

Agenda

Greater Manchester Strategic Commissioning Committee (Public)

Date: 7 October 2026

Time: 14:45-16:45

Venue: MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:45	5 mins	Welcome, Introductions and Apologies received –	Verbal	Information	Dame Sue Bailey <i>Chair</i>
2.			Attendance Matrix & Terms of Reference on a Page	Paper		
3.			Declarations of Interest	Paper	Noting	
			Minutes, matters arising and actions from previous meeting held on 2 September 2026	Paper	Approval	
Strategic Updates						
4.	14:50	10 mins	Chief Officers Update Reports:	Paper	Discussion	Manisha Kumar, <i>Chief Clinical Officer</i> Katherine Sheerin, <i>Chief Commissioning Officer</i> Nicola Hepburn, <i>Acting Chief Reform and Improvement Officer</i> Charlotte Bailey, <i>Chief Strategy, People and Partnerships Officer – Population Health / Place</i>
	15:00	10 mins	Chief Clinical Officer Report			
	15:10	10 mins	Chief Commissioning Officer Report			
	15:20	10 mins	Chief Reform and Improvement Officer Report			
5.	15:30	15 mins	Chief Strategy, People and Partnerships Report			
5.	15:30	15 mins	Performance Report	Paper	Information	Nicola Hepburn, <i>Acting Chief Reform and Improvement Officer</i>
6.	15:45	15 mins	5-Year Commissioning Plan Progress and Commissioning Intentions – From the Forward Plan	Paper	Information	Katherine Sheerin, <i>Chief Commissioning Officer</i>

7.	16:00	15 mins	Quality Assurance Process	Presentation	Information	Claire Smith <i>Associate Director Nursing & Quality Assurance</i>
8.	16:15	10 mins	Thirlwall Inquiry	Paper	Information	Sarah Owen <i>Associate Director Maternity (ICB/LMNS)</i>
9.	16:25	15 mins	SCC Forward Plan	Paper	Information	Dame Sue Bailey <i>Chair</i>
For Information						
	16:40	5 mins	Any other business	Verbal	Discussion	All
			Board Paper Escalations			
			Meeting Reflections			
Date and time of next meeting:						
Wednesday 4 November 2026						

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	Sep-26	Oct-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 Heppollette	Prevention Demonstrator Director, GMCA							
Stephen Downs	Deputy Chief Finance Officer				Deputising for Kathy Roe		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							
Laura French	Public Health Consultant							
Chris Tyson	Assistant Director of Intelligence (Place & Strategic Intelligence)							
Claire Igoe	Associate Director of Sustainability and Estates							
Claire Smith	Associate Director Nursing & Quality Assurance							
Jo Street	Programme Director- Transition						Deputising for Charlotte Bailey	

Terms of Reference on a page



Greater Manchester

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

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To	
Bailey, Ms. Charlotte Elizabeth	Y			Nil				
Kumar, Dr Manisha	Y	Financial Interest	Outside employment	Salaried GP at the Robert Darbishire Practice - 1 session per week		2004	Ongoing	
Kumar, Dr Manisha	Y	Non-financial professional interest	Loyalty interests	Honorary Professor University of Salford		01/05/2023	Ongoing	
Kumar, Dr Manisha	Y	Non-financial personal interest	Loyalty interests	Husband has the following roles: • Operations Director - Primary Eye Care Services LTD • Case Examiner – General Optical Council		2021 2019	Ongoing	
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son works in the finance department at Tameside and Glossop NHS Foundation Trust.		14/10/2024	Ongoing	
Hepburn, Mrs. Nicola	Y	Financial interests	Clinical private practice	From 29 April 2025 I have been an associate clinical nurse assessor for MHS clinical services. MHS often complete work for MIAA. I do not complete any work on behalf of MHS across Greater Manchester or work commissioned by NHS GM. I complete all work via my own personal company outside of my contracted substantive role.		29/04/2025	Ongoing	
Hepburn, Mrs. Nicola	Y	Non-financial professional interest	Outside employment	I am a volunteer Clinical Board Advisor for Now Your Talking a talking based National therapy service.		07/10/2025	Ongoing	
Sheerin, Mrs. Katherine Mary (Katherine)	Y	Non-financial professional interest	Loyalty interests	Trustee and Deputy Chair of the Board of the The Whitechapel Centre, a charity which works to prevent homelessness and support people who are homeless, operating across the Liverpool City Region.	This is a voluntary role with no remuneration or expenses paid.	01/01/2025	Ongoing	
Non-Executive Directors		Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
Bailey, Dr Susan Mary	Y	Financial Interest	Outside employment	Independent NED on the board of 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	Col Date From	Col Date To
Vallance, Leigh	Y	Financial interest	Outside employment	CEO of Bolton Hospice which is part funded by an NHS Grant		2023	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	As Chair of Bolton CVS, (a voluntary sector infrastructure body) who are in receipt of NHS funding		Ongoing	

Minutes

Greater Manchester Strategic Commissioning Committee

Date: 2 September 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present		Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Rachel Egan (RE) – Non-Executive Director (Deputy Chair) Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Prof. Manisha Kumar (MK) – Chief Clinical Officer Leigh Vallance (LV) – VCSE Partner Member Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer Laura French (LF) – Public Health Consultant Chris Tyson (CT) – Assistant Director of Intelligence (Place & Strategic Intelligence) (item 6) Claire Igoe (CI) – Associate Director of Sustainability and Estates (item 8) Claire Smith (CS) - Associate Director Nursing & Quality Assurance Jo Street (JS) - Programme Director- Transition, deputising for Charlotte Bailey Stephen Downs (SD) - Deputy Chief Finance Officer, deputising for Kathy Roe Faye Vaughan (FV) – Governance Advisor (Minutes)		Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer / Acting Deputy Chief Executive
Item No.	Topic	Action
1.	Welcome, Introductions and Apologies SB welcomed everyone to the meeting, introductions were made, and the above apologies were noted.	
2.	Declarations of Interest SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	

3.	Minutes from the previous meeting held on Wednesday 5 August 2026 The minutes were accepted as a true record of the previous meeting held on 5 August 2026.	
4.	Chief Officers Update Reports: <u>Chief Clinical Officer Report:</u> The NHS Greater Manchester Chief Clinical Officer Report provided an update on key clinical governance, quality, patient safety and system improvement matters across the region, emphasising ongoing oversight and assurance activities. It highlighted areas that required attention and approval through the Alert, Advise, and Assure framework. MK reported on the main alerts in the report: • Northern Care Alliance: It was confirmed that a further update would be provided at Octobers meeting. A detailed paper would also be provided in the private part of the meeting to assure the committee on the oversight and plans in place on how concerns in the media would be addressed. • Laureate House: It was reported that the closure of Laureate House had removed approximately 19 beds that could not be repurposed. It was confirmed that NHS Greater Manchester were working with Greater Manchester Mental Health through provider oversight to understand the effect on patients and consider a less bed-based model aligned with strategic intent. • Health Protection Planning: It was explained that local authorities had reviewed jointly owned local outbreak plans to look at how outbreaks and incidents would be managed. It was reported that NHSE had provided new commissioning guidance the previous year on how the ICB should commission outbreaks and incidents. The committee were further made aware of the work with UKHSA and local authority public health teams. It was explained that Pan GM arrangements would also be reviewed including high consequence infectious disease arrangements in partnership with UKHSA. The committee were provided with assurance that they were making sure that they had the ability to put all the elements of outbreak response in place across all localities over the winter period. • HPV Self-Sampling: The committee were made aware of the Greater Manchester rollout of HPV self-testing as an opportunity to address deprivation and ethnicity gaps in cervical screening. The approach was intended to identify people at higher risk and concentrate on follow-up support on those who test positive. • Weight Loss Medicines: It was confirmed that Tirzepatide had received financial oversight and had been considered by the Primary Care Commissioning Committee and Chief Officers. It was reported that Greater Manchester had previously used a highest-BMI-first call-in model to reduce inequity but would follow national cohorts one and two this year while commissioning clinical audit to check eligibility, NICE-aligned prescribing and whether the rollout widened health inequalities. 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 required committee	

	approval. • Noted the remaining items progressed through established governance routes. <u>Chief Commissioning Officer Report:</u> The paper set out the key issues for Alert, Advise, Assurance and Achievement from the Healthcare Commissioning Directorate. It was explained that the commissioning intentions described the material changes proposed for 2027–28 and should be presented as one component of delivering the five-year strategic commissioning plan. The four strategic goals were reported as neighbourhood delivery, improved outcomes and reduced inequalities, system transformation and fulfilment of statutory duties. The full organisational contribution would be set out in the 2027–28 operational delivery plan. KS further explained that the commissioning-intentions needed stronger emphasis on securing and improving the quality of commissioned services. It was reported that quality should be included more explicitly when assessing expected impact, alongside the changes, outcomes and metrics used to evaluate each intention. The committee were informed of the current GP Action alert concerns with awareness raised through posters and communications with patients, MPs and local politicians, without direct service-delivery impacted at present. It was confirmed that teams were monitoring cumulative effects and would intervene if earlier actions began to materially affect services. It was reported that NHS Greater Manchester were not meeting the national 28-day and 62-day cancer targets. It was confirmed that the issue would be discussed with Cancer Alliance working with providers on recovery plans, while early-diagnosis performance remained comparatively strong. 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 informed the committee of the performance concerns at Bolton, Wrightington, Wigan and Leigh and the Northern Care Alliance, linked to theatre availability and the ability to complete planned activity. It was confirmed that operational teams were developing realistic recovery plans intended to return delivery to the original plan by the end of Q4. The committee were also made aware of waiting-list demand at MFT initially appeared to have increased by 20%, but joint review found that the principal issue was reporting. The verified activity increase was approximately 4%. It was confirmed that the position was improving week by week. It was reported that some providers were more than 15% below their four-hour plan after the Q2 review, while others were on or close to plan. It was confirmed that teams were working with Trusts, Primary Care, Community Services and out-of-hospital partners to reduce demand, with early improvement including a 4% year-on-year reduction in ambulance demand in the latest week.	
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	The committee were informed that Greater Manchester remained the highest-performing ICB nationally for the 31-day cancer measure. It was explained that the 28-day and 62-day results could fluctuate because mutual aid affected how activity and patients were counted, but auditable actions and continued work with ambulance and secondary-care providers were in place. It was reported that digital and IT risks remained visible in the risk report and that MIAA audit work plans were now held as a portfolio. It was confirmed that management reviews were underway, with outputs expected to return through committees in October 2026. The committee requested early warning if performance trajectories moved further off plan and noted that a Board Development Session on Data and IT was expected later on in the year. The Committee: • Noted the report and the position as of M5. <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. • Place Partnerships: It was explained that NHS Greater Manchester was working with Foundation Trusts and Councils that would host partnership teams and place boards. The committee were made aware that feedback on the operating-document suite closed after a six-week engagement period and a four-week sprint would take place to convert the feedback into final documents. The place-partnership documents were currently expected to complete the approval routes of each partnership in October and be taken to the NHS Greater Manchester Board in November 2026. • Neighbourhood Health Progress: It was reported that Regional NHS colleagues endorsed neighbourhood health as the organising principle for Greater Manchester's long-term transformation and strategic commissioning plan. The committee were informed that localities were updating neighbourhood health plans to reflect the approved commissioning framework. It was confirmed that the maturity self-assessments had been completed across all 10 places and partner engagement, which included a Primary-Care round table to inform the response to the national consultation on multi-neighbourhood and single-neighbourhood providers. The committee questioned when reporting would move from structural reform activity to measurable impact on population health and inequalities. It was confirmed that the next report would include more detail from the maturity assessment and that a governance, accountability and oversight framework was being developed to compare learning across the 10 places, scale effective practice and allow warranted variation according to local context. KS proposed that the 2027–28 operational delivery plan include a concise contribution plan from each place, showing how it would support strategic objectives and national outcomes-framework metrics.	
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	LV asked for a simple and efficient way to ensure that the whole workforce understood the direction of travel for place partnerships and neighbourhood health, noting uneven awareness among statutory and sector partners. ACTION: JS to develop a clear mechanism for keeping the wider workforce informed about the direction, purpose and operating model of place partnerships and neighbourhood health. The Committee: • Noted the report.	JS
5.	Performance Report This report provided an update on Greater Manchester's progress in achieving NHS operational planning goals and outlined significant risks faced by our providers along with key improvement actions. The committee were provided with the following updates: • Urgent & Emergency Care: Remained challenging, however, it was reported that the team were starting to see impact. • Cancer: Challenges remained from Cancer Alliance. NH explained that GM ICB remained the highest performing ICB. The committee were informed of the work that had taken place to capture patients with treatments that had continued to improve. • Ambulance Service and Secondary Care Providers: The committee were informed that they were one of the strongest in performing. MK described transformation work to address inappropriate inpatient use, inconsistent community provision and data gaps across mental health, learning disability, autism and ADHD, with members seeking clearer expectations for therapeutic care and discharge readiness. The committee were provided with partial assurance. The Committee: • Noted the report.	
6.	Greater Manchester Health Inequalities Statement 2025/26 - Commissioning Committee update This report presented NHS Greater Manchester's 2025/26 Health Inequalities Statement, setting out how the ICB had met its statutory duties to reduce inequalities in access, experience and outcomes. It summarised population need, key inequalities trends and performance against NHS England's Health Inequalities Improvement Metrics, aligned to CORE20PLUS5. The report showed 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. It was explained that ICBs and providers must publish an annual health inequalities statement alongside their annual reports, supported by an integrated needs assessment each March. The committee approved the 2025–26 statement for publication on the NHS Greater Manchester website alongside the annual plan in September and supported continued system action to reduce inequalities in	

	access, experience and outcomes, particularly for CORE20PLUS5 groups and deprived communities. The statement used an NHS England framework, CORE20PLUS5 measures, national and local data, ONS dashboards, statutory returns and operational information. Data was disaggregated at minimum by deprivation, ethnicity, age and sex, triangulated with programme and locality intelligence and linked to commissioning, delivery, oversight and evaluation. CT identified incomplete and inconsistent ethnicity coding across datasets, with variation across maternity, mental health and hospital data, alongside national-data delays, revisions, differing time periods, small numbers and inconsistent definitions. It was confirmed that the team were working with providers to improve completeness, linkage and shared definitions and was seeking more timely analysis from the ADSP. The information continued to show substantial deprivation-related differences in life expectancy and healthy life expectancy, with the strongest relationship among men. CT also reported mixed or concerning trends in infant mortality, overweight and obesity, diabetes prevalence, suicide and alcohol-specific mortality, indicating that service-level improvements had not yet closed the wider population-health gap. It was explained that the 2026–27 focus would be to judge both average improvement and gap reduction, apply the disparity index consistently, target prevention where gaps were widest, scale local and voluntary-sector action and embed disaggregated outcomes in commissioning and performance oversight. The committee suggested that Chief Officers check that each programme used the relevant inequality data when shaping actions, provider relationships, transformation and commissioning intentions. A suggestion was raised for teams to be required to explain what they would do about the findings and distinguish leading indicators, such as health checks, from ultimate outcomes such as improved life expectancy. JS offered to take the statement to a leadership briefing and connect it to organisational-development and commissioning-academy work. ACTION: JS to work with CT to include item in communications to staff, through Live Leadership Briefing, Keep Connected and a dedicated section on the Intranet focused on Health Inequalities. The Committee: • Noted the 2025/26 Health Inequalities Statement and the key inequalities identified across Greater Manchester. • Supported continued system action to reduce inequalities in access, experience and outcomes, particularly for the most deprived communities and CORE20PLUS5 population groups. • Supported continued system action to reduce inequalities in access, experience and outcomes, particularly for the most deprived communities and CORE20PLUS5 population groups. • Approved publication of the statement on NHS GM website alongside the Annual Plan.	JS / CT
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7.	National Quality Strategy CS informed the committee that the strategy was not a quality-team or nursing-only directive, it required an organisation-wide approach across safety, effectiveness and experience. Priorities included improving outcomes, reducing variation and inequalities, strengthening patient and population experience and trust and applying patient-safety approaches across settings. The strategy required commissioning decisions to use population-need data and make outcomes visible. It was explained that patient, carer, staff and community voice should inform decisions, contractual governance, contractual assurance and patient-safety measures. A proposed 30-, 60- and 90-day process would map current quality and safety arrangements to the three national domains, review core, contractual and system quality governance Terms of Reference and agree a coherent NHS Greater Manchester narrative for quality as an organising principle.	
8.	Climate Change Adaptation Plan (CCAP) This paper reported on the plan for climate change adaptation as a statutory requirement for the healthcare sector under the Health and Care Act 2022 which had been developed on behalf of the healthcare system in GM to prioritise action against the key risks for the health system. JS explained that climate adaptation was a statutory ICB responsibility and that the plan was co-produced with provider partners. It addressed mitigation of climate-change impacts on services, distinct from the Green Plan's focus on tackling climate change itself and therefore required oversight through commissioning and provider quality assurance. CI reported that Greater Manchester experienced five heatwaves and wildfires during the summer, with widespread health and public-health effects. The plan was made system-wide at the request of Trusts and was aligned with GMCA, Transport for Greater Manchester and other partners. The pragmatic plan contained eleven high-level actions for system partners. It was explained that it should be embedded throughout strategic commissioning because resilience concerns extend beyond buildings to supply chains and service continuity, with local ownership required across partners. The committee discussed what measures were funded, what was unfunded and where the gaps were. CI clarified that NHS Greater Manchester generally leased rather than owned estates, so building resilience was often the provider or landlord's responsibility, but service disruption could create indirect costs for the ICB. SD asked how cooling buildings would be reconciled with carbon-reduction objectives. CI explained that refrigerants have different global-warming potentials and that lower-impact options exist, while adaptation should also use lower-cost measures such as shading and ventilation. It was identified that universal air-conditioning was neither affordable nor necessarily feasible. MK asked for systematic learning before the next summer on which people with long-term conditions were affected by heat, why emergency-department demand changed and what advice should be provided.	

	The Committee: - Reviewed and approved the GM NHS Climate Change Adaptation Plan 2026 – 2031 and action plan. - Provided senior oversight of climate change adaptation being reflected within the SCC portfolio and associated governance.	
9.	SCC Forward Plan The committee reviewed the readable SCC forward plan, identified the need to distinguish strategic from operational business and track deferred items and agreed governance changes to reduce the risk of agenda items being lost. KS explained that several items marked as monthly would only arise as needed, such as inspection outcomes, procurement pipelines and major commissioning decisions. It was agreed that many updates could be incorporated into Chief Officers' reports, with standalone papers reserved for matters that required detailed treatment. KS suggested placing the forward plan at the beginning of each committee meeting so members could agree whether items should be deferred, brought forward or otherwise adjusted. The committee requested a discussion to take place in the private part of Octobers meeting to discuss agenda prioritisation to ensure strategic items were sufficiently prioritised over operational matters.	
10.	Any other business The committee discussed how they could support colleagues who attend future meeting to present their items to the 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 Boulder supporting.
SCC-08	02/09/2026	4. Chief Officers Update Reports - Chief Strategy, People and Partnerships Report	Request raised to ensure a simple, efficient way to ensure the whole workforce understands the direction of travel.	JS to develop a clear mechanism for keeping the wider workforce informed about the direction, purpose and operating model of Place Partnerships and Neighbourhood Health.	Jo Street	07/10/2026	Closed	08/09: Action has been followed up by Jo.
SCC-09	02/09/2026	6. Greater Manchester Health Inequalities Statement 2025/26 - Commissioning Committee update	Offer from JS to support CT to ensure paper is visible throughout the organisation.	JS to work with CT to include item in communications to staff, through Live Leadership Briefing, Keep Connected and a dedicated section on the Intranet focused on Health Inequalities.	Jo Street	07/10/2026	Closed	03/09: CT to link in with Lindsay Kirby and Kay Wilkes.

Completed at Previous Meeting (Audit Trail)

Completed at Previous Meeting (Audit Trail)

Chief Clinical Officer Report

October 2026

NHS Greater Manchester Strategic Commissioning Committee

October 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 Sarah Owen, Associate Director Maternity Sarah Owen, Associate Director Safeguarding and Nursing Claire Smith, Associate Director Nursing and Quality Assurance Claire Foster, Deputy Chief Pharmacist Kate Provan, Associate Director Clinical Governance and Improvement Waseem Khan, Assistant Director Quality and Safety Tina Mistry, Interim Assistant Director Medicines & Pharmacy - Clinical Standards and Population Health Heather Myers, Head of Clinical Effectiveness and Governance
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive summary	The Chief Clinical Officer Report provides an integrated update on clinical governance, quality, patient safety, safeguarding, medicines and system improvement across Greater Manchester. It identifies significant concerns requiring sustained oversight at Northern Care Alliance, Wrightington, Wigan and Leigh, and Greater Manchester Mental Health, alongside emerging implementation and capacity pressures across maternity, safeguarding, community pharmacy, hospices and medicines. - Alerts relate to concerns about the safety, resilience and sustainability of WWL's homebirth service and formal NHS England undertakings and CQC action arising from sustained quality governance failures at NCA. - Advice includes the hospice capacity dashboard, the new regional maternity assurance model, community pharmacy prescribing, Families First Partnership reforms and continued oversight of quality, workforce and operational pressures across GM providers. - Assurance is provided on safeguarding business continuity, management of Section 29A warning notices, completion of 2025/26 Provider Quality Account scrutiny and clinical governance decisions progressed through CEG. - The risks raised reinforce corporate risks CCPL09A, CCPL09B

	and CCPL17; no new evidence is reported for the paediatric audiology risk. SCC approval is requested for specified medicines, programme and clinical governance recommendations.
The benefits that the population of Greater Manchester will experience.	NHS GM's statutory quality and clinical governance functions support people across Greater Manchester to experience safe, effective and continuously improving services. Through targeted quality improvement, strengthened oversight and refreshed governance pathways, the system is better able to identify risks earlier, intervene more consistently and reduce unwarranted variation. This directly supports improved experience and outcomes for patients and communities.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy, including early identification of inequality-related risks in urgent care, mental health, medicines optimisation and system improvement programmes. It supports more consistent governance and escalation, helping to reduce unwarranted variation and strengthen equitable access and outcomes across Greater Manchester.
The decision to be made and/or input sought	The Committee is asked to • Note the contents of the Chief Clinical Officer Report. • Approve the items 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.
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 oversight of quality, safety, safeguarding, medicines optimisation, prevention and system improvement. The risks raised reinforce CCPL09A through workforce and specialist capacity pressures; CCPL09B through variation in governance, clinical challenge, risk identification and escalation; and CCPL17 through maternity assurance requirements, WWL homebirth concerns and unresolved LMNS capacity, hosting and accountability. Current controls and escalation arrangements mitigate these risks, although residual exposure remains where improvement is not yet embedded or evidenced as sustainable.
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;	Financial, legal and regulatory implications are set out within the relevant sections of the report. These principally relate to medicines and formulary decisions, delivery of statutory quality and safeguarding responsibilities, and oversight of current regulatory action. Any associated funding, legal advice or approval will be managed through established governance routes; no additional implications requiring separate Committee action have been identified.

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

Alert

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

Through routine quality and safety oversight, the Greater Manchester Local Maternity and Neonatal System (LMNS) identified concerns regarding the safety, resilience and sustainability of WWL's commissioned homebirth service. These related to repeated periods of service suspension, limited intrapartum exposure and variable confidence within parts of the community midwifery workforce, and audit findings demonstrating inconsistency in aspects of safe intrapartum care.

WWL midwifery leaders have provided reassurance that the service is currently being supported by a cohort of community midwives confident to provide homebirth care, and the service has subsequently experienced significantly fewer interruptions to availability. A wider programme of improvement remains underway, including workforce development, enhanced training and monitoring arrangements, and changes to equipment, medication and workforce models.

The remaining concern relates to the resilience and sustainability of these arrangements, particularly the reliance on a relatively small cohort of community midwives to maintain the service. The concern therefore remains within the ICB Contract Quality Escalation Mechanism and will continue to be monitored through the Quality Review Meeting process to oversee delivery of the improvement programme and evidence of sustained improvement.

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

Risk Identified — ICB Governance, Care Quality Commission (CQC) oversight and NHS England have determined that the Trust is experiencing a *fundamental failure of quality governance*, with sustained concerns over 18 months relating to spinal surgery, gynaecology, and surgical wards. The CQC cited significant concerns about the trust's management of risk, patient safety, complaints, freedom to speak up processes and workforce wellbeing and inclusion.

Regulatory Trigger — Concerns have escalated to formal action following repeated incidents, inconsistent risk identification, slow improvement pace, and the CQC Section 29A Warning Notice (August 2026) confirming significant deficits in staffing, risk management and safety oversight.

Mitigation —

- A System Improvement Board is in place led by NHS England Regional Team. This Board will monitor progress against the developing single improvement plan, based on the previously reported undertakings and CQC Regulation 29a warning notice.
- Quality Review Meetings in place to gain assurance against contractual quality and patient safety issues, collectively bringing together ICB, NHS England, Specialised Commissioning and CQC with Trust leaders.

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

Advise

GM Hospices Capacity and Operational Pressures Escalation (COPE) Dashboard

The GM Hospices COPE Dashboard is now live, providing daily visibility of hospice capacity and pressures across Greater Manchester. The dashboard provides near real-time information on

inpatient and Hospice at Home capacity, workforce pressures and hospice-specific Operational Pressures Escalation Levels (OPEL) ratings to support operational decision-making and system flow.

Work is underway with hospice, the System Coordination Centre and ICB colleagues to promote use of the dashboard, embed key metrics within system oversight arrangements and develop hospice escalation processes aligned to the GM OPEL Framework.

Engagement is underway to agree communication, escalation and winter planning arrangements, including consideration of how the dashboard can support monitoring of winter capacity funding and utilisation.

The Committee are asked to note this positive development and the further work underway to strengthen this.

Maternity and Neonatal Programme

Greater Manchester

NHS England North West has introduced a new regional assurance model which places increased responsibility on ICBs to provide provider-level assurance of implementation and progress against National maternity and neonatal priorities, through the Perinatal Performance and Oversight Panel (PPOP).

For Greater Manchester, this will require the LMNS to coordinate and assure provider evidence against the NHSE 10-Point Plan and associated national requirements, with initial assurance activity during September and December. Provider-specific assurance, risks and areas of non-compliance will be triangulated through existing ICB governance, including NHS GM Quality Review Meetings and future SCC reporting, and escalated through the Regional PPOP quarterly. The model is also explicitly designed to incorporate future assurance against the National Maternity and Neonatal Taskforce, providing the framework through which these requirements will subsequently be assured by the ICB.

Manchester University NHS Foundation Trust (MFT) (North Manchester Site)

MFT received a 'MOSS Signal' on 30th August 2026. A MOSS signal (Maternity Outcomes Signal System) is an NHS England early warning alert that identifies a potential area of concern and triggers a structured review of the event alongside a wider assessment of intrapartum services using a standardised checklist. The findings are reported to the Trust Board and the NHS England Regional Maternity Team (including the ICB) within 8 working days, providing assurance that any potential risks have been thoroughly investigated and that any necessary actions are identified and addressed.

MFT has completed the required review and has reported this appropriately, with no concerns identified.

Community Pharmacy Prescribing

From autumn 2026/27, a nationally commissioned prescribing service will extend the role of community pharmacy within Pharmacy First, contraception and prescription management. NHS Greater Manchester is establishing the required governance, professional assurance and onboarding arrangements, with 102 (15%) pharmacies indicating an intention to register at launch.

Greater Manchester will also test community pharmacy prescribing within neighbourhood cardiovascular-kidney-metabolic pathways, supporting more accessible care, prevention and

medicines optimisation. Test sites are expected to begin patient consultations in Q4, with national funding in place for up to 2 neighbourhoods for 2 years.

The Committee is asked to note the programme and implementation activity underway.

Safeguarding Children Reforms: Families First Partnership Programme

The national Families First Partnership reforms continue to progress and represent a significant programme of change for safeguarding partners across Greater Manchester. The reforms will require changes to the way health services contribute to Family Help and Multi-Agency Child Protection Teams (MACPT), with an increased focus on earlier intervention, partnership working and integrated approaches to supporting children and families.

NHS GM has statutory responsibilities for the health contribution and is leading work to develop a consistent system-wide approach to commissioning, governance, assurance and delivery, whilst supporting implementation through locality and neighbourhood arrangements. Engagement is underway with safeguarding partners across Greater Manchester to understand current arrangements, identify opportunities for alignment and inform planning for future implementation.

Work is ongoing to establish a Greater Manchester core health offer, assess locality readiness and identify the workforce, governance, commissioning and funding arrangements required to support delivery. Initial work has identified variation across localities in relation to existing models, workforce capacity and funding arrangements, reinforcing the importance of a coordinated system-wide approach.

The programme presents an opportunity to strengthen partnership working, improve consistency and reduce unwarranted variation across Greater Manchester, whilst aligning implementation with wider neighbourhood, Live Well and safeguarding transformation priorities. Executive oversight will continue to be required as the programme develops to support future decisions relating to commissioning arrangements, governance, funding and sustainable delivery, ensuring NHS GM remains well positioned to meet national implementation milestones and statutory responsibilities.

Quality Review Meeting (QRM) Updates

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL)

WWL provided assurance that improvement plans are in place across urgent and emergency care, safe staffing and Referral To Treatment (RTT) performance; however, several risks require continued oversight. The most significant escalation relates to mental health patients experiencing prolonged waits in the Emergency Department following a decision to admit. System-level actions are in place to mitigate against the resultant patient safety, safeguarding and workforce risks, with improvement work being accelerated through the Emergency Department Transformation Programme, Trust-wide Fundamentals of Care Programme, and the system-wide Better Lives Programme.

The Trust also remains subject to a Section 29A improvement programme, with progress being made but some estate compliance actions delayed due to national procurement constraints. RTT performance remains challenged, with an increase in long waiters following reduced theatre capacity over the summer; The work here is being supported by the harm review processes that are in place alongside performance recovery actions. This will continue to be an item on the QRM to enable us to assure the safety of those awaiting further care and treatment. In addition, the emerging impact of the national Band 5 job evaluation programme and collective staff grievances was highlighted as a potential workforce risk requiring ongoing monitoring due to the possible implications for service delivery and patient care.

Greater Manchester Mental Health NHS Foundation Trust (GMMH)

The updated assurance on the temporary closure of Laureate House to facilitate essential repair works proposes completion by mid-December 2026. This has created some risks regarding bed capacity, ward oversight, and the safe delivery of care. whilst this estate is out of use. The Trust has implemented immediate risk reduction measures, including reducing bed capacity, undertaking workforce management actions, and investigating any incidents and putting in mitigation. The ICB continues to support the Trust's improvement plans and will monitor the situation with regular oversight of developments via the Quality Review meetings.

Griffin Ward remains closed following the previously report serious incidents. The ICB are supporting system conversations in developing the future pathways and will further discuss through contractual governance in October 2026.

Whilst remaining a challenged position, the Trust shared their recovery journey and improvement plans across complaints management, talking therapies access, patient and carer engagement, and workforce governance. Commissioners noted significant progress in reducing the complaints backlog and welcomed the structured recovery plan for talking therapies. However, given the ongoing nature of complaints recovery, extended waiting times, carer engagement concerns, mandatory training compliance and unresolved investigation activity, these areas will remain under continued monitoring and assurance scrutiny through future quality review and contract oversight meetings. The ICB has offered specific support in relation to the management of complaints backlog and will share learning alongside the monitoring of the improvement plan.

Manchester University NHS Foundation Trust (MFT)

MFT provided assurance on a number of quality and governance issues during the September 2026 QRM. No matters required escalation to Provider Oversight or contractual action. Ongoing monitoring will continue in relation to the cardiology diagnostic reporting incident, including assessment of potential patient harm and implementation of a sustainable system solution; delivery of the Trust-wide End of Life Care Strategy and associated improvement programme; completion of actions arising from an information governance incident involving historical patient records; and improvement work relating to discharge processes, medication safety and patient flow. The QRM will continue to seek updates on the effectiveness and sustainability of these actions, and subsequently the assurance of standards of care, through future assurance cycles.

Bolton NHS Foundation Trust (BFT)

BFT provided assurance across all areas presented, with no matters requiring escalation. Ongoing monitoring will focus on the maturation of antimicrobial stewardship arrangements, end of life care system challenges (particularly hospice capacity, advanced care planning and locality governance), continued oversight of estates resilience and infrastructure risks, and receipt of final executive assurance ahead of recommencement of the Total Laparoscopic Hysterectomy service.

Assure

Safeguarding Business Continuity

Formal business continuity arrangements remain in place across NHS Greater Manchester, supported by executive oversight and regular assurance mechanisms. Weekly oversight arrangements continue to provide visibility of safeguarding capacity, statutory activity, partnership engagement and emerging risks across all ten localities, enabling risks to be identified and managed at the earliest opportunity.

Despite workforce pressures and vacancies across Designated Nurse and Professional, Named

GP and Project Support functions, statutory safeguarding responsibilities continue to be discharged across Greater Manchester. Workforce risks continue to be actively managed through business continuity arrangements, locality support mechanisms and ongoing recruitment activity, with recruitment underway to strengthen capacity and resilience across the safeguarding system.

Alongside maintaining statutory safeguarding functions, the service continues to progress transformation and organisational change across Greater Manchester. Current assurance is that statutory safeguarding functions, partnership commitments and provider assurance responsibilities continue to be maintained throughout this period of transition and transformation.

Quality Assurance Processes - Section 29a Warning Notices

There has been 3 recent CQC Section 29a warning notices received by trusts:

Northern Care Alliance NHS Foundation Trust

CQC served a Section 29A Warning Notice on Northern Care Alliance NHS Foundation Trust on 13 August 2026. This was due to significant concerns about the trust's management of risk, patient safety, complaints, freedom to speak up processes and workforce wellbeing and inclusion.

A System Improvement Board is in place led by NHS England Regional Team. This Board will monitor progress against the developing single improvement plan, based on the previously reported undertakings and CQC Regulation 29a warning notice.

Quality Review Meetings are in place to gain assurance against contractual quality and patient safety issues, collectively bringing together ICB, NHS England, Specialised Commissioning and CQC with Trust leaders. Where necessary, further deep dives will be undertaken about specific issues where requested by the System Improvement Board.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

On the 29th June CQC issued the trust with a section 29a in relation to urgent and emergency care it highlighted a number of key concerns in relation to facilities and processes not sufficiently able to provide safe care and treatment to patients, including children and young people, who present with mental health needs or significant behavioural disturbances. In addition, it identified that the trust did not always effectively assess and manage the risk to service users in all areas, including but not limited to patients with suspected sepsis presentations.

Quality Review Meetings are in place to gain assurance against contractual quality and patient safety issues, collectively bringing together ICB, NHS England, Specialised Commissioning and CQC with Trust leaders. At the latest meeting on the 4th September, the trust shared progress updates against the UEC improvement plan where work has been accelerated through the Emergency Department Transformation Programme, our Trust-wide Fundamentals of Care Programme, and the system-wide Better Lives Programme. The Quality Review Meeting will receive further updates at future meetings and use the intelligence as part of our site visits to test improvements in practice.

Greater Manchester Mental Health NHS Foundation Trust

The CQC served a warning notice on Greater Manchester Mental Health NHS Foundation Trust on 12 August 2026 for failing to meet the regulations related to oversight of people waiting for treatment or intervention by adult community mental health services. Specifically it highlighted concerns around systems and processes to assess, monitor and improve the safety of services in relation to service users waiting for assessment, treatment or intervention.

Whilst initial assurances have been received around the trusts improvement plans a detailed discussion is scheduled at the November Quality Review Meeting to receive formal assurance around the improvement plan with a particular focus on the new Unallocated (Awaiting CPA) Waiting List Procedure.

The Quality and Safety Team maintains oversight of all CQC activity across Greater Manchester with established relationship meetings with CQC and NHSE. Additionally, CQC are invited to the ICB and Trust Quality Review Meetings which continue to track delivery against improvement actions, ensuring that risks, mitigations and residual concerns are appropriately monitored and escalated where required.

2025/26 Provider Quality Accounts

A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, and are available to the public, they are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided. The requirement is set out in the Health Act 2009.

Integrated care boards (ICBs) have responsibility for the review and scrutiny of quality accounts. The ICB scrutinises the account, assesses the accuracy, completeness and alignment with wider quality intelligence held by the ICB, and prepares a formal ICB Statement of Assurance for each provider. The Quality Accounts are a key element of the ICB Provider Assurance mechanisms as they incorporate intelligence on quality performance, patient safety, patient experience, governance and service improvement. The key priorities identified form part of the mechanisms for contractual quality oversight governance to gain assurance of delivery against key objectives and hold Providers to account on delivery.

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			

10-01	Triptorelin 22.5mg IM injection (generic product)	Already on formulary as amber for shared care medicine for treatment of prostate cancer and for gender dysphoria. Addition of the product to formulary for prostate cancer and make first line gonadotropin-releasing hormone analogue for this indication. The RAG status will be red pending addition to the SCP. If all items in GM were prescribed as triptorelin the savings in drug costs to the GM ICB would be £172k per year and release 9010 appointments.	Approve addition to the formulary following approval by CEG and note additional financial saving.
10-02	TA1152: Semaglutide for reducing the risk of major adverse cardiovascular events in people with cardiovascular disease and overweight or obesity Published 07/05/26	Semaglutide can be used, within its marketing authorisation, alongside a reduced-calorie diet and increased physical activity, as an option for reducing the risk of a major adverse cardiovascular event in adults with established cardiovascular disease and body mass index of at least 27kg/m². Added to formulary as green specialist initiation pending the production of a prescribing pathway. Additional estimated financial impact £3m in year 1 and £11m in year 3 impact forecasted to be less due to phasing. However, through the horizon scanning process it was noted that Greater Manchester has a high incidence of CVD, and that uptake is expected to be much higher than that anticipated by NICE.	Approve addition to the GMMMG formulary, pending production of a prescribing pathway following CEG approval.
10-03	NHS GM position on Metformin in Non-diabetic hyperglycaemia	Proposals to prescribe metformin to people whose blood glucose (sugar) level is high even though they do not have diabetes in line with NICE guidance. Financial impact £1.36m in year 5 assuming 100% adherence with dosing. This is expected to be offset by the avoidance of £400k of diabetes-related complications per year.	Approve publication of position statement, noting the financial and workload impact of a preventative intervention following CEG approval.
10-04	Ivermectin 3mg tablets	Used for the treatment of human scabies as an alternative second line treatment option after topical preparations have been tried. Ivermectin tablets currently has a green formulary status in all settings. Ivermectin 3 mg tablets are already prescribed across Greater Manchester, with expenditure of approximately £1.03 million during the 12 months. The application is not expected to generate a significant increase in overall prescribing expenditure,	Approve addition to formulary. Formulary positioning will ensure used appropriately following CEG approval.

		as existing prescribing is already established.	
10-05	Methenamine Hippurate 1g tablets	For the prevention of recurrent uncomplicated lower urinary tract infection in women and people with a female urinary system aged ≥ 16 years, in accordance with NICE NG112 and the Greater Manchester Recurrent UTI Guideline. Addition to the formulary as green in all settings. Methenamine hippurate is already widely prescribed within Greater Manchester for the prevention of recurrent urinary tract infections. Overall prescribing expenditure is therefore not expected to increase significantly, as prescribing is already established. Current prescribing is £554K, overall prescribing expenditure is therefore not expected to increase significantly, as prescribing is already established. Improved awareness of NICE guidance may increase appropriate use in patients who would otherwise receive long-term antibiotic prophylaxis	Approve addition to GMMMG formulary following CEG approval.
10-06	GM antimicrobial Guidelines – August 2026 update	Greater Manchester Antimicrobial Guidelines, updated to version 17 superseding the October 2024 (v16) edition.	Approve publication following CEG approval.
10-07	NHS Greater Manchester Incretin Therapies (GLP-1 Receptor Agonists and Tirzepatide): Commissioning Position and Prescribing Guidance	The updated incretin therapy commissioning position (including GLP-1 receptor agonists and tirzepatide) and prescribing guidance consolidates the existing NHS Greater Manchester commissioning position.	Approve for publication following CEG approval.
10-08	TA1155: Rozanolixizumab for treating antibody-positive generalised myasthenia gravis Published 20/05/2	Rozanolixizumab, as an add-on to standard treatment, can be used as an option to treat generalised myasthenia gravis in adults who test positive for anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibodies. Addition to formulary as a red (specialist only) drug in this indication, with links to TA1155.	Approve addition to formulary following CEG approval.
10-09	NICE TA1157: Givinostat for treating Duchenne muscular	Givinostat can be used as an option to treat Duchenne muscular dystrophy in people 6 years and over who are ambulant (able to walk or stand, with or without support) at the start of treatment.	Approve addition to formulary following CEG approval.

	dystrophy in people 6 years and over Published 28/05/26	Addition to the formulary as red (specialist only) drug in this indication with links to TA1157.	
10-10	Penicillamine Allergy Review Standard operating procedure	The stand operating procedure represents the Greater Manchester process for identifying, reviewing and correcting penicillamine allergy records that may have been entered in error, in response to National Patient Safety Alert NatPSA/2025/006/NHSPS. The SOP also introduces measures to reduce recurrence, including stronger clinical validation, structured data entry, staff training, system prompts, audit and patient engagement. Completion is expected within four weeks, by the end of October 2026.	Approve SOP for GM use following CEG approval.
10-11	Single National Formulary communication	The communication seeks to provide an update on the work done to prepare the GM system for implementation of the Single National Formulary (SNF) and approve the system communication associated with this.	Approve the communication for circulation to the GM system following CEG approval.
10-12	Levemir Discontinuation	Levemir is an insulin used in the management of diabetes. Its supply is expected to be discontinued by the end of December 2026. A paper was shared outlining the current prescribing position across Greater Manchester, along with the system-wide plan to transition patients to suitable alternative insulins and ensure appropriate monitoring throughout the switch.	Approve the proposed Greater Manchester system-wide plan following CEG approval.
Clinical Effectiveness and Governance Committee Recommendations			
10-13	Perinatal Mental Health Programme	CEG received an update on the Greater Manchester Perinatal Mental Health Programme and supported the continuation of the programme's work to better understand maternal mental health risks, care pathways and opportunities for future system improvement. The Committee noted that programme findings will inform future commissioning and service development considerations, with any identified risks being managed through established governance arrangements and escalated through the appropriate assurance and risk management processes as necessary.	Approve the proposed programme of work
10-14	NHS GM HIV refreshed plan	CEG considered a proposal relating to the Greater Manchester HIV programme and supported the recommended approach. The Committee noted the anticipated benefits in strengthening coordination across the system, improving patient outcomes and	Approve the NHS GM HIV Plan

		addressing health inequalities. Delivery will continue through established governance arrangements, with progress and any emerging risks subject to routine monitoring and escalation through the appropriate assurance and risk management processes where required.	
10-15	NHS GM Clinical Policy Audit and Standards	To Note - no items were recommended for approval through CPAS this month. The Committee continues to provide rigorous clinical scrutiny and assurance, ensuring that proposals are clinically sound, evidence-based and informed by effective system engagement before progressing through the formal governance pathway.	None

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

Risks discussed and emerging issues — Provider-specific quality and patient safety risks remain under active oversight at NCA, WWL, GMMH and MFT. Emerging system issues include implementation of Families First Partnership, community pharmacy prescribing, medicines supply and new prescribing requirements, hospice and end-of-life capacity, and estate, digital and information governance pressures. These matters may increase the exposure or impede mitigation of the corporate risks but should not automatically be treated as new corporate risks where they are already managed through provider, programme, medicines, safeguarding or operational risk routes.

Alignment with Corporate risks owned by the Clinical Portfolio — The risks raised in this report align to CCPL09A (clinical leadership capacity and resilience), CCPL09B (clinical advice, challenge and governance assurance), and CCPL17 (maternity and neonatal quality oversight and improvement arrangements). Workforce and capacity pressures affecting safeguarding, maternity assurance, provider improvement, medicines implementation and the national Band 5 job evaluation reinforce CCPL09A, as delivery depends on sufficient and sustainable clinical leadership and specialist capacity. Variation in provider governance, weak risk identification, inconsistent escalation and changing commissioning and assurance arrangements reinforce CCPL09B, particularly the concerns at NCA, WWL and GMMH and the implementation of Families First Partnership and community pharmacy prescribing. The WWL homebirth concerns, the new regional maternity assurance model and uncertainty over LMNS capacity, hosting and accountability directly reinforce CCPL17. No new evidence is presented on QUP25/07/25 paediatric audiology; this remains an open corporate risk subject to its established assurance arrangements.

These risks are being managed through established provider oversight, Quality Review Meetings, regulatory and contractual escalation, safeguarding business continuity, clinical governance and medicines governance routes. Residual risk remains highest where improvement actions are not yet embedded or their impact and sustainability have not been evidenced.

Achievements

Opioid Stewardship work shortlisted in the HSJ Patient Safety Awards

The ongoing work in opioid stewardship has been shortlisted at the HSJ Patient Safety Awards

2026 taking place on 28th September 2026 at Telford International Centre. NHS Greater Manchester and MFT have been shortlisted for the final in two categories: Best Use of Integrated Care and Partnership Working in Patient Safety and Improving Medicines Safety, for the project titled: "Improving Opioid Stewardship: A system-wide approach". This programme focuses on reducing harm associated with opioid medicines and improving care for people living with pain. Since 2022, it has achieved significant outcomes across Greater Manchester, including:

- A 30% reduction in patients receiving high-dose opioids
- Over 4,000 fewer people prescribed opioids

This has been delivered through strong collaboration across primary care, secondary care, community pharmacy, and specialist services. In addition, NHS Greater Manchester Medicines Optimisation Team (Manchester locality) and Benchill Medical Practice (Wythenshawe Primary Care Network) are finalists in the Improving Medicines Safety Award category for Promoting Safe Opioid Prescribing and Deprescribing within Primary Care, which focussed on a pharmacist-led clinic model targeting patients on long-term or high-dose opioids.

North West (NW) Learning and Improvement Network (LIN) celebration event

Learning and Improvement Networks (LINs) are a core part of the NHS IMPACT (Improving Patient Care Together) approach, bringing together clinical, operational and improvement leaders to test, learn from and spread effective practice across systems. The North West programme includes three LINs focused on Urgent and Emergency Care, Elective Care and Mental Health. Within Greater Manchester, the LINs support existing priorities by strengthening improvement capability, sharing learning across organisations and localities, reducing unwarranted variation and accelerating the adoption of good practice, rather than creating separate programmes of work.

NHS Greater Manchester teams received regional recognition at the NW Learning and Improvement Network (LIN) Celebration Event, with the Elective Care Team winning *Most Impactful Poster* and Greater Manchester Mental Health NHS Foundation Trust (GMMH) winning *Best Poster Overall* and *Best Co-Design*.

The event, hosted by NHS England and AQuA, showcased improvement work from across the region and highlighted the impact of clinically led, data-driven improvement, co-design and collaborative working across systems.

The event reinforced the importance of strong clinical leadership, adoption and spread of best practice, and designing improvement initiatives that can be sustained and scaled across the system.

Learning from the event will be shared through existing improvement networks, with key themes feeding into ongoing quality improvement, transformation and clinical effectiveness work across NHS GM.

The awards recognise the quality and impact of improvement work taking place across Greater Manchester and provide opportunities to further spread learning and innovation.

UK Health Security Agency Annual Conference

UKHSA held their annual conference in Manchester on 22nd and 23rd September 2026. This event is delivered in partnership with the Faculty of Public Health to bring together research, innovative practice and a breadth of discussion around health security. The focus "Securing health together: Partnership, prevention, preparedness" is explored over the 2 days.

Dr Claire Lake joined the presenting panel for a breakout session on “Antimicrobial resistance: delivering the National Action Plan through local and regional partnerships” to share the work underway in Greater Manchester through our GM AMR Improvement Plan.

Dr Laura French joined the panel on vaccine equity “Closing the immunisation gap: What’s working, what’s next” to share views and experience on how we can continue to ensure vaccine equity is at the centre of NHS vaccination programmes.

Greater Manchester Trust Achievements reported into Quality Review Meetings since the last committee

Across Greater Manchester providers, there continues to be significant evidence of innovation, improvement and engagement despite ongoing operational pressures. Trusts highlighted achievements in strengthening patient, service user and carer involvement, with increased co-production, expansion of lived experience partner programmes and new approaches to community engagement that are helping shape service design and improvement. Mental health services reported national recognition for collaborative work with vulnerable groups, youth-led quality improvement initiatives, and strengthened participation models. Acute providers celebrated a range of national and regional awards, including recognition for leadership, innovation, sustainability, patient experience initiatives and clinical excellence, alongside the launch of new patient-focused services such as medical cinema experiences and Martha’s Rule implementation. Workforce development also remains a notable success, with organisations reporting investment in apprenticeships, leadership development, professional training, improved recruitment, reduced vacancies and strengthened clinical teams. There has also been demonstrable improvement in a number of quality and safety measures across the system, including reductions in healthcare-associated infections, pressure ulcers, falls and cardiac arrests, alongside progress in end-of-life care, research activity, community-based care models and service transformation programmes. Collectively, these achievements demonstrate a continued commitment across Greater Manchester to improving patient experience, safety, quality of care and staff development, whilst fostering innovation and collaboration across organisations.

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 Strategic Commissioning Committee

Report from Chief Commissioning Officer

October 2026

Report from:	Katherine Sheerin, Chief Commissioning Officer
Date of Meeting:	Wednesday 7 th October 2026
Authors	Sara Roscoe, Associate Director – Healthcare Commissioning Operations Emma Storer, Senior Project Manager Children & SEND Caroline Bradley, Director of Primary Care and Community Healthcare Services Louise Sinnott, Head of Acute Strategy & Transformation / Place Based Lead for Greater Manchester
Executive Summary	This paper sets out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate.

ALERT	
Primary Care Commissioning	No alerts this month. Previous SCC reports have provided an update on GP Collective Action. Since 1 May 2026, GPC England has introduced monthly actions that have covered shared care arrangements, Medicines Optimisation software, data sharing agreements and raising public awareness of the pressures facing General Practice. Regular updates on the NHS GM ICB position are provided to NHS England. No new action has been introduced by GPC England for September.
ADVISE	
Healthcare Commissioning	Development of the NHS GM Commissioning Framework Work has continued across Programme Leads and Place along with Finance and Data Insight and Intelligence to inform the development of the NHS GM Commissioning

Framework for 2027/28. The Commissioning Frameworks sets out the ICB's commissioning priorities as part of the NHS GM Planning Process for 2027/28.

The Framework comprises of four key components:

Strategic Commissioning Signals – these set out the broader commissioning direction and organisational intent that providers and partners should recognise in future planning.

Material Commissioning Intentions – these are specific commissioning decisions which have been quantified and will be implemented during 2027/28. These Material Commissioning Intentions have been modelled for each relevant provider who are required to build them into their 2027/28 annual plan.

Provider Planning Assumptions – These are known or expected changes that are primarily for large NHS providers to reflect in their plans. However, our system partners will have a role in contributing to the achievement of these, therefore need to be sighted.

Delivery of Existing Programmes – This is the continued delivery of the Organisation's workplans and confirmation of pre-agreed funding streams, along with the delivery of existing transformation Programmes.

As part of the Planning Process, the Commissioning Framework will be communicated to individual Acute and Mental Health Providers along with system partners, such as Primary Care Provider Board and the Alternative Provider Collaborative at the end of September. This will allow providers to consider, engage with the ICB, and factor into Provider plans for 2027/28.

The culmination of the plans set out in the Commissioning Framework will support the continued delivery of NHS GM strategic priorities and mitigate demand growth Acute and Mental Health Providers. It also sets out GM's commitment to Neighbourhood Health as a central tenet of our strategy and outlines the components of neighbourhood teams and the required work to address the needs of high-risk cohorts of patients.

This is included as a separate paper on the agenda.

Oral and Maxillofacial Surgery-Bolton Patient Pathway Update

There has been an interruption to the Oral and Maxillofacial Surgery pathway for Bolton patients following the conclusion of a long-standing service level agreement between Bolton NHS Foundation Trust and East Lancashire Hospitals NHS Trust. The intention was for activity to transfer to Manchester Foundation Trust; however, the timing of this transition was not finalised. The ICB is working closely with all providers to understand the implications for patients and to agree a safe, sustainable pathway for ongoing care.

Establishment of a NW Individual Funding Request Service (hosted by NHS Greater Manchester)

The three NW ICBs (NHS Cheshire & Mersey, NHS Greater Manchester and NHS Lancashire and South Cumbria) have collaborated to develop a single, integrated Clinical Policy and Individual Funding Request service, hosted by NHS Greater Manchester.

The model is intended to reduce variation, support fair and evidence-based decisions, improve efficiency and align clinical policy development across Greater Manchester, Cheshire and Merseyside, and Lancashire and South Cumbria.

The proposed service includes Individual Funding Requests, non-Individual Funding Requests, relevant mental health cases and clinical policy development.

This will benefit the populations of three ICBs by:

- Ensuring more consistent access to treatments through a shared North West approach to clinical policy and Individual Funding Request decision-making.
- Fairer, more transparent and clinically evidence-based decisions for exceptional funding requests.
- Reduced variation in provision and fewer cross-border differences between Integrated Care Board areas.
- Improved use of resources through shared processes, reduced duplication, policy harmonisation and economies of scale.
- Better identification of policy gaps and unmet need, supporting future commissioning decisions and demand management.

All three ICBs formally approved the proposal at their Chief Officer / Executive meetings in August and September which has now triggered the launch of a formal consultation for those staff delivering the service for C&M and LSC in Midlands and Lancashire Commissioning Support Unit (MLCSU). Following consultation, the staff will transfer to NHS GM on 1 November. Enabling work continues involving HR, Organisational Development, Information Governance, and IT to ensure staff transfer safely.

Post November, work will continue to implement the single, NW Integrated Clinical Policy and Individual Funding Request service.

Primary Care Commissioning

A multiyear approach to the Primary Care Service Development Fund (SDF) is proposed. A number of programmes of work are identified for investment via the SDF throughout 2026/27 and 2027/28. The overview below summarises the approach, with a focus on initial commitment of resource within 2026/27.

The available Primary Care Service Development Funding allocation for 2026/27 is £4.048m (excluding GPIT and Digital First programmes). The proposed approach is to commit £3.671m Primary Care SDF expenditure in 2026/27. This will enable continued investment in developing primary care via neighbourhood transformation, primary care excellence programmes, workforce development, primary care quality improvement and targeted practice support. The proposal also releases a further £377k in 2026/27 to support the wider ICB financial position (in addition to the 15% efficiency requirement already applied).

Approval of the Primary Care SDF programme will deliver significant benefits for the people and communities of Greater Manchester by strengthening primary care services, improving access to care, support the delivery of care closer to home together with reducing health inequalities and improving outcomes for the population of Greater Manchester.

Key benefits include:

- Improved access to primary care services, including general practice, community pharmacy, dentistry and optometry, helping residents receive timely care in the most appropriate setting.
- Reducing unwarranted variation in care and outcomes across Greater Manchester through targeted quality improvement programmes, ensuring patients receive a more consistent standard of care regardless of where they live.
- Better same-day access for urgent health needs, reducing delays in treatment and supporting the wider urgent and emergency care system.
- Enhanced support for neighbourhood-based care, enabling services to be designed around local population needs and delivered closer to communities, reducing reliance on hospital-based care.
- Expansion of Pharmacy First and community pharmacy services, providing patients with more convenient access points for advice, treatment and ongoing management of common conditions.
- Improved access to urgent dental services and support for dental recovery and improvement programmes.
- Stronger focus on prevention and proactive care, supporting the early identification and management of long-term conditions and reducing future demand on acute services.
- Improved quality and safety of primary care services through delivery of excellence programmes, peer support, leadership development and targeted support for practices facing challenges.
- Greater integration between primary care services and wider health and care partners, improving coordination of care and patient experience across organisational boundaries.
- Increased use of digital solutions and modern models of care, making it easier for patients to access information, consultations and services in ways that meet their needs.
- A stronger and more resilient primary care workforce, ensuring services remain sustainable and capable of meeting increasing population demand.

For 2027/28, plans show a £3.690m indicative expenditure across the programmes of work identified above. These will be developed further based on 2026/27 delivery and impact.

Specialised Services

Cardiac and Vascular Surgery Review – please refer to Appendix 1.

ASSURE

Healthcare Commissioning

Greater Manchester Tier 3 Community Dermatology Service

NHS Greater Manchester has formally launched the procurement of the Provision of a Tier 3 Community Dermatology Service in Greater Manchester. This follows the decision to abandon the previous procurement following a challenge to the process.

The GM service will deliver a community dermatology service across all localities within Greater Manchester for patients registered with a Greater Manchester GP. Tenders are invited from interested parties to provide a consistent service across Greater Manchester for a range of appropriate conditions which can be assessed, investigated and treated in the community.

This will address the current variation that exists across Greater Manchester, providing a sustainable service for patients. This service will also reduce demand for secondary care providers.

The deadline for the tenders is 23 October, after which there will be a period of evaluation and recommendation for a successful bidder. The aim is for a new service to be mobilised from April 2027.

Children, Young People and Maternity

Area SEND inspection – Salford Local Area Partnership underwent a joint Area SEND inspection by Ofsted and the CQC in July 2026. The recently published report found that the partnership's SEND arrangements typically result in positive experiences and outcomes for children and young people, with appropriate action taken where improvement is needed. This is the highest possible outcome available under the inspection framework and reflects the strength of partnership working across education, health and care in Salford, and the positive difference this is making for children and young people with SEND.

Primary Care Commissioning

The next Primary Care Commissioning Group is 13 October 2026.

ACHIEVEMENTS

Children, Young People and Maternity

Please see Salford SEND Inspection outcome above.

LEARNING FOR SHARING

Primary Care Commissioning

Five members of ICB staff, across various directorates including the Director of Primary Care and Community Healthcare Services, are taking part in the Strategic Commissioning for Neighbourhood Health Programme led by the NHS Alliance and The King's Fund. This is a six part programme delivered between September and December 2026. The initial introductory session, with ICB colleagues across the country, took place on 9 September. Learning from the programme will be shared as available.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
None to escalate this month.

APPENDIX 1 – Cardiac and Vascular Services Review

GM Cardiac & Vascular Reconfiguration Programme

Overall Status The programme continues to progress, with the cardiac consultation work largely complete and attention now focused on finalising financial assumptions ahead of consultation closure on 23 September. For the vascular programme, significant progress has been made on the clinical model, although key risks relating to workforce sustainability, interventional radiology arrangements, critical care impacts and financial affordability remain under active review.

Key Updates

Cardiac Programme

- Consultation responses have been reviewed and are up to date.
- No significant programme actions remain outstanding.
- Financial assumptions will be revisited prior to consultation closure and completion of the business case.

Vascular Programme

- The vascular spoke clinical model has been approved in principle, subject to minor amendments and final approval through the Bipartite meeting on 24 September.
- Financial modelling is underway to assess gross and net costs, stranded costs, affordability and residual financial risk.
- A proposed day-one Vascular Interventional Radiology (VIR) model has been developed, maintaining current Oldham provision alongside phased growth in Salford capacity. Partners aim to secure agreement before 24 September to avoid escalation.

Principal Risks

1. Workforce Sustainability

- Ongoing workforce attrition at Oldham remains the most significant operational risk.
- Clear staffing thresholds, mitigations and contingency plans are being developed to ensure patient safety and service continuity.

2. Hybrid Theatre Capacity

- Concerns remain regarding resilience and continuity of hybrid theatre provision.
- Further work is underway to strengthen business continuity arrangements and clarify operational responses should capacity become constrained.

3. Financial Affordability

- Detailed analysis is required to confirm affordability for commissioners and fully understand residual financial risks associated with the preferred model.

4. Critical Care Capacity

- Agreement has been reached on the broad critical care approach, but further assurance is required regarding bed requirements, system capacity and efficiency implications.

5. Patient Transport Impacts

- NWAS is assessing the impact of longer inter-facility transfer times associated with the proposed model.
- Commissioner input is being sought to understand wider transport and patient flow implications.

Assurance and Governance

- Agreement has been reached on several supporting elements, including diabetic foot activity, repatriation arrangements and critical care assumptions.
- Clinical, critical care network and finance colleagues will be asked to undertake further review of bed capacity requirements, operational implications and associated costs.
- NCA has confirmed it does not intend to submit any additional formal consultation response beyond its existing letter of support.

Immediate Priorities (Next 2 Weeks)

- Finalise and assure vascular financial modelling.
- Secure agreement on the VIR operating model before the 24 September Bipartite meeting.
- Confirm workforce risk thresholds and contingency arrangements.
- Complete review of critical care impacts and capacity requirements.
- Obtain assurance regarding NWAS transfer implications.
- Close remaining cardiac finance queries in preparation for progression of the business case.

Executive Attention Required

The programme remains on track; however, workforce sustainability, hybrid theatre resilience, VIR model agreement and commissioner affordability represent the key risks requiring ongoing executive oversight ahead of the 24 September decision point. Successful

resolution of these issues will be critical to maintaining programme timelines and enabling progression to the next stage of the reconfiguration process.

Acting Chief Reform & Improvement Officer Report

September 2026

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
Contact for further information	Nicola.Hepburn1@nhs.net
Executive summary	This report provides assurance on how NHS Greater Manchester Integrated Care Board is discharging its statutory duties for quality, safety and clinical governance across the organisation and the system as a whole. It brings together intelligence from established governance routes and demonstrates how statutory clinical governance and quality functions are being exercised to identify and manage risk, reduce unwarranted variation, and support safe, effective and equitable care across Greater Manchester. The report highlights key areas of assurance and oversight from the Reform & Improvement portfolio.
The benefits that the population of Greater Manchester will experience.	Continued support for performance oversight of health and care services, digital and data services delivery which enables effective healthcare delivery across the ICS
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy with the intention to deliver financial sustainability, improve our oversight arrangements with our commissioned providers and take forward our digital strategy.
The decision to be made and/or input sought	The Committee is asked to note the AAAA report and the position as of M5
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for the Strategic Commissioning 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 Strategic Commissioning 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 accessibility of report

Alert

Elective Care

- **Elective performance:** The NCA RTT position remains materially off plan, with a substantial additional activity requirement above current assumptions. Industrial Action continues to disrupt service delivery. Capacity offers exist across system but conversion into completed activity remains limited partly due to lack of operational capacity within the NCA.
- **Demand management assurance:** Current reporting (outside-in) does not allow for a full assessment of the impact being made by SPOA, particularly where clinical triage drives internal pathway improvement (straight to test, divert to a different clinic) as e-RS does not allow reporting on this (all badged under an accepted referral). We are reliant on Trusts to develop their own internal reporting, which has not been setup to provide this.
- **Patient safety and delivery capacity:** SPOA implementation requires clearer agreed routes for clinical escalation, without this SPOA implementation may create unmanaged interface risk. A proposal is being discussed via the interface groups.

Urgent and Emergency Care

- In August 71.8% of patients attending ED were seen and treated within 4 hours compared to a plan of 75.5%. Although behind plan, this is 1.6% better than July.
- 7224 (8.4%) of patients in ED waited in excess of 12 hours (type 1 and 2) against a plan of 6082 (7.2%). 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.

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 assessments of any cyber risk, 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.
- 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.

Progress against the ICB and provider 26/27 Medium Term plan Headline Measures

The principal performance challenges are, **Urgent and Emergency Care:** four-hour and 12-hour performance, **Elective Care:** total waiting list size, **Mental Health:** the number of patients completing talking therapies treatment and achieving reliable recovery, the number of out of area placements, and **Learning Disabilities and Autism:** the number of people receiving inpatient care.

The performance team produces a comprehensive report for the Strategic Commissioning Committee, identifying the providers contributing to underperformance and outlining the recovery actions being taken by providers and ICB programme teams.

NHS Oversight Framework

Quarter 1 provider results against the NHS Oversight Framework have been published. The 2026/27 metrics were revised to align with medium-term planning priorities, so direct comparison with 2025/26 is not

possible.

Providers continue to receive an overall segment rating from 1 to 4, with segment 1 representing the strongest performance. The Christie is rated segment 1; Manchester University NHS Foundation Trust is rated segment 2; Bolton NHS Foundation Trust, Stockport NHS Foundation Trust, Tameside and Glossop Integrated Care NHS Foundation Trust, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust and Pennine Care NHS Foundation Trust are rated segment 3; and Northern Care Alliance NHS Foundation Trust (NCA) is rated segment 4. A Region led System improvement Board is in place to support the NCA.

The ICB will also receive a segment rating this year. Publication has been delayed and is now expected by the end of September 2026. The ICB has identified the metrics against which it will be assessed and aligned its work programmes and risks accordingly.

Advise

Elective Care

- Maintain active Chief Officer oversight of NCA recovery and require clear, time-bound delivery plans covering additional activity, long waits, mutual aid and barriers to converting available capacity.
- Confirm system-wide ownership of elective demand management, including consistent SPOA triage outcomes, turnaround times and onward pathway outcomes, supported by routine central reporting.
- Protect a small number of priority analytical and programme-management tasks, with lower-priority work paused where necessary, so refreshed demand analysis and assurance can be completed without further dilution of delivery capacity.

UEC

- Continue using GM wide demand and activity modelling work with DII to inform provider planning assumptions, capacity requirements and future investment decisions ahead of winter and 2027/28 planning.
- Prepare for forthcoming NHSE regional discharge and flow programme, including expectations around reducing bed occupancy towards 80% by Christmas and sustaining improvements.
- Support engagement in emerging regional Communities of Practice for neighbourhoods, discharge and Better Care Fund delivery to share learning and adopt best practice.
- Use outputs from the Hospital at Home review and Frailty improvement programme to identify opportunities to reduce admissions, improve flow and maximise existing service capacity.
- Winter Planning continues with feedback from the NHSE BAS Self Assessment received and work underway to respond to KLOEs.

Digital and IT Services

- 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.

27/28 Planning

Programme teams are finalising commissioning intentions, planning assumptions and the related financial and activity impacts. These will be consolidated into a comprehensive pack for Chief Officer consideration on 23 September, followed by a provider facing pack by the end of that week, completing phase one. The next phase will cover provider engagement, further financial modelling, refinement of activity assumptions and validation of commissioning intentions across acute, mental health, primary care, voluntary sector and wider system partners. This work will inform contractual discussions and the first plan submission in December 2026.

Progress against the ICB and provider 26/27 Medium Term plan Headline Measures

Emerging performance risks include: **Elective Care:** first treatment within 18 weeks, **Cancer:** diagnosis

within 28 days, % of patients treated within 62 days, **Mental Health:** the number of patients completing talking therapies achieving reliable improvement.

Financial Recovery & Improvement

- At Month 5, there remains a £17.3 million of CIP opportunities under development against the total annual target of £150 million.
- Whilst progress continues to be made in identifying and refining emerging schemes, delivery of these opportunities remains a key area of focus.
- Discussions with NHS England regional colleagues regarding Quarter 3 Deficit Support Funding (DSF) remain ongoing. Assurance has been provided that robust plans are under development to mitigate risks, maximise opportunities, and maintain delivery trajectories in support of achieving the agreed financial plan.

Assure

Elective Care:

- A refreshed demand-management analysis is under way using eRS referrals, clock starts and specialist advice data to triangulate demand, activity and performance through August.
- Current programmes provide an established platform for improvement, including SPOA implementation, Consultant Connect, community ENT and gynaecology pathways, provider assurance, surgical hubs and mutual aid.
- The HSSIB interim findings have been reviewed and a GM response prepared. Existing work already addresses many identified issues, with further action focused on interface governance, clinical audit, digital clinical safety and consistent monitoring.

UEC:

- NEPTS mobilisation remains on track, with governance arrangements, mobilisation plans and risk management processes established to support a safe transfer to the new provider on 1 April 2027.
- Ongoing oversight of UCR performance and data quality has improved visibility of referrals, demand and outcomes, enabling better operational planning and performance management.
- Work continues to improve Directory of Services (DoS) profiles and referral pathways, supporting more effective patient streaming and access to urgent care services.
- Planning is underway to meet forthcoming Better Care Fund requirements, including national deadlines for sign-off by Health & Wellbeing Boards and NHS GM ICB by 31 March 2027.
- The SCC continues daily system oversight, OPEL co-ordination and individual patient escalation across acute, community and mental health services. Strengthened tripartite oversight, action tracking and risk management provide greater operational control within the current hosted arrangement.

Digital and IT Services:

- Final SIRO report has been issued
- SIRO accountabilities will move from Colin Scales to Nicola Hepburn effective from October

Progress against the ICB and provider 26/27 Medium Term plan Headline Measures

Areas on track are: Urgent and Emergency Care: Cat 2 ambulance response times, **Diagnostics:** proportion seen within 6 weeks, **Cancer:** treatment beginning treatment within 31 days, **Mental Health:** the number of people accessing individual placement support services and **Community Services:** proportion of patients seen within 18 weeks.

Financial Recovery & Improvement

- Where significant slippage against CIP delivery plans is identified, or where opportunities for additional stretch delivery are identified, joint recovery plans are being developed across the Financial Efficiency and Sustainability PMO and Finance team, led by the CIP Operational Leads.
- These plans are currently under development and intend to take integrated approach to recovery,

encompassing both CIP delivery and wider operational budget pressures, ensuring a coordinated response to achieving overall financial sustainability objectives.

- These plans provide financial phasing, demonstrating the intended financial impact of each action/milestone. This will enable robust monitoring against recovery plans, and where any recovery actions are not delivering further mitigations will be developed.

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.

UEC

- Significant discharge improvement expectations are anticipated from NHSE, with potential operational risks if system bed occupancy and flow targets are not achieved ahead of winter.
- Engagement with UTC DoS improvement work remains inconsistent across localities, creating variation in patient navigation and access.
- Better Care Fund planning timelines are expected to be fixed with no flexibility beyond March 2027, increasing delivery and governance pressures.
- Emerging regional programmes and Communities of Practice will require GM capacity and engagement once confirmed.
- An internal assessment has identified gaps in the hosted model of SCC. This may limit assurance against national requirements of the SCC team.

Digital and IT Services Update:

- End-of-life device risk has been escalated through CEO to Board for formal risk acceptance as a consequence of the current financial and lack of funding for replacement.
- 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.

Achievements

Digital and IT Services

- A Copilot business case and approach to digital workforce development has been submitted to Chief Officers
- 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.

Cancer

- The Cancer 31 day standard from decision to treat, to treatment, has being ranked in the top five, nationally, each month since April. GM was ranked first in June.

UEC

- GM now ranks 5th nationally for UCR referrals, following work to improve capture of referral activity, strengthening intelligence and service planning.
- UCR services are expanding access through strengthened single points of access, wider referral routes and more consistent pathways.
- GM Falls Lifting Service was shortlisted as an HSJ Awards 2026 finalist for integrated care and partnership working, demonstrating recognition of the GM approach.
- The GM Falls Lifting Winter Support Scheme will launch on 1 October 2026, building on strong outcomes from last winter, including supporting the majority of patients to remain safely at home and avoid hospital attendance.
- The SCC has developed a GM-wide OPEL Escalation, Surge and Recovery Framework, establishing clearer triggers, responsibilities and routes for collective action during periods of pressure. The

framework is now being socialised with providers and system partners ahead of implementation. This builds on the completed assessment against national standards and strengthened operational oversight, escalation contacts, action tracking and risk management.

Chief Strategy, People and Partnerships Officer - Alert Report

September 2026

NHS Greater Manchester Strategic Commissioning Committee

September 2026

Required information	Details
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report
Author	Paul Lynce, Jonathan Kerry, David Boulger
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	The Place Partnerships document suite was finalised following an eight-week partner engagement period and a four-week sprint process.

	NHS Greater Manchester responded to the national consultation on Neighbourhood Health contracts by the 10 September deadline. Positive feedback was received from NHS England on the Neighbourhood Health Readiness Assessment, with good practice highlighted across Rochdale, Bury, Stockport and the Greater Manchester-wide BeCCoR programme. A smokefree community spaces toolkit was co-produced with eight local community organisations. The toolkit was launched on 9 September through a national webinar attended by more than 100 colleagues. The Population Health Team contributed to national all-party parliamentary group roundtables on HIV and on smoking and poverty. The draft Greater Manchester HIV Strategy 2026–2030 was co-produced and progressed to system engagement. The Population Health transformation programme completed further due diligence, while retaining the planned go-live date of 1 April 2027.
Leadership and governance arrangements	This paper is produced for this committee and has not been elsewhere.
Engagement to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	There has been no formal engagement on this specific paper – however, it reflects 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 accessibility of report

Key Updates and Escalations

Alert
Place Partnership: Nothing for September Neighbourhood Health: Nothing for September Population Health: The original governance timeline for the Population Health transformation programme has been moved from September 2026 to November 2026 as some additional due diligence was required. The full 'go live' remains unchanged and will take place on 1/4/2027.
Advise
Place Partnership: The Place Outcomes Framework underpins the Place Health and Care Partnership (PHCP) document suite, setting out the shared outcomes, priorities and measures that partner organisations will work towards collectively at Place. It provides a consistent framework to align activity, resources and decision-making, supporting improvements in population health and a reduction in health inequalities. The Outcome Framework: • Defines what success look like for the Place Health and Care Partnership • Provides a shared basis for collective accountability for health, wellbeing and equality • Translates ambition into agreed measures and clear outcomes • Guides decision making, prioritisation and investment across partners • Focuses on impact rather than activity, with transparent tracking of progress Together with the wider Place Mobilisation components, including the Place Partnership Agreement, Place Governance Framework, Place Team arrangements and Place Funding Framework, this framework establishes a clear basis for shared accountability and performance. It supports partners to translate strategic ambition into coordinated delivery, enabling a collective focus on prevention, neighbourhood based care, and sustainable improvement in outcomes for residents. The outcomes are spilt against 4 objectives: <i>The number of outcomes is shown in the brackets</i>

1. A narrowing of the healthy life expectancy gap between the most and least advantaged communities, alongside a general uplift for all residents, measuring this through locally meaningful indicators of inequality, prevention, and early years development, anchored in what matters to people, such as “I feel supported to live a healthier life where I live.”, and also ensuring the future sustainability of the NHS and support economic growth. (27)
2. Increased proportion of care delivered in neighbourhood settings, reducing health inequalities, reliance on emergency services and enabling earlier support. (30)
3. Improved staff wellbeing and retention across sectors, as a marker of a compassionate, sustainable and inclusive local system. (9)
4. More effective use of local partners' collective resource to achieve shared outcomes; evaluating impact and taking an approach of continuous improvement. (12)

The Place Partnerships Outcomes Framework is due to be approved as part of the approval path for the entire Place Partnerships document suite during quarter 3. Running concurrently with approval, will be implementation planning for use of the outcomes framework and commencement of reporting to Strategic Commissioning Committee. Reporting of the outcomes will be done through production of a single place assurance narrative, produced by a reference expert group. It is anticipated that we will be able to commence this style of reporting in quarter 4, with testing and learning of the approach during Q4, with confidence in the method by quarter 1 of 2027/28.

Neighbourhood Health:

Each locality is due to complete its updated Neighbourhood Health Plan by the end of September and an update on progress will be brought to Integrated Care Board in October.

New data packs for Neighbourhood Health are being developed by the Data, Insight and Intelligence Team and will be ready for the end of September. This includes an interactive version of the Neighbourhood Packs. The interactive dashboard will enable users to explore and analyse neighbourhood-level information in a more flexible and user-friendly way, with the ability to filter, drill down and interrogate data according to local requirements. By providing a more interactive analytical experience, the dashboard will support place teams in identifying priorities, understanding variation, monitoring emerging trends and targeting interventions more effectively.

A further enhanced version of the Health Profiles Dashboard is also planned for release. The updated dashboard will extend the existing functionality by introducing neighbourhood-level analysis, enabling users to explore population demographics, health needs and service utilisation at a more granular geographical level. The dashboard will incorporate waiting list information, providing greater insight into elective care demand and supporting a more comprehensive understanding of population health needs, service pressures and care pathways.

In addition, to support our system planning, an evidence base is being developed which quantifies projected demand growth and associated financial pressures, enabling Place Based Partnerships to understand the scale of the challenge within their populations and develop locally led solutions to address future demand.

Population Health:

Work has been ongoing to co-produce a GM HIV Strategy for 2026-2030 and an engagement draft is now subject to system engagement. It is proposed that the final version will be brought to SCC for approval in October 2026. SCC colleagues are asked to confirm if this is agreeable.

Assure

Place Partnership:

The Place Partnerships document suite has been finalised through a 4 week sprint methodology following an 8 week period of engagement with partners. The suite will now progress through its approval path. This means that the Place Partnerships remain on track to be mobilised during quarters 3 and 4.

Neighbourhood Health:

NHS GM has responded to the national consultation on Neighbourhood Health contracts by the national deadline of 10th September. Our response set out what incentives and contractual mechanisms can best enable the delivery of our agreed system strategy as described through NHS GM's Five-Year Strategic Commissioning Plan

Population Health:

As recognised national experts, the NHS GM Population Health Team has participated in recent all party parliamentary group roundtables focussed on HIV, and on Smoking and Poverty. Through this, the ICB can influence national policy, strategy and legislation.

Risks discussed and new risks identified

The risk log is currently being developed and will be subject to further review and discussion at the next meeting of the Population Health and Neighbourhood Supporting Group on 11 September.

For audit purposes, a full list of current risks has been included in this AAA Report. Moving forward, only risks with a score over 12 will be included.

NH:001: The Neighbourhood model is applied inconsistently across GM. Current risk score = 16

NH:002: Partners do not maintain sufficient alignment and commitment. Current risk score = 16

NH:003: Accountability and decision rights remain unclear. Current risk score = 16

NH:004: Organisational priorities override system objectives. Current risk score = 16

NH:005: Financial pressures prevent investment in neighbourhood transformation. Current risk score = 20

NH:006: Commissioning mechanisms do not support neighbourhood delivery. Current risk score = 16

NH:007: Insufficient workforce capacity and capability restrict delivery. Current risk score = 20

NH:008: the cultural and behavioural change required is not achieved. Current risk score = 16

NH:009: Digital capability does not support integrated neighbourhood working. Current risk score = 16

NH:010: Information governance or cyber weaknesses disrupt safe information sharing. Current risk score = 15

NH:011: Communities are not meaningfully involved in neighbourhood design and delivery. Current risk score = 16

NH:012: Neighbourhood working widens inequalities or fails to improve equitable access. Current risk score = 16

NH:013: Activity and funding do not shift from hospital to community, sickness to prevention and analogue to digital. Current risk score = 20

NH:014: Pathway redesign creates clinical, safeguarding or continuity of care failures. Current risk score = 15

NH:015: Transition to neighbourhood delivery destabilises existing services. Current risk score = 20

NH:016: The ICB cannot demonstrate the outcomes or value of neighbourhood working. Current risk score = 16

NH:017: Transition to neighbourhood delivery destabilises existing services. Current risk score = 20

NH:018: Demand exceeds neighbourhood workforce and service capacity. Current risk score = 20

NH:019: Neighbourhood working does not address wider determinants of health. Current risk score = 20

NH:020: Estate, diagnostics and access arrangements cannot support neighbourhood delivery. Current risk score = 16

Mitigations for these risks are currently being worked through. A further update will be provided.

Mitigation plans for these risks are currently being developed and implemented. A further update on progress will be provided in due course. at the next reporting period.

Learning for sharing

Achievements

Place Partnership:

Nothing for September

Neighbourhood Health:

NHS GM received positive feedback from NHS England on our Neighbourhood Health Readiness Assessment.

We appreciated the continued openness and constructive engagement from you and your colleagues. The follow – up discussion provided an opportunity to further review progress and consider the system’s trajectory as neighbourhood health continues to develop.

The feedback from NHSE England highlighted specific examples of good practice in Greater Manchester, covering Rochdale, Bury Stockport and the GM-wide BeCCoR programme.

Population Health:

The NHS GM Population Health function, using funding provided through our involvement in the [Partnership for Health Cities](#), has co-produced a smokefree community spaces toolkit with 8 local community organisations. The toolkit was launched on 9th September via a webinar attended from over 100 colleagues from across the country. The toolkit is available [here](#) and the webinar can be accessed [here](#).

Performance Report 2026-2027

Strategic Commissioning Committee

October 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

Strategic Commissioning Committee Report

October 2026

Executive Summary



Greater Manchester

Overall position

- 8 Alert, 4 Advise and 5 Assure metrics.
- Key risks remain within UEC, elective care, Mental Health, and Learning Disability and Autism.
- The overall position supports a recommendation of partial assurance.
- The Q1 NOF ratings have been published. Both mental health providers are in segment 3 and of our 7 acute providers, 1 is in segment 1, 1 in segment 2, 4 in segment 3 and 1 in segment 4.

Alert (focused system oversight)

- UEC: 4-hour and 12-hour A&E performance remain off plan, reflecting continued patient flow and discharge pressures.
- Elective: Total waiting list remains above plan and is a material risk to the year-end trajectory.
- Mental Health: Talking Therapies reliable recovery and completed courses remain below plan; inappropriate OAPs remain above plan.
- Learning Disability and Autism: Inpatient numbers remain above plan across both cohorts.

Advise (continued oversight)

- RTT 18-week performance remains close to plan but requires continued oversight.
- Cancer 28-day FDS and 62-day treatment performance remain below plan.
- Talking Therapies reliable improvement remains marginally below plan.

Assure (on track / stable delivery)

- Category 2 ambulance response times, diagnostics, 31-day cancer treatment, IPS activity and community waiting times remain on or better than plan.

Key achievements

- Five headline metrics are rated Assure.
- 31-day cancer treatment performance and diagnostic waiting times both rank 4th nationally out of 36 ICBs.
- Category 2 ambulance response times continue to perform well against the national standard, remaining below the 25-minute target.

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.
- note the Quarter 1 provider NOF position, key changes in provider segmentation and that ICB results are awaited from NHS England.

2026/27 ICB Headline Planning Metrics (SCC oversight)



Greater Manchester

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

ICB										
Area	KPI	Period	Actual	Plan	Variance (latest published data vs same period in previous year)			ICB Benchmarking (published data)		
					2025	Variance	Movement	Jul-25	Jul-26	Movement
Elective	Percentage of RTT waiting list within 18 weeks	Jul-26	62.9%	64.0%	56.2%	6.7%	↑	34/36	32/36	↑
	Total waiting list	Jul-26	405,139	357,213	428,230	-23,091	↓			
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Jul-26	12.0%	12.9%	16.3%	-4.3%	↓	10/36	4/36	↑
Cancer	28-day cancer Faster Diagnosis Standard	Jul-26	79.5%	80.4%	77.9%	1.6%	↑	16/36	17/36	↓
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Jul-26	75.7%	75.9%	70.9%	4.8%	↑	15/36	7/36	↑
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Jul-26	96.5%	93.4%	96.6%	-0.1%	↓	3/36	4/36	↓
Mental Health	NHS Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness	Jul-26	46.2%	51.0%	43.6%	2.6%	↑	34/36	23/36	↑
	NHS Talking Therapies: Reliable improvement rate for those completing a course of treatment	Jul-26	67.8%	69.0%	63.4%	4.4%	↑	35/36	23/36	↑
	NHS Talking Therapies: No. completed courses of treatment (YTD)	Jul-26	3,045	3,846	3,045	0	↔			
	Number of patients accessing Individual Placement Support services (12-month rolling metric)	Jul-26	4,740	3,207	2,590	2,150	↑			
	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period (local data)	Aug-26	4	2	3	1	↑			
Learning Disability and Autism	Inpatient care for Adults with Learning Disabilities (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	Jul-26	86.5%	82.7%	83.9%	2.6%	↑	Benchmarking not yet available		

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



Greater Manchester

GM Providers / Ambulance Trust							
Area	KPI	Period	Actual	Plan	Variance (latest published data vs same period in previous year)		
					2025	Variance	Movement
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times	Aug-26	00:19:09	<00:25:00	00:20:30	-00:01:21	↓
	4-hour A&E performance	Aug-26	71.8%	75.5%	71.2%	0.6%	↑
	12-hour A&E performance (type 1&2)	Aug-26	8.1%	7.2%			
Elective	Percentage of RTT waiting list within 18 weeks	Jul-26	61.5%	62.9%	55.2%	6.3%	↑
	Total waiting list	Jul-26	438,906	418,333	464,542	-25,636	↓
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Jul-26	12.0%	10.7%	17.1%	-5.1%	↓
Cancer	28-day cancer Faster Diagnosis Standard	Jul-26	79.6%	80.2%	78.2%	1.4%	↑
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Jul-26	76.4%	76.4%	70.9%	5.5%	↑
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Jul-26	96.9%	94.3%	96.7%	0.2%	↑

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

26/27 Alert, Assure and Advise framework



Greater Manchester

Area	Metric	Alert	Advise	Assure
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times			
	4-hour A&E performance			
	12-hour A&E performance			
Elective	Percentage of RTT waiting list within 18 weeks			
	Total waiting list			
Diagnostics	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over			
Cancer	28-day cancer Faster Diagnosis Standard			
	Percentage of patients receiving a first definitive treatment for cancer within 62 days			
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days			
Mental Health	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 Disabilities (who may also be autistic)			
	Inpatient care for Autistic Adults (with no learning disability)			
Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less			

Oversight Framework Q1 2026/27: Provider Segmentation and Domain Performance

NHS Oversight Framework (NOF) Q1 2026/27 Provider Update



Greater Manchester

Overall Position

The Quarter 1 2026/27 provider results represent the first publication under the revised NHS Oversight Framework. Comparisons with 2025/26 should be interpreted with caution due to changes in methodology, segmentation thresholds and metric definitions. The Greater Manchester provider picture remains mixed, with providers represented across Segments 1 to 4. **The ICB Quarter 1 segmentation results have not yet been published by NHS England and are expected later in September.**

Current Assurance

- Two providers improved their segmentation position, one provider deteriorated and six providers remained unchanged compared to Quarter 4 2025/26.
- The Christie NHS Foundation Trust remains the highest ranked Greater Manchester provider, ranking 9th nationally and retaining Segment 1.
- Greater Manchester Mental Health NHS Foundation Trust and Pennine Care NHS Foundation Trust have both improved from Segment 4 to Segment 3.
- Manchester University NHS Foundation Trust has moved from Segment 1 to Segment 2.
- Northern Care Alliance NHS Foundation Trust remains the only Greater Manchester acute provider within Segment 4.
- The majority of Greater Manchester providers are currently within Segment 3.

Key Themes

- Acute provider performance remains variable across Greater Manchester, with organisations represented across Segments 2, 3 and 4.
- Mental Health provider performance has improved, with both providers moving out of Segment 4.
- Workforce, patient experience and effectiveness measures continue to be common areas of challenge across a number of providers.
- NHS GM continues to monitor provider and ICB metrics through established NOF assurance arrangements pending publication of the ICB results.

Ask of the Committee

Committee is asked to note the Quarter 1 provider NOF position, key changes in provider segmentation and that ICB results are awaited from NHS England.

NHS Oversight Framework Q1 2026/27: Provider Segmentation and Domain Performance



Greater Manchester

Acute Provider	National rank	NOF Segment	Average score	Access	Patient safety	Finance	People	Experience	Effectiveness
The Christie NHS Foundation Trust	9 / 134	1	1.81	No data	1	3	1	1	4
Manchester University NHS Foundation Trust	29 / 134	2	2.24	2	2	3	2	2	1
Stockport NHS Foundation Trust	44 / 134	3	2.22	2	2	2	2	1	4
Tameside and Glossop Integrated Care NHS Foundation Trust	59 / 134	3	2.35	1	3	2	4	4	2
Bolton NHS Foundation Trust	74 / 134	3	2.45	3	2	3	4	4	1
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	109 / 134	3	2.73	3	4	1	4	4	4
Northern Care Alliance NHS Foundation Trust	123 / 134	4	2.83	3	4	4	3	3	4

Mental Health Provider	National rank	NOF Segment	Average score	Access	Patient safety	Finance	People	Experience	Effectiveness
Pennine Care NHS Foundation Trust	48 / 58	3	2.60	4	4	1	4	2	2
Greater Manchester Mental Health NHS Foundation Trust	56 / 58	3	2.74	4	4	2	4	4	1

Segment 1: strongest performance
 Segment 2: generally performing well
 Segment 3: improvement required
 Segment 4: significant concerns

The 2026/27 NHS Oversight Framework includes revised metrics and methodology. Comparisons with 2025/26 should be interpreted with caution.

Appendices

Domain Performance – Elective Care & Diagnostics

Narrative provided for alerts only



Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	- Total waiting list is the Alert metric, with all seven acute providers worse than plan, the ICB is also behind plan. - RTT 18-week performance is rated Advise, with four of seven providers worse than plan, the ICB is also behind plan. - DM01 is rated Assure at ICB level. Performance is better than plan for the ICB, although the provider aggregate is 1.3 percentage points below plan and four of seven providers are off plan, the ICB is also behind plan.	- Delivery of the total waiting list trajectory remains the principal elective risk, with all seven acute providers currently worse than plan. - RTT 18-week performance remains below plan in four providers, indicating continued variation in delivery. - Although DM01 is better than plan at ICB level, four providers remain below plan and continued improvement is required to reduce variation. - Sustained recovery will depend on delivery of provider trajectories, productivity improvement, demand management initiatives and effective use of available capacity.	- Continued oversight through the Elective Recovery Board, with routine monitoring of total waiting list trajectories, RTT performance and provider recovery plans. - Performance, trajectories and delivery risks are reviewed through contract management and assurance meetings, with targeted support and challenge provided where providers are off plan. - Demand management initiatives continue through Beyond Core Contact Review, Advice and Guidance, Community Services and Single Point of Access programmes to reduce avoidable referrals and support pathway management. - Additional elective capacity continues to be utilised through Independent Sector providers and treatment provided outside Greater Manchester to support delivery of recovery trajectories. - Diagnostic improvement programmes remain focused on capacity and demand reviews, productivity improvement, reducing missed appointments, pathway redesign and workforce development to maintain performance and support recovery.	SR2

Elective Care and Diagnostics has one Alert metric: total waiting list. All seven acute providers are worse than plan and delivery of the year-end waiting list trajectory remains the principal elective risk. RTT 18-week performance is rated Advise, with four of seven providers below plan. DM01 remains rated Assure at ICB level, although four providers remain below plan, requiring continued oversight. Improvement activity continues through elective recovery arrangements, waiting list validation, productivity improvement, demand management programmes, additional treatment capacity and diagnostic improvement initiatives.

Domain Performance – Urgent and Emergency Care (UEC)

Narrative provided for alerts only



Greater Manchester

	Current position / performance	Issues of concern	Key actions taken/improvement programmes and impact	Links to BAF risks
Alert	- Two Urgent and Emergency Care metrics are rated Alert. 4-hour performance remains below plan across all six acute providers. 12-hour waits remain above plan, with four of six providers above trajectory. - Category 2 ambulance response times remain rated Assure and continue to perform better than the national standard.	4-hour performance and 12-hour waits remain above plan, reflecting 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.	- NHS GM SCC supports shared oversight of 12-hour waits and manages system pressure through OPEL monitoring, coordination and escalation, enabling earlier identification of deterioration and coordinated system action to reduce 12-hour waits. - The SCC and Mental Health Programme Team are reviewing the escalation process for mental-health patients in ED, as this cohort experiences some of the longest waits and contributes disproportionately to 12-hour breaches. - Care Coordination and the GM UEC Single Point of Access continue to be developed to improve access to appropriate community alternatives, reduce avoidable ED demand and strengthen patient flow across urgent and emergency care pathways. - Winter preparedness plans are being implemented across providers and Places, with continued focus on operational resilience, demand management and discharge improvement.	SR2

Urgent and Emergency Care has two Alert metrics: 4-hour and 12-hour A&E performance. Four-hour performance remains below plan across all six acute providers, whilst 12-hour waits remain above plan in four providers. Performance continues to be impacted by patient flow, discharge delays and operational capacity pressures. System actions remain focused on strengthening oversight of 12-hour waits through OPEL coordination and escalation, improving pathways for mental-health patients attending Emergency Departments, developing community alternatives through Care Coordination and the GM UEC Single Point of Access, and supporting delivery through winter preparedness arrangements.

Domain Performance – Cancer

Narrative provided for alerts only



Greater Manchester

No Alert metrics

- Cancer continues to perform comparatively well, with no metrics rated Alert.
- 31-day treatment performance is better than plan and ranks 4th nationally out of 36 ICBs.
- 28-day FDS remains below plan for both GM providers and the ICB.
- 62-day performance is at plan for GM providers but below plan at ICB level.
- The 28-day and 62-day standards remain rated Advise and continue to be monitored through Cancer Alliance governance.

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	Five Mental Health and Learning Disability & Autism metrics are rated Alert. NHS Talking Therapies reliable recovery and completed courses of treatment, inappropriate Out of Area Placements and Inpatient numbers for adults with Learning Disabilities and autistic adults.	Mental Health - Talking Therapies outcomes and activity remain below trajectory. - Ongoing capacity, flow and discharge pressures continue to impact Out of Area Placements. Learning Disability & Autism - Inpatient numbers remain above trajectory across both cohorts. - Progress remains dependent on community alternatives, timely discharge and appropriate step-down provision.	- Continued oversight through Mental Health governance and assurance arrangements. - Targeted improvement work to support Talking Therapies recovery, improvement and activity measures. - Continued focus on reducing inappropriate Out of Area Placements through improved discharge planning and community alternatives. - Ongoing work to reduce inpatient reliance through crisis support, admission avoidance and step-down provision.	SR2

Mental Health and Learning Disability & Autism has five Alert metrics relating to NHS Talking Therapies performance, inappropriate Out of Area Placements and Learning Disability & Autism inpatient care. Performance continues to present delivery risks across outcomes, capacity and patient flow. System actions remain focused on improving Talking Therapies outcomes, reducing Out of Area Placements and supporting reductions in inpatient reliance through strengthened community alternatives and discharge arrangements.

2027/28 Commissioning Framework 2026-2027

Strategic Commissioning Committee

7th October 2026

Report information.

Required information.	Details.
Title of report.	NHS GMs 2027/28 Commissioning Framework Full document is included in Appendix A.
Author.	Gill Baker – Director of Healthcare Commissioning
Presented by.	Katherine Sheerin – Chief Commissioning Officer
Contact for further information.	Gill.Baker5@nhs.net
Executive summary.	The 27/28 Commissioning Framework is the delivery vehicle for the first year of the 5yr Strategic Commissioning Strategy. The slides describe the key components of the framework and summarise the primary elements. The Framework is NHS GMs mechanism of communicate to all providers what will be commissioned differently in 27/28 and what the expectations of providers are. The framework is integral to the 27/28 Operational Planning round process and sets the direction for providers, to ensure they have a framework to consider when developing their operational plans.

The benefits that the population of Greater Manchester will experience.	The report refers to all aspects of NHS GMS commissioned services and how they are expected to be delivered in 27/28 for the whole population. The report supports the delivery of the national constitutional standards.
How health inequalities will be reduced in Greater Manchester's communities.	The report aligns the 5yr Strategic Commissioning plan, with the 4 core objectives of the organisation being front and centre. The main aim is to reduce variation and ensure all communities' needs are met.
The decision to be made and/or input sought.	The Board / Committee is asked to: 1. Note the content of the framework and support the approach.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This supports the delivery of the 5r yr Strategic Commissioning Strategy and the delivery of constitutional standards.
How this aligns to the new strategic objectives.	This aligns to all 4 strategic objectives, following the flow of the 5 yr Strategic Commissioning Plan.
Key milestones.	Issues to providers by 30 th September 2026 and for delivery through 27/28
Leadership and governance arrangements.	<i>The leadership of the Framework is through the Commissioning Delivery Group, as a sub-group of the Strategic Commissioning Committee.</i>
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	Commissioning Delivery Group – 3 rd September 2026 Trust Provider Collaborative – 25 th September 2027

Financial or Legal Implications	There are financial implications to elements of the Framework, however these specifics have already been taken through NHS GMs governance and are known. The Framework brings the commissioning intentions together and ensure that there is a structured approach to support the Operational Planning process.
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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	Yes	Yes	Yes	No	No	No	No

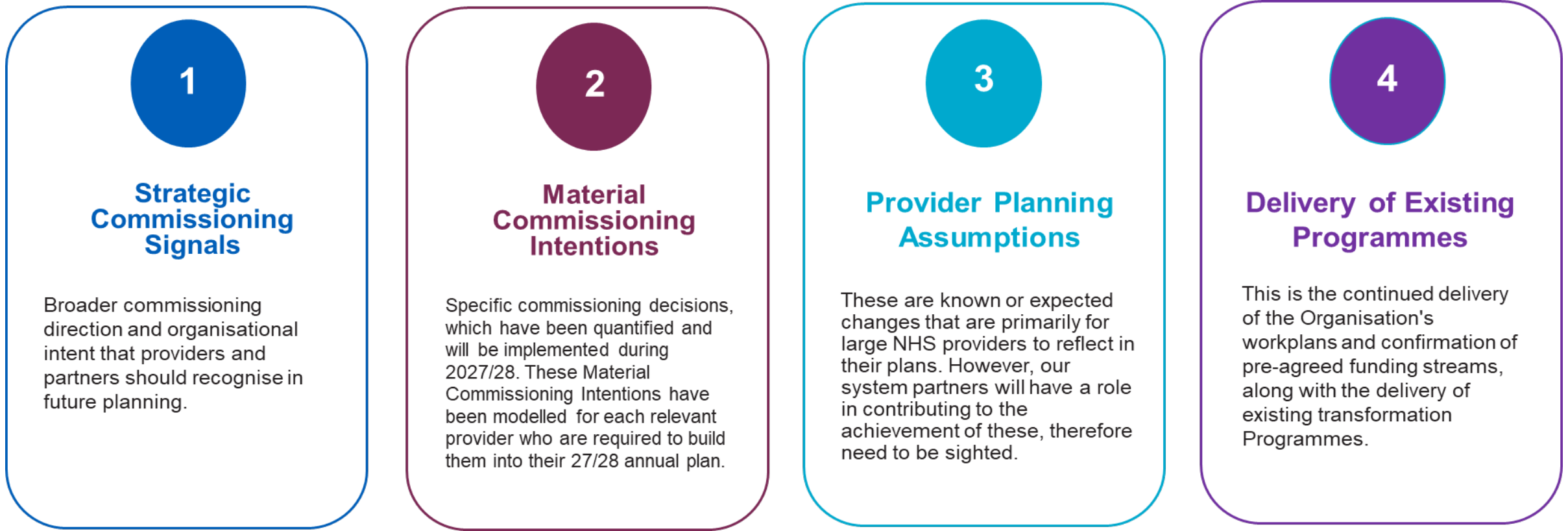
2027/28 Commissioning Framework

Summary messages

Strategic Commissioning Committee Meeting – 07 October 2026

Commissioning Framework - Overview

- NHS GM will be issuing each provider with a copy of the 27/28 Commissioning Framework by the 30th September 2026. The diagram below illustrates the key component parts of the framework.



Summary of Key Messages



Greater Manchester

This pack contains further detail on the Commissioning Framework, however the important messages for TPC members are outlined below.

- We will have provider specific discussions through the autumn to understand the impact of the framework on activity and finance, and ultimately on 27/8 contract offers.
- We have set some initial provider assumptions in this pack, detailed in slide 9. There will be further detail and some expansion on these in the individual provider packs that will be issued next week.
- Neighbourhood Health is the central tenet of our strategy. Next week's publication will be clear on the components of neighbourhood teams and the required work to address the needs of high-risk cohorts of patients.
- Physical and mental health care will feature in all neighbourhood health teams.
- We are concluding modelled, quantified activity for neighbourhood health teams
- The modelled impact of neighbourhood teams will inform a review of care models including acute services during 27/8.
- This will involve an examination of what the future of district general hospital care will need to be in GM.
- On UEC;
 - We will fully implement the new GM major trauma centre service.
 - We expect each trust to implement UEC SPOAs
 - We will develop a single GM frailty model for implementation in 27/8
 - We will specify increased use of Urgent Community Response teams jointly with social care and embedded within neighbourhood teams.
 - Each of these will carry a quantified reduction in ED demand to be agreed with each trust.

Summary of Key Messages (2)

- On elective care:
 - We will continue to see a quantified further reduction in admitted pathways through SPOA, A&G, BeCCoR and community alternatives.
 - OP reform will develop at pace in concert with the development of neighbourhood teams and we will explore opportunities for OP budget delegation.
- On mental health:
 - We will continue to support a reduction in bed-based care and the expansion of neighbourhood mental health and specialist community teams.
 - We will support the conurbation-wide transformation of mental health care levelling-up standards to those of the best in every neighbourhood.
- On children's services:
 - We will co-develop a new GM strategy for children and young people
 - We will review the demand and capacity needed to expand community-based physical health care for children and young people.

Summary of Key Messages (3)



Greater Manchester

- Sustainability does not lie in individual organisations. We will expect partnership working across sectors with leadership from within, including through the work on the Market Development Strategy.
- We will develop new contract models:-
 - lead provider arrangements through MFT and application of IHO principles.
 - lead provider arrangements for cancer care through the Christie with partners across GM
 - lead provider arrangements for LDA with our two mental health trusts.
 - collaborative contracts across VCFSE sector and with statutory organisations
- The completion of the deconstruction of **acute care** block contracts will be a key deliverable for 27/28. This will impact on provider contracts and requires a transparent approach to ensuring that NHS GM and the system are accurately understanding costs in the system and making appropriate use of funding.

The following gives a further indication of our Strategic Commissioning Signals; as previously referenced these will be issued in full to providers and our system partners as part of the issuing of our 27/28 Commissioning Framework.

- **Deliver Neighbourhood Health across all 10 Places and 67 neighbourhoods**, with integrated multi-disciplinary teams and stronger local leadership.
- **Embed Live Well and prevention approaches**, addressing the wider determinants of health and reducing future demand on NHS services.
- **Strengthen Place-Based Commissioning**, using place partnerships, shared outcomes and local delivery models to improve population health.
- **Improve access and shift care into community settings**, reducing reliance on hospital-based care wherever clinically appropriate
- **Modernise commissioning and contracting arrangements**, including new provider models that support neighbourhood delivery and integration
- **Increase transparency and value within provider contracts**, including greater understanding of block contract expenditure and ADHOC funding arrangements.
- **Review and redesign children's services based on population need**, ensuring future investment is targeted to improve outcomes and reduce inequalities
- **Promote system-wide collaboration and workforce sustainability**, supporting integrated delivery across providers and sectors
- **Support financial sustainability and productivity**, ensuring resources are deployed effectively whilst delivering strategic transformation.

There are 19 material commissioning intentions grouped into four themes. A summary of the themes is highlighted below, with the following slides outlining further detail. The full detail of these and the associated activity modelling will be issued to providers as part of the 27/28 Commissioning Framework.

1. **Prevention & Diagnostics (3)**
2. **Community Care Expansion & Workforce Development (10)**
3. **Service Reconfiguration & Efficiency (3)**
4. **Mental Health & CYP Services (3)**

The overarching objectives are to reduce waiting times, shift care into community settings, improve workforce capacity, reduce hospital admissions, improve patient outcomes, and deliver more sustainable GM-wide service models.

Prevention and Diagnostics

1. **Familial Hypercholesterolaemia (FH) Service** - Develop a sustainable GM-wide service. To improve diagnosis, treatment and prevention of cardiovascular disease.
2. **Respiratory Diagnostics Programme** - Improve access to spirometry, FeNO and related diagnostics. To reduce variation and improve early diagnosis.
3. **CYP2C19 Genotyping in Stroke Services** - Introduce pharmacogenomic testing. With expected impact to reduce future stroke and bleeding events.

Community-Based Services and Workforce Development

1. **Community ENT & Audiology Expansion** - Increase community-based ENT and Audiology services. With an expected impact to reduce RTT waits and hospital referrals.
2. **ENT & Audiology GPwER Training** - Train 20 GPs with Extended Roles (GPwERs), which will increase specialist ENT capacity in community settings.
3. **Community Gynaecology Expansion** - Increase community-based gynaecology services. With an expected impact to reduce RTT waits and hospital referrals.
4. **Gynaecology GPwER Training** - Train 10 GPwERs to deliver local community gynaecology clinics.
5. **Community Cardiology Service** - Develop community specialist cardiology pathways. With expected impact to reduce RTT waits and outpatient demand.
6. **Cardiology GPwER Training** - Train 40 GPwERs to deliver community cardiology services.
7. **Community Dermatology Service** - Mobilise the new GM-wide community dermatology model. With expected impact to reduce waits and hospital activity.
8. **Community Vasectomy Service** - Move routine vasectomy procedures into community settings. With expected impact in increasing secondary care capacity.
9. **Integrated Community MSK Service** - Implement new GM Tier 2 MSK model and specification.
10. **District Nursing Specification** - Implement new GM-wide district nursing service specification

Service Reconfiguration and Efficiency



Greater Manchester

1. **Neuro-Rehabilitation Bed Reduction** - Decommission five non-operational beds at Trafford Unit.
2. **Non-Emergency Patient Transport Service** - Mobilise new provider/service model. With an Expected impact to support discharge and reduce delays.
3. **Vascular Surgery Reconfiguration** - Transfer arterial vascular surgery from Royal Oldham to MRI. To Improve resilience, reduce waits, and strengthen specialist services.

Mental Health and Learning Disabilities

1. **Eating Disorder Day Case Model** - Develop community/day-case services and ARFID provision. To reduce inpatient admissions and length of stay.
2. **Children and Young People's Crisis Care** - Implement new GM-wide mental health crisis model. To reduce admissions and A&E attendances.
3. **Shared Care Medicines Model** - Develop new shared-care arrangements for, Mental Health, ADHD and Gender Transition services

Taking into consideration our strategic signals and material commissioning intentions, we have modelled a set of assumptions that we wish to engage with providers on over the course of the next few weeks. Our initial statements on these are as follows:-

- Based on demographic and non-demographic growth, Elective Care demand growth is expected to be **2.3%**, however as a result of improvement initiatives and our material commissioning intentions are expecting this to reduce **to 1%**.
- The forecast growth for UEC is **4.0%**, **however we expect this to reduce to 2.0%**, with improvement work and productivity gains.
- We expect that a forecast growth of **4% in Cancer demand to reduce to 2%, based on demand management initiatives.**

The above position will be issued to providers individually in detail, with context of each provider's current position.

This category recognizes the following:-

- The need for continued delivery of transformation work that is currently underway in all NHS GM portfolio's and across the system.
- The development and delivery of NHS GM's operational workplans
- The communication of 27/28 schemes which have already had funding decisions made.
- The contract review pipeline and the detail of contractual renewals required through 27/28
- The delivery of Capital schemes which are due to complete in 27/28

Providers will receive a letter and the full content of the commissioning framework by the 30th September. This will be in the form of a document that covers the details of all 4 components of the framework, along with an individualised activity modelling pack.

NHS Greater Manchester's 2027/28 Commissioning Framework

September 2026

NHS Greater Manchester has ambitious plans to improve the health of our population. We have a Five Year Strategic Commissioning Plan which outlines our ambition and the core deliverables for our organisation.

It is imperative that we act upon the delivery of this strategy and to ensure that we start to make significant change in 2026/27. This document sets out our Commissioning Framework to make this happen.

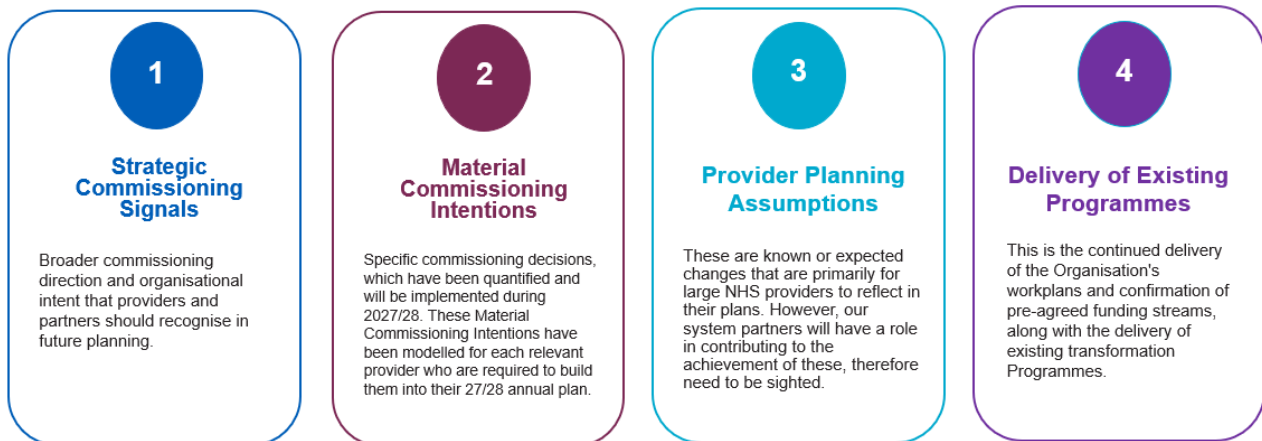
The framework will be our mechanism to embark on our major transformation plans, which are far reaching and require all our Providers and their workforce to be come together to achieve. Everyone has a role to play in the realisation of these ambitions, with clinical leadership at the heart of every part of our system.

The delivery of Neighbourhood Health is the keystone to this transformation agenda; we will expand further on this throughout this document.

The 27/28 Commissioning Framework is to be utilised alongside the National Planning Guidance issued by NHS England, which clearly outlines the required national constitutional standards for the system.

This framework is applicable to all our commissioned providers, and it is important that all our partners are sighted on our 27/28 Strategic Commissioning Plans.

The Framework consists of the following 4 components: -



There are elements of the framework that are tailored specifically to large NHS Providers, who are required to submit an annual finance and activity plan, as per the National Planning process.

This document sets out the detail of the 4 components above.

Strategic Commissioning Signals

Neighbourhood Health

Our Strategic Commissioning Plan 2026-2031 (finalised in July 2026) describes what and how we will commission over the next five years to ensure high-quality service provision and sustained improvement in the health of our population.

The Plan emphasises that the 10 places in Greater Manchester, and the 67 neighbourhoods within them, are where we must start to meet need differently. This begins with Live Well as the most significant commitment that Greater Manchester has ever made to addressing the social determinants of health which drive much of the pressure on NHS services.

This means we are not only integrating health and care services but, through Live Well, uniting the full range of public services and support (including the VCFSE) into a fully integrated, preventative system to meet need in a different way and reduce demand on services.

Place partnerships are integral to the delivery of neighbourhood working, prevention and Live Well. We have therefore designed our Place Partnership Model to enable this delivery. We have done this through a combination of:

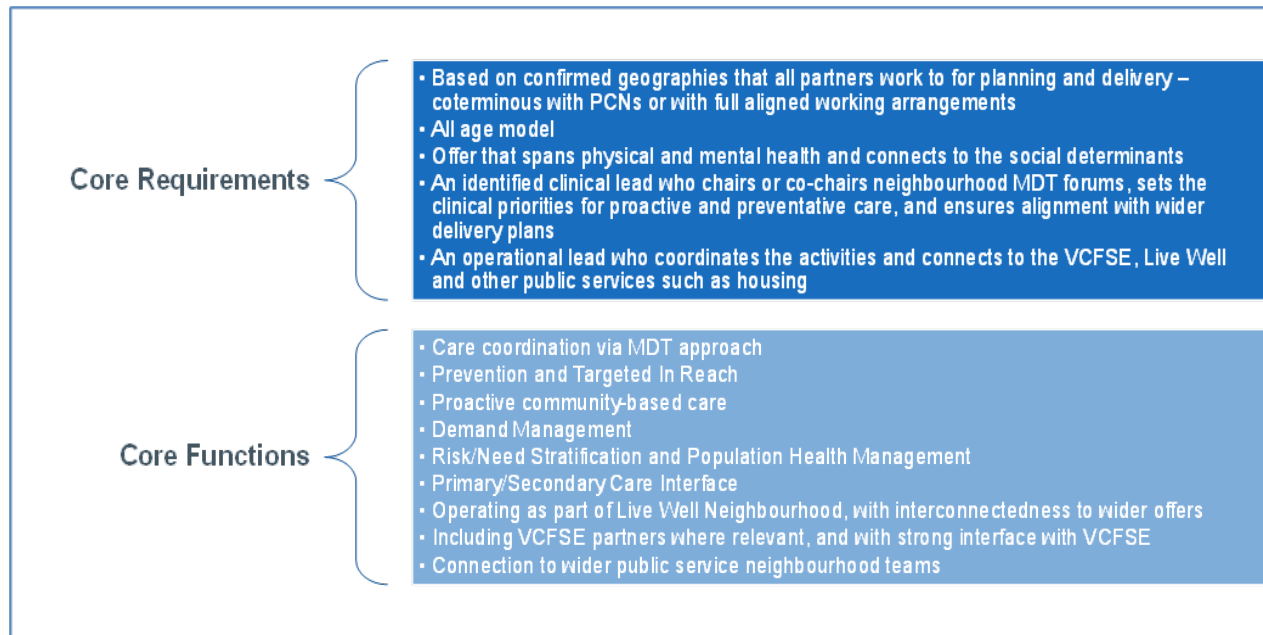
- A Place Partnership Agreement
- Place Outcomes
- Place Fund
- Place Teams

Integrated Place Partnerships require the commitment of all our providers working together to deliver the outcomes that have been set for them.

We have set out the core standards for Neighbourhood Health that people in Greater Manchester can expect whichever locality or neighbourhood they are in. This starts with a core set of functions that each neighbourhood will need to carry out. This is summarised below:

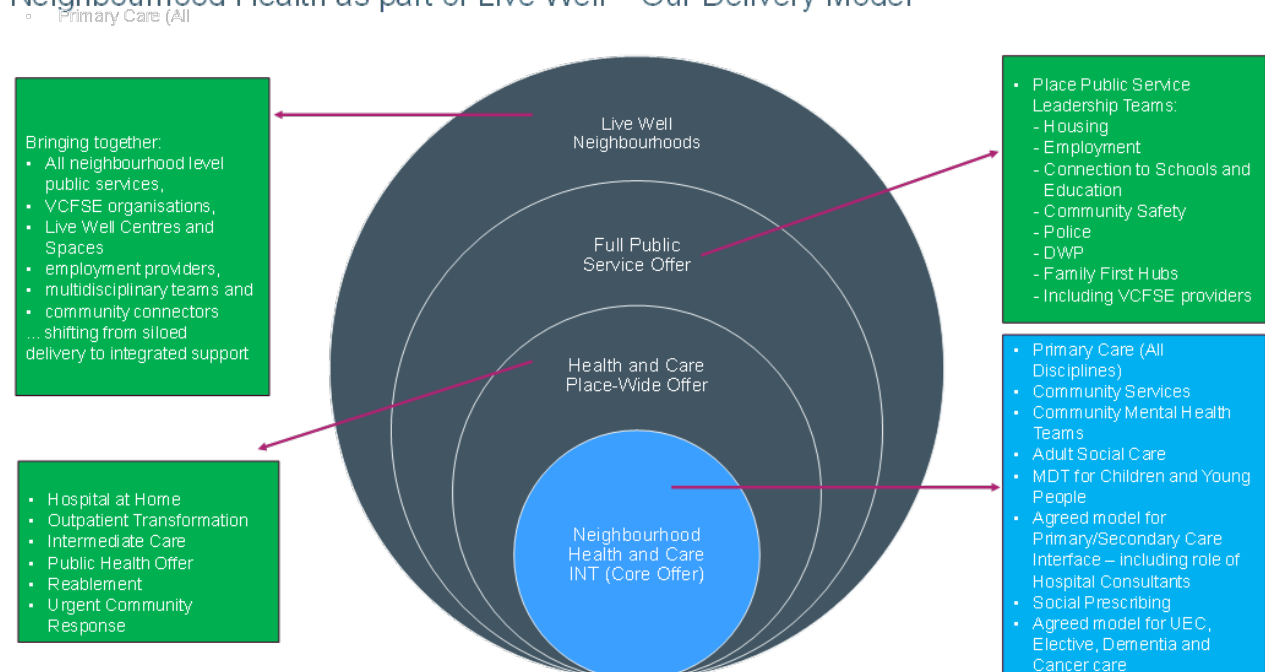
Needs Assessment and Planning	Risk/Need Stratification	Integrated Neighbourhood Teams	Metrics and Outcomes
• JSNA carried out in each locality to inform Neighbourhood Health Plans • Single Neighbourhood Plan for each locality – including alignment to national and GM requirements	• Risk/Need stratification process for every neighbourhood • Agreed set of GM digital products to be used in every place and neighbourhood	• Full coverage of whole locality population • Named clinical and operational leadership for each INT • Set of core service offers	• Single Place Outcomes Framework used consistently across GM • Core set of performance and quality metrics used in every neighbourhood • Focus on reducing inequalities

This leads into the core functions and requirements for each Integrated Neighbourhood Team as shown below:



Integrated Neighbourhood Teams for Health and Care form the central part of the model and should be available consistently across Greater Manchester. These teams will be complemented by the wider infrastructure in the locality as part of Live Well. This is depicted below:

Neighbourhood Health as part of Live Well – Our Delivery Model



Each locality is currently finalising its Neighbourhood Health Plans, as per the National Framework, and these plans will run through to March 2028. NHS GM is committed to a GM-wide soft launch of Integrated Neighbourhood Teams in all 10 places from the start of Q3 27/28.

Neighbourhood Profiles

Each of our 10 localities has a detailed neighbourhood profile pack. The packs support localities and neighbourhood teams on where to target their interventions. The packs include the following sections:

Theme	Content
Population and Prevalence	- How the population is structured. - Which long-term conditions (LTCs) are most prevalent. - How does this differ by age group. - How does this differ by ethnicity. - How does this differ by deprivation - How does this differ by sex
Activity	- What LTCs are associated with the highest activity? - What LTCs are associated with repeat activity? - How does this differ by age? - How does this differ by ethnicity? - How does this differ by deprivation? - How long do people stay when they are admitted?
Conditions of Concern	To aid a deeper understanding about the conditions that may be of concern to the locality including: - How much of a concern are the identified conditions when compared with other localities? - How has this changed over time? - Where are there particular problems for these conditions? The conditions vary for each locality but typically include Frailty; CVD; Respiratory and Depression

The Neighbourhood Packs are available for all ten place teams and have been developed to support the objectives of the Neighbourhood Health Improvement Programme (NNHIP).

In addition to these a significant amount of work has been done regarding predictive modelling; we expect that this is taken into consideration as part of our transformation journey.

Place Outcomes Framework

As previously mentioned, our strategy for Neighbourhood Health is based on role of our 10 Place Partnerships in bringing together partners to deliver a shared set of outcomes.

The Place Outcomes Framework defines what success looks like for the Place Health and Care Partnership and the neighbourhoods within it; translates the ambition into agreed measures and clear outcomes; and focuses on impact rather than activity, with transparent tracking of progress.

A copy of the outcomes Framework is included in this pack.

We expect all of our providers to be working in partnership through the Integrated place partnership arrangements to ensure the delivery of these outcomes. We will be holding to account the Integrated Place Partnerships for the delivery of the outcomes framework.

The roles of providers in delivering prosperous Neighbourhood Health.

As we increasingly work on neighbourhood footprints, the ICB and partners will focus on changing culture in the system, breaking down barriers between sectors and services and working to place and neighbourhood before organisation. This will include how we strengthen the connection between Live Well and Neighbourhood Health and secondary care clinicians whose practice, we expect, will be increasingly defined by population health rather than waiting lists and bed numbers.

The ICB will increasingly commission these models and create the right conditions for all providers to work together to deliver them.

We expect our provider collaboratives, encompassing all sectors of the system, to play a vital role in this: the Trust Provider Collaborative (TPC); Primary Care Provider Board (PCPB); and the Alternative Provider Collaborative (APC).

Whilst there are important bilateral relationships between the ICB and individual providers, there is more benefit to come from GM providers working as one, on key service and delivery challenges. We are working closely with TPC on how we will realise this opportunity. Notwithstanding the pan-GM, regional or national services provided by some of our trusts, there are opportunities for greater collaboration between trusts covering neighbouring geographies in GM. These opportunities are as follows:

- In the north of the conurbation collaboration between Wigan Wrightington & Leigh NHS FT, Bolton NHS FT and the Northern Care Alliance NHS FT
- In the south of the conurbation collaboration between Stockport NHS FT, Tameside and Glossop Integrated NHS FT, East Cheshire NHS Trust and Manchester NHS FT
- Collaboration between the two largest, multi-site trusts – Manchester NHS FT and the Northern Care Alliance NHS FT
- Further collaboration between Greater Manchester Mental Health FT and Pennine Care NHS FT

As we work with the system on the development of these opportunities, we will be examining the future of our District General Hospitals and the types of services that they deliver in the future.

Children's & Young People's Services

As stated in our Five Year Strategic Commissioning Plan, it is imperative for us to ensure we are meeting the needs of our population in the younger years of their lives. As a result, Children's Services will receive a disproportionate level of attention in our transformation plans throughout 27/28.

To ensure the achievement of this, we will be undertaking a Commissioning review of community Paediatric Services. This review will consider current capacity, demand and any future needs analysis.

Our expectation is that Children's Services will form part of Neighbourhood Health models, and we will be working with existing service providers, to carry out this review.

Beyond Core (BeCCoR) – supporting primary care to ‘go beyond’ their contractual obligations

In 26/27 NHS GM invested further in BeCCoR and launched a consistent GM BeCCoR General Practice scheme from April 2026. The delivery of this scheme is underway and encompasses 5 pillars of work which General Practice are currently delivering:

- Quality and Sustainability: supporting general practice to develop via a quality improvement framework to evidence and measure impact across essential and aspirational criteria
- Prevention, Proactive Care and Neighbourhoods: delivering proactive and preventative care to those with the highest unmet need in Cardiovascular disease, Respiratory disease and Renal disease and those at risk of falls and confusion in relation to polypharmacy.
- Elective Quality Improvement: to take a quality improvement approach to demand management by optimising alternatives to referral and embedding and Advice First approach.
- Medicines Optimisation: quality and safety work across key medicines priorities such as Antimicrobial Stewardship
- Locally retained services: maintaining stability of current core offer through local service delivery

The evidence of benefit from BeCCoR is clear. For example, the BeCCoR CVD work has supported GM in an accelerated improvement in NOF CVD metrics, in reducing service utilisation in relation to CVD for both planned and unplanned admissions and in a demonstrable reduction in admissions due to MI (heart attacks) since the work began in 2024.

Given this evidence of benefit, this investment and programme of work, delivered through our primary care providers, will be maintained through 27/28. The 2027/28 scheme will be updated based on learning and early evaluation of the current delivery.

Our intention is to expand BeCCoR across Community Pharmacy, Optometry and Dental Primary Care Providers, embedding the learning and evidence from the BeCCoR work done across General Practice. This will be a multiyear programme starting over 2027/28, within available prioritisation of budgets. Further information on this will be provided throughout the year.

The impacts of BeCCoR schemes over 2027/28 will contribute to contribute to GM key priority areas:

- Measurable quality and patient safety improvements, including for medication safety and targeted ICB NOF metrics
- Prevention/Proactive care: contributing to demand management, improvement in health of GM population and reduction in unplanned admissions/clinical complexity/multiple LTCs
- Acceleration of neighbourhood working for the BeCCoR ‘high unmet need’ cohorts of our population
- Contribution to Elective demand management through adoption of advice first approach, and in future years will support elective transformation through neighbourhoods.

Elective Care

Outpatient transformation represents a significant opportunity for early progress and impact. A review of evidence indicates that c40% of new Outpatient demand from a primary care referral could be managed outside of hospital. You will see our commitment to supporting the achievement of this described in our Material Commissioning Intentions, later in this document.

As part of our plans for elective care, we have considered some of the types of patients who might benefit from Neighbourhood Based Elective Care. This includes:

- **Single-condition, episodic care need:** for less complex patient cohorts in certain (medical) specialties, moving setting of care out of hospital and into neighbourhoods.
- **Multi-condition, complex care needs:** for more complex patient cohorts with certain overlapping characteristics, implementing an MDT approach and joint working between GPs and specialists.
- **Paediatrics:** combination of single-condition episodic care and community paediatrics.
- **Case finding of at-risk patients and proactive intervention:** patients who do not have a referral, are not on a waiting list and therefore are not “known” to the health system yet are likely to have or to develop poor health.

It is anticipated that these cohorts of patients will form a majority of those likely to access neighbourhood services for elective care and will form the focus for service design.

In addition to the above, key areas of focus for providers are as follows: -

- Implementation of outpatient templates, in line with GiRFT targets.
- Implementation of outpatient follow-up protocols at a pathway level.
- Full utilisation of Elective Hubs
- Achieve optimum day case rates, in line with BADS targets
- Ensure optimum levels of theatre productivity (Theatre utilisation & theatre estate utilisation)

Urgent & Emergency Care

Our approach to improving Urgent and Emergency Care is through the management of demand and supporting patients to stay well, preventing them from escalating into Urgent Care Services. This is the role of our Integrated Place Partnerships.

The primary tool to deliver this will be through the Neighbourhood Health model described earlier in this document.

However, to ensure good safe quality care for our patients, we will be expecting NHS Acute providers to continue to develop and embed their models of Integrated Urgent Care SPoAs, contributing to the demand management and left shift agenda. Some excellent examples of well develop Integrated Urgent Care SPoAs have already been established in the system, and we will be expecting providers to share their best practice and to build on the momentum that these models are achieving.

We will also be expecting the further embedding of the national best practice principles outlined in the Model ED framework. These tools are key to reducing long waits in Emergency Departments and improving the quality of care for patients. Corridor Care and 12hr waits in Emergency

Departments need to be eradicated, this will be achieved by all providers implementing the GiRFT Operational clinical standards within the Model ED framework.

NHS GM is committed to co-designing a single model for frailty across GM, ensuring the mechanisms are in place for the early identification of this co-hort of patients, with the appropriate pathway support and management of care.

Within this work, the approach to supporting patients who have higher than expected contacts in the UEC system will be addressed. This co-hort of patients is typically described as “High Intensity Users” and have varying reasons as to why they regularly access urgent care. The appropriate holistic management of these patients can and will improve their outcomes. This will be a key role for Integrated Place Partnerships.

Mental Health Services

NHS GM is committed to a more preventative, neighbourhood model of mental health, which requires greater collaboration between the two specialist mental health trusts in GM. There is an opportunity to accelerate single delivery models of specialist and community mental health services consistently across GM, drawing from the best of both providers and building on their strengths.

The key opportunities for us to transform mental health provision in Greater Manchester will come from the two mental health trusts stepping-up their approach to GM-wide collaboration, and drawing-in contributions from other providers on mental health and care, specifically to:

- Accelerate the single delivery model of specialist and community mental health services consistently across GM, drawing from the best of both providers and building on their strengths. Eliminating duplication potentially by a single approach to a mobile population, reducing hand-offs of care and improving the consistency of excellent care across the GM system.
- Take the opportunity to go further, faster and drive improvements in safety and quality of care and reduce variation, through unified, multi-disciplinary clinical leadership and move towards a standardised model of delivery across all ten boroughs, promoting a recovery approach. GM is working on a standard operating model for neighbourhood health teams, but there is more to do to see a unified, clinically-led approach to both community and inpatient care delivery and standards and evidence shows that where we have strong, dedicated leadership that is associated with better patient outcomes, including reduced mortality rates and higher patient satisfaction.
- Build on the fact that together, the organisations are the largest research active organisations in mental health and learning disability in England and very large providers of health education, including medical education. Historically, competition between the organisations for research funding and competing research priorities has impeded the cultivation of opportunities for research driven innovation and change, which, leading to the implementation of new, more efficient models of care, which is crucial for addressing the increasing demand for mental health services.

The Mental Health Integrated Fund (MHIF) is a key enabler to achieving our ambition. In 2025/26, to support the ‘Left Shift’ in investment flow from hospital beds to community services, the MHIF was developed and implemented. It is our vehicle for significant investment in resilient community mental health services, which align to the GM Live Well model, and our shared strategic drive for prevention

and early intervention to be at the heart of our neighbourhood model of care. We are committed to this approach in 27/28 and will continue to work with providers of our Mental health services on the delivery of this. The focus on effective and high-quality community and crisis offers for the population and partnership with primary care are a commissioning priority in 27/28 building on the strategic direction from Year 3 of the Mental Health and Wellbeing strategy.

In addition to this, a key focus for us is the improvement in services in the community for our population with a learning disability. Greater Manchester has a number of providers of community Learning Disability services for children, young people and adults. This creates inequity in access and pathways. We will be undertaking an options appraisal for these services and following the selection of a preferred provider, we will co-design a new model of care and undertake a procurement for a lead provider.

The MH capital programme will be integrated in the wider GM system transformation programmes for MH EDs, NMHCs, LDA and digital.

New Modern Service Frameworks

There is an expectation that throughout 27/28 our providers will work to embed new Modern Service Frameworks, as part of their service delivery. These include CVD & Cardiac, palliative and end-of-life care (Including Hospice Care), frailty & dementia.

Strategic Commissioning of Medicines

NHS GM will commission medicines as a strategic investment in population health, rather than as an isolated prescribing cost pressure. Medicines investment decisions should be embedded within clinical and commissioning strategies, considering their impact on patient outcomes, prevention, health inequalities, secondary-care demand, system capacity, sustainability and overall cost-effectiveness.

We will adopt a whole-pathway approach to recognise where investment in medicines can improve outcomes, prevent or delay disease progression and enable more effective models of care.

We will use multi-year horizon scanning and population health intelligence to anticipate emerging clinical needs, innovation and medicines-related financial pressures. This should enable earlier incorporation into pathway development, neighbourhood delivery, service design and medium-term financial planning.

NHS Greater Manchester's Material Commissioning Intentions

The following list of material commissioning Intentions are primarily pertinent to the providers who are contracted to deliver these services. However, all providers will need to be aware of this work and any impact that it may have on levels of activity in their services as a result.

Material Commissioning Intention	Impact
GM Community Tier 2 ENT and Audiology Offer – expansion of the Tier 2 and Audiology offer to increase the number of pathways that can be seen and treated in a community setting.	Reduction in RTT and patient pathways for ENT.
GM Community Tier 2 ENT and Audiology Offer (GPwER training) - Train 20 GPwER so they are competent and able to independently deliver community clinics	Expansion of the skilled workforce in primary / community care to deliver community based ENT pathways.
GM Community Gynaecology Offer - expansion of the Tier 2 and Audiology offer to increase the number of pathways that can be seen and treated in a community setting.	Reduction in RTT and patient pathways for Gynaecology.
GM Community Gynaecology Offer (GPwER training) - Train 10 GPwER so they are competent and able to independently deliver community clinics as part of a neighbourhood offer	Expansion of the skilled workforce in primary / community care to deliver community based Gynaecology pathways.
GM Community Cardiology Offer – to commission a community cardiology offer for appropriate common Cardiology presentations that are assessed, investigated or managed through a community specialist pathway	Reduction in RTT and patient pathways for Cardiology.
GM Community Cardiology Offer (GPwER Training) - Train 40 GPwER so they are competent and able to independently deliver community clinics as part of a neighbourhood offer	Expansion of the skilled workforce in primary / community care to deliver community based ENT pathways.
GM Community Dermatology Offer – mobilisation of new GM Community Dermatology Offer following procurement of a new GM wide provider	Reduction in RTT and patient pathways for Dermatology conditions that can be assessed, investigated and managed in the community.
GM Community Vasectomy Offer – to deliver all vasectomies undertaken by local anaesthetic in a community setting, therefore freeing up capacity in secondary care	Reduction in RTT and patient pathways for Urology.

GM Integrated MSK Community Tier 2 Service – the mobilisation of an integrated MSK Community Tier 2 service in accordance with the new GM service specification.	NHS GM will issue a new service specification to providers in October to consider and include as part of their planning submissions.
GM Community Services; District Nursing Specification – implementation of new, GM service specification	NHS GM will issue a new service specification to providers in October to consider and include as part of their planning submissions.
Decommission five Inpatient Unit Beds-Neuro Rehabilitation (Trafford Unit) – Unit is currently commissioned / funded for 40 beds, of these 35 are operational.	To decommission the 5 beds which are no longer operational.
Mobilisation of the new non-emergency Patient Transport Service	It is anticipated that the new service will have an impact on reduced length of stay and delayed discharges.
Development of day case model for people with Eating Disorders (all age) and full implementation of ARFID services for CYP	Timely support to people with an Eating Disorder in community/day case setting to prevent inpatient admissions, reductions in length of stay, left shift of care from acute, earlier intervention and support.
Development and implementation of new pan GM model of MH Crisis Care for vulnerable CYP to prevent admission	The implementation of the new pan GM model will reduce admissions to inpatients, reduced length of stay, improved outcomes for CYP and families/carers, reduced A&E attendances.
GM and East Cheshire arterial vascular surgery reconfiguration - Preferred option transfers Royal Oldham arterial vascular surgery activity to MRI to establish a single arterial centre. Royal Oldham will continue to operate as a vascular spoke site. Anticipated benefits include improved workforce resilience, reduced patient transfers, shorter waits, enhanced clinical responsiveness and strengthened research capability. Business case expected in Q1 2027/28. Wider GMEC network and spoke arrangements remain subject to agreement.	Activity assumptions, patient flows, workforce impacts and financial implications will be confirmed through development of the Decision Making Business Case. It is assumed that Royal Oldham will continue to provide spoke site functions, although the scope of activity to be retained locally remains subject to final service design and approval. Commissioning implications are therefore indicative at this stage.
Develop and implement a sustainable GM Familial Hypercholesterolaemia Service model to improve identification, treatment and prevention of cardiovascular disease.	Improved identification and treatment of FH, reducing future cardiovascular events and improving equity of access across GM.
Commission and implement an equitable all-age respiratory diagnostics model to improve access to spirometry, FeNO and other respiratory diagnostic services across Greater Manchester.	Improved equitable access to respiratory diagnostics, reduced diagnostic variation and earlier diagnosis of respiratory disease.

Implementation of CYP2C19 genotyping in stroke services	Estimated reduction in future stroke/bleeding events in 90 days of 18 events, rising to 46 events avoided in 5 years.
Commissioning a new model for Shared Care of Medicines focusing on Mental Health, ADHD, Gender Transition.	Commissioning implications are indicative at this stage and will be dependent on the outcome of the test of change during 26/27.
The Implementation of a single Greater Manchester Major Trauma Service, across 2 sites	NHS GM will issue a new service specification to the MTC providers providers.

3

Provider Planning Assumptions

Based on our analysis of the current delivery of services, the demand profiles from previous years, our material commissioning intentions and the systemwide improvement work that will be taking place in 27/28, we have modelled some assumptions on the key aspects of our service delivery.

Urgent and Emergency Care

The Greater Manchester urgent and emergency care system continues to face sustained demand growth driven by demographic change, increasing acuity and rising utilisation of emergency services. Modelling based on the current 2026/27 forecast outturn indicates that, without further intervention, A&E attendances would increase from approximately 1.59 million to 1.65 million during 2027/28, representing growth of around 4.1%, with non-elective admissions increasing by approximately 13,400 admissions.

To mitigate this growth, NHS Greater Manchester will continue to invest in and support delivery of a comprehensive urgent and emergency care transformation programme. This includes Urgent Community Response services, Hospital at Home, Same Day Emergency Care, Single Point of Access models, Clinical Assessment Services, Urgent Treatment Centres, frailty services, falls prevention initiatives, community pharmacy support and mental health crisis alternatives.

Collectively, these interventions are expected to reduce forecast A&E attendance growth from 4.06% to 1.96%, resulting in planned activity of 1,618,635 attendances during 2027/28. Non-elective admissions are expected to increase from 387,623 to 395,754, representing residual growth of 2.10% after the impact of the planned interventions. Providers should therefore plan on the basis of growth significantly below underlying demand trends, while supporting delivery of provider-led, place-based and system-wide transformation initiatives. The scale of both demand growth and the impact of mitigating actions will vary between providers and places, reflecting differences in population need, existing service models and local transformation programmes.

Elective Care

Elective demand is expected to continue increasing during 2027/28, reflecting demographic growth and increasing healthcare need across Greater Manchester. The Greater Manchester planning assumption is based on 2.28% underlying growth, comprising 1.28% demographic growth and a further 1.0% non-demographic growth assumption, although provider-specific assumptions vary according to local population need.

NHS Greater Manchester's approach is to manage this demand through a significant expansion of community and neighbourhood-based elective care. Material commissioning intentions include expanded Tier 2 ENT and Audiology services, community gynaecology services, community

cardiology pathways, implementation of a Greater Manchester dermatology model, expansion of Advice and Guidance, further development of Single Point of Access models and redesign of vasectomy pathways.

Collectively, these initiatives are expected to transfer substantial volumes of appropriate activity from acute settings into community-based models, including capacity for approximately 10,000 ENT and Audiology pathways, 14,000 Gynaecology pathways and 4,000 Cardiology pathways.

In addition to the demand reduction because of the material commissioning intentions, there is an expectation on the delivery of productivity and improvement initiatives, such as the further roll out of Elective Care SPoAs and A&G. As a result, providers should be assuming 1% growth in their plans.

Cancer

Demand for Urgent Suspected Cancer referrals is expected to continue increasing during 2027/28. With the support of the Greater Manchester Cancer Alliance, NHS GM has set an underlying “do nothing” growth assumption of 4% for Urgent Suspected Cancer referrals in 2027/28.

To moderate this growth, the Cancer Alliance will continue delivery of pathway optimisation, neighbourhood and Live Well initiatives, primary care engagement, referral management support, self-request pathways, public awareness campaigns and innovation programmes designed to improve pathway efficiency and earlier diagnosis.

As a result, providers are asked to plan on the basis of net urgent suspected cancer referral growth of 2% during 2027/28.

Mental Health, Learning Disabilities and Autism

NHS Greater Manchester intends to continue the shift towards earlier intervention, community-based support and prevention across mental health, learning disability and autism services. Key commissioning intentions include development of an Eating Disorders day-case model, expansion of Avoidant Restrictive Food Intake Disorder provision, implementation of the Skyline model for children and young people with complex needs and development of a Greater Manchester-wide mental health crisis response offer for children and young people.

These programmes are intended to provide earlier intervention, improve outcomes and reduce reliance on crisis and inpatient services. Together, the Skyline and pan-Greater Manchester crisis support offers have an estimated annual reach of 32 children and young people with complex needs. The services are intended to reduce repeated A&E attendance, avoid inappropriate admission, improve placement stability and reduce escalation into high-cost residential care. ARFID expansion is expected to provide support for more than 400 additional children and young people each year.

The proposed direction of travel reflects increasing demand for specialist support and builds on evidence of significant crisis activity across Greater Manchester. Together, these initiatives support a shift towards earlier intervention, strengthened community mental health services, reduced

reliance on crisis and inpatient services, and improved outcomes for some of the most vulnerable children and young people in the system.

Long Term Conditions and Prevention

A central assumption within the 2027/28 planning framework is that improved identification, prevention and management of long-term conditions will make an increasingly important contribution to moderating future demand across urgent, elective and acute pathways.

NHS Greater Manchester therefore intends to progress several system-wide commissioning initiatives during 2027/28, including development of a sustainable Greater Manchester Familial Hypercholesterolaemia service, implementation of an all-age respiratory diagnostics model and introduction of CYP2C19 genotyping within stroke services.

These initiatives are intended to improve diagnosis, reduce variation, support preventative care and reduce future demand generated by avoidable disease progression and acute exacerbations. While immediate activity impacts may be modest, they form an important component of the wider strategic objective to improve population health, reduce health inequalities and moderate long-term growth in acute demand.

4

Delivery of our Existing Programmes & Strategic Finance

In addition to the specific elements that we have outline in components 1, 2 & 3 of our Commissioning Framework, we are committed to the continuation and progression of our existing transformation work programmes.

These programmes of work will involve all our commissioned providers and may result in some in year changes to commissioned services as a result. Any changes that are recommended and are approved through our appropriate governance routes, will be communicated in a timely manner with the relevant providers throughout the course of the year. We will utilise our existing business processes to enact these changes, such as the contract variation process.

Closing the Gap

The mitigating actions described within this framework are expected to reduce, but not eliminate, underlying demand growth. The resulting net demand growth will continue to place pressure on provider capacity, finances and operational performance during 2027/28.

NHS Greater Manchester is therefore asking providers, both individually and collectively through the Trust Provider Collaborative and Place Partnerships, to identify and deliver their own productivity and transformation priorities. These should include adoption of nationally recognised models of care, such as Model Emergency Department, alongside locally developed initiatives that improve outcomes, productivity and value.

The ICB will continue to work with providers, Place Partnerships and system leaders to identify further commissioning, transformation and service redesign opportunities that help close the remaining gap between underlying demand and available resources.

Finance and Contracting Arrangements

NHS Greater Manchester will be working with the system to develop and utilise new contracting models. These will include Lead Provider arrangements, Multi-Neighbourhood Providers and Single Neighborhood Providers.

We will be developing our model of commissioning enabling some of our NHS providers to take the lead for end-to-end pathway delivery for our patients, such as the delivery of Gynecology and ENT. This will require all our providers working together to ensure our patients get the best possible experience, through potential sub-contracting arrangements. Specifically, these models will include:-

- lead provider arrangements through MFT and application of IHO principles.
- lead provider arrangements for cancer care through the Christie with partners across GM
- lead provider arrangements for LDA with our two mental health trusts.

This will include commissioning arrangements with the VCFSE sector, with contracting models which promote partnerships across the sector and with statutory services being activity explored. Work is underway to produce a Market Development Strategy which will strengthen our commissioning arrangements with the sector and embed more innovative and sustainable contracting arrangements.

Deconstruction of the block contracts

For acute services we have made significant progress on improving the transparency between contract income and service / activity delivery. There does, however, remain £94m of historic block items within acute contracts which are currently being reviewed with providers. The objective is to complete this work ahead of 1st April 2027 so that we have full line of sight on all contract income. We await the national guidance for 2027/28 on how financial differences are to be treated and the pace of change. To inform this, we will work with providers using month 6 activity data to generate a forecast year end position, onto which we can model the 2027/28 national payment guidance/tariffs when they are published.

For community and mental health contracts, the recent work provides a good baseline to take this work forward. For example, two next steps are:

- Specifically, how we address the issues with activity data capture?
- We will establish an agreed understanding of historic financial contract adjustments, which total £129m.

As with acute services, we await national guidance on how this work will be used in 2027/28 operational planning.

Work is also in progress for specialised commissioning. This is taking longer than anticipated because of the scale of local tariffs/arrangements, in addition to the added complexity of disaggregating the data by commissioner. The expectation is that all specialised services are within scope (delegated, retained and secure mental health).

Local Financial Planning Assumptions

- National funding from NHS England for Diagnostic Networks ceased in 2025/26. The ICB agreed to provide transitional funding in 2026/27 for the diagnostic network. This funding will cease at the end of 2026/27.
- Return to constitutional standards capital - consistent with the bids, providers should not be assuming incremental revenue funding.
- Non-Recurrent funding (acutes) - for planning purposes, where applicable, providers should assume the following services continue with the exact funding to be agreed as part of contract setting: Alcohol care teams, Medical examiners, Community diagnostic centres, Lung health checks.
- Demand and Capacity Funding - during quarter 3 we will review the impact of the current demand and capacity schemes on managing and reducing UEC demand. This will be used to inform 2027/28 operational planning with the finalisation of schemes and funding in quarter 4.

NHS GM Quality & Safety Management Strategic Commissioning Committee Update October 2026

Strategic Commissioning Committee

7th October 2026

Report information.

Required information.	Details.
Title of report.	NHS GM Quality & Safety Management
Author.	Claire Smith Associate Director Quality & Safety NHS GM
Presented by.	Claire Smith Associate Director Quality & Safety NHS GM
Contact for further information.	Claire Smith Associate Director Quality & Safety NHS GM claire.smith23@nhs.net
Executive summary.	- NHS GM proposes an integrated quality-and-safety assurance framework focused on safe, effective, person-centred and financially efficient care. - Assurance combines patient experience with safety, workforce, governance, regulatory, performance and inequalities intelligence to identify risks and drive improvement. - Priorities in the immediate future are consistent contractual oversight, provider dashboards and clear risk-tolerance and escalation thresholds. - The MIAA audit will be pivotal in identifying gaps and areas that require further strengthening.

The benefits that the population of Greater Manchester will experience.	NHS GM's statutory quality and clinical governance functions support people across Greater Manchester to experience safe, effective and continuously improving services. Through targeted quality improvement, strengthened oversight and refreshed governance pathways, the system is better able to identify risks earlier, intervene more consistently and reduce unwarranted variation. This directly supports improved experience and outcomes for patients and communities.
How health inequalities will be reduced in Greater Manchester's communities.	By strengthening oversight, assurance and escalation in response to these concerns, NHS Greater Manchester can help ensure that people receive safer and more consistent care regardless of where they live or which service they access. This includes promoting equitable access to follow-up, clear communication, and timely response where patient safety concerns arise, so that people who may already face barriers to navigating services are not disadvantaged further.
The decision to be made and/or input sought.	The Board / Committee is asked to: 1. Note the quality-and-safety assurance framework 2. Provide oversight or challenge on the next steps, including the audit, dashboards and escalation thresholds.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The areas within this report and the progress made to improve them relate to Board Assurance Framework risk SR5.

How this aligns to the new strategic objectives.	Delivers against the objectives by outlining the process and governance for assuring quality & safety standards across contracted providers.
Key milestones.	Ongoing review against the operating model. Detailed review planned for quarter 4 against the newly published NHS Oversight Framework, the Quality Strategy and the expected NHS England Quality Metrics.
Leadership and governance arrangements.	This is a key operating process which sits within the Clinical Portfolio. This is a strong example where matrix working to ensure a holistic view of oversight and improvement work is vital to give assurance and remain outcomes focused. This includes strengthened relationships with colleagues across the system and with NHS England and Specialised Commissioning underpinned by a robust RASCI approach.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	Engagement through internal teams, including Clinical Portfolio Leadership, System Quality Group, Contracts and Performance. Public engagement is not indicated in this circumstance.
Financial or Legal Implications	This paper does not in itself create additional financial or legal obligations or decisions. It summarises current working practices and governance arrangements for the NHS GM management of Quality & Safety.

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	Yes	Yes	No	No	No	Yes	No

NHS GM Quality & Safety Management & Assurance

Quality and Safety oversight of contractual requirements for NHS GM commissioned services – update for Strategic Commissioning Committee

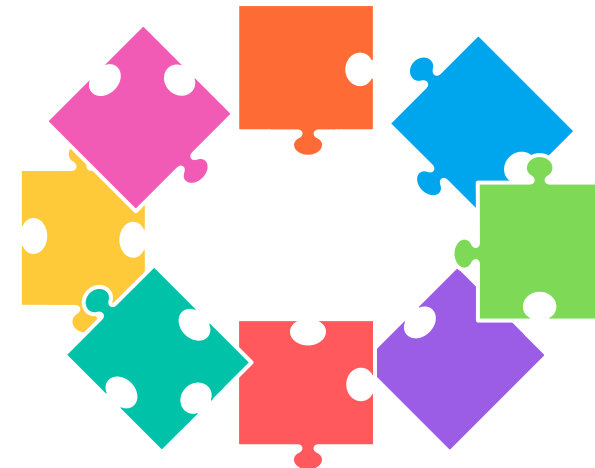
Quality & Safety Assurance within Strategic Commissioning



Greater Manchester

- ❖ The Integrated Care Board need to be assured that the commissioned care is meeting the needs of the GM population in a safe and efficient way, and that there are mature processes in place to inform the Board's understanding. The arrangements described build on a firm foundation of assurances that we know work well. Working from the principle of continuous improvement, the approach taken will ensure current and up to date clinical and professional and managerial strategies are used to enable safe and effective care.
- ❖ This document focusses on how quality within the commissioning and contracting cycle is a key outcome measure for both safe and effective care, as well as financially efficient care provision. Quality assurance is led by the Clinical team; however, effective matrix working enables a collaborative and positive culture to be role modelled across all directorates and the system. Partnership working with all system partners is essential to achieve improved outcomes for the people of GM.
- ❖ There are a number of published reports and documents that set out the national strategy and specific ICB requirements, primarily the National Quality Strategy (July 2026). Also, the national report, 'Transitioning to the new NHS Operating Model: Changes to quality governance and risk escalation' notes that all health & care organisations remain accountable for Quality and have a responsibility to work together to proactively share intelligence, drive improvement and mitigate and escalate quality risks. This includes the Office of Pan ICB commissioning (OPIC).

The slide deck is designed to give a comprehensive view of the different components of quality & safety within a strategic commissioning organisation. It can be viewed as a whole or used as a resource and guidance tool for particular activity and expectations as set out in each of the chapters. The document makes reference to where there are links and collaboration with other functions, i.e. Safeguarding, Maternity, Specialised Commissioning however these areas are not included in their entirety and therefore the approach needs to be considered in conjunction with other models & documents.



ICB Operating Model



Greater Manchester

System Convenor – to enable delivery of the ICP strategy

Improving Population Health Outcomes / Reducing Inequalities / Social & Economic Development / Statutory Accountabilities / Constitutional Standards / System Resilience

Strategic Commissioner

Needs Assessment & Outcomes Setting

- In-depth population analysis
- Analysis of resource utilisation (finance)
- Clinical-led evidence on opportunity
- Health economics (Public Health)

Strategy and Planning

- NHS GM / ICP / GMCA partnership priorities
- Assessment of national policy and local analysis (Planning)
- Setting system strategic ambition and place expectations.
- Setting clinical and professional commissioning policy for the system (Clinical)
- Setting financial policy rules (Finance)
- Strategic resource allocation (Finance)
- Operational planning (Planning)
- Agree transformation priorities based on constitutional standards
- Strategic digital leadership and development

Contracting & Evaluating Impact of System

- Manage market rules and core NHS contracts
- Assure delivery at place, provider, system groups
- Quality improvement



Clear Accountability and Trust



Ten Integrated Place Partnerships

Local Insight-led Planning

Develop priorities and plans to address:

- Agreed strategic goals and outcomes
- Utilising value based analytical capability
- JSNA, in-depth population analysis & community insight (BI / Planning / Insight)

Integrated Delivery at Place

- Engage partners, clinicians and communities in designing solutions to deliver priorities.
- Integrated Neighbourhood Health - work with partners to create neighbourhood health model
- Drive benefits realisation (Planning)
- Demand management
- Supporting the system wide Live Well model
- Population Health
- Co-design with communities
- Single view of allocation of place allocation

Aligning Partnership Incentives & Resource

- Coordinate the resources across pathways and partners to achieve shared outcomes.
- Support the development / strengthening of provider partnerships.

Enablers: portfolio/s to encompass all of these functions

Clinical & Professional Leadership

Communications & Engagement

Corporate & Clinical Governance

Digital & DII

EDI

Finance

People & Culture

Programme Management

Quality & Safety (Experience)

WHAT: Quality & Safety Assurance at a glance



Greater Manchester

Safety, Effectiveness, Experience
Improving Health Outcomes, Improve patient satisfaction, Reduce Health Inequalities

Collaborating with wider ICB colleagues to

ensure

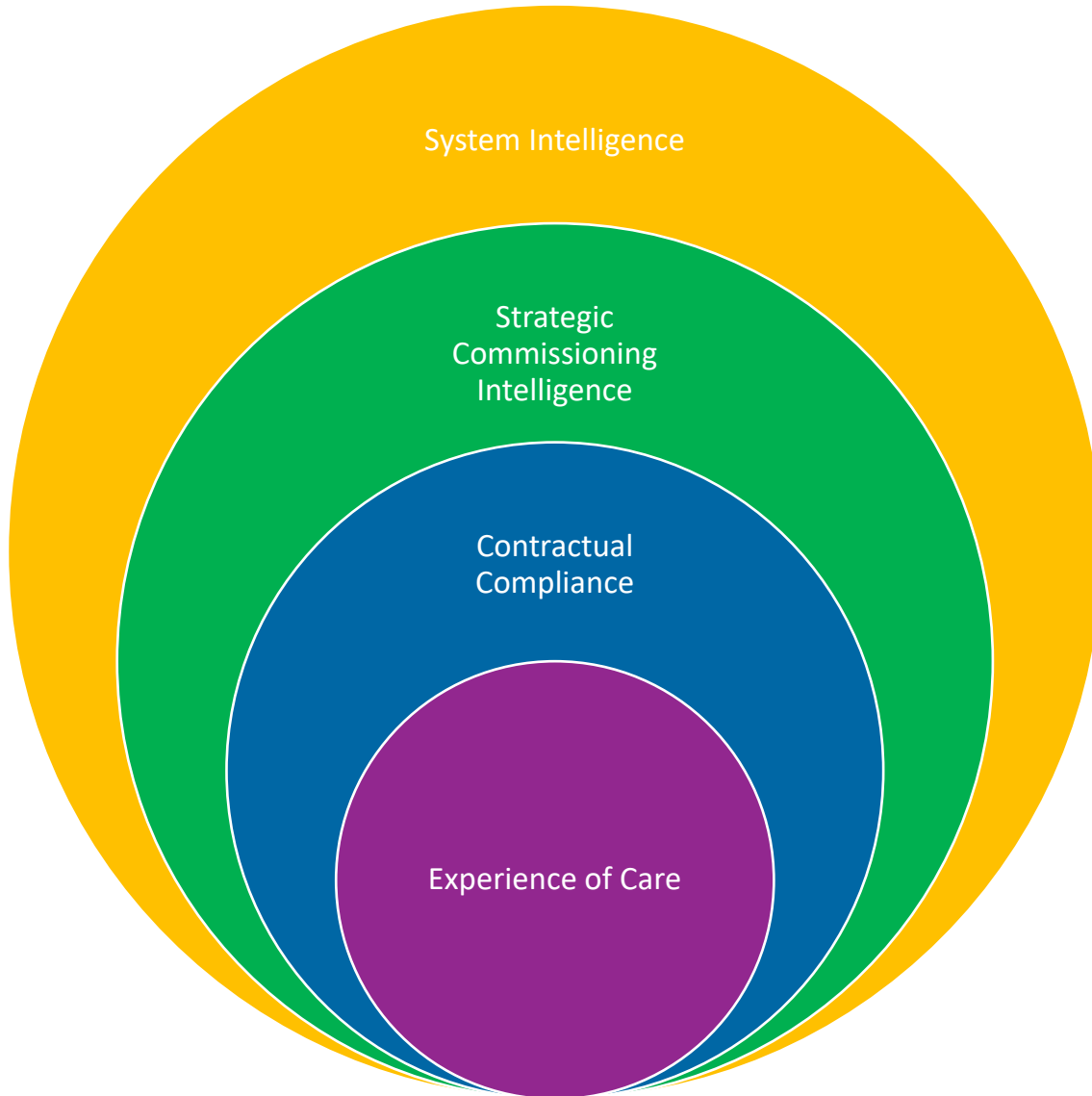
Quality is everybody's business



Collaborating with external stakeholders to
ensure
Quality is everybody's business

Together, these pieces support safe, effective, person-centred care and continuous improvement.

HOW: Quality & Safety Data, Intelligence & Triangulation



System Intelligence

Triangulation of data from multiple sources to ensure a multi-factoral, multi-perspective view of each provider/service. Including intelligence from Place Partnerships, Local Authorities, Regulators, NHS England, Other ICBs, Sub-contractors etc.

Strategic Commissioning Intelligence

Matrix working within the ICB to ensure that a position is triangulated across Commissioning, Contracts, Performance, Quality & Finance and considers all elements of the core portfolios of the organisation. Fluctuations in one area may initiate quality deep dives, Safety concerns may initiate performance analysis, and system intelligence will then influence future commissioning decisions

Contractual Compliance

A robust system with required governance is wrapped around each provider to ensure the ICB is sighted on the Provider's ability to deliver on their NHS Contractual Obligations. Specific focus on Quality schedules underpin the approach to give a benchmark position. A risk stratification approach is undertaken to rationalise how resource is attributed to the significant number of contract holders across Acute & Mental Health Providers, Non-NHS and Independent Sector Providers, Primary Care and host commissioning arrangements.

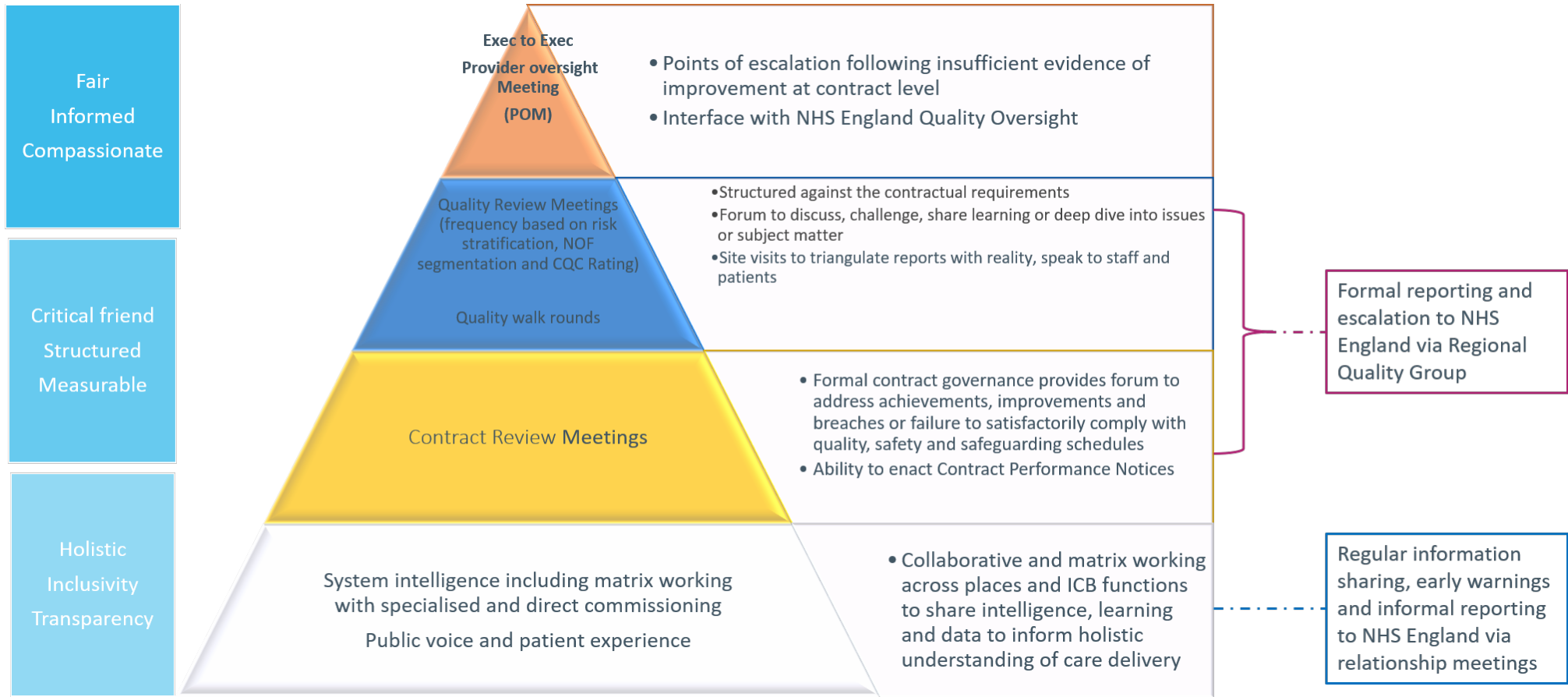
Experience of Care

Central to all is the experience of those accessing or in receipt of care. Intelligence from all aspects of the system brought together through a range of participation groups, complaints and compliment reports, Patient Safety investigations, Safeguarding and Coroner's reports are key to improving outcomes and preventing recurrence of poor experience

HOW: Analysis, Assurance & Escalation



WHEN: Quality Governance & Infrastructure



Next Steps

Post reform a lot of work has gone in to building the team, adapting ways of working to deliver the new operating model aligned with NHS England changes and staffing numbers. This has included a refresh of data sources, outputs and methodology for triangulating data. This work continues and the next steps include:

- Further work within the Clinical Portfolio and across the ICB Chief Officer Portfolios to embed a consistent and robust mechanism for ensuring contractual compliance and delivering statutory functions in relation to quality & safety.
- MIAA audit commenced which will scrutinise and identify gaps as well as positive assurance
- Finalising provider focused dashboards for consistency across Acute, MH, Primary Care, Independent Sector provision.
- Setting and implementing a clear threshold for concern and tolerance for risk and escalation



Data sources & examples

Intelligence Lens	Typical Sources
Safety	LFPSE, PSIRF, StEIS, Mortality, Incidents
Experience	Complaints, PALS, FFT, Surveys
Workforce	ESR, Staff Survey, Vacancies, Sickness
Governance	AQSSA, Audits, Board Reports, Risk Registers
Regulation	CQC, NHSE, CNST, External Reviews
Performance	Access, Activity, RTT, Appointments, KPIs
Inequalities	IMD, JSNA, Core20PLUS5, Demographics

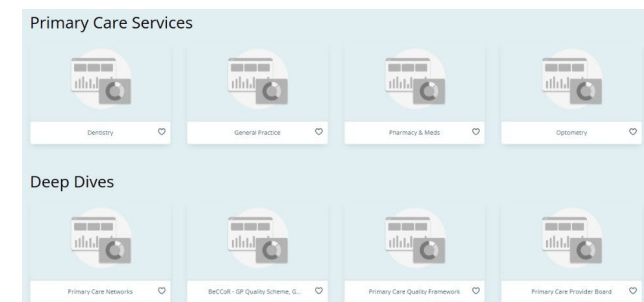
CQC Data

- 14_may_2025_CQC_directory (003)
- 14_may_2025_CQC_directory (003)44
- 14_may_2025_CQC_directory

Steis & LFPSE data

	A	B	C	D	E	F	G	H	I	J	K	L		
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Curator Dashboards



Thirlwall Inquiry - Report & Recommendations

7th October 2026

NHS Greater Manchester Strategic Commissioning Committee

7th October 2026

Report information.

Required information.	Details.
Title of report.	Thirlwall Inquiry Report & Recommendations
Author.	Sarah Owen, Associate Director of Maternity, (GM ICB/LMNS)
Presented by.	Sarah Owen, Associate Director of Maternity, (GM ICB/LMNS)
Contact for further information.	Sarah Owen, Associate Director of Maternity, (GM ICB/LMNS) Sarah.Owen61@NHS.net
Executive summary.	The Thirlwall Inquiry was published on 15 September 2026 and makes 17 recommendations following its examination of events at the Countess of Chester Hospital. NHS England subsequently issued immediate requirements for NHS Trusts and Integrated Care Boards (ICBs). This paper summarises the findings and immediate requirements, sets out the implications for NHS Greater Manchester (NHS GM), and proposes how specialist neonatal assurance will be received through the Regional Assurance Process and North West Neonatal Operational Delivery Network (ODN), with system oversight through the NHS GM Maternity & Neonatal Programme.
The benefits that the population of Greater Manchester will experience.	Supports safer neonatal care by strengthening line of sight to provider implementation, emerging safety concerns and escalation, while using specialist neonatal expertise and established NHS GM quality and contractual routes.

How health inequalities will be reduced in Greater Manchester's communities.	The report does not introduce a separate inequalities intervention. It supports consistent oversight of safety and quality across commissioned neonatal services; existing national maternity and neonatal frameworks require consideration of variation and inequalities within quality assurance and commissioning.
The decision to be made and/or input sought.	The Strategic Commissioning Committee is asked to: • Note the Inquiry findings and immediate NHS England requirements • Support the proposed GM assurance approach • Support quarterly reporting of the GM assurance position through the NHS GM Maternity & Neonatal Programme • Support escalation of provider-specific risks or gaps in assurance through the established NHS GM Contract Quality Mechanism where required.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Supports NHS GM strategic commissioning and Quality & Safety Management responsibilities by strengthening system oversight, provider assurance and escalation for maternity and neonatal services.
Key milestones.	• 15 September 2026 - Thirlwall Inquiry report published. • 21 September 2026 - NHS England immediate requirements issued. • 28 September 2026 - provider SUDIC communication deadline. • 30 November 2026 - interim insulin-storage CCTV deadline. • 31 March 2027 - neonatal units to meet GIRFT insulin access/storage requirements. • Further implementation requirements will develop through the National Maternity and Neonatal Taskforce and Regional Assurance Process.

Leadership and governance arrangements.	NHS GM oversight will sit within the Maternity & Neonatal Programme, with routine quarterly reporting to the Strategic Commissioning Committee. Specialist neonatal assurance is anticipated through the North West Neonatal ODN and Regional Assurance Process. Provider-specific risks or gaps in assurance will be escalated through the established NHS GM Contract Quality Mechanism where required.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	No public engagement has been undertaken specifically for this paper. The paper responds to the published statutory Inquiry and subsequent NHS England requirements. Specialist neonatal clinical engagement and assurance will be undertaken through the North West Neonatal ODN and Regional Assurance Process as the national response develops.
Financial or Legal Implications	No new NHS GM financial decision is sought through this paper. Some national and provider implementation requirements may have financial implications as the response develops; these will need to be considered through the appropriate national, provider and commissioning routes. No separate legal advice has been sought for this paper.

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

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

1. Thirlwall Inquiry - key findings and recommendations

The Thirlwall Inquiry report was published on 15 September 2026 following an independent statutory inquiry into events at the Countess of Chester Hospital between 2015 and 2018. The Inquiry was established following the convictions of former neonatal nurse Lucy Letby and examined the circumstances surrounding the deaths and unexpected deterioration of babies on the neonatal unit, the response of the Trust and wider NHS, and the arrangements in place for raising and responding to concerns.

The Inquiry describes repeated organisational and individual failings in recognising and acting upon unusual patterns of neonatal death and deterioration, escalating clinical concerns, safeguarding babies, maintaining Board visibility of neonatal safety and ensuring effective external scrutiny. Its findings extend beyond the specific circumstances at the Countess of Chester and raise wider considerations for provider governance, neonatal safety, mortality surveillance, safeguarding, speaking up and the effectiveness of organisational assurance.

The Inquiry identifies a number of recurring findings and areas of concern, including:

Failure to recognise and connect safety signals. Neonatal deaths and unexpected collapses were repeatedly considered individually rather than as a developing pattern. The Inquiry found that an unexplained rise in neonatal mortality required active investigation until an explanation was established.

Clinical concerns were not acted upon with sufficient urgency. Consultant paediatricians repeatedly raised concerns, but organisational responses were delayed and were influenced by hierarchy, process, reputation and assumptions about what could plausibly be happening.

Neonatal safety lacked sufficient organisational visibility. The Trust Board did not receive reports about deaths of babies and children during the period examined. The Inquiry linked this to governance arrangements that had diminished the profile and voice of paediatrics and neonatology.

Assurance did not always adequately respond to unexplained safety signals. Reviews and external scrutiny did not consistently follow unexplained signals across organisational or clinical boundaries. Of particular relevance, a maternity and obstetric review concluded that maternity care had not caused the increase in neonatal deaths. The Inquiry found that this was treated as reassurance without sufficient further consideration of what was driving the unexplained mortality.

Safeguarding arrangements were not used effectively when deliberate harm by a member of staff was suspected. Thirlwall therefore recommends a national Suspicion of Deliberate Harm Protocol, strengthened safeguarding training and contractual duties.

Mortality and data intelligence require stronger real-time oversight. Recommendations include Board-level monitoring of all child and baby deaths, predetermined escalation routes for concerning trends, and a trained lead reporter for hospitals with neonatal units.

Wider system dependencies. The report identifies dependencies including neonatal monitoring, medicines security, bereavement care, digital interoperability, medical examiner

arrangements, paediatric and perinatal pathology capacity, regulation and accountability of managers, Care Quality Commission practice and whistleblowing.

Implementation and accountability are themselves a central safety issue.

Recommendation 17 proposes a new National Audit Office responsibility for auditing implementation of recommendations from statutory inquiries into NHS bodies.

or NHS GM, these findings reinforce the importance of maintaining sufficient visibility of neonatal safety across commissioned services, supported by clear reporting and governance arrangements and appropriate specialist neonatal clinical oversight. The North West Neonatal Operational Delivery Network (ODN) provides an established route for oversight and interpretation of neonatal safety, mortality and performance intelligence across providers. NHS GM should therefore maintain a clear line of sight to this intelligence through the ODN, with a defined route for routine reporting and escalation into the NHS GM Maternity & Neonatal Programme where emerging trends, concerns or unexplained variation indicate potential risk, and onward escalation through established NHS GM quality and contractual routes where required.

The Inquiry makes 17 recommendations, directed to provider organisations, NHS England, the Department of Health and Social Care, the Care Quality Commission and other national bodies. None of the 17 recommendations within the Inquiry itself are assigned directly to Integrated Care Boards (ICBs). A summary of the recommendations, key requirements and assigned responsibilities is provided at Appendix 1.

The Thirlwall recommendations will not sit in isolation from the wider national maternity and neonatal improvement programme. The published objectives of the National Maternity and Neonatal Taskforce explicitly include addressing recommendations arising from the Thirlwall Inquiry, alongside the Amos National Maternity and Neonatal Investigation and the Ockenden Nottingham Review. The national response to Thirlwall will therefore form part of the wider programme of maternity and neonatal reform previously considered by the Strategic Commissioning Committee (SCC) through the Amos & Ockenden briefing.

2. NHS England response - immediate requirements

As with the NHS England 10 Point Plan issued following publication of the Amos and Ockenden reports, the full national response to Thirlwall will be developed through the National Maternity and Neonatal Taskforce. However, a number of actions require more immediate implementation and assurance and cannot wait for the wider National Taskforce action plan.

On 21 September 2026, NHS England wrote to all NHS Trust and ICB Chief Executives, Chairs and senior clinical and operational leaders setting out the immediate actions required following publication of the Inquiry. The letter provides the first stage of the national response while Government considers the 17 recommendations in full and the Taskforce develops the wider National action plan. It is explicit that Thirlwall is not solely a matter for organisations with neonatal services, stating that every Trust and ICB Board should consider the findings.

The immediate requirements are summarised below:

Area	Immediate NHS England requirement	Primary responsibility	Timeframe
Board consideration	Review Thirlwall at the next available public Board meeting; consider whether similar events could occur locally; seek assurance that sufficient measures protect babies and children; urgently discuss identified risks with the Regional Team.	Provider and ICB Boards	Next available public Board meeting
Sudden Unexpected Death in Childhood (SUDIC)	Communicate to relevant staff and Boards that SUDIC processes apply to sudden and unexpected neonatal deaths in hospital.	Providers with neonatal units	By 28 September 2026
Bereavement care	Take immediate action to improve care of the bereaved, building on requirements already set out in the NHS Medium Term Planning Framework.	ICBs and providers	Immediate; no specific completion date stated
Insulin security	Meet Getting It Right First Time (GIRFT) requirements for insulin access control and storage. Until biometric access is in place, install closed-circuit television focused on insulin storage and retain recordings for at least 28 days.	Providers with neonatal units	CCTV by 30 November 2026; GIRFT requirements by 31 March 2027
Safeguarding	Ensure staff and Board members are compliant with safeguarding training at the appropriate level, understand how to raise and escalate concerns, and assure appropriate prominence for safeguarding babies and children.	Providers and ICBs	Immediate; no specific completion date stated
Parents and staff	Consider local steps to reassure parents and families receiving neonatal care and review support mechanisms for staff working in neonatal services.	Providers with neonatal services	Immediate; no specific completion date stated

The letter therefore creates immediate requirements for both NHS GM and commissioned providers ahead of the full Taskforce response. For NHS GM, this includes direct requirements relating to Board consideration, safeguarding and bereavement care, alongside appropriate oversight of provider delivery of the neonatal-specific actions. NHS GM will utilise the newly established Regional Assurance Process to provide assurance of individual provider progress against the national immediate requirements, alongside established NHS GM quality, contractual and commissioning arrangements, ensuring that any identified gaps or areas of concern are appropriately managed and escalated where required.

3. Implications for Greater Manchester

A number of the requirements highlighted by Thirlwall build upon existing national expectations and established provider and neonatal arrangements. Providers will need to consider the immediate requirements set out by NHS England and identify any areas requiring further action. The North West Neonatal Operational Delivery Network (ODN) will have an important role in providing specialist neonatal oversight and assurance of the provider response. NHS GM understands that this assurance will be captured through the newly established Regional Assurance Process, providing the ICB with visibility of provider progress and any residual risks or concerns requiring further action or escalation.

The NHS GM Maternity & Neonatal Programme will receive quarterly updates through this process and provide a system-level position to SCC, with any provider-specific risks or gaps in assurance escalated through the established NHS GM Contract Quality Mechanism where required.

Bereavement care

Bereavement care is not a new area of national expectation. The NHS England Three-Year Delivery Plan for Maternity and Neonatal Services established expectations for compassionate, high-quality bereavement care, including access to appropriate bereavement services and facilities, and the National Bereavement Care Pathway is already established nationally. The 21st September letter now requires ICBs and providers to take immediate action to improve care of the bereaved.

This requirement should be considered alongside, but not conflated with, the post-death care requirements arising from the Fuller Inquiry and reflected within Point 10 of the Maternity and Neonatal 10 Point Plan. The Fuller work provides assurance regarding governance and respectful, safe care after death; it does not in itself provide assurance on the quality of bereavement support provided to families. The neonatal response should therefore confirm that existing provider bereavement arrangements include the National Bereavement Care Pathway for neonatal death and identify any residual gaps requiring action.

Safeguarding

Safeguarding training is already governed through the NHS England Safeguarding Accountability and Assurance Framework (SAAF), which sets out the safeguarding responsibilities and competency requirements for NHS organisations and commissioned providers. The NHS England Thirlwall letter reinforces these existing requirements, requiring both providers and ICBs to ensure that staff and Board members are compliant with safeguarding training at the appropriate level and understand how to raise and escalate concerns. For NHS GM, assurance of its own organisational compliance should continue through established safeguarding governance and reporting arrangements. As a commissioner, NHS GM must also maintain assurance that commissioned providers meet the required safeguarding standards; for the neonatal-specific response to Thirlwall, provider assurance will be supported by the North West Neonatal ODN through the Regional Assurance Process, with any areas of concern escalated through established NHS GM routes

Speaking up, professional curiosity and Board oversight

Thirlwall places particular emphasis on professional curiosity, the ability of staff to raise concerns and the responsibility of Boards to understand whether governance processes are effective in practice. These are established national expectations. The National Maternity & Neonatal Three-Year Delivery Plan required provider Boards to listen and act on staff feedback, including Freedom to Speak Up data and concerns raised, while the Maternity Incentive Scheme requires evidence of Board oversight, staff feedback, culture and escalation within maternity and neonatal services.

These existing sources of assurance are relevant and should be triangulated rather than recreated. They do not, however, provide complete assurance against the wider Thirlwall requirements. In particular, Freedom to Speak Up was not a standalone Maternity Incentive Scheme Year 7 compliance requirement. The assurance question for SCC is therefore not simply whether a process exists, but whether the available intelligence demonstrates that concerns are recognised, connected, escalated and acted upon. It is anticipated that assurance against this will be provided through the North West Neonatal ODN as part of the Regional Assurance Process, with the GM position reported through the quarterly SCC update.

Neonatal-specific requirements and specialist assurance

A significant proportion of the Thirlwall recommendations and immediate NHS England actions relate directly to neonatal clinical services, including SUDIC, insulin security, mortality surveillance, data reporting and future requirements relating to neonatal monitoring. These are provider delivery responsibilities requiring specialist neonatal interpretation and oversight. NHS GM should retain clear line of sight to implementation and risk without recreating within the ICB the specialist clinical function already available through the North West Neonatal ODN.

Recommendation 17 strengthens the emphasis on demonstrable implementation rather than self-reported compliance. NHS GM will need to maintain assurance against those requirements that apply directly to the ICB through the relevant organisational governance arrangements. For provider and neonatal requirements, it is anticipated that the North West Neonatal ODN will provide specialist assurance of implementation through the Regional Assurance Process, giving NHS GM line of sight to provider progress, any residual gaps or concerns, and areas requiring further action or escalation. This will enable the NHS GM Maternity & Neonatal Programme to maintain system oversight and ensure that any identified risks or concerns are escalated through established NHS GM routes where required.

4. Greater Manchester oversight and assurance approach

The Regional Assurance Process is underpinned by the North West Perinatal Quality Assurance & Oversight Model, which provides the framework through which implementation of national maternity and neonatal priorities will be assured. The model is supported by the Perinatal Performance & Oversight Panel (PPOP), bringing together ICB assurance with specialist clinical and network assurance, including that provided by the North West Neonatal ODN. The Regional Assurance Process is designed to remain dynamic and incorporate emerging national requirements, including the outputs of the National Maternity and Neonatal Taskforce.

PPOP will provide the regional assurance route for implementation of the National Maternity and Neonatal Taskforce action plan. As the Taskforce is explicitly required to address the Thirlwall recommendations, Thirlwall will therefore form part of the national requirements tracked through this regional assurance process.

The North West Neonatal ODN provides the specialist neonatal network function across the three North West ICBs and is represented within PPOP. It is proposed that the ODN leads the specialist neonatal element of the Thirlwall response with providers, providing professional and clinical assurance into PPOP on behalf of the North West system. NHS GM will retain commissioning and Quality & Safety Management oversight of the neonatal services it commissions and use the resulting specialist assurance to inform its wider provider oversight, escalation and commissioning responsibilities.

This approach will strengthen, rather than duplicate, existing NHS GM provider oversight and commissioning arrangements. Where assurance is obtained, this will be captured through routine oversight. Where concerns or gaps in assurance are identified, these will enter the established NHS GM Contract Quality Escalation Mechanism through provider Quality Review Meetings and, dependent upon the level of assurance and response, can escalate through Contract Review Meetings and ultimately to Provider Oversight Meetings, providing an ICB Executive-to-provider Executive route where required.

In parallel, the planned quarterly maternity and neonatal assurance update to SCC, aligned to the PPOP reporting cycle, will provide routine system-level visibility of the GM position. This will enable SCC to see areas of assurance, emerging themes, direct ICB responsibilities and any provider escalation within one joined-up assurance route, rather than receiving separate updates for each national review or requirement.

The immediate actions within the NHS England letter should progress now through the routes described in Sections 2 and 3. The wider implementation requirements will develop through the Taskforce action plan and PPOP. This provides a clear distinction between actions which cannot wait for the national response and the longer-term assurance framework through which the full Thirlwall recommendations will be tracked.

5. Recommendations

The Strategic Commissioning Committee is asked to:

- Note the findings and recommendations of the Thirlwall Inquiry and the immediate requirements subsequently set out by NHS England.
- Support the proposed Greater Manchester approach to assurance, with requirements applying directly to NHS GM managed through the relevant organisational governance arrangements, and specialist neonatal assurance of provider implementation anticipated through the North West Neonatal Operational Delivery Network (ODN) and Regional Assurance Process.

- Support the NHS GM Maternity & Neonatal Programme receiving routine updates on the GM assurance position and reporting this to SCC through the forward planned quarterly maternity and neonatal updates.
- Support escalation of any provider-specific risks, concerns or gaps in assurance through the established NHS GM Contract Quality Mechanism where required.

Sources

[Department of Health and Social Care \(15 September 2026\), Thirlwall Inquiry report.](#)

[The Thirlwall Inquiry, Summary Report and Chapter 45: Recommendations.](#)

[NHS England \(21 September 2026\) » Thirlwall Inquiry report and recommendations](#) letter to NHS Trusts and Integrated Care Boards

[Department of Health and Social Care, National Maternity and Neonatal Taskforce - published objectives.](#)

[NHS England, Perinatal Quality Oversight Model.](#)

NHS England North West, Perinatal Quality Assurance & Oversight Model.

[NHS England, Three-Year Delivery Plan for Maternity and Neonatal Services.](#)

[NHS England, Safeguarding Accountability and Assurance Framework \(fifth edition, 2026\).](#)

[NHS England, Maternity and Neonatal 10 Point Plan assurance process.](#)

[NHS Resolution, Maternity \(Perinatal\) Incentive Scheme Years 7 and 8.](#)

Appendix 1 - Summary of Thirlwall Inquiry recommendations

The table below summarises the 17 recommendations and the responsibility explicitly assigned by the Inquiry. No recommendation within the Inquiry itself is assigned directly to an Integrated Care Board.

Recommendation	Key requirement	Inquiry-assigned responsibility
1. CCTV and monitoring	Baby monitors with livestreaming video on all neonatal cots/incubators; centrally managed, ring-fenced funding; implementation roadmap by 31 March 2027.	NHS England / national funding arrangements
2. Insulin	Digital access controls for insulin; neonatal units to meet GIRFT requirements by 31 March 2027; CCTV until biometric access is established; national laboratory guidance to become mandatory.	Providers / NHS England
3. Bereavement care	National Bereavement Care Pathway for neonatal death implemented nationally and in all providers by 31 August 2027.	Providers / national implementation
4. Safeguarding and employment contracts	Safeguarding training for all provider staff and Boards; employment, bank and agency contracts to require compliance with safeguarding guidance and the new deliberate-harm protocol.	Providers / NHS employers
5. Digital interoperability	Timed route to harmonised NHS computer systems by December 2028 and mandatory interoperability standard.	NHS England
6. Monitoring deaths	Board-level monitoring of all deaths of children and babies and predetermined escalation routes for concerning trends by 31 March 2027.	Providers
7. Data reporting	Hospitals with neonatal units to appoint a trained lead reporter; at least weekly data input/review of real-time MBRRACE neonatal and maternity data; Board reporting at least six-monthly or immediately where action is required.	Providers with neonatal units
8. SUDIC	Confirm Sudden Unexpected Death in Childhood processes apply to babies dying suddenly and unexpectedly without leaving hospital; provider briefing and revised national guidance.	NHS England / DHSC / providers
9. Suspicion of Deliberate Harm	National protocol and short guidance by 31 March 2027; immediate action on good-faith concerns; providers to embed protocol locally.	NHS England / providers
10. Independent expert panel	Consider establishment of a multidisciplinary national expert panel for rapid independent investigation of emerging concerns about patient harm.	DHSC
11. Medical examiners	Neonatal-specific guidance, stronger safeguarding questioning, interim access to neonatologists and review of the Medical Examiner system.	National Medical Examiner / DHSC
12. Paediatric/perinatal pathology	Increase training capacity to 37 doctors in paediatric/perinatal pathology posts by June 2033 and maintain incentives until achieved.	DHSC / NHS England
13. Regulation/accountability of managers	Manager barring system by September 2027; strengthened fit-and-proper arrangements, individual duty of candour and revised leadership standards.	Government / NHS England
14. Care Quality Commission	Unannounced departmental inspections using current practising specialists; greater focus on whether safety processes are effective rather than simply present.	Care Quality Commission
15. Care Quality Commission performance	Rigorous and consistent review of Care Quality Commission performance.	Health and Social Care Committee

Recommendation	Key requirement	Inquiry-assigned responsibility
16. Whistleblowing	Transfer National Guardian's Office functions to the Parliamentary and Health Service Ombudsman with expanded powers relating to mishandled whistleblowing.	National / Government action
17. Implementation	National Audit Office responsibility for auditing implementation of recommendations arising from statutory NHS inquiries.	Government / National Audit Office

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		
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 and Commissioning Intentions		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					
National Quality Strategy	X		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

Items deferred:

Delivery of Mental Health and Well Being Strategy priorities - deferred from October meeting due to item being taken to Board recently.