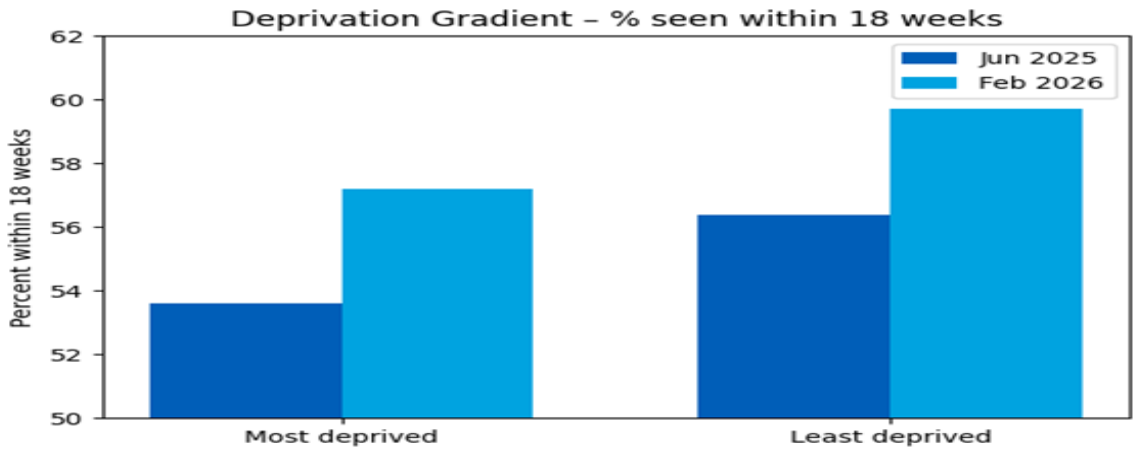
Figure 14: Referral to Treatment (RTT): Percentage Seen Within 18 Weeks and Percentage Waiting Over 52 Weeks by Sex



Source: NHSE Published statistics

Differences by sex are small and stable. Both males and females reduced very long waits to around 2.3% and improved treatment within 18 weeks to 57–58%, with only a marginal male advantage. Waiting list reductions were almost identical (-9.8% for males; -9.6% for females). DNA rates are higher for males (8.5%) than females (7.2%), with both above the England average, reinforcing a modest but consistent engagement gap.

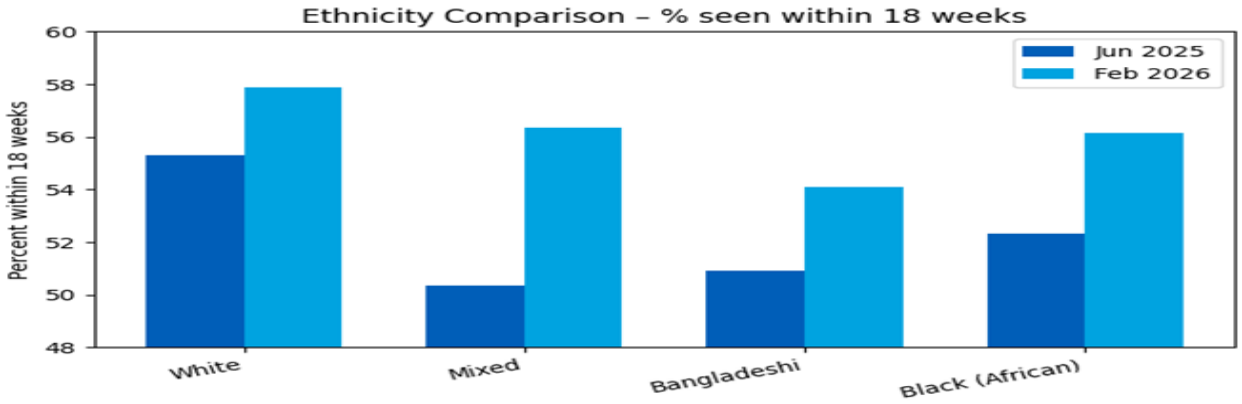
Figure 15: Comparison of the Percentage Seen Within 18 Weeks Between the Most and Least Deprived Quintiles for June 2025 and February 2026



Source: NHSE Published statistics

A persistent social gradient remains. In June, 4.0% of the most deprived waited over 52 weeks compared with 3.5% of the least deprived, and 53.6% vs 56.4% were treated within 18 weeks. By February, long waits reduced to 2.4% and 2.1%, and within-18 performance improved to 57.2% and 59.7%, narrowing deprivation gaps. All deprivation groups saw waiting list reductions (around 6–8%). DNA rates mirror this gradient, with the most deprived communities experiencing the highest non-attendance (10.6%), above the national average, compared with 4.0% in the least deprived.

Figure 16: Comparison of the Percentage Seen Within 18 Weeks Between Ethnicity Groups for June 2025 and February 2026



Source: NHSE Published statistics

RTT performance varies by ethnicity. In June, White patients had the highest proportion seen within 18 weeks (55.2%), while Mixed (50.0%), Bangladeshi (50.4%) and Black (African) patients (51.6%) had lower levels of timely access. By February, performance improved across all groups, with the largest gains observed among Mixed and Black (African) patients. Despite this improvement, variation between ethnic groups remains, with White patients continuing to achieve the highest proportion seen within 18 weeks.

The findings suggest that elective care recovery has benefited all ethnic groups, with evidence of narrowing inequalities in timely access. However, differences persist and continued targeted action will be required to ensure improvements are sustained and gaps continue to close.

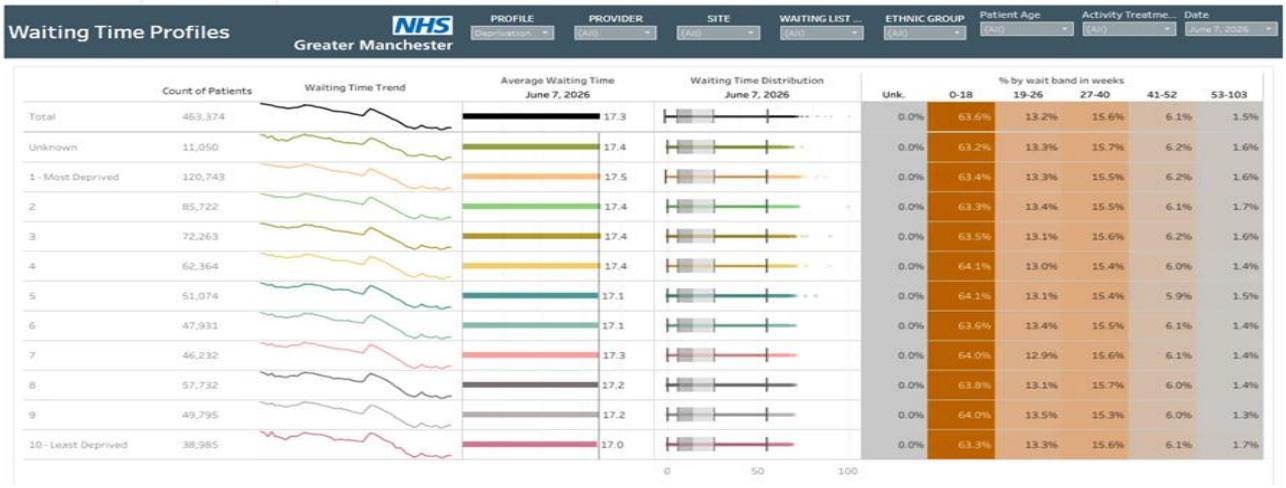
Additional analysis showed reductions in waiting list size and very long waits across all ethnic groups. DNA rates remained highest among Black or Black British (11.6%) and Mixed ethnicity groups (11.2%), both above the England average, while White patients had the lowest rate (7.3%).

6.1 Inequalities in annual change in size of waiting list

In Greater Manchester we have developed an Elective Equalities dashboard that helps us to

look at the weekly waiting list data to review waiting time trends for our patients by age, deprivation and ethnicity. We can see that there are more patients from the most deprived areas in GM on the waiting list but over the past 12 months we can see that this trend is declining by deprivation, age and ethnic group. There is more work to do on this in 2026/27 but this shows progress we are making in monitoring the waiting list and inequalities to ensure that all patients in GM are treated equally regardless of demographics.

Figure 17: RTT Waiting Time Profile by Deprivation Decile, Greater Manchester



Source: NHS Greater Manchester Elective Equalities Waiting Time Profiles – GM ADSP

Figure 18: RTT Waiting Time Profile by Age Group, Greater Manchester

Source: NHS Greater Manchester Elective Equalities Waiting Time Profiles – GM ADSP

Figure 19: RTT Waiting Time Profile by Ethnic Group, Greater Manchester

Source: NHS Greater Manchester Elective Equalities Waiting Time Profiles – GM ADSP

6.2 Inequalities in percentage of people waiting over 18 weeks, over 52 weeks, over 104 weeks for community services

Currently we are not able to demonstrate inequalities in annual change in waiting list size or in the percentage of people waiting over 18, 52 and 104 weeks for community services. Work is underway to improve the quality, completeness and linkage of community services data to support more comprehensive reporting of waiting times by deprivation, age and ethnicity in future annual reports.

7. Adult Urgent and Emergency Care

7.1 Overview

Addressing health inequalities remains a core priority for NHS Greater Manchester. Within Urgent and Emergency Care (UEC), inequalities are assessed across experience, access and outcomes, with a focus on identifying unwarranted variation between population groups.

This section presents key inequalities metrics across UEC, covering:

- Emergency Department (ED) experience.
- Ambulance care pathways for time-critical conditions.
- Children and Young People (CYP) ED attendances.

The analysis considers variation by deprivation, ethnicity, age and locality, and is intended to support targeted system action and continuous improvement.

7.1.1. Summary of Key Inequalities Findings - Analysis of UEC performance in 2025/26 highlights:

- Overall improvement in ED waiting times, but with continued variation across localities and population groups.
- Significant age-related inequality, with older patients experiencing substantially longer ED waits.
- Variation by ethnicity in ED experience, requiring further investigation.
- Clear deprivation gradient in CYP ED attendances, reflecting underlying differences in need and access.
- Data limitations in ambulance care measures and community setting measures restricting current ability to assess inequalities in some high-impact pathways.

These findings reinforce that while overall system performance has improved, inequalities in experience and access persist and require targeted, system-wide action.

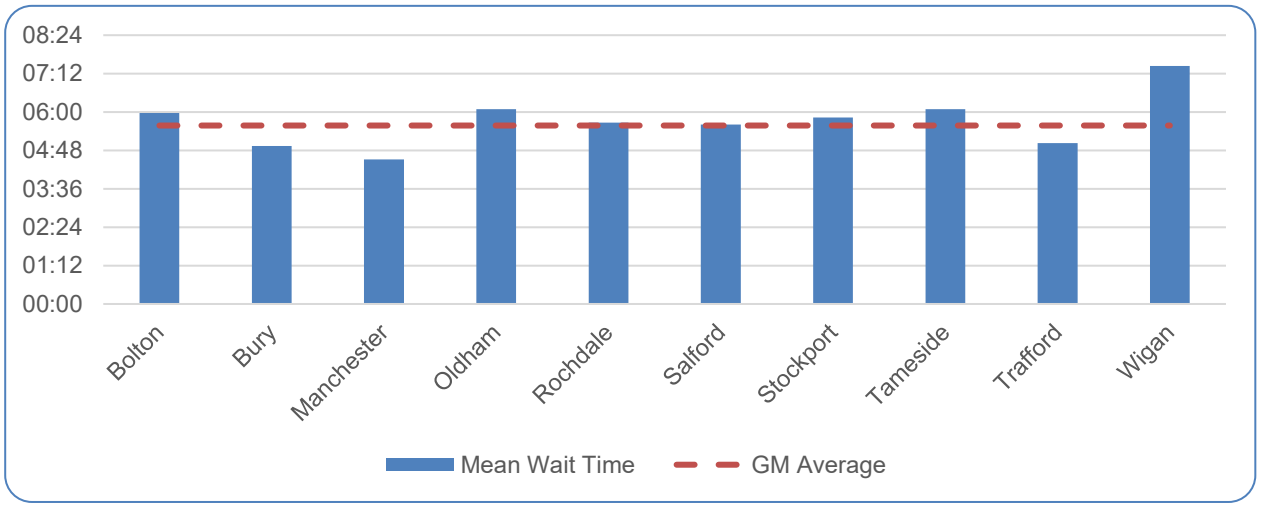
7.2 Core Adult Urgent and Emergency Care Inequalities

7.2.1 Emergency Department (ED) Waiting Times

Mean ED waiting time improved from 5 hours 54 minutes in 2024/25 to 5 hours 34 minutes in 2025/26, representing a reduction of 5.6%. Despite this improvement, waiting times remain above 2023/24.

Substantial variation remains across localities, with mean ED waiting times ranging from 4 hours 31 minutes in Manchester to 7 hours 26 minutes in Wigan. This variation suggests that local system pressures, patient flow and service configuration continue to influence performance.

Figure 20: Mean Emergency Department (ED) Wait Time (hours:minutes) by Locality

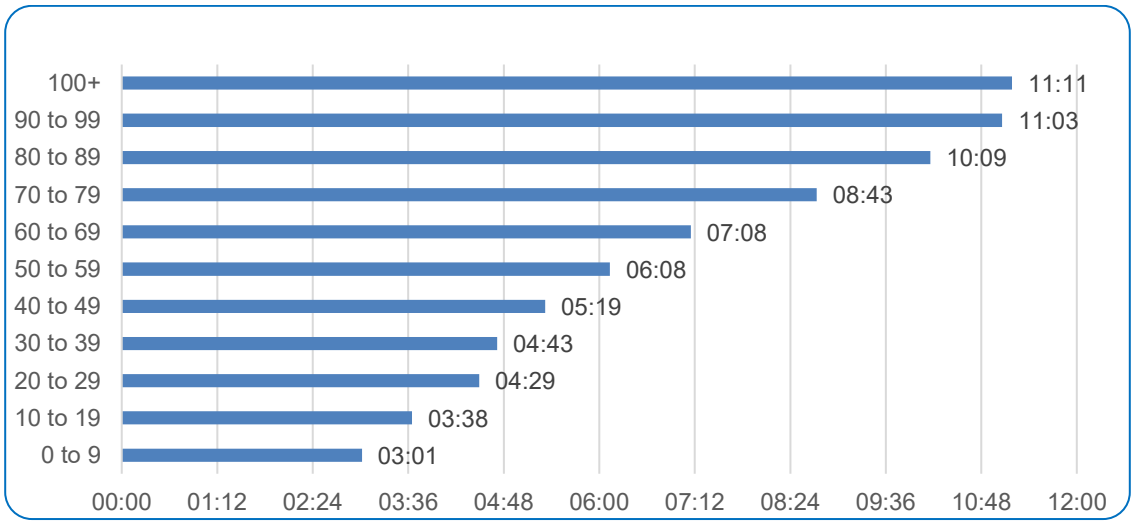


Source: NHS Greater Manchester Emergency Department Performance – GM ADSP

Age remains the most significant inequality dimension within ED waiting times. Mean waiting time increases steadily with age, from around 3 hours in children aged 0-9 to more than 11 hours in those aged 90-99 years. Patients aged 80 years and over experience average waits exceeding 10 hours. Differences between males and females are small across all age bands, suggesting that age is a substantially greater driver of variation than sex. The longer waits experienced by older adults are likely to reflect increased clinical complexity, higher admission

rates and pressures on inpatient capacity.

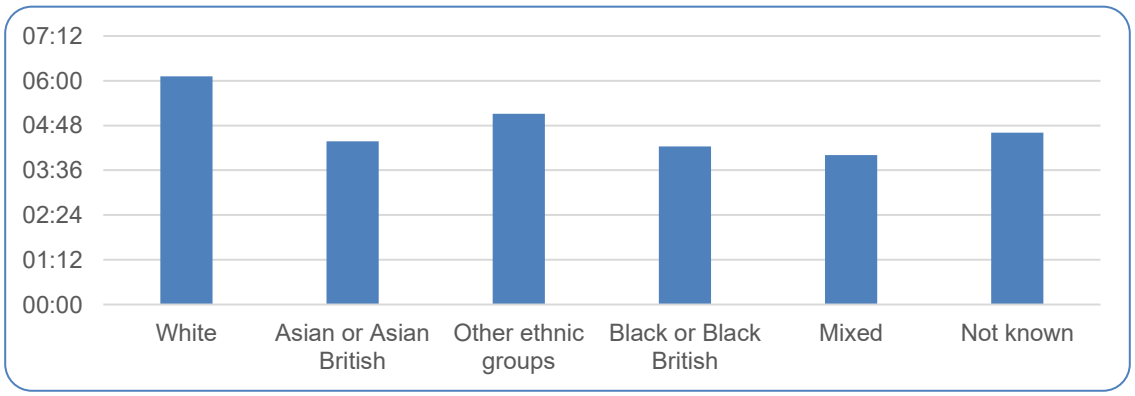
Figure 21: Mean Emergency Department (ED) Wait Time by Age Band



Source: NHS Greater Manchester Emergency Department Performance – GM ADSP

ED waiting times vary by ethnicity. In 2025/26, White patients experienced the longest average waits (6 hours 7 minutes), while shorter waits were observed among Asian, Black and Mixed ethnic groups. The reasons for this variation require further investigation, including consideration of case-mix, acuity and pathway differences.

Figure 22: Mean Emergency Department (ED) Wait Time by Ethnicity

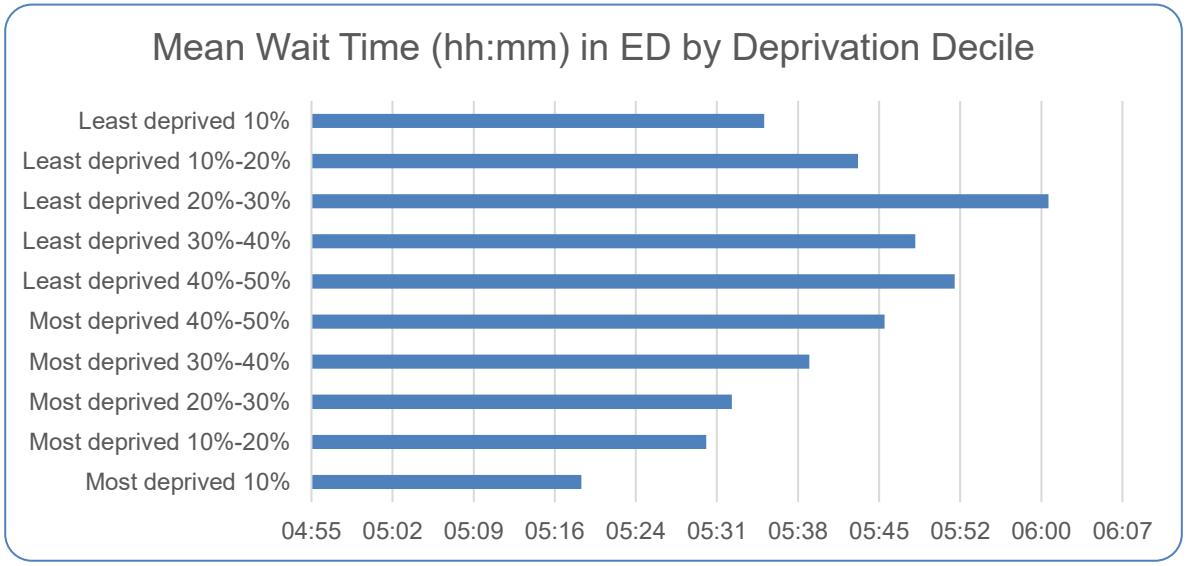


Source: NHS Greater Manchester Emergency Department Performance – GM ADSP

Mean ED waiting times vary across ethnic groups in Greater Manchester. Patients recorded as White have the highest mean wait times, whilst shorter waits are observed among several other ethnic groups. These differences are likely to reflect a combination of factors including case mix, acuity, mode of arrival and admission pathways, and should therefore be interpreted alongside wider measures of access and outcomes.

Mean ED waiting times varied across deprivation deciles, although no consistent deprivation gradient was observed. Waiting times were highest among people living in the least deprived 30-40% areas, while shorter mean waits were observed for those living in the most deprived deciles. These differences are likely to reflect a combination of factors, including differences in case mix, clinical acuity, mode of arrival and admission pathways, and should therefore be interpreted alongside wider measures of access and outcomes.

Figure 23: Mean Emergency Department (ED) Wait Time by Deprivation Decile



Source: NHS Greater Manchester Emergency Department Performance – GM ADSP

Differences by sex were minimal, with mean ED waiting times of 5 hours 35 minutes for females and 5 hours 34 minutes for males. This indicates that relative to age, ethnicity, locality and deprivation, gender is a less prominent driver of variation in mean ED time in the aggregate.

While overall ED performance has improved, inequalities in experience remain significant, particularly for older patients and across different localities.

System priorities include:

- Strengthening frailty pathways and flow for older patients.
- Improving system flow and discharge capacity.
- Further analysis of ethnic variation in ED pathways.

7.3 Ambulance Care

7.3.1 Post- Return of Spontaneous Circulation (ROSC) Care Bundle (Cardiac Arrest)

This measure assesses whether patients who achieve ROSC receive the full recommended post-resuscitation care bundle prior to hospital arrival.

At present, there is insufficient data available to robustly assess variation in post-ROSC care by age, deprivation, ethnicity or gender. Work is underway to improve the quality, completeness and linkage of the available data to support more comprehensive assessment of inequalities in future reporting.

The absence of detailed inequalities data limits the system's ability to assess equity in this critical pathway. Improving data capture and analytical capability is required to enable meaningful assessment in future reporting.

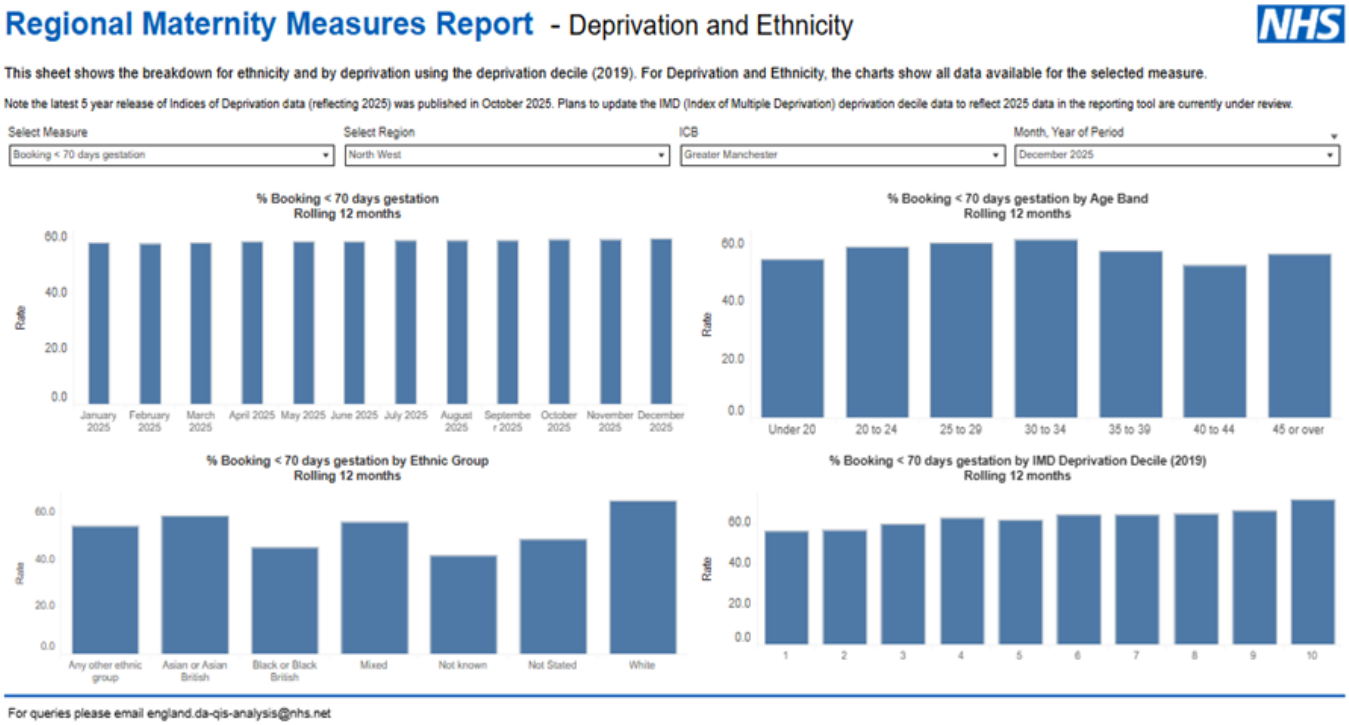
7.3.2 ST-Elevation Myocardial Infarction (STEMI) Care Bundle

This measure assesses delivery of the full pre-hospital care bundle for patients experiencing ST-elevation myocardial infarction (STEMI). Current data do not support detailed analysis of inequalities by age, deprivation, ethnicity or sex. Further development of data collection and reporting is planned during 2026/27 to enable assessment of equity of access and care delivery across population groups.

8. Maternity and Neonatal Health

8.1 Trends in Early Antenatal Bookings

Figure 24: Early Antenatal Booking (<70 Days' Gestation): Patient Characteristics and Demographics



Source: NHS Futures - Maternity Services Data Set, Regional Maternity Measures Report

The Maternity Services Data Set (MSDS), analysed on a rolling 12-month basis to December 2025, shows that across Greater Manchester approximately half of women are booking before 70 days (10 weeks) of gestation. Performance has remained broadly stable across the calendar year, consistently trending well below nationally recommended standards.

Disaggregating this picture by demographic group reveals clear and persistent inequalities across three dimensions:

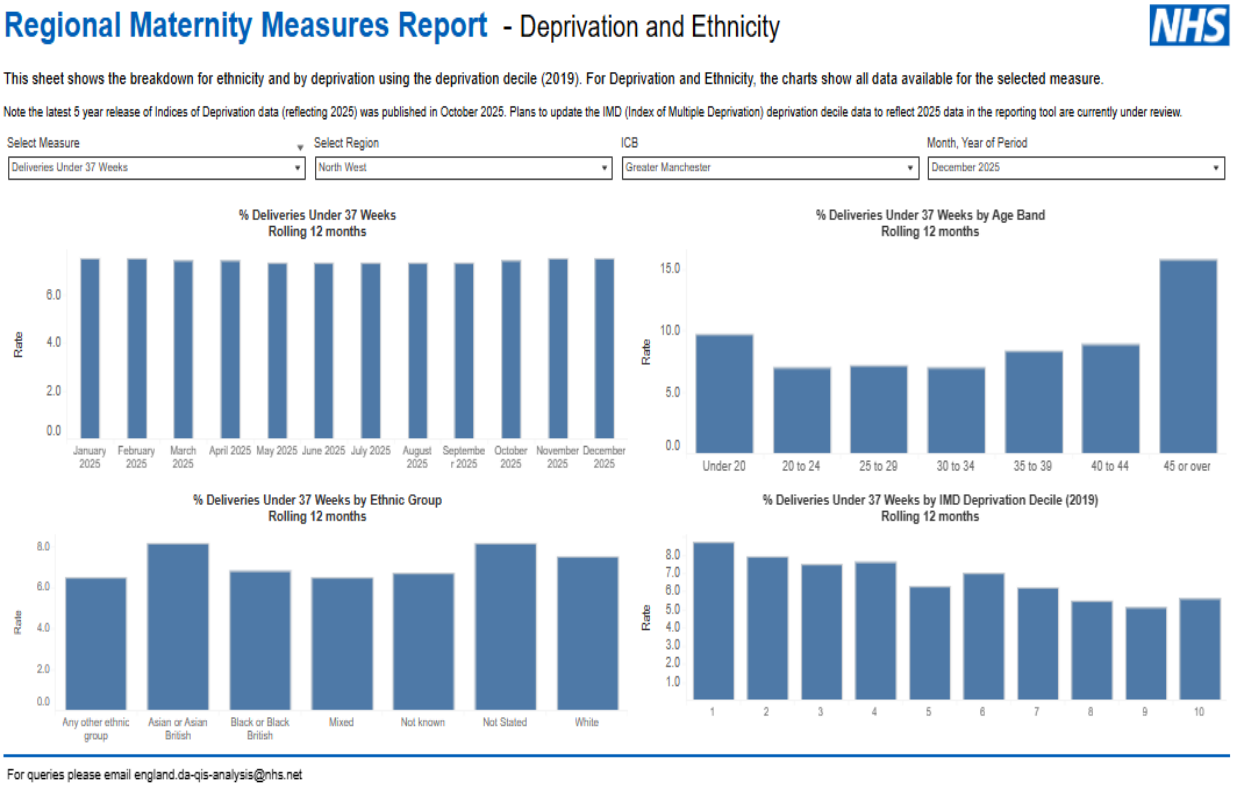
- **Ethnicity:** Women from Black or Black British and Asian or Asian British backgrounds book before 70 days at lower rates than White women. Women recorded as 'Any other

ethnic group' show some of the lowest rates, while those in the 'Not Stated' category also lag behind. These disparities are consistent across the rolling 12-month period and are not explained by random variation.

- **Age:** Women under 20 and those aged 45 or over show the lowest rates of booking before 70 days of any age group. Rates among women aged 25 to 34 are closer to the system average, while the extremes of the age distribution represent a consistent area of concern.
- **Deprivation:** Analysis by IMD deprivation decile shows variation across the range, with women living in the most deprived areas showing lower rates of early booking than those in less deprived deciles. The relationship is not perfectly linear but the direction of inequality is consistent with the national evidence base.

Delays in booking reduce opportunities for timely screening, early identification of clinical and social risk factors, and personalised care planning, all of which are critical to improving maternal and neonatal outcomes. The MSDS data on deliveries before 37 weeks of gestation further illustrates this risk: women under 20 and those aged 45 or over also show the highest rates of preterm delivery, with women aged 45 or over showing a particularly elevated rate above 15%.

Figure 25: Preterm Deliveries (<37 Weeks): Patient Characteristics and Demographics



Source: NHS Futures - Maternity Services Data Set, Regional Maternity Measures Report

Figure 25 highlights the breakdown of the proportion of women booking before 37 days of gestation by age, ethnicity and deprivation decile.

8.1.1 What the Local Maternity and Neonatal System (LMNS) is doing to Address Early Access to Antenatal Care

Improving early access to antenatal care is a core priority within the GMEC LMNS Maternity Equity and Equality Action Plan 2022–2027, set out under Intervention 10. This intervention is focused specifically on reducing late booking and increasing the proportion of women booking before 10 weeks, with a particular focus on women from ethnic minority backgrounds and those living in deprivation.

As part of this work, the LMNS commissioned a scoping exercise to develop an evidence-

informed understanding of the barriers driving late booking in Greater Manchester and to identify what interventions are most likely to be effective. This scoping has examined both the local data picture and the national evidence base, and has identified the following as the most significant and modifiable barriers:

- **Ethnicity, migration and language:** Non-white ethnicity and non-UK birthplace are among the strongest predictors of late booking, with language barriers identified as a modifiable system failure. These are not patient deficits but reflect gaps in how services are designed and communicated.
- **Socioeconomic deprivation and housing instability:** Living in a deprived area is strongly associated with late booking. Housing instability compounds this through missed correspondence, GP registration difficulties, and disrupted continuity of care. Late booking in this context reflects structural disadvantage and competing priorities, not disengagement from care.
- **Service design and system barriers:** Difficulty registering with a GP, unclear or inconsistent booking pathways, long waits for appointments, and miscommunication between primary care and maternity services are repeatedly identified in the evidence as causes of late booking even among women who are motivated to engage early. The scoping has examined current booking pathway provision across GM trusts, including the availability and accessibility of self-referral routes.
- **Awareness, cultural and psychosocial factors:** Cultural norms around not disclosing pregnancy in the first trimester, beliefs that care is only needed when unwell, negative prior experiences of maternity services, and psychosocial complexity including mental health needs, domestic abuse and safeguarding involvement are all identified as contributing factors in the evidence base reviewed.

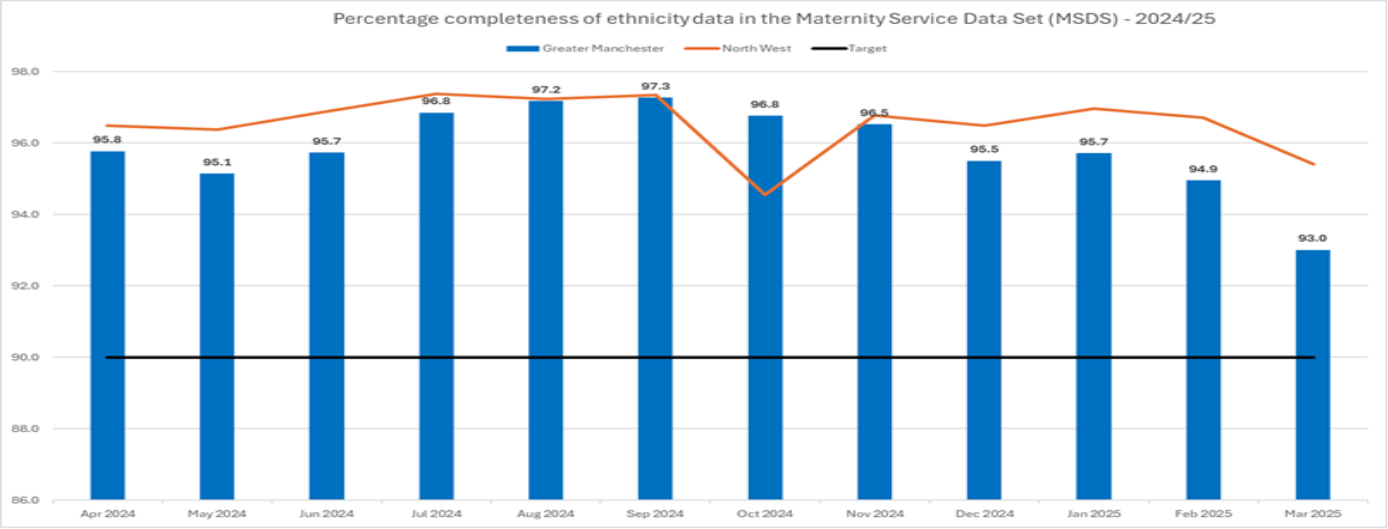
The LMNS commissioned the ASAP – As Soon As You're Pregnant campaign: a GM-wide public-facing resource developed in partnership with Early Years services, Family Hubs, Maternity Voices Partnerships and Voluntary Community Sector and Faith Enterprises (VCSFE) organisations to encourage women to book by 10 weeks. Following this, the LMNS

commissioned a scoping exercise to build a deeper, evidence-informed understanding of the barriers driving late booking and to identify what further interventions are most likely to be effective. The scoping has reviewed national evidence on intervention models including community-based peer outreach, co-produced education programmes, community health worker approaches, and digital self-referral models.

The data is clear that Greater Manchester has not yet achieved the trajectory needed to close the gap with national early booking rates, and that inequalities by ethnicity, age and deprivation remain pronounced. The next phase of work under Intervention 10 will need to translate the insight from the scoping exercise into commissioned, targeted action.

8.2 Completeness of Ethnicity Data in the Maternity Services Data Set (MSDS)

Figure 26: Completeness of Ethnicity Data in the Maternity Services Data Set



Source: Maternity Services Data Set (MSDS)

Greater Manchester has maintained ethnicity data completeness rates consistently above the 90% threshold required by Safety Action 2 of the Maternity Incentive Scheme (MIS) throughout 2024/25. Monthly performance ranged from 93.0% to 97.3% across the year, with a peak in September 2024 and the lowest recorded figure of 93.0% in March 2025. While this end-of-year

figure remains above the national standard, the downward trend from the mid-year peak warrants continued monitoring.

Throughout the year, Greater Manchester's performance has tracked broadly in line with, but slightly below, the Northwest regional average. The regional average showed more sustained performance in the 95–97% range for much of the year, suggesting there is headroom for GM to improve further. Both GM and the Northwest regional average remain above the 90% MIS target at all data points.

8.2.1 What the LMNS is doing to Address Completeness of Ethnicity Data in the Maternity Services Data Set (MSDS)

All GM trusts have been supported by the LMNS through a structured assurance process to meet the ten national MIS safety actions, including Safety Action 2 on ethnicity data completeness. The sustained performance above 90% across all months of 2024/25 reflects the effectiveness of this approach and the commitment of provider organisations to embedding high-quality data collection as a routine part of maternity care.

Safety Action 2 is subject to external validation by NHS Resolution following formal Trust Board sign-off, providing a robust and transparent assessment framework that ensures reported performance reflects genuine data quality. This level of assurance is important in establishing the reliability of the ethnicity data that underpins the LMNS's equity monitoring and improvement work.

While overall performance is strong and above the national standard, the year-end dip and the gap with the Northwest average indicate that continued investment in data quality processes is needed.

9. Vaccinations and Screening

9.1 COVID-19 and Flu Vaccinations

COVID-19 and Flu vaccinations in Greater Manchester continue to be delivered through a broad and accessible provider model including local pharmacies, Primary Care Networks, Hospital Hubs and pop-up clinics. The number of GM residents eligible for AW COVID-19 vaccination in the period 2025/26 was 318,986 in comparison 2024/25 had 1,003,125 eligible patients, this reduction was due to changes in the eligible cohorts, Flu eligibility remained at 1,629,347. The programme maintained a strong focus on identifying and reaching Core20 and "PLUS" population groups through analysis of the nationally defined eligible cohorts, supplemented by local intelligence and partner insight. In addition to reviewing uptake across eligible cohorts, intersectionality is considered where appropriate by exploring variation across characteristics such as race/ethnicity, gender, age, disability and deprivation/class, recognising that overlapping factors can compound barriers to access and drive unequal uptake.

To address prevalence and distribution of known risk factors (including digital exclusion, transport barriers, health literacy and language needs), the vaccination offer was designed around multiple routes of access. This included digital booking opportunities, a phone booking option via 119, and walk-in models. The programme also supported physical accessibility through a wide footprint of provision, helping to mitigate transport and convenience barriers. There were 540 of 639 community pharmacies (84.5%) and 407 of 411 GP practices (99.0%) in GM engaged in delivering flu vaccinations in 2025/26. There were 44 of 67 Primary Care Networks (65.7%) and 352 of 639 community pharmacies (55.1%) delivering the COVID-19 vaccination programme. There were 10 hospital trust sites delivering flu vaccinations to staff and key at-risk patient groups (maternity, immunosuppressed, long stay inpatients and patients discharged to care homes). Two hospital sites also delivered COVID-19 vaccinations to patients on wards.

Communications and information were developed in accessible formats, including translated materials (supported by website translation functionality for adverts in a person’s preferred language), easy read materials and video content, to reduce language and health-literacy

barriers and to support informed decision-making.

A key feature of programme delivery has been the use of linked and routinely processed data to identify under-represented population groups in NHS datasets and to understand patterns of access and demand among those experiencing inequalities. We draw on different data sources, including the Federated Data Platform and the GM system extracting data from GP records, to provide a robust method for establishing the eligible population and measuring uptake in a way that reflects recorded population characteristics. Reporting of uptake by MSOA and ethnicity has been available for many years in the COVID-19 and Flu programme, enabling localities to identify variation, target interventions and monitor change over time. Routine disaggregation of performance and quality data, including ethnicity reporting, is embedded within programme dashboards that are accessible to all localities and used to support operational decision-making and performance conversations.

Vaccine uptake nonetheless continued to decline year-on-year, reflecting national trends. COVID-19 vaccine uptake is not comparable to previous years due to the cohort change, Flu vaccine uptake decreased across the largest eligible cohorts for over 65 years old, however a large increase in uptake for pregnant women.

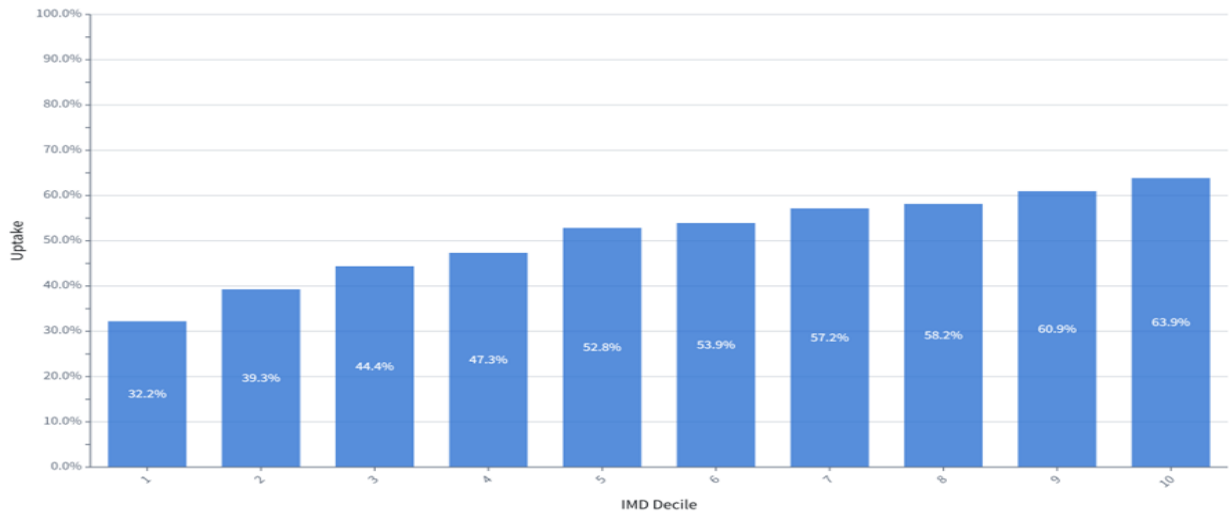
Inequalities in uptake persist across Greater Manchester and with the data reports we can demonstrate that they remain by deprivation, age and ethnicity. Uptake in areas of high deprivation (IMD Decile 1) for COVID-19 was 32.2% compared to 63.9% in the most affluent areas (IMD Decile 10). Non-White British groups continued to show lower vaccination rates, with Black/African/Caribbean groups reporting 44% Flu uptake among those aged 65+, compared to 76.6% for White British individuals.

These insights have been treated as a driver of performance and resource allocation, with the programme using disaggregated data and partner intelligence to prioritise targeted investment, improve reach and optimise service delivery. We have used data from previous years to know what gaps exist and the programme has worked with Voluntary, Community and Social Enterprises (VCSE) and community partners to understand gaps and to use lived experience and local knowledge to guide pop-up locations and investments via the Access and Inequalities Fund. Approaches that have been effective include targeted mobile clinic sessions delivered at

places of worship and community events; PCN-led clinics working alongside community groups supporting older people, homeless residents and other at-risk groups; VCSE-led engagement with small community and faith groups to constructively challenge myths and support trusted community leaders to promote uptake; and the distribution of translated and accessible materials (leaflets, posters, social media content and videos) in the most commonly used local languages.

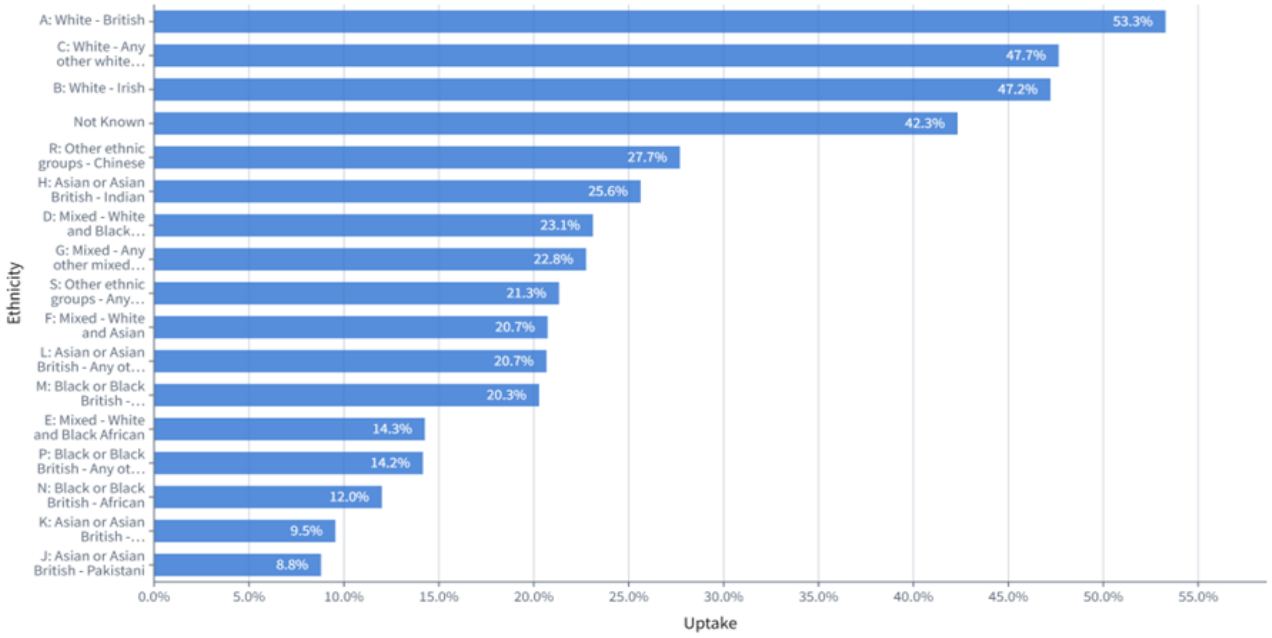
Health inequalities information is incorporated into routine performance reporting and has informed operational planning and strategic decision-making, particularly around targeting of under-vaccinated groups and the design of pop-up and outreach delivery, with over 50 schemes being used to help improve access. Performance is reported to localities and escalated through system governance routes, supporting a consistent approach to monitoring and responding to inequality patterns. Uptake and inequality metrics are reported bi-weekly in 2025/26 to the Primary Care Board and included within the Inequalities ICB reporting, ensuring board-level visibility of variation and supporting sustained focus on actions intended to narrow gaps in uptake.

Figure 27: Autumn 2025 COVID-19 Vaccination Uptake by IMD Decile



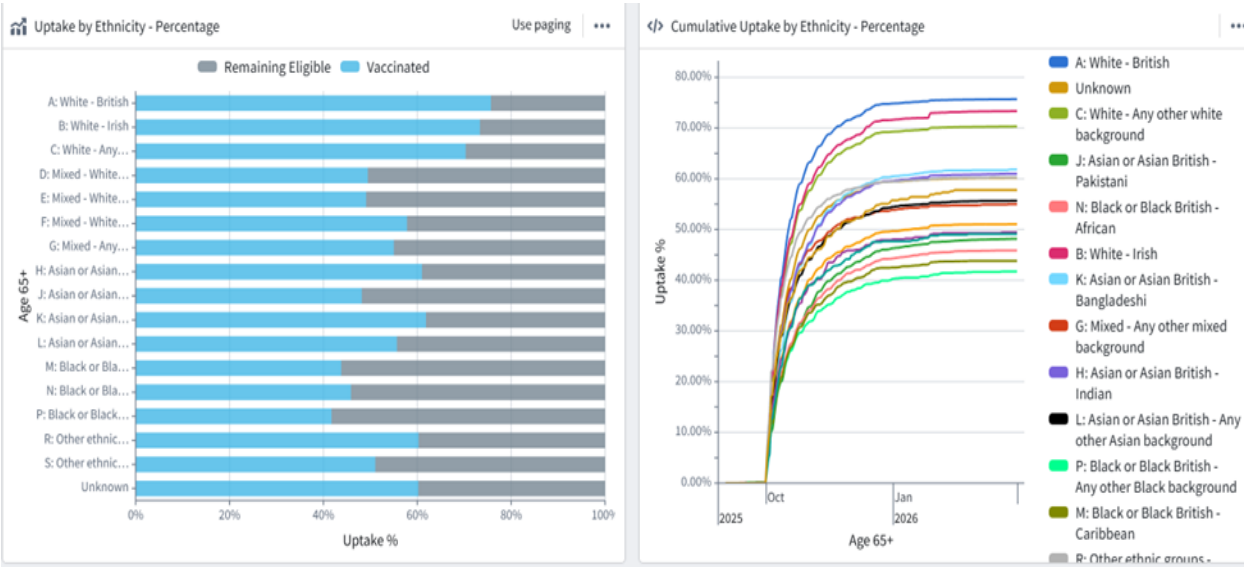
Source: NHS Federated Data Platform, COVID-19 Vaccination Dashboard

Figure 28: Autumn 2025 COVID-19 Vaccination Uptake by Ethnicity



Source: NHS Federated Data Platform, COVID-19 Vaccination Dashboard

Figure 29: Flu Vaccination Uptake by Ethnicity (%) Among Adults Aged 65+ (Single-Cohort Waterfall)



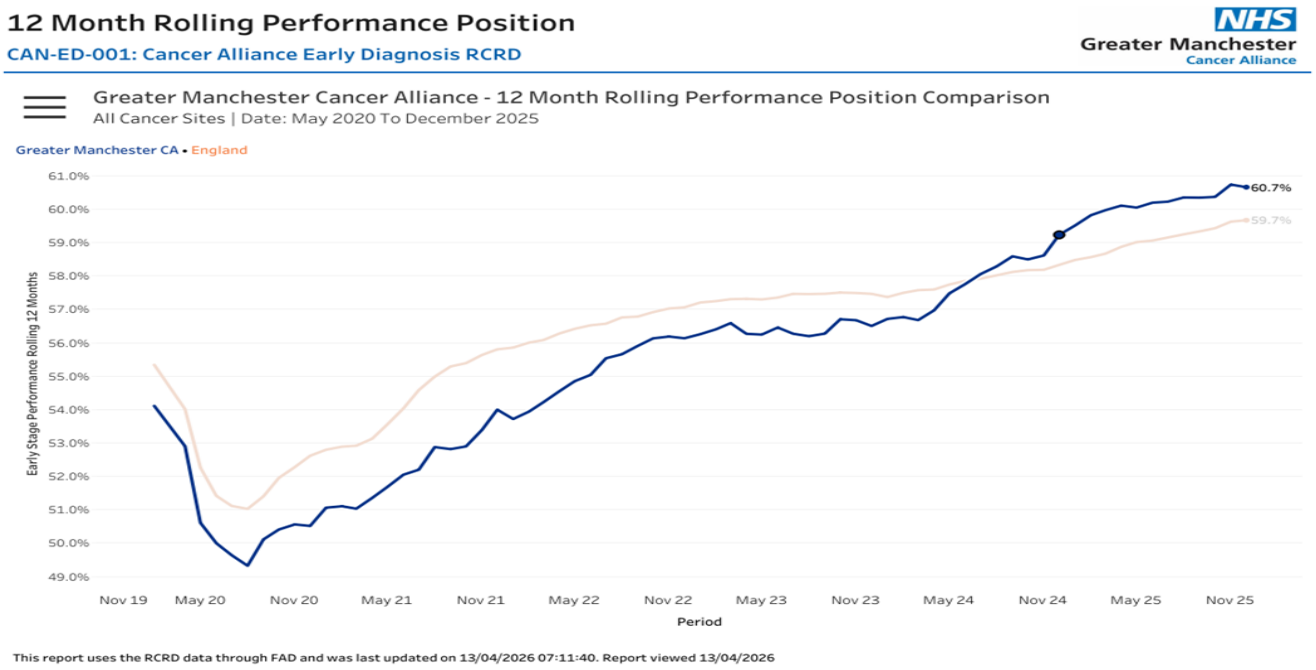
Source: NHS Federated Data Platform, COVID-19 Vaccination Dashboard

9.2 Cancer

Early cancer diagnosis is critical for reducing the impact of cancer on people's health and wellbeing, their requirement for health and care services, and for maximising positive outcomes and response to treatment.

Percentage cancers diagnosed at stage 1 and 2 (early stage) measures the number of patients with early-stage cancer diagnosis as a percentage of all cancer diagnoses. A higher percentage indicates better outcomes. Improvements in the rate of early diagnosis increasing from 59.2% in December 24 to 60.7% in December 2025 (12 month rolling position), with GM now consistently above the England average. However, there is variation in early diagnosis figures across Greater Manchester by locality; with the proportion of people diagnosed at an early stage in November 2025 varying from 58.2% in Oldham to 63.2% in Bolton.

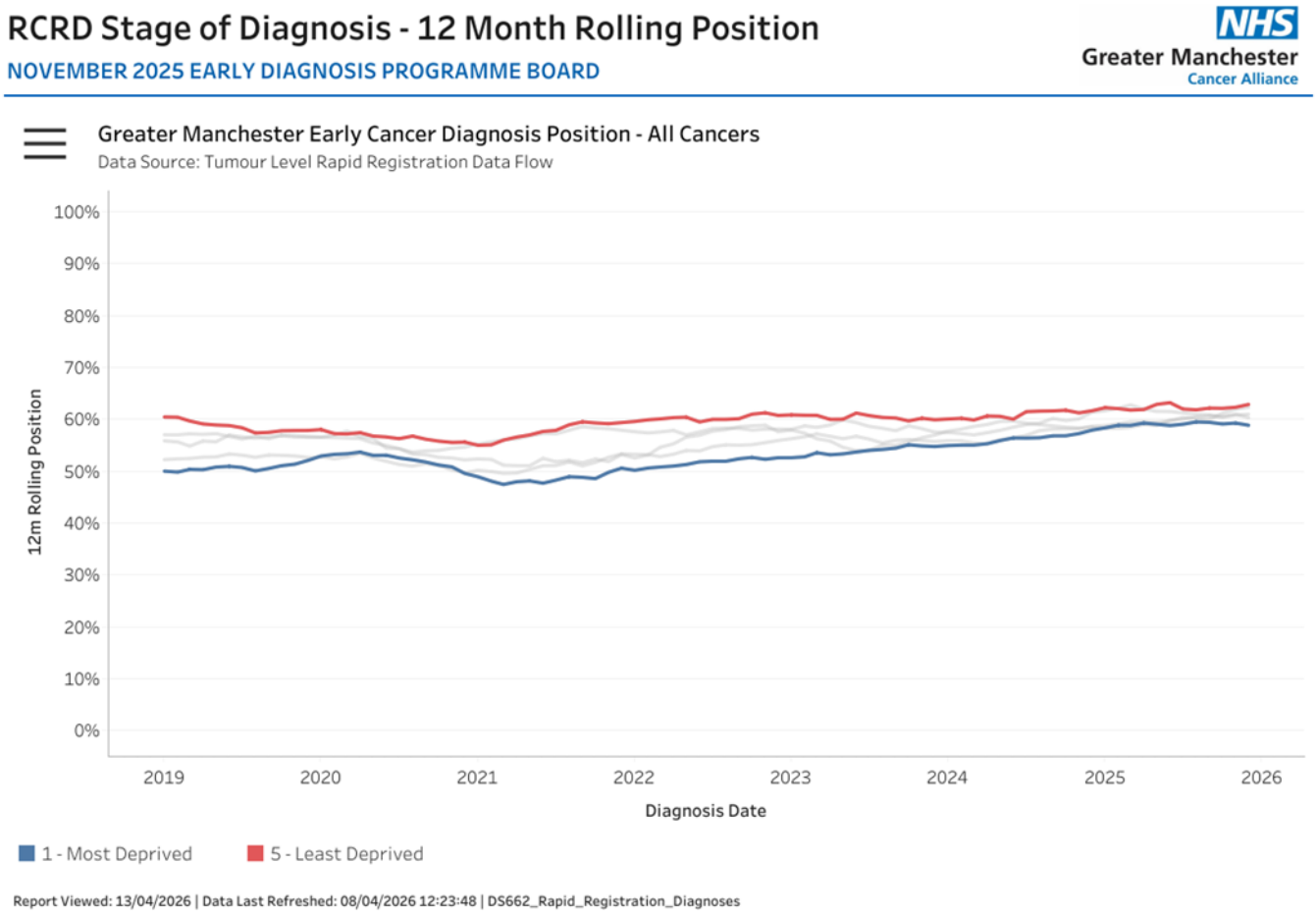
Figure 30: Comparison of 12-Month Rolling Early Diagnosis (RCRD Stage of Diagnosis) Performance Between Greater Manchester Cancer Alliance and England



Source: Greater Manchester Cancer Alliance

There is also variation by deprivation with a 4.01% difference, as of December 2025 (12 month rolling position), in early diagnosis rate between our least and most deprived communities, this is a 0.27% improvement since December 2024.

Figure 31: Comparison of 12-Month Rolling Early Diagnosis (RCRD Stage of Diagnosis) Performance Between the Most Deprived and Least Deprived Quintile

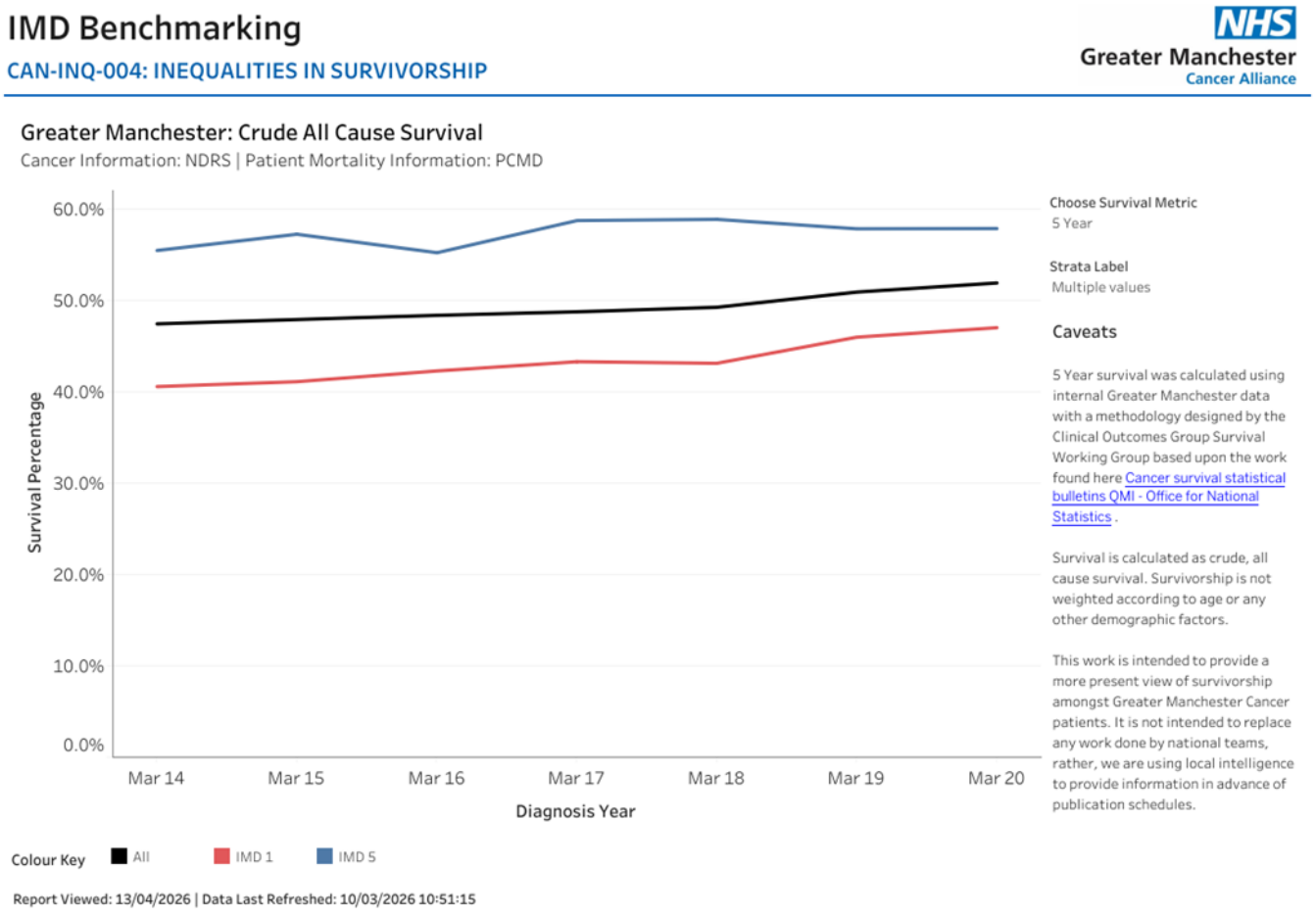


Source: Greater Manchester Cancer Alliance

These figures are presented regularly to the Early Diagnosis Programme Board which feeds into our system level Cancer Board to ensure proper oversight of variance within the early diagnosis rate.

The chart below shows five-year survival in Greater Manchester by Index of Multiple Deprivation (IMD). These figures represent crude all-cause survival and are not adjusted for case mix or age, but they provide an indication of inequalities in survival across the region. As of March 2020, the gap between the least and most deprived communities was 10.9%. This reflects an improvement of 1.0 percentage point since March 2019 and 4.0 percentage points since March 2014.

Figure 32: Five-Year Survival (%) by Year of Diagnosis for Overall, Most Deprived, and Least Deprived Quintiles



Source: Greater Manchester Cancer Alliance

The Greater Manchester Early Cancer Diagnosis Strategy focuses on raising public awareness, reducing health inequalities, fostering collaboration with primary care, enhancing cancer

screening programs, and driving innovation to improve early diagnosis rates and outcomes. A specific pillar of the strategy is a reduction in variation, while identifying and tackling health inequalities in a foundation and cross cutting theme. Work in 25/26 to meet these priorities has included:

- The ‘Get Cancer Clever’ campaign and the mobile ‘This Van Can’ initiative will target Primary Care Networks (PCNs) with the lowest rates of early-stage cancer diagnosis. By directing awareness campaigns and diagnostic capacity towards communities experiencing the 4.01% deprivation gap in early diagnosis, these initiatives aim to improve earlier diagnosis, increase equitable access to diagnostic services, and reduce inequalities in cancer outcomes across Greater Manchester.
- Barret’s Oesophagus case finding
- Targeted Lung Health Check (Lung Cancer Screening) programme, where a stratified roll out has been planned based on deprivation, smoking rates, and lung cancer mortality at a Primary Care Network population level.
- VCSFE grant funding to support reduction in inequalities of early diagnosis, timely presentation and screening uptake.

The GM Cancer Alliance carries out a robust EIA process for each project to ensure inequalities are being considered and addressed. These are reported through our governance process and are review at the Early Diagnosis Programme Board.

9.3 Cancer Screening

The three Section 7A cancer screening programmes (breast, bowel and cervical) are commissioned and delivered locally in line with national direction and service specifications. Nationally published data is high-level and does not provide detailed insight into inequalities. Locally developed dashboards enable more granular analysis, including breakdowns by ethnicity, learning disability (LD), severe mental illness (SMI), deprivation and language, however, there are important caveats to this data. It is derived from GP records, which may be incomplete or inconsistently coded. This is a particular challenge for breast screening, where

data relies on manual coding by practices.

To complement this, additional intelligence is obtained from providers delivering the screening programmes. These services are often able to offer valuable local insight into barriers to access and emerging inequalities that may not be fully captured in routine datasets.

In 2024/25, behavioural insight work was commissioned across Greater Manchester to better understand barriers and drivers for cancer screening participation. It combined qualitative and quantitative research, including surveys, interviews and stakeholder workshops, followed by co-design with communities and partners. Key barriers identified related to knowledge, access and motivation, with targeted interventions developed in response. The outputs have informed local toolkits, communications and service improvements to support more tailored approaches to increasing uptake, particularly in underserved populations.

Answer Cancer is a VCSE consortium commissioned to work with communities across Greater Manchester where screening uptake is lowest, particularly among underserved populations. It delivers culturally appropriate awareness and community-led approaches through VCSE partners and Cancer Champions, alongside funding local initiatives to address barriers. In 2024/25, £93,000 was awarded through grants and spot purchasing to support this work. This model improves engagement with groups less likely to respond to traditional NHS communications, helping to increase awareness, access and informed decision-making, and reduce inequalities in screening uptake.

Health inequalities is a standing agenda item on GM boards and provider performance monitoring meetings. It is also evaluated as part of the Screening Quality Assurance (SQAS) visits to all screening providers, with recommendations made where there are gaps. All screening providers are required to produce health equity audits as part of their service specifications.

To support the awareness raising of all 3 screening programmes among patients whose first language is not English, plans are progressing to commission a range of short videos in community languages and BSL. These will update previously produced videos with new

programme changes and significantly expand the languages available. Accompanying text messages will be produced for practices to use in the practice call and recall of non-responders.

Nationally, programmes are moving to a digital first approach to invitations and results letters. This will facilitate the use of alternative formats, such as information in alternative languages in the future. Where a patient does not have the app, alternative methods (e.g. letter) will be used to prevent digital exclusion.

9.3.1 Bowel Screening

Uptake of bowel screening in the 50-59 age group has increased in all areas of GM since March 2025. Across the GM localities the increase in uptake ranges from 11% - 13.2%. GM uptake is currently 35.86%. In the 60-74 age group, all localities are showing a slight increase in uptake ranging from 0.8% - 2%. GM uptake is 63.15%. Wigan locality is seeing the highest increase in both cohorts. Since January 2026, 9 out of 10 localities are showing increases in both cohorts, with only Trafford maintaining the same level of uptake.

The bowel screening learning disabilities (LD) flagging project has been rolled out to all screening centres in GM, following a successful pilot in the Bury locality. Patients with a learning disability are offered tailored support to understand their screening invitation and make informed choices, including access to reasonable adjustments and specialist help, where required. Of those referred to the service the project has resulted in an uptake of 56% within the LD cohort. For further information, please read the published story of change on NHS GM Bowel Cancer Screening Programme.

An online video has been developed showing the journey of an LD patient accessing colonoscopy services, through the bowel screening pathway: Endoscopy Journey. This has been shared with the LD Primary Care practitioners to support their discussions with patients.

Each screening centre has a designated Cancer Screening Improvement Lead (CSIL). The CSILs attend community events to raise awareness of the bowel cancer screening programme. There has been a focus on men as they have a lower uptake of screening than women as well

as a focus on raising awareness in areas of higher deprivation. The CSILs are also working with patients who have received a Specialist Screening Practitioner (SSP) appointment following a positive screening test but fail to attend for the colonoscopy. They work with GP practices who have low uptake among their patients, by providing training and support. They also support practices in identifying non-responders and have the option to submit a 3rd party screening kit request for any patients who wish to take part in the programme.

In 2026, a severe mental illness (SMI) inpatient pathway for bowel screening has been established, at Prestwich hospital. The first patient has successfully completed the pathway following a positive screening result. It is hoped that this can be extended to all sites with SMI inpatients and are eligible for bowel screening.

The screening centres in GM have increased access to services for patients by increasing the number of sites offering colonoscopy services. Clinics are now being held in Leigh, Stockport, Salford and are due to commence at North Manchester shortly. This allows more patients to attend a hospital for colonoscopy at closer and more convenient sites. More sites are being considered to expand the offer across Greater Manchester.

Further work to increase access and provide information in alternative formats has taken place in 2026 as a digital pre-invitation is now in place for bowel screening in GM. Patients receive a notification on the NHS App, ahead of their bowel screening invitation letter. If a patient does not have the app, a letter will be sent, to prevent digital exclusion.

For patients registered as having additional care needs a letter will continue to be issued alongside a digital pre-invitation, with relevant easy-read resources.

During 2026/27 commissioners are progressing discussions with Northwest colleagues to further improve access to bowel cancer screening services, including exploring the use of Community Diagnostic Centres (CDCs) to deliver elements of the screening pathway. This work will support a more localised, neighbourhood-based offer that reduces barriers to access and addresses inequalities in uptake, particularly among populations with historically lower participation.

9.3.2 Breast Screening

Uptake regionally has seen a positive uptrend across all three programs with coverage increasing nearly 2% in the period (Oct 24 – Oct 25). Current GM coverage as of April 2025 is 69.7% compared to national coverage of 67.8%, with Wigan achieving highest at 75.7% and Manchester the lowest at 59.6%. Source: Workbook: Cancer_Coverage_Uptake_v3.

Regional insight work, alongside nationally recognised barriers to engagement, shows that screening uptake remains consistently lower among ethnic minority women, particularly South Asian communities, as well as Roma and Gypsy women with a learning disability (LD). Key factors include language barriers, cultural norms, limited awareness and discomfort with the screening pathway.

Each programme has a Cancer Screening Improvement Lead (CSIL) who supports all practices to engage women who are due to be called for breast screening, low-uptake practices, engages non-responders and has developed and shared a primary care toolkit. CSILs also run open days, develop culturally appropriate materials and videos, and work with local partners to reach homeless communities through outreach that builds awareness and trust. They have also led targeted work for patients with learning disabilities, including tours of screening facilities with local LD teams to make services more inclusive and person-centred.

Specific targeted work remains ongoing from the regional Answer Cancer service, providing a wide range of training and education particularly addressing community groups with low uptake. The program also delivers breast screening specific interventions with PCNs and GP as well as supporting through grant funding other local VCSFE organisations providing greater reach to underserved communities.

All breast screening programs now operate extended access appointments, with options for women to attend evening and weekend appointments across several locations supporting access. In line with national strategy, breast screening programs have started to identify and bring online Community Diagnostic Centers (CDCs) with both Manchester and Oldham centers expected to be live later this year, supporting increased choice and improved access for patients.

In 2025/26, the annual capital bid programme supported the purchase of new breast screening equipment, enabling two new, more accessible sites in Bolton and Leigh focused on underserved communities. It also funded two new mobile units across GM to replace older units that were less accessible for disabled patients, removing this barrier.

Following a successful trial at Bolton FT, plans for 2026 include supporting the introduction of a multilingual clerical support worker in each programme to call and recall non-responders and women who did not attend appointments.

9.3.3 Cervical Screening

Uptake for cervical screening overall in GM ranges from 70.3 % (Manchester) to 80% (Stockport) in the 50-64 cohort, and 56.8% (Manchester) to 76.5% (Stockport) in the 25-49 cohort. Uptake within localities varies further, with uptake as low as 29.8% in one PCN.

Across the programme, uptake is highest in the white British population 76.4%, with the lowest uptake seen within the Chinese (47.1%), Indian (51.6%) and Arab (51.5%) populations. In areas of deprivation, uptake in the White British population falls to 68.3%, with uptake in the least deprived areas at 84.7% -surpassing the 80% ambition.

Overall uptake among patients on the SMI register is 63%, compared to 68.7% for those not on the register. The gap for patients living with a learning disability is wider, with uptake at 40.9% compared to 68% for those not on the LD register.

Extensive work has been ongoing to support the LD community. In the past 12 months, a range of videos have been co-produced with patients, to support those with LD to attend cervical screening, colposcopy, and to receive their HPV vaccination. A GM primary care pathway, outlining best practice for sample takers and GP practices, has been produced and will be piloted in Bury.

Bespoke toolkits have been produced to support primary care in the delivery of the programme. A toolkit based on the commissioned behavioural insights work was shared last year, which

included evidence-based approaches to improving accessibility and uptake, as well as good practice examples from practices and PCNs within GM. In addition, a trans and non-binary toolkit was updated and shared to coincide with the introduction of a national call and recall for patients with a cervix registered as male in 2025, reducing inequalities within the group.

Specific targeted work is ongoing from Answer Cancer, addressing community groups with low uptake, including work with the Chinese community in South Manchester, an area where uptake is particularly low within the group, and further work is planned to understand barriers within this population. Answer Cancer deliver cervical screening specific interventions with PCNs and GP practices to support call and recall of underserved groups, with support from their grant funding, and in 26/7 will be exploring ways of improving the sustainability of this.

In 2026, the NW cervical screening bus pilot will be expanded into Greater Manchester. So far, the bus has reached over 2000 patients, with a high proportion of patients non responders and/or from deprived communities. The bus will provide a drop-in cervical screening service outside of usual clinical locations, such as supermarkets and leisure centres, and will be focused on areas with low uptake and high levels of deprivation.

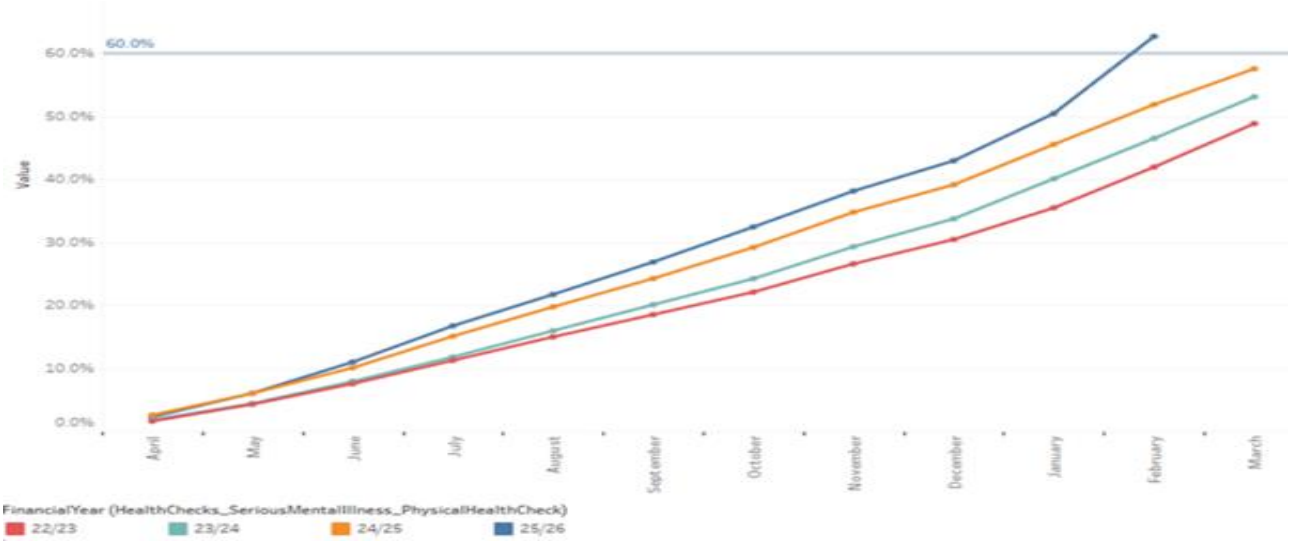
10. Adult Mental Health

10.1 Overall number of Severe Mental Illness (SMI) physical health checks

Figure 33 shows performance against the Physical Health Severe Mental Illness (SMI) Physical Health Check target over the last four years. Performance in 2025/26 has exceeded that observed in previous years across all reported months.

The latest data (February 2026) shows that performance was 62.7%, exceeding the national target of 60% and representing an improvement from to 51.9% in February 2025. This equates to 18,991 people on the SMI register receiving all six elements of their annual physical health check. Overall, uptake of SMI physical health checks increased during 2025/26 compared with 2024/25.

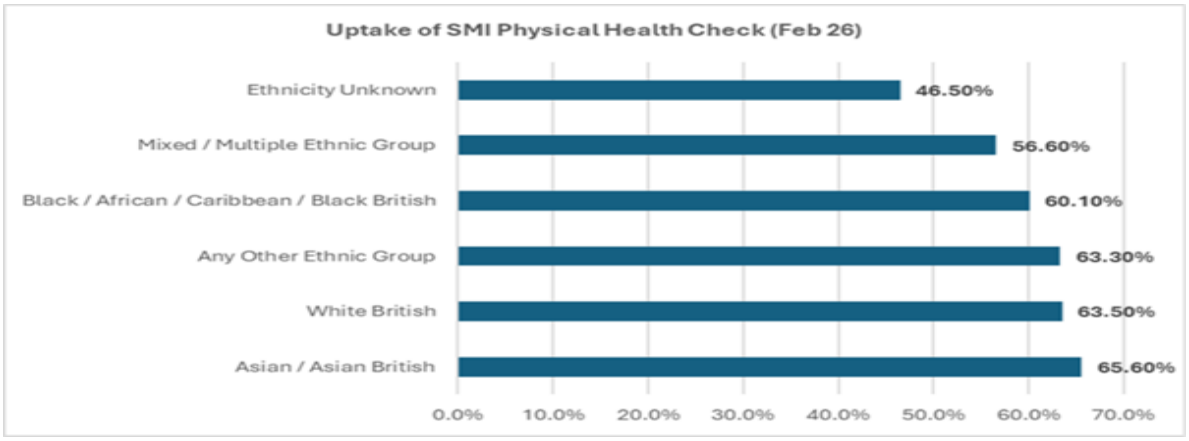
Figure 33: Achievement of Physical Health Severe Mental Illness (SMI) Targets within the ICB, 2022/23–2025/26



Source: NHS Greater Manchester Severe Mental Illness Physical Health Dashboard – GM ADSP

Interpretation of variation by ethnicity remains limited by incomplete ethnicity recording within the dataset. Further work is underway to improve data completeness and support more robust assessment of inequalities.

Figure 34: Achievement of Physical Health SMI Targets within the ICB, as of February 2026, by Ethnic Group



Source: NHS Greater Manchester Severe Mental Illness Physical Health Dashboard - Tableau

Cloud

Among patients with recorded ethnicity, uptake varied by 9.0 percentage points, ranging from 56.6% to 65.6%. Uptake was highest among Asian or Asian British patients (65.6%), followed by White British (63.5%) and Any Other Ethnic Group (63.3%). Lower uptake was observed among Black/African/Caribbean/Black British patients (60.1%), while Mixed/Multiple Ethnic Groups recorded the lowest uptake (56.6%), representing the largest observed inequality gap.

10.2 Inequalities in use of the mental health act including use of community treatment orders (CTOs)

The latest Mental Health Services Data Set (MHSDS) for 2025/26 provides an updated view of the number of people subject to the Mental Health Act (MHA), including those receiving mental health services.

Across Greater Manchester, the number of people subject to the Mental Health Act has increased compared with 2024/25. Local dashboard data indicate variation by ethnicity, deprivation, age, sex and locality. Higher numbers are observed within White ethnic groups, reflecting the underlying population profile, while greater volumes are also seen in more deprived and urban areas.

However, local dashboard data are based on absolute counts rather than population-adjusted rates. In some areas, including Community Treatment Orders, small numbers limit the ability to present disaggregated analyses or draw robust conclusions regarding inequalities.

Among patients with recorded ethnicity, uptake varied by 9.0 percentage points, ranging from 56.6% to 65.6%. Uptake was highest among Asian or Asian British patients (65.6%), followed by White British (63.5%) and Any Other Ethnic Group (63.3%). Lower uptake was observed among Black/African/Caribbean/Black British patients (60.1%), while Mixed/Multiple Ethnic Groups recorded the lowest uptake (56.6%), representing the largest observed inequality gap.

While recognising the system-wide achievement of meeting the 60% national target for annual physical health checks for people with SMI, further work is underway across Greater

Manchester to improve the completeness of ethnicity recording on the SMI register. Improved data quality will support more robust assessment of inequalities and help reduce the current 9.0 percentage point variation in physical health check completion over time.

Figure 35: Characteristics and Demographic Profile of Individuals Subject to the Mental Health Act, 2025/26

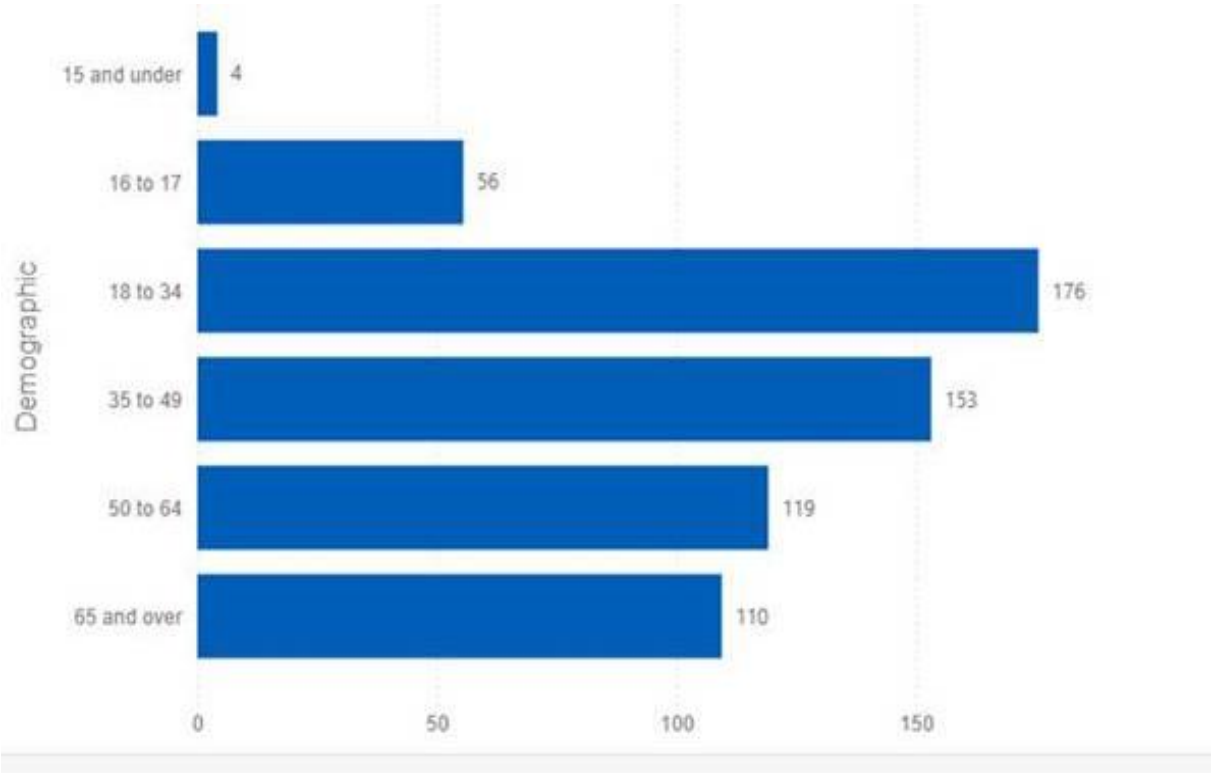
Source: GMADSP – NHS Greater Manchester Mental Health Services Dataset – GM ADSP

Figure 36: Characteristics and Demographic Profile of Individuals Subject to the Mental Health Act (and in receipt of services), 2025/26

Source: NHS Greater Manchester Mental Health Services Dataset – GM ADSP

Inequalities by age: Crude detention rates vary substantially by age. Rates are highest among young adults aged 18-34 years and decrease progressively across older age groups, with the lowest rates observed among children and young people aged under 18 years. This pattern indicates that young adults are disproportionately affected by detention under the Mental Health Act compared with other age groups.

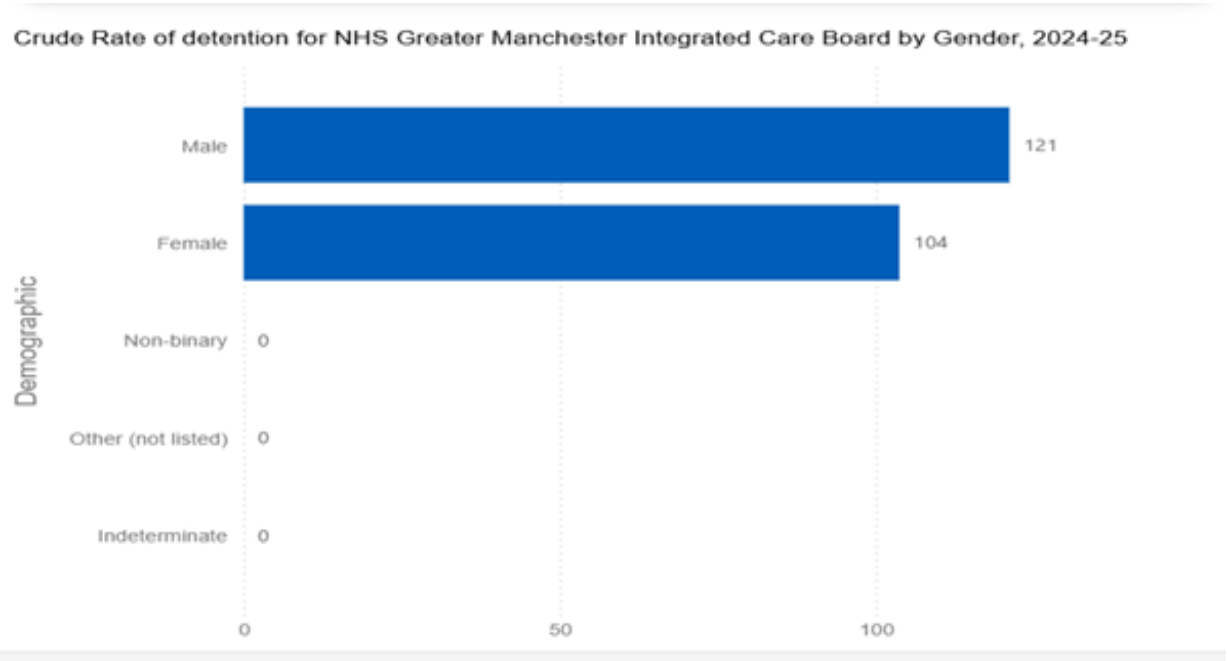
Figure 37: Crude Rate of Detention Under the Mental Health Act per 100,000 Population by Age Group, NHS Greater Manchester ICB, 2024/25



Source**:** NHS England Mental Health Act Time Series Dashboard

Inequalities by gender: There is a consistent difference in detention rates by gender, with males experiencing higher rates of detention than females. The difference is present but less pronounced than other inequality characteristics, indicating a moderate but consistent disparity.

Figure 38: Crude Rate of Detention Under the Mental Health Act per 100,000 Population by Gender, NHS Greater Manchester ICB, 2024/25

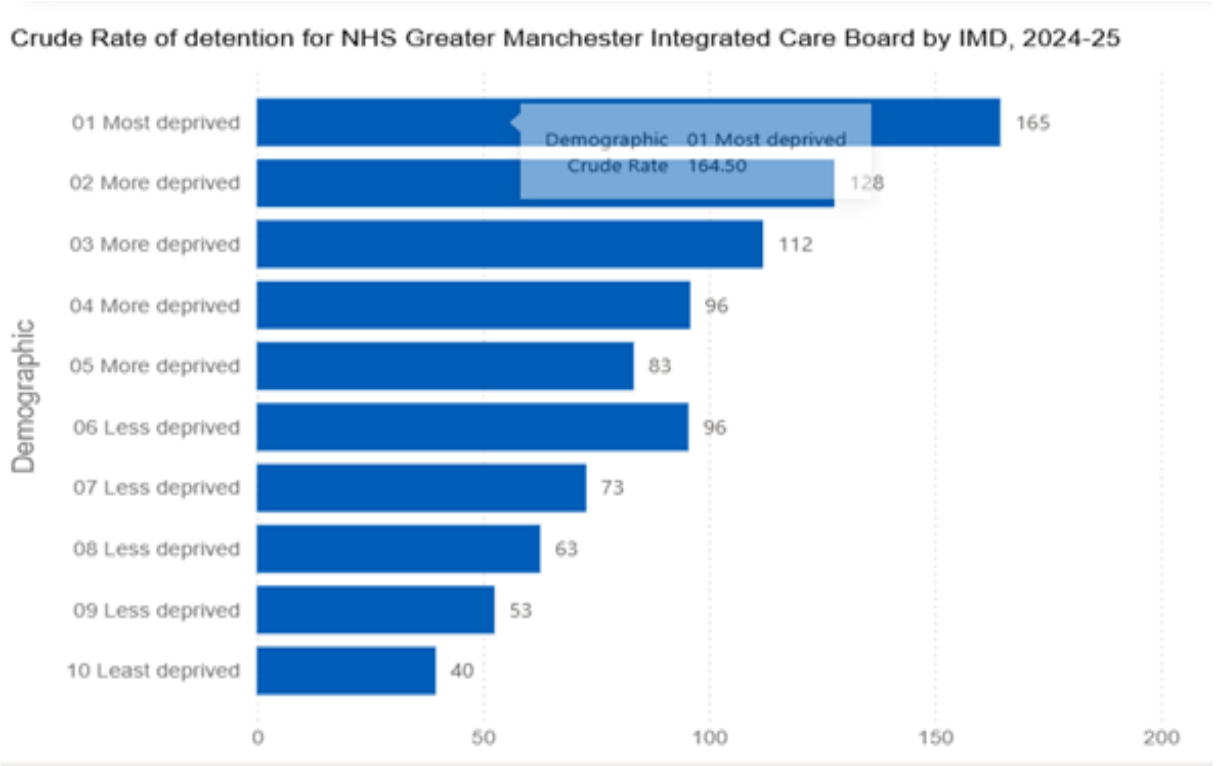


Source**:** NHS England Mental Health Act Time Series Dashboard

Inequalities by deprivation: There is a strong and sustained relationship between deprivation and detention rates. People living in the most deprived communities experience significantly higher rates of detention than those in the least deprived areas, with rates approximately four times higher in the most deprived decile compared to the least deprived.

This demonstrates a clear social gradient, with deprivation strongly associated with higher rates of detention under the Mental Health Act. This is likely to reflect wider inequalities in: mental health need, access to early support, and the impact of broader social determinants

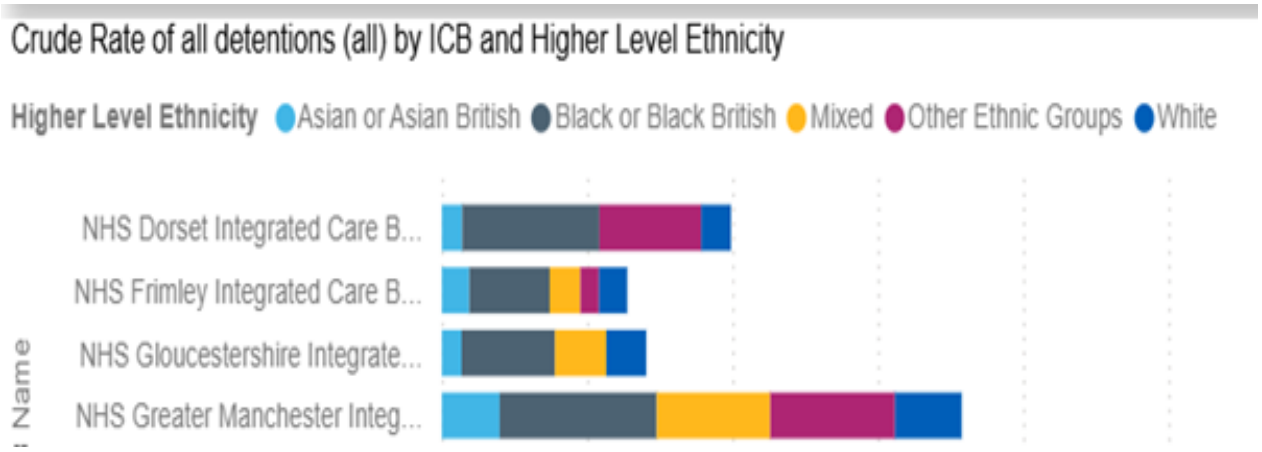
Figure 39: Crude Rate of Detention Under the Mental Health Act per 100,000 Population, NHS Greater Manchester ICB, by Deprivation (IMD Decile), 2024/25



Source**:** NHS England Mental Health Act Time Series Dashboard

Inequalities by ethnicity: National data demonstrates variation in detention rates by ethnic group. However, interpretation should be undertaken with caution as differences may be influenced by population size, data completeness and underlying need.

Figure 40: Comparison of Crude Rate of Detention Under the Mental Health Act by per 100,000, NHS Greater Manchester ICB by Ethnicity, 2024/25



Source**:** NHS England Mental Health Act Time Series Dashboard

Taken together, the data highlights persistent inequalities in the use of the Mental Health Act. Detention rates are highest among young adults aged 18-34 years, higher among males than females, and show a clear deprivation gradient, with substantially higher rates in more deprived communities. Variation by ethnicity is also evident, although interpretation should be considered alongside data quality and population factors.

While local dashboard data provide valuable context on service activity, national rate-based analyses offer a more robust assessment of inequality. Both sources indicate that inequalities in detention remain significant and are closely associated with wider social and health determinants.

Reducing inequalities in the use of the Mental Health Act and Community Treatment Orders remains a system priority and aligns with the objectives of the Patient and Carer Race Equality Framework (PCREF) and NHS Oversight Framework, with a focus on improving equity of access, experience and outcomes across mental health services.

10.3 Inequalities in rates of restrictive interventions in inpatient services

Reducing the use of restrictive interventions remains a priority within the Inpatient Quality Transformation Programme and forms a key component of the Patient and Carer Race Equality Framework (PCREF). The programme aims to reduce inequalities in experience, safety and outcomes for people receiving inpatient mental health care.

To support this work, NHS Greater Manchester commissions the HOPES service, which provides specialist advice, training and support to clinical teams working with people subject to long-term segregation or at risk of restrictive interventions. The service promotes alternative approaches to care, improves understanding of patient.

The latest data on restrictive interventions in inpatient mental health services indicate continued variation across providers, localities and population groups within Greater Manchester. Differences are likely to reflect a combination of service models, patient acuity and case mix.

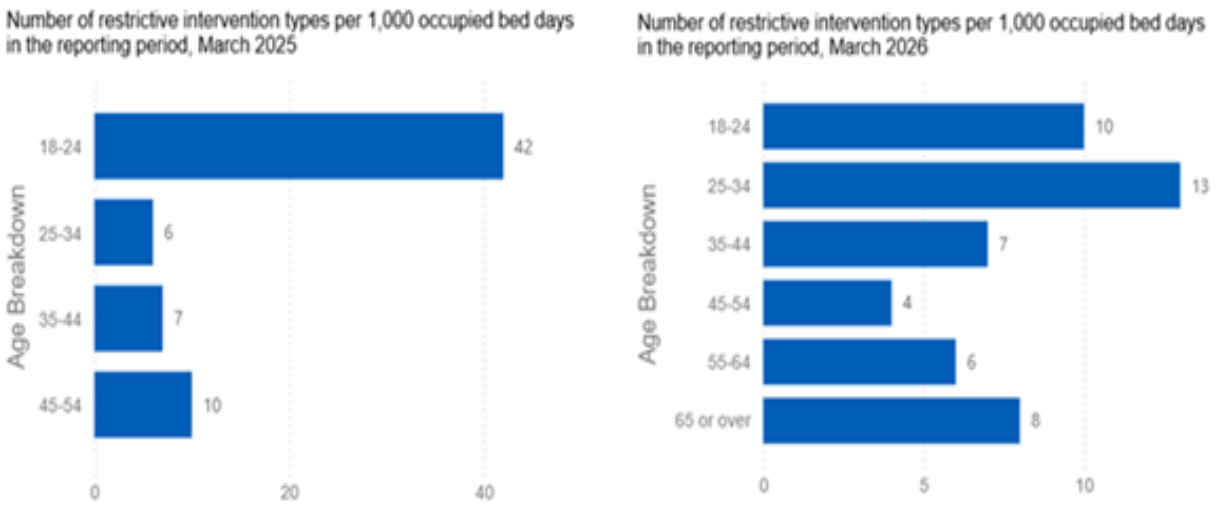
Analysis of the available data highlights variation by age and ethnicity, although interpretation should be considered alongside data quality limitations and the use of activity-based rather than population-adjusted measures.

Inequalities by age

Higher rates of restrictive interventions continue to be observed among younger adults, particularly those aged 18-24 years. Although this age group remains the most affected, comparisons between March 2025 and March 2026 suggest some reduction in the number of restrictive interventions experienced by younger adults.

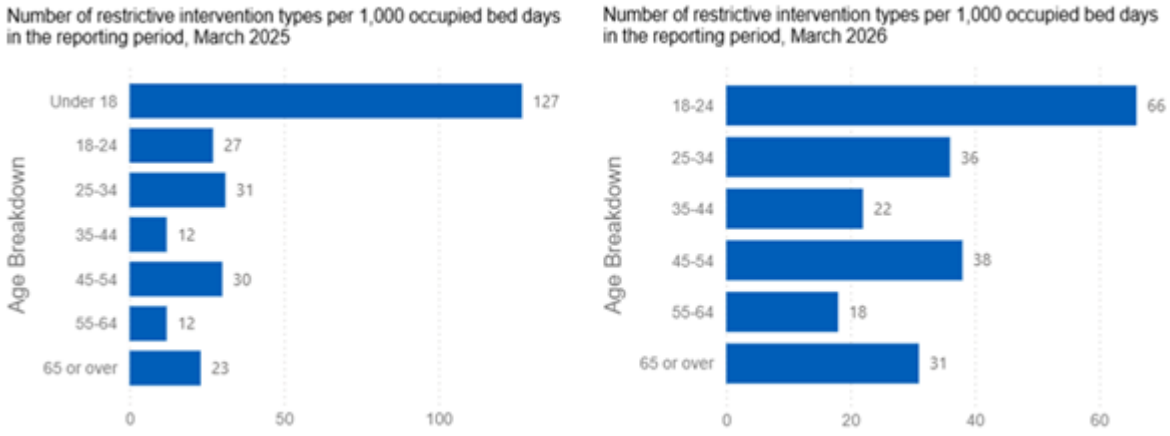
Patterns across other age groups vary between years and providers, indicating that the age profile of restrictive interventions is not static. Nevertheless, the findings suggest that younger adults remain disproportionately affected and should remain a focus for ongoing quality improvement activity.

Figure 41: Restrictive Interventions by Age Group for Greater Manchester Providers (Pennine Care NHS FT): Comparison of March 2025 and March 2026



Source: NHS England Restrictive interventions Dashboard

Figure 42: Restrictive Interventions by Age Group for Greater Manchester Providers (Greater Manchester Mental Health NHS FT): Comparison of March 2025 and March 2026



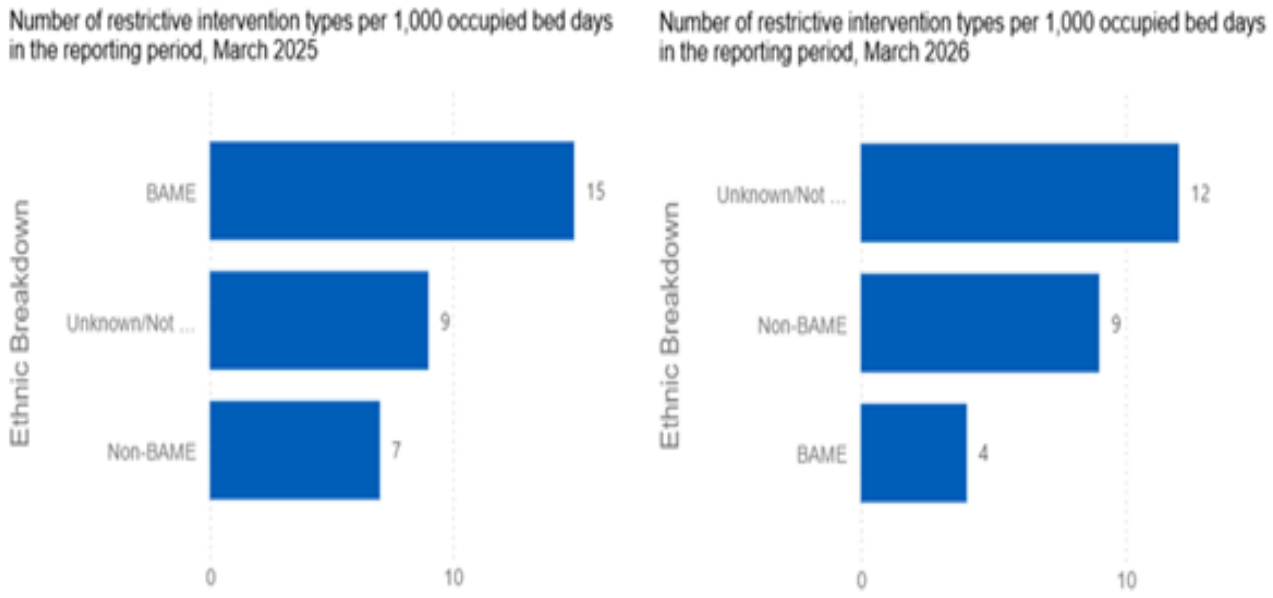
Source: NHS England Restrictive interventions Dashboard

Variation by ethnicity

Variation in rates of restrictive interventions is evident across ethnic groups. However, changes between March 2025 and March 2026 do not demonstrate a consistent direction of travel, with increases observed in some groups and reductions in others.

Interpretation is further limited by the proportion of records with unknown ethnicity. While the available data suggest variation in experience between ethnic groups, improvements in ethnicity recording are required to support more robust assessment of inequalities over time.

Figure 43 and Figure 44: Restrictive Interventions by Ethnicity for Greater Manchester Providers (Pennine Care NHS FT): Comparison of March 2025 and March 2026



Source**:** NHS Greater Manchester Mental Health Act Patient Metrics Dashboard

Taken together, the data indicate:

• Continued variation in the use of restrictive interventions across providers and population groups.

• Higher rates among younger adults, particularly those aged 18-24 years, despite some evidence of improvement over the reporting period.

• Persistent limitations in ethnicity data, restricting the ability to draw firm conclusions regarding inequalities.

• Fluctuation between reporting periods rather than a clear and consistent trend over time.

While variation is evident, the data reflect activity rates rather than population-adjusted measures and should therefore be interpreted with caution. Reducing the use of restrictive interventions remains a key priority within the Inpatient Quality Transformation Programme and supports the aims of the Patient and Carer Race Equality Framework (PCREF) to improve equity, safety and outcomes in mental health services.

Figure 45: Characteristics and Demographic Profile of Individuals Subject to Restrictive Interventions, 2025/26

Source: NHS Greater Manchester Mental Health Services Dataset – GM ADSP

10.4 Inequalities in people achieving access and outcomes for NHS Talking Therapies

The latest NHS Talking Therapies data demonstrates continued variation in access, treatment completion and recovery outcomes across Greater Manchester. Overall recovery performance remains below the national standard of 48% reliable recovery.

Performance continues to be influenced by local service configuration. In some areas, Step 2 and Step 3 services are commissioned separately, resulting in care episodes being recorded independently. As recovery is only recorded within the episode in which it is achieved, this may lead to an underestimation of overall recovery rates and limit comparability across localities.

Plans to implement a shared Patient Case Management Information System (PCMIS) across Greater Manchester remain a priority for 2026/27 and are expected to support more consistent reporting and performance measurement.

Local variation

Variation remains evident across Greater Manchester, with the impact of split commissioning arrangements most apparent in Manchester, Salford and Stockport. Areas operating more integrated service models demonstrate more complete recovery reporting and improved comparability of outcomes.

Inequalities by deprivation

Deprivation remains the most pronounced inequality dimension across NHS Talking Therapies.

Substantial differences are observed between the least and most deprived communities across the care pathway:

• Access to treatment: 58.3% in the least deprived areas compared with 45.7% in the most deprived areas.

• Treatment completion: 52.9% in the least deprived areas compared with 36.7% in the most deprived areas.

• Recovery: 58.0% in the least deprived areas compared with 41.0% in the most deprived areas.

Although a greater number of people from more deprived communities access NHS Talking Therapies services, they are less likely to complete treatment and achieve recovery. This pattern reflects wider social determinants of health, including housing, employment and income, which continue to influence mental health outcomes.

Inequalities by ethnicity

Access among people from Black, Asian and minority ethnic backgrounds has improved and is increasingly reflective of the Greater Manchester population. However, recovery outcomes for these groups remain below the overall average, indicating persistent inequalities in treatment outcomes.

Inequalities by age

Access among older adults aged 65 years and over has improved, although uptake remains below expected levels. Local data indicates that older adults experience higher treatment completion and recovery rates than the overall service population, suggesting that targeted interventions for older adults and people living with long-term conditions may be having a positive impact.

Summary

Taken together, the data demonstrates:

• Persistent inequalities in access, treatment completion and recovery outcomes, particularly by deprivation.

• Improved access for Black, Asian and minority ethnic communities, although recovery outcomes remain lower than average.

• Stronger treatment completion and recovery outcomes among older adults compared with the overall service population.

• Ongoing challenges in interpreting recovery performance due to variation in local commissioning and reporting arrangements.

Future focus

Priorities for 2026/27 include:

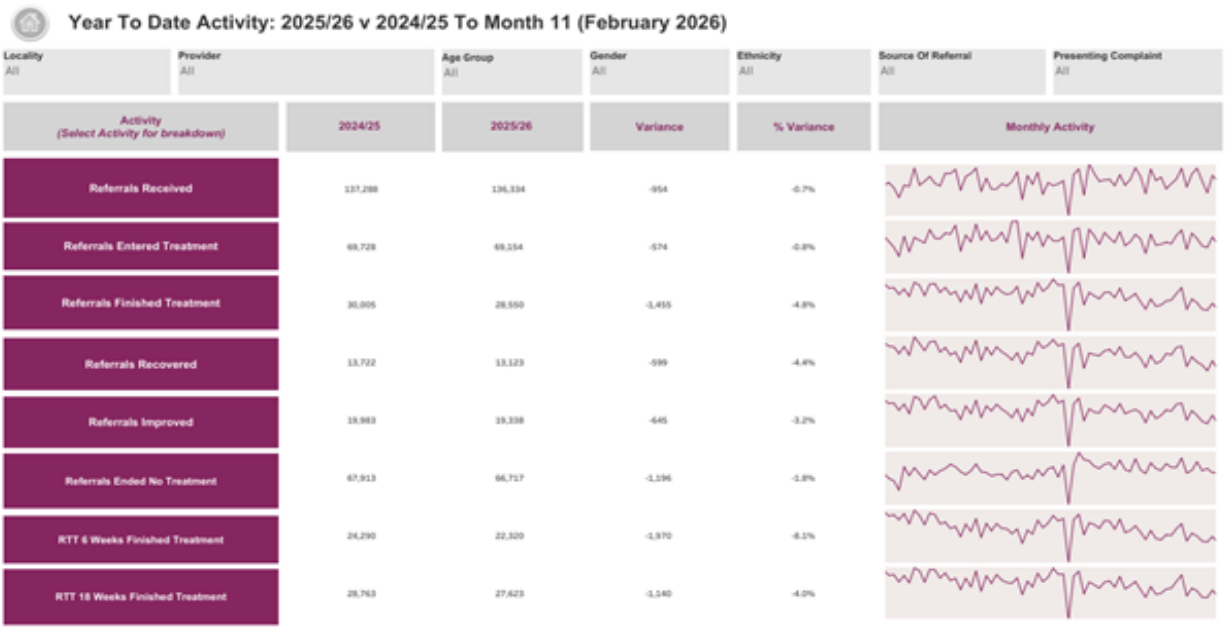
• Implementation of a shared PCMIS across Greater Manchester to improve consistency of reporting.

• Continued action to reduce inequalities in access and outcomes, particularly those associated with deprivation and ethnicity.

• Sustained focus on improving access for older adults and other underserved groups.

• Broader system-wide action to address the social determinants of mental health that contribute to inequalities in recovery outcomes.

Figure 46: NHS Talking Therapies Performance: Access, Completion, and Recovery, 2025/26



Source**:** Improving Access to Psychological Therapies (IAPT) Dataset – GM ADSP.

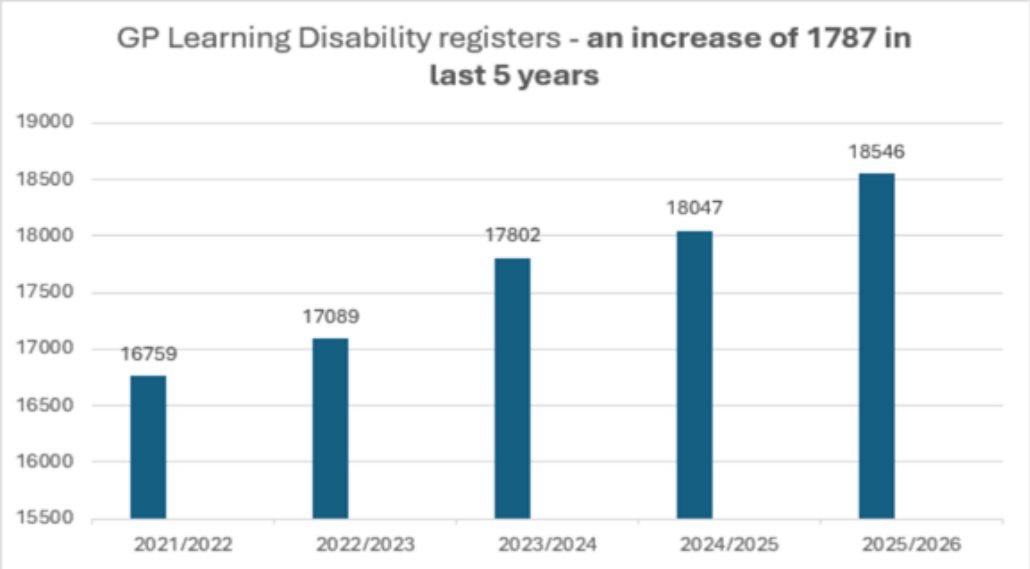
11. Learning Disability & Autism

11.1 Overview

Data from the Assuring Transformation (AT) dataset indicates that, at the latest reporting point, 99 people from Greater Manchester were recorded as being in a mental health inpatient setting with a learning disability and/or autism.
As this figure is derived from the national Assuring Transformation dataset, it should be interpreted within the context of the reporting methodology and inclusion criteria used by the programme.

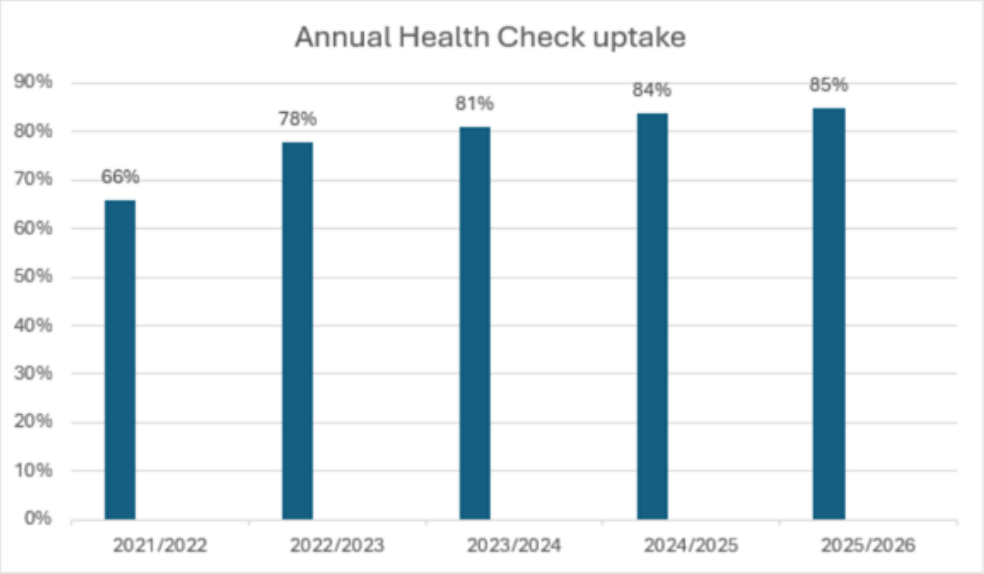
Figures 47 to 49 summarise key indicators relating to people with a learning disability and/or autism, including GP learning disability register coverage, annual health check uptake and health action plan completion. Annual health checks remain an important mechanism for identifying unmet health needs, supporting earlier intervention and reducing health inequalities experienced by people with a learning disability.

Figure 47: Number of People Aged 14 Years and Over Recorded on General Practice Learning Disability Registers



Source: NHS England

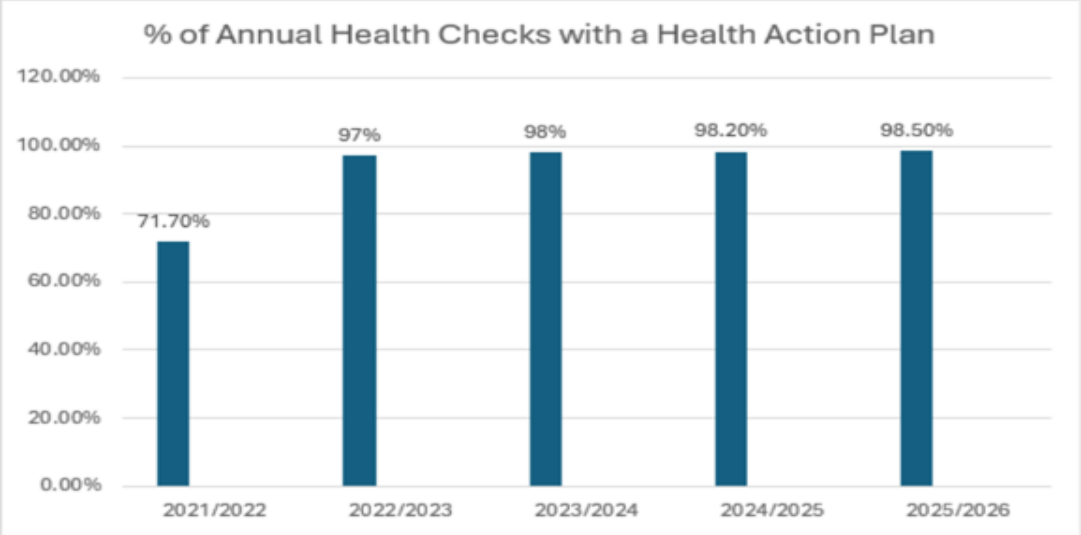
Figure 48: Percentage of Individuals Aged 14 and Over on GP Learning Disability Registers Who Have Received an Annual Health Check



Source: NHS England

Final validated 2025/26 performance data show that Greater Manchester achieved annual health check coverage of 85% among people recorded on GP learning disability registers.

Figure 49: Percentage of Individuals Aged 14 and Over on GP Learning Disability Registers Who Have a Health Action Plan



Source: NHS England

Final validated 2025/26 performance data show that Greater Manchester achieved health action plan coverage in excess of 98%.

High levels of health action plan completion demonstrate continued commitment to personalised care planning and support for people with a learning disability, helping to improve coordination of care and health outcomes.

11.1.1 Waiting Times for Autism Assessment Pathways

The latest available data indicates that a substantial proportion of people referred for autism assessment continue to wait longer than 13 weeks for first contact.

Analysis suggests that delays are experienced across all population groups, with no consistent pattern of variation by age, ethnicity or deprivation. This indicates that waiting times represent a system-wide challenge rather than an inequality concentrated within specific demographic groups.

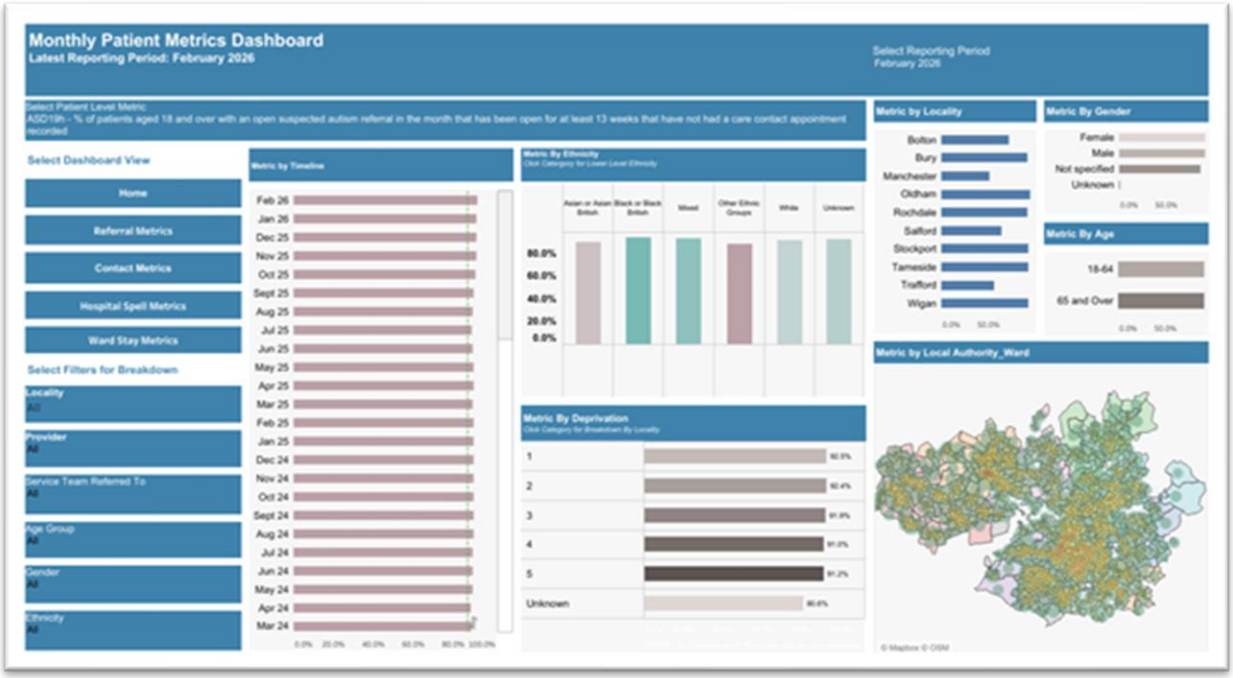
Variation is evident at locality level, reflecting differences in demand, service configuration and available capacity across Greater Manchester.

Overall, the findings suggest that improving timely access to autism assessment pathways remains a key priority. Work is ongoing through the neurodevelopmental transformation programme to improve pathway consistency, increase capacity and reduce waiting times across the system.

11.1.2 Inequalities

Current data does not demonstrate consistent inequalities in waiting times by age, ethnicity or deprivation. However, delays are experienced across all groups, indicating a system-wide access challenge affecting the wider population.

Figure 50: Characteristics and Demographic Profile of Individuals Waiting More Than 13 Weeks for Initial Autism Contact, 2025/26



Source: NHS Greater Manchester Mental Health Services Dataset – GM ADSP

NHS Greater Manchester has access to GP-level Learning Disability Annual Health Check data, which provides a more granular understanding of uptake across different population groups. This enables further exploration of potential health inequalities by locality, deprivation, age, ethnicity and gender, helping to identify variation in uptake and support targeted improvement activity across Greater Manchester. Source: Learning Disability (Health Check) Breakdown | GM ADSP.

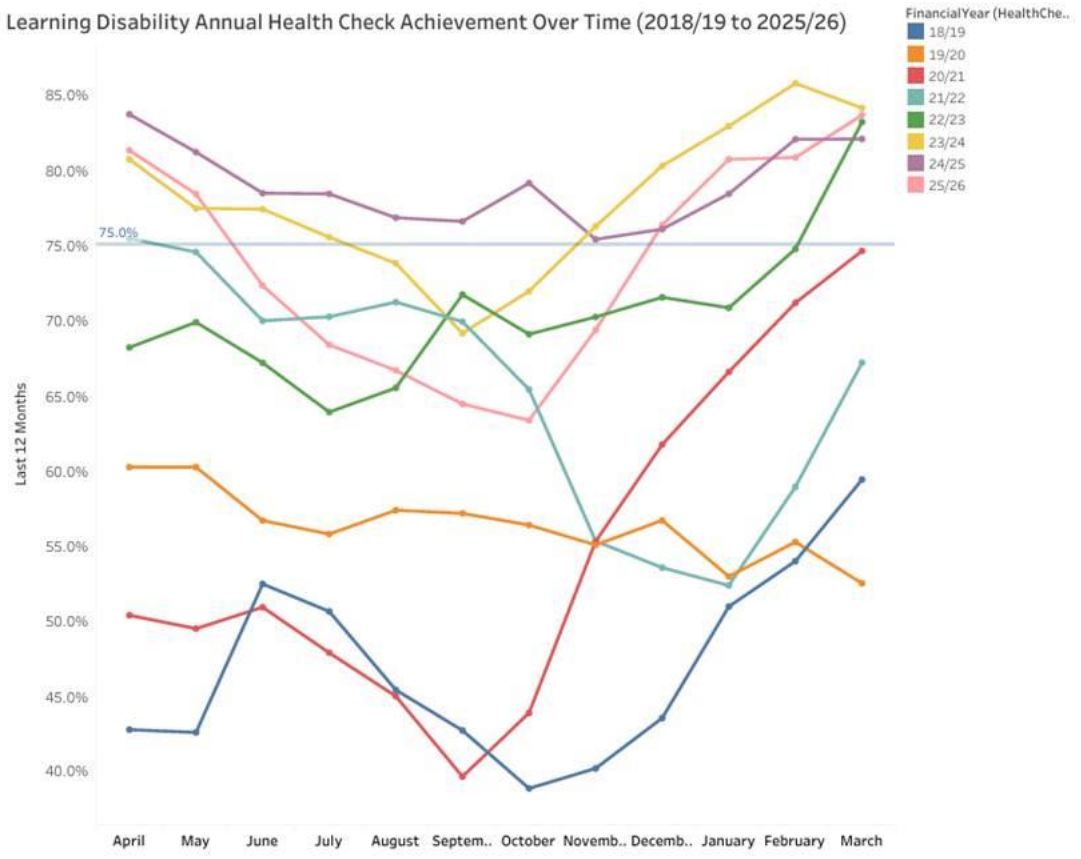
11.2 Monitoring Inequalities in Learning Disability Annual Health Check

Source*:* Learning Disability (Health Check) Breakdown, GM ADSP 05/06/2026.

Whilst published NHS Learning Disability Annual Health Check data remains the primary source for reporting performance, Greater Manchester also uses a locally developed primary care dashboard to provide a more granular understanding of variation in uptake across different population groups and geographical areas.

This intelligence enables ongoing monitoring of health inequalities and supports targeted improvement activity by identifying differences in annual health check achievement by locality, deprivation, age, ethnicity and gender.

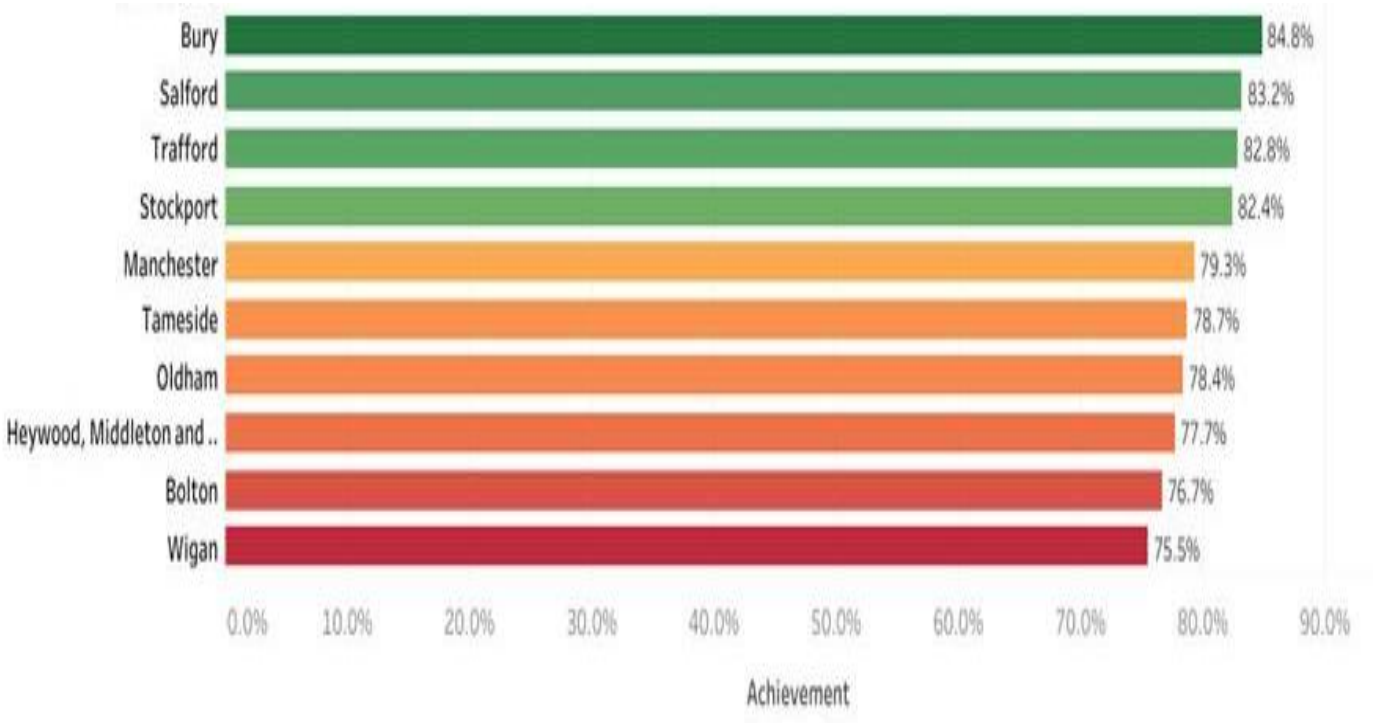
Figure 51: Trend Analysis of Learning Disability Annual Health Check Achievement, 2018/19 to 2025/26



Source: NHS Greater Manchester Learning Disability Health Checks Dashboard – GM ADSP

The proportion of people with a learning disability receiving an annual health check has increased substantially over time across Greater Manchester. Achievement has improved from approximately 43% in 2018/19 to over 80% in recent years, demonstrating sustained progress in delivery of annual health checks. Monitoring trends over time supports understanding long-term improvement and helps identify periods where additional intervention may be required.

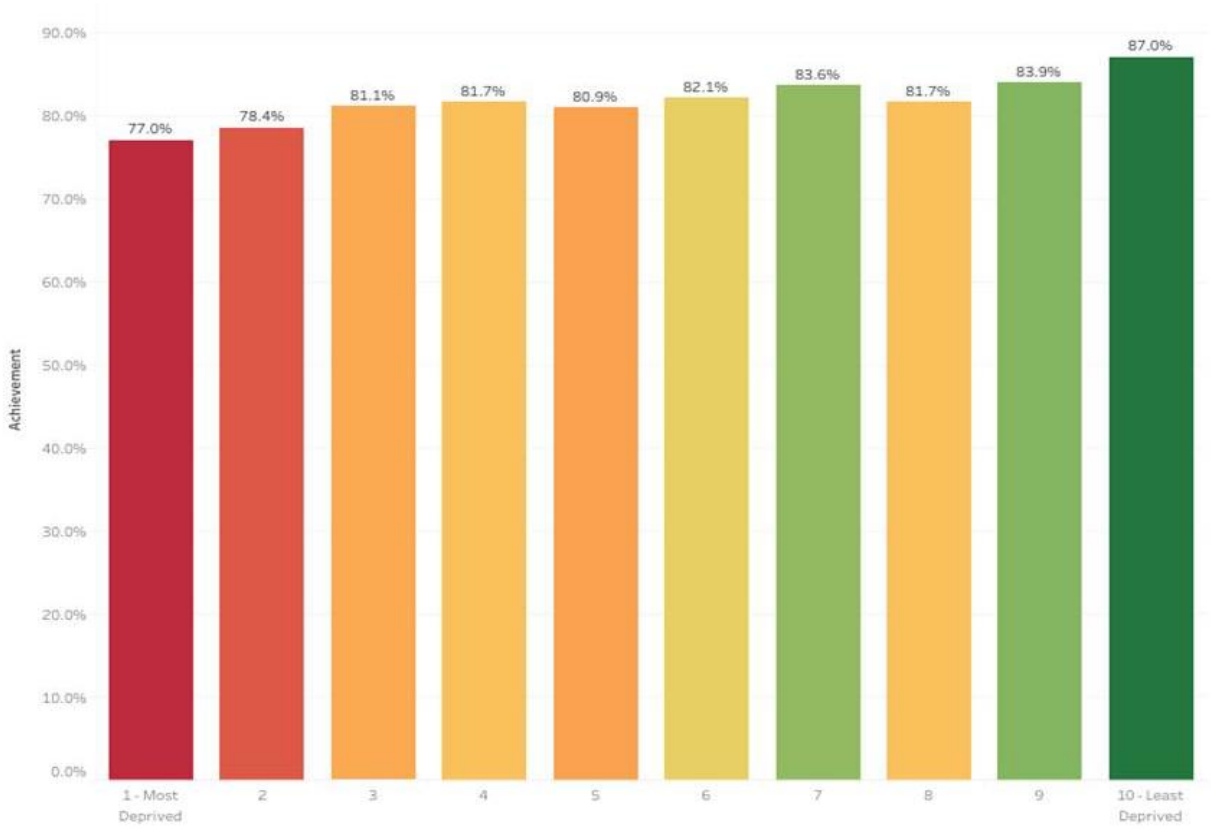
Figure 52: Percentage Achievement of Learning Disability Annual Health Checks by Greater Manchester Locality



Source: NHS Greater Manchester Learning Disability Health Checks Dashboard – GM ADSP

Variation in achievement is monitored across all Greater Manchester localities to identify geographical inequalities in access and uptake. Current achievement ranges from 75.5% in Wigan to 84.8% in Bury, representing a variation of approximately 9 percentage points across the system. Understanding locality-level variation supports targeted improvement activity and the sharing of good practice between areas.

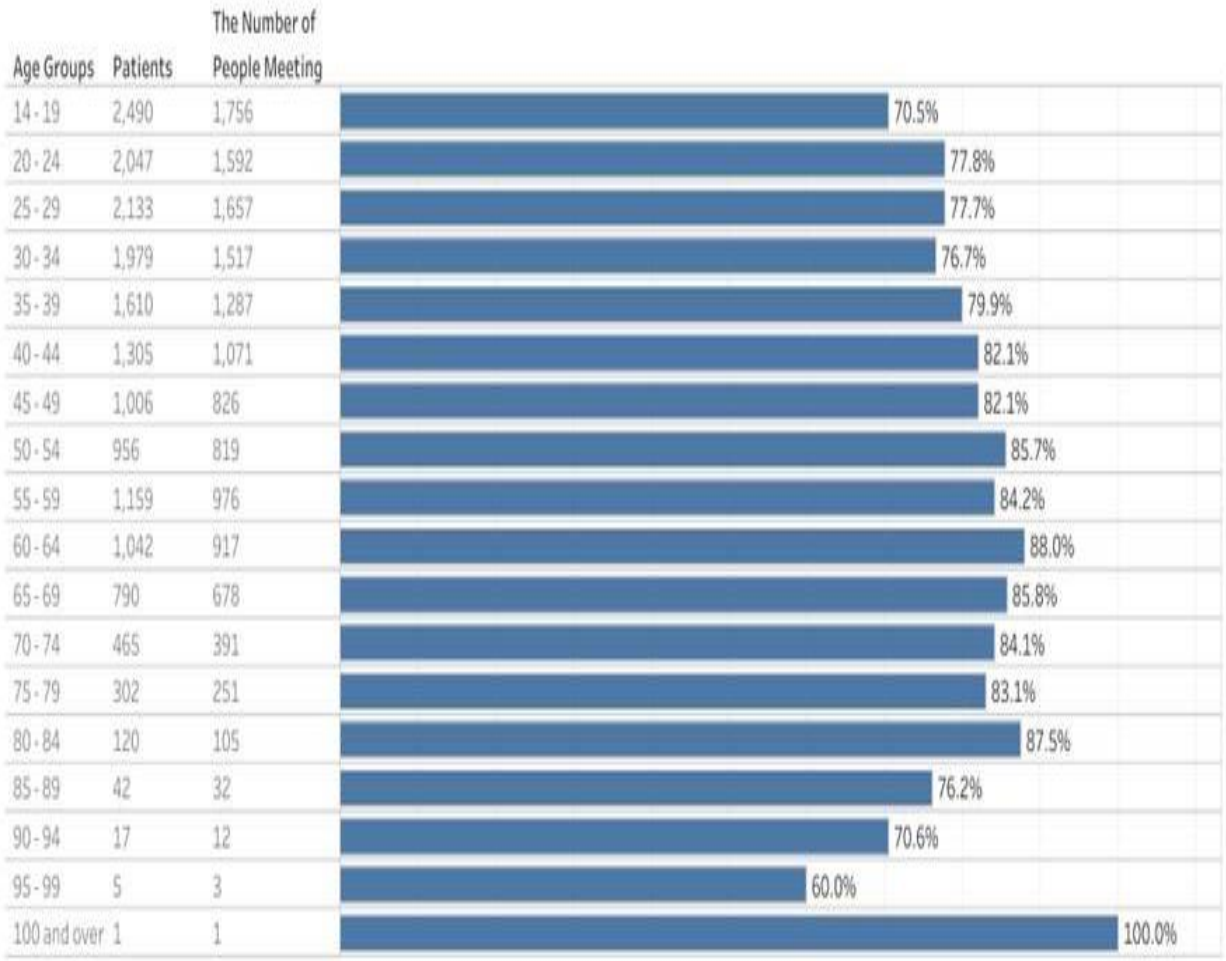
Figure 53: Percentage Achievement of Learning Disability Annual Health Checks by Deprivation Decile



Source: NHS Greater Manchester Learning Disability Health Checks Dashboard – GM ADSP

Achievement is monitored by deprivation to assess whether people living in more deprived communities experience different levels of access to annual health checks. Achievement is generally lower amongst residents living in the most deprived areas (77.0%) compared with the least deprived areas (87.0%), indicating a deprivation-related gradient in uptake. Monitoring deprivation supports Greater Manchester's wider commitment to reducing health inequalities and improving outcomes for underserved populations.

Figure 54: Achievement of Learning Disability Annual Health Checks by Age Group



Age Groups	Patients	The Number of People Meeting	
14 - 19	2,490	1,756	70.5%
20 - 24	2,047	1,592	77.8%
25 - 29	2,133	1,657	77.7%
30 - 34	1,979	1,517	76.7%
35 - 39	1,610	1,287	79.9%
40 - 44	1,305	1,071	82.1%
45 - 49	1,006	826	82.1%
50 - 54	956	819	85.7%
55 - 59	1,159	976	84.2%
60 - 64	1,042	917	88.0%
65 - 69	790	678	85.8%
70 - 74	465	391	84.1%
75 - 79	302	251	83.1%
80 - 84	120	105	87.5%
85 - 89	42	32	76.2%
90 - 94	17	12	70.6%
95 - 99	5	3	60.0%
100 and over	1	1	100.0%

Source: NHS Greater Manchester Learning Disability Health Checks Dashboard – GM ADSP

Achievement varies across age groups, with lower uptake observed amongst younger adults. Achievement is lowest amongst those aged 14-19 years (70.5%), whilst rates generally increase amongst older age groups, reaching over 85% in several cohorts. Monitoring age-related variation helps identify groups that may benefit from targeted engagement and support to improve uptake.

Table 3: Achievement of Learning Disability Annual Health Checks by Ethnicity and Sex

Ethnicity	Cis female	Cis male	Trans female	Trans male	Unknown	Grand Total
Any other ethnic group	78.4%	80.0%				79.4%
Asian or Asian British	80.3%	81.0%		100.0%		80.7%
Black, African, Caribbean …	80.4%	76.8%				78.2%
Mixed or multiple ethnic groups	76.0%	71.9%			100.0%	73.6%
Unknown	63.2%	62.3%				62.6%
White British	81.3%	79.2%	80.0%	40.0%	66.7%	80.0%
Grand Total	**80.7%**	**78.8%**	**80.0%**	**57.1%**	**80.0%**	**79.5%**

Source: NHS Greater Manchester Learning Disability Health Checks Dashboard – GM ADSP

Results for transgender and unknown gender categories should be interpreted with caution due to small numbers.

Achievement is monitored by ethnicity and gender to identify potential inequalities in access and uptake. Overall achievement is broadly similar across most ethnic groups, with rates ranging from 78.2% to 80.7% where ethnicity is recorded. Lower achievement is observed amongst individuals with unknown ethnicity (62.6%), highlighting the importance of improving data completeness. Monitoring protected characteristics enables Greater Manchester to assess equity of access and ensure that services are responsive to the needs of diverse communities.

Together, these analyses demonstrate Greater Manchester's approach to monitoring inequalities in Learning Disability Annual Health Check uptake, providing insight into variation across population groups and geographical areas and supporting targeted action to improve equitable access to preventative healthcare services.

11.3 Inequalities identified in learning from lives and death reviews (LeDeR) faced by people with a learning disability and autistic people

11.3.1 Overview

King's College London's most recently published national LeDeR report, Learning from Lives and Deaths: People with a Learning Disability and Autistic People (2023*)*, highlights persistent and significant health inequalities experienced by people with a learning disability and autistic people. These include reduced life expectancy, higher rates of avoidable mortality, inequitable access to preventative healthcare, and poorer health outcomes across a range of long-term conditions.

The findings are consistent with challenges observed across Greater Manchester and continue to inform local improvement priorities. Key areas of inequality and the actions being taken to address them are summarised below.

11.3.2 Key priorities and actions include:

• Preventative care and annual health checks: Improving uptake of annual health checks remains a key priority. Performance at the end of January 2026 was 66.11%, representing a 14.04% increase from the same point in the previous year, with a forecast year-end trajectory of 90%.

• Data and intelligence: The Greater Manchester Learning Disability and Autism Dashboard was launched in March 2026, providing intelligence on GP learning disability registers, annual health checks, screening uptake, vaccination uptake, long-term conditions and wider health inequalities to support targeted improvement activity. Source: Adult Social Care Specialist Services Dashboard, GM ADSP.

• Respiratory disease and long-term conditions: Respiratory disease remains a leading cause of death identified through LeDeR reviews. Greater Manchester continues to strengthen respiratory care, dysphagia pathways, vaccination programmes and long-term condition management, including epilepsy improvement work.

• Reducing ethnic inequalities: Evidence continues to show poorer outcomes for some ethnic minority groups. Greater Manchester is strengthening ethnicity data quality, undertaking focused reviews and improving access to equitable screening and healthcare pathways.

• Mental Capacity Act and reasonable adjustments: Work continues to improve application of the Mental Capacity Act, DNACPR processes and the consistent provision of reasonable adjustments, supported by specialist learning disability services and workforce development.

• Supporting autistic adults: Greater Manchester is aligning improvement activity with the Greater Manchester Autism Strategy, including strengthened post-diagnostic support, improved mental health pathways and increased focus on reducing health inequalities experienced by autistic adults.

We are currently awaiting publication of the 2025/26 LeDeR report and associated recommendations, which will further inform priorities for reducing preventable harm and improving outcomes for people with a learning disability and autistic people across Greater Manchester.

11.4 Special Educational Needs and Disabilities (SEND), Learning Disability and Autism (LDA) and Epilepsy (Children & Young People (CYP))

11.4.1 Inequalities in access to epilepsy specialist nurses in the first year of care for those with a learning disability or autism

Regional epilepsy benchmarking completed in April 2025 identified variation in access to specialist epilepsy support, including for children and young people with a learning disability or autism. Epilepsy remains a significant contributor to avoidable morbidity and mortality for people with a learning disability and continues to be a system priority across Greater Manchester.

Greater Manchester has undertaken system-wide epilepsy benchmarking and improvement work with NHS England and specialist partners to better understand variation, identify opportunities for improvement and strengthen access to specialist support. Further work is planned through ongoing learning disability and long-term condition improvement programmes.

Pages 43-47 of the NWENY Step Together report identifies a plethora of learning and actions from GM; to be actioned in 2026/27.

11.4.2 Inequalities identified in National Child Mortality Database (NCMD) deep dives experienced by autistic children and young people, and those with a learning disability

The National Child Mortality Database (NCMD) thematic review identified a number of recurring factors associated with avoidable harm among autistic children and young people and those with a learning disability. These included inequalities in access to healthcare, delays in diagnosis and support, challenges during transition between services, and variation in care coordination.

The findings align with existing priorities across Greater Manchester and continue to inform system-wide improvement programmes.

11.4.3 Key areas of action include:

• Reasonable adjustments and accessible care: Providers are expected to deliver care that is accessible and responsive to individual needs, supported by workforce development, autism training and implementation of the Accessible Information Standard.

• Coordinated care for children with complex needs: Greater Manchester continues to strengthen care coordination for children and young people with learning disabilities, autism and co-existing physical health conditions through improved clinical leadership, named professionals, annual health checks and vaccination programmes.

• Transition between services: Transition remains a key priority, with work underway to strengthen planning, improve coordination between services and support autistic young people and those at increased risk of mental ill-health, self-harm or suicide.

• Access to neurodevelopmental assessment and support: Reducing waiting times for autism and ADHD assessment remains a significant priority. The Greater Manchester neurodevelopmental transformation programme is redesigning pathways and expanding access to support while children and young people await diagnosis.

• Access to mental health support: Continued investment in CAMHS, Mental Health Support Teams, community provision and digital support aims to improve access, reduce variation and provide targeted support for children and young people at greatest risk.

• Suicide prevention and wellbeing: Suicide prevention remains a priority through school-based mental health programmes, workforce development and the wider Shining a Light on Suicide programme.

• Support for bereaved families: Greater Manchester commissions a dedicated bereavement service to provide timely emotional and practical support to families following the death of a child or young person.

The Greater Manchester Children and Young People Learning Disability and Autism programme continues to support community-based care, reduce avoidable admissions and improve outcomes through nationally mandated services, including Dynamic Support Registers, Care, Education and Treatment Reviews (CETRs), Keyworker services and intensive support provision.

11.4.4 Number of under 18s with a learning disability or who are autistic in a mental health inpatient setting

At the latest reporting period, there were 9 children and young people aged under 18 with a learning disability or who were autistic receiving care within a mental health inpatient setting.

Reducing avoidable inpatient admissions remains a key priority across Greater Manchester. The Children and Young People Learning Disability and Autism programme continues to strengthen community-based support, early intervention and crisis prevention services, with the aim of enabling more children and young people to receive care closer to home and reducing the need for inpatient admission wherever clinically appropriate.

NOTE: Inpatient figures are derived from operational Assuring Transformational data and represent a point-in-time snapshot. They may differ from other published sources due to variations in reporting definitions and data collection methods.

12. Tobacco Dependence and Smoking Cessation

12.1 Inequalities in Smoking Prevalence

Greater Manchester Treating Tobacco Dependency Programme

Tobacco dependency remains a leading cause of preventable illness, premature death and health inequalities across Greater Manchester, disproportionately affecting people living in deprivation and those with severe mental illness and long-term health conditions.

The Greater Manchester Tobacco Treatment Dependency Programme has been designed to reduce these inequalities through an evidence-based, opt-out approach across acute, maternity and mental health services. The programme ensures patients are routinely identified and proactively offered behavioural support and pharmacotherapy, helping to remove barriers to treatment access and engagement.

Combining specialist treatment pathways, digital infrastructure and real-time performance assurance, the programme supports more equitable access to evidence-based care and improved quit outcomes amongst populations most impacted by smoking-related harm.

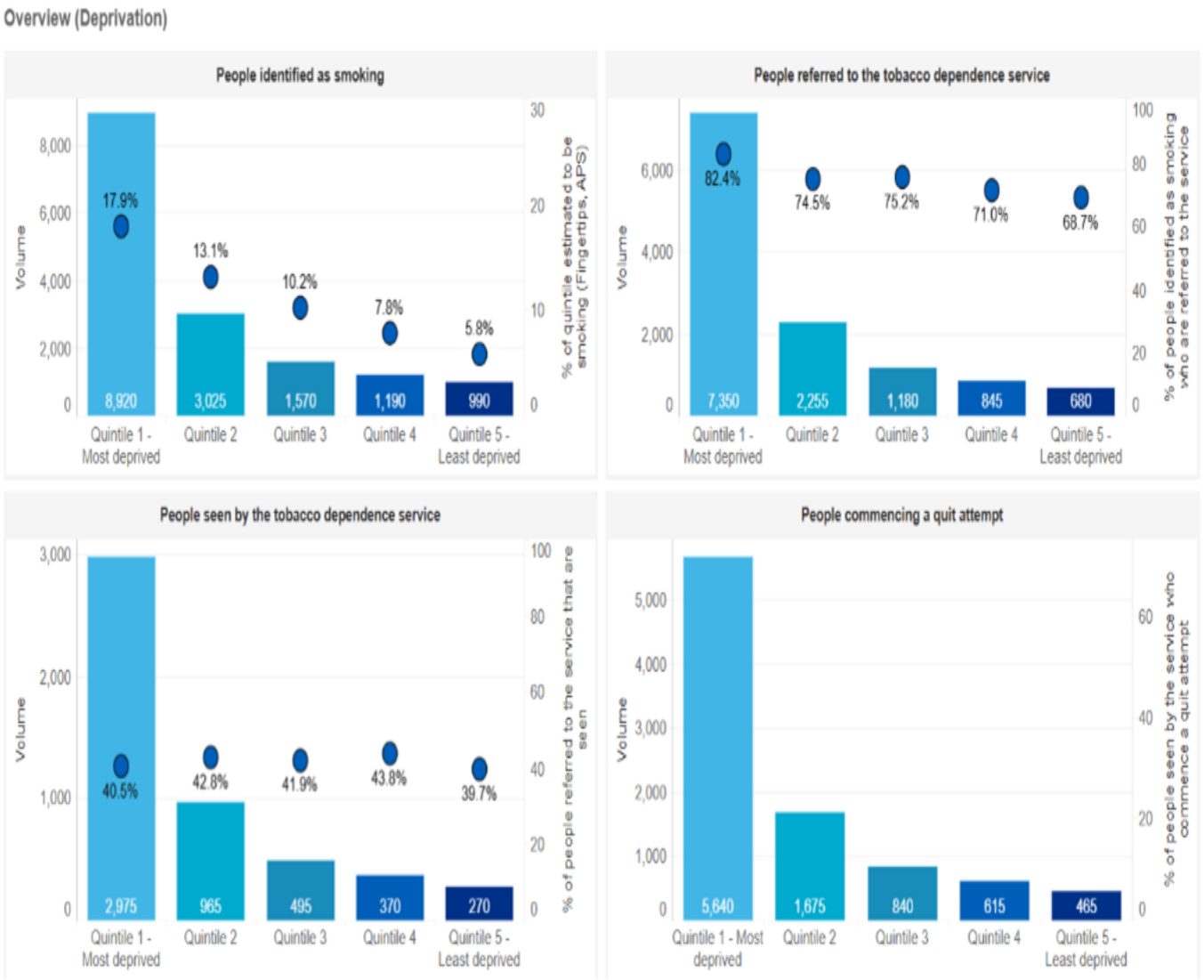
The programme aligns strongly with the NHS Long Term Plan, Core20PLUS5 and wider prevention ambitions. By treating tobacco dependency as a clinical condition, the programme supports improved health outcomes, reduces pressure on NHS services and contributes to narrowing long-standing health inequalities across Greater Manchester.

The data by age, ethnic group, deprivation decile, and gender is reflective of secondary care hospital services. We know that these patients are often older and from more deprived communities. The data clearly shows that populations with poorer health outcomes such as living in deprived communities and ethnic minority groups are engaging with inpatient treating tobacco dependency services.

There are, however, significant gaps in data reporting across Greater Manchester, which limit the completeness of inequalities analyses. Work is ongoing across secondary care providers to

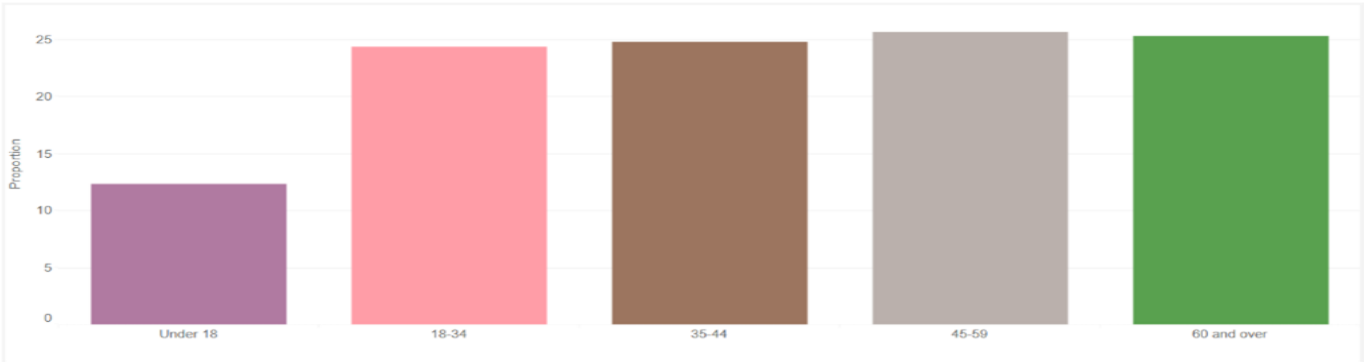
improve reporting functionality and support the continued rollout of the Greater Manchester Treating Tobacco Dependency digital platform. These improvements are expected to strengthen the completeness and consistency of reporting, enabling more robust assessment of inequalities across the pathway over time.

Figure 55: Inpatients Identified as Smokers, Referred to Tobacco Dependency Services, Seen by Services, and Making a Quit Attempt, by Deprivation Quintile



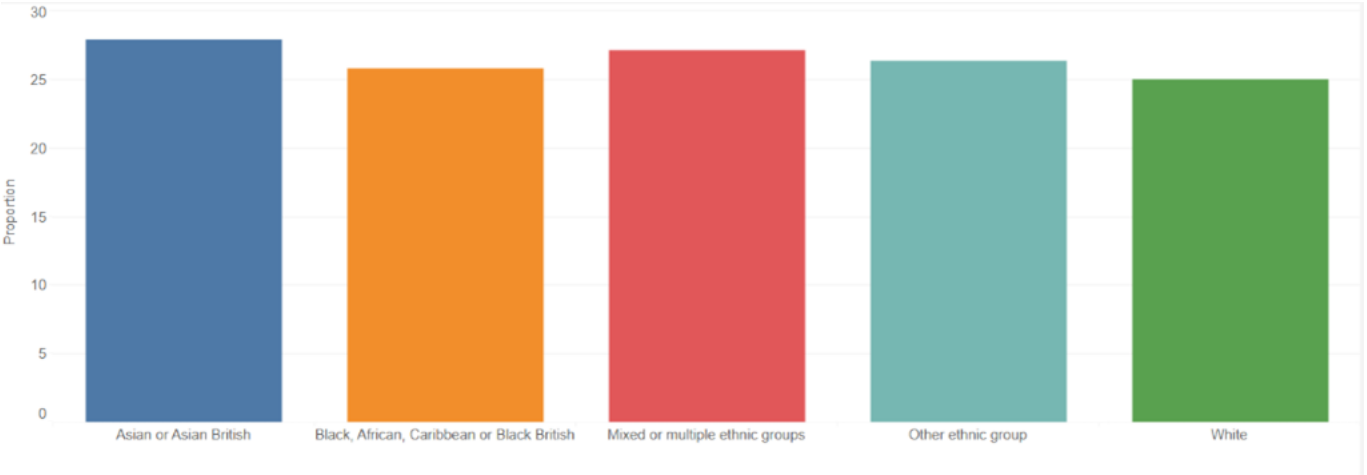
Source: NHS England Tobacco Dependence Services Dashboard

Figure 56: Proportion of Inpatients Commencing a Quit Attempt by Age Group



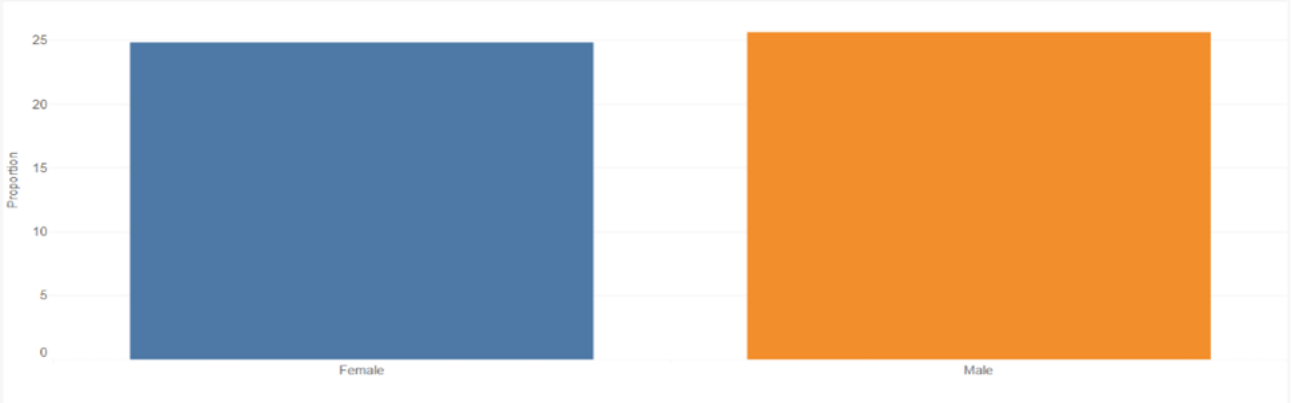
Source: NHS England Tobacco Dependence Services Dashboard

Figure 57: Proportion of Inpatients Commencing a Quit Attempt by Ethnicity Group



Source: NHS England Tobacco Dependence Services Dashboard

Figure 58: Proportion of Inpatients Commencing a Quit Attempt by Sex



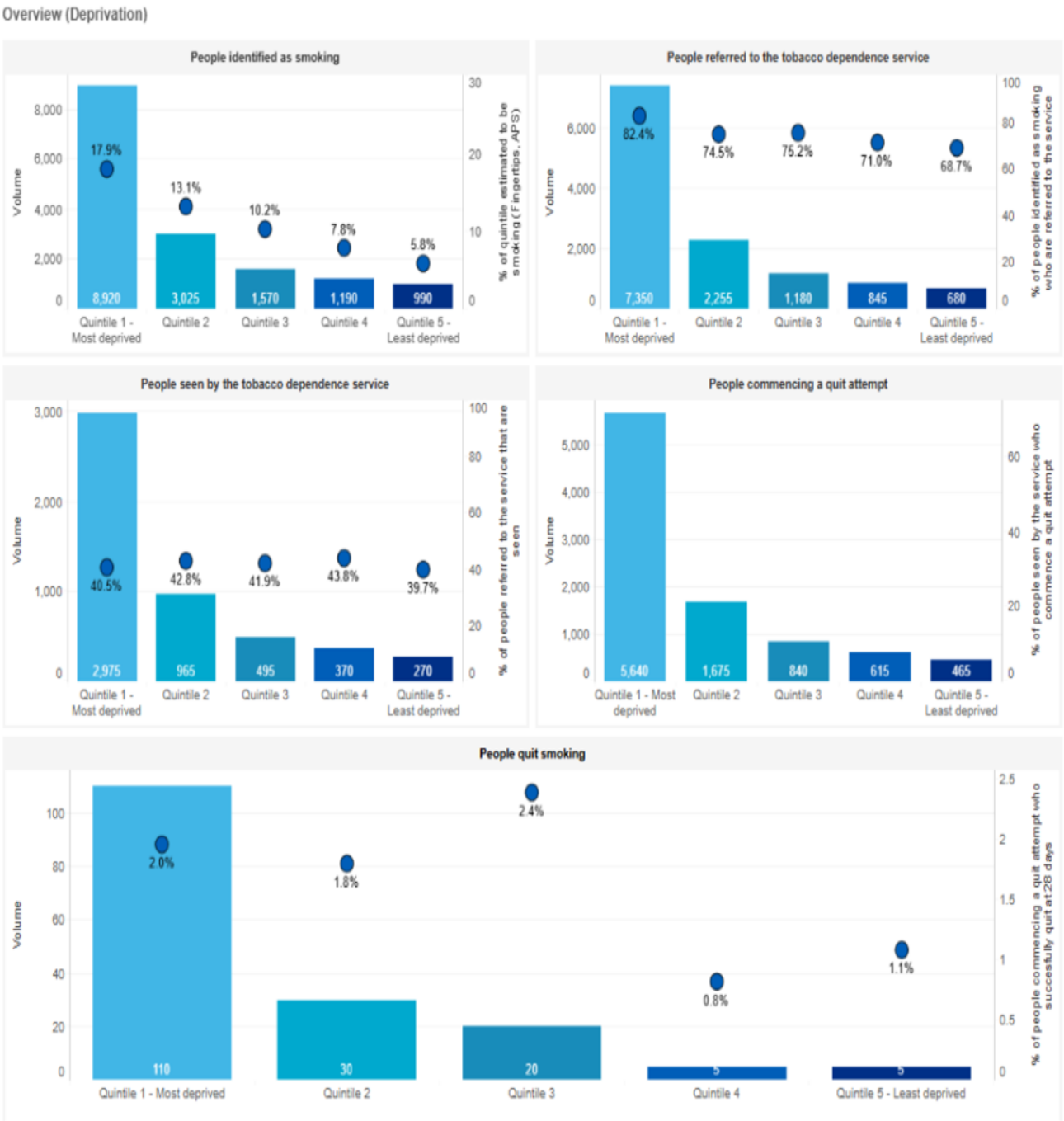
Source: NHS England Tobacco Dependence Services Dashboard

Although capacity within our Inpatient Treating Tobacco Dependency Services is challenging, and we are aware that there is limited capacity in hospital-based teams to support all inpatient smokers, the data demonstrates uptake and engagement by populations who are at greatest risk of experiencing inequalities. In our approach to address capacity issues within the services, NHS GM is doing a deep dive in to the pathway data which will help to inform decision making.

12.2 Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt

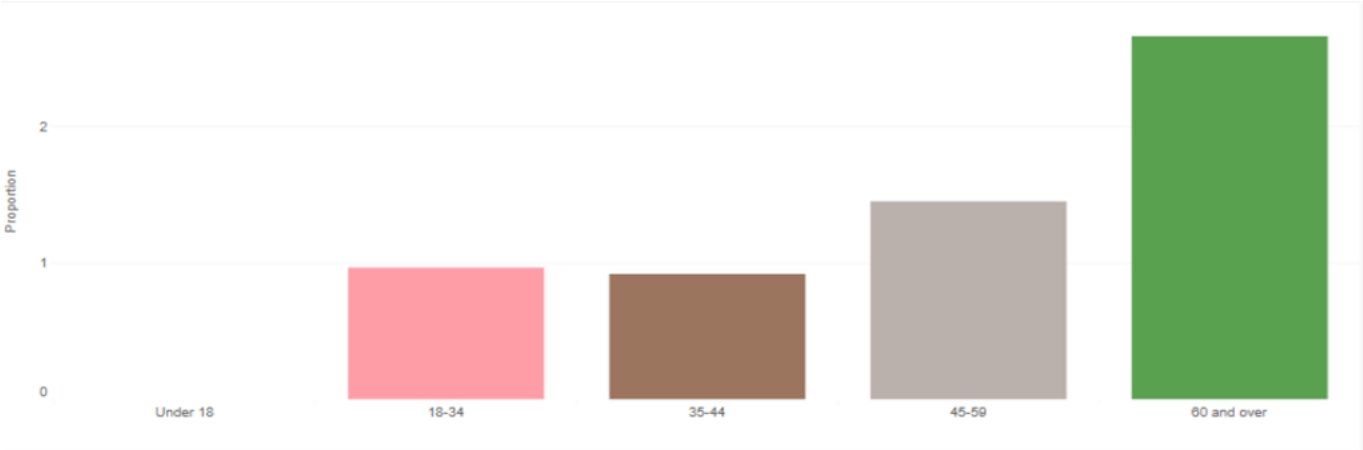
The data on the proportion on patients who have successfully quit 28 days after commencing a quit attempt does demonstrate inequalities by deprivation decile with a higher proportion of smokers successfully quitting from deprivation quintile 3 (moderately deprived) followed by deprivation 1 (most deprived). In the ethnic group data, the proportion of patients who successfully quit smoking at 28 days after commencing a supported quit attempt are highest in the white ethnic group and the Asian or Asian British ethnic group. This is reflective of GM's highly diverse region with large numbers of residents identifying with the White ethnic group followed by the Asian ethnic group.

Figure 59: Inpatients Identified as Smokers, Referred to and Seen by Tobacco Dependency Services, Making a Quit Attempt, and Successfully Quitting at 28 Days, by Deprivation Quintile



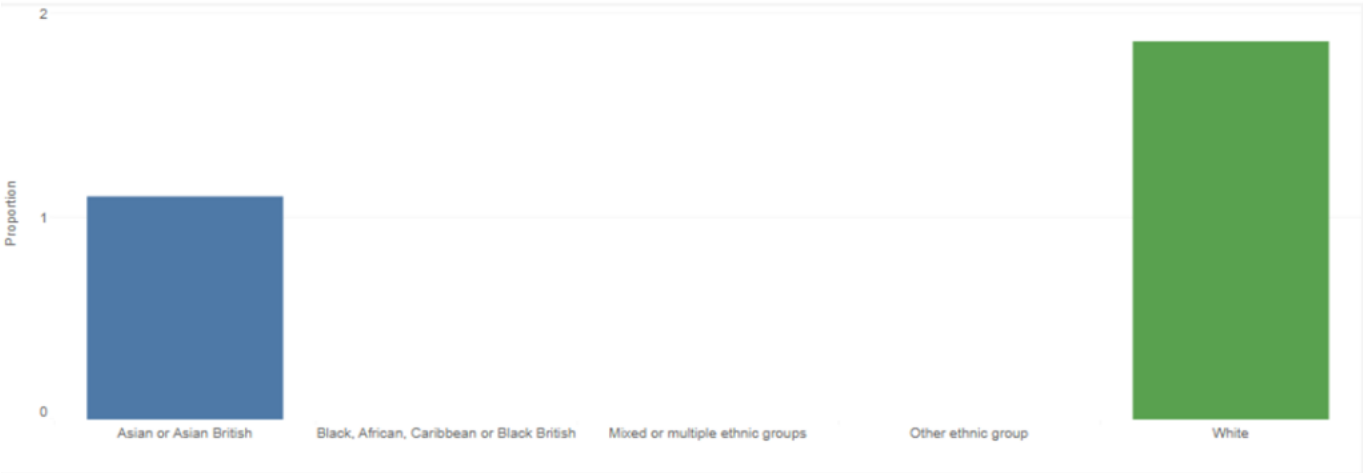
Source: NHS England Tobacco Dependence Services Dashboard

Figure 60: Proportion of Inpatients Who Have Quit Smoking at 28 Days Following a Supported Quit Attempt, by Age Group



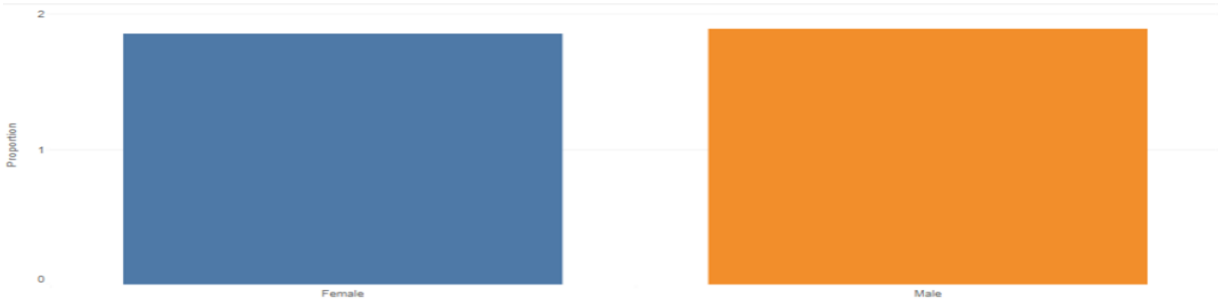
Source: NHS England Tobacco Dependence Services Dashboard

Figure 61: Proportion of Inpatients Who Have Quit Smoking at 28 Days Following a Supported Quit Attempt, by Ethnic Group



Source: NHS England Tobacco Dependence Services Dashboard

Figure 62: Proportion of Inpatients Who Have Quit Smoking at 28 Days Following a Supported Quit Attempt, by Sex



Source: NHS England Tobacco Dependence Services Dashboard

12.3 Smoke-free Pregnancy

Smoking in pregnancy remains a major contributor to health inequalities across Greater Manchester, disproportionately affecting women living in deprivation and contributing to poorer maternal and neonatal outcomes including stillbirth, pre-term birth, low birth weight, neonatal admissions and sudden infant death syndrome (SIDS).

The Greater Manchester Smoke-free Pregnancy Programme has been designed to address these inequalities through an evidence-based, opt-out approach embedded across maternity services. The programme combines specialist pregnancy stop smoking support, universal carbon monoxide monitoring, behavioural support, nicotine replacement therapy, digital engagement and the National Smoke-free Pregnancy Incentive Scheme (NSPIS) to improve access, engagement and quit outcomes for women most at risk.

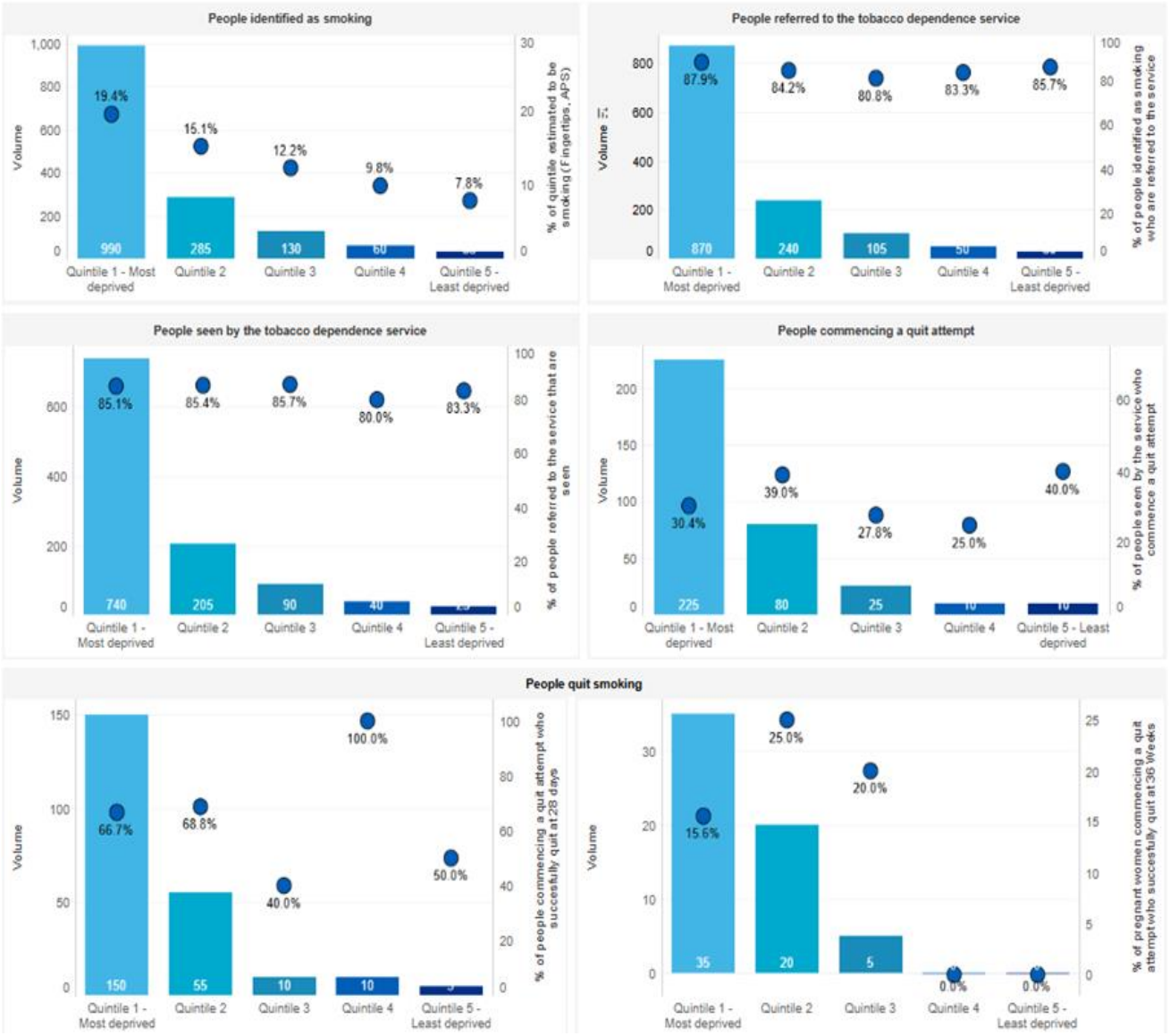
12.3.1 Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks' gestation

The data in the chart below demonstrates that the highest proportion of pregnant women identified as smokers live in quintile one (19.4) compared to quintile five least deprived (7.8%). Referral rates are then highest in quintile one where 87.9% women of the identified smokers are referred for support compared to 85.7% in quintile five. The proportion of pregnant women seen

by the TTD service then remains high in quintile one (85.1%) compared to quintile five (83.3%). In contrast, the proportion of pregnant women making a quit attempt is higher in quintile 5 (40%) compared to quintile 1 (30.4%).

Converting quit attempts into quit rates is where inequalities start to develop, with 66.7% of pregnant smokers in quintile one beginning at 28 days compared to 50% in deprivation quintile five and this then reducing further by 36 weeks to 15.6% of pregnant smokers remaining quit in deprivation quintile one. It should also be noted that in deprivation decile five, compared to the 50% of pregnant smokers beginning a quit at 28 days, 0% of pregnant smokers remained quit at 36 weeks.

Figure 63: Percentage of Pregnant Women Identified as Smokers, Referred to and Seen by Tobacco Treatment Dependency (TTD) Services, Commencing a Quit Attempt, and Achieving Quit Status at 28 Days and 36 Weeks, by Deprivation Quintile

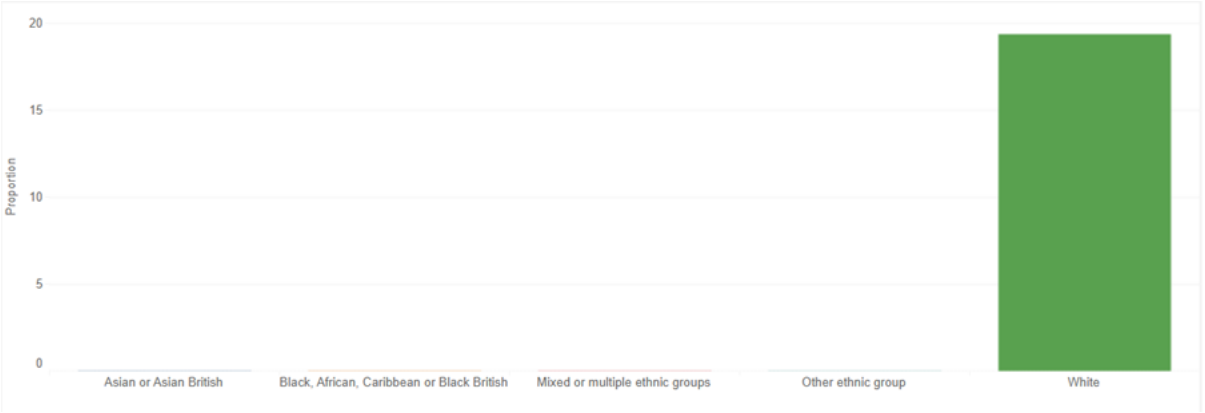


Source: NHS England Tobacco Dependence Services Dashboard

The quit rate for pregnant women at 36 weeks is highest among white women at 19.4%. However, it should be recognised that there are gaps in the data reported by local maternity systems and to resolve this, there is ongoing work to ensure that the inequalities data held in

the data tables in the back end of the Greater Manchester Smoke Free Pregnancy digital platform can be reported during 2026/27.

Figure 64: Proportion of Pregnant Women Who Have Quit Smoking by 36 Weeks' Gestation, by Ethnic Group



Source: NHS England Tobacco Dependence Services Dashboard

The latest NHS Digital data for Q3 2025/26 shows Greater Manchester's Smoking at Time of Delivery (SATOD) rate reduced to 3.7%, compared to the England average of 4.1%. This is the first clear indication that Greater Manchester is on trajectory to achieve its ambitious target of reducing SATOD to 4% by 2028, while continuing to outperform the national average.

The programme aligns strongly with national priorities including the NHS Long Term Plan, Core20PLUS5, the Tobacco and Vapes Bill and the Saving Babies' Lives Care Bundle. By reducing tobacco dependency in pregnancy, the programme supports maternity safety, reduces avoidable harm, improves infant outcomes and contributes to breaking intergenerational cycles of health inequality across Greater Manchester. For further information on the success of the smoke free pregnancy programme visit: Story of Change: Helping with Smokefree Beginnings | FHFA Academy.

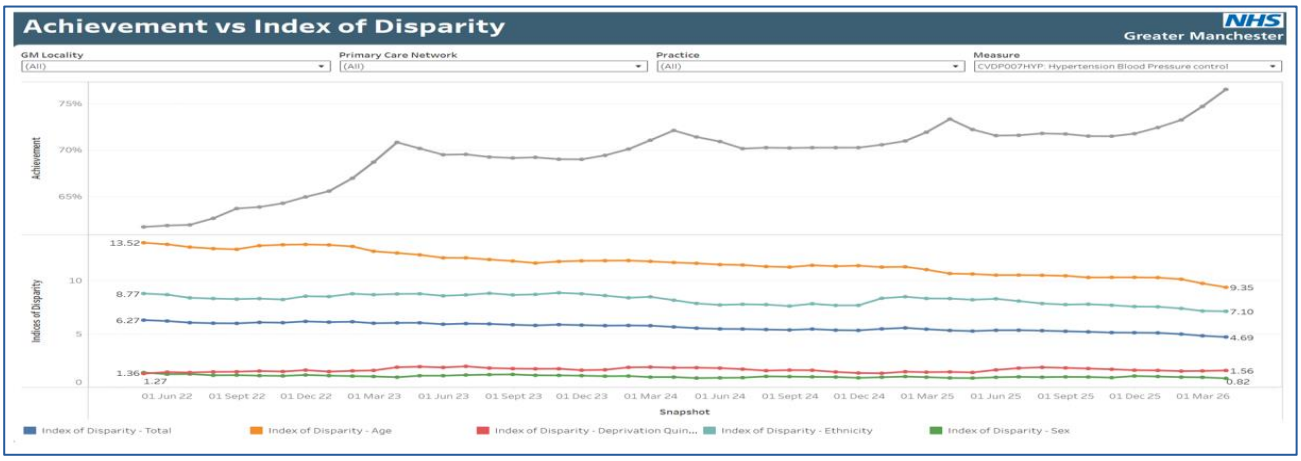
13. Cardiovascular Disease Prevention

13.1 Greater Manchester CVD Prevention: A Whole-Systems Approach to Tackling Inequalities

Over the past year, Greater Manchester has continued to strengthen its whole-system approach to CVD prevention, combining intelligence-led population health management, primary care improvement, medicines optimisation and community-based case-finding. A major development has been the introduction of a validated, live '*Index of Disparity*' across CVD prevention measures, enabling tracking of inequalities by age, sex, ethnicity and deprivation at system, locality, PCN and GP practice level. Lower *Index of Disparity* scores indicate lower inequality. This represents a significant improvement in analytical capability, moving the system beyond broad descriptions of variation towards routine, measurable tracking of whether improvement is being delivered equitably. This new metric and the continued use of CVNeed ensures a data-driven approach to prevention and that we are reaching the right people at the right time.

Hypertension blood pressure control has improved substantially, with the latest GM dashboard (**figure 65**) showing achievement increasing from just over 60% in 2022 to above 75% in the latest view. This has been accompanied by a reduction in overall *Index of Disparity* from 6.27 to 4.69. Age and ethnicity remain the largest residual gaps, although both have reduced.

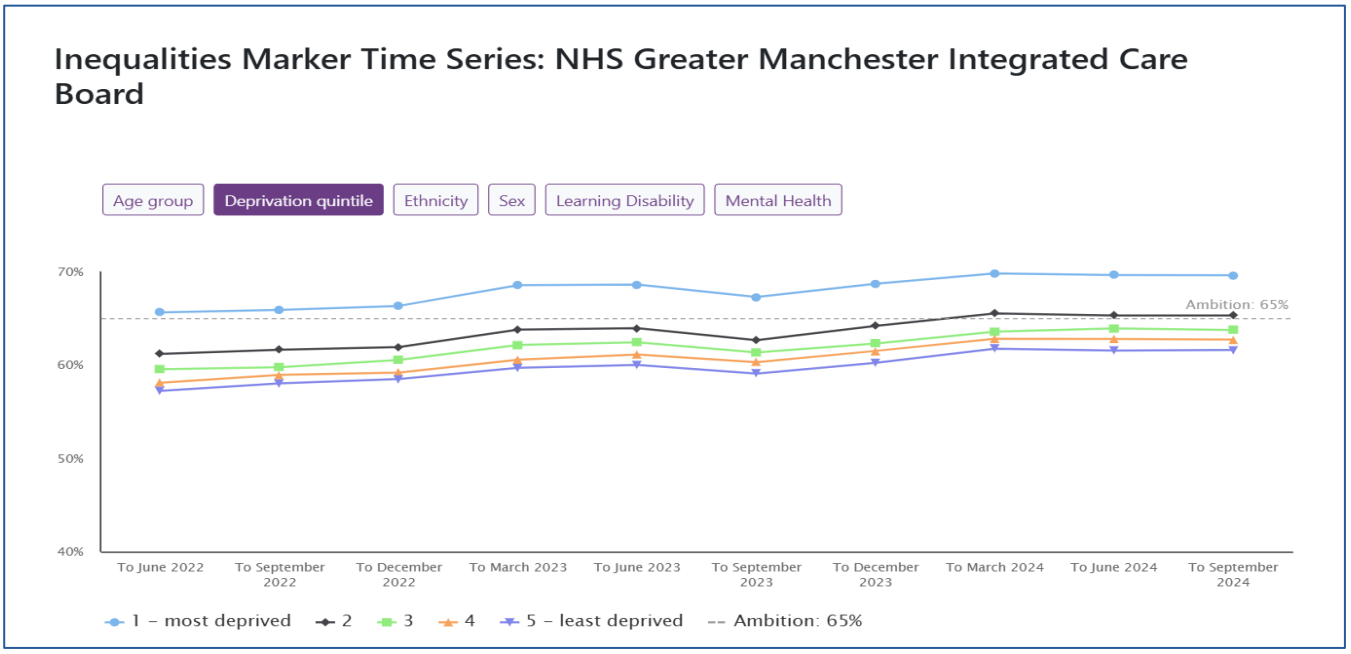
Figure 65: CVD007HYP: Increase in Controlled Hypertension in Greater Manchester with Reduced Inequalities



Source: NHS Greater Manchester Hypertension Dashboard – GM ADSP

The updated inequalities graph for patients with no GP-recorded CVD and a QRISK score of 20% or more (**figure 66**) shows that the most deprived quintile is performing above the 65% national ambition, with uptake in the most deprived population around 70% and higher than in the least deprived population. This is important because it suggests that targeted prevention is not simply improving average performance but is also reaching populations with higher underlying cardiovascular risk.

Figure 66: CVDP003CHOL: Patients Without Recorded CVD and a QRISK ≥20% Receiving Lipid-Lowering Therapy



Source: [CVD Prevent NHS Insights Website]

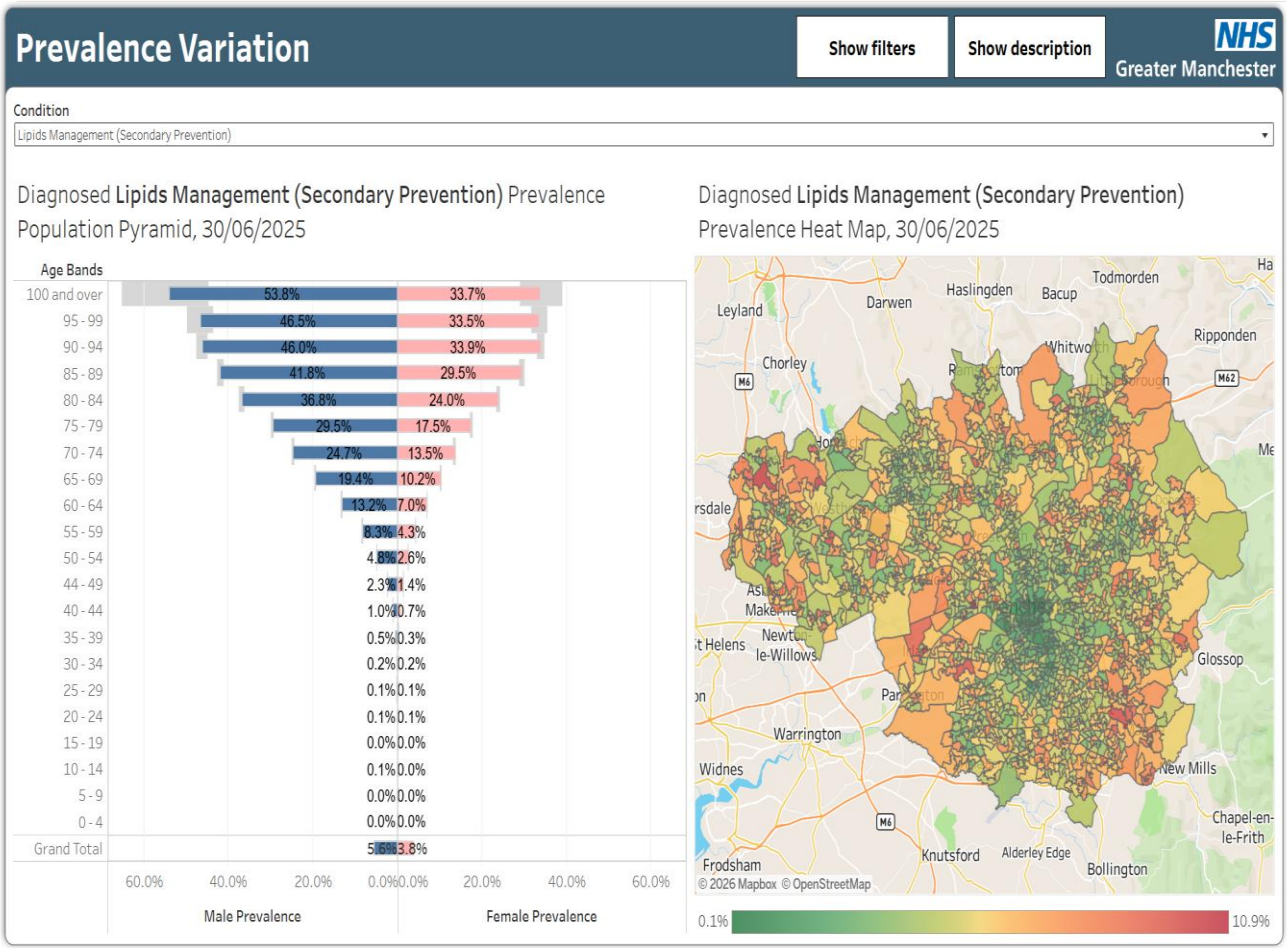
The wider CVDPrevent extract also shows continued improvement for QRISK of 10% or more lipid-lowering therapy, increasing from 56.82% to 58.83% over the latest year and from 47.5% in March 2021 to 58.83% in September 2025.

For secondary prevention lipid control, GM's internal inequalities dashboard shows strong improvement in both achievement and equity. The revised cholesterol control measure has

increased to around 62% in the latest dashboard view. The clearest reduction in inequality is seen in deprivation, where the *Index of Disparity* has fallen from 6.61 to 1.76, and in ethnicity, where it has reduced from 12.15 to 6.30. Age remains the largest residual source of inequality, with the *Index of Disparity* remaining high at around 15 and will therefore be a key focus for further targeted improvement.

The updated prevalence variation dashboard (**figure 67**) also shows substantial underlying age and sex variation in secondary prevention need, with prevalence at 5.6% in males and 3.8% in females overall; and marked concentration in older age groups. This reinforces the need to interpret variation in achievement alongside variation in underlying need.

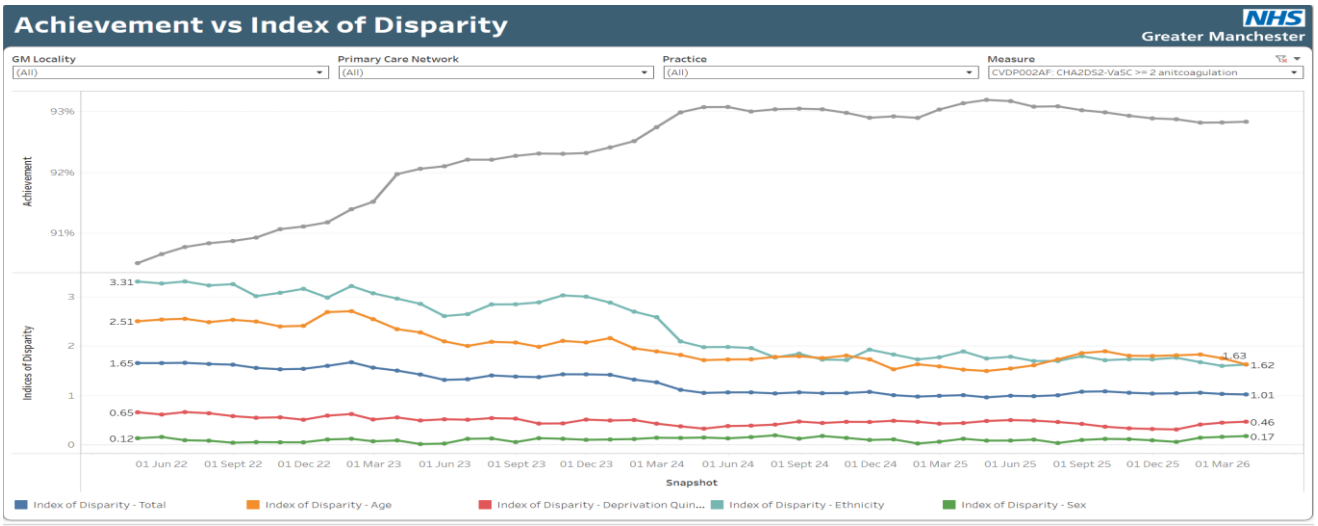
Figure 67: CVNeed Prevalence Variation for Lipid Management



Source: NHS Greater Manchester CVNeed Dashboard – GM ADSP

There has also been progress in other CVD prevention measures. For atrial fibrillation anticoagulation, GM has achieved around 93%, while reducing overall disparity. The *Index of Disparity* has reduced from 1.65 to 1.01, with particularly notable reductions in ethnicity-related disparity (3.31 to 1.62) and age-related disparity (2.51 to 1.63). This demonstrates that high levels of achievement can be maintained while also narrowing variation between population groups.

Figure 68: CVDP002AF Performance in Greater Manchester: Achievement of 93% with Reductions in Ethnic and Age-Related Inequalities



Source: NHS Greater Manchester CVD Prevention Dashboard – GM ADSP

The system has also continued to expand access to case-finding through community settings. The optometry hypertension case-finding pilot reached 4,625 people, with 1,238 patients from the most deprived decile and 2,532 patients from deciles 1-3. This means 54.7% of people accessing the pilot were from deprivation deciles 1 to 3. This demonstrates the value of shifting prevention into high-access community settings and targeting activity towards areas of greatest unmet need.

Table 4: Optometry Case-Finding Pilot: Patients by IMD Decile.

IMD Decile	Patients	%
1	1,238	26.8%
2	733	15.8%
3	561	12.1%
4	316	6.8%
5	290	6.3%
6	286	6.2%
7	376	8.1%
8	342	7.4%
9	273	5.9%
10	210	4.5%
Grand Total	**4,625**	**100.0%**

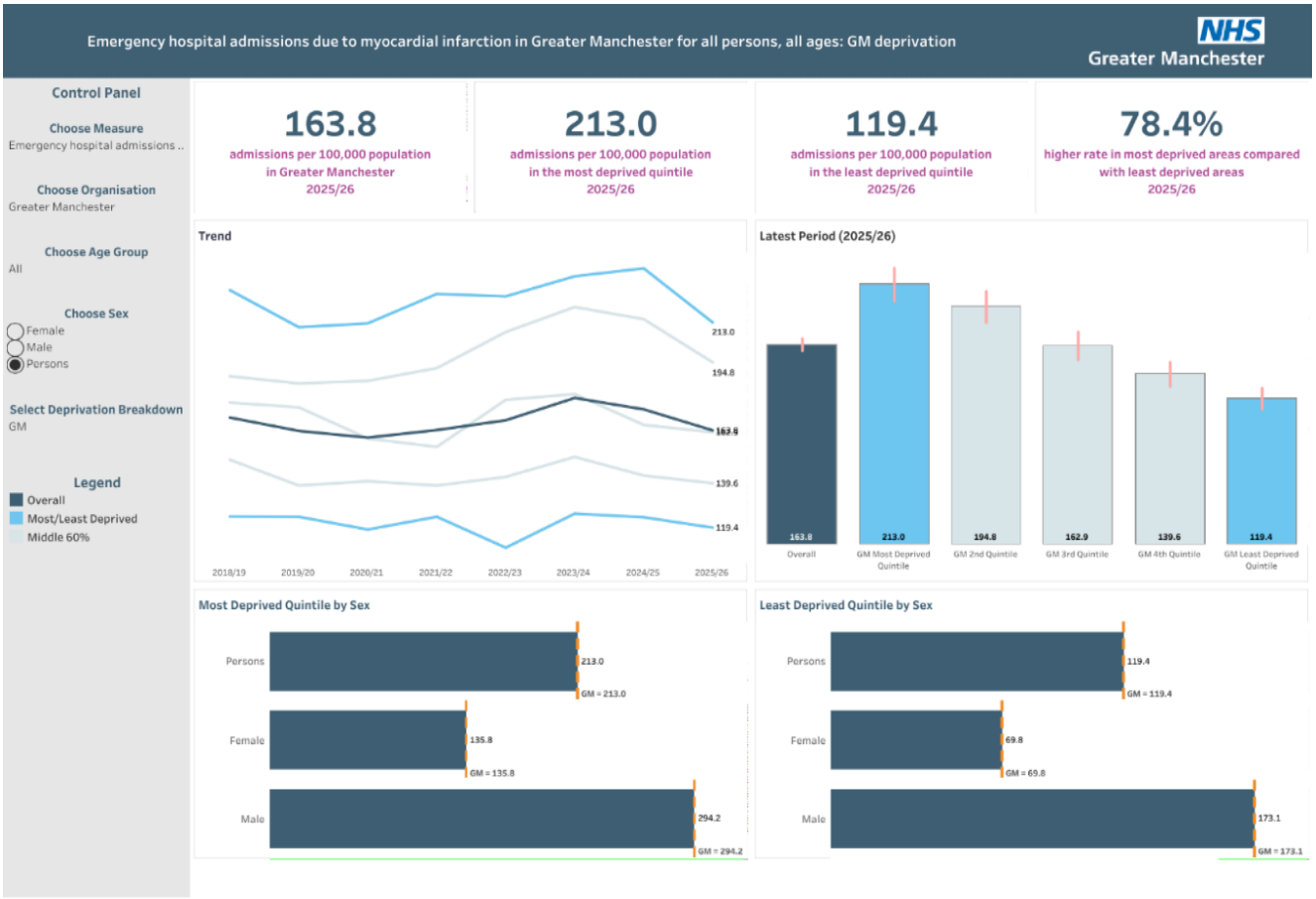
Source: NHS Greater Manchester Optometry Caso-Finding Pilot – GM ADSP

Outcomes data continues to improve and is encouraging. In the hypertension cohort, combined stroke and MI admissions have reduced from 0.809 to 0.782 over the latest year, driven mainly by lower MI admissions. Mortality is also moving in a positive direction overall: all-cause mortality in the hypertension cohort has reduced from 1502.5 to 1461.7 per 100,000 over the latest year and remains below the 2022 baseline. CVD mortality in the hypertension cohort also remains below baseline, although year-on-year change is broadly stable.

The overall picture is one of improving performance, stronger identification of unmet need and early signs of improvement in outcomes. The key challenge for the next year is to ensure that the improved analytical capability provided by the Index of Disparity is translated into consistent targeted action across localities, PCNs and practices, particularly where age, ethnicity and geographic variation remain persistent sources of inequality.

13.1.1 Emergency Myocardial Infarction (MI) Admissions in Greater Manchester

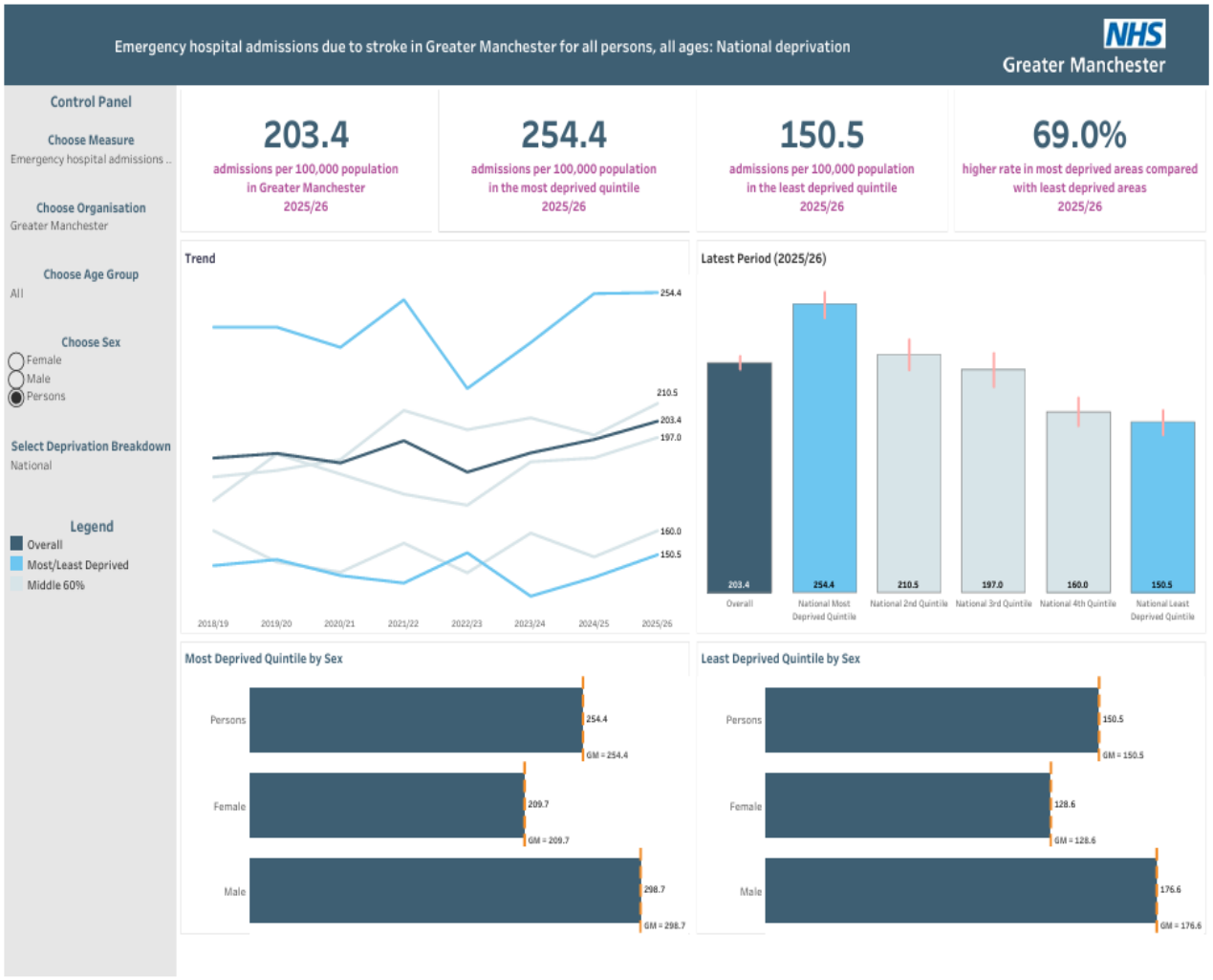
Figure 69: Emergency Myocardial Infarction Admissions in Greater Manchester: Trends, Patient Characteristics, and Demographics



Source: Population Health Hospital Activity Explorer v2: Hospital Admissions Deprivation – GM ADSP

13.1.2 Emergency Stroke Admissions in Greater Manchester

Figure 70: Emergency Stroke Admissions in Greater Manchester: Trends, Patient Characteristics, and Demographics



Source: Population Health Hospital Activity Explorer v2: Hospital Admissions Deprivation – GM ADSP

13.1.3 Deprivation, CORE20PLUS5 and the System Response

Emergency hospital admissions for myocardial infarction (MI) in Greater Manchester (GM) show a clear, persistent and graded relationship with deprivation, with substantially higher admission rates in the most deprived communities. In 2025/26, the emergency MI admission rate in the most deprived quintile was 213.0 per 100,000 population, compared with 119.4 per 100,000 in

the least deprived quintile — a 78.4% higher rate. This inequality is evident across all deprivation quintiles and remains consistent over time, indicating a structural rather than transient issue.

The pattern observed in this data is entirely consistent with the epidemiological profile of cardiovascular disease in GM, where deprivation, early onset disease, multi-morbidity and barriers to prevention combine to drive higher rates of emergency presentation. Viewed through a CORE20PLUS5 lens, the data highlights both the population groups at highest risk and the priority clinical areas where action is most likely to reduce avoidable admissions and premature mortality.

Importantly, this inequality is already recognised and actively addressed through the GM Cardiac Services Strategy (2025–2027) and the wider programme architecture led by NHS GM and the GM Cardiac Strategic Clinical Network.

13.1.4 CORE20: responding to deprivation at scale

The MI admission gradient represents a strong CORE20 signal. People living in the most deprived communities in GM are more likely to:

- develop cardiovascular disease at a younger age
- have undiagnosed or sub-optimally managed hypertension and hyperlipidaemia
- experience barriers to accessing preventative, diagnostic and follow-up care
  This increases the likelihood that disease presents **acutely**, rather than being prevented or stabilised earlier.

The Cardiac Services Strategy directly responds to this challenge through a full-pathway model, explicitly aligned to GM's CVD Prevention Plan and Multi-Year Prevention Programme. Prevention and early detection are positioned as core system priorities, not adjuncts to acute care. The expansion of CVNeed and BeCCoR GP cardiovascular prevention incentive scheme, GM-wide hypertension, AF and lipid toolkits, and targeted approaches to finding the "missing thousands" are all designed to shift risk detection and management upstream, particularly in

deprived populations.

This ensures that the MI admission data does not sit in isolation but is used to justify and prioritise system-wide preventative action where the inequality burden is greatest.

13.1.5 PLUS: recognising overlapping disadvantage

Although the MI dashboard reports all persons and all ages, the deprivation gradient inevitably reflects overlapping PLUS characteristics that are particularly relevant in GM. The Cardiac Strategy explicitly acknowledges and responds to:

- Higher cardiometabolic risk in some ethnic minority communities.
- Inclusion health populations with barriers to accessing care.
- Early onset cardiovascular disease in deprived neighbourhoods.

The Prevention & Early Detection workstream explicitly commits to targeting underserved populations, using population health management and VCSE partnerships to reduce inequitable access. This strengthens the interpretation that the MI admission pattern reflects **intersectional inequality**, and that system action is being designed accordingly.

13.1.6 CORE5: clinical priorities aligned to MI admissions

The MI deprivation gradient aligns most strongly with three CORE5 priorities, all of which are central pillars of the Cardiac Services Strategy and supporting programmes.

1. Hypertension

The scale of emergency MI admissions in deprived communities is consistent with missed or late diagnosis and optimisation of blood pressure. GM’s strategy embeds hypertension case-finding, optimisation and education across prevention, primary care, community pharmacy and secondary prevention pathways, supported by GM-wide dashboards and standardised toolkits.

2. Lipid management

Inequalities in lipid optimisation are a known driver of acute coronary events. The Strategy's secondary prevention work, including GM lipid pathways, post-MI protocols and evaluation frameworks, directly addresses this risk. The commitment to structured post-MI care is particularly relevant to preventing recurrent events and reducing future emergency admissions.

3. Smoking

Although smoking prevalence has reduced overall, it remains concentrated in deprived communities. The Strategy recognises smoking cessation as a cross-cutting enabler within prevention, secondary prevention and cardiac rehabilitation, reinforcing its central role in addressing acute MI risk.

13.1.7 The role of secondary prevention and rehabilitation

The Strategy strengthens the link between acute events and long-term risk reduction, recognising that emergency MI admissions are only the visible tip of the inequality iceberg. The development of a standardised post-MI pathway, improved uptake and quality of cardiac rehabilitation, and consistent medicines optimisation are critical system responses to the MI admission data.

By embedding NACR standards, targeting uptake in ACS and heart failure cohorts, and integrating rehabilitation with return-to-work and community-based models, GM is explicitly acting to break the cycle of repeat admissions, particularly in deprived populations.

13.1.8 Acute and emergency care: reducing harm and variation

While prevention is essential, the Strategy also recognises that deprivation-driven MI risk will continue to generate urgent need. The Acute & Emergency workstreams (including CATS redesign, standardisation of ACS pathways, cath lab optimisation and the implementation of direct transfer of patients suffering an Out of Hospital cardiac Arrest) ensure that where emergencies do occur, outcomes are equitable, timely and consistent across GM.

This dual focus is critical: prevent where possible but deliver high-quality acute care

everywhere. It reinforces that reducing MI inequality is not solely about reducing admissions, but also about improving survival and experience when admission is unavoidable.

13.1.9 Governance, delivery and assurance

Critically for the ICB, the Strategy demonstrates that this is not aspirational work without delivery infrastructure. The Cardiac Oversight Group and defined task-and-finish workstreams provide:

- Clear lines of accountability.
- Clinically led pathway design.
- Data-driven monitoring against national and GM-specific metrics.

This ensures that MI admission trends can be tracked, challenged and responded to over time, rather than reported retrospectively without consequence.

13.1.10 Summary

The emergency MI admission data highlights a significant and entrenched inequality in GM, particularly affecting the most deprived communities. However, when considered alongside the Cardiac Services Strategy, it becomes clear that:

- The system understands the drivers of this inequality.
- The response is multi-year, clinically led and system-wide.
- Action spans prevention, secondary prevention, acute care and diagnostics.
- Delivery is explicitly aligned to CORE20PLUS5.

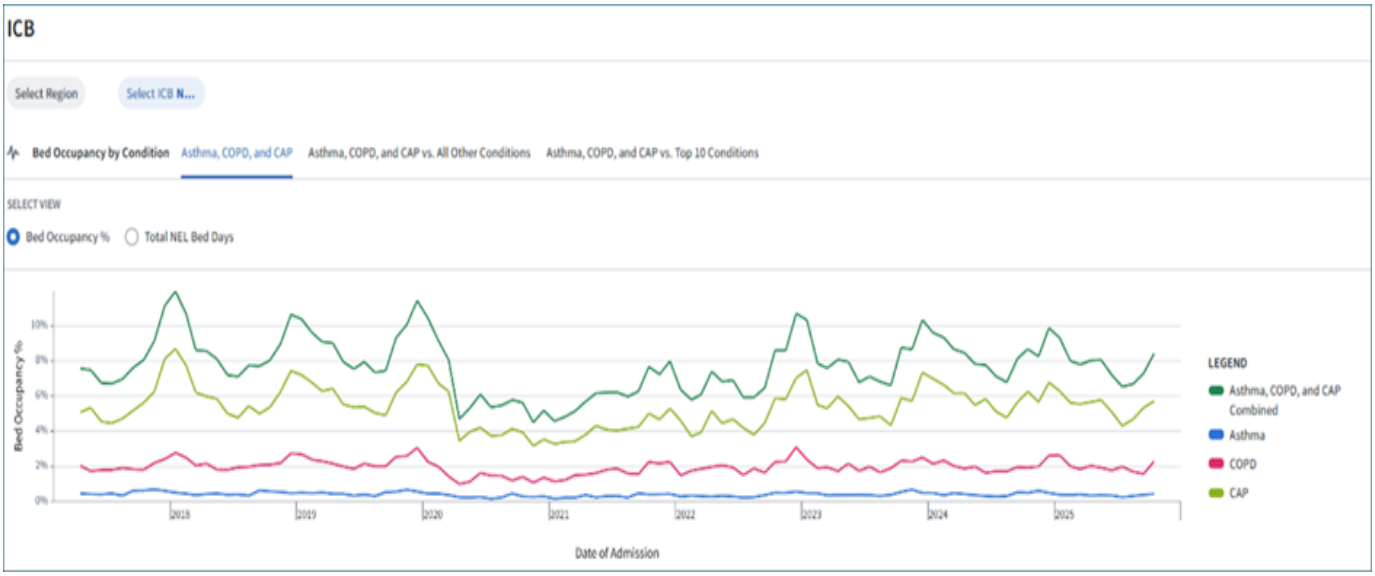
In this context, the data does not signal a gap in strategy but rather reinforces the importance of sustaining and scaling the work already underway, particularly in prevention, post-MI care and place-based delivery for CORE20 populations.

14. Respiratory Disease

14.1 Inequalities in Respiratory Disease in Greater Manchester: Non-elective bed days for asthma, COPD and community-acquired pneumonia (CAP)

Respiratory disease represents one of the most significant and unequal causes of avoidable harm and system pressure in Greater Manchester (GM).

Figure 71: Trend in Non-Elective Bed Occupancy by Condition Over Time



Source: NHS England National Respiratory Programme Dashboard

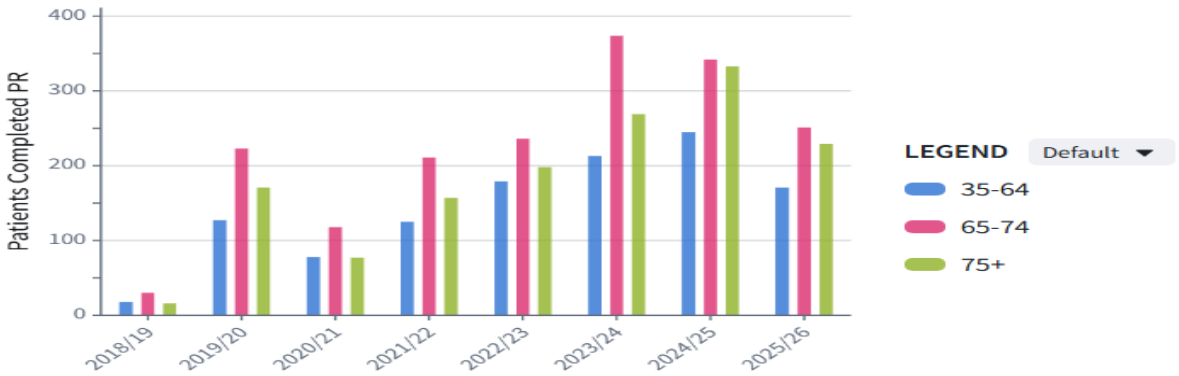
Non-elective bed days occupied by asthma, chronic obstructive pulmonary disease (COPD) and community-acquired pneumonia (CAP) illustrate a clear and persistent inequality gradient, reflecting not only higher rates of acute presentation in disadvantaged communities, but also longer lengths of stay, slower recovery and repeated admissions.

Data from NHSE National Respiratory Programme Dashboard (viewed on 12th June 2026) tells us across NHS GM ICB there were 39 service providers operating in 25/26 (Latest PR Data runs up to December 2025). Within the same time period 1245 patients attended an initial assessment, of which 1043 (83.8%) started the PR programme. 651 patients (62.4) completed

the discharge assessment.

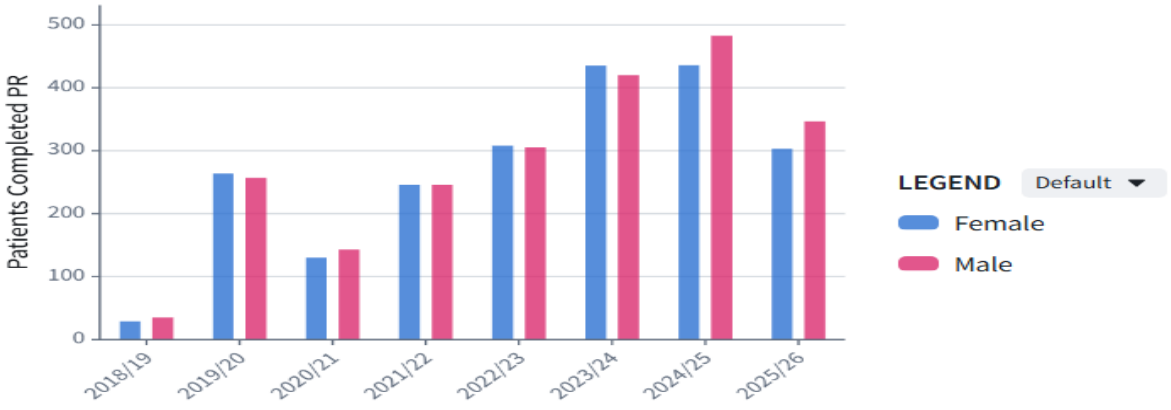
Completion rates are predominately within the 65+ age bracket with slightly more Males (347M/303F) completing the programme. Majority of those completing the programme can be seen in the most deprived IMD quintiles (IMD 1& 2 355 vs IMD 3,4&5 273).

Figure 72: Number of Completed Pulmonary Rehabilitation by Age Group, 2018/19–2025/26



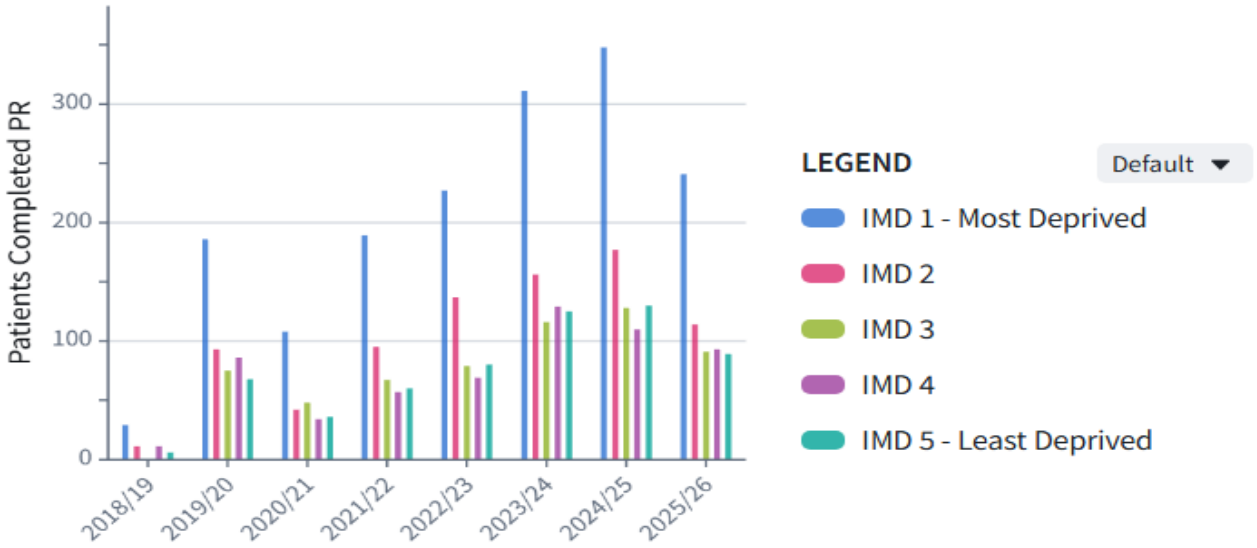
Source: NHS England National Respiratory Programme Dashboard

Figure 73: Number of Completed Pulmonary Rehabilitation by Sex, 2018/19–2025/26



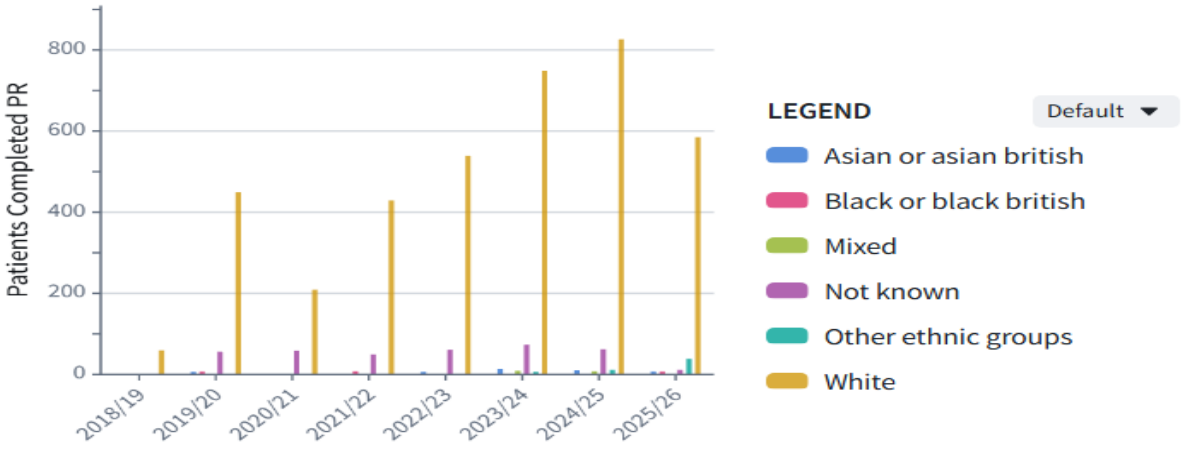
Source: NHS England National Respiratory Programme Dashboard

Figure 74: Number of Completed Pulmonary Rehabilitation by Deprivation Quintile, 2018/19–2025/26



Source: NHS England National Respiratory Programme Dashboard

Figure 75: Number of Completed Pulmonary Rehabilitation by Ethnic Groups, 2018/19–2025/26



Source: NHS England National Respiratory Programme Dashboard

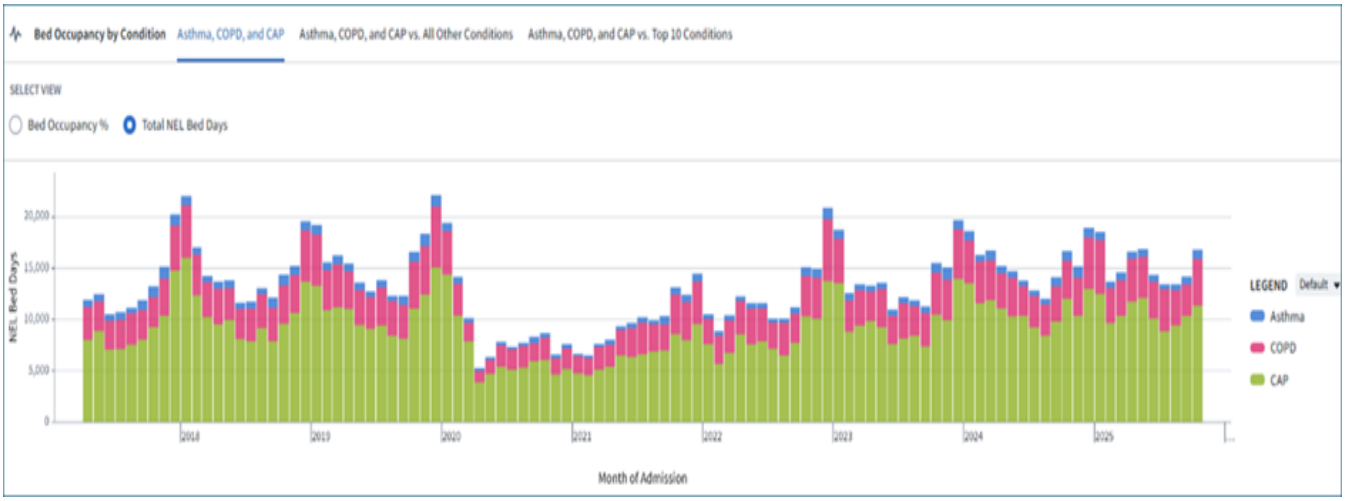
Ethnicity recording shows that from the 651 PR Completed, 585 is recorded as ethnic group

white (89.9%)

Taken together with mortality, pulmonary rehabilitation and pathway data, this evidence confirms that respiratory inequality in GM is structural, cumulative and preventable, and that addressing it requires sustained, whole-pathway action rather than isolated improvements in acute flow.

14.2 Understanding the inequality in non-elective bed days

Figure 76: Trend in Total Non-Elective (NEL) Bed Days for Respiratory Conditions



Source: NHS England National Respiratory Programme Dashboard

Analysis of non-elective respiratory bed days shows that COPD and CAP account for the majority of occupied bed days, with asthma contributing smaller but still unequal volumes. These bed days are heavily concentrated in the most deprived communities, with demand rising sharply during winter and remaining elevated for longer than in less deprived areas.

This pattern is consistent over time and demonstrates that inequality manifests not only in admission rates, but in:

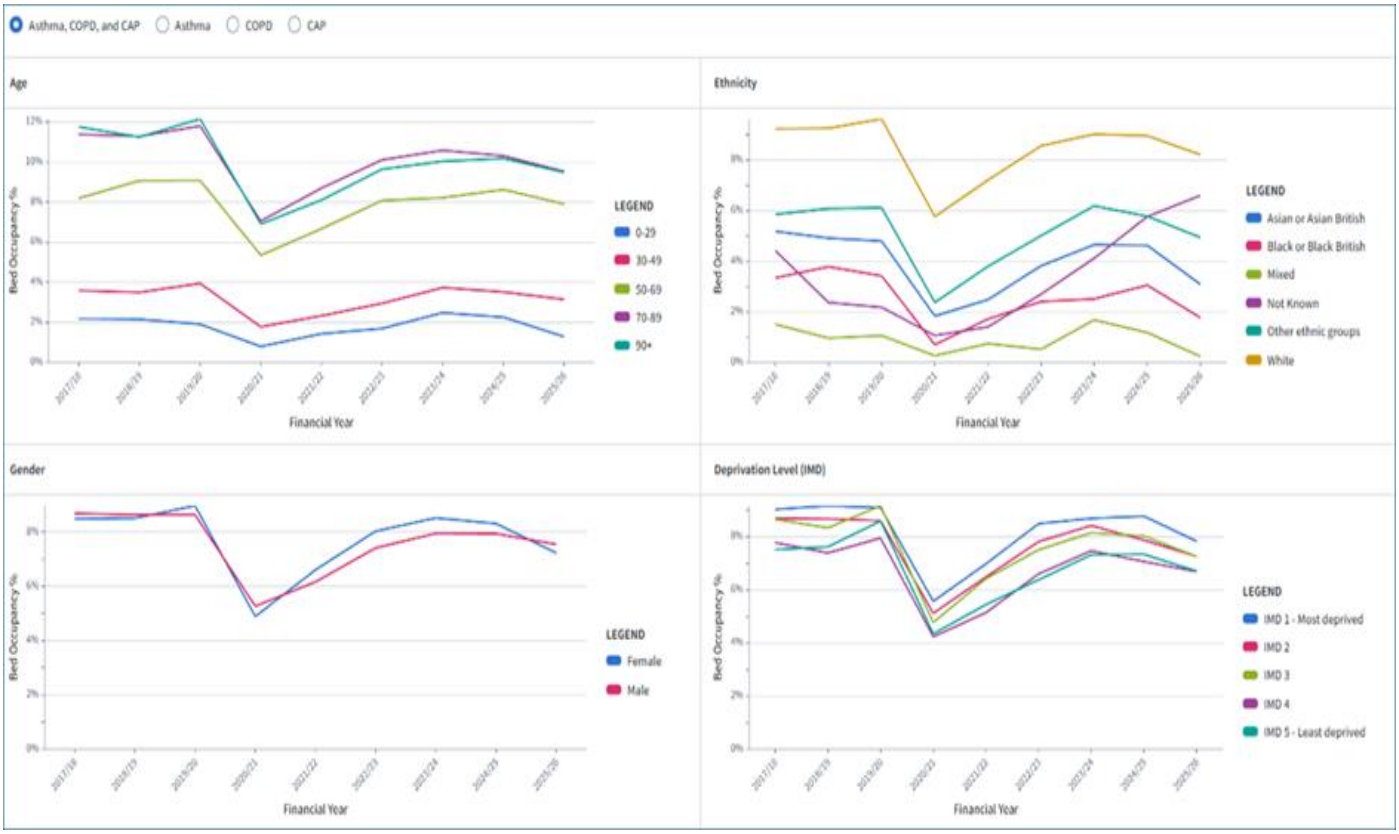
- Prolonged length of stay once admitted.

- Higher likelihood of complications.
- Greater risk of readmission.
- Sustained winter escalation and system instability.

Non-elective bed days therefore act as a downstream indicator of inequity across the respiratory pathway, rather than simply an operational metric

14.2.1 Deprivation, age and ethnicity: compounding disadvantage

Figure 77: Trend in Total Non-Elective (NEL) Bed Occupancy (%) by Age Group, Ethnic Group, Sex, and Deprivation Quintile



Source: NHS England National Respiratory Programme Dashboard

The inequality is not explained by age alone. While older populations account for higher

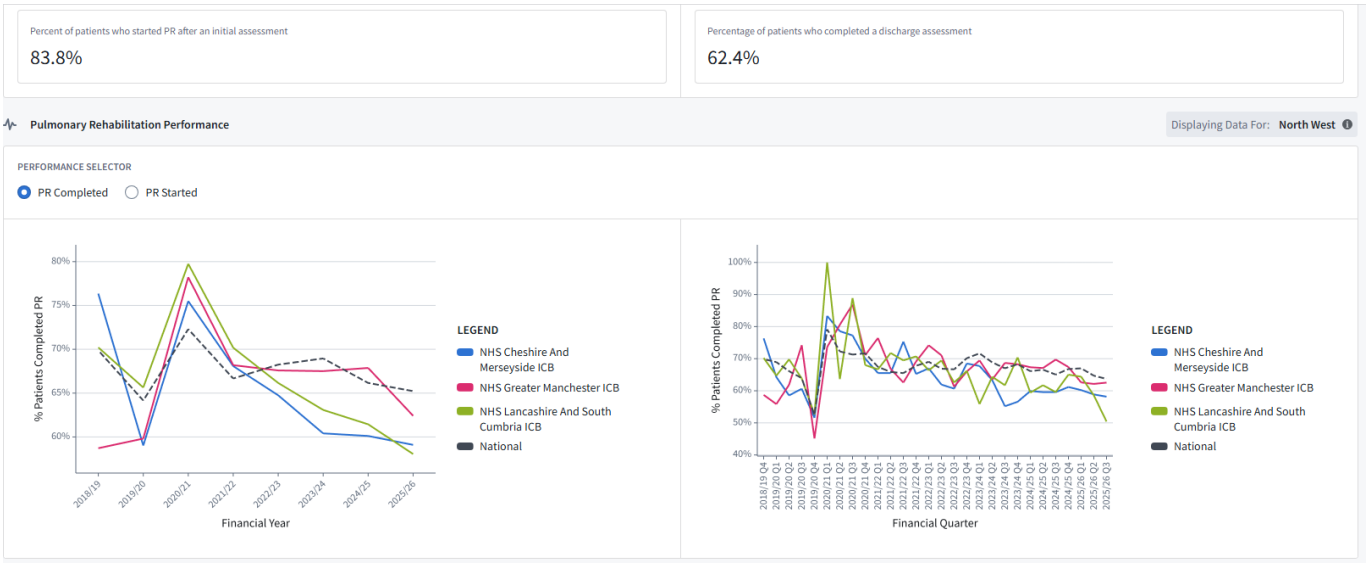
absolute bed-day use, deprivation remains the dominant driver within age groups, demonstrating that socioeconomic factors significantly influence disease severity, recovery and access to alternatives to admission.

Ethnicity-based analysis further reinforces this picture. Differences in non-elective bed days across respiratory conditions reflect unequal exposure to risk factors, barriers to early diagnosis and variation in access to preventative and recovery services, with uneven recovery following the COVID-19 period. These patterns mirror wider evidence of structural inequality in respiratory outcomes.

Together, deprivation, age and ethnicity interact to create overlapping PLUS populations under the CORE20PLUS5 framework, who experience disproportionate respiratory harm and system reliance.

14.3 Pulmonary rehabilitation: a critical inequality lever

Figure 78: Comparison of Pulmonary Rehabilitation (PR) Completion Rates with Other Northwest ICBs and National Performance



Source: NHS England National Respiratory Programme Dashboard

Inequalities in pulmonary rehabilitation (PR) completion rates provide a crucial explanatory link between acute pressure and long-term outcomes. Data shows consistently lower and more variable PR completion among populations with the highest non-elective bed-day use, particularly in deprived and ethnically diverse communities.

This is significant because incomplete or absent rehabilitation is associated with:

- Higher exacerbation rates.
- Poorer functional recovery.
- Increased likelihood of future admissions.
- Prolonged hospital stays for subsequent exacerbations.

PR inequity therefore contributes directly to sustained non-elective bed occupancy, making it a core intervention for reducing respiratory inequality rather than an optional add-on.

14.4 CORE20PLUS5: why respiratory disease is a system priority

Chronic respiratory disease, particularly COPD, is identified nationally as a CORE20PLUS5 clinical priority and represents a significant contributor to health inequalities in Greater Manchester. Respiratory conditions are associated with higher rates of emergency admission, longer hospital stays and poorer outcomes among disadvantaged populations, making them a key focus for prevention and system transformation.

14.4.1 CORE20 – the most deprived communities

A substantial proportion of Greater Manchester's population lives within the most deprived 20% of neighbourhoods nationally. In these communities, respiratory disease is more likely to:

• Develop earlier in life.
• Progress more rapidly.
• Present at a later stage.
• Result in slower recovery following exacerbation or admission.

These factors contribute to avoidable emergency admissions, increased non-elective bed use and greater pressure on services, particularly during winter.

14.4.2 PLUS Populations

Within deprived communities, additional inequalities are experienced by:

- Older people living with multiple long-term conditions.
- People living in poor-quality or overcrowded housing.
- Some ethnic minority groups.
- People with severe mental illness or other mental health conditions.

These groups are more likely to experience delayed diagnosis, barriers to accessing care, prolonged hospital stays and higher rates of readmission.

14.4.3 CORE5 relevance

Respiratory disease aligns closely with the CORE5 priorities through its association with:

- Tobacco dependence and smoking cessation.
- Vaccination uptake and prevention of infection.
- Earlier diagnosis and optimisation of treatment.
- Long-term condition management and pulmonary rehabilitation.

Reducing respiratory inequalities therefore requires action across the full CORE20PLUS5 framework, spanning prevention, early intervention and long-term disease management.

14.5 The GM Respiratory Strategy: the system response

The GM Respiratory Strategy provides a coordinated, clinically led response to the inequalities described above. It recognises that respiratory ill health and winter pressures are predictable and, to a significant extent, preventable, positioning respiratory transformation as central to both health equity and system resilience.

Key elements of the strategy include:

Prevention

• Targeted tobacco dependency treatment and support through Making Smoking History.
• Equitable delivery of vaccination programmes, including flu, pneumococcal, RSV and COVID-19 vaccines.
• Alignment with wider population health initiatives, including housing quality and air quality improvement.

Earlier Diagnosis and Intervention

• Restoration and expansion of quality-assured spirometry and FeNO testing.
• Risk stratification to identify individuals at greatest risk of exacerbation.
• Timely optimisation of medicines and support for self-management.

Shifting Care Closer to Home

• Integration of community respiratory teams and consultant-supported neighbourhood models
• expansion of virtual wards, step-up and step-down care pathways
• strengthened discharge support and post-discharge follow-up, particularly following pneumonia

Reducing Inequalities in Recovery and Rehabilitation

• Expansion and standardisation of pulmonary rehabilitation services.
• Reducing variation in referral, uptake and completion, particularly within CORE20PLUS5 communities.
• Embedding rehabilitation across COPD, asthma and post-pneumonia pathways.

Data-Driven Improvement

• Use of the NHS GM Respiratory Dashboard to monitor admissions, bed days and outcomes by deprivation, ethnicity, age and locality.
• Targeted improvement support for localities where inequalities are greatest.

Summary

Inequalities in non-elective bed days associated with asthma, COPD and community-acquired pneumonia reflect longstanding and interconnected respiratory health inequalities across Greater Manchester. These inequalities are driven by preventable disease, delayed diagnosis, unequal access to services and variation in recovery following admission.

The GM Respiratory Strategy provides a comprehensive system response that addresses these challenges across the whole pathway, from prevention and early diagnosis through to rehabilitation and recovery. Reducing non-elective respiratory bed days is therefore not solely an inpatient challenge but a measure of success in delivering sustained, equitable improvement across the wider respiratory system.

15. Core20PLUS5: Children and Young People

15.1 SEND, Learning Disability, Autism and Epilepsy (CYP)

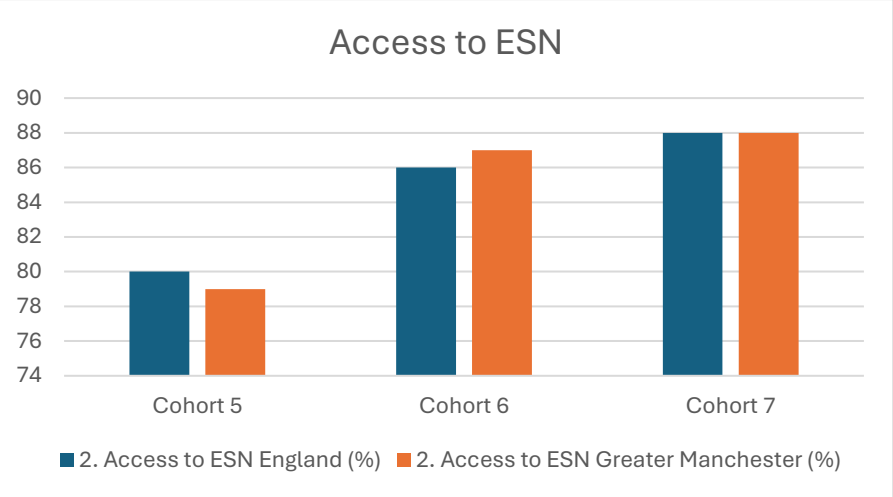
Inequalities in access to epilepsy specialist nurses in the first year of care for those with a learning disability or autism.

The Epilepsy12 National Audit collects data on children and young people (CYP) during their first year of epilepsy care, including access to Epilepsy Specialist Nurses (ESNs). However, the published data are not currently stratified by learning disability or autism, meaning it is not possible to assess inequalities in access to ESNs for these groups at Greater Manchester level.

This limits the ability to understand whether CYP with a learning disability or autism experience equitable access to specialist epilepsy support. Improving the availability of disaggregated data will be important to support future monitoring of inequalities and targeted service improvement.

Cohort 7 includes CYP whose first year of care was completed between 1 December 2023 and 30 November 2024.

Figure 79: Access to ESN (%) in Greater Manchester Compared with England, Cohorts 5, 6, and 7



Source: NHS England

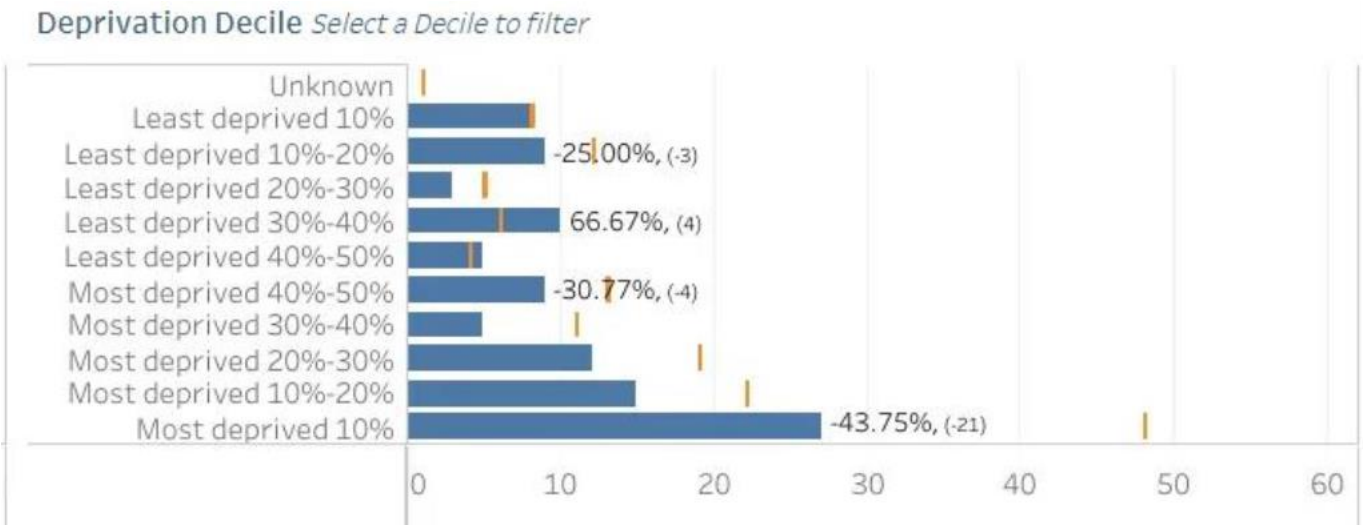
Access to ESNs in Greater Manchester has increased since 2022 due to focused work to support services to address this. All services now have ESNs and the Greater Manchester CYP Epilepsy Group has adapted and updated standards developed by Healthy London Partnership for use in Greater Manchester. These clinical standards include how and when CYP with epilepsy should access ESNs, and workforce recommendations for 1 ESN to 250 caseload.

Further work to understand caseload demographics, including CORE 20 Plus groups is planned for when data becomes readily available. There is a risk to the CYP epilepsy programme however as due to reorganisation, GM CYP Epilepsy clinical leadership posts are vacant.

GM Tableau Inpatient Activity dashboard indicates most inpatient activity occurs in the most deprived and second most deprived deciles, with British and Pakistani ethnicities having highest rates of emergency and non-elective admissions.

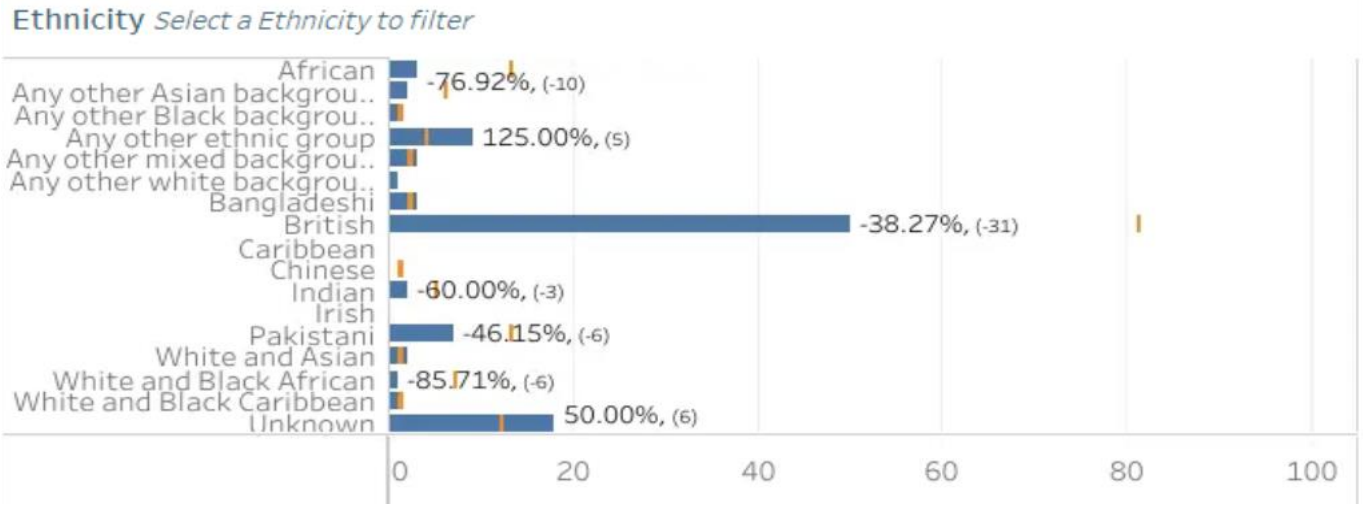
Figure 80: Comparison of the Number of Emergency and Non-Elective Epilepsy Admissions (primary diagnosis G40: Epilepsy or G41: Status epilepticus) in Children and Young People (0–17 years) in Greater Manchester between the Current Period (blue bars,

May 2026) and the Previous Reporting Period (orange line, April 2026), with the Difference shown, by Deprivation Decile



Source: NHS Greater Manchester Inpatients Dashboard Explorer – GM ADSP

Figure 81: Comparison of the Number of Emergency and Non-Elective Epilepsy Admissions (primary diagnosis G40: Epilepsy or G41: Status epilepticus) in Children and Young People (0–17 years) in Greater Manchester between the Current Period (blue bars, May 2026) and the Previous Reporting Period (orange line, April 2026), with the Difference shown, by Ethnicity



Source: NHS Greater Manchester Inpatients Dashboard Explorer – GM ADSP

15.2. Children's Mental Health

Greater Manchester continues to exceed its access target for children and young people's community mental health services, with 55,540 CYP access against a target of 55,000.

However, access remains unequal. Data from the past 12 months shows variation by ethnicity, deprivation, gender, age, and locality. On average, children are referred at age 10.3. Boys are referred younger (9.5 years) than girls (10.9), and children from more deprived areas are referred earlier (age 10) compared to those from the least deprived areas (11.1). CYP from more deprived areas often have greater need but still face more barriers, particularly in communities with higher proportions of racially minoritised children. Missing ethnicity data in referrals also limits our full understanding of these trends. We will work with Trusts to track CYP mental health access by care status, ethnicity, and location to measure reach to vulnerable groups.

We will continue to expand our MHST teams in those areas in most need and expand our digital support into communities. We are expanding our Thrive VCSE offer and will looking at neighbourhood delivery models to further develop the offer into communities to deliver mental health support in trusted spaces.

In line with NHS operational planning priorities for 26 / 27 we will continue to take action and to reduce inequalities in access to CYP mental health services, between disadvantaged groups and the wider CYP population. We will utilise GM #BeeWell data to inform service development and improvement. As part of our ongoing CAMHS investment we will develop and promote a range of supporting materials and ensure they are accessible utilising Youth focus NW to coproduce these.

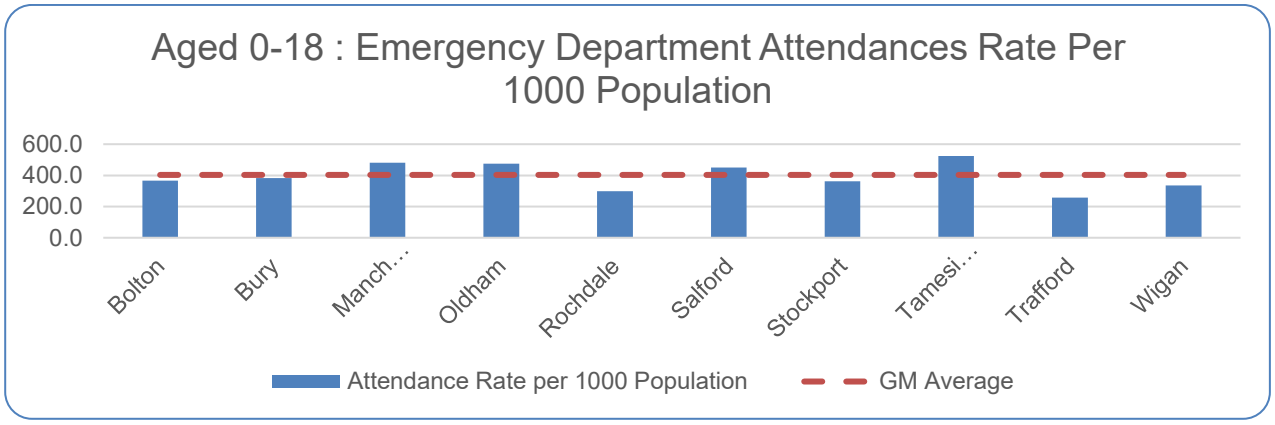
15.3 Children's Urgent, Emergency and Community Care

15.3.1 Emergency Department Attendances (Aged 0–18)

ED attendance rates for children and young people vary significantly across Greater

Manchester, with several localities reporting rates above the GM average, indicating unequal demand on emergency services. This illustrates that where a child lives matters to their likelihood of attending ED, reflecting differences in service configuration, availability of urgent primary care, community paediatric provision, mental health and SEND pathways, as well as local population characteristics. This reinforces the need for place-based analysis and solutions rather than a one-size-fits-all approach.

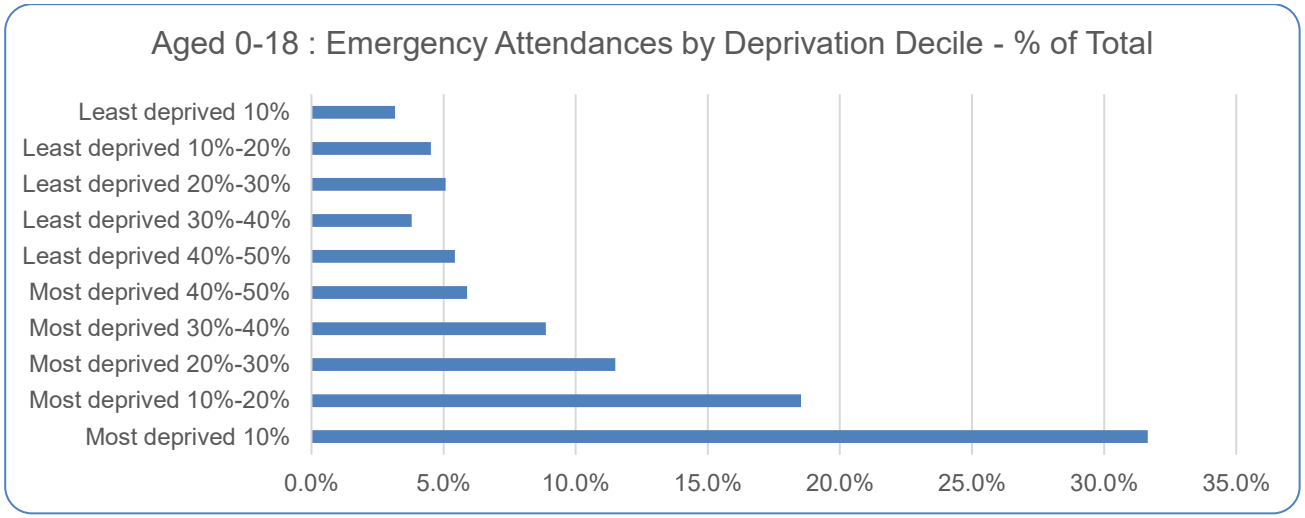
Figure 82: Children and Young People (CYP) Emergency Department Attendance Rate per 1,000 Population by Greater Manchester Locality and Overall Greater Manchester Average



Source: NHS Greater Manchester Emergency Department Dashboard – GM ADSP

A clear social gradient is observed, with higher ED attendance rates among children from more deprived communities. This reflects higher levels of underlying health need and differences in access to preventative and community-based services. This pattern reflects the well-established relationship between deprivation and child health outcomes, including higher rates of respiratory illness, injury, long-term conditions and wider social pressures. Persistently higher ED use among more deprived CYP indicates unmet need upstream and reinforces the importance of targeted prevention, early intervention and neighbourhood-level support.

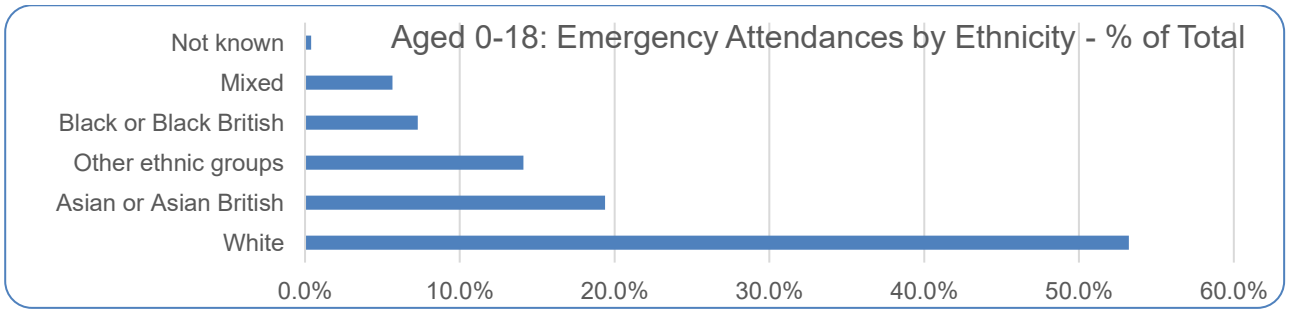
Figure 83: Distribution of Emergency Department Attendances Among Children and Young People (CYP) by Deprivation Decile



Source: NHS Greater Manchester Emergency Department Dashboard – GM ADSP

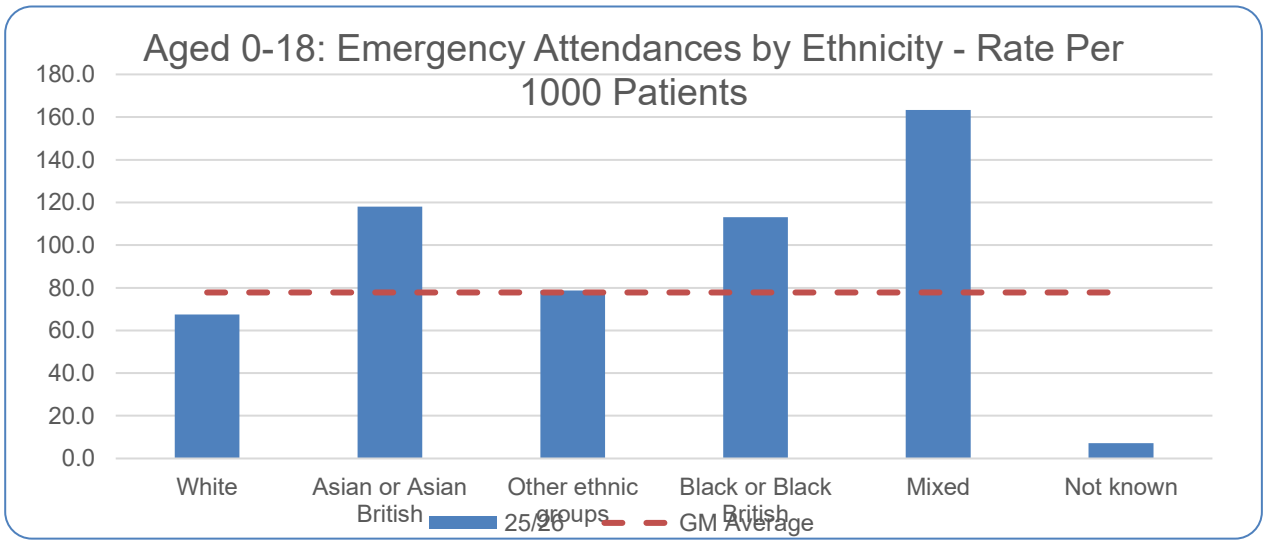
Variation in attendance rates across ethnic groups indicates differences in how services are accessed and utilised. These differences likely reflect a complex interaction of factors, including underlying health need, cultural or language barriers, confidence in navigating alternative services, and differing experiences of primary and community care. Monitoring these patterns supports a more nuanced understanding of CYP inequalities and helps ensure that responses are culturally appropriate and effective.

Figure 84: Distribution of Emergency Department Attendances Among Children and Young People (CYP) by Ethnicity Group



Source: NHS Greater Manchester Emergency Department Dashboard – GM ADSP

Figure 85: Children and Young People (CYP) Emergency Department Attendance Rate per 1,000 Population by Ethnicity Group and Overall Average



Source: NHS Greater Manchester Emergency Department Dashboard – GM ADSP

Higher ED attendance does not necessarily indicate inappropriate use, but instead highlights areas where needs are not being met elsewhere in the system.

This measure highlights system-level inequalities in access and reliance on emergency care for children and young people.

System priorities include:

- Strengthening neighbourhood and community-based services.
- Improving access to urgent primary care and early intervention.
- Enhancing mental health and SEND support pathways.
- Supporting a shift toward prevention and demand reduction.

15.3.2 Inequalities in access to specialist paediatric and multidisciplinary community support

At present, there is insufficient data available to robustly assess variation in access to specialist paediatric and multidisciplinary support for CYP in community settings age, deprivation, ethnicity

or gender. This will be progressed through 2026/27.

15.4 Children's Oral Health

In 2025, GM hospitals reported 2,820 decay-related tooth extraction episodes among children and young people aged 0-19 years due to tooth decay. This represented 69.5% of all hospital tooth extraction episodes in this age group in Greater Manchester. Nationally, there were 33,976 decay-related tooth extraction episodes among children and young people aged 0-19 years, representing 60.5% of all hospital tooth extraction episodes in England. These figures relate to hospital activity only and do not include tooth extractions undertaken in primary care. This represents a small increase of approximately 100 decay-related tooth extraction episodes since 2024. There were 1,855 decay-related tooth extraction episodes in NHS GM hospitals among children aged 0-9 years. This equated to rates of 180.1 per 100,000 children aged 0-4 years and 802.2 per 100,000 children aged 5-9 years, compared with 135.0 and 568.7 per 100,000 children respectively in England. The rate decreases with age, as older children are more likely to require dental extractions for reasons other than tooth decay, such as malocclusion, and are more likely to have these procedures undertaken in primary care.

The decay-related tooth extraction episode rate for children and young people living in the most deprived communities was over 3 times higher than those living in the most affluent communities. In areas with higher comparative caries prevalence, and where deprivation has more of an impact on children's health, it could be expected that there would be more episodes and higher rates of decay-related tooth extractions. This pattern is not evident across all areas.

There were variations by Lower Tier Local Authority (LTLA) in the rates of decay-related tooth extraction episodes. Five GM areas report lower rates than 2022. The highest rate of decay-related tooth extraction episodes was reported in Manchester (557.6 episodes per 100 000 children with the proportion of decay-related tooth extraction episode 80.6%). The lowest rate was reported in Bury (172.8 episodes per 100 000 children with the proportion of decay-related tooth extraction episode 65.4%).

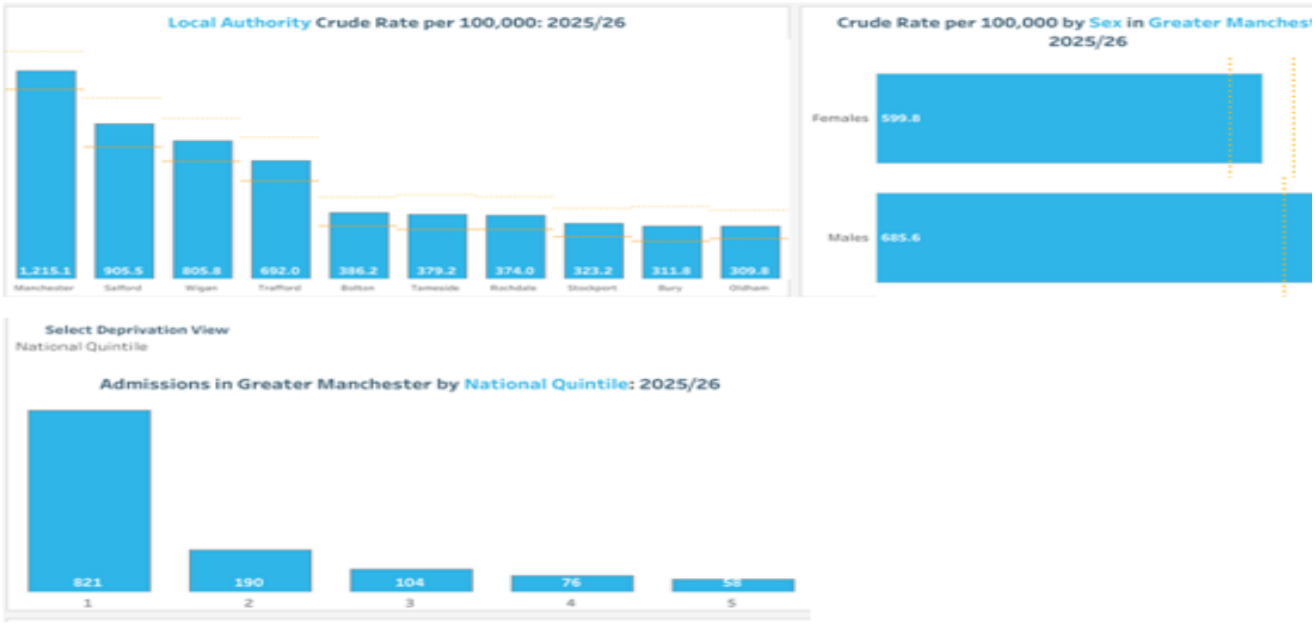
The following data provides an overview of the demographic cohorts with greater prevalence for extraction episodes. The prevalence for 6-10 years olds (shown in Table 5, figure 86) is also seen in the 0-5 years age group. The number of tooth extractions for children living in Manchester LA and carried out at MFT is significantly higher than in the other Greater Manchester Trusts shown.

Table 5 Hospital Admissions for Tooth extractions in Greater Manchester for children aged 6-10 years, by financial year

Local Authority	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Bolton	220	185	18	142	143	107	73	82
Bury	129	73	7	49	57	57	41	39
Manchester	406	414	168	422	297	390	465	451
Oldham	125	97	18	82	101	54	57	56
Rochdale	152	103	18	67	86	59	66	61
Salford	178	143	26	106	126	183	141	162
Stockport	182	176	50	122	113	135	149	61
Tameside	159	156	49	88	79	61	65	56
Trafford	117	106	41	109	81	111	139	117
Wigan	361	310	52	232	320	218	182	164
Greater Manchester	2029	1763	447	1419	1403	1375	1378	1249

Source: NHS Greater Manchester Dental Hospital Admissions – GM ADSP

Figure 86: Trends, Characteristics, and Demographic Profile of Hospital Admissions for Tooth Extraction Among Children Aged 6–10 Years in 25/26



Source: NHS Greater Manchester Dental Hospital Admissions – GM ADSP

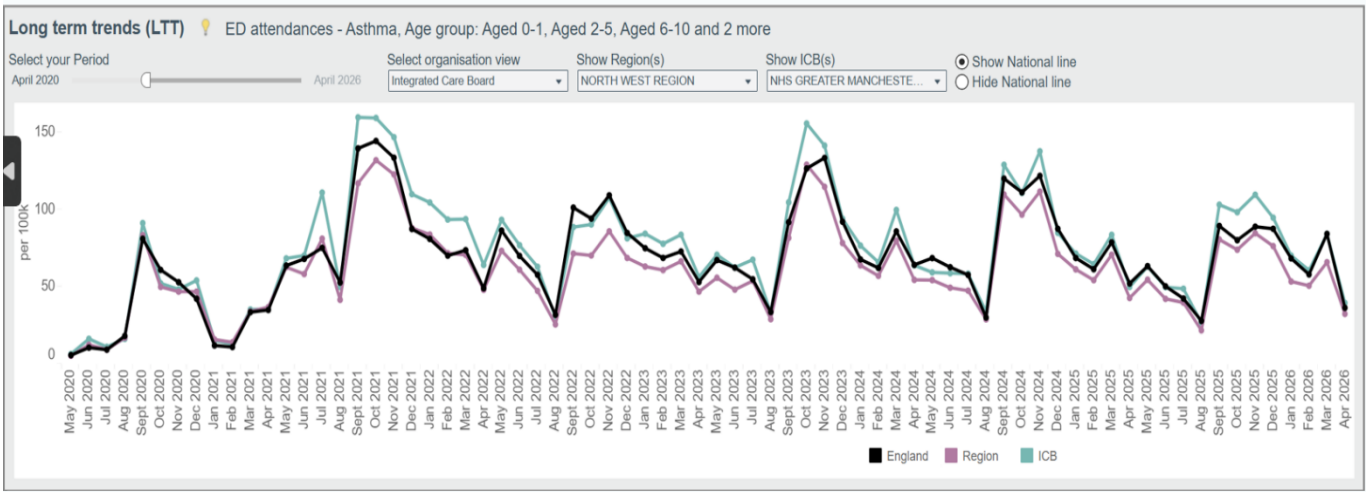
The Greater Manchester Oral Health Improvement Programme targets young children through schools to encourage improved tooth brushing and oral hygiene. In addition to the educational elements, toothbrush and paste packs were procured for key communities with greatest oral health improvement need (which correlates to deprivation). This provision is in addition and complementary to the work of the Oral Health Improvement teams undertaken through Local Authorities.

15.5. Childhood Asthma

The latest data from the Children and Young People's (CYP) Transformation Programme dashboard for Greater Manchester indicates emergency department attendances for asthma in CYP are high overall, with rates above the national average (figure 87). The data suggests that there is a clear inequality by deprivation, with the highest levels of attendance among children living in the most deprived areas. There is also variation by ethnicity with the highest number of

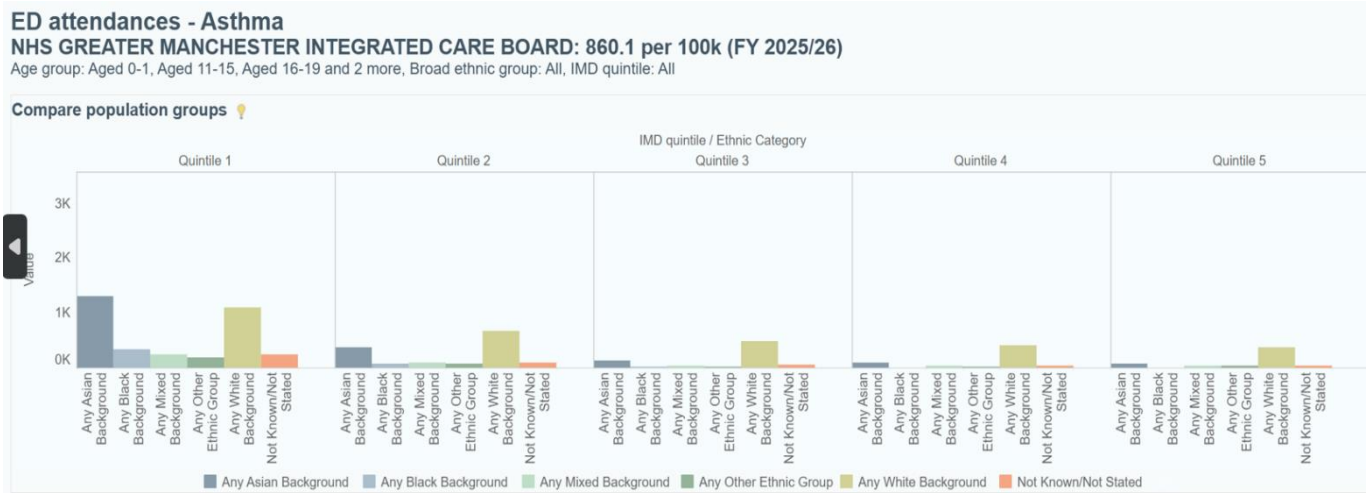
attendances seen among children from White backgrounds, followed by those from Asian backgrounds, with lower numbers recorded for other groups (figure 88).

Figure 87: Trend in Emergency Department Attendances for Asthma Among Children and Young People Aged 0–19 Years in Greater Manchester, the Region, and England



Source: NHS Greater Manchester CYP Transformation Programme Dashboard: Asthma workstream – GM ADSP

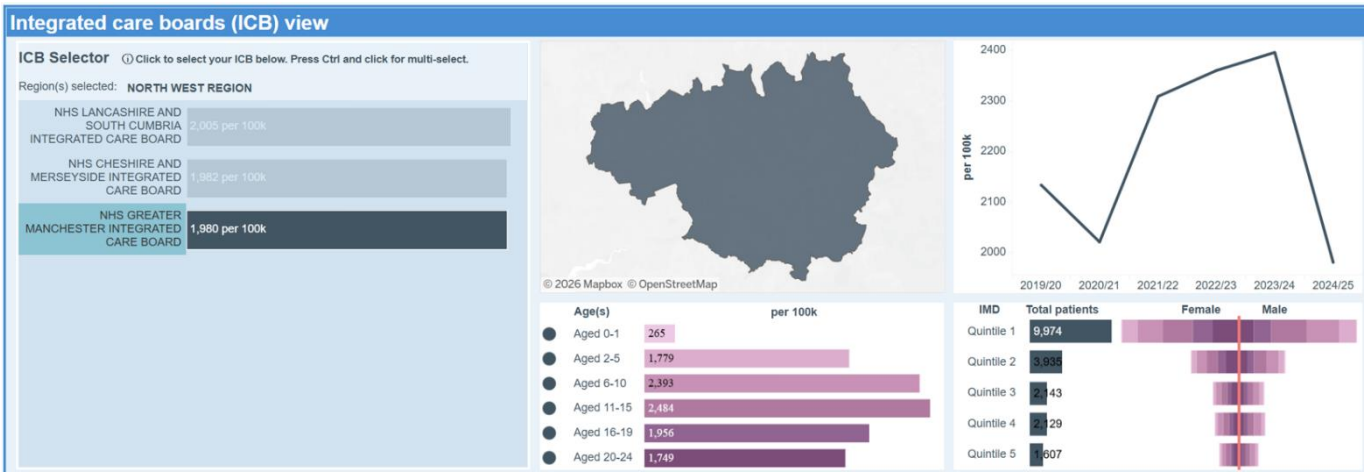
Figure 88: Emergency Department Attendances for Asthma Among Children and Young People Aged 0–19 Years by Ethnicity and deprivation quintile for 2025/26



Source: NHS Greater Manchester CYP Transformation Programme Dashboard: Asthma workstream – GM ADSP

Prescribing data for CYP aged 0–19 indicates that Greater Manchester has a rate of 1,980 per 100,000. Activity is highest in school-aged children, particularly those aged 6–15, where managing asthma day-to-day can often be more difficult. The number of children receiving treatment is also much higher in the most deprived areas, which mirrors the pattern seen in emergency attendances (figure 88 and 89).

Figure 89: Prescribing for Asthma in Children and Young People in Greater Manchester by Age and Deprivation Quintile



Source: NHS Greater Manchester CYP Transformation Programme Dashboard: Asthma workstream – GM ADSP

Across Greater Manchester, a range of preventative and improvement work has been undertaken to support better asthma control and reduce avoidable emergency attendances for children and young people. These approaches focus on strengthening care both in the community and at key points of contact with services. This includes the rollout of the Asthma Friendly Schools programme, which aims to improve how asthma is managed in schools and support staff to meet agreed standards of care. Early evaluation of the programme has shown positive impact, with schools reporting improvements in practice and reductions in breathing-related A&E attendances, alongside a 27% reduction in hospital admissions. The programme has continued to expand across Greater Manchester, with a growing number of schools achieving accreditation.

Targeted work has also been undertaken to identify and support children at higher risk. A **risk** stratification tool for primary care is being used in some practices to help identify children who may benefit from earlier review, while medicines management has been supported through initiatives such as the wheeze discharge leaflet, which aims to improve understanding of inhaler use and reduce reliance on reliever inhalers. In secondary care, the TAPES discharge toolkit is supporting safer and more consistent discharge following an asthma or wheeze admission, helping to ensure children leave hospital with clear plans and appropriate follow-up.

In addition, wider prevention work is being delivered by Health Innovation Manchester via the Innovation for Healthcare Inequalities Programme (InHIP) in Tameside, which focuses on improving how asthma is diagnosed and managed, as well as reducing the impact of smoking within households. This includes the use of FeNO testing to better understand lung inflammation and support more tailored treatment, alongside offering families advice and support to stop smoking, recognising that exposure to smoke can worsen asthma symptoms and increase the risk of hospital admission.

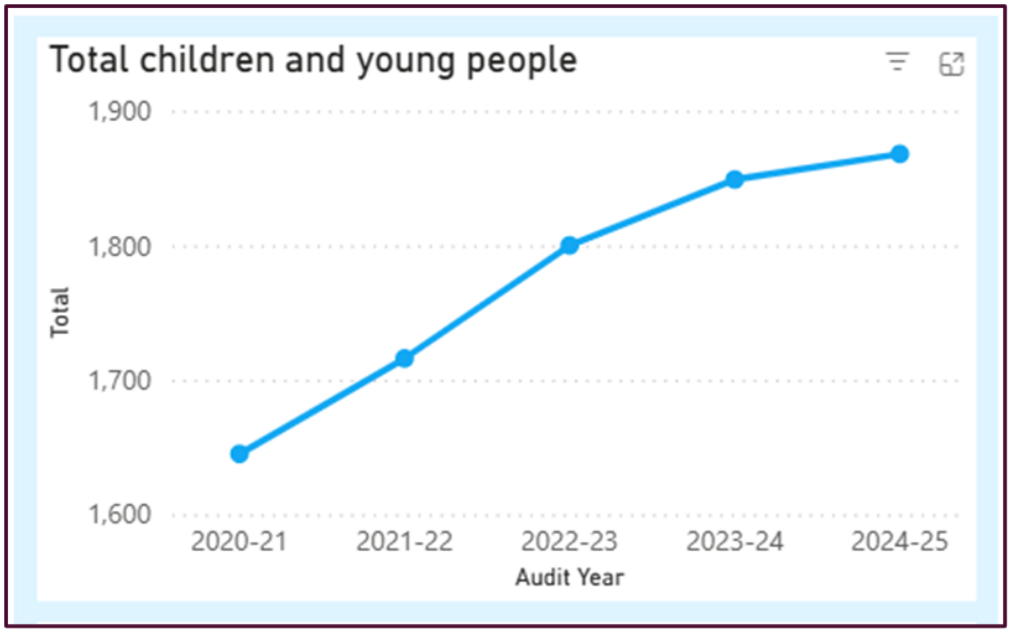
Taken together, these interventions are helping to strengthen routine asthma care, improve understanding among families and professionals, and support earlier intervention. While the full impact will take time to be seen, this joined-up approach is expected to improve asthma control and help reduce avoidable escalation to emergency care, particularly in areas with the highest levels of need.

15.6 Childhood Diabetes

15.5.1 Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes

The most recent National Paediatric Diabetes Audit 2024/25 (NPDA, 2026) covers the period from 1 April 2024 to 31 March 2025. Since 2020/21, caseloads within Greater Manchester Paediatric Diabetes (PDUs) have increased by 13.6%, slightly higher than the 13.2% increase reported across England, Jersey and Wales.

Figure 90: Diabetes Caseload in Greater Manchester from 2020 to 2025

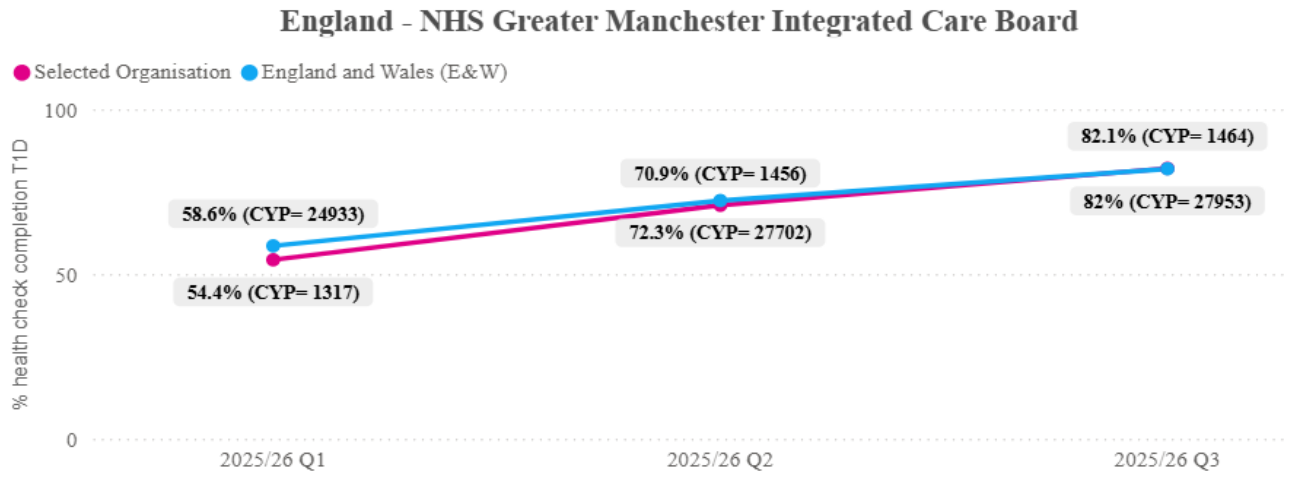


Source: National Paediatric Diabetes Audit (NPDA) - Reporting dashboards | RCPCH.

Data from the National Paediatric Diabetes Audit (NPDA) and Greater Manchester diabetes dashboards are reviewed quarterly through the Greater Manchester Children and Young People (CYP) Diabetes Group. Findings are used to identify variation in outcomes and access to care, inform service improvement activity and monitor progress in reducing inequalities.

Recent work has focused on improving awareness of Type 1 and Type 2 diabetes, supporting equitable access to diabetes technology and developing resources tailored to local population needs.

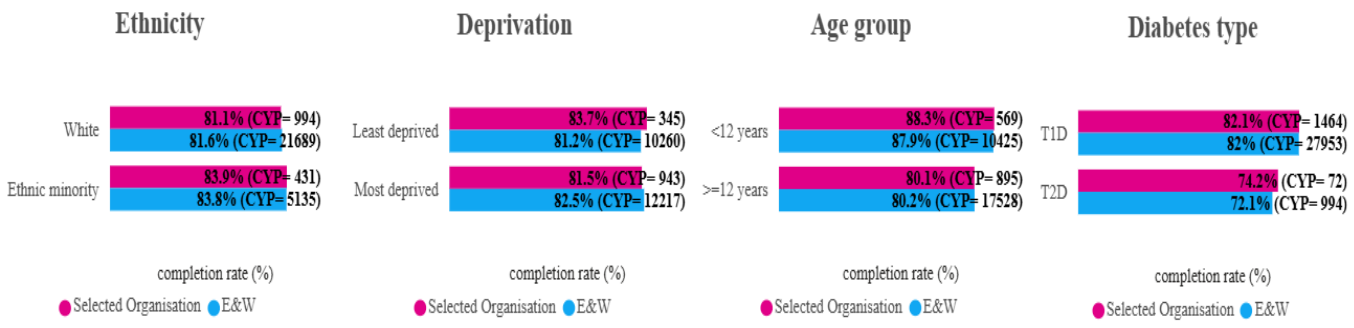
Figure 91: Percentage of Key Recommended Health Checks Received by Individuals with Type 1 Diabetes Who Have Not Transitioned to Adult Services, Q1–Q3 2025/26



Previous audit year results	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4
England - NHS Greater Manchester Integrated Care Board	54.5%	68.2%	78.7%	90.9%

Source: National Paediatric Diabetes Audit (NPDA) - Reporting dashboards | RCPCH.

Figure 92: Percentage of Key Recommended Health Checks Received: Greater Manchester Compared with England and Wales, by Ethnicity, Deprivation, Age Group, and Diabetes Type



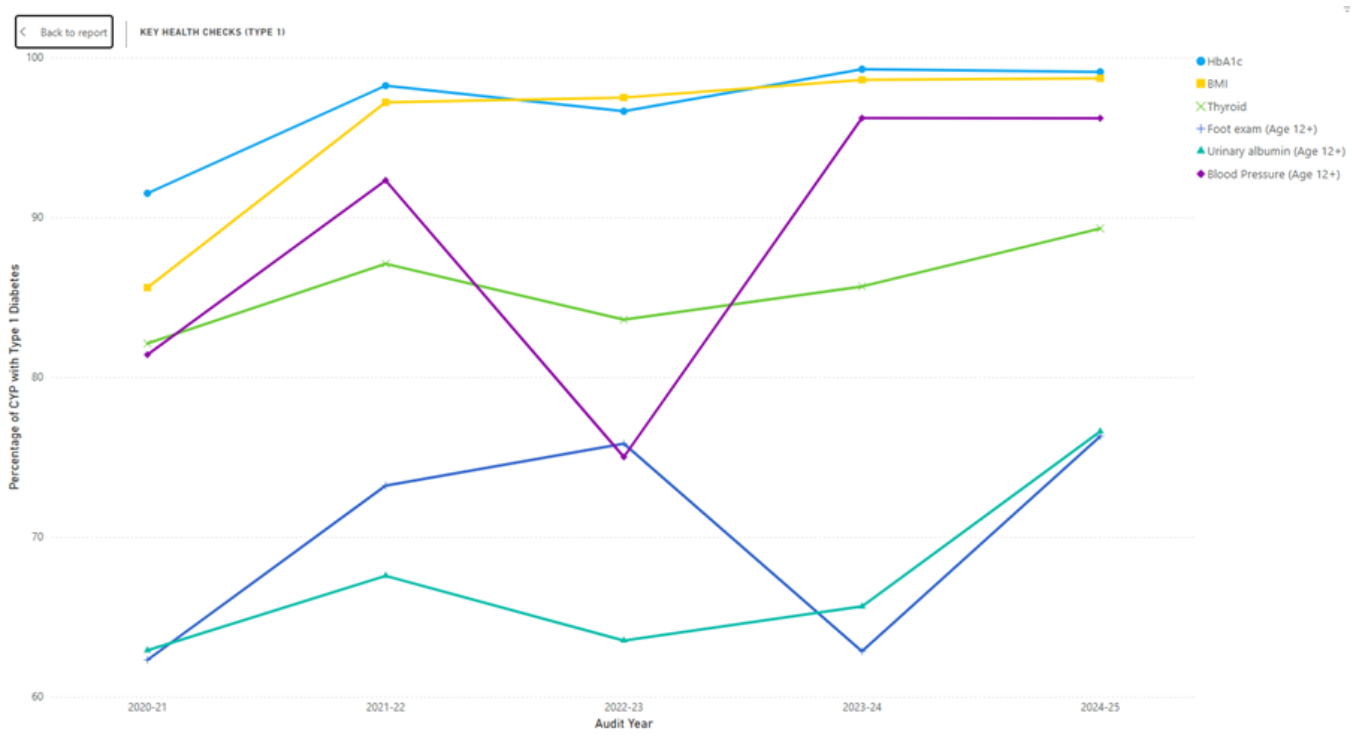
Source: National Paediatric Diabetes Audit (NPDA) - Reporting dashboards | RCPCH.

Six recommended health checks are monitored for children and young people with Type 1 and

Type 2 diabetes. Completion rates are generally higher for CYP with Type 1 diabetes than for those with Type 2 diabetes, although the Type 2 cohort is substantially smaller.

In Greater Manchester, performance is broadly comparable with England and Wales. Completion rates are slightly higher among CYP living in the least deprived areas compared with the most deprived areas. Quarterly NPDA data also indicate improving completion rates over time, although some health checks are completed annually and final year-end performance will not be confirmed until Quarter 4 data are available.

Figure 93: Trend in Key Health Checks for Children and Young People with Type 1 Diabetes on Greater Manchester Paediatric Diabetes Unit (PDU) Caseloads



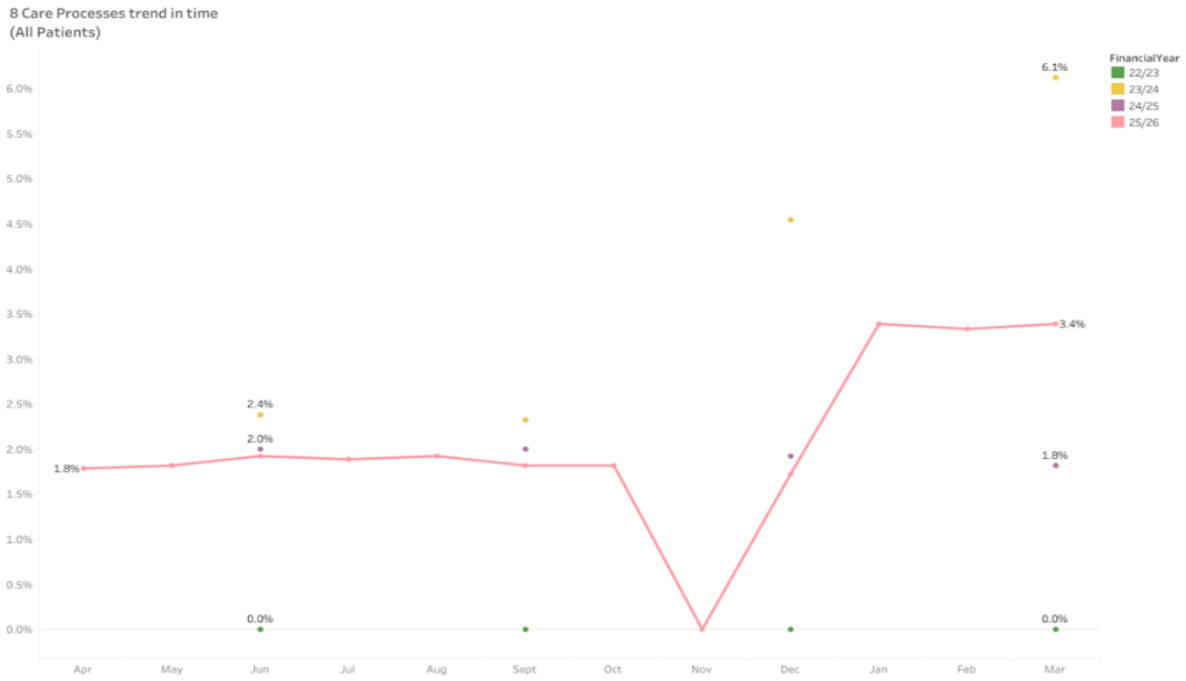
Source: National Paediatric Diabetes Audit (NPDA) - Reporting dashboards | RCPCH.

Table 6: Key Health Checks for Children and Young People with Type 1 Diabetes on Greater Manchester PDU Caseloads.

Audit Year	HbA1c	BMI	Thyroid	Foot exam (Age 12+)	Urinary Albumin (Age 12+)	Blood Pressure (Age 12+)
2020-21	91.50	85.60	82.10	62.30	62.90	81.40
2021-22	98.24	97.19	87.09	73.21	67.56	92.31
2022-23	96.63	97.49	83.60	75.84	63.52	75.00
2023-24	99.27	98.60	85.67	62.84	65.65	96.21
2024-25	99.10	98.70	89.30	76.30	76.60	96.20

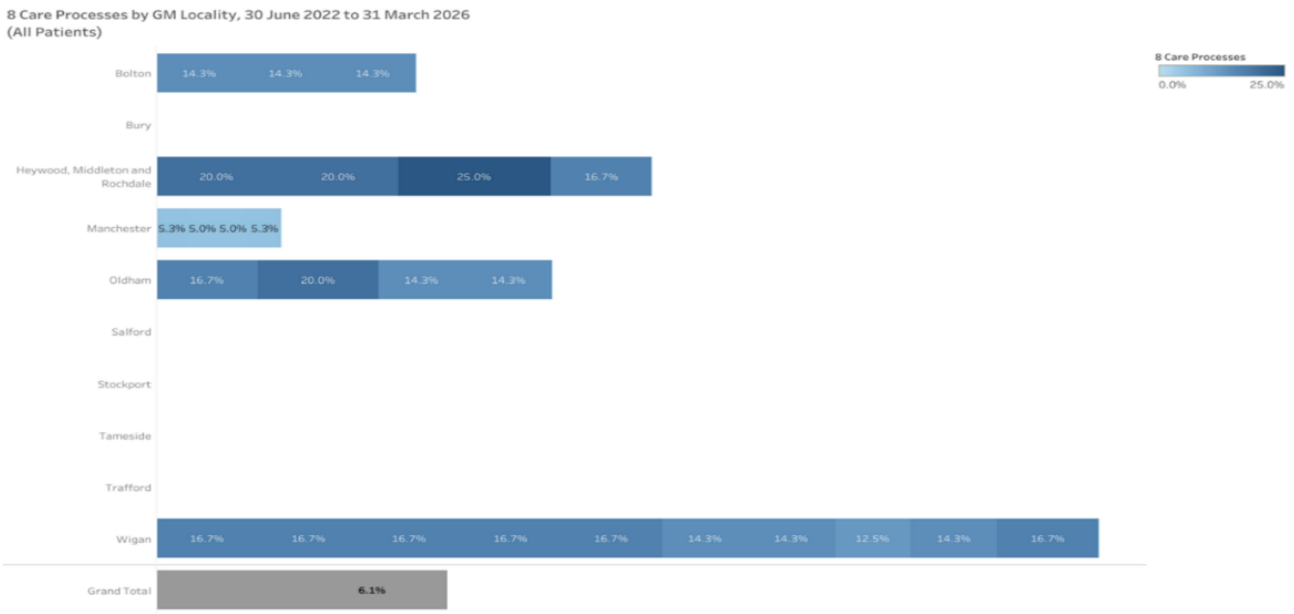
Source: National Paediatric Diabetes Audit (NPDA) - Reporting dashboards | RCPCH.

Figure 94: Trend in Key Health Check Completion for Children and Young People with Type 2 Diabetes on Greater Manchester PDU Caseloads



Source: National Paediatric Diabetes Audit (NPDA) - Reporting dashboards | RCPCH.

Figure 95: Breakdown of Key Health Check Completion for Children and Young People with Type 2 Diabetes within Greater Manchester Paediatric Diabetes Unit Caseloads



Source: NHS Greater Manchester Diabetes dashboard – GM ADSP

The dashboard was designed with consideration for adult patients and therefore with eight key health checks (care processes) displayed, compared to six which are routinely conducted for CYP.

Work has been undertaken to test a screening tool in weight management services to identify CYP who have, or at risk of T2D but are not diagnosed. A referral pathway has also been developed. Clinicians believe that there are likely to be more CYP with T2D who remain undiagnosed. Training for primary care staff has been delivered to raise awareness of the symptoms of diabetes (T1D and T2D).

15.5.2 Inequalities in percentage of CYP using diabetes technology, including continuous glucose monitoring, insulin pump, and hybrid closed loop

NPDA data indicate that access to diabetes technology in Greater Manchester is improving and broadly follows the national trend. Uptake of continuous glucose monitoring, insulin pumps and

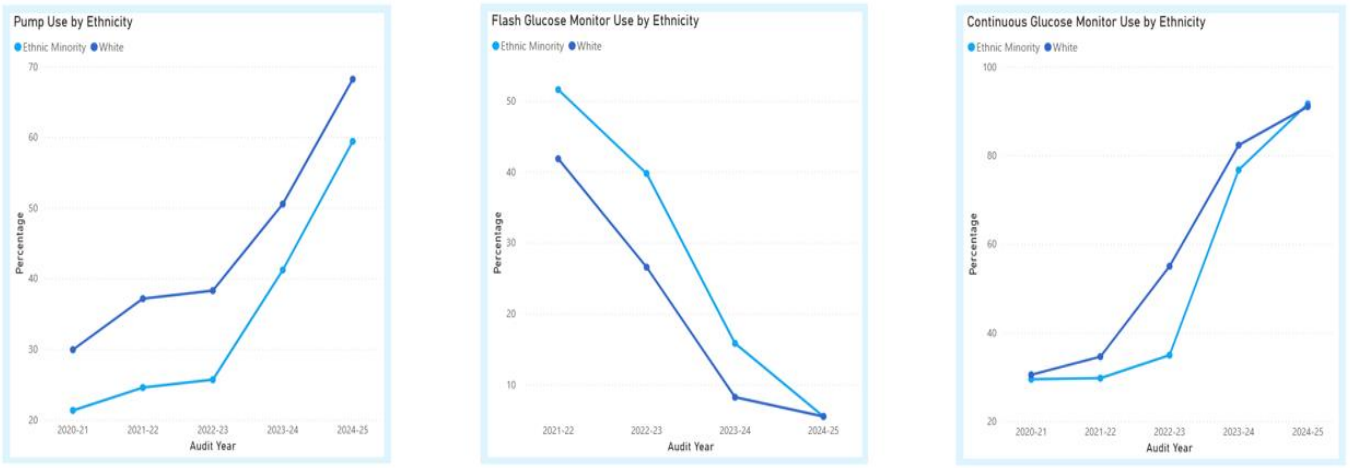
hybrid closed-loop systems has increased since Q1 2025/26.

Figure 96: Hybrid Closed-Loop Use in Greater Manchester Compared with England and Wales (NPDA Q1 2025/26 to Q3 2025/26)

Source: National Paediatric Diabetes Audit (NPDA)

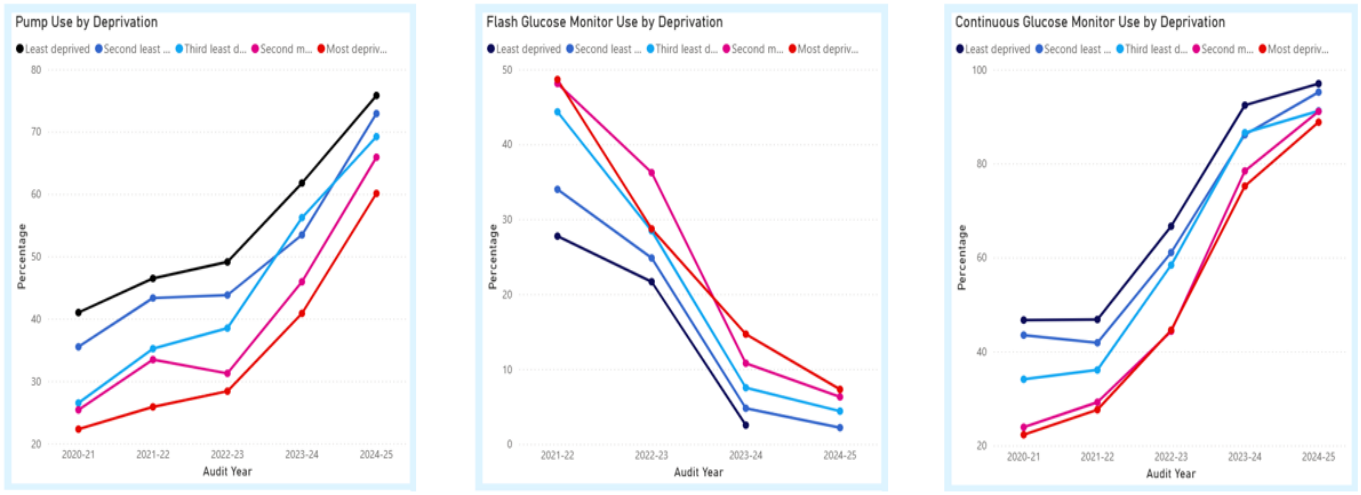
The gap in technology uptake between deprivation groups and ethnic groups has narrowed over time, although some variation remains. Local initiatives, including targeted support and culturally appropriate patient information resources, have been implemented to support equitable access to diabetes technology across Greater Manchester.

Figure 97: Technology Usage in Greater Manchester Compared by Ethnicity Group



Source: NHS Greater Manchester Diabetes dashboard – GM ADSP

Figure 98: Technology Usage in Greater Manchester Compared by Deprivation Quintile



Source: NHS Greater Manchester Diabetes dashboard – GM ADSP

Emergency admission rates for diabetes vary across deprivation groups and localities. Higher admission rates among young adults aged 19-24 years may reflect challenges associated with transition from paediatric to adult services. This remains an important area for service improvement and ongoing monitoring across Greater Manchester.

APPENDICES

Appendix 1: NHS England Health Inequalities Improvement Metrics Framework

NHS England » NHS England's statement on information on health inequalities

Appendix 2: Greater Manchester Population Demographic Profile – Inequalities Statement

Appendix 2.1 Registered Demographic Population (as at Jan 26)

Greater Manchester has a diverse population with a registered population of **3.32 million** people; **81% are under the age of 65**, over **62% identify as White/White British** and **43% live in the most deprived 20%** (deciles 1&2).

Greater Manchester is made up of ten localities or local authorities; Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan.

Registered populations vary across the ten localities from **Bury which represents 6.4%** of registered population to **Manchester which represents 22.9%**.

Age distribution and deprivation vary across localities; Trafford has the lowest proportion of people living in the most deprived 20%; **10.6%** compared to Manchester with **58%. Stockport and Wigan have this highest proportion of people aged 65+** (approx. 22%) and are above the **Greater Manchester average, of 19%.**

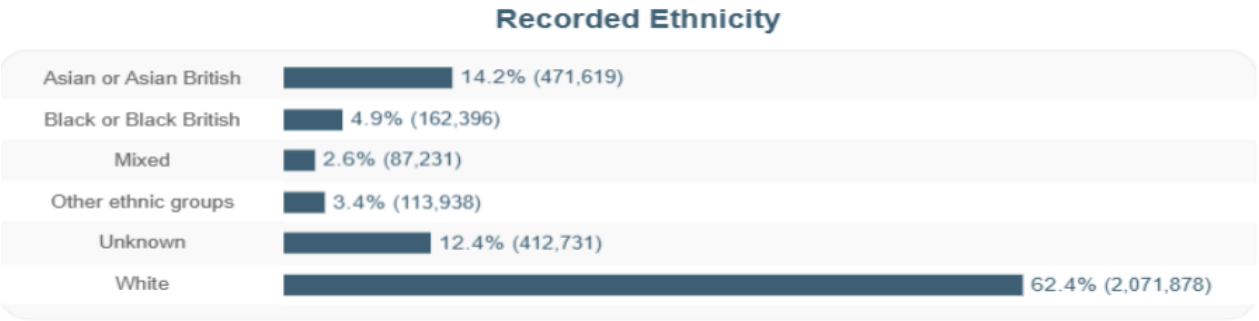
Appendix 2.2 Ethnicity Recording (as of January 2026)

Greater Manchester has a predominately White/ White British community which represents 62.4% of the registered population (over 2 million people). This is closely followed by the **Asian and Asian British community with** 14.2% of the registered population (approx. 472k). People who identify as mixed, represent 2.6% of the registered population (87k); this is the smallest group with ethnicity recorded.

Over 12% of the population of Greater Manchester are recorded as 'unknown' which

means that no ethnicity group is recorded. Ethnic recording for the purpose of this statement is taken from our commissioning datasets and grouped in accordance with the NHS Data dictionary categorisations.

Appendix Figure A2.1: Ethnicity Recording for Greater Manchester as of Jan 2026



Source: NHS Greater Manchester Health Profiles – GM ADSP

Variation across Localities/Local Authorities – ethnicity recording (as at Jan 26)

Summary Of Ethnicity recording.

All localities have a predominant white/white British community however this does vary across Greater Manchester. Manchester has the lowest proportion recorded of this ethnic group; **42.5%** compared to Wigan with **84%.**

The largest proportion of the Asian/Asian British community can be found in Oldham with **23.7%** compared to Wigan with **2.6%.**

The largest proportion of the Black community reside in Manchester with **9.9%** compared to Stockport with **1.3%.**

Please be aware these are proportions of populations, represented as percentages and actual numbers should be considered when looking at this data.

Overall, Manchester has the largest and most diverse population, representing the highest proportion of recorded ethnicity for Black and Mixed ethnic groups. It also has the second

highest community of Asian/Asian British people.

Understanding populations and their service utilisation helps strategic commissioners to understand level of need. This can sometimes differ depending on a variety of demographic factors including ethnicity.

Percentage of records with blank or null codes for ethnicity

Demographic data available for the HI statement metrics is variable as the completeness and accuracy of recording of ethnicity, country of birth, religion, sexuality or language varies across different NHS datasets (see table 1). This report, therefore, presents an initial analysis, based on current demographic data available at locality and GM level.

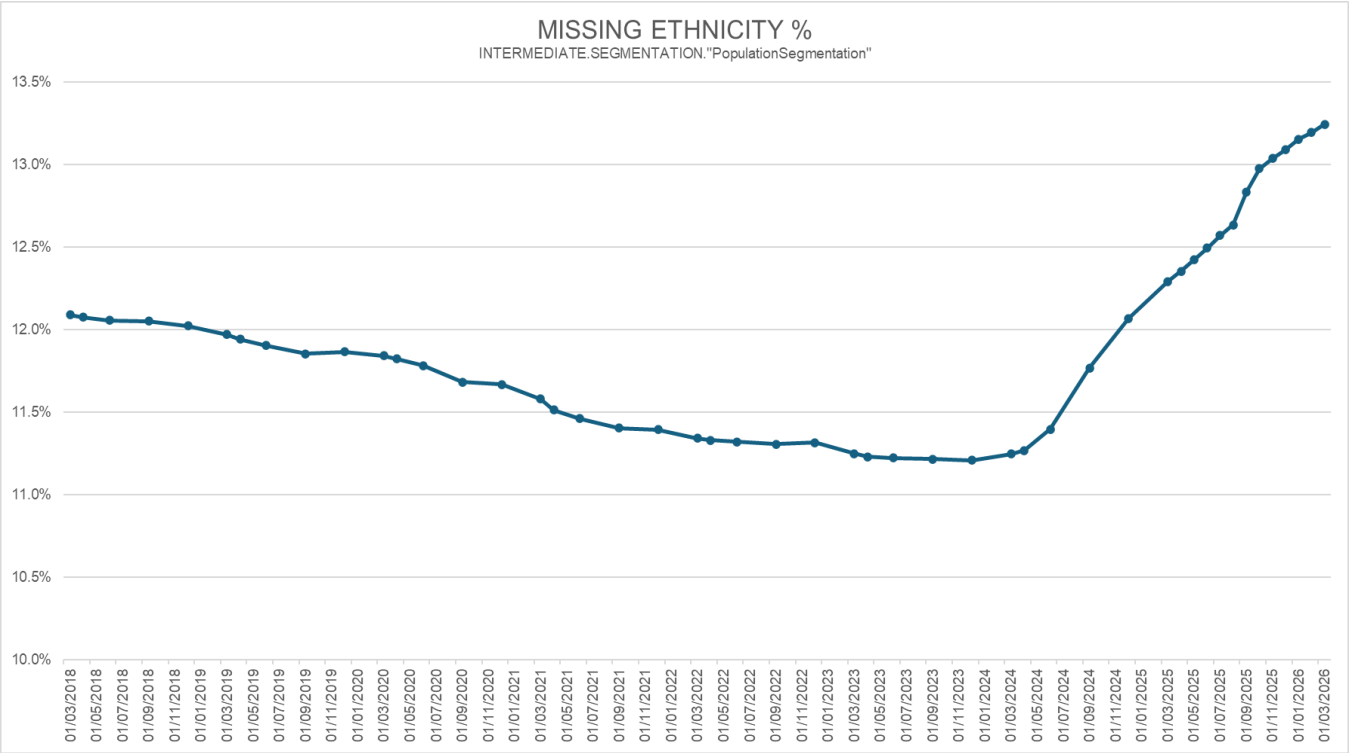
Appendix Table A2.1: Data Completeness Across Key NHS Datasets

Data Source	*Not Known*	*Not stated*	*Blank*	Total Ethnicity Missing	Ethnicity Completion
Mental Health Services	*12%*	*13%*	*2%*	**27%**	**73%**
Emergency Care	-	*5%*	*6%*	**11%**	**89%**
Outpatient Appointments	*5%*	*9%*	*2%*	**16%**	**84%**
Maternity Services	*2%*	*4%*	*2%*	**7%**	**93%**
Inpatient Admissions	*3%*	*5%*	*0%*	**8%**	**92%**
Continuing Health Care	*17%*	*9%*	*37%*	**63%**	**37%**
Community Services	*20%*	*3%*	*26%*	**49%**	**51%**
Improving Access to Psychological Therapies	*4%*	*8%*	*0%*	**12%**	**88%**
NCRAS Cancer Registration	*0.1%*	*0.4%*	*0.8%*	**1%**	**99%**
Alcohol Dependence Record	*0.8%*	*1.4%*	-	**2%**	**98%**
Tobacco Dependence Record	*4%*	*6%*	*0%*	**10%**	**90%**
All Age Continuing Care	*25%*	*10%*	*26%*	**61%**	**39%**
National Diabetes Audit	-	*1%*	*38%*	**39%**	**61%**

Source: NHS Greater Manchester Data Completeness Analysis – GM ADSP

The next graph shows ethnicity completion from the population segmentation dataset, a consolidated dataset that draws on multiple sources to build an overall picture of the population.

Appendix Figure A2.2: Trend in Missing Ethnicity Recording, Greater Manchester Population Segmentation Dataset (2018-2026)

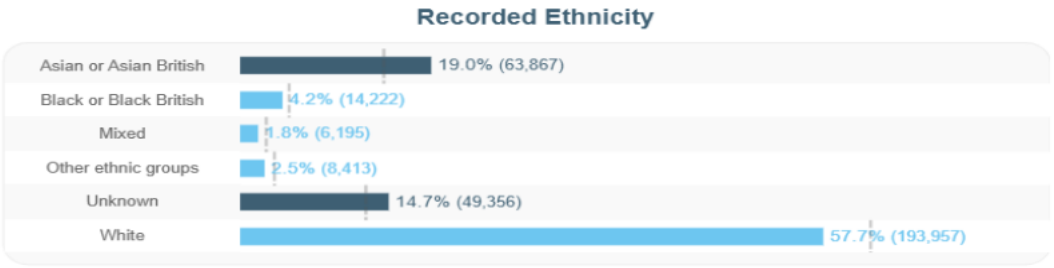


Source: NHS Greater Manchester Population Segmentation Dataset – GM ADSP

Appendix 2.3 Locality Specific summary

Bolton has a registered population **of 336K (10.1% of GM population)**. Nearly **58%** of the population identify as White/White British, which is below the GM average. It has a higher proportion of people identifying as Asian/Asian British than GM at **19% v 14.2%.**

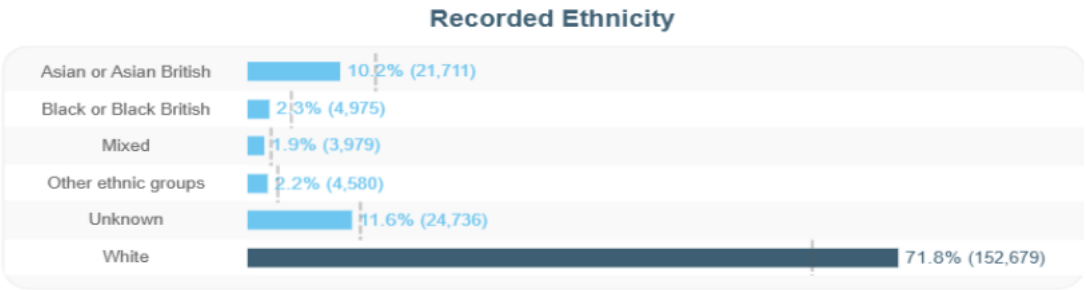
Appendix Figure A2.3: Ethnicity Recording for Bolton



Source: NHS Greater Manchester Health Profiles – GM ADSP

Bury has a registered population of **213K (6.4% of GM population)**. Nearly **72%** of the population identify as White/White British, which is above the GM average. It has lower proportions of people identifying in all other ethnic groups including unknown when compared to Greater Manchester.

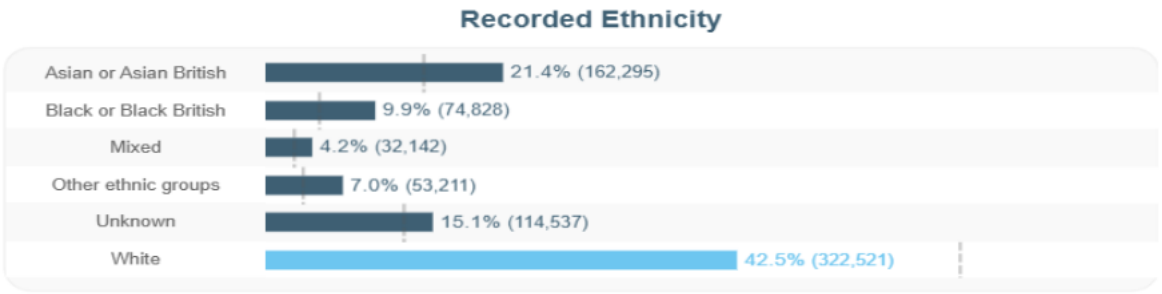
Appendix Figure A2.4: Ethnicity Recording for Bury



Source: NHS Greater Manchester Health Profiles – GM ADSP

Manchester has a registered population of **760K (22.9% of GM population)**. Nearly **43%** of the population identify as White/White British, which is below the GM average. It has higher proportions of people identifying in all other ethnic groups including unknown when compared to Greater Manchester.

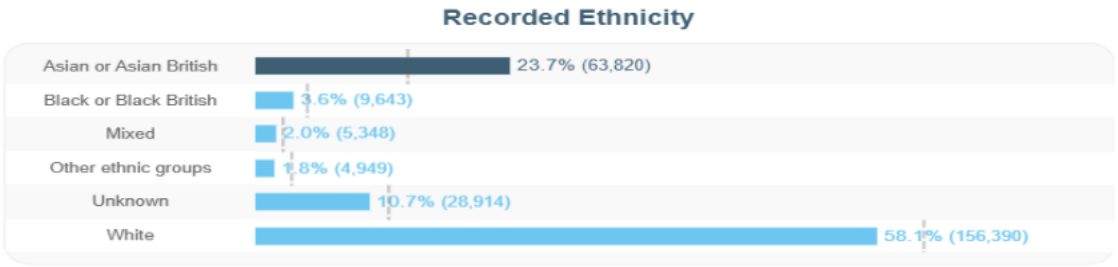
Appendix Figure A2.5: Ethnicity Recording for Manchester



Source: NHS Greater Manchester Health Profiles – GM ADSP

Oldham has a registered population of **269K (8.1% of GM population).** Just over **58%** of the population identify as White/White British, which is below the GM average. It has a higher proportion of people identifying as Asian/Asian British compared to Greater Manchester, **23.7% V 14.2%.**

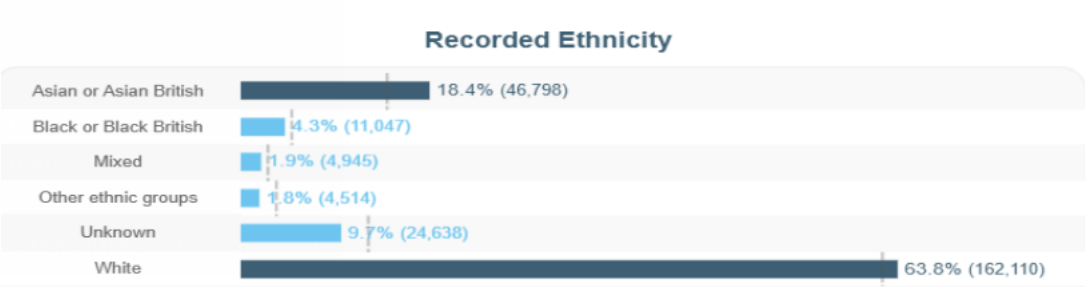
Appendix Figure A2.6: Ethnicity Recording for Oldham



Source: NHS Greater Manchester Health Profiles – GM ADSP

Rochdale has a registered population of **254K (7.7% of GM population).** Nearly **64%** of the population identify as White/White British, which is above the GM average. It has a higher proportion of people identifying as Asian/Asian British compared to Greater Manchester, **18.4% V 14.2%.**

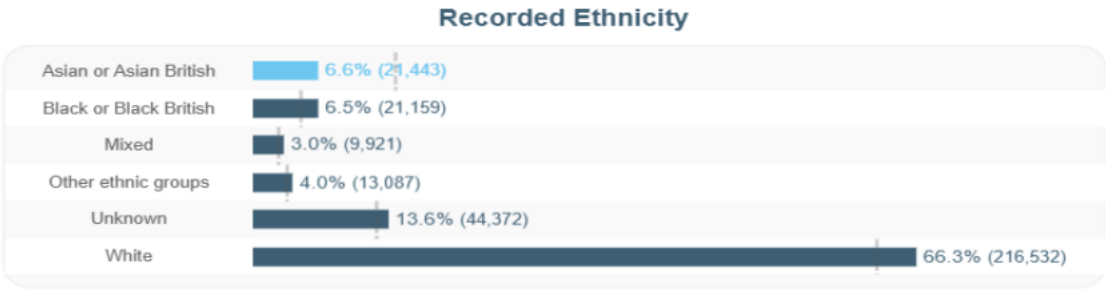
Appendix Figure A2.7: Ethnicity Recording for Rochdale



Source: NHS Greater Manchester Health Profiles – GM ADSP

Salford has a registered population of **327K (9.8% of GM population).** Just over **66%** of the population identify as White/White British, which is above the GM average. It has a higher proportion of people identifying in most other ethnic groups when compared to Greater Manchester. The Asian/Asian British community is significantly lower than Greater Manchester, **6.6% V 14.2%.**

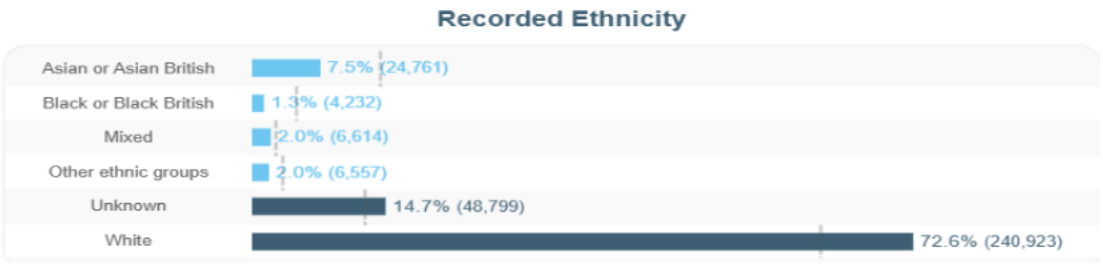
Appendix Figure A2.8: Ethnicity Recording for Salford



Source: NHS Greater Manchester Health Profiles – GM ADSP

Stockport has a registered population of **332K (10% of GM population).** Nearly **73%** of the population identify as White/White British, which is above the GM average. It has a lower proportion of people identifying in all other ethnic groups when compared to Greater Manchester.

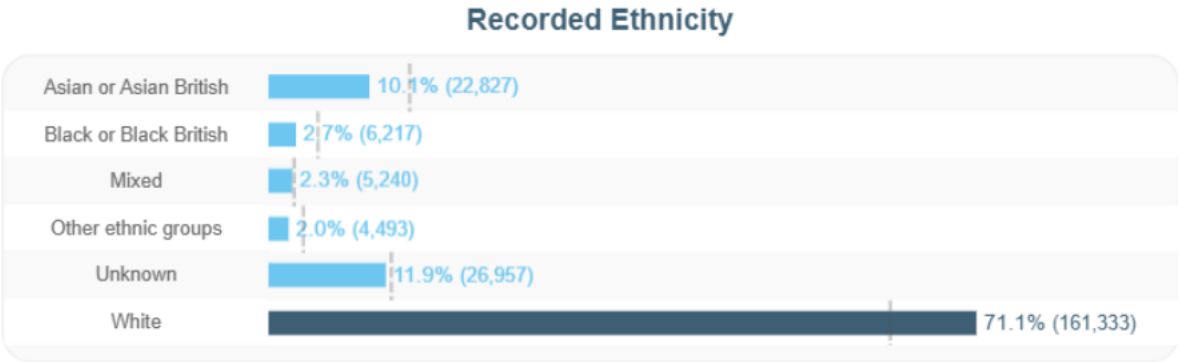
Appendix Figure A2.9: Ethnicity Recording for Stockport



Source: NHS Greater Manchester Health Profiles – GM ADSP

Tameside has a registered population of **227K (6.8% of GM population).** Just over **71%** of the population identify as White/White British, which is above the GM average. It has a lower proportion of people identifying in all other ethnic groups when compared to Greater Manchester.

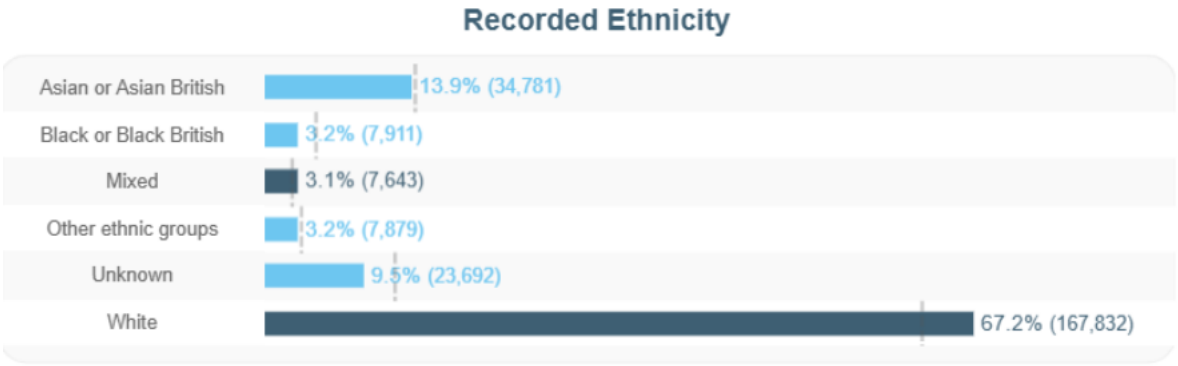
Appendix Figure A2.10: Ethnicity Recording for Tameside



Source: NHS Greater Manchester Health Profiles – GM ADSP

Trafford has a registered population of **250K (7.5% of GM population).** Just over **67%** of the population identify as White/White British, which is above the GM average. It has a lower proportion of people identifying most other ethnic groups when compared to Greater Manchester. Trafford has a slightly higher proportion of people identifying as mixed compared to Greater Manchester, **3.1% v 2.6%.**

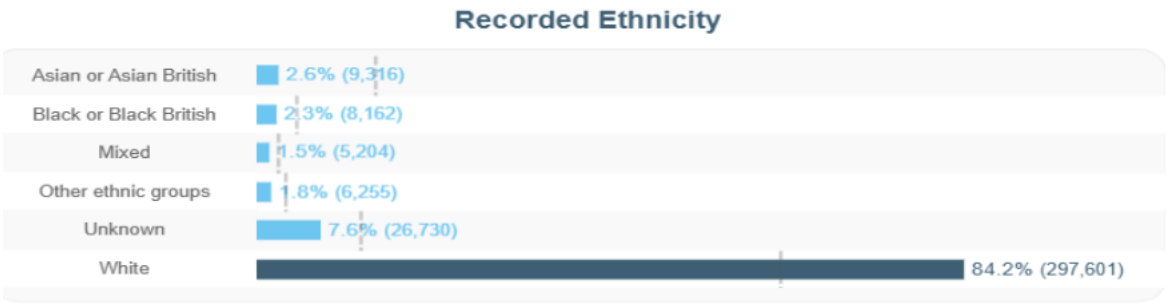
Appendix Figure A2.11: Ethnicity Recording for Trafford



Source: NHS Greater Manchester Health Profiles – GM ADSP

Wigan has a registered population of **353K (10.6% of GM population).** Over **84%** of people identify as White/White British, which is above the GM average and is the highest proportion of this community across Greater Manchester. It has a lower proportion of people identifying in all other ethnic groups when compared to Greater Manchester.

Appendix Figure A2.12: Ethnicity Recording for Wigan



Source: NHS Greater Manchester Health Profiles – GM ADSP

Appendix 2.4 Recording of demographic information in GP IT Systems

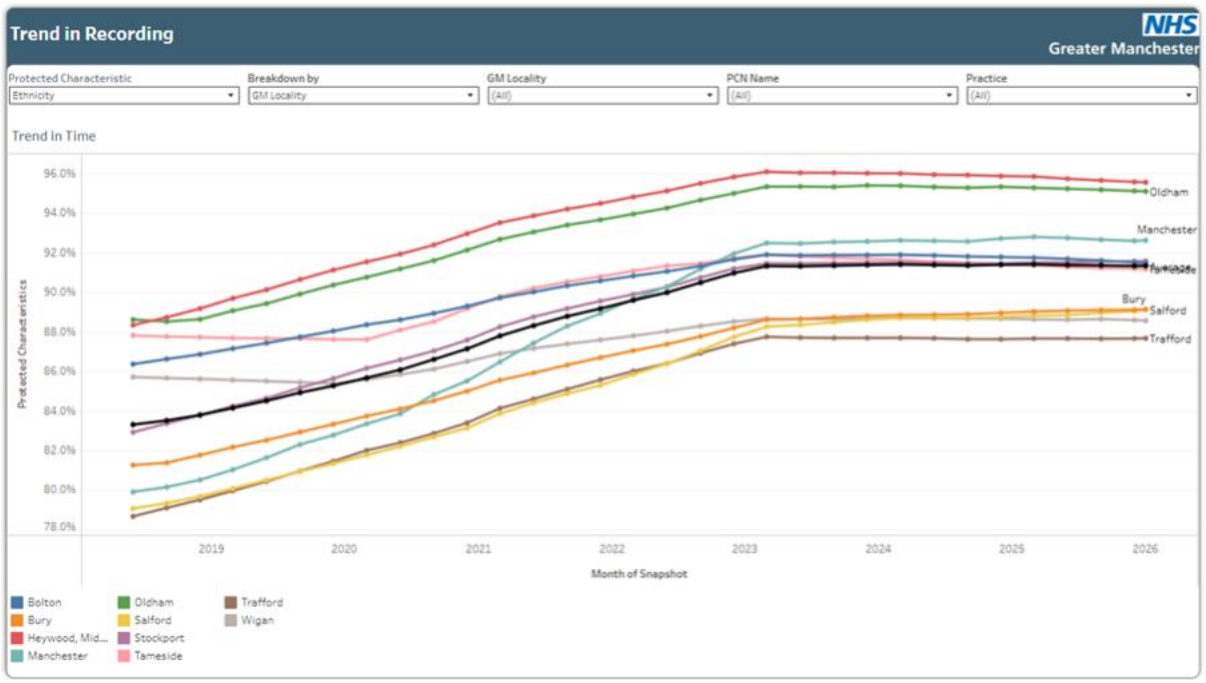
Work is continuing to support practices across Greater Manchester to improve the coding of demographics and protected characteristics to support equalities work.

This includes;

- Sharing of an EMIS and SystemOne template to support standardised coding
- "Data cleansing" searches to identify patients who have incorrect or unsuitable codes

Across Greater Manchester 91.3% of patients have a "valid" ethnicity code (i.e. an actual value, not including patients who have codes such as "ethnicity not recorded");

Appendix Figure A2.13: Trend showing Ethnicity Recording for Greater Manchester Localities



Source: NHS Greater Manchester Ethnicity Recording Dashboard – GM ADSP

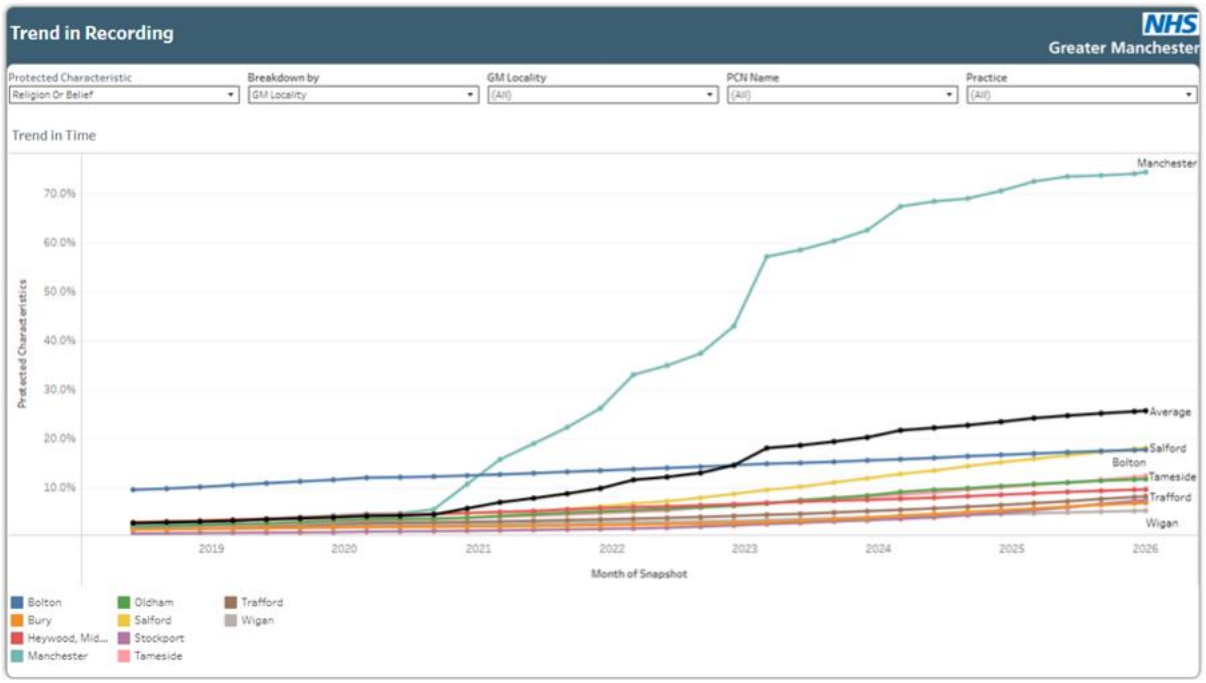
Work is also underway to improve the recording of other demographics and protected

characteristics such as Sexual Orientation, Religion or Belief, Marriage or Civil Partnership and Spoken and Reading Language.

Religion or Belief data has been synthesised into individual denominations, allowing differentiation between individuals of the same overarching religion but with different beliefs, e.g. Romain Catholic Christians having different beliefs to Jehovah's Witnesses.

Whilst not at the same recording rate of Ethnicity, these other demographics and protected characteristics are seeing incremental gains and in time will allow for rich analysis to be undertaken. As shown overleaf for Religion or Belief, the Manchester locality has seen significant increases through incentivising recording of this data;

Appendix Figure A2.14: Trend showing Religion or Belief Recording for Greater Manchester Localities



Source: NHS Greater Manchester Religion or Belief Recording Dashboard – GM ADSP

Appendix 2.5 Index of Disparity (IoD) to quantity inequalities

NHS Greater Manchester has, for some time, been trying to utilise the rich patient level GP data available to quantify inequalities and to track any improvements.
We have recently trailed an implementation of the “Index of Disparity (IoD)”, developed by Pearcy and Keppel (2002) to monitor disparities across time, indicators and demographic groups. Pearcy, Jeffrey N., and Kenneth G. Keppel. 2002. ‘A Summary Measure of Health Disparity’. Public Health Reports® 117 (3): 273–80. https://doi.org/10.1093/phr/117.3.273.

Using the IoD it is possible to attribute a value for inequalities, with a larger value indicating greater inequalities. Inequalities have been calculated across 4 groups;

- Age
- Sex
- Ethnicity
- Deprivation (IMD Quintile)

As well as calculating the IoD for each of these 4 groups it is also possible to calculate an aggregated IoD score. IoD has been implemented across local CVDPrevent data, showing that the greatest overall inequalities are within CVDP012CHOL (Cholesterol Control for patients with a diagnosed CVD).

Appendix Figure A2.15: Achievement Summary and Index of Disparity (IoD) Scores across Four Population Groups (Age, Sex, Ethnicity and Deprivation Quintile) for Selected Clinical Indicators (Snapshot from 28 February 2026)

Name	Denominator	Numerator	Achievement	Target	Absolute Distance to Upper Threshold	Index of Disparity Age	Index of Disparity Deprivation	Index of Disparity Ethnicity	Index of Disparity Sex	Index of Disparity Total
CVDP012CHOL (CVD Cholesterol Control Revised)	121,580	75,399	62.02%			15.09	1.76	6.30	8.87	8.01
Primary Prevention (QRisk ≥ 10%)	369,849	218,891	59.18%			3.58	3.12	8.15	4.98	4.96
CVD Lipid lowering therapy treatment	143,320	124,174	86.64%	95.0%	-8.36%	10.83	0.78	3.61	3.38	4.65
Primary Prevention (QRisk ≥ 20%)	152,156	101,891	66.96%	60.0%	6.96%	4.94	4.36	8.24	0.73	4.57
Hypertension Blood Pressure control	392,856	325,735	82.91%	80.0%	2.91%	6.58	0.81	4.54	0.05	3.00

Blood Pressure monitoring	437,620	392,856	89.77%	90.0%	-0.23%	3.52	0.70	2.78	0.85	1.96
CHA2DS2-VASc ≥2 anticoagulation	48,817	45,301	92.80%	95.0%	-2.20%	1.81	0.46	1.63	0.17	1.02

Source: NHS Greater Manchester CVD Prevention Dashboard – GM ADSP

Using the IoD we can then pinpoint specific groups where there is inequality, develop and implement specific interventions to hopefully reduce the inequality. In the example for CVDP012CHOL, we can look at the variation by Age (with an IoD of 15.09).

Appendix Figure A2.16: Index of Disparity Summary across Clinical Indicators, with analysis by Age Group (Snapshot from 28 February 2026)

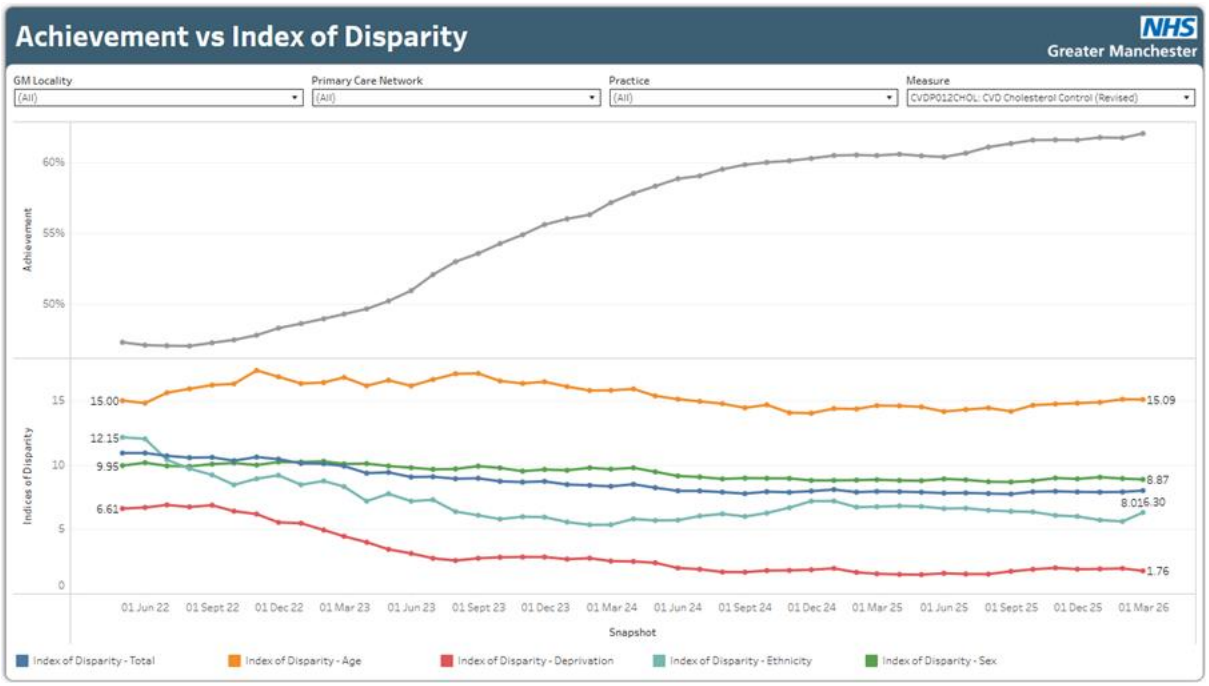
ID	Short Name	Achievement	Index of Disparity - Age	Age - Children	Age - Students	Age - Young Adults	Age - Adults	Age - Older Adults
CVDP012CHOL	CVD Cholesterol Control (Revised)	62.02%	15.09		49.12%	42.60%	56.06%	64.72%
CVDP009CHOL	CVD Lipid lowering therapy treatment	86.64%	10.83		7.19%	59.99%	87.33%	87.45%
CVDP007HYP	Hypertension Blood Pressure control	82.91%	6.58	93.26%	75.70%	70.58%	81.18%	85.20%
CVDP003CHOL	Primary Prevention (QRisk ≥ 20%)	66.96%	4.94			68.28%	72.44%	65.82%
CVDP006CHOL	Primary Prevention (QRisk ≥ 10%)	59.18%	3.58		0.00%	59.27%	55.09%	61.36%
CVDP004HYP	Blood Pressure monitoring	89.77%	3.52	69.42%	79.11%	84.98%	87.27%	91.95%
CVDP002AF	CHA2DS2-VASc ≥ 2 anticoagulation	92.80%	1.81		0.00%	79.53%	89.72%	93.09%

Source: NHS Greater Manchester CVD Prevention Dashboard – GM ADSP

Specific work on “Young Adults” and “Students” in particular could lead to a reduction in inequalities for this measure by Age. IoD can also be tracked in time to understand if, as achievement hopefully increases, if inequalities are exacerbated or reduce.

IoD can also be tracked in time to understand if, as achievement hopefully increases, if inequalities are exacerbated or For CVDP012CHOL we can see that achievement has increased by 15% since June 2022, but the total IoD (blue line) has decreased from 10.93 to 8.01 suggesting that inequalities have decreased.

Appendix Figure A2.17: Trend showing Achievement Summary and Index of Disparity (IoD) Scores across Four Population Groups (Age, Sex, Ethnicity and Deprivation Quintile) for Selected Clinical Indicators



Source: NHS Greater Manchester CVD Prevention Dashboard – GM ADSP

This work has been well received within NHS Greater Manchester and we are looking to implement IoD across a range of dashboards in 26/27.

Appendix 3: Additional Health Inequalities Activity Programmes and Activity

Additional Work not already shared above, that is happening within Greater Manchester that contribute to reduction in/addressing of health inequalities

Appendix 3.1 Fairer Health for All

Fairer Health for All (FHFA) is our system-wide commitment and framework for reducing health inequalities in Greater Manchester. The framework outlines our priorities for coordinated action to reduce inequalities across the life course through a set of shared principles, enablers, tools and resources and a set of ambitions for 2030**.** The Fairer Health for All Ambitions and Goals for 2030 are to:

1. **Improve the Health & Wellbeing to narrow the gap in life expectancy and healthy life expectancy** –Narrow the gap by at least 15% between Men and Women living in GM between all 10 localities in GM, as well as between GM & England average.

2. **Reduce unwarranted variation in health outcomes and experiences** – Eliminate the difference between the highest & lowest social groups in the experience of having 2 or more multiple health harming behaviours.

3. **Increased social & economic activity because of reduced ill health** – Narrow the 15-year gap in the onset of multiple morbidities between the poorest & wealthiest sections of the population to 5 years.

4. **Reduce preventable or unmet health and care needs leading to reductions in health and care demand** –Close the health inequalities gap in smoking prevalence with England. Reduce avoidable mortality rates by 40%.

5. **Reduce the difference in life expectancy and the incidence of physical health conditions for people with Severe Mental Illness (SMI)** –Narrow the gap with England by 15%.

6. **Reduce infant Mortality** –Narrow the gap in infant mortality with England by 15% & close the school readiness gap.

For further information please visit the Fairer Health for All Academy.

Appendix 3.2 Health Profiles for NNHIP (National Neighbourhood Health Implementation Programme)

Across Greater Manchester, two localities, Stockport and Rochdale, were successful in application to be part of the National Neighbourhood pilot phase 1 also known as NNHIP. To support the programme each locality had to define a population group to target following the national definition as below.

NNHIP definition – *target cohort adults with multiple long-term conditions (LTCs) or one LTC and identified as being at intermediate or high risk of hospital admission*

The national programme focuses on inequalities to try and understand whether some population groups are more/less disadvantaged in access to services depending on age, ethnicity and deprivation decile they reside in.

Analytical packs have been developed with a strong focus on disease prevalence, utilisation of emergency and planned care services (outpatient only) with a further inequalities breakdown by age, gender, ethnicity and deprivation. This intelligence has highlighted inequalities for people accessing services which has allowed further approaches to be more targeted.

To follow on from this work, all ten localities in Greater Manchester can now access a 'Neighbourhood' pack which provides a focus of where to look addressing the delivery outcomes of the national programme.

Below is an extract of some of the key inequalities' headlines identified for one locality as part of this work.

Inequalities are Deep and Widening

- Deprivation and ethnicity are strongly linked to higher prevalence and urgent care use for almost all conditions of concern.

- Patients in the most deprived areas are more likely to have higher rates of A&E and emergency admissions.
- Ethnic inequalities are evident, with Asian patients more likely to have Diabetes and higher urgent care use, and Black patients more likely to have Asplenia and higher rates of urgent care activity.

Appendix 3.3 Socio-Economic Duty (SED)

NHS Greater Manchester ICB is the only ICB in England to have supported voluntary adoption of the Socio Economic Duty (SED). Contained within Section 1 of the Equality Act 2010, but not enacted in England, the duty requires that all public bodies actively consider the way in which their decisions increase or decrease inequalities that arise from socio-economic disadvantage. The ICB board in July 2025 approved a proposal to voluntarily adopt the duty with specific commitments. Adoption of the duty has progressed the commitment in the NHS GM Strategy to "Enhance the Role of NHS GM in Tackling Poverty as a Driver of Poor Health" and contributes to the GM prevention Demonstrator.

SED work to date includes:

- **Visible leadership** – NHS GM has established an SED Implementation Group with senior representation from across the ICB
- **Commissioned strategic partners to support a poverty literate workforce** – 1500 ICP staff trained in poverty literacy by Resolve Poverty and The Shared Health Foundation facilitated a three day deprivation conference.
- **Meaningful impact assessments** - NHS GM include socio-economic disadvantage in all EIAs, alongside the nine protected characteristics in the Equality Act 2010.
- **Shaping a new commissioning framework –** with SED consideration at its centre
- **Poverty Proofing© -** We tested a 'poverty proofing' approach to health and care led by Children North East with plans to scale up across the health and care system in 2026/27

- **Working in partnership with people with lived experience** – The Tackling Poverty Programme has established a People with Lived Experience Reimbursement Fund to support increased co-production.
- **Using data and insights to inform decisions** – analysis of primary care data to identify those 'missing in healthcare' which will inform missingness research and interventions in 2026/27

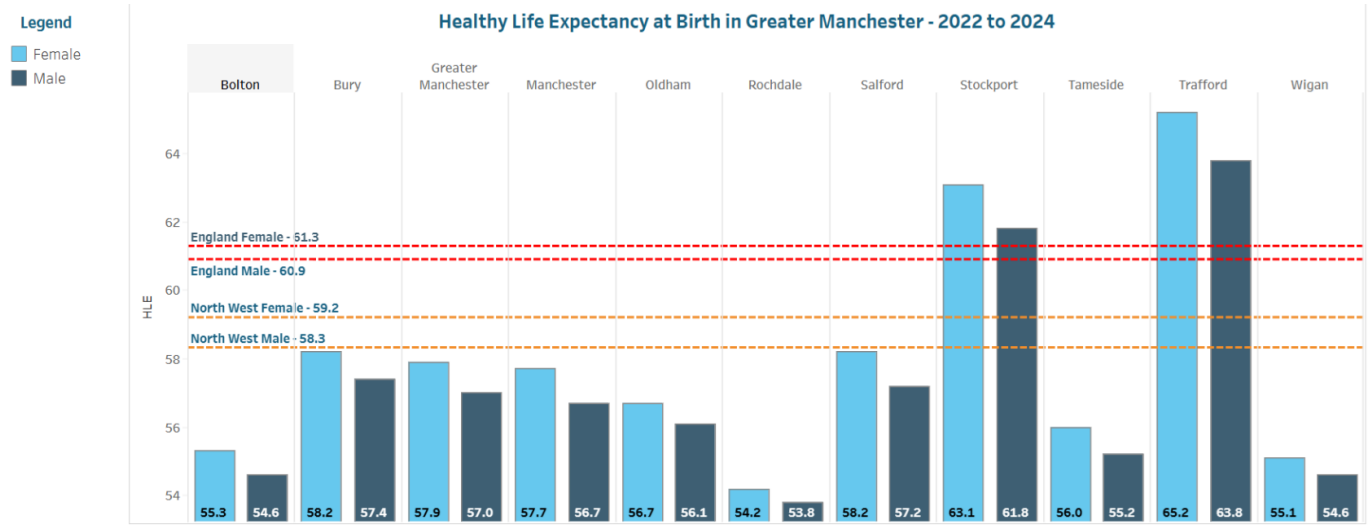
Strengthening the adoption of the socio-economic duty is a business 2026/27 business priority for NHS GM and the Greater Manchester Public Health Network.

Appendix 3.4 Healthy Life Expectancy (HLE) in Greater Manchester

Using the same ONS data to present national picture, key insights about healthy life expectancy in Greater Manchester are as follows:

- HLE for males and females is lower at the GM level, and in 8 out of 10 localities, than the Northwest and England average and there is significant variation across localities. The variation across localities will mask further variation within localities, but the data is insufficiently robust to map that.
- HLE for males in GM is 57 years, 3.9 years below the England average and 9 years below pensionable age. It has fallen from 59.7 years in 2012-14 (-2.7) and from a peak of 60.7 years in 2017-19 (-3.7).
- HLE for females in GM is 57.9 years, 3.4 years below the England average and 8 years below pensionable age. It has fallen from 60.3 years in 2012-14 (-2.4) and from a peak of 61.2 years in 2018-20 (-3.3).
- Males (74% v 77%) and Females (70% v 74%) in GM spend a smaller proportion of their life in good health compared to the England average, and there is wide variation across localities as demonstrated in figure 115.

Appendix Figure A3.1: Variation in Healthy Life Expectancy (HLE) Across Greater Manchester Localities by Sex (2022–2024), with Comparison to England and the North West



Source: NHS Greater Manchester Healthy Life Expectancy Dashboard – GM ADSP

What next for HLE in GM?

GM has previously demonstrated that it can generate a ‘value added’ dividend in relation to health as shown by the independent academic reviews published in 2022 and 2024, which concluded that improvements to population health were driven by a combination of “improvements in health services and wider social determinants of health”, “the allocation of sustainability and transformation funding” and “the alignment of decision-making across health, social care and wider public services”. The improvement in HLE found through the independent research mirrors the ONS data for GM which shows gradual improvements in HLE in GM up to 2018-20 when it peaked and then began to fall. This strong track record, alongside existing strategic priorities such as Live Well, the Prevention Demonstrator and the ambitions set out within the Greater Manchester Strategy, provide a platform upon which to build and once again drive an improvement in the health and wellbeing of our population

Data Limitations: The latest data release has been designated by ONS as “official statistics in

development" due to the underlying APS data losing its status as accredited official statistics, as set out here. The statistical limitations to the data are summarised here. As such, a degree of caution should be applied to the data.

Appendix 3.5 Live Well, Health Literacy, Social Prescribing, Creative Health and Equality Health Impact Assessments

Live Well approach - In the past 12 months Live Well has convened over 2,000 stakeholders in high-profile community-based events, growing a bottom-up movement to reduce inequality and further enhance collaboration between communities and the local public services that serve them. A new Live Well Communities Fund was prototyped, and funded community led health and wellbeing work of 400 community groups, reaching over 13000 in deciding and or benefitting from grants.

Social Prescribing - Social prescribing is a key part of Greater Manchester's approach to reducing health inequalities by connecting people to practical, non-clinical support in their communities. Through a network of link workers embedded in primary care and neighbourhood teams, residents are supported to access services that address wider determinants of health such as housing, debt, loneliness, physical activity and employment. This approach helps people take more control over their health and wellbeing, particularly those in the most deprived communities or experiencing multiple disadvantages. In GM, social prescribing is aligned with the Live Well model and wider VCSFE partnerships, helping to shift care closer to communities and improve access to trusted, culturally appropriate support. Further information on social prescribing services available can be found on the social prescribing page of GMICP website.

Health Literacy Work - NHS Greater Manchester is addressing health inequalities by building a system-wide focus on organisational health literacy, recognising that how services communicate is a key driver of access, safety and experience, rather than an individual's ability to understand information. This is particularly important locally, where around two thirds of residents struggle to understand health information that includes both words and numbers, and where those most affected by inequalities face the greatest barriers. Initial work has focused on establishing a

shared ambition and raising awareness, including convening a cross-system Health Literacy Group and delivering a Greater Manchester Health Literacy training event for senior leaders to highlight the importance of and increase understanding of organisational health literacy.
The GM Health Literacy Group is focused on building a shared, GM-wide understanding of organisational health literacy, aligned with national policy and local priorities, and embedding these principles across health, care and wider public services. Its work centres on promoting clear, accessible and inclusive communication, strengthening co-production with communities, and bringing organisations together to coordinate efforts and share good practice. The group is also supporting the development of workforce skills and confidence in health literacy. By improving how services communicate, NHS GM aims to help residents better understand and use health information, increasing their ability to access services, participate in their care and achieve better outcomes, particularly for those most affected by health inequalities.

Creative Health in Greater Manchester is addressing health inequalities by embedding creative and cultural activity into neighbourhood-level prevention and Live Well approaches, with a clear focus on communities experiencing the greatest disadvantage. Through the GM Creative Health Place Partnership, activity is targeted towards priority cohorts and pressures linked to inequality – including early years and school readiness, older adults with caring responsibilities, neurodivergent young people, and residents affected by multiple disadvantage. By working through trusted local assets such as libraries, family hubs, carers' centres and community venues, creative health interventions reduce practical and psychological barriers to engagement, supporting earlier access to support, improved wellbeing and stronger social connection in communities where traditional services often struggle to reach people effectively.

Equality Health Impact Assessments (EHIA's) - EHIA's sit alongside the tools available as part of the fairer health for all framework, which will enable collation of vast and diverse intelligence, data, and insights from across public VCFSE partners to drive resource and interventions where they are needed most. These tools will build capacity for people, systems, and places and provide strategic insights and collaborative approaches for integrated working. This will ensure we hardwire equity, inclusion and sustainability into our policies, initiatives, and programmes to meet our six Integrated Care Partnership missions and strengthen leadership and accountability. Over

the last year (April 2025 – March 2026) EHIA Rigour Panel have provided insight and guidance to review over 60 EHIAs.

Appendix 4: Abbreviations List

Abbreviation	Full Wording abbreviation stands for
AF	Atrial Fibrillation
CSIL	Cancer Screening Improvement Lead
CVD	Cardiovascular Disease
CYP	Children and Young People
CVNeed	Not an abbreviation but this is a Cardiovascular tool
CVDPrevent	Not an abbreviation but this is a Cardiovascular Disease Prevention Audit
FeNO	Fractional Exhaled Nitric Oxide
FHFA	Fairer Health for All
GM	Greater Manchester
GMADSP	Greater Manchester Analytics and Data Science Platform
GMMH	Greater Manchester Mental Health
GP	General Practitioner
HI	Health inequalities
HLE	Healthy Life Expectancy
ICB	Integrated Care Board
ICP	Integrated Care Partnership
IMD Decile	Index of multiple deprivation decile
InHIP	Innovation for Healthcare Inequalities Programme
IS Providers	Independent Sector Providers
LD	Learning Disability
LSOA	Lower Super Output Area
LTC	Long Term Condition
LTLA	Lower Tier Local Authorities

MI	Myocardial Infarction
MFT	Manchester Foundation Trust
NHSE	NHS England
NPDA data	National Paediatric Diabetes Audit
NW	North West
OHID	Office for Health Improvement and Disparities
ONS	Office National Statistics
PCMIS	Patient care management information system
PCN	Primary Care Network
QRISK	This is a Clinical tool used to estimate the risk of developing cardiovascular disease (CVD) over the next 10 years).
Q1	Quarter 1 (April to end of June)
Q3	Quarter 3 (October to end of December
SMI	Severe Mental Illness
STEMI	ST-elevation myocardial infarction
T1D	Type 1 diabetes
T2D	Type 2 diabetes
VCSE	Voluntary, community and social enterprise
VCSFE	Voluntary, community, social and faith enterprise

END OF REPORT

NHS
Greater Manchester

Health Inequalities Statement 2025/26
Strategic Commissioning Committee Update

Chris Tyson – Assistant Director of Intelligence (Place & Strategic Intelligence)
Khalada Abdullah – Strategic Lead Population Health & Strategy & Equity

NHS Greater Manchester

The Statement turns statutory duty into action

WHAT IT IS **An annual evidence-to-action account of how NHS GM identifies, measures and responds to unfair, avoidable differences in access, experience and outcomes.**

Statutory requirement

- ICBs and NHS bodies must consider and address inequalities in service planning and delivery.
- The legal duty covers inequalities in access to healthcare and in health outcomes.
- The annual statement demonstrates fulfilment of duties and how insight informs local action.

The annual cycle must demonstrate

1. **Understand need** Identify Core20PLUS groups, risk factors and local need.
2. **Disaggregate** At minimum by deprivation, ethnicity, age and sex.
3. **Improve the data** Expose gaps, unknowns and recording weaknesses.
4. **Use the insight** Target commissioning, service delivery and evaluation.
5. **Publish progress** Report transparently and sustain accountability.

HI statement will be published in September 2026 alongside the Annual Plan

NHS Greater Manchester

How we approached the Statement this year

DEVELOPMENT

01 Framework-led

NHS England HI Improvement Metrics, Core20PLUS5 and KLOEs.

02 Multiple sources

National and local data, ONS, dashboards, statutory returns and operational data.

03 Disaggregate

Compare deprivation, ethnicity, age and sex across key outcomes.

04 Triangulation

Programme intelligence, locality insight and service context.

05 Action focus

Link findings to commissioning, delivery, oversight and publication.

06 Matrix working

Led by Population Health, DII and Strategy, working alongside System leads.

NEW CAPABILITY **Index of Disparity added to test equitable improvement.**

This year's constraints

37–99% ethnicity completeness across key datasets

- Missing ethnicity in population segmentation rose from ~11% to >13% in the latest period.
- National datasets lag, may be revised and often cover different time periods.
- Snapshot measures and small numbers can fluctuate or limit disaggregation.
- Coding, definitions and local reporting arrangements reduce comparability.

IMPACT OF REFORM **Loss of capacity, skills and organisational knowledge**

KEY FINDINGS | REMINDER

Deprivation shapes length and quality of life

3.3m+ people registered with GM GP practices

25% of residents live in England's most deprived national decile

9.5 years

male life-expectancy gap

Most vs least deprived communities

7.5 years

female life-expectancy gap

Most vs least deprived communities

57.0 years

male healthy life expectancy

3.9 years below England

57.9 years

female healthy life expectancy

3.4 years below England

THE PATTERN **More deprived places consistently experience shorter lives and fewer years in good health; the relationship is strongest for men.**

NHS Greater Manchester

60+ indicators: A mixed, concerning picture

60+ indicators

Several headline outcomes are worsening and remain worse than England.

5.3 per 1,000	67.1%	8.0%	12.5 per 100k	+22.8%
Infant mortality	**Overweight / obesity**	**Diabetes prevalence**	**Suicide rate**	**Alcohol-specific mortality**
England 4.1	England 64.5%	England 7.7%	England 10.7	2017–19 to 2020–22
Up from 4.9	**Gap widened**	**Up from 7.7%**	**Male rate 19.3**	**Females +26%**

Bottom line: service-level gains have not yet shifted the overall population-health gap.

NHS Greater Manchester

Access is improving — but not equitably

ELECTIVE RECOVERY

Long waits are falling

2.4%

CYP >52 weeks
5.2% → 2.4%

Persistent gradient

10.6% vs 4.0%

DNA — most vs least deprived

URGENT & EMERGENCY

Overall wait improved

5h 34

mean ED wait
−20 min (−5.6%)

Age gap remains

80+

average wait >10 hours

VACCINATION

Broad delivery model

50+

targeted outreach
50+ schemes in 2025/26

Uptake gap is stark

32.2% vs 63.9%

COVID uptake — most vs least deprived

NHS Greater Manchester

Targeted action works — but major gaps persist

Cardiovascular

PROGRESS

>75% controlled hypertension

IoD 6.27 → 4.69

GAP

+78.4%

MI admissions most vs least deprived

Cancer

PROGRESS

60.7% early-stage diagnosis

Now above England

GAP

4.01 pp

deprivation gap in early diagnosis

Mental health

PROGRESS

62.7% SMI physical health checks

Above 60% target

GAP

~4×

MHA detention most vs least deprived

Prevention & inclusion

PROGRESS

85% LD annual health checks

SATOD 3.7% vs England 4.1%

GAP

77% vs 87%

LD check uptake most vs least deprived

NHS Greater Manchester

Next: Turn measurement into targeted action

2026/27 FOCUS

01 Make equity the test

Judge both average improvement and gap reduction.

02 Use disparity

Apply it consistently across programmes and places.

03 Fix demographic data

Improve completeness, linkage and shared definitions.

04 Target prevention

Focus on the pathways and groups with widest gaps.

05 Scale local action

Build on Live Well, Neighbourhood Health, community settings and VCSFE reach.

06 Account for equity

Embed disaggregated outcomes in decisions and oversight.

Leadership implication

Fair improvement — not simply faster.

- Require disaggregated outcomes in performance and commissioning decisions.
- Concentrate resources where the evidence shows the widest avoidable gaps.
- Track whether interventions improve outcomes and narrow inequality over time.
- Strengthen the strategic commissioning health inequalities skills and capability.

Supported by:

Inequalities Data Group to cover integrated needs assessment and HI statement

Neighbourhood Health Plan data group supporting Place Partnership

NHS
Greater Manchester

Climate Change Adaptation Plan (CCAP) – for approval

2 September 2026

Part of Greater Manchester Integrated Care Partnership

Required information	Details
Title of report	Climate Change Adaptation Plan (CCAP) – for approval
Author	Claire Igoe, Associate Director of Sustainability and Estates
Presented by	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
Contact for further information	Claire Igoe claire.igoe@nhs.net
Executive summary	This paper asks for Strategic Commissioning Committee approval for the Climate Change Adaptation Plan 2026 - 2031. Climate change adaptation is a statutory requirement for the healthcare sector under the Health and Care Act 2022 and this plan has been developed on behalf of the healthcare system in GM to prioritise action against the key risks for the health system. The plan has been approved by Chief Officers and it has been agreed that next steps are consideration by SCC and then PRC.
The benefits that the population of Greater Manchester will experience.	The Climate Change Adaptation Plan will improve the resilience of health and care services during extreme weather, helping to maintain safe and timely access to care. It will reduce health risks for vulnerable groups, including older people and those in deprived communities, while strengthening neighbourhood responses and addressing wider determinants such as housing and environment.
How health inequalities will be reduced in Greater Manchester's communities.	The plan addresses widening health inequalities linked to climate exposure. The elderly, the young, populations facing socioeconomic disadvantage and those with chronic illness are particularly vulnerable to the impacts of climate change.
The decision to be made and/or input sought	SCC are asked to: ○ Review and approve the GM NHS Climate Change Adaptation Plan 2026 – 2031 and action plan ○ Provide senior oversight of climate change adaptation being reflected within the SCC portfolio and associated

	governance
How this supports the delivery of the strategy and mitigates the BAF risks	Supports the delivery of SR1: There is a risk that the health of the population will worsen due to wider economic and social conditions deteriorating. This could include societal challenges and structural inequalities that relate to poverty / socio-economic disadvantage, housing and local infrastructure, early years experiences and educational attainment, access to good employment, crime and safety, air quality and transport. This will result in poorer health, unsustainable demand on health and care services and will impede economic growth. Supports delivery of SR9: There is a risk that the ICS system is significantly disrupted due to an emergency e.g. pandemic, major incident, etc. This could result in health services becoming overwhelmed.
Key milestones	Will be embedded within the Green Plan delivery plan.
Leadership and governance arrangements	Green Plan Oversight Group (GPOG) which is chaired by Charlotte Bailey, portfolio holder for environmental sustainability, and reports into PRC.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement with Trust Sustainability Leads, EPRR Leads, Estates Leads, LA and GMCA adaptation leads. GPOG commented on and approved plan in principle - members represent Public Health, Localities, GMCA, Trusts, TfGM, Clinical Leads, Estates Leads, and Procurement Leads. EQIA assessment completed for Green Plan.
Financial or Legal Implications	Climate change adaption is a legal requirement for NHS GM. There are no financial implications directly related to this paper but there are financial implications of not adapting to climate change.

Table 1 - core information relating to the content and creation of paper

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

Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report

Strategic Context

Climate change presents a material and escalating risk to population health and the operational resilience of NHS services. The latest UK Climate Change Risk Assessment (CCRA4, May 2026) identifies health systems and infrastructure amongst the highest residual risk.

Greater Manchester is already experiencing disruption due to climate change, which is projected to intensify. The summer of 2026 has seen five heatwaves so far, with high humidity making conditions particularly uncomfortable, and GM has seen several major incidents declared from wildfires. In June 2026, the Met Office issued red warnings for extreme heat for three consecutive days in the UK for the first time in the history of the current weather warning system, and 2,877 excess deaths occurred because of the May and June heatwaves. Widespread disruption occurred across the NHS, including theatre closure, diagnostics and equipment failure, record A& E attendances, alongside the impact on staff and patients. Our aging healthcare estate is ill-equipped to cope with the increased severity and frequency of extreme weather. The World Weather Attribution (WWA) analysis showed that the June 2026 heatwave would have been virtually impossible without fossil-fuel driven climate change.

Recent national attention has further reinforced the role of climate adaptation within the NHS, with Yvette Cooper recently warning that the NHS needs to prepare for summer pressures in the same way that the NHS has prepared for winter pressures for a long time. Rising temperatures, flooding, infrastructure disruption and changing patterns of demand have implications for service configuration, workforce models, access to care, digital delivery, prevention and health inequalities. As strategic commissioners, NHS GM play a key role in ensuring that commissioned services are resilient.

This should refocus our attention on the actions we should be taking as an ICB to strengthen leadership on this vital agenda. As Lord Darzi noted in his 2024 report, ‘there is no trade-off between climate responsibilities and reduced waiting lists’.

Adaptation focuses on taking proactive measures to manage the unavoidable impacts of climate change to strengthen resilience. This differs from climate change mitigation which focuses on reducing the emissions associated with our activities.

The Climate Change Adaptation Plan responds to the following requirements:

- Statutory duties for ICBs and Trusts under the Climate Change Act 2008, and the Health and Care Act 2022 (noting no change to ICB duties in the forthcoming new Health Bill)
- NHSE 4th Health and Climate Adaptation Report
- GMCA 5 Year Environment Plan, Climate Change Risk Assessment and Climate Change Adaptation Strategy
- Task Force on Climate Related Financial Disclosure (TCFD) Framework which requires mandatory disclosures within annual reports

A comprehensive overview of the main national, GM and international legislative and policy drivers is provided within the full version of the plan.

Development and Engagement Process

NHS Green Plans are the key strategic documents for organisations to discharge their environmental sustainability obligations. These are high-level strategic documents, and it is recognised that due to the nature and technical evidence base associated with some of the content, underpinning plans will be required in some cases. In recognition of this, a commitment to developing a standalone CCAP was made within the NHS GM Green Plan 2025 - 2028.

The development of the CCAP has been an iterative process. The initial scope was to produce a plan for NHS GM, with capacity from a Public Health Registrar used to synthesise the extensive evidence base and develop an initial draft. Once this was shared with the GM NHS trusts, there was a consensus for this to evolve into a system-wide plan. To ensure the plan also reflects any specific site, organisation or asset specific climate risks, an annex has been included within the plan to help guide this process.

Some of the NHS trusts have taken the draft plan through their own governance routes, and we have subsequently received positive feedback about the high-quality content, and the benefits of a collaborative approach.

Extensive engagement took place throughout the development process. We have supported adaptation planning for Manchester Climate Ready and the GMCA, ensuring a strong healthcare voice in the stakeholder engagement process. We led a task and finish group comprising of trust leads which has met regularly throughout the process and collaboratively developed CCAP content. Draft content was also shared with leads at region and national NHSE for review and comment. Consultation and in-principal approval was included within the March Green Plan Oversight Group (GPOG), which includes key internal leads as well as representation from the Public Health Leadership Network, GMCA, NHS Providers and TfGM. Following this, the CCAP was approved by Chief Officers in August.

This stage was delayed slightly due to the publication of the Climate Change Committee's fourth national climate change risk assessment in late May. As these are only produced every 5 years, it was prudent to update the plan accordingly. Whilst there were changes to the national risk assessment including the healthcare context, as well as the number of risks, risk narrative and risk codes, this did not materially alter the original plan and action plan.

Overview of the Climate Change Adaptation Plan

Climate risks span all sectors and systems, with independencies that reach far beyond any single organisation. The plan has been informed by the Climate Change Committee's Independent Assessment of Climate Risk and contextualised for Greater Manchester and the health and care system. The plan aligns to this whole-system perspective, positioning adaptation as part of Greater Manchester's wider resilience approach. From an NHS GM perspective, the action plan is prioritised and pragmatic, reflecting the limited staff resource and the need to make a meaningful contribution to city-region and health system action.

The plan is structured around a GM-wide climate risk assessment, drawing on national and local evidence, and identifying priority risks to population health, service delivery and physical

infrastructure. These risks are translated into a targeted action plan organised across six key domains, including clinical services, estates, supply chain, infrastructure, governance and system capability. Actions are designed to operate at two levels: a set of system-led interventions where a coordinated 'do once' approach adds value, and organisation- and place-based actions which should be embedded within existing organisational delivery mechanisms. This structure supports consistent direction at system level while enabling flexibility in local implementation.

The action plan contains eleven high-level actions which address the risks and opportunities most relevant to the healthcare system in GM, detailed in Appendix 1. The delivery plan will be integrated into existing Green Plan programme management and governance processes. To ensure successful delivery, action will need to be embedded into all relevant portfolios across the organisation, for example, ensuring climate resilience of Neighbourhood Health Centres, integrating adaptation into contracting, assurance and commissioning processes, and ensuring a strong healthcare voice in ensuring housing retrofit programmes are climate resilient.

Recommendations

SCC are asked to:

- Review and approve the GM NHS Climate Change Adaptation Plan 2026 – 2031 and action plan
- Provide senior oversight of climate change adaptation action being reflected within the SCC portfolio and associated governance.

Appendix 1: Executive Summary – GM Climate Change Adaptation Plan 2026 – 2031

Executive Summary

The Greater Manchester (GM) Climate Change Adaptation Plan (CCAP) (2026-2031) sets out a system-wide approach to building the resilience of the healthcare system to the unavoidable impacts of climate change. National evidence published in May 2026 (A Well-Adapted UK, the Fourth Independent Assessment of UK Climate Risk), indicates that current levels of adaptation are insufficient to address the scale of climate risk, reinforcing the need for urgent action.

Climate change adaptation is a statutory requirement for the healthcare sector under the Climate Change Act 2008 and the Health and Care Act 2022 and forms a core component of National Health Service (NHS) Green Plans, which incorporate actions to reduce carbon emissions to limit future climate change as well as adapting to the impacts of climate change that are already locked in. The Climate Change Committee's (2025/26) 'A Well-Adapted UK' report identifies significant gaps in delivery across infrastructure and health.

This plan builds on the summary content in the NHS GM and Trust Green Plans and outlines the healthcare sectors contribution to national and Greater Manchester Combined Authority (GMCA) 5 Year Environment Plan climate change adaptation priorities. It will support delivery of the GM Climate Adaptation Strategy, which is currently in development.

The plan provides an evidence base and prioritises actions to build climate resilience across the GM healthcare system. It identifies risks and opportunities from the GM Climate Change Risk Assessment where the healthcare system needs to take action to respond, setting out measures to protect population health, maintain service continuity and strengthen resilience. National evidence identifies health systems and infrastructure as among highest residual climate risks.

Actions cover six categories:

- clinical services,
- estates,
- supply chain,
- supporting infrastructure,
- engagement and awareness,
- governance and finance.

For each action, the part of the healthcare system responsible for delivery is indicated. Climate change adaptation is an integrated agenda, with action required at all levels from globally through to locally. Investment will be required to deliver against some of the action plan, and there will be opportunities to integrate physical measures into estate redevelopment and refurbishment, as well as considering climate change impacts and opportunities within clinical pathway redesign. Failure to adapt will result in significant financial and social costs, estimated at 2.5% of GM's GDP by the 2050's under current policies. Proactive adaptation, particularly when delivered alongside mitigating measures, will reduce associated financial and social costs, as well as reduce associated health inequalities and improve service resilience.

Climate Change Adaptation Action Plan

This section details the action plan. This contributes to the third overarching goal of the NHS GM Green Plan 2025-2028, and equivalent within Trust Green Plans:

> *"An NHS which is climate-adapted, actively supports nature and health related activities, and promotes interventions that reduce air pollution."*

NHS GM Climate Change Adaptation Plan Actions

The table (Table 1) in this section outlines specific actions, including the system level responsibility, list of partners/stakeholders, and timeline for completion. Actions have been divided into specific areas of operation, one of: Clinical Services, Estates, Supply Chain, Supporting Infrastructure, Engagement and Awareness, Governance and Report, Finance. Each action has been linked to the healthcare specific risks listed in the Climate Change Risk Assessment.

Each action has also been identified as a type of action: one that builds capacity (including creating the environment required for adaptation action, through producing data and research, governance structures and organisational partnerships) or that directly delivers adaptation actions (including actions which directly minimise climate change vulnerability or take advantage of potential opportunities). We recognise further research and insight is required to determine current progress and actions required to deliver the most population benefit.

We have identified the following outcomes as reflecting the purpose of the actions:

- Protecting population health in GM from the present and potential future impacts of climate change and utilise potential benefits.
- Creating a climate resilient healthcare system that is accessible and adaptable in a changing climate, with a robust supply chain with supportive infrastructure that are resilient to climate change.
- Ensuring communities across GM are equipped with the knowledge, skills and resources to adapt to climate change and extreme weather events.
- Provide quality and accessible healthcare during extreme weather, especially to the population groups most vulnerable effects of climate change.

Table 1 - Climate Change Adaptation Action Plan

Action ID	Action	Further Detail	Responsibility	Partners	Timeline	Area of Operations	Relevant Risk Code	Type of Adaptation Action
CCA1	**Build capability of the organisation to adapt and become resilient to the impacts of climate change.**	Effective leadership and governance arrangements, and collaboration across teams and services is key to successful adaptation. The NHSE adaptation framework sets out four capabilities for every organisation, with four maturity stages for each of the capabilities. Organisations should assess themselves against the framework and undertake the recommended tasks to improve, as relevant to their context. Each organisation should set their own target for improvement. Some of the tasks will overlap with other areas of the action plan.	NHS GM, NHS Trusts		2027	Engagement & Awareness	H1, H2, H3, H4, I9, H6, GM-H15	Building Adaptive Capacity
CCA2	**Strengthen partnerships and collaboration between organisations across the system.**	A collaborative multi-stakeholder approach to climate adaptation is essential as no single organisation will hold all of the knowledge, resources and skills. This action involves all partners playing their part in community, locality, city-region and national action. Each organisation should consider the stakeholder landscape in which they operate and how they interface from a healthcare sector perspective to make the most efficient use of available resource and build capacity around adaptation solutions using coproduction principles.	System wide	VCFSE Sector, 10GM, GMCA, LAs	Ongoing	Governance & Finance	H1, H2, H3, H4, H6, GM-H15, E3, E8	Building Adaptive Capacity
CCA3	**Integrate climate vulnerability intelligence and improve understanding of climate risks within prevention activities and clinical services.**	This requires strengthening the understanding and ability of services and staff to respond to climate related health risks by utilising and embedding climate vulnerability data and building the understanding of staff that work with the most vulnerable groups. Climate vulnerability datasets can be incorporated into the GM Health and Care Intelligence Hub, prevention programmes can include climate related risk considerations, and training and resources can be promoted to staff working with high-risk groups.	System wide	NHS GM, Trusts, Primary Care, Clinical teams, NHSE	2027	Clinical Services	H1, H2, H3, H6, GM-H15, BE9	Building Adaptive Capacity

CCA4	**Monitor the impact of extreme weather events on the healthcare sector, utilising and improving existing information and metrics.**	Whilst preparedness should take priority, logging details of specific events builds an evidence base of the consequences of climate change for the healthcare sector and helps build the business case for adaptation. Trusts already report overheating events through the ERIC (Estates Returns Information Collection) data returns although there are inconsistencies. Monitoring hospital admissions and excess deaths from heatwaves provides additional context to specific events and flooding incidents can be reviewed for both direct and indirect consequences for the sector.	NHS GM Sustainability Team	Trusts, UKHSA, EPRR teams	Ongoing	Clinical Services	H1, H2, H6, GM-H15, E4	Building Adaptive Capacity
CCA5	**Support research opportunities aimed to increase health system climate resilience and understanding of climate change impacts.**	This requires proactively providing health sector input into transdisciplinary research and innovation from across the GM system and beyond around Climate Change Adaptation and Health System Resilience. This will include knowledge exchange, sharing of data and providing support for and input into specific programmes. This is essential to inform policy, shape action and address gaps in the understanding of climate issues. Where there is a significant time ask, this will require assessment of available capacity and priorities.	NHS GM, Trusts	GMCA, NIHR Research Hubs, Health Innovation Manchester, Universities	Ongoing	Clinical Services	H1, H2, H6, GM-H15, BE4, BE9	Building Adaptive Capacity
CCA6	**Undertake flood risk assessments across the NHS estate, prioritising sites where there are known vulnerabilities.**	Flooding is a key risk from climate change and greater assessment of the vulnerability of our estates is required to understand and mitigate this risk, to determine potential impacts on healthcare access and delivery. A wide range of spatial datasets are available to highlight geographical areas and social vulnerabilities where there is a higher risk of flooding which requires concerted action to address. Delivery of measures to address identified issues will be required across a range of stakeholders.	NHS Trusts NHS GM Sustainability Team (Primary Care).	GMCA, LAs, Environment Agency, NHSPS, CHP and Primary Care Networks, Estates Teams	2026	Estates	H1, H6, BE2, I9, E4	Building Adaptive Capacity
CCA7	**Identify and deliver nature-based solutions on high-risk healthcare sites**	Biodiversity Net Gain (BNG) is a statutory requirement and the GMCA Local Nature Recovery Strategy (LNRS) is the statutory strategy across all ten districts, with climate adaptation stated as one of its purposes. Nature based and SuDS	NHS Trusts and Primary Care	GMCA, LAs	Ongoing	Estates	H1, H6, BE2, I9, E4	Delivering Adaptation Action

	to reduce vulnerability to the current and expected impacts of climate change.	(Sustainable Urban Drainage Systems) solutions provide shading, cooling and water management functions to reduce vulnerability. They have broader co-benefits such as providing amenity spaces, sequestering carbon, reducing noise and supporting local biodiversity. This action applies to both planned enhancement of existing outdoor areas and new developments to provide functional green spaces that enhance resilience, moving from ornamental green spaces to those that provide a range of ecosystem services, as part of complying with statutory planning requirements.						
CCA8	**Identify and deliver healthcare building adaptations to reduce vulnerability to the current and predicted impacts of climate change.**	Building level interventions can help users cope with extreme weather events. For example, reflective surfaces and shading, improved insulation and passive cooling deliver both net zero and adaptation outcomes. Paved surfaces can be replaced with permeable to help manage stormwater. Measures should be considered as part of both building refurbishment and new developments (larger new developments will need to comply with the NHS Net Zero Building Standard). Measures can address particularly vulnerable areas – e.g. medicines storage facilities or whole buildings. Several Health Building Notes (HBN's) are relevant to this action e.g. HBN 00-07 which focuses on a resilient estate.	NHS Trusts and Primary Care	GMCA, LAs	2027	Estates	H1, H6, BE2, BE4, I9, E4	Building Adaptive Capacity
CCA9	**Integrate climate adaptation into strategic commissioning process.**	As the Strategic Commissioner, NHS GM has a role to play in considering climate adaptation in the commissioning of services and ensuring that providers have taken steps to adapt to the current and predicated impacts and not just mitigate their emissions. This action requires considering the whole strategic commissioning cycle and working with commissioners to integrate adaptation considerations into the process. It is anticipated that this will be delivered in a phased manner, and there are interdependencies with national policy, frameworks and training.	NHS GM	NHSE	2027	Clinical Services	H6, GM-H15, I1, BE2, I8	Building Adaptive Capacity

CCA10	**Improve understanding of climate-related supply chain disruptions and use to inform action.**	Climate related supply chain disruption will increasingly impact the supply of raw materials, manufacturing and distribution of critical healthcare supplies, compounding existing geopolitical and economic risks. Whilst the assessment of risks and solutions will be led by other organisations, for example, NHS Supply Chain, climate risk should be integrated into local policy and processes. There is an interface with other Green Plan priorities – for example, adopting circular economy principles in relevant procurements reduces the vulnerability to disruptions to the supply of single use products.	GM NHS Procurement Team	NHSE, GMCA, TfGM, LAs	2026	Supply Chain & Supporting Infrastructure	H6, E3, I1, BE2, I8	Building Adaptive Capacity
CCA11	**Improve understanding of financial support available for adaptation measures.**	Whilst some climate adaptation actions require limited resources, others require substantial financial investment across the system. This action focuses on building the understanding of financing options available and promoting key opportunities.	NHS GM, System wide	GMCA	Ongoing	Governance & Finance	H1, H3, H4, H5, I9, GM-H15, I1, BE2, I2, I5	Building Adaptive Capacity

Forward Plan Public Meeting

Area / Item	September	October	November	December	January	February	March	April	May	June
Standing Items										
Apologies for Absence and Quoracy	X	X	X	X	X	X	X	X	X	X
Declarations of Interest	X	X	X	X	X	X	X	X	X	X
Matters Arising, Action Log & Minutes of Last Meeting	X	X	X	X	X	X	X	X	X	X
Forward Plan Review (at end of meeting in preparation for the next one)	X	X	X	X	X	X	X	X	X	X
Governance and Committee Effectiveness										
Terms of Reference Review	X					X				
Review Committee Priorities							X			
Committee Review of Effectiveness							X			
Thematic Areas - Strategic										
Delivery of Mental Health and Well Being Strategy priorities		X						X		
Delivery of Clinical Strategy				X						
Maternity						X				
Strategic Commissioning Framework for Neighbourhood Health	X									
Live Well Annual Delivery Plan						X				
Neighbourhood Health Plans 2027/28							X			
5-Year Commissioning Plan Progress		X						X		
Clinical Portfolio Statutory Reports										
Chief Clinical Officer Report	X	X	X	X	X	X	X	X	X	X
Safeguarding Adults Partnership Annual Report				X						
Health Protection & Outbreak Management - Statutory Responsibilities Update			X						X	
S7a Public Health Commissioning - Statutory Responsibilities Update			X						X	
Research Annual Report				X						
Caldicott Annual Report					X					
LeDeR Annual Report						X				
Commissioning										
Chief Clinical Officer Report	X	X	X	X	X	X	X	X	X	X
Annual Commissioning Strategy Delivery Plan (including clinical strategy)										
Commissioning Strategy & Intentions	X		X		X		X		X	
All Age Continuing Health Care		X			X			X		
Procurement Pipeline & Major Commissioning Decisions	X	X	X	X	X	X	X	X	X	X
SEND Inspection Outcome Reports (as and when required)	X	X	X	X	X	X	X	X	X	X
System Reform and Improvement										
Chief System Reform and Improvement Officer Report	X	X	X	X	X	X	X	X	X	X
Integrated Performance and Quality Report	X	X	X	X	X	X	X	X	X	X
Annual Planning (timings subject to national timescales)		X		X			X			
Year End Position of NHS Oversight Framework (NOF)										X
EPRR Annual Assurance & Winter Readiness			X			X				
Digital Strategy Approval (PRC also)			X							
Data Assurance Briefing (PRC also)		X								
Digital and Data Annual Review (PRC also)				X						
Strategy, People and Partnerships (including Population Health)										
Chief Strategy, People and Partnerships Officer Report	X	X	X	X	X	X	X	X	X	X
Population Health Activity & Impact Update covering the full breadth of ICB Population Health Activity		X								
Population Health Investment Standard Feasibility Assessment (February 2027)						X				
GM Prevention Demonstrator Quarterly Update		X		X			X			
Population Health & Inequalities Deep Dive and implication for strategic commissioning and operational planning	X									
GM Public Health Network Transformation	X			X			X			
Socio-Economic Duty: Work to date and next steps										
Public Engagement Annual Report 2025/26		X								
VCSE Engagement Model		X			X					
Other										
BAF and Risk Register - Assurance	X		X		X		X		X	
Mersey Internal Audit Agency Reports (as and when required)	X	X	X	X	X	X	X	X	X	X