

Agenda

Greater Manchester Integrated Care Board (Public including AGM)

Date: 16th September 2026

Time: 2.00pm to 3.30pm

Venue: Boardroom, Tootal Buildings

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	2.00	5 mins	Welcome, Introductions and Apologies: Owen Williams	Verbal	-	Jackie Njoroge, Acting Chair
2.	2.00		Declarations of Interest	Verbal	-	Jackie Njoroge, Acting Chair
3.	2.05		Minutes of previous meetings and matters arising	Paper	Approval	Jackie Njoroge, Acting Chair
Actions: Log attached						
Leadership Reports						
4.	2.05	5 mins	Chair’s Briefing including appointment of AC Independent Member and reappointment of partner member	Verbal	Information	Jackie Njoroge, Acting Chair
5.	2.10	10 mins	Acting Chief Executive’s Update including Reform and OPIC	Paper	Discussion	Colin Scales, Acting Chief Executive
Strategic Updates						
6.	2.20	20 mins	Neighbourhood Delivery Plans as well as update on commissioning intentions/emerging plans for delivery in 2027/28	Paper	Discussion	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
7.	2.40	10 mins	Committee Operating Principles	Paper	Decision	Chris Gaffey, Associate Director of Corporate Governance
8.	2.50	5 mins	Modern Day Slavery Statement	Paper	Decision	Manisha Kumar, Chief Clinical Officer

Assurance Reports and Updates						
9.	2.55	10 mins	People and Resources: • Committee Report	Paper	Information	Richard Paver, Non-Executive Director / Deputy Chair of the People & Resources Committee
			• Finance Report	Paper	Discussion	Kathy Roe, Chief Finance Officer
10.	3.05	10 mins	Strategic Commissioning: • Committee Report	Paper	Information	Sue Bailey, Non-Executive Director / Chair of the Strategic Commissioning Committee
			• Quality & Performance Report	Paper	Approval / Discussion / Information	Anita Rolfe, Deputy Chief Clinical Officer
11.	3.15	5 mins	Audit Committee: Audit Committee Report	Verbal	Information	Richard Paver, Non-Executive Director / Audit Chair
12.	3.20	5 mins	Remuneration Committee	Verbal	Information	Rachel Egan, Non-Executive Director / Chair of the Remuneration Committee
13.	3.25	5 mins	North West Specialised Commissioning Committee	Paper	Information	Katherine Sheerin, Chief Commissioning Officer
For Information						
14.	3.30	5 mins	Approved minutes of Committees: • People and Resources Committee • Strategic Commissioning Committee • Audit Committee (Draft)	Paper	Information	-
15.			Any other business	Verbal	-	Jackie Njoroge, Acting Chair
16.			Date and time of next meeting: 18 th November 2026, 2-4pm	Verbal	Information	

Please note that due to the limited time we have we cannot respond to public questions within the Board meeting. We will acknowledge all the questions we get and will respond to them formally within 20 days. The questions and answers will also be published on our website.

Acting Chair, NHS Greater Manchester	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
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	
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
Scales, Mr. Colin	Y	Non-financial professional interest	Loyalty interests	Honorary Professor of UCLan		2024	
Scales, Mr. Colin	Y	Indirect interests	Outside employment	Wife works at NCA as a nurse		19/09/2024	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			
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Outside employment	Interim FD Derian House Childrens Hospice		06/10/2025	
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Shareholdings and other ownership interests	Director and Shareholder of GSD Financial Consulting Ltd	Set up my own consultancy firm	01/04/2025	
Kay, Mrs. Khalida (Kal)	Y	Non-financial personal interests	Outside employment	Great Academies Education Trust	Trustee (non remunerated)	20/04/2020	
Kay, Mrs. Khalida (Kal)	Y	Non-financial professional interest	Shareholdings and other ownership interests	Association of Camerados	Non Exec, non remunerated director	22/10/2018	
Paver, Mr. Richard	Y			Nil			
Partner Members	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Chief Medical Officer for Health Innovation Manchester		Dec-25	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Clinical Director, Gorton and Levenshulme Primary Care Network		Apr-19	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Executive Committee Member, Manchester Local medical Committee		Jan-26	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Salaried GP, West Point Medical Centre		Apr-23	Ongoing
Hassall, Anthony	Y	Financial interest	Outside employment	Chief Executive, Pennine Care NHS Foundation Trust		2022	Ongoing
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	
Williams, Dr Owen	Y	Non-financial professional interest	Outside employment	Co-Chair of the Chairs and CEO Ethnic Minority Network		2021	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Outside employment	Acute Partner Member of the NHS Greater Manchester Integrated Care Board (ICB)		2022	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Outside employment	Chair - Yorkshire and Humber PSRC Strategic Advisory Board		Jan-24	Ongoing
Williams, Dr Owen	Y	Financial interest	Loyalty Interests	Chief Executive Officer – Northern Care Alliance NHS Foundation Trust		Nov-21	Ongoing
McKenzie Folan, Alison	Y	Financial interest	Outside employment	Chief Executive at Wigan Council		2019	Ongoing

Minutes

NHS GM Integrated Care Board (Public)

Date: Wednesday 15th July 2026
Time: 2pm to 4:30pm
Venue: Boardroom, 1st Floor, The Tootal Buildings

Present		
Members:		
Jackie Njoroge	JN	Interim Chair, NHS GM
Dame Sue Bailey	SB	Non-Executive Director and Chair of the Performance & Quality Committee, NHS GM
Rachel Egan	RE	Non-Executive Director and Chair of the Remuneration and Population Health Committees, NHS GM
Richard Paver	RP	Non-Executive Director and Chair of Audit Committee, NHS GM
Anthony Hassall	AH	Board Member bringing the perspective of Mental Health, Chief Executive of Pennine Care NHS Foundation Trust
Leigh Vallance	LV	Board Member bringing the perspective of the Voluntary Community, Faith and Social Enterprise (VCFSE) Sector, Chief Executive of Bolton Hospice
Kathy Roe	KR	Chief Finance Officer, NHS GM
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer, NHS GM
Katherine Sheerin	KS	Chief Commissioning Officer, NHS GM
Executives:		
Nicola Hepburn	NH	Acting Chief Reform & Improvement Officer, NHS GM
Attendees / Participants:		
Chloe Dyson	CD	Project Support Officer, NHS GM (Minutes)
Chris Gaffey	CG	Associate Director of Corporate Services, NHS GM
Claire Lake	CL	Deputy Chief Medical Officer (Deputising for Manisha Kumar)
Lindsay Kirby	LK	Head of Internal, Stakeholder and Media Relations (Deputising for Claire Connor)
Anita Rolfe	AR	Deputy Chief Clinical Officer (Nursing and Nurse Advisor to the Board), NHS GM
Andrea Patel		Associate Director Nursing for Safeguarding
Majid Hussain	MH	Director of Equality and Inclusion, NHS GM
Selina Morgan	SM	Freedom to Speak Up Guardian, NHS GM
Sophie Porter	SP	Freedom to Speak Up Guardian, NHS GM
Warren Heppollette	WH	Director: Prevention Demonstrator, GMCA
Apologies:		
Alison McKenzie-Folan	AMK	Chief Executive Wigan Council, Place Based Lead Health & Care for Integrated Care Partnership
Colin Scales	CS	Acting CEO, NHS GM
Kal Kay	KK	Non-Executive Director and Chair of the Finance Committee/Senior Independent Director, NHS GM
Professor Manisha Kumar	MK	Chief Clinical Officer, NHS GM
Dr Owen Williams	OW	Board Member bringing the perspective of Acute Providers, Chief Executive of Northern Care Alliance (NCA) NHS Foundation Trust

Dr Vish Mehra	VM	Board Member bringing the perspective of Primary Care, General Practitioner
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	Topic	Action
1.	<u>Welcome, Introductions and Apologies</u> JN welcomed attendees and members of the public to the Board meeting. Apologies were noted. JN confirmed the recording and transcript were in place and noted that several colleagues were attending to support specific agenda items.	
2.	<u>Declarations of Interest (DOI)</u> JN reminded Board members to ensure their declarations of interest were accurate and up to date. No additional declarations relating to items on the public agenda were raised.	
3.	<u>Minutes of previous meetings and matters arising</u> The minutes of the previous public Board meeting were approved as an accurate record. No matters arising were raised and members were content with the action list.	
4.	<u>Chair's Briefing</u> JN provided a verbal Chair's briefing and invited members to share any ideas for improving future meetings through Teams or by email.	
5.	<u>Acting Chief Executive's Update including Reform and OPIC</u> KR presented the Chief Executive's update on behalf of CS. The update referenced the publication of the independent review into maternity and neonatal services at Nottingham University Hospitals Trust and the immediate national response, including the roll out of Martha's Rule and reviews of mortuary records. The Board was advised that the majority of NHS England direct commissioning functions are expected to transfer to Integrated Care Boards from April 2027. It was noted that NHS Lancashire and South Cumbria will host the North-West Office for Pan ICB Commissioning (OPIC), with shadow arrangements planned for autumn 2026. The Board noted changes within NHS GM since the previous meeting, including the retirement of Sir Richard Leese as Chair and KR taking up the role of Acting Deputy Chief Executive while wider acting-up arrangements are in place. KR highlighted the significance of 1 July 2026 in the NHS GM reform journey, with most colleagues now moving into new structures. The Board recognised that teams were still settling into new arrangements and that some colleagues remained displaced and in an unsettled position. The update also referenced the continuing development of neighbourhood health, including engagement on the Place Health and Care Partnership documents, and the public launch of phase two of the Greater Manchester No Space for Racism campaign.	

	Topic	Action
	<u>Discussion:</u> Members discussed the need to ensure that recommendations from the Ockenden and Amos reviews are reflected in future commissioning intentions and oversight processes. AH asked that the improvement in Pennine Care's rating be formally acknowledged in a future report. Members discussed the need to measure sustained cultural change, including how services work in partnership with patients/service users/residents. CL confirmed that work was taking place with public health colleagues, UKHSA, community pharmacy and universities on vaccination catch-up activity, including through freshers' fairs.	
6.	<u>Strategic Objectives, Priorities and BAF</u> KR introduced the item, explaining that the strategic objectives, priorities and BAF were intended to show a clear line of sight between the commissioning strategy, neighbourhood health framework, organisational priorities and principal risks. CG presented the proposed strategic objectives and high-level BAF risks. He explained that the objectives were designed to link delivery of the five-year commissioning plan with NHS GM's contribution to the wider ICB strategy. CG advised that the proposed BAF risks were at an early stage and would be developed further if agreed by the Board, with future reporting moving towards outcomes and metrics rather than static sources of assurance. <u>Discussion:</u> Members requested that the risks and measures become more specific, quantifiable and outcome focused. RP noted that the financial sustainability risk read more like a system risk than an ICB risk and asked that commissioning payment reform be reflected in future iterations. SB asked for clearer deliverables, timelines and evidence of what would be delivered within the proposed timeframe. RE asked whether the risks sufficiently captured the most significant strategic threats, including public confidence, staffing capacity, pace and interdependencies between risks. AH requested stronger triangulation between the strategic objectives, system performance and the National Oversight Framework, with particular attention to how commissioning would improve performance and outcomes. KS confirmed that Chief Officers had reviewed the new National Oversight Framework metrics and that the strategic risks would be mapped against the applicable ICB metrics and wider national framework requirements. Members also asked that the BAF consider the impact of combined risks occurring at the same time.	

	Topic	Action
	<u>Discussion outcome:</u> The Board agreed the proposed strategic objectives as the basis for further development. The Board supported the proposed approach to the BAF and requested that the next iteration include clearer metrics, a stronger commissioning lens, alignment to national oversight measures and consideration of risk interdependencies. CG to further develop the BAF, including outcome measures, metrics, strategic commissioning risks and risk interdependency modelling, to be discussed at the next meeting.	
7.	<u>Strategic Commissioning Plan</u> KS introduced the Strategic Commissioning Plan, noting that it had previously been presented to the Board in February and had since been strengthened. KS explained that the plan on a page remained the central framework and that delivery plans would sit beneath it. PH presented the updated plan and highlighted that it now reflected further work on neighbourhood health, place partnerships, elective care and urgent and emergency care. He advised that the narrative had been sharpened to focus on neighbourhoods, Live Well, meeting need differently and embedding health equity within the commissioning cycle. PH noted that delivery plans, an outcomes scorecard and reporting through the Strategic Commissioning Committee would support implementation. <u>Discussion:</u> RE asked how health inequalities would be applied to major commissioning decisions before they came to Committee or Board, how investment would be targeted differentially and when a quantified trajectory for investing in prevention, primary care, community services and VCFSE support would be available. AH welcomed the development of the plan and asked how NHS GM would align its strategic commissioning approach with local authority commissioning, using drug and alcohol services as an example where greater consistency could improve outcomes. SB supported the use of substance misuse and addictions as a worked example to test the plan in practice. JN encouraged colleagues to resist unnecessary complexity and to maintain a clear strategy and concise delivery plan, with health inequalities running strongly throughout. <u>Discussion outcome:</u> The Board supported the foundations of the Strategic Commissioning Plan. The Board requested that future development focus on a clear delivery plan, stronger visibility of health inequalities, alignment with partner commissioning plans and	

	Topic	Action
	practical worked examples.	
8.	<u>Neighbourhood Commissioning Framework</u> CB introduced the Strategic Commissioning Framework for Neighbourhood Health, explaining that it translated the national neighbourhood health framework into a Greater Manchester approach aligned to the five-year commissioning plan. PH explained that feedback from system engagement had reinforced the importance of place in driving neighbourhood health and integration. He described the need for a reliable core offer available consistently in every neighbourhood and locality across Greater Manchester. PH highlighted core features including integrated neighbourhood teams, full geographical coverage, named clinical and operational leadership and alignment between health and care integration and wider public service integration. The framework also set out implementation steps and the opportunity to grow investment in the place fund over time if the system continued to rebalance investment and manage demand differently. <u>Discussion:</u> SB asked that the framework go beyond individual service responses to address the underlying life circumstances that contribute to addiction and poor health, and suggested describing this as an individual and family left shift. RE asked how providers would be engaged in the neighbourhood health journey, how the approach would reflect a shift from adults to children and how place would be supported to buy into VCFSE-delivered support. CL emphasised the importance of Live Well as a person-centred approach and described opportunities around multi-generational prevention, trauma-informed services and clinical conversations about prevention, neighbourhood working and outpatient transformation. AH highlighted the need to use commissioning leverage to reduce unwarranted variation, using integrated mental health team provision as an example. LV emphasised the need to shift how commissioners and frontline staff think, see and hear things differently, so that services are shaped around people rather than fitting people into existing solutions. RE reminded the Board of the need to ensure that the voices of people experiencing health inequalities are heard and translated into service change. <u>Discussion outcome:</u> The Board endorsed the direction of travel for the Neighbourhood Commissioning Framework. The Board requested that future iterations strengthen the focus on children and families, communities of identity, VCFSE support, provider engagement, commissioning leverage and resident voice.	

	Topic	Action
9.	<u>Prevention Demonstrator</u> WH presented a substantive update on the Greater Manchester Prevention Demonstrator and confirmed that the programme was moving into mobilisation. He explained that the work had been shaped with government departments and Greater Manchester partners to align with national objectives and local commissioning intentions. WH described the Prevention Demonstrator as the first national demonstrator of its kind spanning public services, with significant national interest in how Greater Manchester could shift the system towards a more preventative and proactive model. The Board heard that all ten places were progressing Live Well mobilisation, with Manchester, Stockport, Rochdale and Wigan providing additional support as blueprinting and evaluation partners. WH outlined the blueprinting work, including understanding models that shift demand, activity and outcomes; strengthening civic data capabilities; and developing financial frameworks for investment, benefits realisation and reinvestment in prevention. The evaluation approach would include dashboards, process evaluation, resident and practitioner testimony, impact and value for money studies and learning system methods to understand variation and spread. <u>Discussion:</u> Members emphasised that the annual report should include resident and family voices, alongside data, to demonstrate whether people experience the change intended through Live Well. RE asked how the demonstrator would avoid measuring only activity or gross improvement and instead prove sustained, attributable impact capable of shaping mainstream budgets and devolution discussions. WH explained that logic models were being developed to test attribution, inputs, outputs, outcomes and impacts across the four localities. AH highlighted the importance of culture, leadership, regulation, workforce training and a practical focus on what would be different for residents and families. CB reflected that the demonstrator should help describe the workforce, skills, capabilities, roles and ways of working needed for prevention in future. WH agreed that workforce and frontline practice were central to the shift, and that learning would likely need to be generated at neighbourhood or smaller place-based levels to remain practical without creating artificial cohorts. <u>Discussion outcome:</u> The Board supported the approach to the Prevention Demonstrator. The Board requested that future reporting include resident and practitioner voice, stronger articulation of workforce and cultural implications, and clear evaluation methods capable of demonstrating impact and value.	

	Topic	Action
10.	<u>Annual PSED Report</u> CB introduced the Annual Public Sector Equality Duty Report and noted that, while progress had been made, there remained significant work to do to embed equality within the reformed organisation and future commissioning arrangements. MH presented the report, explaining that it looked back over the previous 12 months and demonstrated compliance with the Public Sector Equality Duty. He advised that NHS GM had reached the end of a four-year cycle of equality objectives and now needed to develop a new set of objectives. MH explained that the future objectives would be aligned with the Strategic Commissioning Plan, the Mann Review, work on anti-Semitism and racism, and the new staff standards. He also highlighted work to embed equality within the commissioning cycle, including understanding need, co-production, contracts, commissioning and outcomes. MH noted that work had started on the new integrated needs assessment to provide a more detailed understanding of needs and gaps across communities. <u>Discussion outcome:</u> The Board noted the progress made and the areas of focus required. The Board approved publication of the report in a plain English version.	
11.	<u>FTSU Report</u> SM and SP introduced themselves as Freedom to Speak Up Guardians and presented the Freedom to Speak Up report. SP advised that, following organisational change and the departure of the previous Guardian, work had been undertaken to re-establish the Freedom to Speak Up service. New arrangements were now in place to support continuity, governance and clearer reporting processes. The Board heard that, since April 2026, Freedom to Speak Up documentation had been reviewed, including the policy and tracker. An anonymous e-form refreshed intranet page, Teams channel and shared mailbox had also been established. SP reported that six concerns were raised during quarter one, with one in April and five in May. No concerns were received in June. The most common themes were attitudes and behaviours, and leadership and management. SP emphasised that staff should feel comfortable, confident and safe to speak up, and that several routes were available including line managers, Guardians, the mailbox, anonymous e-form, Teams conversations and the Champion Network. The Champion Network was being expanded, with training delivered to two directors and further requests being received. Communications activity was also being considered through leadership briefings, team talks and other regular channels. SP highlighted risks relating to capacity, as the Guardian role is voluntary and undertaken alongside substantive roles and noted ongoing signposting arrangements for primary care queries.	

	Topic	Action
	<u>Discussion:</u> Members thanked the Guardians for their work and recognised the importance of the role during the reform period. KS asked how the organisation could help increase champion visibility in areas with more direct contact with patients and families, including all-age continuing care, medicines optimisation, safeguarding and designated clinical officers. NH offered to link the work with wellbeing champion arrangements and noted the importance of non-executive support and system signposting. RE reflected that the Executive Team should engage with Guardians about the support and protected time required to fulfil the role effectively. RP asked whether NHS GM had an overview of the different champion roles across the organisation and how support and executive leadership for these roles was coordinated. Members discussed how Freedom to Speak Up arrangements were considered through provider and primary care quality arrangements, while avoiding unnecessary duplication of regulatory responsibilities. AH noted that Freedom to Speak Up is an important barometer of culture and that trends should be kept under review, including caution about interpreting zero reports as positive. SB emphasised the importance of shared learning from all routes of staff feedback to avoid staff feeling that raising concerns did not lead to change. <u>Discussion outcome:</u> The Board noted the Freedom to Speak Up report. The Board thanked the Guardians for their contribution and supported continued development of the Champion Network, awareness activity, reporting arrangements and learning from themes.	
12.	<u>People and Resources</u> The Chair confirmed that assurance reports would be taken by exception because members had read the papers in advance. The People and Resources Committee report and Finance Report were included in the meeting papers. No questions were raised. <u>Discussion outcome:</u> The Board noted the reports.	
13.	<u>Strategic Commissioning</u> The Strategic Commissioning Committee report and Quality and Performance Report were included in the meeting papers. No questions were raised.	

	Topic	Action
	<u>Discussion outcome:</u> The Board noted the reports.	
14.	<u>Audit Committee</u> The Audit Committee report was included in the meeting papers. No questions were raised. <u>Discussion outcome:</u> The Board noted the report.	
15.	<u>Remuneration Committee</u> RE provided a brief verbal update from the Remuneration Committee. The Committee had met the previous week and agreed the arrangements for the interim Deputy Chief Executive. RE advised that the Committee had also agreed to move to the next stage of the process for a number of compulsory redundancies. Final decisions had not been made and were subject to further assurance requested by the Committee. <u>Discussion outcome:</u> The Board noted the verbal update.	
16.	<u>North-West Specialised Commissioning Committee</u> The North-West Specialised Commissioning Committee report was included in the meeting papers. RE asked how the work would transition into, or align with, OPIC arrangements ahead of April 2027, and whether there were specialised commissioning risks requiring visibility through the BAF. KS confirmed that the North-West Specialised Commissioning Committee would be stood down and replaced by a new joint committee with responsibility across OPIC services. Governance work was being taken forward with colleagues across the three ICBs. KS confirmed that a cross-check would be undertaken between the specialised commissioning risk register and NHS GM's overarching strategic risks to ensure alignment. It was noted that specialised commissioning risks should be incorporated within strategic risks rather than included as a separate standalone risk. <u>Discussion outcome:</u> The Board noted the report and the need to cross-reference specialised commissioning risks with the strategic risks.	

	Topic	Action
17.	<u>Approved minutes of Committees</u> The approved minutes of Committees were included in the meeting papers for information.	
18.	<u>Any other business</u> JN noted that the next meeting would take place on 16 September 2026 and reminded members that the Annual General Meeting would take place before the formal Board meeting. JN invited feedback from members and colleagues who had attended the meeting on ways future meetings could be improved.	
19.	<u>Date and time of next meeting</u> The next meeting is planned to take place on Wednesday 16 September 2026. The Annual General Meeting would take place before the formal Board meeting.	

Actions Log: ICB Board							
No	Date	Item	Details of action agreed	Action Lead	Deadline	Status	Further Detail
19	19/11/2026	10. Major Trauma	Assurance on compliance, clinical safety and long-term sustainability including timescales for the NHS GM Major Trauma model to be provided to QPC.	KS	15/07/2026		Proposal to update the new Committee in June then back to Board in July as part of our undertakings. Update: Regular updates have been provided to the Strategic Commissioning Committee. A full report will be provided in August with an update to the Board in September.
24	20/05/2026	7. Board Assurance Framework (BAF)	To bring a proposal back to Audit Committee including the difference between risks and issues.	CG	17/09/2026		This will be reported to Audit Committee.
Completed at Previous Meeting (Audit Trail)							
1	17/07/2024	4. Chair's Briefing	WH to meet with members of the KONP group to discuss the petition and agree next steps	WH	18/09/2024		The meeting went ahead on the 20th August, and the group submitted questions back to WH which the Communication Team are collating the answers.
2	17/07/2024	6. Single Improvement Plan	Single Improvement Plan should be shared with members of the board as soon as it is available showing progress against the plan.	MF	18/09/2024		The plan was shared with members at the Board strategy session on 21st August and updates will be provided.
3	18/09/2024	3. Matters arising	The Chair to meet with MP and team regarding the data in the performance report following concerns raised at the previous meeting	MP/CS	20/11/2024		The performance matrix is still under review and discussed at QPC. Meeting with the Chair has taken place.
4	18/09/2024	4. CEO Report	RB to provide update on Health and Care Review at next meeting in November.	RB	20/11/2024		On agenda for November meeting
8	19/02/2025	4. 2025/26 operational plan	Board meeting to be reconvened prior to final submission of the draft plan on 27th February which would be held in public.	JN	27/02/2025		Meeting reconvened on 26th February
9	26/02/2025	4. Annual plan 25/26 update	Board seminar to be arranged prior to formal meeting.	JN	26/03/2025		Seminar held on 19th March and formal meeting moved to the 26th
6	15/01/2025	7. Board Assurance Framework	Risk appetite to be discussed as part of operational planning at February Board.	CS	05/02/2025		Deferred to June Board development session. Complete
7	15/01/2025	13. Quality and Performance	MP and JW to meet with SMC and SB to discuss maternity workforce issues.	MP/JW	05/02/2025		Meeting took place on 7th April
10	26/03/2025	7. Board Assurance Framework	CS to meet with Committee Chairs in April prior to Board Seminar.	CS	16/04/2025		Meeting took place on 14th April
11	21/05/2025	7. Committee ToR	JN to amend the Quality and Performance TOR after the meeting.	JN	16/07/2025		Complete
14	16/07/2025	6. NHS Reform	MP to meet with RE to discuss the process and decision behind the safeguarding as part of the reform agenda.	MP/RE	17/09/2025		Complete
15	16/07/2025	6. VR Scheme	CB to share the EIA that had been to the T&F Group.	CB	17/09/2025		Complete
16	16/07/2025	16. GM Alcohol Harm Strategy	WH to share map of drug and alcohol services in GM.	WH	19/08/2025		Info can be found here: https://gmintegratedcare.org.uk/find-a-service/type/alcohol-and-drug-support/
5	17/07/2024	12. Primary Care Blueprint Delivery Update	RB to work with John Herring and his team to provide a briefing to the People and Culture Committee and bring a position statement back to Board at a future meeting.	RB	20/11/2024		A paper has been prepared and presented to the PC Blueprint Group. This is in respect to FTSU for Primary Care. We have a proposed model, with delivery through PCB but delivery resource dependent. Update on Primary Care Blueprint provided in Sep 25
13	21/05/2025	10. Assertive outreach	To share report with AMK and other place leads via the Exec Committee	MK	TBC		Complete
17	17/09/2025	3. Matters arising	MK to provide update on the ADHD consultation after the meeting	MK	ASAP		Update provided and paper on agenda for November meeting
12	21/05/2025	9. Federated Data Platform (FDP)	To bring FDP back to Board at later date.	WH	19/11/2025		Paper to come back to the board 6 months following the last meeting. Update provided in CEO report
18	19/11/2026	8. Draft Clinical Strategy	Commissioning intentions including plan to be presented to Board at strategy session in December.	KS	17/12/2025		Presented at December meeting
20	19/11/2026	15 People and Culture Report	Freedom to Speak Up report to be shared with RP.	CB	21/01/2026		Sent to RP on the 21/11/25
21	17/12/2026	3. Approval of 2026/7 planning submission	JN to reschedule February Board meeting from the 18th to the 11th and arrange seminar in January.	JN	11/02/2026		Complete
22	18/03/2026	6. Governance and SORD update including new committee structures	CG to check primary care delegations and report back to Board	CG	20/05/2026		Verbal update provided at May meeting
23	20/05/2026	6. Financial Scheme of Delegation Amendments	Updated FSoD paper to be taken to next Committee meetings	CG	15/07/2026		

Acting CEO's Report to the Board

September 2026

Board

16 September 2026

Report for Information

Required information.	Details.
Title of report.	Acting CEO's Report to the Board
Author.	Jenny Noble on behalf of Professor Colin Scales
Presented by.	Professor Colin Scales
Contact for further information.	gmhscp.gmicb.corporate@nhs.net
Executive summary.	The paper details updates from the Acting CEO with reference to the national, regional and local system positions.
The benefits that the population of Greater Manchester will experience.	The NHS Greater Manchester (GM) response to NHS Reform, with consideration being made through the necessary due diligence.
How health inequalities will be reduced in Greater Manchester's communities.	Proactively responding to the independent review into maternity and neonatal services at Nottingham University Hospitals NHS Trust.
The decision to be made and/or input sought.	The Board is asked to note the contents of the CEO's Report to the Board. Also, disseminate and cascade the necessary key messages and information as appropriate.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Delivering key messages in the context of NHS Reform which is BAF SR10.

Key milestones.	Key messages in the context of NHS Reform.
Leadership and governance arrangements.	For consideration and dissemination by the Board.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	Engagement has already commenced with the GM system's key stakeholders and NHS GM staff in response to NHS Reform. Any formal decisions to be taken, will proceed through the necessary governance routes.
Financial or Legal Implications	NHS GM proceeding with the organisational change programme in response to NHS Reform.

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

Introduction

- 1.1. The paper details updates from the Acting CEO with reference to the national, regional and local system positions.

National and Regional Updates

- 1.2. This section of my report is aimed to update the Board on the key areas of development from a national and regional position, since the last Acting CEO's Report to the Board in July.
- 1.3. I have attached the final version of our 2025/26 Annual Assessment Letter which provides a balanced reflection of our organisation's performance over the past year, recognising

both the progress made and the matters discussed through our ongoing dialogue with regional colleagues.

Launch of HPV self-testing

- 1.4. The NHS is introducing Human Papillomavirus (HPV) self-testing as part of the NHS Cervical Screening Programme, following a recommendation from the UK National Screening Committee. Initially, self-testing will be offered to eligible women and anyone with a cervix aged 30 to 65 who have not attended cervical screening after previous invitations.
- 1.5. The service will be rolled out gradually over the next year, with invitations issued nationally via the NHS App, text message, email or letter. Eligible participants can order a free self- testing kit online or by telephone.
- 1.6. HPV self-testing does not replace routine cervical screening. Anyone who receives a positive high-risk HPV result from a self-test will still need to attend for a clinician-taken sample. The initiative aims to improve screening participation among people who do not regularly attend appointments, helping to reduce health inequalities, improve patient experience and support the goal of eliminating cervical cancer by 2040.

Transfer of NHS England Direct Commissioning Functions and Office of Pan-ICB Commissioning (OPIC)

- 1.7. Progress continues across the North West in preparation for the transfer of NHS England direct commissioning functions to Integrated Care Boards from 1 April 2027, (subject to approval of the required legislation). The three North West ICBs and NHS England North West continue to make progress in developing the operating model, governance arrangements and workforce planning required to support the transition and establishment of the North West Office of Pan-ICB Commissioning (OPIC).
- 1.8. To support the next phase, a North West Transition Board comprising the three ICBs and NHS England North West has been established. The Board will oversee and drive the transition programme from October 2026 through to the formal transfer of responsibilities on 1 April 2027, ensuring appropriate governance and workforce readiness, operational continuity and risk management throughout the transition period.
- 1.9. In parallel, the three ICBs will establish an OPIC Management Group from October 2026. Working in partnership with the NHS England regional commissioning team, the group will shape the design, operating arrangements and organisational development of OPIC during 2026/27 to ensure a fully functioning office is in place for transfer to LSC ICB as the host from April 2027. The Group will provide executive oversight of planning, performance, workforce, finance, quality, governance and risk, supporting the safe and effective transition and delivery of commissioning functions across the region.

- 1.10. This programme represents a significant step towards establishing ICBs as strategic commissioners and ensuring robust regional arrangements are in place to commission specialised services, health and justice services, and screening and immunisation services at scale across the North West.

Greater Manchester (GM) System Updates

- 2.0 This section of my CEO Report is specifically focussed on what is happening here within the GM system.

The NHS GM Board and Proposed Change to the Constitution

- 2.1. Recruitment to appoint Sir Richard's successor as ICB Chair is still under way. As announced earlier this year, this role is expected to also take on the Health Commissioner responsibilities for Greater Manchester, working closely with the Mayor. In light of the recent Makerfield by-election and election for the Mayor of Greater Manchester, the recruitment process was paused temporarily but interviews are now scheduled to take place in October.
- 2.2. As a result, we have been mandated by region to amend our constitution. The change relates to section 3.3.3, as the current wording prohibits the Chair from holding a role in another health and care organisation within the ICB area.
- 2.3. This section has been amended in the GM constitution to read:

3.3.3 Individuals will not be eligible if:

a) they hold a role in another health and care organisation within the ICB area, **except a role in a strategic authority;**

b) any of the disqualification criteria set out in 3.2 apply.
- 2.4. No other changes are proposed at this time although we are currently reviewing the Committee Terms of Reference which may result in further amendments.

NHS Reform Programme

- 2.5. NHS Greater Manchester is now in Year 2 of its reform programme, with a focus on completing organisational restructuring, stabilising the organisation, and supporting the next phase of service transfers required to achieve the target operating model.
- 2.6. The majority of organisational change activity has now been completed and most colleagues have transitioned into new roles. However, for the small number of colleagues

who remain displaced, this continues to be an extremely difficult and uncertain period. The organisation remains committed to supporting affected colleagues with compassion, fairness and appropriate support as these processes are concluded. We remain fully committed to supporting colleagues to find suitable alternative employment and to continuing with meaningful work whilst processes are concluded.

- 2.7. Alongside completing structural change, our focus is on stabilising the organisation and embedding the new operating model. This is a multifaceted programme of work that includes establishing a clear strategic direction through the Strategic Commissioning Plan, implementing the two-year Organisational Development Plan, strengthening leadership and culture, and improving core business processes and ways of working to support effective delivery.
- 2.8. The second phase of delivering our target operating model involves a number of transformation programmes that will see services transfer both into and out of the organisation. These changes are intended to align functions with the strategic commissioner role of the ICB, strengthen delivery arrangements across the system and ensure services are located in the organisations best placed to deliver them. This programme of work will be progressed in partnership with staff, trade unions and system partners over the coming months.

Cardiac and vascular public consultations

- 2.9. The Board will be aware from previous updates about the two ongoing NHS Greater Manchester public consultations regarding the future of specialist heart and vascular surgery services across Greater Manchester and Eastern Cheshire.
- 2.10. These consultations are asking for feedback on proposals which would see:
 - Adult cardiac surgery: proposals to deliver all adult cardiac surgery at Wythenshawe Hospital
 - Specialist vascular surgery: proposals to deliver specialist vascular surgery at Manchester Royal Infirmary.
- 2.11. Outpatient appointments, diagnostic tests and follow-up care would continue to be provided from a range of locations across Greater Manchester. Both consultations close on 22 September 2026. Feedback from patients, families, staff, partners and the public will from both consultations will be used by the Commissioners to refine and improve the proposals before any final decisions are made. I will keep the Board updated on any necessary developments going forward.

Winter vaccinations

- 2.12. In September we will launch our 'Keep protected this winter' vaccination campaign, which aims to tap into our natural instinct to keep ourselves and our loved ones safe and protected. The first phase of the campaign focuses on vaccinations for pregnant women, 2-3s and school-aged children. This will be live across a number of channels including radio, on buses and trams across GM, and online across a number of digital channels. We have also created a pack of engaging content for partners to use to help support an increase in uptake of winter vaccinations in GM. Resources such as newsletter copy, leaflets, including Easy Read, graphics for waiting room digital screens, social media content and more will be available to download from our campaigns resource centre.
- 2.13. We are also continuing to encourage students heading to university this autumn to not only register with a local GP, but also make sure they're up to date with their vaccinations. Eligible students under 25 who are starting university or residential further education for the first time are being urged to take up the new MenB vaccination programme. MenB is a rare but serious infection that can become life-threatening very quickly. Students need two doses of the vaccine, given at least four weeks apart, for the best protection. The first dose is available until 31 December 2026, with the second available until 31 March 2027.
- 2.14. Students are also encouraged to plan ahead for repeat prescriptions, learn how to access NHS services, and look after their mental wellbeing as they adjust to university life.

Launch of the Inclusive Leadership Steering Group

- 2.15. I am pleased to update members on the launch of NHS Greater Manchester's Inclusive Leadership Steering Group (ILSG).
- 2.16. The ILSG brings together colleagues from across the organisation, including staff and peer networks, trade unions, senior leaders and those with lived experience, to help shape and improve inclusive leadership, organisational culture and workforce experience. The Group has been established as a collaborative critical friend, bringing together workforce evidence, staff feedback, lived experience and organisational insight to support learning, challenge and continuous improvement.
- 2.17. Working alongside existing programmes and governance arrangements, the ILSG will provide a forum for co-production, ensuring that the experiences and perspectives of colleagues help inform organisational decisions and improvement activity. It will play an important role in helping us create a workplace where everyone feels valued, included, respected and able to thrive.

Northern Care Alliance update

- 2.18. The Northern Care Alliance NHS Foundation Trust continues to operate in challenging circumstances, with significant public and media scrutiny concerning organisational culture, leadership and the management of incidents and concerns. The Trust has acknowledged the seriousness of the issues raised and the need to listen to patients,

colleagues and communities, establish the facts and demonstrate sustained improvement. This scrutiny should not detract from the commitment and compassionate care shown by many NCA colleagues, but nor should positive experiences diminish the concerns raised.

- 2.19. The Trust remains subject to significant regulatory oversight, including the Care Quality Commission Section 29A Warning Notice, NHS England enforcement undertakings and enhanced oversight through the System Improvement Board. These requirements are being brought together through a single, coordinated improvement and assurance plan covering quality and safety, governance, culture, workforce, performance and the use of resources.
- 2.20. NHS Greater Manchester is working closely with the NCA, NHS England and wider system partners to support and oversee delivery of the required improvements. Our focus is on ensuring that progress is assessed not only through the completion of actions, but through clear evidence of impact, sustained improvement and better experiences and outcomes for patients and staff. Continued openness, engagement and shared ownership across the NCA's four localities will be essential to rebuilding confidence.
- 2.21. Industrial action involving theatre services took place on 24, 26 and 28 August. The dispute relates to terms and conditions, alongside wider workforce concerns including vacancies, leadership, civility, shift management and the impact of meetings on clinical priorities. The NCA continues to engage with colleagues and trade union representatives while maintaining safe services and managing the operational, workforce and financial pressures arising from the dispute. NHS Greater Manchester and partners have supported system coordination and patient-safety arrangements throughout.
- 2.22. Further Industrial Action is planned to take place next week with some of NCA's theatre staff. The Trust are working hard to minimise the impact on patients and maintain high standards of care and quality at all times. They also have contingency plans in place for emergency situations.
- 2.23. The NCA remains committed to constructive discussions and finding a fair and sustainable resolution while maintaining safe care for their patients. A meeting will be taking place with UNISON on Friday with the hope of finding a resolution.

Health Innovation Manchester (HInM) Update

- 2.24. A significant recent win has been Greater Manchester's success in securing funding through the UKRI Local Innovation Partnerships Fund (LIPF), building directly on the strong foundations established through the Health Innovation Accelerator (HIA), lead by Health Innovation Manchester with partners. The award includes £6.7m for Health Innovation Manchester's Greater Data Accelerator programme, which will create a globally distinctive real-world evidence and data innovation platform by linking population-scale health data, UK Biobank assets and advanced analytics capabilities to reduce the time, cost and risk of research and innovation. In parallel, Manchester University NHS

Foundation Trust secured £5.5m for the Greater Manchester Wearables and Remote Monitoring Innovation Cluster, which will establish a national-scale platform for the development, testing and adoption of wearable and remote monitoring technologies, integrating wearable device data with NHS systems to support both patient care and commercial innovation. Together, these programmes represent a major vote of confidence in Greater Manchester's innovation ecosystem, demonstrating how the collaborative partnerships, delivery capability and system leadership developed through previous programmes are now attracting substantial external investment, accelerating inward R&D activity and strengthening the city region's position as a leading UK centre for health innovation, life sciences and data-enabled growth. Through public and private co-investment, the value of these programmes to GM over 7 years is forecast to be £59m.

Health and Safety Oversight

- 2.25. I have previously committed to updating the Board on health and safety matters through a standing item within my report. Work continues to implement the outstanding recommendations from the Mersey Internal Audit Agency (MIAA) Health and Safety Audit. Implementation of the new incident-reporting system remains planned for September 2026 and will support more consistent reporting, improved identification of trends and organisational learning. By the end of September, the Lone Worker Policy is also expected to be finalised and approved through the People and Resources Committee, alongside completion of the review of NHS GM's internal risk-assessment documentation. Progress against the remaining audit actions will continue to be monitored through the established governance arrangements.
- 2.26. Work is also continuing to establish sustainable health and safety arrangements following the structural changes arising from NHS Reform. Appropriate interim arrangements are in place to support the discharge of NHS GM's statutory responsibilities while the future model is developed. As the responsible Committee, the People and Resources Committee will continue to receive regular updates on Health and Safety matters, with assurance provided to the Board through the Committee's regular reports.

Board Assurance Framework

- 2.27. Work to develop the Board Assurance Framework (BAF) remains ongoing. Although the BAF risks have been agreed and were originally planned for consideration by the Board in September, further time has been required to develop the detail underpinning those risks and to review the corporate risk profile in light of NHS Reform and implementation of the new operating model. The extended timeline will enable the corporate risks to be more fully developed and aligned to the agreed BAF risks, providing a stronger basis for their ongoing management through clearer controls, assurances, ownership and mitigating actions. A Chief Officers' workshop is planned for September to consider the BAF risks, including the organisation's risk appetite, ahead of the revised BAF being presented to the Board for consideration in November.

NHS GM Winter Plan

- 2.28. Planning is under way for winter 2027/28, with a focus on strengthening system resilience and readiness to manage seasonal pressures. The Board will be kept informed as the plan develops.

Recommendations

- 3.0** The NHS GM Board is asked to:
- 3.1. Note the contents of the Acting CEO's Report to the Board including the 2025/6 Annual Assessment Letter.
 - 3.2. Note the proposed amendment to the constitution.
 - 3.3. Provide feedback on any future topics they wish to be covered within the Acting CEO's Report to the Board in November 2026.

To: Jackie Njoroge, Chair (Interim)
Colin Scales, Chief Executive (Acting)

Greater Manchester Integrated Care
Board

Louise Shepherd
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

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31 July 2026

Dear Jackie and Colin,

Annual assessment of Greater Manchester Integrated Care Board's performance in 2025–26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and continued organisational change. In parallel, ICBs have been required to adapt to an evolving operating model, while maintaining a clear focus on statutory duties, system leadership and delivery for local populations.

Against this backdrop, I recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. I also acknowledge the additional burden created by structural changes, and the need to maintain stability and continuity across systems during a period of transition.

In reaching this assessment, I have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners and stakeholders, and the discussions my team and I have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, I have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

I remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

I would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. My team and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

A handwritten signature in black ink, reading 'Louise Shepherd'.

Louise Shepherd CBE
Regional Director (North West)

Section 1: ICB performance assessment

In reaching this assessment, I have considered how successfully the ICB delivered national priorities, discharged its statutory duties and improved outcomes for its population during 2025/26.

Greater Manchester ICB demonstrated progress across a number of national priorities. Cancer performance improved, with the 62-day standard delivered above target and stronger evidence of pathway redesign and system-wide improvement activity. Elective recovery and diagnostics also improved, supported by reductions in long waits, strengthened delivery arrangements and expanded Community Diagnostic Centre capacity. The ICB also reported improved GP booking satisfaction and strong performance on a number of mental health access and capacity measures.

Urgent and emergency care remained an area of challenge. Four-hour A&E performance improved compared with the previous year but remained below the national standard, and constitutional performance remained inconsistent overall.

The ICB demonstrated a well-developed strategic approach to population health and reducing inequalities, including the use of population health management, neighbourhood models and linked datasets to identify and target priority cohorts. This supports a more proactive, preventative and outcomes-focused model of care. However, further work is required to embed this consistently within decision-making, commissioning and Board assurance arrangements, and to demonstrate measurable impact across places.

The annual report evidences a well-described quality governance architecture and use of priority metrics to identify risks and shape improvement activity. Positive progress has been made, including in public engagement and delegated oversight of primary care complaints. However, further assurance is required on how wider quality metrics, patient experience intelligence and complaints themes are triangulated and used to demonstrate impact through Board-level reporting.

The ICB delivered its financial plan for 2025/26 and submitted a compliant break-even plan for 2026/27. The ICB also reported that it met the annual Mental Health Investment Standard. However, the underlying financial position remains challenging, with a significant efficiency requirement and continued reliance on non-recurrent delivery during 2025/26. Financial sustainability remains a significant strategic risk and will require sustained leadership focus throughout 2026/27.

I have also considered the recent SEND inspection of the Tameside Local Area Partnership, which identified significant concerns and requires a priority action plan and future monitoring. This is relevant to the ICB's responsibilities for planning and commissioning services with local partners. I have also noted the positive findings from the Oldham and Bury re-inspections, which found effective action had been taken by partners, including the ICB, in response to previously identified areas for improvement.

Overall, Greater Manchester ICB demonstrated progress across several important priorities, particularly cancer performance, elective recovery, diagnostic improvement, population health and strategic commissioning development. Nevertheless, significant challenges remain in urgent and emergency care, mental health pathways, financial sustainability, inequalities and achieving consistent delivery across all priority standards requiring sustained focus during 2026/27 to deliver necessary improvements.

Section 2: ICB capability assessment

In considering capability, I have reviewed how effectively the ICB has commissioned services for its population, exercised system leadership, taken appropriate professional advice, engaged with local communities and discharged its statutory responsibilities during a period of considerable organisational change.

The evidence indicates an organisation with clear strategic intent and developing strategic commissioning capability. Governance and operating model arrangements have strengthened, with clearer alignment to the Model ICB Blueprint, stronger place-based partnerships, more explicit system governance and provider oversight arrangements, and a clearer strategic commissioning cycle linking population health intelligence, prioritisation and delivery.

The ICB demonstrates a clear commitment to partnership working through collaboration with providers, local authorities, place partnerships, communities and wider system stakeholders. The annual report provides stronger evidence of public involvement, organisational development, workforce transition support and wider partnership structures supporting the system's aims.

The ICB has continued to operate in a context characterised by system reform, reduced organisational capacity and continued financial and operational pressure. Despite these pressures, governance, commissioning and system leadership arrangements have continued to strengthen. However, further work is required to ensure that these arrangements consistently translate into improved operational delivery, measurable outcomes and sustainable organisational performance. In light of the Tameside SEND inspection outcome, continued evidence will also be required on how commissioning, quality governance and partnership arrangements are supporting delivery of the required improvements and sharing best practice across statutory partners within Greater Manchester.

Overall, my assessment is that Greater Manchester ICB demonstrates many of the characteristics of a capable strategic commissioner, with strengthening governance, increasing organisational maturity and strong partnership working. Continued focus will be required to translate this capability into sustained improvement across performance, quality, inequalities and financial outcomes.

Section 3: Support and intervention

During 2025/26, Greater Manchester ICB remained subject to formal undertakings, with enforcement arrangements in place throughout the year.

The evidence demonstrates progress in a number of areas, particularly delivery of the 2025/26 financial plan, submission of a compliant financial plan for 2026/27, strengthening governance arrangements, improved oversight and greater financial grip. This progress has resulted in a narrowing of the areas requiring ongoing oversight. The annual report also provides stronger evidence of the governance structures, provider accountability arrangements and reform programme supporting this progress.

While the evidence demonstrates tangible progress against the objectives underpinning the undertakings, continued focus will be required to ensure that financial recovery and governance improvements are sustained over the longer term. You have provided assurance

that the ICB is targeting continuation of the improvements achieved during 2025/26, and this will be required in order to deliver your plans and objectives for 2026/27.

The regional team will continue to work closely with the ICB to support delivery of its strategic commissioning ambitions and ensure progress is sustained over time.

Conclusion

In forming this assessment, I have sought to take a balanced and proportionate view of the ICB's performance, recognising both the progress made and the scale of the challenges that remain. The organisation has continued to evolve its operating model and strategic commissioning approach during a period of significant change and has strengthened a number of the foundations required for successful strategic commissioning.

The next phase of ICB development requires clear and continued focus on translating strengthened governance and commissioning capability, alongside the system leadership required for Greater Manchester, to ensure these improvements translate into sustainable improvements in outcomes, experience, quality and financial sustainability for the population.

I ask that you share this assessment with your Board and senior leadership team and consider publishing it alongside your annual report at a public meeting. In line with statutory requirements, NHS England will publish a summary of the outcomes of all ICB annual performance assessments.

Neighbourhood Health Update

Integrated Care Board

16th September 2026

Report information

Required information	Details
Title of report	Building the Foundations for Delivering Neighbourhood Health and Live Well
Author	Paul Lynch, Director of Strategy and Health Equity Zoe Porter, Associate Director, Live Well & Neighbourhoods
Presented by	Charlotte Bailey, Chief Strategy, People and Partnerships Office
Contact for further information	Paul.lynch@nhs.net
Executive summary	This paper outlines how NHS Greater Manchester is building the foundations for a shift towards preventative and proactive care delivered through neighbourhoods, through our Live Well approach. It sets out progress to date on neighbourhood health planning, engagement, intelligence and delivery infrastructure, aligning with NHS England's Neighbourhood Health Framework while reflecting Greater Manchester's broader Live Well ambitions.
The benefits that the population of Greater Manchester will experience	The work described in this report supports the delivery of more preventative, proactive and joined-up care closer to home. Through the development of Neighbourhood Health and Live Well the aim is to improve people's experience of services, support earlier intervention, reduce fragmentation between organisations and enable residents to access support that is better connected to the needs of their local communities, more easily.

How health inequalities will be reduced in Greater Manchester's communities	Reducing health inequalities is a core principle of both the Strategic Commissioning Plan and the development of Neighbourhood Health. The work outlined in this report supports a greater focus on prevention, neighbourhood delivery, population health intelligence and community-led approaches, helping to target resources and support towards communities experiencing the poorest health outcomes and greatest barriers to accessing services.
The decision to be made and/or input sought	The Board is asked to: 1. Support the GM approach to Neighbourhood Health, through a broader Live Well ambition, with partners. 2. Note the foundations being put in place to deliver on the requirements of NHS Neighbourhood Health Framework.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks	This report supports delivery of the NHS Greater Manchester Strategic Commissioning Plan by setting out progress towards preventative and proactive care in neighbourhoods and the development of Live Well as Greater Manchester's model for Neighbourhood Health. It contributes to the delivery of the Plan's objectives around prevention, population health improvement, neighbourhood-based care and system transformation, whilst strengthening the evidence base, planning arrangements and delivery infrastructure needed to support implementation. It responds to the following BAF risks: • Risk 1 – Failure to deliver prevention-led population health improvement and reduce inequalities • Risk 2 – Inability to deliver financial sustainability • Risk 3 – Failure to transform services through strategic commissioning • Risk 4 – Failure of system partnership and place-based delivery • Risk 5 – Insufficient workforce, leadership and organisational capability Through outlining steps to create the foundations for preventative and proactive care in neighbourhoods.

Key milestones	• Agreement of Greater Manchester Strategic Commissioning Framework for Neighbourhood Health – July 2026 • GM team to finalise full report on Neighbourhood Health engagement with key recommendations to system – August 2026 • Place Leads to lead the work to finalise Neighbourhood Health Plans for each of the 10 localities – September 2026. • Confirm process for predictive modelling of emergency care activity and elective referrals – September 2026 • Complete process for predictive modelling with projected growth quantified and allocated to place and neighbourhood – October 2026 • In parallel and running to Q3: We will finalise the supporting infrastructure for our 10 places - Partnership Agreements, Employment Model, Outcomes Framework and Place Fund
Leadership and governance arrangements	Neighbourhoods work reports into the Population Health & Neighbourhoods Strategic Group – a sub-group of the Strategic Commissioning Committee. It is chaired by the Strategy People and Partnerships Chief Officer and provides oversight and assurance of the ICB's statutory and strategic commissioning responsibilities across population health, public health, and neighbourhood health.
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees	From April – June we held conversations with leaders from across our system, including those from the voluntary and community sector, about how we would lead our work on Neighbourhood Health. Over 200 people were involved in this. The report gives some of the findings and messages from this engagement, which continues to shape how we are approaching this work.
Financial or Legal Implications	Financial implications logged via Commissioning Intentions

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

Table 1: Assurance needed about the document. * If yes, then please include narrative in the report itself
Version Number v1.2

1. Delivering the Strategic Commissioning Plan

- 1.1. In July 2026, NHS Greater Manchester approved its five-year Strategic Commissioning Plan, setting out how we will improve health outcomes, reduce inequalities and create a more sustainable health and care system over the period to 2031. The Plan recognises that the scale of the challenges facing Greater Manchester cannot be addressed through traditional models of care alone and requires a fundamental shift towards prevention, earlier intervention and stronger neighbourhood-based support.
- 1.2. Central to the Plan is the ambition to shift care and investment upstream, moving from treatment to prevention, from hospital to community, and increasingly organising services around people, communities and neighbourhoods. The Plan identifies preventative and proactive care in neighbourhoods, targeted action on population health and inequalities, and wider system transformation as key priorities for the next five years.
- 1.3. Neighbourhood Health is not a standalone programme. It is the principal mechanism through which Greater Manchester intends to deliver the broader ambitions of the Strategic Commissioning Plan, including improving healthy life expectancy, reducing inequalities, supporting prevention, transforming models of care and delivering a sustainable health and care system. It encompasses both the transformation of NHS services, including general practice, community services, urgent care and elective pathways, and the broader Live Well ambition to improve health through stronger communities, prevention and partnership working. Through Live Well, Greater Manchester is developing a neighbourhood-based approach that brings together health services, local government, communities and, crucially, the voluntary sector, to provide more joined-up support closer to home.
- 1.4. Live Well is our vision for healthier communities. Neighbourhood Health is the delivery model for us as a health system. Strategic commissioning is a key mechanism through which we will make that shift happen.
- 1.5. This paper provides an early overview of NHS Greater Manchester's progress in developing the neighbourhood health model that will underpin delivery of many of the Plan's strategic ambitions. It summarises the progress made to date and highlights the areas that are likely to shape delivery during 2027/28.

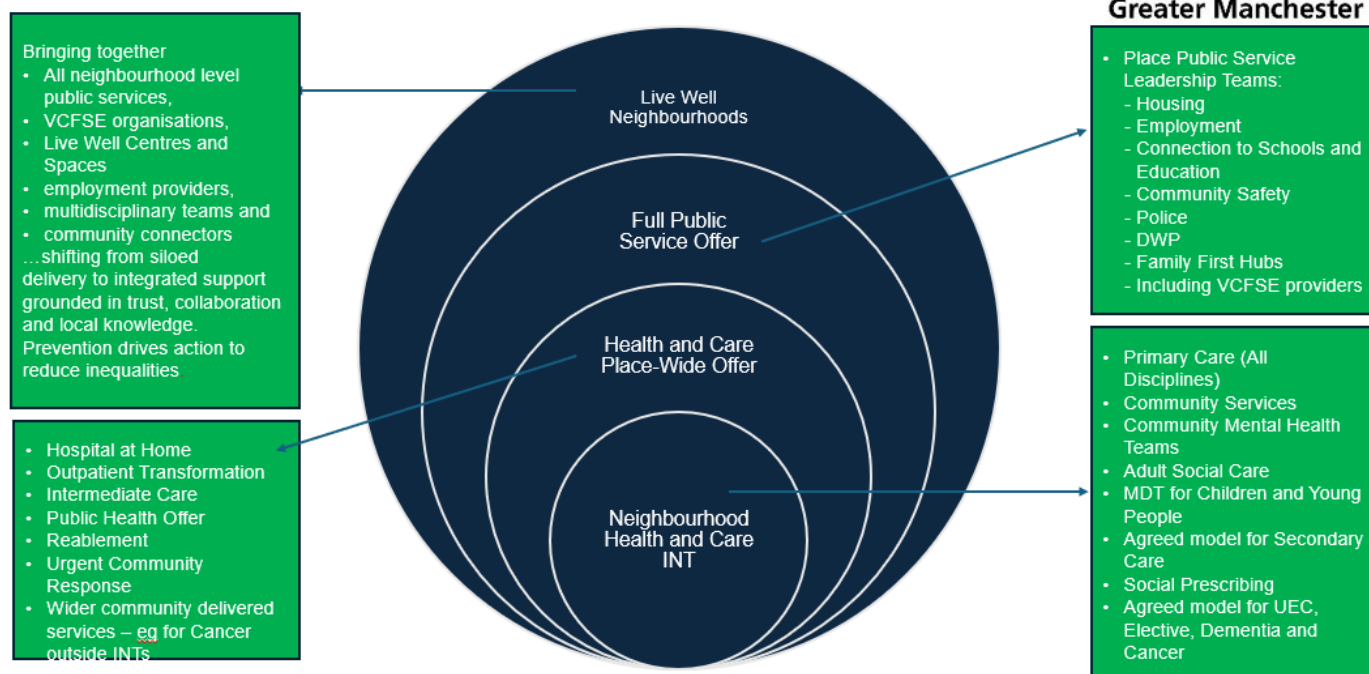
2. Delivering Through Neighbourhood Health and Live Well

- 2.1. Live Well provides Greater Manchester's overarching vision for creating healthier, fairer communities. It recognises that health is shaped by far more than healthcare services alone and requires action across public services, communities, housing, employment and the voluntary sector.
- 2.2. Neighbourhood Health provides the delivery model for that vision for NHS Greater Manchester. This includes both the redesign of NHS services around neighbourhoods, through integrated teams, proactive care, demand management and care closer to home, and wider action with communities and partners to improve population health and wellbeing. By organising services and support around neighbourhoods, we work with partners to address local need, invest in and build on community strengths and provide more joined-up

accessible support centred on people rather than organisations. Our approach to delivering Neighbourhood Health through communities and partnerships is a key component of Greater Manchester's role as a Prevention Demonstrator, helping to build a fully integrated prevention model that strengthens community, preventative and protective capacity.

- 2.3. In July 2026, Board approved the Strategic Commissioning Framework for Neighbourhood Health, setting out a shared direction for delivery across the city region. Since then, work has focused on building the foundations required for implementation, including extensive system engagement, self-assessment against the national Neighbourhood Health Framework, development of locality plans, our tools for neighbourhood-level intelligence and analysis of future demand.
- 2.4. The Strategic Commissioning Framework provides the mechanism through which Greater Manchester intends to translate the ambitions of the Strategic Commissioning Plan into a consistent model of neighbourhood delivery. It establishes a shared set of expectations for what good neighbourhood health should look like across Greater Manchester, recognising that whilst localities will deliver services differently, residents should be able to expect a core and reliable offer regardless of where they live. The Framework therefore sets out the key components that should be present in every locality, including neighbourhood planning, population health management, integrated neighbourhood teams and a consistent approach to outcomes and measurement.

Neighbourhood Health as part of Live Well



- 2.5. The Framework also clarifies the complementary roles of Greater Manchester, Place and neighbourhoods in delivering this agenda. Greater Manchester's role is to provide strategic leadership, commissioning direction and shared standards, while Place Partnerships are

responsible for leading local delivery and integration. Taken together with local Neighbourhood Health Plans and the supporting Place Partnership arrangements, the Framework represents an important step towards establishing a more preventative, proactive and neighbourhood-based health and care system.

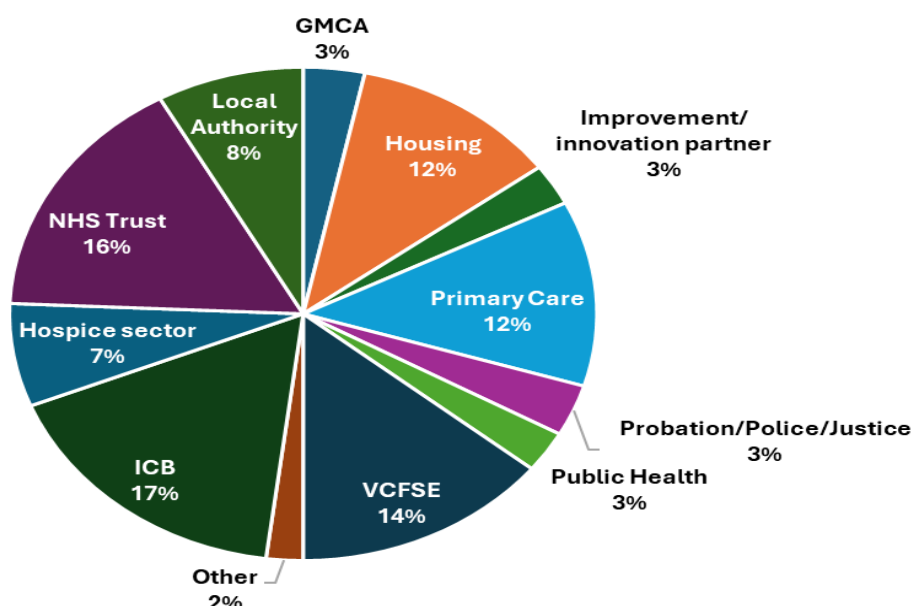
3. Building our Foundations for delivery

- 3.1. NHS Greater Manchester's Strategic Commissioning Plan sets out a clear ambition to shift towards preventative and proactive care delivered through neighbourhoods, with Live Well providing Greater Manchester's model for achieving this change. Delivering this ambition will require both significant NHS service transformation and wider action to strengthen prevention, community capacity and partnership working. Alongside neighbourhood planning and Live Well, this includes transforming how primary care, elective care, outpatient services, community services and proactive care are organised and delivered. This requires a shared understanding of the changes needed, a strong evidence base to inform decision-making, alignment across partners and localities, and a clear understanding of future demand and population need.
- 3.2. Over the last six months, a significant programme of work has been undertaken to build these foundations. This has included engagement with system leaders and partners, assessment against the national Neighbourhood Health Framework, development of neighbourhood intelligence and demand modelling, and the continued development of locality Neighbourhood Health Plans.

3.3. What We Learned Through the Engagement

- 3.4. Between May and June 2026, NHS Greater Manchester and the Greater Manchester Combined Authority led a leadership conversation to inform the future development of Neighbourhood Health. This included engagement with Boards and Committees across the system, workshops involving over 150 leaders, targeted sessions with programme leads and a dedicated system leadership event. Perspectives were gathered from NHS organisations, local government, the voluntary, community, faith and social enterprise (VCFSE) sector and wider public service partners.
- 3.5. The engagement demonstrated strong support for the ambition of Neighbourhood Health and a broad consensus that improving outcomes, reducing inequalities and creating a sustainable health and care system will require a greater focus on prevention, community power, integrated services and partnership working. Participants consistently identified Live Well as Greater Manchester's overarching model for delivering this ambition.
- 3.6. However, participants were equally clear that the next phase requires greater clarity about delivery. The most consistent messages related to the need for a clearer articulation of the neighbourhood model, greater agreement about what should be delivered consistently across Greater Manchester and where local flexibility should apply, and a stronger understanding of roles, responsibilities and accountability across neighbourhood, Place and Greater Manchester levels.

Range of partners who contributed to Neighbourhood Health online workshops



3.7. The engagement also highlighted that Neighbourhood Health is fundamentally a leadership and culture challenge. Participants described the need for stronger collective leadership, trust, partnership working and community influence if system partners are to move beyond organisational interests and deliver outcomes together. There was particular emphasis on strengthening the role of communities and the voluntary, community, faith and social enterprise sector as equal partners in shaping and delivering change. Participants were clear that, for the VCFSE sector to play this role effectively, there will need to be increased access to sustainable long-term funding.

3.8. Finally, participants consistently identified commissioning, contracting, funding, data, workforce, digital and organisational development arrangements as critical enablers of successful delivery. There was widespread recognition that existing incentives and funding arrangements often support organisational priorities rather than prevention and population outcomes, and that future approaches will need to better align resource, accountability and decision-making with neighbourhood delivery.

3.9. These findings informed the development of the Strategic Commissioning Framework for Neighbourhood Health and continue to shape the emerging delivery priorities and commissioning intentions for 2027/28.

3.10. Assessing readiness

3.11. Alongside the wider engagement and planning activity, Greater Manchester has recently completed an initial self-assessment against the national Neighbourhood Health Framework. This was undertaken in response to a national request from Claire Fuller, Medical Director, NHS England.

3.12. The self-assessment produced a high-level position statement rather than a comprehensive assessment of neighbourhood health activity across Greater Manchester,

and, in reflecting NHSE policy requirements, it does not emphasise the broader Live Well ambitions we have here. However, the exercise provided a valuable opportunity to consider current progress against the national framework and identify areas requiring further development and alignment. The feedback letter received from NHS England is appended to this report.

3.13. Whilst the assessment was high-level, it suggests that Greater Manchester has the strongest levels of development in areas such as neighbourhood footprints, organisational arrangements and elements of primary care transformation. More variation exists at this early stage in areas including neighbourhood approaches to elective care, integrated neighbourhood delivery models and the use of data and evaluation. This reinforces the need for the next phase of work to focus not only on neighbourhood plans, but on the practical infrastructure required to support delivery consistently across Greater Manchester.

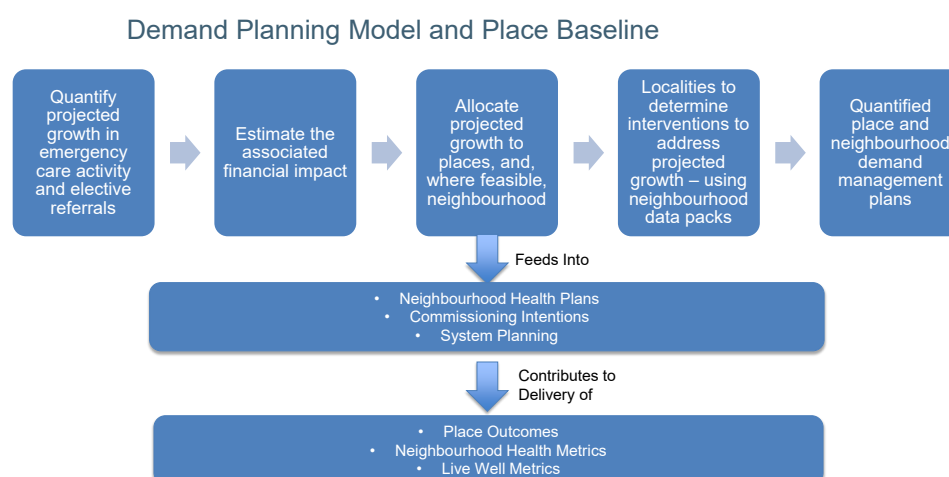
3.14. The findings are being used to inform both GM-wide priorities and local delivery plans, helping to ensure that investment and improvement activity is focused on the areas most critical to successful delivery.

3.15. Understanding Need and Demand

3.16. Delivering the ambitions of the Strategic Commissioning Plan will require a stronger and more consistent understanding of population need, future demand and the impact of neighbourhood-based interventions. As part of this, work is underway to develop a shared evidence base that can support Neighbourhood Health Plans, commissioning decisions and wider system planning.

3.17. A key challenge for Greater Manchester has been the absence of a consistent approach to measuring the impact of neighbourhood health interventions. Whilst multiple datasets already exist, there is currently no agreed methodology for demonstrating how neighbourhood-based approaches contribute to improvements in outcomes, activity, finance and inequalities.

3.18. Work is therefore underway to establish a common framework linking neighbourhood planning, projected demand and outcomes. This will strengthen future commissioning decisions and provide a clearer understanding of the contribution neighbourhood health is making to managing demand and improving population outcomes. The diagram to the right illustrates the main components of the process:



3.19. Data and predictive modelling are critical to the success of Neighbourhood Health in Greater Manchester. The capability that we are developing will enable us to identify need, target interventions (including with a focus on inequalities), forecast future demand, evaluate impact, and demonstrate value. We are well placed to build this capability in GM given the strong foundations we have in place, including the GM Care Record (GMCR), the Analytics and Data Science Platform (ADSP) and the Secure Data Environment (SDE).

3.20. Neighbourhood Data and Profiles

3.21. 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:

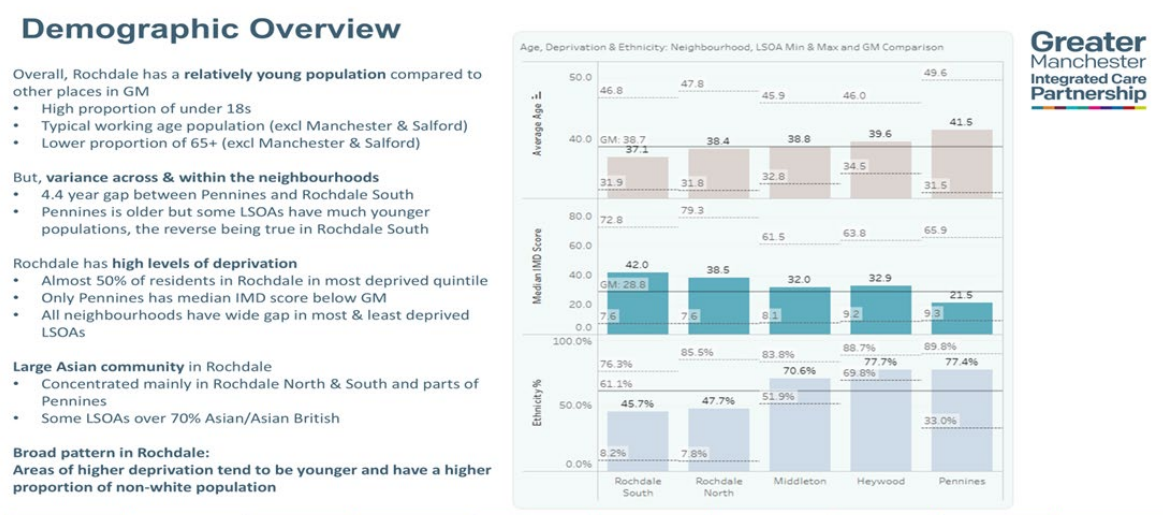
Theme	Content
Population and Prevalence	- How the population is structured. - Which long-term conditions (LTCs) are most prevalent. - How does this differ by age group. - How does this differ by ethnicity. - How does this differ by deprivation
Activity	- What Long Term Conditions are associated with the highest activity? - What Long Term Conditions 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

3.22. 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). They provide actionable intelligence to inform proactive and preventative care approaches, with a particular focus on understanding and reducing avoidable reliance on emergency care services. Using a combination of population health intelligence, service utilisation data and analytical insights, the packs help place teams identify priority areas for intervention and support evidence-based planning. They are designed to answer the question of “where to look”, enabling teams to target resources and initiatives where they are likely to have the greatest impact.

3.23. An interactive version of the Neighbourhood Packs is planned for release by end of September 2026. 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.

3.24. A further enhanced version of the Health Profiles Dashboard is planned for release by end of September 2026. 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. These enhancements are intended to strengthen the dashboard's role as a population health management tool, supporting more targeted planning, resource allocation and decision-making across neighbourhoods, localities and Primary Care Networks (PCNs).

3.25. The graphic below shows an example of a demographic overview for Rochdale. It specifically describes variation across and within neighbourhoods.



Locality Neighbourhood Health Plans

3.26. Delivery of Neighbourhood Health will be led by Place leadership in each of our 10 localities, supporting our sixty-seven neighbourhoods. Localities are therefore continuing to develop Neighbourhood Health Plans that reflect local needs, assets and priorities whilst operating within a shared Greater Manchester framework. These plans provide a framework for describing how each Place will implement both Greater Manchester commissioning priorities and locally determined priorities. They will set out how neighbourhood teams will organise services, engage residents, use data and resources, and measure impact across population health, activity, finance, performance and quality.

3.27. The plans, which are being finalised during September 2026, are bringing together local partners around a common vision for neighbourhood delivery and are expected to become an important mechanism for aligning health services, local government, community provision and wider public services as part of Live Well. Although the next iteration of plans is still being finalised, common themes are emerging across localities, including integrated neighbourhood teams, prevention, tackling inequalities, community-led approaches and improved use of neighbourhood-level intelligence.

3.28. These plans are being developed alongside the establishment of strengthened Place Health and Care Partnerships. The Partnerships will bring together NHS organisations, local authorities, the voluntary sector and wider partners across each locality to lead delivery of neighbourhood health and improve population outcomes. Across Greater Manchester, partners have worked collaboratively to develop the underpinning arrangements for this model, including a Partnership Agreement, Outcomes Framework, Place Fund and governance framework, creating stronger foundations for shared leadership, accountability and investment at Place level.

3.29. Delivering NHS Transformation through Neighbourhood Health

3.30. While Live Well provides the broader framework for neighbourhood health, delivery of the NHS Neighbourhood Health Framework also requires significant transformation in the way NHS services are organised and delivered. Alongside neighbourhood planning, Greater Manchester is therefore progressing a number of NHS service transformation programmes that support the shift towards preventative and proactive care, improve patient outcomes and reduce future demand on hospital-based services.

3.31. Prevention and proactive care through primary care

3.32. A core element of this work is the continued development of population health management approaches through general practice. Through the Beyond Core Contract Review Programme (BeCCoR), all 406 general practices have participated in proactive identification and management of unmet need associated with cardiovascular disease and diabetes. The programme is now expanding to include a broader range of long-term conditions, including chronic kidney disease, COPD, asthma and safer prescribing. This approach combines clinical reviews with neighbourhood-based 'Live Well' support and aims to intervene earlier, improve health outcomes and reduce avoidable demand for hospital services.

3.33. Evidence from the programme demonstrates both clinical benefit and a reduction in avoidable utilisation. Early analysis suggests improvements across a number of priority conditions, alongside reductions in cardiovascular admissions and avoidable hospital activity amongst those with the highest levels of unmet need.

3.34. Elective care and outpatient transformation

3.35. Neighbourhood Health is also informing a wider programme of elective care transformation. This includes expansion of Advice and Guidance services, investment in community-based elective care pathways, development of Single Points of Access and redesign of referral management processes. Collectively, these programmes aim to provide patients with access to appropriate specialist advice earlier, reduce unnecessary referrals, improve patient experience and support more care to be delivered closer to home.

3.36. Alongside these neighbourhood-facing changes, NHS providers are working together to improve outpatient productivity and patient experience through initiatives such as outpatient pathway redesign, follow-up standardisation, waiting list validation, improved patient communication and the adoption of new technologies. These developments complement

neighbourhood delivery by helping to ensure that specialist services are configured in a way that supports prevention, proactive care and improved access.

3.37. Moving from activity management to transformation

3.38. Whilst individual programmes differ in scope and focus, they reflect a common strategic direction. Rather than responding to increasing demand solely through additional activity, Greater Manchester is increasingly focusing on identifying unmet need earlier, enabling more holistic approaches, improving outcomes, reducing variation, supporting self-management and delivering more care through neighbourhood and community settings. This aligns directly with the objectives of the Strategic Commissioning Plan and the wider ambition to shift care upstream, reduce inequalities and improve the sustainability of health and care services.

4. Conclusion

- 4.1. While the work described in this paper is at an early stage, several consistent themes are emerging across the leadership engagement, self-assessment, neighbourhood planning activity and demand analysis.
- 4.2. Firstly, there is broad agreement that a continued shift towards preventative and proactive care delivered through neighbourhoods should remain a central strategic priority for Greater Manchester. Through Live Well and the transformation of NHS services, this means not only better and broader integration between health and care services, but also working with communities and partners to create healthier, more resilient places where people can access support earlier and are less likely to require crisis or unplanned care.
- 4.3. Secondly, there is growing evidence that successful neighbourhood delivery will require greater clarity and consistency across Greater Manchester in areas such as accountability, commissioning arrangements, outcomes, data and evaluation. At the same time, localities will need the flexibility to respond to their own communities, assets and priorities.
- 4.4. Finally, Greater Manchester's experience of developing preventative and community-centred approaches over many years reinforces the importance of investing in community capacity, partnership working and prevention at every level. If we are to improve population health, reduce inequalities and manage future demand sustainably, we will need to support a genuine shift of resource, effort and decision-making towards neighbourhoods and communities. This is fundamental to achieving the ambitions of the Strategic Commissioning Plan and enabling more people to live healthier, longer and more independent lives.

The challenge for all of us is now to move from describing this shift to delivering it at scale. The mobilisation of Neighbourhood Health Plans, underpinned by our Commissioning Intentions and informed by the data and demand modelling described above, represents the next step in translating our ambitions into practical delivery.

4.5. Immediate next steps:

Action	When
Place Leads to lead the work to finalise Neighbourhood Health Plans for each of the 10 localities – September 2026.	September 2026
Confirm process for predictive modelling of emergency care activity and elective referrals	September 2026
Finalise and sign off the supporting infrastructure for our 10 places - Partnership Agreements, Employment Model, Outcomes Framework and Place Fund	October 2026
Complete process for predictive modelling with projected growth quantified and allocated to place and neighbourhood	October 2026

5.0 Recommendations

5.1 The Integrated Care Board is asked to:

- 5.1.1 Support the GM approach to Neighbourhood Health, through a broader Live Well ambition, with partners.
- 5.1.2 Note the foundations being put in place to deliver on the requirements of NHS Neighbourhood Health Framework

ICB Chief Executive
ICB Chair

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

9 September 2026

Dear Jackie and Colin

Neighbourhood Health – Greater Manchester

Thank you to you and your team for meeting with us to discuss progress following the recent Neighbourhood Health Readiness Visit.

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.

There are a number of strong examples of good practice across Greater Manchester.

These include:

Heywood, Middleton & Rochdale:

- HMR's approach demonstrates how neighbourhood health can be embedded through a genuinely place-based model that combines community power, integrated service delivery and aligned investment. Alongside strengthening relationships across the system, the model is already contributing to reduced emergency care demand, increased community-based management and improved support for people to remain well and independent within their neighbourhoods.

Bury:

- Bury's neighbourhood model demonstrates how integrated governance and place-based leadership can support delivery of neighbourhood health at scale. Recognising that prevention and early intervention require action beyond health services alone, Bury has established five neighbourhood footprints that bring together integrated health and care teams, neighbourhood leadership teams, Live Well delivery and family support around a shared vision of "one public service".



Stockport:

- Stockport's neighbourhood health approach demonstrates how a place can align population health management, primary care leadership and integrated neighbourhood working around shared outcomes. Building on well-established partnerships across primary care, health and care services, local government and the VCFSE sector, Stockport has used neighbourhood-level data and risk stratification to focus effort on the cohorts and conditions driving demand and inequalities, including frailty, dementia, cardiovascular disease, diabetes and alcohol-related harm.

Population Health, Prevention and Neighbourhood working at scale enabled by GP incentivisation scheme:

- Greater Manchester's Beyond Core Contract Programme (BeCCoR) demonstrates how General Practice, population health management and neighbourhood working can be integrated at scale to deliver the shift from treatment to prevention. The programme uses advanced risk stratification tools to identify cohorts requiring proactive support and is already demonstrating measurable impact at scale. In 2024/25 alone, the approach is estimated to have prevented approximately 180 heart attacks and 200 strokes, generating around £6.7 million in avoided system costs.

Taking together the visit and follow-up process, alongside the subsequent system and Place level self – assessments, the accompanying single page summary provides an agreed reflection of the system's current position.

We would encourage you to share the agreed single page summary with your Board and system partners to support local oversight of neighbourhood health priorities, agreed next steps and future delivery.

As discussed, the key areas of focus over the coming months are to:

- Place Leads to lead the work to finalise Neighbourhood Health Plans for each of the 10 localities. As per the National Framework, these plans will run through to March 2028 in line with the national framework with clear stepped improvements and quantifiable impact - September 2026
- Development of ICB 'Roadmap' across all elements of Neighbourhood Health, showing requirements and ambitions, milestones, and becoming the basis for understanding progress, dependencies, risk and opportunities – Oct 2026
- Review and iterate formal Governance and reporting, including through Public Boards – November 2026
- We will finalise the supporting infrastructure for our 10 places - Partnership Agreements, Employment Model, Outcomes Framework and Place Fund – by December 2026
- GM-wide soft launch of Integrated Neighbourhood Teams in all 10 places from January 2027

- A range of longer term commitments that represent key areas of focus that will support sustained delivery of the framework requirements and accelerate the shift towards neighbourhood health, prevention, integrated care and population health improvement across Greater Manchester.

Thank you again for the time and commitment shown by you and your teams throughout both the visit and follow-up process. We look forward to continuing to work with you as neighbourhood health develops across Greater Manchester.

Yours sincerely



Professor Claire Fuller MRCGP DRCOG MBBS
National Priority Programme Director – Neighbourhood Health

Annex:

Single slide summary

NHS Greater Manchester ICB

08 September 2026

ICB at a glance					
ICB CEO	Prof Colin Scales			Local authorities	10 unitary metropolitan boroughs; no two-tier areas; LGR not applicable.
ICB Chair	Jackie Njorage (Interim).			Providers	Acute: MFT, NCA, Bolton FT, WWL, Stockport FT, Tameside and Glossop ICF, The Christie (specialist). Mental health and community: GMMH (Bolton, Manchester, Salford, Trafford, Wigan), Pennine Care (Bury, HMR, Oldham, Stockport, Tameside). Ambulance: NWAS.
Registered population	approx. 3m			Workforce	ICB running-cost reduction underway (c.200 redundancies early 2026; second VR phase Feb 2026).
Places	10 (coterminous with 10 HWBs).			Pilots and designations	2 of 10 Places selected (Rochdale/HMR, Stockport); all 10 submitted bids.
Footprint	Greater Manchester; metropolitan, urban.				
Place level maturity score					

Place (fill = maturity)	HMR (Rochdale) SCORE: 50	Stockport SCORE: 41	Bury SCORE: 44	Manchester SCORE: 54	Salford SCORE: 41	Oldham SCORE: 45	Bolton SCORE: 46	Wigan SCORE: 42	Trafford SCORE: 56	Tameside SCORE: 48
Population	253,339	330,500	211,388	747,439	323,870	267,824	334,432	352,424	247,653	228,640
HWB sign-off	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced	Not evidenced
NbH footprints / PCNs	6 PCNs. 5 NbHs. Cooperative Communities Model; 5 neighbourhoods; ICPIC oversight, each neighbourhood has co-located health & care team	6 PCNs. 7 NbHs. One Stockport Health and Care Board; 7 neighbourhoods, 7 INTs, expanded remit - Integrated Neighbourhood Networks	4 PCNs. 5 NbHs. Delegated Sub-Committee of NHS GM Board; 5 INTs with public service leadership team for each.	14 PCNs. 13 NbHs. MFT-led LCO; 13 INTs; Making Manchester Fairer	5 PCNs. 5 NbHs. Integrated Fund (s75); 5 neighbourhoods, 5 INTs	5 PCNs. 5 NbHs. Oldham Integrated Care Partnership; 5 neighbourhoods, each to have a Live Well Centre	9 PCNs. 6 NbHs. 6 INTs – soon to be expanded to include children and families' services.	7 PCNs. 13 townships. Progress with Unity; 14 townships; 7 Strategic Neighbourhood Health Teams	5 PCNs. 4 NbHs. MFT-led LCO; 4 neighbourhoods, Strategic Neighbourhood Leads and multi-agency management leads for each neighbourhood and several MDTs.	4 PCNs. 4 NbHs. Strategic Partnership Cttee (TSPC); 4 neighbourhoods, 4 INTs in development, supported by neighbourhood forums and leadership teams.
HLE (M / F)	LE M 77.3/ LE F 81.5	HLE M 53.8 / HLE F 54.2	LE M 79.7/ LE F 83.8	HLE M 61.8/ HLE F 63.1	LE M 78.4/ LE F 82.3	HLE M 57.4/ LE F 58.2	LE M 76.0/ LE F 80.5	HLE M 56.7/ HLE F 57.7	LE M 77.0/ LE F 81.2	HLE M 57.2/ HLE F 58.2
GP federation/integrator	2 GP Federations HMR Place Partnership	1 GP FederationStockport Place Partnership	1 GP Federation Bury Place Partnership	Manchester Place Partnership	1 GP Federation Salford Place Partnership	Oldham Place Partnership (lead integrator role TBC)	3 GP federations (plus 1 PC Partnership); Bolton Place Partnership	Wigan Place Partnership (lead integrator role TBC)	Trafford Place Partnership 1 GP Federation	Tameside Place Partnership (lead integrator role TBC)

- Examples of practice surfaced across Places
- **HMR (Rochdale):** Cooperative Communities Model since 2018; NCA-led LCO, c.380m pooled budget; EASY hubs every township. HSJ Integrated Care Initiative of the Year 2023; NHS Confederation Funding Flows Pilot (Lord Adebowale).
 - **Bury:** 5 Integrated Neighbourhood Teams operational since April 2019; Locality Board is a delegated Sub-Committee of NHS GM Board; 70m s75. LGA review cited integration as enviable and exemplary.
 - **Stockport:** Stockport Live Well (frailty, diabetes, CVD, alcohol); 109.9m devolved budget; PCNs in CLEAR national pilot (clinically-led workforce activity redesign). MJ Local Authority of the Year 2025.
 - **GM-wide (interface):** BeCCoR programme (c.48m, quality / elective / proactive care / meds optimisation); Consultant Connect pan-GM extension 2026/27; 10 Single Points of Access in highest-impact specialties; community Gynae, ENT, Dermatology.
 - **Salford / Tameside:** Salford DWP WorkWell Vanguard for ill-health-driven economic inactivity (MH + MSK). Tameside CLEAR Dementia at Home plus WorkWell plus Fit Note Innovation (Sep 2025), integrated NHS-Council-VCFSE.
 - **GM-wide (prevention):** UK's first national Prevention Demonstrator (July 2025 10YHP); GM Live Well as the City Region operating model; all 10 Places submitted Wave 1 NNHP bids (largest ICB submission profile in England).

Five Goals (ICB Explorer, 17 July 2026; band shown by cell colour). Single merged-ICB score				
G1 Health outcomes	G2 GP access and experience	G3 Planned care	G4 Urgent and emergency care	G5 Patient and staff satisfaction
Strongest G1 (Health outcomes, above England). Weakest G5 (Satisfaction), the only Amber-red Goal; all four Staff Survey sub-measures Q3/Q4 (Engagement rank 30, Morale 27, Advocacy 28, Motivation 34). GM 2/42 on 78+ week count but 41/42 on 52+: extreme waits cleared, medium-long-wait volume high.				
Enablers (Section 4)				
Enabler (fill = rating)	Key point			
Data	Shared GM Care Record plus GM Analytics and Data Science Platform plus CVNeed risk-stratification tool: a mature, system-wide data infrastructure. Leads: Matt Hennessey, Matthew Conroy. Uniform coverage of risk-stratification templates across all 10 Places to confirm.			
Workforce	SRO Charlotte Bailey (Chief People Officer). G5 Amber-red across all four sub-measures; c.200 redundancies early 2026 plus second VR phase, running in parallel with NbH stand-up across 10 Places. Workforce and OD Delivery approach for neighbourhood health at early stage of development, with partners.			
Finance	656m GM CIP target (175m ICB, 481m providers); 42.5m DSF conditional on plan; 39% operating-cost reduction; MFT 1-day cash buffer. Gap: financial sustainability of GM Live Well.			
Digital	Shared GM Care Record plus analytics platform plus CVNeed, a structural strength. Not signed up to FDP (platform exceeds FDP capacity). Gap: uniform coverage across all 10 Places.			
Estates	GM successfully secured capital for one of the first 27 Neighbourhood Health Centres in Radcliffe, Bury. A further £44M of Primary Care Strategic Capital has been secured for another 10 NHC schemes over the next 4 years. Stakeholders were engaged to develop a further pipeline of schemes and there are a further 16 of these that have been prioritised to submit for a potential second wave of funding. The pipeline is aligned with the network of Live Well Centres being developed across GM in conjunction with partners. Stakeholder engagement on plans for LIFT estate end of concession has commenced, with formal process to start once DHSC confirm their process. Expectation is that revenue costs will be covered by existing budgets as we reconfigure the estate and improve utilisation, therefore RDEL should not be a constraint as it will remain broadly unchanged.			

Forward look - Key actions over next 6 months:		Forward look – Key actions over next 18 months	
1.	Place Leads to lead the work to finalise Neighbourhood Health Plans for each of the 10 localities. As per the National Framework, these plans will run through to March 2028 in line with the national framework with clear stepped improvements and quantifiable impact - September 2026	S1. Urgent, Rehabilitation and Reablement Capacity:	Delivery focus: Strengthen neighbourhood-based alternatives to hospital care by 1: Increase Urgent Community Response capacity and responsiveness, including delivery of two-hour response standards, 2: Improve access, responsiveness and waiting times within community health services, 3: Expand Virtual Wards, Hospital at Home and intermediate care capacity to support admission avoidance and early discharge.
2.	Development of ICB 'Roadmap' across all elements of Neighbourhood Health, showing requirements and ambitions, milestones, and becoming the basis for understanding progress, dependencies, risk and opportunities – Oct 2026	S2. General Practice Access and Variation:	Delivery Focus: Improve access to general practice and reduce unwarranted variation by 1: Continue to tackle unwarranted variation in GP access and quality, including same-day urgent access, routine access and patient experience, 2: Use peer review and benchmarking approaches through BeCCoR (our GP incentivisation scheme) to reduce referral variation and support consistent clinical decision-making.
3.	Review and iterate formal Governance and reporting, including through Public Boards – November 2026	S3. Neighbourhood Footprints:	Delivery Focus: Establish neighbourhood delivery arrangements aligned to local communities by 1: Establish and mature Place Partnerships for Health and Care as the vehicle for integrating Live Well with wider public services and communities, 2: Align neighbourhood footprints with Best Start Hubs, Young Futures Hubs and Family First Partnerships.
4.	We will finalise the supporting infrastructure for our 10 places - Partnership Agreements, Employment Model, Outcomes Framework and Place Fund – by December 2026	S4. INTs for Priority Cohorts:	Delivery Focus: Develop integrated neighbourhood approaches for priority population groups by 1: Develop core offers and strategic alignment so health services operate as part of Live Well neighbourhoods, 2: Focus neighbourhood delivery on people with cardiovascular disease risk, diabetes, respiratory conditions and lower-level mental health need, 3: Implement a consistent Greater Manchester frailty MDT model, proactive care approaches, falls prevention and earlier identification of rising risk.
5.	GM-wide soft launch of Integrated Neighbourhood Teams in all 10 places from January 2027	S5. Neighbourhood Approach to Elective Pathways:	Delivery Focus: Shift appropriate elective care into community settings by 1: Commission and expand community-based elective services, shifting clinically appropriate activity out of acute hospitals, 2: Implement consultant-led Single Points of Access in high-volume specialties to support triage, straight-to-test and community pathways.
		S6. Community Waits:	Delivery Focus: Reduce waiting times and variation in community services by 1: Develop a core offer and standards for community services across Greater Manchester, 2: Reduce variation in MSK, continence, paediatric and audiology pathways, 3: Deliver national 18-week community health waiting time standards and reduce long waits.
		S7. Better Care Fund and Pooled Funding:	Delivery Focus: Increase investment in prevention and neighbourhood-based support by 1: Develop new strategic commissioning models that support prevention and early intervention, 2: Increase investment and longer-term funding approaches for VCFSE partners, 3:Support delivery of the Healthy Homes for All programme, recognising the impact of housing and homelessness on health outcomes.
		S8. Primary and Secondary Care Interface:	Delivery Focus: Improve collaboration between primary and specialist care by 1: Expand consultant-led Advice and Guidance services across Greater Manchester, 2: Support collaborative commissioning arrangements based on population health management and neighbourhood health models, 3: Increase the delivery of care within neighbourhood and primary care settings.
		S9. Organisational Ownership:	Delivery Focus: Develop the organisational capability required for neighbourhood health by 1: On-going development of Place Partnerships, with development of new contracting and commissioning arrangements in line with national models, 2: Develop an OD approach to support this transformation, 3: Develop the workforce needed to support a shift from hospital-focused care to community and neighbourhood-based practice, 4: Develop a GM-wide workforce baseline and modelling approach covering skills, roles, MDT composition, competencies and productivity.
		S10. Data Sharing, Identification and Evaluation:	Delivery Focus: Strengthen the digital and insight infrastructure required for neighbourhood delivery by 1: Scope and develop digital solutions to support integrated Live Well neighbourhood working, 2: Develop the data and insight infrastructure needed to support Neighbourhood Health and show impact over time, 3: Comply with national digital requirements and develop community infrastructure that supports the shift towards neighbourhood-based care.

NHS GM Committee Meetings: Operating Principles and Terms of Reference

16 September 2026

NHS GM Board

16 September 2026

Report information.

Required information.	Details.
Title of report.	NHS GM Committee Meetings: Operating Principles and Terms of Reference
Author.	Chris Gaffey, Associate Director of Corporate Governance
Presented by.	Chris Gaffey, Associate Director of Corporate Governance
Contact for further information.	Jenny Noble, Board Secretary jennynoble@nhs.net
Executive summary.	This report sets out proposed operating principles for NHS GM committees for the Board's consideration. The principles cover committee meeting arrangements, transparency, Executive, Non-Executive and Partner Member involvement, and formal governance. This report seeks the Board's endorsement of the principles and approval of proposed amendments to the NHS GM Constitution and to the Terms of Reference for the Strategic Commissioning Committee (SCC) and People and Resources Committee (PARC).
The benefits that the population of Greater Manchester will experience.	Good governance arrangements will facilitate effective decision making which will benefit the population of GM.

How health inequalities will be reduced in Greater Manchester's communities.	Effective and efficient decision making will help to reduce health inequalities.
The decision to be made and/or input sought.	The NHS GM Board is asked to: • Agree the overarching principles for the operation of the Board's committees set out in this report. • If agreed, approve the proposed change to the NHS GM Constitution as set out in paragraphs 1.17 of this report. • If agreed, approve the proposed changes to the Terms of Reference for the Strategic Commissioning Committee and People and Resources Committee, which are appended to this report.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The proposals strengthen governance by clarifying committee operating arrangements, preserving independent challenge and assurance, supporting collective leadership and maintaining proportionate transparency. Clear and effective committee arrangements support timely, well-governed decisions and Board oversight of delivery of the Integrated Care Partnership strategy, NHS GM's Strategic Objectives, and management of Board Assurance Framework risks.
Key milestones.	Board consideration: 16 September 2026.
Leadership and governance arrangements.	The Board will retain oversight of its committees through agreed Terms of Reference, appropriate publication of minutes and committee reporting to the Board. An appropriate balance of Executive and Non-Executive membership, clear voting status and a Chair's casting vote will provide formal governance safeguards.

Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	The principles have been developed through discussions at the People and Resources Committee and the Strategic Commissioning Committee, and a meeting of NHS GM Non-Executive Directors and Executive Directors.
Financial or Legal Implications	N/A

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

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

Table 2: Assurance needed about the document.

Introduction

- 1.1. This report presents proposed overarching principles for the operation of the committees of the NHS GM Board and seeks the Board's endorsement before amendments are implemented to the NHS GM Constitution and individual committee Terms of Reference. If the proposed principles are agreed, revised Terms of Reference for the Strategic Commissioning Committee (SCC) and the People and Resources Committee (PARC) are appended for the Board's consideration and approval. No changes are proposed to the operating arrangements or Terms of Reference of the Audit Committee (AC) or Remuneration Committee (RC).
- 1.2. The principles are intended to support effective discussion and decision-making, preserve appropriate independent challenge and assurance, and maintain transparency and Board oversight.

Background

- 1.3. Recent discussions at PARC and SCC, followed by a discussion between NHS GM Non-Executive Directors and Executive Directors, identified the need for changes to NHS GM's committee operating principles and the relevant Terms of Reference.
- 1.4. PARC increasingly considers sensitive commercial, contractual, workforce and organisational matters. It is therefore proposed that PARC should meet solely in private so that these matters can be considered in an appropriate setting, while maintaining transparency, external accountability and the Board's oversight through proportionate

reporting. No change is proposed to the meeting arrangements of other committees, which may continue to hold parts of meetings in private where justified by the nature of the business.

- 1.5. These proposals should also be considered in the context of NHS GM's development as a strategic commissioner. This role requires early and integrated consideration of population need, commissioning priorities, resource choices, service options and their potential contractual, workforce and organisational consequences. Existing committee arrangements already allow particular items to be considered in private where emerging proposals, commercially sensitive information or other confidential matters require this.
- 1.6. The detailed benefits associated with the proposed operating principles are set out following the principles themselves.
- 1.7. National benchmarking provides supporting context for this approach. Across ICBs, the prevalent model is for statutory Board meetings to be held in public while most Board committee meetings are not held in public, which supports, but does not replace, the NHS GM-specific governance and operational rationale set out above.

Proposed Principles

- 1.8. **Committee operation.** PARC should meet solely in private to enable full and candid consideration of sensitive, confidential, contractual, commercial, workforce and organisational matters. This is the only proposed change to the public or private operating model. Other committees will continue to operate under their existing arrangements, including holding meetings in public where applicable, with particular items considered in private where required under standard procedures relating to confidentiality, commercial sensitivity, personal information or other established grounds.
- 1.9. **Transparency, accountability and Board oversight.** PARC's private operating model will be balanced by proportionate publication of minutes, clear reporting of decisions and assurance to the Board, and the Board's continuing oversight of committee activity. Existing transparency arrangements for all other committees will remain unchanged.
- 1.10. **Executive attendance and membership balance.** All Chief Officers will be members of SCC and PARC. The voting arrangements will nevertheless maintain an appropriate balance between Executive and Non-Executive influence, with clear voting and non-voting status, so that collective leadership is accompanied by effective independent challenge.
- 1.11. **Partner Member arrangements.** Partner Members make an important contribution to NHS GM's wider governance arrangements. Their formal committee membership will reflect the distinct remit and risk profile of each Committee. It is proposed that Partner Members will remain members of SCC, subject to appropriate management of conflicts of interest, commercial sensitivity and confidentiality, and that Partner Members will not be members of PARC because its remit creates a greater likelihood of actual, potential or perceived conflicts of interest. This distinction is intended to protect the objectivity and

integrity of PARC's scrutiny and decisions, rather than to reduce partner or external accountability.

- 1.12. **Formal governance safeguards.** An appropriate balance of voting members, clear arrangements for declarations and management of conflicts of interest, and a Chair's casting vote will be retained. These safeguards will support robust scrutiny, defensible decisions and clear accountability.
- 1.13. **Collective leadership and independent assurance.** Committee membership will support collective leadership while preserving effective independent challenge and assurance through Non-Executive Directors. The proposed arrangements are intended to strengthen the quality of scrutiny by combining informed Executive contribution with a clear and influential non-executive role.
- 1.14. **Implementation and review.** The Board should agree the overarching principles before revised Terms of Reference are finalised. The effectiveness of the arrangements, including the operation of transparency, scrutiny and assurance safeguards, will remain subject to Board oversight and periodic review.

Benefits of the Proposed Arrangements

- 1.15. The proposed arrangements will support effective scrutiny and timely, well-informed decisions while maintaining transparency and accountability. PARC's new arrangements will enable candid consideration of sensitive matters. Accountability will be maintained through proportionate publication, committee reporting and Board oversight.
- 1.16. The arrangements will support NHS GM's strategic commissioning role by enabling committees to test emerging options, risks and trade-offs before recommendations are finalised. PARC will provide an appropriate setting for scrutiny of sensitive workforce, organisational and resource matters, while other committees will continue to consider individual items in private where necessary. Decisions, assurance and key outcomes will remain subject to proportionate reporting and Board oversight.

Further Considerations and Actions Required

- 1.17. If the proposed operating principles for Committee arrangements are agreed, paragraph 7.3.1 of the NHS GM Constitution will require amendment from:

Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

To:

Board meetings will be held in public except where a resolution is agreed to consider particular business in private on the grounds that it would not be in the public interest for that business to be considered in public. Committees may meet wholly or partly in private

where this is provided for in their Terms of Reference or other arrangements approved by the Board, having regard to the nature of the business to be considered.

All other proposed amendments to arrangements can be implemented via the updating of the Committees' Terms of Reference.

Other Proposed Terms of Reference Amendments

- 1.18. Following additional feedback, to provide greater clarity in terms of Committee roles and responsibilities and cross working, it is also proposed that the Terms of Reference more clearly distinguish the complementary digital, data and intelligence roles of SCC and PARC.
- 1.19. The proposed amendments make clear that SCC would oversee the use of data, analysis and intelligence to inform commissioning priorities, service design, transformation and evaluation, whilst PARC would oversee digital and IT infrastructure, cyber security, data governance and security, regulatory compliance, investment, resource planning and related corporate risks.
- 1.20. It is also proposed that the Terms of Reference clarify how the Committees would coordinate where commissioning proposals have infrastructure, cyber security, investment, governance or risk implications. This would reduce duplication by aligning analytical capability with SCC and operational IT and infrastructure matters with PARC.

Recommendations

- 1.21. The NHS GM Board is asked to:
 - Agree the overarching principles for the operation of the Board's committees set out in this report.
 - If agreed, approve the proposed change to the NHS GM Constitution as set out in paragraphs 1.17 of this report.
 - If agreed, approve the proposed changes to the Terms of Reference for the Strategic Commissioning Committee and People and Resources Committee, which are appended to this report.

NHS Greater Manchester
Strategic Commissioning Committee
Terms of Reference

Purpose	The purpose of the Strategic Commissioning Committee ('the Committee') is to obtain assurance, on behalf of the Board, that the ICB has the right <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. The Strategic Commissioning and People and Resources Committees collectively provide Board assurance across the end-to-end strategic commissioning cycle, from assessment of population need and outcomes, through prioritisation and design, to resource enablement, implementation, performance, value and learning. The Strategic Commissioning Committee leads on commissioning intent, outcomes, service models and priorities, and provides assurance that these are clinically, population and evidence-led. The People and Resources Committee leads on the workforce, finance, estates, digital and IT infrastructure, cyber security, and secure data infrastructure required to enable delivery of agreed commissioning intent. The Committee will provide strategic oversight and assurance on the use of data and intelligence to assess population need, inform commissioning priorities and service design, and evaluate outcomes, performance and impact. Oversight of digital and IT infrastructure, cyber security, and the governance, security and resilience of data assets and associated infrastructure will sit with the People and Resources Committee. The Committees will share information, risks, and escalations in a systematic and timely way to support effective Board oversight.
Duties	The Committee will: 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 Clinical strategy - Provide assurance to the Board that the ICB is compliant with the National Quality Board (NQB) requirements. - Apply constructive challenge to the <u>clinical strategy (including system clinical governance, patient safety and continuous improvement arrangements)</u>, make recommendations to the Board and monitor their implementation. - Apply constructive challenge regarding the effectiveness of the arrangements in place to support <u>quality planning, management, control and improvement</u> across the system. Performance and Planning - Oversight of the development of annual and medium-term plan as required by NHSE and in line with the ICP Strategy. - Receive assurance on the delivery of the constitutional standards as core deliverables for the organisation. System oversight
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	- Obtain assurance that effective mechanisms (including System Oversight Framework mechanisms) are in place to review and monitor the quality of care delivered by providers and localities and are working effectively. This is mainly done by applying constructive challenge to the Integrated Performance Report. Continuous improvement - Apply constructive challenge to <u>learning</u> from patient safety, clinical effectiveness and patient experience activity. Digital Transformation in Strategic Commissioning - Apply constructive challenge to how digital transformation supports commissioning strategy, service redesign, care delivery, population health, system performance and outcomes. - Oversee and obtain assurance that relevant digital transformation priorities are reflected in commissioning strategy, service models and improvement programmes. - Ensure that the strategic use of digital approaches in commissioning is aligned with the GM Health and Care Digital Transformation Strategy and relevant national policy. - Coordinate with the People and Resources Committee where proposals have implications for digital or IT infrastructure, cyber security, data governance, data security, investment or operational resilience. Population Health - Take comprehensive action and exert influence across the organisation to ensure the delivery of the core aims of the ICB as they relate to improving health, reducing inequalities, retaining people in good health for longer, and driving whole system left shift. - Provide assurance to the ICB that NHS GM is meeting its statutory responsibilities in relation to population health (including those responsibilities discharged through localities). - Provide assurance that population health intelligence and analytical capabilities are robust in generating insight on population needs and inequalities, and that these insights are utilised to drive improvement action through a population health management approach. - Ensure that the opportunities for the ICB to work with partners to improve the health of the population are maximised
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	Data and Intelligence - Provide oversight and assurance that high-quality intelligence, analytical insight and modelling are embedded across strategic commissioning, performance and population health activity, and are used to inform prioritisation, strategy development, service redesign, decision-making and the evaluation of outcomes and impact. - Oversee and obtain assurance that the analytical capability required to support strategic commissioning is developed and used effectively. - Coordinate with the People and Resources Committee where the use of data and intelligence gives rise to matters relating to data governance, security, infrastructure, investment, commercial arrangements or corporate risk. <u>Delegated NHS England Responsibilities</u> Ensure that NHS GM fulfils its delegated statutory Public Health requirements as set out in the annual S7A Public Health Functions Agreement and collaborates with regional and national colleagues through the emerging Office for Pan-ICB Commissioning (OPIC) arrangements. Ensure that NHS GM fulfils its delegated responsibilities for Primary Care Commissioning under the NHS England delegation agreement, providing system-level assurance, oversight and strategic direction across primary medical, dental, ophthalmic and pharmaceutical services. Oversight of this area will be provided by the Primary Care Commissioning Group. Strategic risks - Monitor and provide assurance to the Board on <u>BAF risks</u> assigned to the committee, as well as relevant Corporate Risks. Statutory Functions - Apply constructive challenge to the delivery of the ICB <u>key statutory and policy requirements</u>, including All Age Continuing Healthcare (AACHC), complaints, mortality and learning from deaths, safeguarding adults and children, SEND, infection prevention and control, equality and diversity in relation to service delivery, patient safety incident response, medicines optimisation and safety and citizen involvement. 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,
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	embedded and sustained. - Apply constructive challenge to the oversight of <u>EPRR arrangements</u>.
Membership	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.
Attendees	Where any conflicts arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting. Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers. The Chief Executive should be invited to attend the meeting at least annually. The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.
Delegated authority	The Committee is established by the Board as a Committee of the Board in accordance with its constitution. The Committee has delegated responsibility by the Board to: • Investigate any activity within its terms of reference • Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference • Commission any reports it deems necessary to help fulfil its obligations • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • The Committee may establish a sub-committee and arrange for the functions exercisable by the Committee to be exercised by the sub-committee.

	For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. Members will be expected to conduct business in line with NHS GM values and behaviours, including demonstrably considering the equality and diversity implications of decisions they make.
Meeting management	Frequency The Committee shall meet monthly a minimum of 10 times per year. Any arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. Meetings will be held in public, however there may be occasions where items will need to be considered in private. And decisions to consider items in private will be evidenced, and be by agreement with the Chair. Agenda and papers The agenda and papers for meetings will be distributed five working days in advance of the meeting. Attendance and Quorum A quorum shall consist of 43 voting committee members, including the Chair or Vice Chair the Chief Clinical Officer or Chief Commissioning Officer (or nominated Clinical Deputy) and one other Chief Officer. Members should attend at least 75% of meetings within any calendar year. Members are expected to nominate a deputy to attend in their absence. Deputies must be of appropriate seniority and approved by the Chair in advance. An approved deputy attending in place of a member will be treated as that member for the purposes of quorum and will exercise the same voting rights as the member they are replacing. Attendance will be monitored and addressed by the Chair, who will be responsible for discussing regular non-attendance with the relevant member. The Chair of the Committee will also be required to bring to the attention of the Chair of NHS GM if they feel that lack of attendance has not enabled adequate discussion or decision making. Support The Corporate Governance team will support the Committee and the Chair of the Committee. Conflict of interest Conflicts of interest should be disclosed and managed in line with the NHS GM Conflict of Interest Policy. The Chair is responsible for the management of all conflict of interest matters.

	Reporting The Committee Chair shall report to the Board on the Committee's activities by: • Providing a written update report following each meeting • The presentation of an annual report • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board of any issues that require disclosure to the full Board of Directors, or require action. Annual self-assessment The Committee shall undertake an annual self-assessment. It will report thereon to the Board. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
Date agreed by the Strategic Commissioning Committee:	TBC
Date approved by the Board:	TBC
Review date:	TCB

Appendix: Constructive challenge

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

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

NHS Greater Manchester

People and Resources Committee

Terms of Reference

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

	- Ensure delivery of the ICB financial plan / strategy and make recommendations to the Board - Have oversight of the ICS financial position - Where delivery of the financial plan is not assured, ensure the necessary actions are being taken to recover the position wherever possible - Apply constructive challenge to <u>medium and long-term ICB financial plans</u> and monitor their implementation. Approve and receive assurance on the delivery of the Procurement and Contracting Strategy. Financial resource allocation - Apply constructive challenge to proposals in line with Financial Scheme of Delegation. - Apply constructive challenge to business cases for <u>major investments / disinvestments</u> for material service change or efficiency schemes. - Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the People and Resources Committee will scrutinise financial implications and make relevant decisions, or where appropriate, escalate recommendations to the Board. Financial performance - Provide assurance in relation to the ICB achieving its statutory duties. <u>People</u> Strategy and planning - Review the <u>NHS GM People, Culture and Organisational Development Plan</u> and monitor progress with its implementation, through regular highlight reports. - Review delivery of the ICB workforce elements of the <u>10 Year Health Plan</u>, with a focus on sustainability and effectiveness. - Oversee workforce planning, transformation and change programmes on behalf of the organisation. - Oversee our performance against CQC standards, with a focus on the ‘well led’ measure.
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	Statutory duties - The approval of disciplinary process and arrangements for employees, including the accountable officer (where he/she is an employee of NHS GM) and for other persons working on behalf of NHS GM. - Making recommendations regarding the approval of arrangements for discharging NHS GM's statutory duties as an Employer and for staff appointments. - Making recommendations to the Remuneration Committee on items relating to the terms and conditions, remuneration and allowances for non-AfC employees. - Reviewing national policy and implementing accordingly, to ensure the organisation follows core employment legislation changes etc. - Provide system oversight of workforce efficiencies. Workforce performance and experience - To monitor and review workforce key performance indicators for the organisation, including sickness absence, training, appraisal, bank and agency usage and escalate any issues to the NHS GM Board. - Review the results of the annual <u>staff survey and any other staff surveys</u> and proposed organisation action plans. - Review reports from the <u>Freedom to Speak Up Guardian</u> regarding activity within the organisation, reflecting the updated national and regional models. - Review and approve partnership agreements with staff side. Equality, diversity and inclusion - Review workforce elements of the organisation's <u>Equality, Diversity and Inclusion Implementation Plan</u> prior to its submission to the Board, and monitor progress with delivery, including review of <u>WRES, WDES, PSED, Gender, Disability and Ethnicity Pay Gap reports</u>. - Oversee progress to act on the Anti-Racism Framework and the Sexual Safety Charter. <u>Estates</u> Strategy - To monitor implementation of the Infrastructure Strategy ensuring outcomes are achieved in line with required timescales - Apply constructive challenge whilst working collaboratively with Strategic Partners and Stakeholders to drive the development of a flexible, greener and
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	cost-efficient estate, aligned with service transformation priorities Utilisation - Provide strategic direction and support in achieving realistic cost efficiencies and effective use of accommodation whilst ensuring optimum utilisation of retained estate - Ensure Department of Health Property Companies work in partnership with NHS GM to increase levels of utilisation; reduce void and subsidy costs; increase capital investment in the retained estate and to consider options at the end of the Local Improvement Finance Trust (LIFT) lease concessionary periods Primary Care - Review GP non mandatory occupational subsidies to reduce reimbursement costs and achieve an equitable outcome for all NHS GM practices - Ensure adherence to statutory requirements under the provisions of the Premises Cost Directions in relation to GP Practice new leases and lease renewals in order to achieve value for money in terms of rent reimbursement - Provide strategic advice and support to ensure primary care capital and revenue business case governance and approvals processes are followed Corporate - Review the corporate estate to establish strategic need and drive best practice in terms of provision and utilisation - Promote flexible access to accommodation throughout the corporate estate - Promote a robust Health & Safety culture ensuring compliance with statutory regulations and business policies <u>Environmental Sustainability</u> - Assurance of appropriate oversight for the implementation of the NHS Greater Manchester Green Plan - Assurance of appropriate oversight for NHS Greater Manchester's statutory responsibilities on environmental sustainability <u>Digital, IT Infrastructure and Cyber Security</u> - Apply constructive challenge to the operational resourcing, resilience and delivery of digital and IT infrastructure.
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	- Oversee and obtain assurance on resource planning and allocation for digital and IT infrastructure. - Oversee and obtain assurance on cyber security, including organisational resilience, statutory and regulatory compliance, and the management of associated risks. - Apply constructive challenge to deliverability, value and integration with estates and workforce functions. <u>Data Governance, Security and Infrastructure</u> - Oversee and obtain assurance on the governance, security, resilience and development of the ICB's data assets and associated infrastructure, including secure data environments. - Oversee and obtain assurance on investment in data infrastructure and the management of associated corporate risks, costs and commercial arrangements. - Ensure that matters relating to data governance, security and infrastructure are coordinated with the Strategic Commissioning Committee where they affect the use of data and intelligence for strategic commissioning. Enabling strategies - Provide assurance around any enabling strategies, e.g. capital, and monitor their implementation. Strategic risks - Monitor and provide assurance to the Board on <u>BAF risks</u> assigned to the committee, as well as relevant Corporate Risks. Other Duties - Review and recommend the ICB's Standing Financial Instructions to the ICB Board. - Apply constructive challenge to action taken in response to changes in relevant national policy. - Approve any business cases, procurements, non-healthcare contracts and expenditure and also be notified of any Individualised Commissioning healthcare placements or packages in line with the financial scheme of delegation.
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Membership	The membership of the committee shall comprise of the following members: • Non-executive director (Chair) • Non-executive director (Deputy Chair) • Non-executive director • Non-executive Director • Chief Finance Officer • Chief Strategy, People and Partnerships Officer • Chief Reform and Improvement Officer • Chief Clinical Officer • Chief Executive Officer (Non-Voting Member) • Chief Commissioning Officer (Non-Voting Member)
Attendees	Where any conflicts of interest arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting. Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter. The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.
Delegated authority	The Committee is established by the Board as a Committee of the Board in accordance with its constitution. The Committee has delegated responsibility by the Board to: • Investigate any activity within its terms of reference • Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference • Commission any reports it deems necessary to help fulfil its obligations • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • The Committee may establish a sub-committee and arrange for the functions exercisable by the Committee to be exercised by the sub-committee. For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. Members will be expected to conduct business in line with NHS GM values and behaviours, including demonstrably considering the equality and diversity implications of decisions they make.

Meeting management	Frequency The Committee shall meet monthly a minimum of 10 times per year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. Meetings will not be held in public. Agenda and papers The agenda and papers for meetings will be distributed five working days in advance of the meeting. Attendance and Quorum A quorum shall consist of 4 Committee members, including the Chair or Vice Chair, one other Non-Executive Director, the Chief Finance Officer (or Deputy Chief Finance Officer) and one other Chief Officer. Members should attend at least 75% of meetings within any calendar year. Members are expected to nominate a deputy to attend in their absence. Deputies must be of appropriate seniority and approved by the Chair in advance. An approved deputy attending in place of a member will be treated as that member for the purposes of quorum and will exercise the same voting rights as the member they are replacing. Attendance will be monitored and addressed by the Chair, who will be responsible for discussing regular non-attendance with the relevant member. The Chair of the Committee will also be required to bring to the attention of the Chair of NHS GM if they feel that lack of attendance has not enabled adequate discussion or decision making. Support The Corporate Governance team will support the Committee and the Chair of the Committee. Conflict of interest Conflicts of interest should be disclosed and managed in line with the NHS GM Conflict of Interest Policy. The Chair is responsible for the management of all conflict of interest matters. Reporting The Committee Chair shall report to the Board on the Committee's activities by: • Providing a written update report following each meeting • The presentation of an annual report • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board of any issues that require
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	disclosure to the full Board of Directors, or require action. Annual self-assessment The Committee shall undertake an annual self-assessment. It will report thereon to the Board. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
Date agreed by the People and Resources Committee:	
Date approved by the Board:	
Review date:	

Appendix: Constructive challenge

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

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

NHS Greater Manchester Modern Slavery and Human Trafficking Statement

2026-2027

NHS GM ICB Board

16th September 2026

Required information	Details
Title of report	NHS Greater Manchester Modern Day Slavery and Human Trafficking Statement (Revised June 2026 until June 2027)
Author	Andrea Patel NHS GM Associate Director of Safeguarding and NHS GM Designated Safeguarding Leads
Presented by	Manisha Kumar, Chief Clinical Officer
Contact for further information	Andrea Patel – andrea.patel@nhs.net
Executive summary	This report contains the updated 2026–27 Modern Slavery and Human Trafficking Statement, which reaffirms the organisation’s legal commitment under the Modern Slavery Act 2015 to prevent slavery and trafficking across its operations and supply chains.
The benefits that the population of Greater Manchester will experience.	Strengthened protections against exploitation in healthcare services and supply chains, improved safeguarding practices, greater transparency and accountability, and enhanced staff training and reporting mechanisms—all contributing to a safer, more ethical, and rights-respecting health system.
How health inequalities will be reduced in Greater Manchester’s communities.	Promoting ethical practices across healthcare services and supply chains, ensuring fair and safe working conditions, and safeguarding vulnerable individuals.
The decision to be made and/or input sought	The Board is asked to: 1. Approve the ICB Modern Day Slavery and Human Trafficking Statement 2026-27. 2. Recommend publication on the ICB website as per statutory requirements.
How this supports the delivery of the strategy and mitigates the BAF risks	Supports strategic delivery by reinforcing legal compliance, ethical commissioning, and safeguarding practices across the system. It mitigates Board Assurance Framework (BAF) risks by strengthening provider accountability, promoting workforce transparency, and embedding anti-exploitation measures into governance and procurement processes.
Key milestones	To be reviewed June 27
Leadership and governance arrangements	Ratification

Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	NHS GM Chief Officers September 2025 ICB Board September 2025
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

1.0 Purpose Of Report

- 1.1. The purpose of this paper is to advise NHS Greater Manchester [NHS GM] Integrated Care Board of the annual review requirement for our statement of Modern Slavery and Human Trafficking in accordance with Section 54, Part 6 of the Modern Slavery Act 2015. Organisations are required to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains
- 1.2. The following NHS GM Modern Day Slavery and Human Trafficking Statement has updated for 2026-27. The NHS GM Chief Officers are asked to consider and approve the statement and agree the publication on the NHS GM internal and external website accordingly.

2.0 Introduction

- 2.1. NHS GM currently has a 2025-26 Modern Slavery and Human Trafficking Statement which is a requirement of the Modern Slavery Act 2015. This requires an annual update for the ICB to ensure alignment with statutory requirements for 2026-27.
- 2.2. There have been no changes to statutory legislation or requirements during the time period, so the 2026-27 review updates the previous statement.

System Support and Implementation

3.0 Modern Slavery And Human Trafficking Statement 2026-27

3.1. What Is Modern Day Slavery?

Modern Day Slavery is a violation of a person's human rights. It can take the form of human trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery, and domestic slavery. A person is considered to be in modern slavery if they are;

- Forced to work through mental or physical threat.
- Owned or controlled by an "employer", usually through mental or physical abuse.
- Dehumanised, treated as a commodity, or sold or bought as "property".
- Physically constrained or has restrictions placed on their freedom of movement.

3.2. The Use of Slavery in The Production of Goods And Services

Typically, products bought have passed through a long chain of producers, manufacturers, distributors, and retailers who have all participated in its production, delivery and sale. It can therefore be very difficult to certify that a product has or has not been produced using slavery. However, the way in which companies operate and manage their supply chain can affect the likelihood of slavery being a part of the final product. The Modern Slavery Act 2015 places responsibility on organisations to ensure that no slavery has occurred, and this applies not only

to the products they sell or the services they provide themselves but also to their suppliers, and the suppliers of their suppliers, all the way along the supply chain.

3.3. What are we required to do?

Section 54 (1) of the Act requires those organisations with a turnover of 36 million pounds or more to prepare and publish a transparency statement setting out the steps that they have taken during that financial year to ensure that modern slavery and human trafficking are not taking place in their own business or in their supply chains. The Act places responsibility on organisations to ensure that no slavery has occurred, and this applies to the products they sell, the services they provide themselves but also to their suppliers, and the suppliers all the way along the supply chain.

3.4. NHS Greater Manchester modern slavery and human trafficking statement, 2026-27 - for publication:

Modern slavery and human trafficking remain significant challenges in Greater Manchester. The increase in National Referral Mechanism (NRM) referrals from 549 in 2020–21 to 1,023 in 2024–25 demonstrates the scale of exploitation affecting our communities. Behind these figures are individuals, including children, who need protection and support. NHS GM is committed to ensuring that every person receives compassionate care and appropriate safeguarding.

As a commissioner of care and statutory partner of Safeguarding Adult Boards and Safeguarding Children Partnerships, NHS Greater Manchester (NHS GM) plays a key role in supporting local efforts and strategic priorities to tackle modern slavery and human trafficking.

NHS GM fully supports the Government's objective to eradicate modern slavery and human trafficking and recognises the significant role of the NHS in combating these crimes and supporting victims. We are committed to ensuring that our commissioned services and supply chains comply with all relevant legislative requirements.

NHS GM acknowledges the provisions of the Modern Slavery Act 2015 and is committed to openness and transparency. We will use effective due diligence processes to identify and address any risk or evidence of modern slavery or human trafficking within the organisation, our commissioned services and our supply chains.

As both a local leader in commissioning healthcare for the population of Greater Manchester and an employer, NHS GM provides this statement to set out its commitment and actions to prevent modern slavery and human trafficking across its supply chains and employment practices.

3.5. Our Commitment to Preventing Modern Slavery and Human Trafficking

NHS GM aims to address the risk of modern slavery and human trafficking by:

- Being committed to ensuring there is no modern slavery or human trafficking within our commissioned services and/or supply chains in any part of our business
- Adhering to National NHS Employment Standards, including verification of UK address, right to work in the UK, and obtaining suitable references
- Maintaining systems that support staff in reporting concerns, including via the Freedom to Speak Up initiative
- Continuing to build strong relationships with Providers and making clear our expectations around ethical and legal business behaviour. We expect local, national, and international supply chains to have appropriate anti-slavery and human trafficking policies and procedures in place
- Including modern slavery and human trafficking within the NHS Greater Manchester Integrated Care Board (ICB) Safeguarding Children and Adults at Risk Policy
- Provision of a multi-agency approach to raising awareness of modern slavery and human trafficking, led by the Greater Manchester Challenger Executive Board
- Providing accessible training and information to our workforce on modern slavery and human trafficking

Learning and Innovation

3.6. Our Arrangements for Preventing Modern Slavery and Human Trafficking

NHS GM aims to be as effective as possible in ensuring that modern slavery and human trafficking do not occur within any part of our operations by:

- Maintaining strong working relationships with safeguarding leads in Provider organisations to ensure:
 - Adherence to the Working Time Regulations 1998
 - Safe and fair working conditions
 - Awareness of risks within their supply chains
 - Responsible management practices that comply with all legal requirements, as reflected in policies, procedures, and contracts with suppliers
- Working in partnership across Greater Manchester to monitor and respond to safeguarding referrals related to modern slavery and human trafficking, including the outcomes of investigations
- Continuing robust NHS employment checks and payroll systems (e.g., ensuring individuals brought into the country illegally cannot be employed due to lack of National Insurance numbers and non-compliance with minimum wage laws)

- Ensuring regular communication with commissioned Providers, ensuring they understand and comply with NHS terms and conditions, including modern slavery and human trafficking requirements
- Applying safer recruitment principles in line with our Recruitment and Selection Policy, including identity verification, right-to-work checks, and criminal record screening
- Maintaining policies such as Freedom to Speak Up, Raising Concerns, Dispute Resolution, and Equality and Diversity to support a culture of openness and accountability
- Ensuring our Procurement Policy details how goods and services will be sourced in line with procurement laws and standards. Both the NHS Terms and Conditions for non-clinical procurement and the NHS Standard Contract for clinical procurement require suppliers to comply with relevant legislation
- Raising awareness throughout 2025–2026 of the Modern Slavery Act 2015 across all procurement processes, including requiring Providers to detail their preventative plans and actions
- Continuously review our internal procedures to ensure actions align with anti-slavery and trafficking goals
- Working in partnership with local Adult Safeguarding Boards, Safeguarding Children Partnerships, Community Safety Partnerships, and the Greater Manchester Challenger Executive Board, while also contributing to and influencing NHS England's work both regionally and nationally

3.7 Achievements in 2025–2026

- NHS Greater Manchester responded to identified safeguarding risks associated with Unaccompanied Asylum-Seeking Children (UASC) being placed in hotel accommodation within Greater Manchester. In collaboration with local partners, a comprehensive briefing was developed and shared across the health economy to raise awareness of best practice in identifying and safeguarding UASC. This initiative strengthened professional curiosity among frontline health staff and promoted multi-agency coordination to prevent exploitation and re-trafficking of vulnerable children.
- NHS Greater Manchester acted as a key partner in the Greater Manchester Modern Slavery Week of Action, contributing to a range of impactful activities. We played a leading role in the GM Modern Slavery Conference by sharing best practice guidance with stakeholders, engaged directly with the public through community events on the Freedom Bus, and collaborated as a partner to deliver a specialist webinar on best practice when collating evidence to support National Referral Mechanism (NRM) referrals. These actions reinforced our commitment to raising awareness, improving safeguarding responses, and strengthening multi-agency collaboration across the region.

- These actions are designed to strengthen professional curiosity among health staff, improve safeguarding responses, and reach hundreds of members of the public during engagement events.

NHS GM fully recognises that combatting modern slavery and human trafficking requires a coordinated, collaborative, and sustained approach.

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our Modern Slavery and Human Trafficking Statement for the financial year ending 31st March 2027.

Recommendations

This paper outlines the statutory requirement for NHS GM to have in place a Modern Slavery and Human Trafficking Statement which should be readily accessible on our webpage. The paper provides a copy of the required statement for consideration and agreement via NHS GM Chief Officers for 2026-2027.

The NHS GM ICB Board is asked to:

- Approve the ICB Modern Day Slavery and Human Trafficking Statement 2026-27.
- Recommend publication on the ICB website as per statutory requirements.

People & Resource Committee Report

17 September 2026

Integrated Care Board

17 September 2026

Required information	Details
Title of report	People & Resource Committee Report
Author	Ross Baxter, Governance Advisor
Presented by	Kal Kay, Non-Executive Director/ Chair of People & Resource Committee
Contact for further information	Kal Kay, Non-Executive Director/ Chair of People & Resource Committee
Executive summary	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The Board is asked to: Note the contents of the report and provide feedback to the Committee Chair.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
Key milestones	N/A
Leadership and governance arrangements	Overview of discussions at the People & Resource Committee
Engagement* to date	N/A
*Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	
Financial or Legal Implications	N/A

Table 1 - core information relating to the content and creation of paper

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

Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

Report from:	People & Resource Committee
Date of Meeting:	July & August 2026
Chair:	Kal Kay
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
Northern Care Alliance - At the start of the August meeting the committee were notified regarding the significant pressures being experienced across the Greater Manchester system as a result of the developing situation at the Northern Care Alliance (NCA). Patient safety remained the overriding priority and members were asked to be mindful of the extraordinary pressures on officers during consideration of the agenda. It was noted that while the organisation was not formally operating under business continuity arrangements, it was approaching that level of operational intensity. At the July meeting, members expressed concern regarding the Northern Care Alliance's continuing inability to provide complete activity data and noted wider operational and performance challenges affecting the organisation. Provider Representation and Committee Membership Members discussed the appropriateness of provider representation within committee structures and whether current arrangements remained fit for purpose. The issue was linked to wider discussions regarding committee membership, governance arrangements and the review of Terms of Reference. It was suggested that further consideration be given to the role of provider representatives and whether any changes should be reflected within future governance arrangements. ICB Responsibilities under the New NHS Oversight Framework The Committee discussed the implications of the newly published NHS Oversight Framework and the extent of the ICB's accountability for provider and system performance. Members agreed that there remained a need for greater clarity regarding the ICB's responsibilities in relation to system financial and operational performance and that this should be considered through a future Board development session.
Advise

People & Resource Committee Workplan – The Committee continued to receive updates on the workplan, and agreed a version of this to ensure the committee is receiving the required updates in a timely manner. This document will continue to evolve with business needs.

Joint Capital Resource Use Plan - The Committee received the Joint Capital Resource Use Plan which was a statutory requirement set by NHS England and followed a nationally prescribed format, with organisations required to complete specific sections and provide standardised information regarding planned capital investment and capital resource utilisation. The document was largely procedural in nature and reflected established national reporting requirements rather than introducing any significant new local proposals. The committee formally approved the report before publication.

Committee Approvals – The Committee approved;

- Distribution of 2026-27 Depreciation Funding

Assure

GM Month 4 Financial Position - The reported Cost Improvement Programme risk had reduced to £28.5 million using the NHS risk methodology and noted continuing work to reduce the risk further. Members were also informed that the system's cash position had improved and that the deficit support funding for Quarter 2 had now been received. While recognising ongoing financial pressures, the committee noted the progress being made against recovery plans and agreed that the more detailed provider-level issues would be explored further in the private session. The Committee also reviewed Contract Financial Performance in the private session.

Chief Officers' Update Reports – The Committee continued to receive reports from the three portfolios, namely Strategy, People & Partnerships, Reform and Improvement, and Finance. These reports are undergoing continual improvement in order to best serve the committee and ensure the appropriate assurances are given. This includes Workforce Reports, Digital & IT Reports and Finance Reports that will form part of the regular Chief Officer updates.

Mersey Internal Audit Reports - The committee considered an internal audit report from the Mersey Internal Audit Agency (MIAA) relating to data governance and digital arrangements. Members quickly identified that the report had been presented without an accompanying cover paper, management response or action plan, which limited the committee's ability to undertake effective scrutiny. The discussion therefore focused primarily on governance, assurance and the process for managing limited assurance audit findings rather than the detailed content of the audit itself, and the report would be brought to a future meeting for a more complete update.

Risks discussed and new risks identified

Risk reports will be brought to future meetings, however risks to the organisation were discussed throughout each item where appropriate.

Learning for sharing

There were no specific points of learning from the meetings.

Month 4 Finance Report

2026/27

NHS GM Integrated Care Board – Public

16 September 2026

Required information	Details
Title of report	Month 4 Finance Report
Author	Jackie Gardiner – Director of Operational Finance
Presented by	Kathy Roe – Chief Finance Officer / Acting Deputy Chief Executive
Contact for further information	Jackie Gardiner – Director of Operational Finance
Executive summary	The purpose of the report is to update the Board on the Month 4 financial position for NHS GM as at 31 st July 2026.
The benefits that the population of Greater Manchester will experience.	Effective financial management will contribute to the delivery of the ICP strategy and delivery of health and social care services to the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester’s communities.	Effective financial management will support the delivery of the ICP strategy and the focus on commissioning decisions to reduce health inequalities.
The decision to be made and/or input sought	The Board is asked to: 1. Note the Month 4 year to date and forecast reported financial position which is in line with the balanced plan including Deficit Support Funding. 2. Note and discuss the areas of key risks, pressures and the requirements for early intervention and mitigations to bring spend back in line with plan, and planned presentation of the monitoring of the recovery plans which are in development. 3. Note the delivery of CIP as at Month 4 of £50.8m against a plan of £44.9m, an over delivery of £5.9m YTD. 4. Note that the forecast capital position is expected to deliver in line with the allocation including the additional allocation notified for GPIT. 5. Note the NHS GM cash position which

	continues to be closely monitored. 6. Note that enhanced financial controls remain in place to strengthen financial grip and control, ensuring that only essential additional expenditure is committed. Chief Officers continue to provide rigorous oversight of the financial position and CIP delivery.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks	The report provides an update aligned to the strategic risk to ensure financial balance for NHS GM for 2026/27.
Key milestones	Monthly reporting within 2026/27 Financial Year.
Leadership and governance arrangements	Presented to Chief Officers on 26th August 2026. Presented to People & Resources Committee on 26th August 2026. Presented to the NHS GM Integrated Care Board on 16th September 2026.
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	N/A, part of on-going monthly reporting.
Financial or Legal Implications	N/A as this is the monthly Finance Report.

Table 1 – core information relating to the content or creation of paper

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

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

1. Introduction

- 1.1 The purpose of the report is to update the Board on the financial position for NHS GM as at 31st July 2026.

2. Key Messages

2.1 Plan

NHS GM has submitted a breakeven plan to NHS England (NHSE) for 2026/27, which includes the receipt of deficit support funding of £17.7m.

2.2 Month 4 reported position

As at Month 4, NHS GM is reporting in line with plan.

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

Key messages are as follows:

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

2.3 Efficiencies / CIP

The overall efficiency target for NHS GM for 2026/27 is £150.0m. At Month 4 delivery is now ahead of the plan by £5.9m. Against the overall target, £17.7m is still being identified as an opportunity whilst schemes are being scoped. The current risk adjusted forecast is £28.5m, which has reduced by a further £5.9m since last month.

2.4 Corporate Operating Costs

The NHS Reform Programme is nearer to being concluded and during July, ESR was updated to reflect the new structures and to move the majority of staff into their substantive roles. Until the final changes are made, the Admin/Running Costs position continues to show an underspend which is offset with an overspend in Programme Operating Costs. YTD there is a slight underspend overall, due to the expected phasing of non-pay spend later in the year, with the forecast position reported in balance overall.

2.5 Cash

At M4 NHS GM has drawn down £3,169.9m of cash against a straight-line national profile of £3,154.6m, reflecting an additional drawdown of £15.3m, which is a further reduction compared to M3. The closing cash balance was £3.4m, which is significantly lower than last month and back to normal levels. Cash drawdown assumptions will continue to be reviewed to ensure that cash can be managed appropriately and that the ICB remains within the allowable limits.

2.6 Capital

The NHS GM annual capital plan remains at £20.1m, which is split £6.6m for BAU, £10.5m relating to the first year of the 4-year Strategic Allocation and £3.0m relating to the Utilisation and Modernisation Fund. The additional allocation of £0.8m for GPIT has not yet been received but has been recognised in the forecast position. It is expected that all of this will be fully utilised in year. This month there is further information provided on the Neighbourhood Health Centre (NHC) schemes and the pipeline.

3. Recommendations

3.1 For the NHS GM Financial position, the Board is asked to:

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

NHS Greater Manchester Finance Slide Pack Month 04 – July 2026

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

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

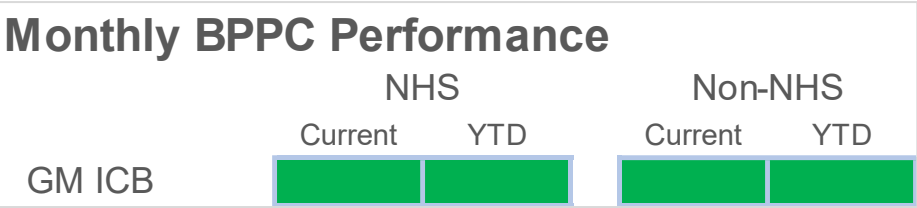
Key points to note for Month 4 are:

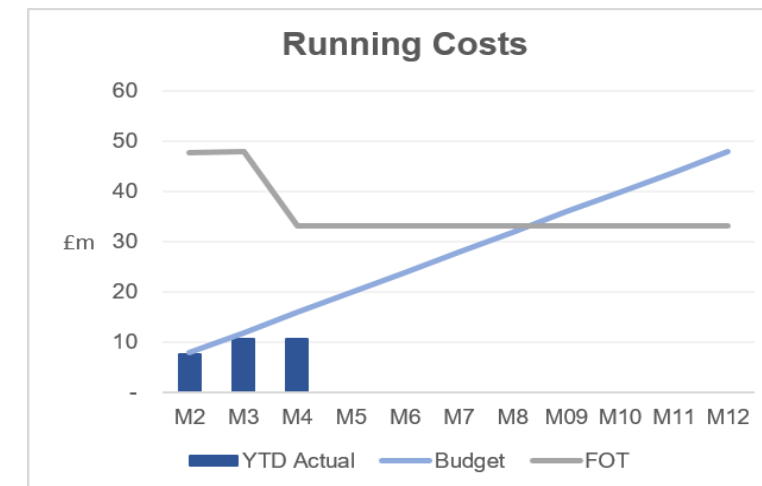
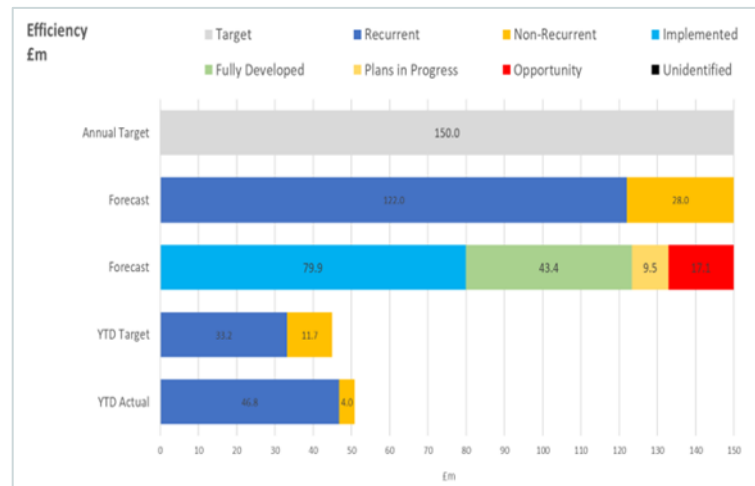
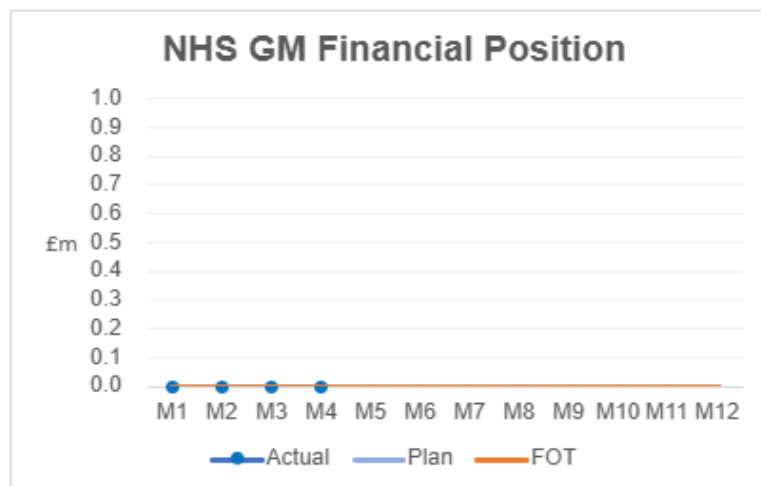
- There continues to be pressures being reported across a number of key risk areas including Prescribing, All Age Continuing Care and Mental Health packages, which are being offset with underspends in other areas of spend within the overall position and over delivery against the CIP target YTD.
- Delivery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

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

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

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





NHS GM Financial Position

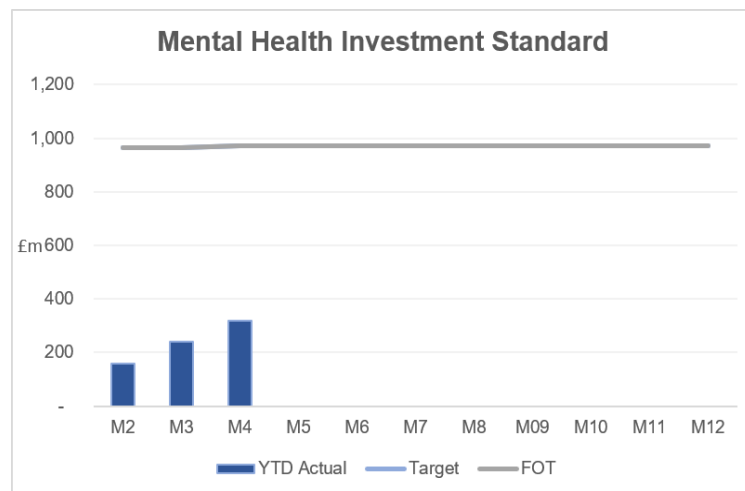
- As at Month 4 NHS GM is reporting in line with the year-to-date and annual plan.
- This is after Deficit Support Funding (DSF) of £17.7m has been allocated to NHS GM. To date £8.9m for Q1 and Q2 has been received, of which £5.9m is profiled to Month 4.
- DSF for the remainder of the year will be subject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

NHS GM Efficiency

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

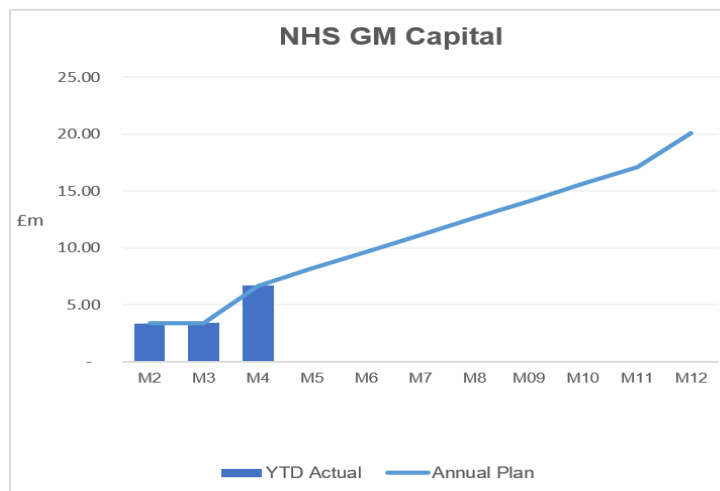
NHS GM Running Costs

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



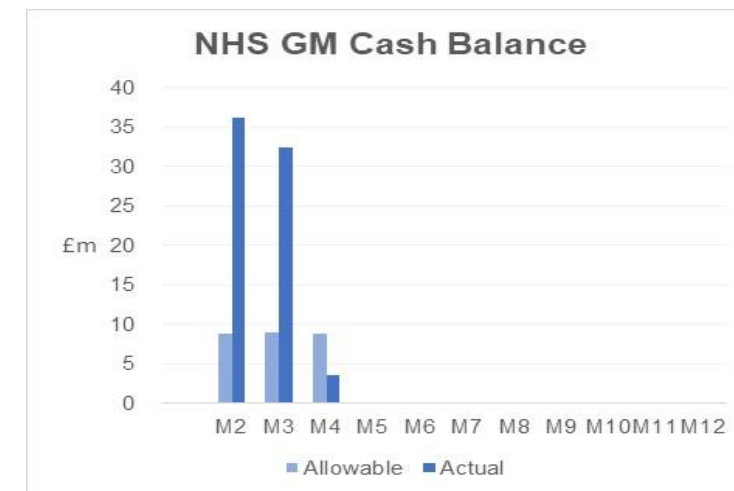
Mental Health Investment Standard

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



NHS GM Capital

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



Cash

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

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

Greater Manchester

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

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

For the NHS GM Financial position, the Board is asked to:

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

Strategic Commissioning Committee Report

16 September 2026

Integrated Care Board

16 September 2026

Required information	Details
Title of report	Strategic Commissioning Committee Report
Author	Rachel Egan, Non-Executive Director/ Deputy Chair of Strategic Commissioning Committee (Chaired for August meeting) Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee
Presented by	Rachel Egan, Non-Executive Director/ Deputy Chair of Strategic Commissioning Committee (Chaired for August meeting) Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee
Contact for further information	Rachel Egan, Non-Executive Director/ Deputy Chair of Strategic Commissioning Committee (Chaired for August meeting) Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee
Executive summary	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The Board is asked to: Note the contents of the report and provide feedback to the Committee Chair.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
Key milestones	N/A
Leadership and governance arrangements	Overview of discussions at the Strategic Commissioning Committee
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	N/A
Financial or Legal Implications	N/A

Table 1 - core information relating to the content and creation of paper

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

Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

Report from:	Strategic Commissioning Committee
Date of Meeting:	5 August 2026
Chair:	Rachel Egan
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
• Chief Clinical Officer Report: Northern Care Alliance Oversight and Laureate House Repairs: The committee were provided with updates on daily oversight of the Northern Care Alliance, legal undertakings and the progress of repairs at Laureate House. The committee also approved the recommendations set out in the report from Clinical Effectiveness and Governance (CEG). • A Briefing on Donna Ockenden's Review into Nottingham UHT Maternity Services & Baroness Amos's Review of Maternity & Neonatal Services in England, July 2026: The committee were presented with a comprehensive briefing on recent national maternity and neonatal reviews, the 10-point plan, implications for GM and gaps in perinatal mental health.
Advise
• Performance Report: The committee discussed the performance report and outlined three key recovery actions to improve performance. The committee provided partial assurance to the report. • Chief Commissioning Officer Report: The committee were informed of the performance challenges in specialised services, particularly gynaecology, neurosurgery and spinal, as well as progress on major trauma service redesign, including clinical workshops taking place and pathway revisions. • Chief Strategy, People and Partnerships Report: Updates on the progress of place partnerships, neighbourhood health plans and population health programmes were shared. The committee were made aware of the record-low smoking rates and supported increased visibility of Population Health successes. • Chief Reform and Improvement Officer Report: Updates on elective waiting lists, urgent & emergency care recovery plans, mental health & LD reporting, digital & IT service achievements and financial recovery progress were shared with the committee. • NHS GM Safeguarding Adult Board and Childrens Partnerships Annual Reports 2025/26: The committee were presented with the first iteration of

the annual safeguarding reports, with committee approval for submission and discussion of governance improvements for future reporting.
Assure
• Socio-economic Duty Implementation: The committee were presented with the progress and achievements of the voluntary adoption of the Socio-Economic Duty by NHS Greater Manchester, with committee endorsement of priorities, toolkit development and plans for embedding the duty in commissioning decisions.
Risks discussed and new risks identified
Risks scoring above 16 that are monitored via the Strategic Commissioning Committee: • Chief Reform and Improvement Officer Report: The committee were in acceptance of digital and cyber risk mitigations.
Learning for sharing
Summary of learning points to share from the Strategic Commissioning Committee August meeting. • Chief Strategy, People and Partnerships Report: Early engagement with localities, providers and sector partners improves the quality and deliverability of programme outputs. • Chief Clinical Officer Report: The Greater Manchester Inclusive Research Network (GM IRN) was established to address inequalities in research participation by supporting primary care practices serving deprived and ethnically diverse populations to engage in research activity. This work supports the wider ambitions to reduce health inequalities, increase inclusion in research and ensure that innovation and evidence generation better reflect the needs of Greater Manchesters diverse population.
Achievements
Summary of the appreciation shared from the Strategic Commissioning Committee August meeting. • Chief Reform & Improvement Officer Report: Digital and IT Services: All key service levels have been met during June 2026.

- **Chief Clinical Officer Report:** Greater Manchester Maternity and Neonatal Voice Partnerships (GM MNVP) achieved national recognition at the MNVP STAR Awards, receiving eight nominations across listening and coproduction categories. The GM MMVPs were awarded the National STAR Award for co-production for its pre-term birth leaflet project, recognising exemplary co-production with women, families and communities.
- **Chief Commissioning Report:** 2026 GP Patient Survey: Patient confidence in NHS GM clinicians remains exceptionally strong, with 93% of patients reporting confidence and trust in the healthcare professional they saw or spoke to.
- **Chief Strategy, People and Partnerships Report:** Population Health: Enabled by the Make Smoking History programme, the latest data for Smoking Status at Time of Delivery (SATOD) for GM showed that Greater Manchester had a Q4 2025/26 SATOD rate of 3.7%, our lowest quarterly rate on record, whilst the annual 2025/26 SATOD rate was 4.2%. This represents a significant improvement from 7.8% in 2024/25, equating to a reduction of 3.6 percentage points in a single year or a 46% relative reduction in SATOD across Greater Manchester.

Report from:	Strategic Commissioning Committee
Date of Meeting:	2 September 2026
Chair:	Dame Sue Bailey
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
• Chief Clinical Officer Report: The committee were made aware of Greater Manchester's outbreak, incident and winter-readiness arrangements. The committee noted the report, approved items requiring committee approval and endorsed items progressing through established governance. The committee were also informed that the Northern Care Alliance's previously private 29A information and related board papers were now public. A detailed assurance will be provided at a future meeting on the NCA 29A and other 29A notices, including how concerns are being addressed and overseen.
Advise
• Performance Report: The committee provided partial assurance on performance, with recovery work focused on elective capacity, urgent and emergency care, data quality and digital risks. Cancer performance included a strong 31-day result despite continuing 28-day and 62-day challenges. • Chief Commissioning Officer Report: The committee were informed as to how the 2027–28 commissioning intentions will support, but not replace, NHS Greater Manchester's five-year strategic commissioning plan, while reporting ongoing GP-action monitoring and cancer recovery work for missed national targets. • Chief Strategy, People and Partnerships Report: It was reported that Place Partnerships are on track for approval in October and Board consideration in November. • Chief Reform and Improvement Officer Report: The committee were informed 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 move further off plan and noted that a Board Development session on Data and IT was expected later on in the year.
Assure
• Greater Manchester Health Inequalities Statement 2025/26 - Commissioning Committee update: The committee were presented with the 2025–26 Health Inequalities Statement for approval, explaining how Greater Manchester is using disaggregated data and a disparity index to target action. The committee approved

publication and committed Chief Officers and partners to use the findings in commissioning and delivery. • National Quality Strategy: The committee were informed that the national quality strategy makes quality and safety ICB-wide, organising principle across safety, effectiveness and experience. The committee agreed to use the strategy to test its own work. It was confirmed that a detailed implementation plan would be shared with the committee in November. • Climate Change Adaptation Plan (CCAP): The committee were presented with a system-wide climate adaptation plan with 11 high-level actions. The committee approved the plan while requesting clearer commissioning requirements, funding visibility, estate responsibilities and preparation for future heat-related impacts.
Risks discussed and new risks identified
Risks scoring above 16 that are monitored via the Strategic Commissioning Committee: • Risk reports included in Chief Officer Updates. • Chief Strategy, People and Partnerships Report: Ongoing changes to governance arrangements continue to create uncertainty regarding programme timelines and approval processes.
Learning for sharing
Summary of learning points to share from the Strategic Commissioning Committee September meeting. • Chief Strategy, People and Partnerships Report: The NHS GM Population Health function co-authored a blog for the GM Public Health Network on the lessons learned for the development of a comprehensive Alcohol Harm Strategy in Greater Manchester. This was published by the Institute for Alcohol Studies. • Chief Commissioning Report: GM Cancer Alliance - The Get Cancer Clever programme is due to be expanded to employers and businesses across Greater Manchester with an event at the People's History Museum on Tuesday 22nd September, 8:30 - 10:30, delivered in partnership with The Growth Company. As part of this programme, GM Cancer Alliance commissioned a survey of 1,000 working age adults which showed: 72% of respondents agreed it would be easier to recognise early cancer symptoms if their workplace regularly shared resources about what these were. Only 56% of people feel confident that their employer would know how to support them. 54% of respondents weren't aware of any cancer support available to them through their workplace.
Achievements

Summary of the appreciation shared from the Strategic Commissioning Committee September meeting.

- **Chief Reform & Improvement Officer Report:** Elective - As of the end of July, NCA, Stockport, Tameside and MFT have all launched Single Point of Access in several services.
- **Chief Clinical Officer Report:** GM Mental Health Integrated Fund has been successfully shortlisted for a 2026 HSJ Award, representing significant national recognition of the partnership approach taken across the NHS Greater Manchester ICB, Greater Manchester Mental Health NHS Foundation Trust (GMMH), Pennine Care NHS Foundation Trust (PCFT), and wider system partners.
- **Chief Commissioning Report:** GM Cancer Alliance received positive feedback from the NHS NW regional team and the NHSE national cancer programme on the progress that is being made in the delivery of the annual cancer plan for GM.
- **Chief Strategy, People and Partnerships Report:** Positive feedback was received from NHS England Region on the Neighbourhoods approach via the Quarterly Executive Strategic Review meeting on 22 July.

Quality and Performance Board Paper

September 2026

NHS Greater Manchester Board – September 26

Required information.	Details.
Title of report.	Quality and Performance Report
Author.	Claire Scott – Performance Lead Anita Rolfe, Deputy Chief Nursing Officer Amy Jeffery, Quality Manager
Presented by.	Manisha Kumar, Chief Clinical Officer
Contact for further information.	Ed Dyson: edward.dyson@nhs.net
Executive summary.	This report provides the Board with an overview of current system performance and quality across NHS Greater Manchester, using the Assure, Alert and Advise approach. It highlights key areas of achievement, areas requiring continued oversight and escalation, and the actions being taken through provider, locality and system governance arrangements. The Board is asked to discuss and agree the levels of assurance set out in this report, noting areas rated Alert, Advise and Assure across performance and quality.
The benefits that the population of Greater Manchester will experience.	Improvement in performance and quality will support safer care, better access, reduced waits, improved outcomes and a more consistent experience for people using services across Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	The report includes oversight of variation in service performance and quality across Greater Manchester and supports targeted action to reduce unwarranted variation, improve access and strengthen outcomes for communities experiencing poorer care or longer waits.
The decision to be made and/or input sought.	The Board is asked to: Discuss and agree the levels of assurance for performance and quality set out in the report.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This report supports delivery of operational priorities by providing Board oversight of system performance, quality risks and improvement actions. It also contributes to assurance against relevant Board Assurance Framework risks relating to quality, operational delivery and service resilience.
Key milestones.	The report reflects monthly and quarterly monitoring of key performance standards, quality risks, provider oversight arrangements and improvement actions across the system.
Leadership and governance arrangements.	The report is informed through established provider, locality and system governance arrangements, including quality review meetings, provider oversight processes, system boards and committees.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	The report draws on information from localities, providers, system boards and committees. Specific engagement activity sits within the individual programmes and services referenced, rather than within the preparation of the report itself.
Financial or Legal Implications	There are no direct financial or legal implications arising from this report. It is provided for assurance and oversight.

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

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

1. Introduction

- 1.1 This paper advises the Board on the levels of assurance regarding performance and quality. It is completed using information from localities, system boards and committees within the NHS Greater Manchester (NHS GM) integrated care system. The paper highlights material issues for Board. The paper also briefs Board on provider and locality assurance arrangements.
- 1.2 This report uses the “Assure, Alert and Advise” approach aimed to direct members to the key issues and provide an understanding of the work that is being completed to address these issues.

ALERT: Alert to matters that require escalation for the board’s attention or action

ADVISE: Advise of areas of ongoing monitoring or development

ASSURE: Inform the board where assurance has been achieved

- 1.3 The Board is asked to discuss and agree levels of assurance set out in this report.

2. Performance

- 2.1 This section highlights current performance against key deliverables. It uses the latest nationally published data and/or the latest unvalidated data or forecast position. Narrative commentary is provided for Alert domains only, to focus Board attention on areas of material delivery risk requiring system oversight. Some 2026/27 metrics are early in the reporting cycle and data is not yet available for a small number of measures.

Alert

- 2.2 The total elective waiting list remains above plan and is the principal elective care Alert metric. In June, the GM Acute Provider waiting list reduced slightly to 437,332 from 438,882 in May; however, five of seven providers were above plan and the ICB waiting list trajectory remained off track. Delivery of the year-end planned position remains a significant system risk.
- 2.3 Recovery actions continue through the Elective Recovery Board and contract management and assurance arrangements. These include delivery of provider trajectories, waiting list validation, productivity improvement, demand management through BeCCoR/EQIS, Advice and Guidance, community services and Single Point of Access programmes, and maximising Independent Sector activity and treatment outside Greater Manchester.
- 2.4 In July, 8.4% of patients attending type one and two A&E departments waited more than 12 hours, against a plan of 7.4%. This improved from 9.2% in June, but four of six providers remained above plan. Challenges relating to patient flow, discharge delays and operational capacity continue to affect delivery.
- 2.5 UEC actions remain focused on measurable improvement in patient flow, discharge and long waits, supported by strengthened oversight, provider and Place ownership, trust-by-

trust assessment, stronger analytics and shared learning. Priority work includes frailty, children and young people, and high-intensity service users.

- 2.6** NHS Talking Therapies reliable recovery, reliable improvement and completed courses of treatment remain below plan. In June, reliable recovery was 45.3% against a target of 51.1%; reliable improvement was 68.8% against a target of 69.1%; and completed courses of treatment increased to 2,780 from 2,460 in May but remained below plan.
- 2.7** Targeted improvement work continues through established mental health governance, contract management and assurance arrangements, with focus on pathway efficiency, treatment completion, workforce and capacity pressures, and delivery of recovery trajectories.
- 2.8** Inappropriate Out of Area Placements reduced from eight in June to four in July but remained above the plan of two. Action remains focused on discharge planning, patient flow, admission avoidance, community alternatives and step-down provision.
- 2.9** In June, there were 45 adults with a learning disability, who may also be autistic, and 60 autistic adults in inpatient care, compared with planned positions of 42 and 50 respectively. Reducing inpatient reliance remains dependent on community alternatives, timely discharge arrangements and resolution of placement and funding barriers. A business case to address the commissioning gap has been developed, but funding has not yet been identified.

Advise

- 2.10** Four-hour emergency care performance improved in July to 72.5%, compared with 70.9% in June, but remained below the planned trajectory of 74.8%. The direction of travel is positive, and performance will continue to be monitored through established UEC governance arrangements.
- 2.11** The 28-day Faster Diagnosis Standard reduced in June. GM Acute Providers achieved 79.6%, with GM Registered performance at 79.3%. Performance remains close to the 80% standard and will continue to be monitored through Cancer Alliance governance arrangements.
- 2.12** The 62-day cancer treatment standard reduced in June. GM Acute Providers achieved 73.9%, with GM Registered performance at 73.1%. Performance remains close to trajectory and will continue to be monitored through Cancer Alliance governance arrangements.

Assure

- 2.13** RTT 18-week performance remains broadly on trajectory. In June, GM Acute Providers achieved 61.9% against a plan of 62.1%, while GM Registered performance was 63.5% against a plan of 63.3%. Overall performance remains close to plan despite continued elective recovery pressures.

- 2.14** In July, the average Category 2 ambulance response time was 19 minutes and 56 seconds, remaining better than the 30-minute national standard.
- 2.15** The 31-day cancer treatment standard remains above plan. In June, GM Acute Providers achieved 97.2%, with GM Registered performance at 96.9%. Greater Manchester was the highest performing ICB nationally against this standard.
- 2.16** In June, 11.8% of patients at GM Acute Providers waited more than six weeks for a diagnostic test, compared with a plan of 11.5%. GM Registered performance remained above trajectory at 12.2% against a plan of 14.3%. Although performance deteriorated slightly from the previous month, it remains significantly improved compared with earlier in the year and is rated Assure within the September framework.
- 2.17** Community waiting times remained above trajectory, with 86.9% of patients seen within 18 weeks in June compared with a plan of 83.3%. Performance improved from the previous month.
- 2.18** Individual Placement and Support activity continued to exceed plan. In June, 4,740 people accessed support compared with a planned position of 3,175, increasing from 4,580 in May.

2 Quality Update

Alert

Segment 4 Oversight: Northern Care Alliance NHS Foundation Trust

3.1 Northern Care Alliance NHS Foundation Trust continues to be subject to enhanced scrutiny following the issuing of NHS England regulatory undertakings and regulatory activity undertaken by the Care Quality Commission. A system approach is in place, with the ICB working closely with Care Quality Commission and NHS England North West Regional colleagues and the Trust to develop and assure the necessary improvement plan and determine the immediate and ongoing oversight arrangements required. An Improvement Board was scheduled for 3 September 2026.

Greater Manchester Mental Health NHS Foundation Trust

3.2 The ongoing closure of Laureate House remains a significant quality, safety and operational risk across the Greater Manchester mental health system. The closure has resulted in reduced older adult, acute and Psychiatric Intensive Care Unit bed capacity, increased pressure on patient flow and increased use of Local Spot Placements and Out of Area Placements.

3.3 Construction and remediation work remain on track for completion in December 2026. A phased reopening programme is planned between October and December 2026, with full restoration of services planned from January 2027.

Care Quality Commission inspection: acute wards and Psychiatric Intensive Care Units

3.4 The Care Quality Commission inspected Greater Manchester Mental Health NHS Foundation Trust's adult acute wards and Psychiatric Intensive Care Units across North View, Atherleigh Park, Rivington Unit, Meadowbrook Unit and Moorside Unit in July 2026. Preliminary feedback highlighted several areas requiring improvement, with potential implications for patient safety, patient experience and regulatory assurance. These areas are being monitored through the ICB's contractual quality oversight arrangements.

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

Care Quality Commission inspection: Adult Community Mental Health Services

3.6 A warning notice was served on the Trust on 12 August 2026 in relation to oversight of people waiting for treatment or intervention from Adult Community Mental Health Services.

The final inspection report is awaited and will inform the development of the associated improvement plan.

Advise**Maternity and Neonatal Programme**

- 3.7** Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust continue to progress their action plans under the Maternity Enhanced Surveillance Programme. Both Trusts are working towards entering the exit period, during which regular evidence of sustained improvement will be considered over two quarters before a recommendation is made to the ICB regarding step-down to routine surveillance.

Achievements**Greater Manchester Mental Health Integrated Fund**

- 3.8** The Greater Manchester Mental Health Integrated Fund has been shortlisted for a 2026 HSJ Award, providing national recognition of the partnership approach taken across NHS Greater Manchester, Greater Manchester Mental Health NHS Foundation Trust, Pennine Care NHS Foundation Trust and wider system partners.
- 3.9** The award recognises the innovative use of the Integrated Fund to improve patient outcomes, reduce Out of Area Placements, support community alternatives and strengthen collaborative commissioning arrangements across Greater Manchester. The next stage of the awards process requires a formal judging presentation, with the awards ceremony scheduled for 19 November 2026 in London.

3 Recommendations

- 4.1** The NHS GM Board is asked to discuss and agree the levels of assurance set out in this report

Meeting of the NW Specialised Services Committee - Part A

16 September 2026

Integrated Care Board

16th September 2026

Required information	Details
Title of report	NW Specialised Commissioning Committee Report
Author	Steve Spill, Committee Chair
Presented by	Katherine Sheerin, Chief Officer for Commissioning
Contact for further information	Katherine Sheerin
Executive summary	To highlight key escalation and discussion points from the Committee meeting.
The benefits that the population of Greater Manchester will experience.	Access to high quality specialised services to improve health and clinical outcomes.
How health inequalities will be reduced in Greater Manchester's communities.	The work of the NW Specialised Services Committee will be supported by a Health Inequalities Task Force to ensure that inequalities in access and outcome are central to commissioning programmes.
The decision to be made and/or input sought	The Board is asked to: Note the contents of the report.
How this supports the delivery of the strategy and mitigates the BAF risks	
Key milestones	N/A
Leadership and governance arrangements	This is a summary report following the last NW Specialised Commissioning Committee meetings.
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	NW Specialised Commissioning Committee comprises members (clinical, managerial and NEDs) from across the 3 NW ICBs and NHSE. Each programme has its own arrangements for wider engagement.
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 2 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

Meeting of the NW Specialised Services Committee Part A

2nd July 2026

Highlight report of the Chair of the NW Specialised Services Committee

Committee Chair: Steve Spill

NOTE

RED TEXT IS ADVISORY AND SHOULD BE REMOVED WHEN FINALISING PAPER

NOTE

BLUE AND BLACK TEXT SHOULD NOT BE REMOVED

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Highlight report of the Chair of the North West Specialised Services Committee

Committee Chair	Steve Spill
Terms of Reference	
Date of meeting	2 nd July 2026

Key escalation and discussion points from the Committee meeting	
Alert	
• Ongoing performance concerns relating to: ○ Cardiac surgery waiting lists at Blackpool Teaching Hospitals. ○ Spinal surgery waiting times at Northern Care Alliance (NCA). ○ Capacity pressures within complex gynaecology and endometriosis services. • National concerns regarding renal dialysis capacity, with growing demand outstripping existing provision however work already in place in NW addressing this. • Continued neonatal service review risks, particularly following publication of the Ockenden and Amos reports, requiring alignment with maternity service planning. • Ongoing quality concerns regarding complex spinal surgery services at NCA, including patient safety findings from retrospective case reviews. • Fragility within paediatric rheumatology services at East Lancashire Hospitals following clinician departures.	
Advise	
• Specialised commissioning contract values have now been agreed with all providers, with Indicative Activity Plans (IAPs) nearing completion. • OPIC development continues to progress, supported by a governance task and finish group focusing on implementation from October 2026. • Greater Manchester specialist cardiac and vascular surgery reconfiguration programme has successfully completed NHS England Stage 2 assurance and entered public consultation. • Urology reconfiguration programme has recommenced following earlier delays, with a compliant service model expected by the end of summer 2026. • Committee members supported bringing a detailed update on neonatal review options and implications to a future meeting. • Finance and Contract Subgroup continues to oversee contract deconstruction, contract management and performance monitoring arrangements, with Phase 1 expected to complete by the end of summer.	
Assure	
• Month 2 financial position remains on plan, reporting an overall surplus against allocation.	

• Renal dialysis quality concerns at NCA are now being managed through established quality oversight arrangements within the wider system. • Strengthened governance arrangements have been introduced for spinal surgery services at NCA, including enhanced MDT and mortality review processes. • Collaborative quality governance arrangements between NHS England, ICBs and providers continue to provide oversight of specialised commissioning quality concerns. • Significant progress has been made in the national contract deconstruction programme, with acute contract reviews well advanced and provider validation underway.	
Regional Director Update	Progress reported on OPIC development and governance arrangements. All provider contract values agreed and IAPs nearing completion. Updates received on St Andrew's Healthcare, renal dialysis capacity planning, mental health contract reviews, and implications of the Ockenden and Amos maternity/neonatal reviews.
ICB update	GM cardiac and vascular reconfiguration programme progressed to consultation phase. Committee discussed neonatal review complexities, maternity pathway implications, Blackpool cardiac service resilience and urology service reconfiguration.
Items for decision/endorsement	No items presented for decision or endorsement.
Quality Update	Updates received on renal dialysis incidents, spinal surgery concerns at NCA and paediatric rheumatology services at East Lancashire Hospitals. Committee sought assurance regarding quality governance arrangements across organisations.
Finance & Planning Update	Month 2 financial position remains on plan. Progress reported on IAP completion, contract deconstruction and future contract management arrangements.
Risks	Principal risks relate to cardiac surgery, spinal surgery, complex gynaecology capacity and neonatal review delivery. Workforce risks have been consolidated into a single organisational capacity risk.

OPIC Development Update	Governance task and finish group established to develop OPIC arrangements for October implementation and future governance requirements. Progress across the programme was reported as positive, although there remains work to do to address the financial and staffing risks, with a paper going to each of the ICB board meetings in July to set out the issues and challenges in more detail.
AOB	No substantive items raised.

Minutes

NHS Greater Manchester People & Resources Committee – Public

Date: Wednesday 22 July 2026

Time: 14:00 – 15:30

Venue: MS Teams

MEMBERS:		
Kal Kay	KK	Non-Executive Director, Chair
Richard Paver	RP	Non-Executive Director
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer
Nicola Hepburn	NH	Acting Chief Reform and Improvement Officer
IN ATTENDANCE:		
Stephen Downs	SD	Deputy Chief Finance Officer
Chris Gaffey	CG	Associate Director of Corporate Services
Jackie Gardiner	JG	Corporate Director of Operational Finance – Financial Management
Ross Baxter	RB	Corporate Governance and Risk Advisor (Minutes)
APOLOGIES:		
Colin Scales	CS	Acting Chief Executive Officer
Vish Mehra	VM	Partner Member - GP
Owen Williams	OW	Partner Member - Chief Executive Officer, Northern Care Alliance
Kathy Roe	KR	Chief Finance Officer
Manisha Kumar	MK	Chief Clinical Officer

Item No	Item
PUBLIC	
1.	Introductions and Apologies KK welcomed everyone to the meeting and the apologies were noted. The Attendance Matrix was shared for information.
2.	Declarations of Interest The People & Resources Committee Conflict of Interest Register was shared for information. There were no additional declarations or conflicts of interest declared at the meeting.
3.	Minutes, Action Log and Matters Arising The minutes of the last People and Resource Committee were approved as an accurate record. There were no updates to the action log to be noted.

4.	People & Resource Committee Workplan The Committee received the first draft of the People and Resources Committee forward workplan. It was explained that the workplan had been developed following Board consideration of the five-year commissioning intentions and strategic objectives. Work had been undertaken with Chief Officers to identify the most appropriate areas for scrutiny through the Committee, with a further review planned to ensure there was no duplication with the responsibilities of other committees. Members were advised that the workplan was intended to be a live document that would require ongoing review and refinement as the Committee matured and became clearer about its assurance requirements. During discussion, several areas were highlighted that were considered not sufficiently reflected within the proposed workplan. It was noted that health and safety was an important area of Board responsibility, particularly given recent changes to organisational arrangements, and suggested that the Committee should receive dedicated assurance reporting in this area rather than relying solely on updates contained within the Chief Executive's report. Freedom to Speak Up arrangements were also raised, proposing that the Committee should receive more substantive assurance regarding themes, lessons learned and organisational responses. While acknowledging that routine performance information could be reported regularly, it was felt there should also be periodic, more in-depth reviews, potentially in the private section of the agenda where appropriate. Attention was drawn to data-related issues, questioning whether the proposed workplan sufficiently addressed organisational capability and assurance around data quality. He referenced forthcoming findings from the Manchester Internal Audit Agency (MIAA), noting that weaknesses had already been identified and suggesting that a specific focus on data capability may be required alongside planned assurance work. In addition, he reminded the Committee that all MIAA limited assurance reports relevant to the Committee's remit should be routinely presented for consideration, with some reports potentially requiring discussion in private session depending on their content. Responding to these points, it was advised that an internal audit report relating to data quality was awaited and would be brought to the Committee. It was explained that the findings would help shape future priorities within the workplan, noting that the organisation had carried a significant level of risk in relation to data quality and capability since the establishment of the ICB and previously. Rather than introducing a range of separate agenda items before the audit findings were available, it was proposed that the Committee wait for the report's conclusions before agreeing a more targeted recovery and improvement programme, which could then be reflected within the workplan. It was commented that, to achieve greater consistency of oversight, there had been consideration to incorporating health and safety and Freedom to Speak Up reporting within the Chief Officer update report, allowing regular visibility of both quantitative information and softer intelligence. It was suggested this mechanism could include emerging themes from staff surveys, staff networks and Freedom to Speak Up channels. However, the Committee's preference for ensuring that deeper assurance reviews were also scheduled within the annual workplan if members considered this necessary was acknowledged. Observations regarding the structure and sequencing of the proposed programme of
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	work were raised. There was concern that the February and March meetings appeared particularly congested and this should be reviewed to look at whether some discretionary items could be moved to other points in the year to achieve a more manageable distribution of business. It was also noted that some meetings contained more than one planned deep-dive session and this was considered given the Committee's wider agenda responsibilities. Officers were asked to revisit the scheduling of these items to ensure sufficient time would be available for detailed scrutiny. It was also highlighted that although the Committee was receiving a workforce summary report, this recurring item was not currently reflected within the workplan. It was requested that a monthly workforce or people report be formally incorporated into the plan so that the Committee's ongoing oversight responsibilities were clearly documented. It was further noted that the Committee may wish to consider the terminology used to describe such reporting at a future meeting. The Committee then considered whether the proposed programme of work was achievable. Assurance was sought from Chief Officers that reports and planned deep dives could be delivered according to schedule and that the Committee would not experience significant slippage, and this was confirmed. It was acknowledged that the timing of planning-related reports would remain dependent on national timetables, although officers had attempted to build flexibility into the schedule where possible. This prompted a wider discussion regarding the Committee's private business arrangements. It was observed that the workplan had been developed primarily for public business and suggested that officers consider whether a parallel schedule of private agenda items might also be required. This would ensure that confidential matters requiring more detailed scrutiny were appropriately planned and reported throughout the year. In concluding the discussion, members broadly supported the proposed direction of travel and agreed that the workplan should be revised to reflect the issues raised. The Committee noted that the workplan would remain a developing document and would be refreshed regularly as priorities evolved and assurance needs became clearer. NHS GM People & Resources Committee approved the proposed forward plan, noting the intention to continually review and refine this as part of the Committee's work.
5.	Chief Officers' Update Reports <u>Chief Strategy, People & Partnerships Officer</u> The Committee received the Chief Strategy, People & Partnerships Officer update which presented key workforce, organisational development and equality matters. Mandatory training compliance was the principal area requiring attention. Following the organisational reform programme, many staff were transitioning into new roles and the organisation was supporting colleagues to complete outstanding mandatory training requirements. Particular concern was noted regarding information governance training compliance, although it was explained that some data remained affected by workforce changes and limitations within workforce records, with former employees still appearing in some reports while system updates were completed. It was acknowledged that workforce data remained in a period of transition and would continue to improve as reform activity concluded.

An update was provided on health and safety arrangements, reporting that the organisation was reviewing options for a future operating model. In the interim, a dedicated health and safety lead had been appointed to ensure appropriate governance and oversight arrangements remained in place. The Committee also noted that all staff had now received outcomes from the organisational reform process, although 69 displaced employees remained subject to suitable alternative employment arrangements. It was advised that until these processes concluded, workforce data would remain subject to fluctuation and should be interpreted accordingly.

The Committee heard a positive update regarding the anti-racism campaign, which had generated significant engagement both internally and externally. The campaign had achieved considerable reach across digital channels and partner organisations, attracting interest from national NHS colleagues who were exploring opportunities to utilise elements of the campaign more widely. Members noted that whilst engagement metrics were encouraging, the longer-term success of the initiative would be evaluated through its impact on workforce race equality outcomes and organisational culture.

The recent launch of the NHS Leadership and Management Framework and accompanying staff standards was outlined, which had been developed in response to the Messenger Review and aligned with wider NHS strategic priorities. It was explained that implementation would require additional support and development for managers, alongside the introduction of new assessment tools and greater accountability around leadership performance and achievement of objectives. The framework represented a significant shift towards more structured leadership expectations across the NHS.

The Committee received its first workforce executive summary and noted the organisation's reported establishment of approximately 1,219 whole-time equivalent staff. Turnover figures were currently elevated as a consequence of organisational reform, voluntary redundancy activity and forthcoming workforce transfers. Sickness absence levels remained below both Greater Manchester and national benchmarks, although mental health-related absence represented the largest category of sickness absence and reflected the pressures and uncertainty associated with organisational change. Members also noted that a staff pulse survey had recently been launched to provide additional insight into staff wellbeing and experience.

An update was provided on Freedom to Speak Up arrangements, reporting that new reporting mechanisms were being developed following receipt of the organisation's first report from Freedom to Speak Up volunteers. Future workforce reports would incorporate relevant themes and intelligence from these arrangements to provide a broader picture of workforce culture and staff experience. There were also a number of achievements, including recognition for the workforce team's management of organisational reform and the success of the organisation's T-Level Industry Placement Programme, which had received a Greater Manchester Skills Award.

The Committee considered the interim Equality Impact Assessment associated with the reform programme. Whilst the assessment remained incomplete pending the conclusion of workforce changes, the findings indicated no significant adverse impact on protected characteristic groups. Members noted positive changes in workforce diversity, including increased proportions of Black, Asian and minority ethnic staff and disabled staff within the organisation. The assessment also demonstrated demographic changes associated with staff departures and organisational restructuring, and a final Equality Impact Assessment would be presented once all reform activities had been completed.

During discussion, the breadth of information presented was welcomed but there was a preference for future meetings to receive a standalone workforce report alongside the Chief Officer update, similar to the Committee's approach to finance reporting. The workforce executive summary relied heavily on numerical data and would benefit from more narrative analysis explaining the significance of trends and key issues. It was also observed that the demographic changes identified within the Equality Impact Assessment were largely influenced by the profile of employees who had left the organisation rather than by active workforce redesign.

Concerns regarding information governance compliance were noted to be consistently low across organisational teams. She welcomed the introduction of workforce reporting but emphasised the need for future reports to provide greater analysis, context and assurance regarding emerging workforce risks and mitigating actions. In response, it was acknowledged that the workforce report was at an early stage of development and agreed that future iterations would contain stronger narrative reporting, clearer links to Board Assurance Framework risks, and greater explanation of actions being taken to address issues such as mandatory training compliance. Members were also assured that extensive equality monitoring and mitigating actions had been embedded throughout the reform programme and confirmed that there had been no grievances or appeals relating to unfair treatment arising from the application of equality considerations during the process.

The Committee noted the report and welcomed the assurance provided regarding workforce reform, equality monitoring, staff wellbeing initiatives and the continued development of workforce reporting arrangements.

Acting Chief Reform and Improvement Officer

The Committee received the Acting Chief Reform and Improvement Officer, noting that the paper submitted to the Committee had been the version previously presented to the Strategic Commissioning Committee. This had resulted from a period of unplanned leave and so the report had not been fully tailored for the Committee's remit. Discussions had taken place with the team regarding quality assurance and report review processes.

There were no issues requiring immediate escalation to the Committee at that time. However, the significant work underway to establish and embed the new operating model across the Reform and Improvement Directorate following recent organisational changes was highlighted. She advised that substantial workforce and service transformation had taken place and that particular focus was being given to data, digital and information management functions. Members were informed that reviews of data, digital and IT services were currently being undertaken through the internal audit programme and that the resulting reports would be brought to the Committee before being considered by the Audit Committee. These reviews would provide an important assessment of current organisational risks, particularly in relation to data quality, digital capability and information governance. It was anticipated that the findings would require detailed discussion by the Committee and would help to shape future improvement activity.

The Committee also received an update on the Federated Data Platform (FDP) and wider digital developments. A series of staff questions and answers had been developed to support understanding of the programme, reflecting the high level of interest and

queries being received across Greater Manchester. It was suggested that this material could be shared with the Committee at a future meeting to provide greater visibility of the programme and the organisation's position. More broadly, it was reported that IT and digital programmes remained on track and that an internal work programme had been agreed within the directorate to support delivery of agreed priorities.

Considerable progress had been made in strengthening the organisation's approach to cyber security, digital risk management and service improvement. Reports on cyber security arrangements and mitigations had already been considered through Chief Officer governance arrangements, with a clear emphasis on understanding and addressing risks while improving services for both internal users and wider stakeholders. Digital and IT functions had historically operated somewhat separately from wider organisational priorities, but work was now underway to align these services more closely with the needs of the organisation and ensure that digital functions played a central role in supporting strategic objectives.

The Committee was updated on financial recovery and improvement activity. Significant effort had been devoted to strengthening delivery arrangements and planning processes. A dedicated "sprint team" had been established at the end of Quarter 1 to support delivery into Quarter 2, ensuring that plans remained realistic, achievable and appropriately risk assessed. It was reported that the organisation was now planning and managing delivery further in advance than had previously been the case and that this approach was already yielding benefits. A Financial Recovery and Improvement Director had also been appointed providing dedicated leadership and capacity to support the recovery programme.

In terms of assurance and performance, all key service-level targets across digital and IT functions had been achieved, providing assurance that appropriate management focus and operational oversight were in place and that services were performing in line with expectations despite the significant organisational changes taking place.

During discussion, it was suggested that consideration should be given to establishing a standing assurance report for digital, data, cyber security and IT matters, similar to the regular workforce and finance reporting arrangements being developed for the Committee. These areas represented a significant part of the Committee's responsibilities and could benefit from a consistent assurance mechanism at each meeting. The suggestion was welcomed and was already under consideration. The function had first needed to stabilise its operating model and restructure arrangements but that there was now an opportunity to develop more regular assurance reporting. It was also noted that teams across digital, data and IT were keen to become more integrated within the wider organisation and would welcome opportunities to showcase both achievements and emerging risks through Committee reporting.

Queries were raised regarding the ongoing issue of GPIT services, and it was explained that discussions had recently concluded regarding future regional delivery arrangements and that agreement had been reached to continue providing GPIT services across Greater Manchester for the remainder of the year. Work would now focus on standardising service provision, strengthening financial sustainability and integrating GPIT more fully into the wider digital and IT strategy. While GPIT provision would continue, further work was required to consider how services should operate in the future, particularly given differing service models across localities, and an options appraisal would be brought through the Committee's work programme, with recommendations for future arrangements expected later in the year.

The Committee welcomed the update, noted the progress being made to strengthen digital, data and improvement functions, and supported the continued development of formal assurance reporting in these areas.

Chief Finance Officer

The Committee received the Chief Finance Officer update which provided a high-level overview of the organisation's financial position, governance developments and key risks. There were no issues requiring escalation to the Board under the alert section of the report.

Members were informed that the Greater Manchester system's financial position had improved at Month 3 compared with the previous month. The system had moved closer to its planned financial position after previously being significantly off-plan. While detailed information relating to the financial performance of individual organisations would be discussed within the private session, it was confirmed that the ICB itself remained on plan, and had successfully secured Quarter 2 deficit support funding, with additional funding being made available to support delivery of the financial plan.

The Committee noted amendments to the Financial Scheme of Delegation following previous discussions regarding the role of the Strategic Commissioning Committee. Authority had now been delegated to the Strategic Commissioning Committee to approve decisions between £5 million and £15 million. In addition, arrangements had been strengthened to improve transparency, with decisions taken by Chief Officers above agreed thresholds to be routinely reported to the People and Resources Committee. It was confirmed that there were no transactions requiring reporting under these arrangements during the reporting period.

An update was also provided on the finance workforce element of the NHS reform programme, and all finance staff had now been successfully matched to roles within the new structure and there were no displaced employees remaining within the finance function. This outcome had required several workforce processes, including expressions of interest and ring-fenced recruitment arrangements, which had inevitably generated some anxiety amongst staff. However, the successful conclusion of the process and the fact that all finance colleagues had secured roles was welcomed.

The report also highlighted the organisation's principal strategic financial risk relating to the delivery of financial sustainability. The current paper contained only a summary of the risk, supported by a much larger and more detailed schedule of controls, mitigations and actions, but work was underway to develop a more accessible way of presenting this information to the Committee, as the supporting documentation was too extensive and complex to include within the report in its existing format. The underlying financial risk score had increased compared with the end of the previous financial year, reflecting the financial pressures facing the organisation and wider system during 2025/26.

During discussion, concerns were raised about the wording of the strategic risk description, particularly the section linking financial sustainability with investment in preventative care and demand management. It was felt that the narrative was difficult to follow and risked creating ambiguity about the relationship between financial pressures, prevention activity and service demand, with a suggestion that the risk would be clearer if it followed a more conventional "if-then" format, explicitly setting out the potential consequences of failing to achieve financial sustainability. It was agreed that

	this would be updated for future reports. There would also be discussions on how best to present the information more effectively for future reports. The Committee noted the positive progress made in stabilising the organisation's financial position, welcomed the completion of the finance workforce restructuring process, and supported the continued refinement of financial risk reporting and assurance arrangements. NHS GM People & Resource Committee noted the reports
6.	Finance Report – Month 3 The Committee received the Month 3 Finance Report from Jackie Gardiner, who presented the organisation's financial position at the end of the first quarter of 2025/26. Members were advised that NHS Greater Manchester continued to report a balanced financial position, with both the year-to-date position and year-end forecast remaining in line with plan. Jackie highlighted a number of ongoing financial pressures, particularly within prescribing, all-age continuing care, mental health packages of care, and ADHD and autism-related expenditure. These pressures were currently being offset by underspends in other areas, including primary care and community services, although she noted that the position within community services required further review as significant changes within the supporting finance team meant that some reported variances might not yet fully reflect the underlying position. The Committee noted that the Cost Improvement Programme (CIP) was reporting delivery ahead of plan by £4.5 million at Month 3. Jackie explained that this favourable position largely reflected the agreed profiling of savings schemes across the year rather than permanent resolution of financial risk. Following a detailed review of all CIP schemes and delivery assumptions, officers had identified a residual delivery risk of £34.4 million. As a result, continued focus would be required throughout the year to ensure planned efficiencies were achieved and additional opportunities identified where necessary. Members also received an update on cash management and capital expenditure. Jackie reported that cash drawdown remained above the straight-line trajectory and that year-end balances continued to be higher than expected. However, she advised that this was anticipated and would take several months to normalise. Capital expenditure remained broadly in line with plan, although an additional GPIT capital allocation had been notified but not yet formally received. This had been reflected within the financial forecasts and explained a small variance against plan in that area. In relation to financial risks, Jackie reaffirmed that the primary areas of concern remained prescribing costs, continuing healthcare expenditure, mental health placements and ADHD/autism-related activity. Recovery and mitigation plans developed in the previous financial year continued to operate in several areas, while others required refreshment to reflect the current position. She advised that detailed discussions regarding recovery actions and financial pressures would take place within the Committee's private session. Members were informed that prescribing pressures continued to be driven largely by National Concessionary Supply Order (NCSO) costs, which remained outside local control and were being raised nationally through NHS England channels. Whilst awaiting any national response, officers would continue to pursue all available local opportunities to reduce expenditure within pressure areas. During discussion, Richard Paver queried the apparent discrepancy between the report's confirmation that the Mental Health Investment Standard (MHIS) was being achieved and separate references to financial pressures associated with mental health placements and ADHD services. Jackie explained that the reported pressures largely

	related to areas of spend outside those formally categorised within MHIS. However, Richard observed that previous years' overspends had often been linked to mental health placement activity and sought further clarification. Jackie acknowledged the point and undertook to review the position and provide confirmation to the Committee regarding the relationship between MHIS expenditure and the identified pressures. Richard also questioned the reported underspend within running costs and sought clarification regarding how the £19 per head running cost requirement was being managed following organisational reform. Jackie explained that while a formal running cost allocation remained in place, reductions associated with the revised NHS operating model had predominantly been applied to programme allocations rather than running costs. She further advised that workforce structures and employee records had not yet been fully updated within ESR following organisational restructuring, meaning some staffing costs were currently recorded in the wrong expenditure categories. Once these system changes had been completed and backdated adjustments processed, the position would become clearer. Nevertheless, she anticipated that some level of running cost underspend would remain due to the current allocation arrangements. Chair Kal Kay sought assurance regarding the monitoring of high-cost care packages and reminded officers of a previous commitment to provide visibility of individual packages above agreed financial thresholds. She suggested that, similar to the reporting arrangements recently introduced elsewhere, a standing reference could be included within future finance reports to ensure that such expenditure remained visible to the Committee. Jackie welcomed the suggestion and agreed that a suitable reporting mechanism could be incorporated within future finance updates. Following discussion, the Committee noted the Month 3 financial position, acknowledged that the organisation remained on plan despite a number of significant cost pressures, and recognised that delivery of the Cost Improvement Programme and management of expenditure within prescribing, continuing healthcare and mental health-related services would remain key areas of focus throughout the remainder of the financial year. The report and associated recommendations were noted. NHS GM People & Resource Committee; • Noted the Month 3 year to date and forecast reported financial position which is in line with the balanced plan including Deficit Support Funding. • Noted and discuss the areas of key risks and pressures and the requirements for early intervention and mitigations to bring spend back in line with plan. • Noted the delivery of CIP as at Month 3 of £36.5m against a plan of £32.0m, an over delivery of £4.5m YTD. • Noted that the forecast capital position is expected to deliver in line with the allocation including the additional allocation notified for GPIT. • Noted the NHS GM cash position which continues to be closely monitored. • Noted that an increased financial control framework of enhanced grip and control still remains in place to ensure only essential additional expenditure is committed, and on-going scrutiny of the financial position and delivery of CIP through the Chief Officers continues.
7.	Joint Capital Resource Use Plan The Committee received the Joint Capital Resource Use Plan which was a statutory requirement set by NHS England and followed a nationally prescribed format, with organisations required to complete specific sections and provide standardised information regarding planned capital investment and capital resource utilisation. The document was largely procedural in nature and reflected established national reporting

	requirements rather than introducing any significant new local proposals. This was expected to be the final year in which the ICB would be required to produce the plan in its current form as the requirement originated from previous arrangements under which Integrated Care Boards held responsibility for managing a single system-wide capital envelope on behalf of providers. However, from 2026/27 provider organisations had been allocated their own capital envelopes directly by NHS England, meaning the ICB no longer held the same system-wide capital management responsibilities. Whilst NHS England had not formally confirmed the future position, the expectation was that this would be the final year that the Joint Capital Resource Use Plan would be required. The Committee noted that the report had already been considered through Chief Officer governance arrangements and that, once approved, it would be published on the website. The document was broadly consistent with previous years' plans and continued to reflect national priorities around elective recovery, backlog maintenance, diagnostic capacity and other areas associated with delivery of constitutional standards and national NHS programmes. The content largely represented continuation of existing investment priorities rather than a significant shift in strategic direction. Looking ahead, a more substantive discussion regarding the ICB's capital programme would be brought to a future Committee meeting. Future reports would focus on areas of greater strategic significance, including GPIT investment and, in particular, the development of Neighbourhood Health Centres. Investment in Neighbourhood Health Centres represented a major component of future capital planning and would provide a more meaningful discussion for the Committee regarding how capital resources would support service transformation and delivery of neighbourhood-based models of care across Greater Manchester. NHS GM People & Resource Committee; • Noted the content of this report and the Joint Capital Resource Use Plan 2026-27 • Formally approved the report before publication.
8.	Equality Impact Assessment Workforce Profile Report Discussion of this item was held under the Chief Strategy, People & Partnerships Officer update. NHS GM People & Resource Committee; • Noted the interim Equality Impact Assessment workforce profile report and the comparison between the December 2025 pre-reform baseline and June 2026 workforce position. • Noted that the organisational change programme remains ongoing and that no compulsory redundancies have yet been processed. • Noted that, based on June 2026 workforce profile data, there is currently no evidence of disproportionate adverse impact at organisational level across the protected characteristics reviewed. • Recognised that the findings are provisional and that the full equality impact of the change programme cannot be concluded until all appointment, consultation, suitable alternative employment, redeployment and compulsory redundancy outcomes are complete.

	• Endorsed the proposed equality monitoring and action plan, including continued monthly review of workforce demographic data and reform outcomes by protected characteristic where data allows. • Supported continued focus on flexible working, reasonable adjustments, age profile monitoring, data quality and staff engagement as key mitigating actions during the remaining stages of reform. • Agreed that a final post-implementation Equality Impact Assessment report will be brought back to the Committee once the organisational change programme has concluded.
9.	Workforce Report Discussion of this item was held under the Chief Strategy, People & Partnerships Officer update. NHS GM People & Resource Committee reviewed and discussed the paper
10.	Performance Report This report provided an update on key performance indicators for GM. The indicators included were those considered high risk and/or form part of the undertakings process. NHS GM People & Resources Committee noted the information provided.
11.	Any Other Business There was no additional business raised. Board Paper Escalations There were no further specific escalations noted, and the Board Report would be drafted based on the discussions in the meeting. Meeting Reflections Members felt that the meeting had been effective with robust discussion and debate.

Minutes

NHS Greater Manchester People & Resources Committee – Public

Date: Wednesday 24 June 2026

Time: 14:00 – 15:15

Venue: MS Teams

MEMBERS:		
Kal Kay	KK	Non-Executive Director, Chair
Jackie Njoroge	JN	Non-Executive Director, Deputy Chair
Vish Mehra	VM	Partner Member - GP
Colin Scales	CS	Acting Chief Executive Officer
Kathy Roe	KR	Chief Finance Officer
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer
IN ATTENDANCE:		
Manisha Kumar	MK	Chief Clinical Officer
Stephen Downs	SD	Deputy Chief Finance Officer
Chris Gaffey	CG	Associate Director of Corporate Services
Ross Baxter	RB	Governance Advisor (Minutes)
APOLOGIES:		
Richard Paver	RP	Non-Executive Director
Owen Williams	OW	Partner Member - Chief Executive Officer, Northern Care Alliance
Nicola Hepburn	NH	Acting Chief Reform and Improvement Officer
Jackie Gardiner	JG	Corporate Director of Operational Finance – Financial Management

Item No	Item
PUBLIC	
1.	Introductions and Apologies KK welcomed everyone to the meeting and the apologies were noted. The Attendance Matrix was shared for information.
2.	Declarations of Interest The People & Resources Committee Conflict of Interest Register was shared for information. There were no additional declarations or conflicts of interest declared at the meeting.
3.	Minutes of the Last Meeting and Action Log The minutes of the last People and Resource Committee were approved as an accurate record. There were no updates to the action log to be noted.

4.	People & Resource Committee Workplan The Committee received a verbal update on the development of the People and Resources Committee workplan, which is being designed as part of a wider organisational planning framework aligned to the five-year commissioning plan. It was explained that the intention is to establish a clear “golden thread” linking the organisation’s long-term strategic vision through to annual Board priorities, committee workplans, and ultimately individual staff objectives and risk management processes. The Committee noted that Chief Officers had recently met to identify and refine a draft set of strategic objectives, with these due to be finalised imminently and formally presented to the Board in July. These strategic priorities will form the foundation for subsequent workplan development across all committees, including People and Resources. The approach seeks to ensure that committee activity is directly aligned to the organisation’s overarching priorities, rather than being developed in isolation. It was emphasised that work to begin shaping committee workplans is already underway, but that finalisation will follow Board agreement of the strategic objectives to ensure full alignment. The Committee further noted that this approach is intended to create a coherent cascade from strategy through to delivery, whereby committee workplans, team objectives, and individual performance objectives all reflect the same agreed priorities. This alignment will also inform the development of the Board Assurance Framework (BAF), with risks being explicitly mapped to the delivery of the strategic objectives. A detailed timetable supporting this process has been developed, with key milestones including presentation of strategic priorities to the July Board, finalisation of committee workplans in late July to early August, and subsequent BAF approval in September. In discussion, members welcomed the proposed approach, recognising the benefits of strengthening the connection between strategy, performance, and governance oversight. It was highlighted that, alongside the definition of strategic objectives, equal importance should be placed on clearly identifying what will not be prioritised, in order to maintain organisational focus. The importance of aligning performance metrics and data with the agreed objectives was also emphasised, with the Committee noting the need for clear measures of success and visibility of how interventions will deliver outcomes. The Chief Officer confirmed that work is underway to align the organisation’s performance dashboard accordingly, including input from the data and intelligence function. The Chair sought assurance that the workplan development would also address committee governance arrangements, including the coordination of forward plans and the management of overlaps between committees, particularly between the People and Resources Committee and other committees such as Strategic Commissioning. In response, it was acknowledged that while this level of detail was not yet fully incorporated into the draft materials, further refinement would be undertaken to ensure appropriate synchronisation across the governance structure before circulation. Overall, the Committee noted the progress made in developing a structured and aligned approach to the workplan and endorsed the direction of travel, subject to further detail being circulated to members following refinement. NHS GM People & Resources Committee provided comment and views on the current proposals on the Committee workplan.
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5.	Chief Officers' Update Reports <u>Chief Strategy, People & Partnerships Officer</u> The Committee received the Chief Strategy, People and Partnerships Officer's report and noted that there were no issues requiring escalation at this time. The update focused primarily on workforce, organisational development, and people-related priorities during a period of continued organisational change. The Committee was advised that the workforce data infrastructure had been significantly rebuilt in response to reductions in staffing capacity, with a transition towards a more decentralised, line manager-led model of data access. Under this new approach, managers will be able to access and generate live workforce data for their teams directly, rather than relying on centrally produced reports. Whilst the system had been successfully developed, it had not yet gone live, pending completion of the final allocation panels and confirmation of the organisation's establishment. It was noted that once staff are fully aligned to roles within the Electronic Staff Record (ESR), the organisation will be in a stronger position to produce accurate and timely workforce reporting, including the reintroduction of routine reports to the Committee. In terms of workforce metrics, the Committee noted that statutory and mandatory training compliance stood at 94.3% for May, slightly below the 95% target. It was anticipated that the new system would enable more targeted management action to address areas of lower compliance. The reported headcount was 1,232 whole-time equivalents, and sickness absence remained at 3.2%, below the national target of 3.4%, with the majority of absence attributed to long-term sickness. Members noted these figures and welcomed the intention to provide more comprehensive workforce reporting at future meetings once systems are fully operational. The Committee also noted the planned programme of staff engagement and insight activity. This includes the introduction of a regular cycle of pulse surveys in January, April and July, alongside the national NHS Staff Survey scheduled for September. It was confirmed that national benchmarking data would be available through these mechanisms, including comparisons with other Integrated Care Boards where applicable, and that results could be analysed across the domains of the NHS People Promise. Members highlighted the importance of monitoring staff sentiment closely in light of the sustained period of organisational change and sought assurance that appropriate benchmarking and trend analysis would be available; the Chief Officer confirmed that national dashboards would support this. Further updates were provided on key organisational initiatives. The Committee noted the launch of the second phase of the anti-racism campaign, which has now expanded from an internal focus to a system-wide, public-facing campaign. In addition, the annual appraisal process has commenced, with a revised and streamlined appraisal framework now in use. Early feedback from members indicated that the updated approach was an improvement on the previous system, offering a more effective structure for performance conversations. It was also noted that the organisation is preparing for staff to transition into new roles from 1 July, with line managers supported to facilitate this process, and that an all-staff away day is planned for September to support organisational development and engagement. During discussion, members emphasised the importance of maintaining regular oversight of workforce indicators, including training compliance and sickness absence,
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suggesting that these should be reviewed with similar regularity and rigour as financial performance data. The Committee also sought clarification on the scope of workforce data available through ESR, particularly in relation to protected characteristics. It was confirmed that demographic data, including ethnicity and other protected characteristics, is captured within ESR where staff have chosen to provide it. Members were also reminded that a final Equality Impact Assessment would be brought back to the Committee and Board following completion of the organisational change process, to assess the impact of reforms on the diversity and composition of the workforce.

The Chair additionally requested that Non-Executive Directors be invited to attend the forthcoming staff away day where possible, to support engagement across the organisation.

Overall, the Committee noted the report and the progress being made in strengthening workforce data systems, staff engagement mechanisms, and organisational development activity, recognising the importance of these elements in supporting the organisation through a period of transition.

Acting Chief Reform and Improvement Officer

This item was taken as read due to apologies received. Members were asked to direct any questions to NH outside of the meeting.

Chief Finance Officer

The Committee received the Chief Finance Officer's report and noted a broadly stable financial position at Month 2, with the ICB reporting a break-even position both year-to-date and on forecast. It was highlighted that, although the system reported an overall year-to-date variance of just under £21 million, this remained within the wider provider system and did not impact the ICB's reported financial balance. Members were advised that, notwithstanding this position, a number of financial risks were beginning to emerge, and these would require strengthened management attention over the coming months.

In presenting the report, the Chief Finance Officer drew attention to a number of key pressure areas, noting that the Committee would recognise recurring themes from previous discussions. These included pressures associated with the delivery of the Cost Improvement Programme (CIP), increasing expenditure on individual packages of care—particularly within Continuing Healthcare—and rising demand and cost pressures within mental health services. In addition, prescribing expenditure was identified as an area of concern, with a significant and unexpected increase observed in March, and further clarity on subsequent months awaited. The Committee was advised that a more rigorous and focused recovery approach would now be implemented across these areas to strengthen financial control and mitigate emerging risks.

The Committee noted that the current position must be understood in the context of organisational reform, which had resulted in a reduction of approximately one-third of the organisation's capacity. It was acknowledged that this had had an impact on operational oversight, particularly in high-risk financial areas, during the early months of transition as staff moved into new roles. The Chief Finance Officer confirmed that this reduced focus was now being addressed, with actions being developed and implemented to re-establish effective financial grip and control, supported by ongoing discussions at Chief Officer level.

Members also received an update on national requirements relating to deficit support funding (DSF), noting that NHS England had set expectations regarding the maturity and credibility of CIP schemes by the end of Quarter 1. The Committee was advised that, while there remained a level of risk across Greater Manchester in meeting these requirements in full, NHS England's assessment would not be entirely binary and would also take into account overall system performance, governance arrangements, and evidence of progress. It was noted that, across the system, approximately £100 million of DSF was at stake on a quarterly basis, with around £4 million applicable to the ICB. Members were advised that, even where thresholds were not met initially, there remained an opportunity to recover funding in subsequent periods, and further clarity would be provided following upcoming discussions with NHS England.

The Committee further discussed the ongoing work to deconstruct block contracts for community and mental health services, recognising this as a major and complex programme of work. It was explained that the aim of this exercise is to re-establish a clear line of sight between expenditure and activity delivered, addressing long-standing limitations in data quality and transparency. Members noted that, historically, block arrangements had obscured understanding of the value and outcomes associated with investment in these services, and that the move towards activity-based approaches would support improved commissioning, identification of unwarranted variation, and better-informed decision-making. The scale of the task was emphasised, including the absence of consistent national data sets and variation in existing provider approaches.

In discussion, members recognised both the opportunities and risks associated with this programme of work. It was noted that, while the primary objective was to improve transparency and understanding of activity and cost, it was also likely to expose areas where commissioned services or inputs were not aligned with expectations. Members highlighted the complexity of community service delivery, where outcomes may be achieved through a combination of inputs across different parts of the system, and emphasised the need to ensure that commissioning approaches appropriately reflect this complexity. It was further noted that the work would be of value to both commissioners and providers, enabling a more informed understanding of cost bases and supporting the shifting of resources into community settings as part of wider system transformation.

The Committee also received assurance regarding workforce changes within the strategic finance function, noting that, despite a reduction of more than 40 posts, all staff had been successfully redeployed without the need for compulsory redundancies. This was recognised as a positive outcome, particularly in the context of broader organisational change where this had not been universally achievable. Members were also advised of the successful submission of the annual accounts, which had been delivered ahead of deadline and supported through Audit Committee, resulting in a clean audit opinion. While the accounts reflected an underlying deficit position, this had been anticipated and managed, and the overall outcome was considered positive.

Finally, the Committee noted external recognition of the organisation's work through the Healthcare Management Awards, including commendations for the mental health integrated fund and ADHD programme, as well as the shortlisting of a senior finance colleague for an individual award. Members welcomed this recognition as evidence of the strength of collaborative working across the system.

Overall, the Committee noted the report and took assurance from the current financial position and progress made, while emphasising the importance of maintaining focus on

	emerging risks, strengthening recovery actions, and ensuring that forthcoming national financial requirements are effectively managed. NHS GM People & Resource Committee; • Noted the reports • Supported the progress and direction of travel for establishing the new People and Culture Sub-Group • Noted scrutiny of performance takes place at the Strategic Commissioning Committee and is presented to Board.
6.	Finance Report – Month 2 The Committee received the Month 2 Finance Report, outlining the key financial position and emerging risks. It was noted that, at Month 2, the ICB remained on plan, reporting a break-even position in line with its year-to-date target, with no change to the overall forecast outturn at this stage. The Committee was advised that while the headline position remained stable, a number of underlying pressures were beginning to emerge, particularly in relation to individual packages of care, including Continuing Healthcare and mental health placements. These pressures had been mitigated within the Month 2 position but were indicative of a trend that required close monitoring. In presenting the report, it was highlighted that the Cost Improvement Programme (CIP) position at Month 2 appeared slightly ahead of plan; however, this was largely attributable to phasing effects, with schemes that had already been identified contributing earlier in the year. It was acknowledged that greater challenge would arise in subsequent months as delivery became increasingly dependent on schemes still in development. This position aligned with earlier discussion that there remained a degree of risk regarding the maturity and completeness of CIP schemes across the system. The Committee noted that there were apparent variances between running costs and programme costs; however, Members were assured that this reflected timing differences associated with organisational restructuring and the realignment of budgets, rather than a substantive underlying financial issue. It was further noted that the capital programme remained at an early stage in the financial year, with no significant issues reported, and that cash drawdown was proceeding broadly as expected, albeit with some variation from a straight-line profile. In discussion, Members sought clarification on the drivers behind the emerging pressure on packages of care. It was explained that, in part, this reflected increased demand, particularly within mental health, including delays associated with patients being clinically fit for discharge. Additionally, it was acknowledged that reduced organisational capacity during the transition period had impacted the level of operational scrutiny applied to these areas. The Committee was advised that this had led to the identification of instances where costs included within care packages may not have been appropriately challenged, for example where duplicate or already-funded elements had been incorporated. It was confirmed that work was underway to strengthen oversight and reintroduce greater operational grip in these areas. Members further explored whether lessons identified in individual cases were being systematically applied across the system. Assurance was provided that the consolidation of locality teams into a single Greater Manchester function presented opportunities to standardise processes, identify inconsistencies, and improve value for money. This included the ability to benchmark practice across localities, identify

	anomalies, and explore opportunities for market management and service redesign to reduce reliance on high-cost individual placements over the medium term. The Committee also considered the position in relation to cash management, noting an apparent increase in cash drawdown compared to the expected profile. It was explained that this largely reflected the settlement of year-end creditor balances, with payments being made in the early part of the new financial year. It was further clarified that, given the ICB's underlying financial position, cash management required active balancing throughout the year, including engagement with providers regarding payment timing, while ensuring that smaller organisations were appropriately protected. In concluding discussion, the Chair sought assurance on the approach to managing emerging financial risks, particularly in areas showing early signs of overspend. It was confirmed that more detailed monitoring arrangements would be put in place, including the development of run-rate analyses for key cost pressures such as Continuing Healthcare, prescribing, and acute spend. These would be presented to the Committee in future cycles to provide greater visibility of trends and trajectories. In addition, recovery actions would be developed and implemented where necessary, with further detail to be brought to the Committee, including through private session where appropriate due to commercial sensitivities. Overall, the Committee noted that the financial position at Month 2 remained stable and on plan, but emphasised the importance of strengthening operational oversight, improving CIP delivery assurance, and closely monitoring emerging pressures to mitigate risks to the year-end position. NHS GM People & Resource Committee; • Noted the Month 2 year to date and forecast reported financial position which is in line with the balanced plan. • Noted and discuss the areas of key risks and pressures and the requirements for early intervention and mitigations to bring spend back in line with plan. • Noted the delivery of CIP as at Month 2 of £20.7m against a plan of £20.5m, a slight over delivery of £165k YTD. • Noted that the forecast capital position is expected to deliver in line with the allocation. • Noted the NHS GM cash position which continues to be closely monitored. • Noted that an increased financial control framework of enhanced grip and control still remains in place to ensure only essential additional expenditure is committed, and on-going scrutiny of the financial position and delivery of CIP through the Chief Officers continues.
7.	Financial Scheme of Delegation The Committee considered the update to the Financial Scheme of Delegation (FSOD), with a particular focus on clarifying the role and delegated authority of the Strategic Commissioning Committee (SCC). The update reflected previous Board discussions regarding the appropriate level of financial authority to be exercised by SCC and how this should operate within the wider governance framework. The Committee was advised that the proposed approach would delegate authority to SCC to approve investments up to a threshold of £15 million, with any decisions above this value requiring escalation to the People and Resources Committee. It was further

noted that, to maintain appropriate visibility and assurance, all decisions above £5 million, although within SCC's delegated limits, would be formally reported to the Committee. This reporting mechanism was recognised as an important enhancement, addressing previous concerns regarding transparency and ensuring that significant decisions remained within the Committee's line of sight even where formal approval was not required.

In addition, the Committee noted that a gateway process would be established whereby proposals would require Chief Officer endorsement before progression to SCC. This was intended to ensure that SCC time was focused on fully developed and strategically aligned business cases, thereby strengthening decision-making quality and efficiency. Members acknowledged that this approach would provide a more structured and proportionate framework, aligning SCC's role with other established governance thresholds and supporting more effective delegation across the organisation.

The Committee also considered the conditionality of the proposed delegation. It was explained that the £15 million threshold would be subject to review in the event of deterioration in the organisation's financial position. In such circumstances, it may be necessary to reduce delegated limits or reintroduce tighter controls. Members welcomed this flexibility but emphasised the importance of clearly defining the conditions under which such changes would be triggered. In discussion, it was suggested that any review mechanism could be linked to the organisation's risk framework, including the Board Assurance Framework (BAF), with increases in risk scores acting as a potential prompt to revisit the delegation.

The Chair sought clarification regarding the Committee's authority to approve the proposed changes, noting that the Financial Scheme of Delegation is typically a Board-approved framework. In response, it was confirmed that the Board had previously delegated authority to the People and Resources Committee to determine the appropriate threshold for SCC, and therefore approval at Committee level was appropriate in this instance.

Members further discussed the importance of aligning this update with wider governance arrangements, including ensuring consistency across committees and appropriate engagement with the Audit Committee. It was acknowledged that Audit Committee members, particularly the Chair, would likely have an interest in the changes, given prior discussions on delegation and assurance. While it was agreed that formal approval from other committees was not required, the Committee supported the proposal to engage informally with Audit Committee leadership to ensure visibility and address any concerns.

Overall, the Committee considered the proposals to be pragmatic and proportionate, balancing the need for efficient decision-making with appropriate oversight and assurance. Members expressed support for the clarity provided by the updated framework, particularly the introduction of reporting thresholds and the gateway process.

The Committee formally approved the proposed update to the Financial Scheme of Delegation in respect of SCC thresholds, noting that the decision would be reported to the Board in line with the delegated authority, and that the arrangements would be kept under review with the ability to amend as necessary in response to changing circumstances.

	NHS GM People & Resource Committee; • Approved the proposed financial delegation to the SCC, enabling approval of healthcare-related expenditure up to £15m, subject to the conditions and caveats outlined • Approved the proposed framework for reporting financial decisions above £5m, ensuring a consistent, transparent, and proportionate approach across all decision-making forums.
8.	Performance Report This report provided an update on key performance indicators for GM. The indicators included were those considered high risk and/or form part of the undertakings process. NHS GM People & Resources Committee noted the information provided.
8.	Any Other Business There was no additional business raised. Board Paper Escalations It was noted that an Alert needed to be raised regarding the Financial Scheme of Delegation. There were no further specific escalations noted, and the Board Report would be drafted based on the discussions in the meeting. Meeting Reflections Members felt that the meeting had been effective with robust discussion and debate.

Minutes

Greater Manchester Strategic Commissioning Committee

Date: 1 July 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 Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Leigh Vallance (LV) – VCSE Partner Member Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Stephen Downs (SD) – Deputy Chief Finance Officer Ed Dyson (ED) – Director of Performance, Improvement & Assurance, deputising for Nicola Hepburn Claire Lake (CL) - Deputy Chief Medical Officer (item 5) Mark Green (MG) – Director, Oka People David Boulger (DB) - Associate Director - Population Health (item 7) Faye Vaughan (FV) – Governance Advisor (Minutes)		Prof. Manisha Kumar (MK) – Chief Clinical Officer Kathy Roe (KR) - Chief Finance Officer Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer
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 3 June 2026 The minutes were accepted as a true record of the previous meeting held on 3 June 2026.	
4.	Financial Scheme of Delegation Approval & Reporting Key Financial Decisions Over £5M	

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

	<u>Chief Commissioning Officer Report:</u> The paper set out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. KS outlined the approved public consultation on centralising specialist cardiac and vascular surgery, including adjustments to consultation timelines following scrutiny by the Health Overview, Scrutiny Committee and NHS England Assurance. KS detailed the submission and approval of SEND reform plans across local authorities, the positive outcome of Bury's re-inspection and upcoming inspections in Salford and Stockport. Progress on the Office of Pan ICB Commissioning (OPIC) was discussed, with plans to bring further updates to the committee in the future. 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. There were no alerts in the report. ED presented data that showed Greater Manchester benchmarked poorly for overall 12-hour waits but better for high-acuity patients. Notably, it was reported that 22% of long-wait patients were not admitted and age was the primary demographic factor associated with long waits. The committee highlighted the high mortality rate within 30 days for patients experiencing 12-hour waits, particularly those at end-of-life, prompting discussion on the need for better advanced care planning and system-wide targets to reduce such occurrences. The committee further questioned the impact of senior decision-making delays and complexity of patient needs on long waits, suggesting further analysis to identify preventable factors and improve admission avoidance strategies. LV declared an interest in the item as CEO of Bolton Hospice. ACTION: ED, CL, NH, LV, DB to collaborate on a system wide action plan, including reviewing successful interventions at MFT for scalability and developing targeted quality improvement initiatives. Update to be provided at a future meeting. The Committee: • Noted the report and the position as of M3. <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.	ED / CL / NH / LV / DB
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	There were no alerts or advise in the report. The committee were made aware that the Neighbourhood Health engagement programme had closed. CB explained that they had met with 15 stakeholder groups and 150 colleagues during the online sessions. A meeting had taken place that week with the Senior Leadership Group to present the findings from the engagement and share the first draft of the Neighbourhood Health Model. The Committee: • Noted the report.	
6.	Performance Report The report provided an update on Greater Manchesters progress in achieving NHS operational planning goals, outlining significant risks faced by providers along with key improvement actions. It was explained that MFT had improved from segment 3 to segment 1, indicating sustained progress, while Wrightington, Wigan and Leigh had moved from segment 4 to 3. NCA and GMMH remained in segment 4, facing ongoing challenges and additional regulatory oversight. It was reported that Pennine Care had moved to segment 4 due to staff survey results and service responsiveness, despite a positive well-led CQC rating, highlighting the distinction between performance outcomes and leadership quality. LV highlighted the correlation between financial performance and quality outcomes. It was noted that the NOF now placed greater emphasis on quality in regulatory oversight. The committee agreed to a status of partial assurance, recognising improvements but noting that key alert metrics remained in critical areas such as A&E and UEC, and emphasised the importance of sharing learning across trusts. The Committee: • Noted the report.	
7.	GM Public Health Network Transformation - Quarterly Update The report provided an update on the Population Health transformation programme including progress to date and key next steps. CB described the three-phase approach: a shadow year with a single leadership team, followed by a section 75 agreement with Manchester City Council to host the network and a final phase integrating management teams and resources. It was reported that they were in the first phase at present until September 2026. DB highlighted Greater Manchester's track record in public health initiatives, such as reducing smoking prevalence and supporting people with HIV, but noted persistent inequalities and declining healthy life expectancy as drivers for further integration. RE raised questions around potential vulnerabilities due to changes at Manchester City Council and GMCA. Assurance was provided that robust due diligence and legal frameworks were in place to mitigate risks.	

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

Minutes

Greater Manchester Strategic Commissioning Committee

Date: 5 August 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present		Apologies
In attendance: Rachel Egan (RE) – Non-Executive Director (Deputy Chair) Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Leigh Vallance (LV) – VCSE Partner Member Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Prof. Manisha Kumar (MK) – Chief Clinical Officer Kathy Roe (KR) - Chief Finance Officer Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer Sarah Owen (SOw) - Associate Director of Nursing Safeguarding (item 4) David Boulger (DB) - Associate Director - Population Health (item 6) Rachael Nielsen (RN) - Strategic Lead – Population Health (item 6) Sarah Owen (SO) - Associate Director of Maternity Assurance (ICB/LMNS) (item 7) Sam Evans (SE) - Corporate Director of Finance – Commissioning & Financial Assurance Adam Shipp (AS) – Clinical Director for Womens and Children Faye Vaughan (FV) – Governance Advisor (Minutes)		Dame Sue Bailey (SB) – Non-Executive Director (Chair)
Item No.	Topic	Action
1.	Welcome, Introductions and Apologies RE welcomed everyone to the meeting, introductions were made, and the above apologies were noted.	
2.	Declarations of Interest RE reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	
3.	Minutes from the previous meeting held on Wednesday 1 July 2026	

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

	SO presented the first iteration of the annual safeguarding reports. It was explained that one adult and one children's report were submitted, with recommendations to note and approve the children's report for Department of Education submission. MK highlighted the establishment of a new Safeguarding Accountability Group post-reform, providing clear statutory oversight. It was explained that the following year, guidance would be issued to align report deadlines and ensure earlier committee sign-off. The Committee: • Approved the submitted annual reports for publication and/or submission, as applicable. <u>Chief Commissioning Officer Report:</u> The paper set out the key issues for Alert, Advice, Assurance and Achievement from the Healthcare Commissioning Directorate. KS reported ongoing quality issues in specialised services, with active work on mutual aid across the Northwest to manage patient care and performance, especially in gynaecology, neurosurgery and spinal services. It was noted that it was the third month of primary care collective action. KS explained a new shared care arrangements and weekly position statements that had been introduced, with oversight and risk mitigation fed to NHS Northwest. MK informed the committee of a clinical workshop that had taken place which involved over 35 clinicians, including air ambulance and pre-hospital pathway teams which had resulted in an agreement on revised pre-hospital and supplementary pathways. It was confirmed that there were plans for further collaboration in research, innovation and quality assurance. KS updated on the cardiac and vascular service change programme, noting a 12-week consultation period. The committee were also made aware of the positive GP patient survey results for Greater Manchester. MK explained the importance of data sharing for quality improvement in primary care, with some practices expressing discomfort. It was confirmed that digital facilitators were working with these practices to address concerns. The Committee: • Noted the report. <u>Chief Reform and Improvement Officer Report:</u> The report highlighted the key areas of assurance and oversight from the Reform & Improvement portfolio. NH described ongoing work with Trusts to validate elective waiting lists, resulting in positive improvements to be demonstrated in future Provider Oversight meetings. NH reported challenges in UEC performance, leading to accelerated recovery	
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	plans with Trusts and Regional colleagues to meet 4 and 12-hour standards. The committee were made aware of the collaborative work taking place to improve reporting and outcomes for vulnerable populations, with increased oversight and risk management. The committee were further informed that all key service levels for digital and IT had been met. Risks related to operational workforce recruitment and ongoing efforts to close financial gaps were noted. The committee accepted the digital and cyber risk mitigations outlined. The Committee: • Noted the report and the position as of M4. <u>Chief Strategy, People and Partnerships Report:</u> The paper informed the committee of the key priorities, risks and mitigations relating to Live Well, Population Health Transformation, Place Partnerships development and Neighbourhood Health plans. There were no alerts or advise in the report. The Place Partnership Development Programme continued to progress to plan, with a strong focus over July and August 2026 on socialising the final draft of the Place Partnership Document Suite across localities, provider collaboratives and wider sector partners. Neighbourhood Health Plans were being updated by Place Leads. It was reported that they had been asked to lead the process of updating Neighbourhood Health Plans to reflect the new Commissioning Framework by September 2026. Population Health programmes were on track, with the draft Section 75 due for committee review in September 2026. CB highlighted record-low smoking rates. The committee encouraged greater visibility and celebration of population health achievements. The Committee: • Noted the report.	
5.	Performance Report The report provided an update on Greater Manchesters progress in achieving NHS operational planning goals, outlining significant risks faced by providers along with key improvement actions. MK suggested providing an update on learning disability and autism standards at a future meeting. NH identified validation of elective standards, recovery and mitigation for urgent & emergency care and proactive winter planning as the three main actions to improve performance. The committee agreed on partial assurance for performance.	

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

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

Minutes

Greater Manchester Audit Committee (Part A)

Date: Wednesday 17 June 2026

Time: 9:00am to 10:35am

Venue: Boardroom, The Tootal Buildings, Manchester

Present		
Members:		
Richard Paver	RP	Non-Executive Director and Audit Committee Chair, NHS GM
Sue Greenhill	SG	Independent Member
Jackie Njoroge	JN	Senior Non-Executive Director, Vice Chair
Attendees / Participants:		
Stephen Downs	SD	Deputy Chief Finance Officer, NHS GM
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer, NHS GM
Chris Gaffey	CG	Associate Director of Corporate Services, NHS GM
Izhar Chaudhary	IC	Associate Director of Finance – Financial Assurance, NHS GM
Kal Kay	KK	Non-Executive Director and Chair of the Finance Committee, NHS GM
Colin Scales	CS	Acting Chief Executive
Richard Leese		Chair, NHS Greater Manchester
Jackie Gardiner	JG	Director of Operational Finance
Kaye Abbott	KA	Associate Director of Finance – Financial Control, NHS GM
Darrell Davies	DD	Regional Assurance Director, MIAA
Perminder Sethi	PS	Senior Manager, Grant Thornton
Paul Bell	PB	Head of Anti-Crime Services, MIAA
Faye Vaughan	FV	Governance Advisor, NHS GM (minutes)
Apologies:		
Kathy Roe	KR	Chief Finance Officer, NHS GM
Anthony Hassall	AH	Partner Member bringing the perspective of Mental Health Providers, Chief Executive of Pennine Care NHS Foundation Trust

	Topic	Action
1.	<u>Welcome, Introductions and Apologies</u> The Chair welcomed members and attendees to the meeting.	
2.	<u>Declarations of Interest (DOI)</u> RP reminded Committee members of their obligation to declare any interest relating to items on the agenda. No interests were declared.	
3.	<u>Minutes from the last meeting</u> The minutes of the last Audit Committee meeting on 23 April 2026 were approved as an accurate record.	
4.	<u>Action Log</u> The action log was reviewed noting that updates had been provided against the open actions, with any closed actions recorded on the log.	
5.	<u>Head of Internal Audit Opinion</u> The committee were informed that the Head of Internal Audit (HoIA) Opinion contributed to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. It was reported that the final opinion for 2025/26 was one of Substantial Assurance. The Internal Audit Plan aimed to address all of the key risks of the ICB on a cyclical basis. The committee were made aware of the one draft report that needed to be finalised at present. It was explained that they were awaiting management responses however, the draft outcome from the report had been included in the opinion as it was not anticipated to have any material changes. NHS GM Audit Committee noted the contents of the report.	
6.	<u>Anti-Fraud Annual Report 2025/26</u> The Anti-Fraud Annual Report offered the Audit Committee the opportunity to consider the work completed by the ICB's Anti-Fraud Specialist (AFS) during the period from April 2025 to March 2026. In completing the annual report on counter fraud, bribery and corruption work, the AFS had referred to and assessed the organisation against the Government Functional Standard 013 for Counter Fraud (which also applied to any relevant subsidiary company). The report highlighted relevant anti-fraud activities carried	

	out and their outcomes. It was explained that the anti-fraud work plan was designed to be dynamic to enable to respond to changing requirements, ensuring the most effective use of anti-fraud resource and meeting the requirements as set out in the relevant components of the fraud standard. The committee were made aware that the 2025/26 annual self-assessment against the Government Functional Standard 013 for Counter Fraud, known in the NHS as the Counter Fraud Functional Standard Return (CFFSR), was submitted early in Q1 of 2025/26, ahead of the deadline, with the ICB receiving green ratings across 11 of the 12 assessed requirements resulting in an overall green rated self-assessment. NHS GM Audit Committee noted the contents of the report.	
7.	<u>Annual Report and Accounts (including Annual Governance Statement) and Letter of Representation</u> The report detailed to the Audit Committee the changes made to the draft Annual Report and Accounts submitted in April 2026. The report also included the Letter of Representation. The committee were made aware of the minor amendments that required updating in the combined papers. JN thanked all involved and acknowledged the amount of work that had taken place to complete this work. A suggestion was raised to create an easier to read Annual Report in future for the public. CG confirmed that this is something that could be considered for future years, and would check with other ICBs whether this was something they produced. ACTION: CG to investigate whether any other ICBs had created an easy-to-read version of their Annual Report. The Audit Committee: • Approved the NHS GM Annual Report and Accounts for submission (subject to any minor, immaterial presentational amendments). • Confirmed the delegation to the Deputy CFO to undertake the national submissions required. • Approved the Letter of Representation for signature by the organisation.	CG
8.	<u>External Audit Findings Report 2025/26</u> A summary of the key findings and other matters arising from the statutory audit of NHS Greater Manchester ICB and the preparation of the ICB's financial statements for the year ended 31 March 2026 for those charged with governance were shared in the paper.	

	The number of recommendations in the report were highlighted to the committee. The committee were also made aware that the ICBs draft financial statements showed that the ICB had overspent against its revenue resource limit. As this was a breach of the statutory duty, the committee were made aware that it had been reported under the section 30(b) of the Local Audit and Accountability Act 2014 to flag the issue. It was acknowledged that this overspend had been agreed with NHS England as part of the planning process. The committee were made aware that the overall opinion on the Financial Statements was an unqualified audit opinion. Thanks were shared to the Finance Team for their support and collaborative working throughout the process. The committee were informed of the number of contract variation agreements or baseline contracts relating to specialised commissioning that had not been signed the previous year. Whilst signed agreements had been obtained or alternative confirmations received, it was explained that it would be essential to ensure all contracts and contract variations should be agreed and signed prior to payments being made. A recommendation to enforce it for the following year for best practice was raised. It was explained that compulsory redundancy and other departures reported in 2025/26 had been paid in accordance with the provisions of the redundancy scheme as agreed with NHS England. The committee were made aware that an Audit certificate could not be formally issued at present, in accordance with the requirements of the Local Audit and Accountability Act 2014 until the National Audit Office had concluded their work in respect of consolidation returns for the year ending 31 March 2026. The committee questioned whether any further progress had been made on the investment in third party company. It was confirmed that an update would be brought to the September 2026 private meeting. A discussion took place concerning the letter to the Secretary of State regarding NHS England allocated additional resource in advance of the expenditure. The committee further discussed the capacity issue in the organisation and assurance was sought on knowledge and skills retained in the organisation. It was confirmed that work would be undertaken to review the skills and capacity required across the organisation and to ensure that sufficient capability was retained to support effective delivery. The Mental Health Investment Standard was highlighted and a question was raised as to whether there was reference to meeting the Mental Health Investment Standard and the work that had taken place around it the report. It was confirmed that the disclosure was in the report which showed the target had been achieved.	
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	The Committee: • Approved the report, the recommendations and the management responses. • Agreed the additional fees proposed in the report.	
9.	<u>External Auditors Annual Report 2025/26</u> The report summarised the work undertaken by the external auditors for the 2025/26 financial year and in particular the commentary on Value for Money. It was explained that it set out the auditor's commentary on whether NHS GM had in place proper arrangements for securing Value for Money in its use of resources in respect of: • Financial Sustainability • Governance • Improving economy, efficiency and effectiveness The report reviewed the progress on implementation of recommendations made in 2024/25 and identified improvements required going forward. <u>Financial sustainability</u> It was explained that in 2025/26 the ICB delivered its agreed financial plan of a £7.5m deficit, including £175m of efficiency savings. This represented an improvement in financial delivery compared with prior years. However, a £7.5m deficit resulted in a technical breach of the ICB's statutory duty. It was explained that the key recommendation set out in the report was designed to support the ICB in strengthening arrangements to protect and deliver the medium-term strategy. It was reported that the ICB had submitted a compliant and balanced forward plan for 2026/27 to 2028/29, though this relied on significant savings. It was further explained that the ICB would need to demonstrate that prevention and transformation investment could be consistently translated into sustainable savings. <u>Governance</u> It was reported that the governance arrangements operated effectively during the year, with clear Board and Committee oversight of key risks. The committee were made aware that the ICB was now largely free from its Statutory Undertakings, with those remaining at year-end both relating to finance. As with many ICBs, it was explained that the ICB had worked to establish arrangements for consistent application of the Provider Selection Regime (PSR). However, the nature of the regime presented an ongoing risk and experience during the year which suggested that there was scope to further develop controls and governance in this area. It was reported that improvement recommendations had been raised to support assurance resilience during a time of significant transition and specifically to strengthen procurement and PSR compliance. <u>Improving economy, efficiency and effectiveness</u> The committee were informed that the ICB had maintained arrangements to oversee provider quality and performance and to support system improvement, including reporting of key performance metrics and escalation where concerns	

	appeared. The committee discussed the interplay between prior recommendations and highlighted that management had felt that all actions had been addressed whereas the report felt there was still areas to pick up. GT recognised the significant progress made in the financial sustainability area, however, highlighted that it was still a significant weakness for the current year. It was confirmed that discussions took place with Finance colleagues who agreed it should be a key recommendation, however, the improvement was acknowledged in the ICBs performance in this area. The constraints of the reporting framework in place was also highlighted. A suggestion was raised to provide further context in the report to ensure people were aware of the detail in future. The Committee: • Approved the report, the recommendations and the management responses.	
10.	<u>SIRO Report</u> Item deferred to Part B of the meeting.	
11.	<u>Anti-Fraud, Bribery and Corruption Policy</u> The NHS GM Anti-Fraud, Bribery and Corruption Policy had been reviewed and updated. It was confirmed that the updated policy would be shared with the committee after the meeting with the minor amendments raised. ACTION: IC to share the updated Anti-Fraud, Bribery and Corruption Policy with the committee. The Committee: • Approved and ratified the NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan policy prior to publication on the NHS GM website.	IC
12.	<u>Standing Items:</u> <u>Conflicts of Interest Guardian</u> There were no updates to note. <u>Board Summary Report</u> Report to be completed noting items during the meeting. Audit Committee noted the updates provided.	
13.	<u>Audit Committee Workplan</u>	

	Suggestions were raised for topics that would need including in the workplan for future meetings.	
14.	<u>Any Other Business, reflections on the meeting and items for escalation to the Board</u> There were no other items of business for consideration. <u>Reflections on the meeting:</u> Suggestion raised for a Board Development Session on PSR to understand the detail and implications. ACTION: Future Board Development Session to cover PSR.	JN
15.	<u>Date and time of next meeting:</u> 17 September 2026, 10:00 – 13:00pm, MS Teams	

DRAFT