NHS Greater Manchester

NHS Greater Manchester Annual Report and Accounts

1 April 2025 – 31 March 2026

Part of Greater Manchester Integrated Care Partnership

Contents

This is the 2025/26 Annual Report and Accounts for NHS Greater Manchester Integrated Care Board (NHS GM) covering the period from 1 April 2025 to 31 March 2026.

NHS GM is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services across Greater Manchester. It supports ten place-based integrated care partnerships within Greater Manchester as part of a well-established way of working to meet the diverse needs of our citizens and communities.

*It should be noted that throughout the document there are links to the websites of external organisations and information outside NHS GM. These are included to provide further background for readers who want to access it. This information should not be interpreted as having been audited by our auditors (Grant Thornton) unless expressly stated.

Foreword

Welcome to the 2025/26 Annual Report and Accounts for NHS Greater Manchester Integrated Care Board. This report provides an overview of the progress we have made, the pressures we have continued to face, and the work underway to improve health and care for the people of Greater Manchester.

This year has been a significant one for NHS Greater Manchester (NHS GM) and our partners across the Greater Manchester Integrated Care Partnership. Our shared ambition remains the same: for Greater Manchester to be a place where everyone can live a good life - growing up, getting on and growing old in a greener, fairer, more prosperous city region.

We have continued to operate in a time of considerable challenge. Demand has remained high, workforce pressures have persisted, and the financial context has required tough decisions and tight discipline. These pressures have been felt most sharply in urgent and emergency care, diagnostics, elective recovery and mental health services. And yet, throughout the year, teams across our system have continued to deliver improvements, strengthen resilience, and build the shift towards more preventative, community-based care.

A defining feature of 2025/26 has been national NHS reform and significant organisational transition. In response to the Model ICB Blueprint, we have undertaken a major programme to reshape NHS GM into a leaner, more focused strategic commissioner while maintaining grip on quality, performance and delivery. We recognise this has been an exceptionally difficult period for staff with sustained uncertainty, organisational change and workforce reductions having a real impact on our colleagues. Yet they have continued to deliver for patients while managing heavy workloads and personal concern about their futures. Throughout, we have engaged with staff, trade unions and partners, and we want to thank everyone who has continued supporting patients and communities during such a challenging time. We also want to record our appreciation to colleagues who have left the organisation this year for their contribution and commitment.

Against this backdrop, there are important areas of progress to highlight.

Planned care (elective care) has remained one of our biggest priorities. Across Greater Manchester, teams have worked together to tackle the longest waits and improve consistency for patients, combining targeted work on long waits with stronger validation of waiting lists and practical changes to pathways, so people can get to the right care more quickly. This has been

supported by continued focus on productivity and reforms that help services work more smoothly, including clearer access approaches, better use of specialist advice, and more effective use of dedicated elective capacity.

We have also continued to strengthen cancer and diagnostic services, with a strong focus on earlier detection and faster routes to diagnosis and treatment. The report sets out how the Greater Manchester Cancer Alliance has driven improvements through prevention and early diagnosis work, alongside practical pathway changes designed to reduce delay and variation. This includes more consistent approaches to straight-to-test models, better coordination with diagnostics, and innovation to support patients to move through services with fewer unnecessary steps. Alongside performance improvement work, there has been a continued emphasis on tackling inequalities in outcomes and experience, recognising that earlier diagnosis needs to reach the communities who face the greatest barriers to care.

Diagnostics remains a challenging area nationally, and we are clear about where further improvement is needed. At the same time, we have continued to expand capacity and strengthen system infrastructure to help more people access tests sooner and closer to home. Community Diagnostic Centres are an important part of that shift - supporting elective and cancer recovery and helping to provide a more convenient experience for patients.

Mental health continues to be a major focus for transformation, particularly crisis and urgent care. This year has seen progress in reducing inappropriate out-of-area placements, meaning more people are supported closer to home. The report also describes significant work to strengthen crisis pathways, including a single, consistent offer through NHS 111 option 2, enhanced triage arrangements, and the continued development of neighbourhood and community mental health models to improve access and provide more joined-up support.

Across primary and community care, we are building the foundations for care that is more preventative and neighbourhood-based. General practice has delivered more appointments than last year and remains above pre-pandemic levels. Community services have reduced long waits, and urgent community response continues to be a strong part of the offer, helping people get timely support at home and avoiding unnecessary escalation to hospital wherever possible.

At the same time, we are clear about the scale of the ongoing challenge in urgent and emergency care. The system has faced high and volatile demand, workforce pressures and constraints on flow and discharge. However, the year has also seen stronger system governance and clearer shared accountability, including the introduction of the 45-minute

ambulance handover standard (“Handover 45”) and strengthened escalation arrangements. This work matters because improving flow, discharge and alternatives to emergency departments is essential to delivering safer, more reliable care - and to supporting staff working under significant pressure.

Financial pressures continued to frame much of our work, and this report sets out our position transparently. NHS GM delivered a £7.5m deficit in year, in line with the plan agreed with NHS England, and met the running cost target. We have maintained a strong focus on responsible stewardship: making value-based decisions, strengthening grip and control, and working with partners to improve productivity and sustainability, while protecting front-line services wherever possible.

Progress across Greater Manchester has only been possible because of the deep collaboration at the heart of our system - across place-based partnerships, provider collaboratives, primary care, local government, and the voluntary, community, faith and social enterprise sector. That partnership approach remains central to our long-term direction: strengthening prevention, tackling inequalities, and building neighbourhood-based models that support people earlier, closer to home, and in ways that reflect what matters to communities.

This Annual Report is part of our commitment to transparency and accountability. It sets out where we have made progress, where performance remains under pressure, and how we are responding through reform, partnership working, and a relentless focus on improving outcomes and tackling inequalities. Above all, it reflects the effort of people across Greater Manchester who keep services running, keep improving them, and keep putting patients and communities first.

Sir Richard Leese

Chair

Colin Scales

Acting Accountable Officer

PERFORMANCE REPORT

Colin Scales

Acting Accountable Officer

17 June 2026

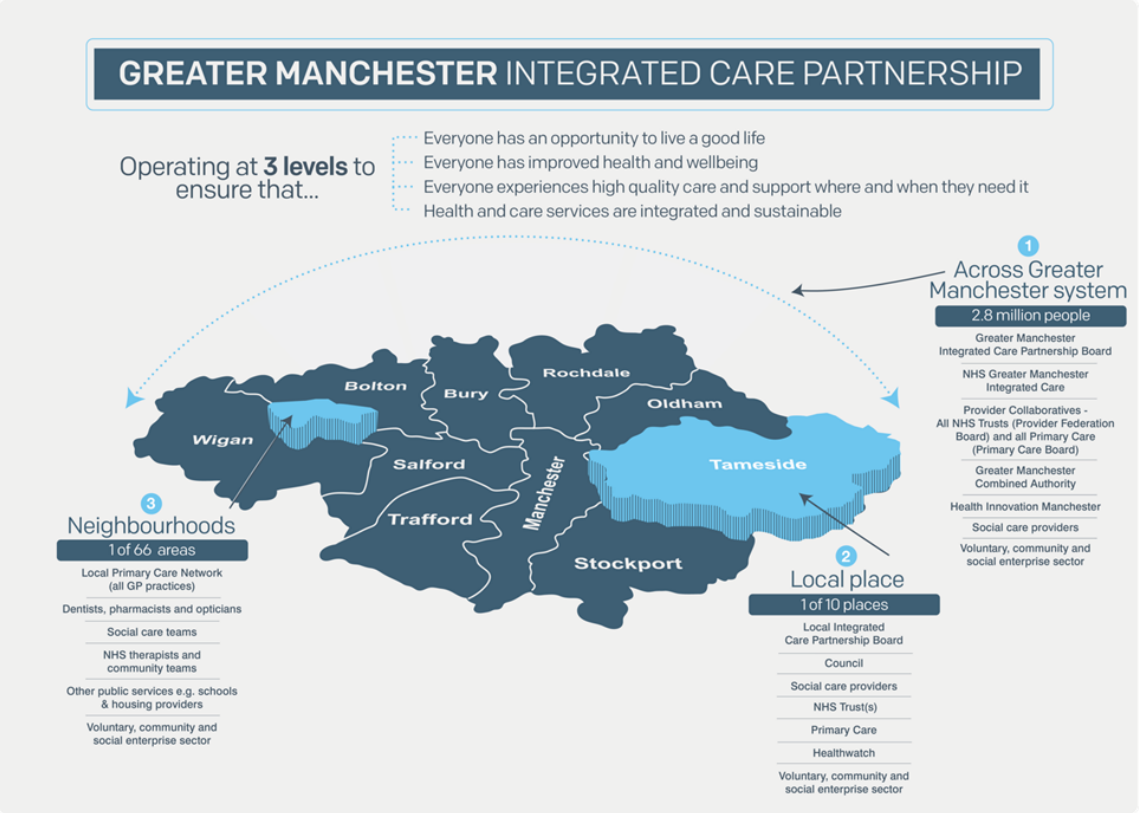
Performance overview

NHS Greater Manchester Integrated Care – or NHS Greater Manchester (NHS GM) - is part of the Greater Manchester Integrated Care Partnership (ICP), which is our integrated care system (ICS) bringing together all health and social care partners across Greater Manchester and wider public sector and community organisations to improve the health and wellbeing of the 2.8 million people who live in Greater Manchester.

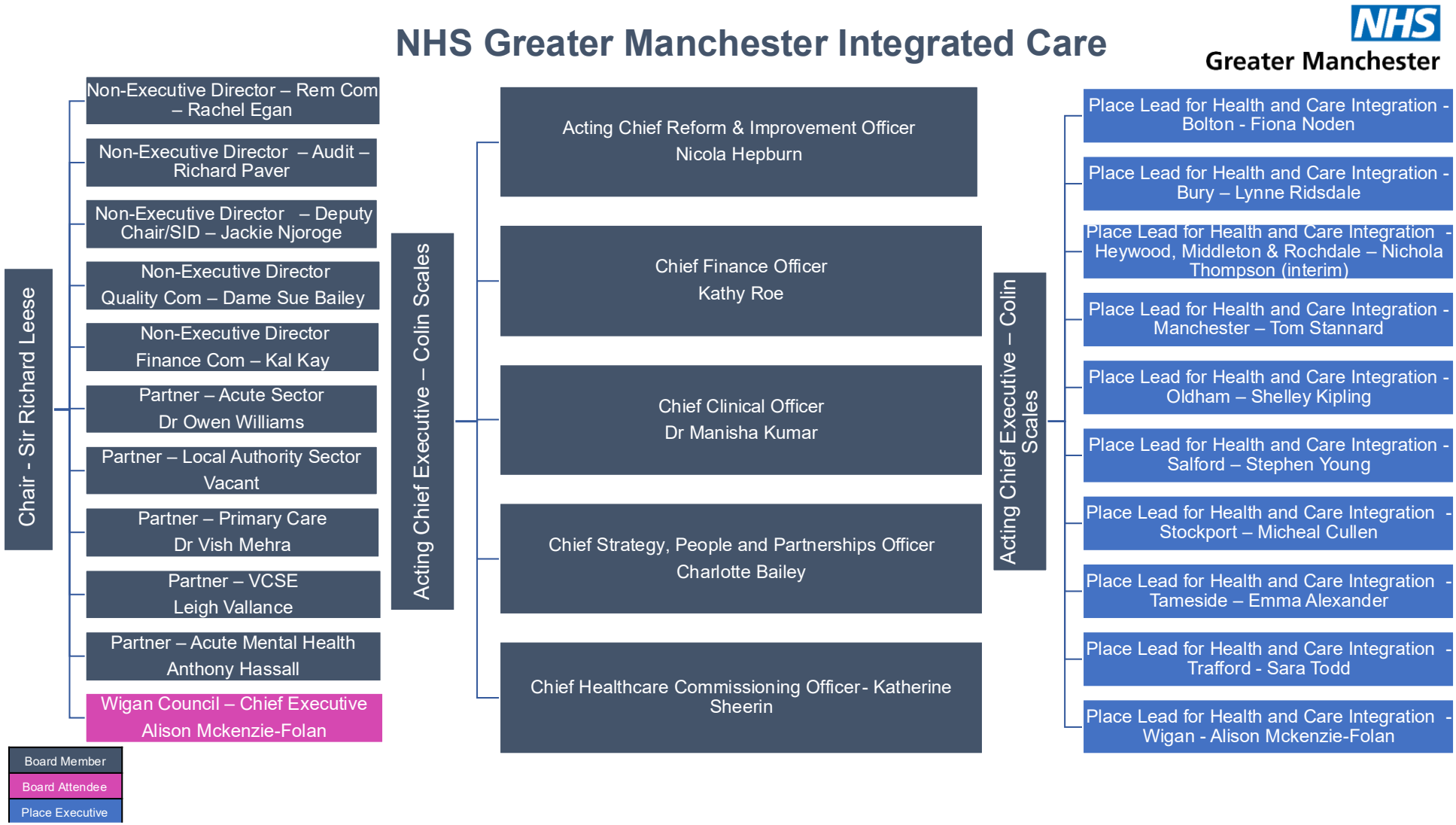
The Greater Manchester ICP connects NHS Greater Manchester, the Greater Manchester NHS trusts and NHS primary care providers with councils, the Greater Manchester Combined Authority (GMCA), and partners across the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, Healthwatch and the trade unions

NHS Greater Manchester is the Integrated Care Board; a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services in a geographical area. It supports ten place-based integrated care partnerships in Greater Manchester, fostering a well-established way of working to meet the diverse needs of our citizens and communities, and has a role in the delivery of the NHS constitutional standards and statutory duties of the GM ICP.

The Greater Manchester Integrated Care Partnership Board is a statutory joint committee made up of NHS GM and the 10 councils within Greater Manchester. It brings together a broad set of system partners and it is the responsibility of this ICP Board to develop our integrated care strategy - a plan to address the wider health, and care needs of the population.


GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP
Operating at 3 levels to ensure that...
Everyone has an opportunity to live a good life
Everyone has improved health and wellbeing
Everyone experiences high quality care and support where and when they need it
Health and care services are integrated and sustainable
1
Across Greater Manchester system
2.8 million people
Greater Manchester Integrated Care Partnership Board
NHS Greater Manchester Integrated Care
Provider Collaboratives - All NHS Trusts (Provider Federation Board) and all Primary Care (Primary Care Board)
Greater Manchester Combined Authority
Health Innovation Manchester
Social care providers
Voluntary, community and social enterprise sector
Bolton
Bury
Rochdale
Oldham
Wigan
Salford
Manchester
Tameside
Trafford
Stockport
2
Local place
1 of 10 places
Local Integrated Care Partnership Board
Council
Social care providers
NHS Trust(s)
Primary Care
Healthwatch
Voluntary, community and social enterprise sector
3
Neighbourhoods
1 of 66 areas
Local Primary Care Network (all GP practices)
Dentists, pharmacists and opticians
Social care teams
NHS therapists and community teams
Other public services e.g. schools & housing providers
Voluntary, community and social enterprise sector

Our leadership team comprises chief officers leading our key organisational functions and place-based leads overseeing health and social care integration in our 10 localities (information as of 31 March 2026):



In March 2023, we published our first five-year strategy for the Integrated Care Partnership.

Our vision

As partners in Greater Manchester, we share the overarching Greater Manchester Strategy (GMS) vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer, more prosperous city-region.

Specifically, we as an integrated care system want to see a Greater Manchester where:

- Everyone has an opportunity to live a good life
- Everyone has improved health and wellbeing
- Everyone experiences high quality care and support where and when they need it
- Health and care services are integrated and sustainable prosperous city-region

To achieve these outcomes, we will:

- Ensure our children and young people have a good start in life
- Support good work and employment and ensure we have a sustainable workforce
- Play a full part in tackling poverty and long-standing inequalities
- Help to secure a greener Greater Manchester with places that support healthy and active lives
- Help individuals, families and communities feel more confident in managing their own health
- Make continuous improvements in access, quality, and experience – and reduce unwarranted variation
- Use technology and innovation to improve care for all
- Ensure all our people and services continue to recover from the effects of the COVID-19 pandemic as effectively and fairly as possible
- Manage public money well to achieve our objectives
- Build trust and collaboration between partners to work in a more integrated way

Embedding the Greater Manchester model for health

Our Model for Health sets out how we will work together, with our communities, to enable the conditions for good lives, prevent poor health and ensure support is available before crises

occur and to provide consistent and high-quality care wherever it is accessed. This is a social model for health, rather than a predominantly medical one, so focuses on the role of people and communities as well as health and care services.

Acting on our missions

Our strategy sets out the following missions, which are our priority actions in response to the current challenges:

- Strengthening our communities
- Helping people get into, and stay in, good work
- Recovering core NHS and care services
- Helping people stay well and detecting illness earlier
- Supporting our workforce and our carers
- Achieving financial sustainability

We are delivering our Integrated Care Partnership Strategy in highly challenging circumstances for the NHS. To make sure that we had the right plan to meet the extent of the challenge, we developed the Sustainability Plan for NHS GM – which was approved by our Board in September 2024.

The Sustainability Plan sets out how the GM system both returns to financial balance through addressing the underlying deficit and secures a sustainable future through addressing future demand growth and implementing new models of care.

The Plan identified five aspects of sustainability that we need to pursue: the 'pillars' of sustainability (see below) are interdependent and do not exist in isolation.

NHS Reform and transition

During 2025/26, NHS Greater Manchester (NHS GM) led a significant programme of NHS

reform and organisational transition in response to national direction on the future role, purpose and operating model of Integrated Care Boards. This work was undertaken in an exceptionally challenging context, alongside sustained operational pressure, financial constraint and the need to maintain grip on system performance, while preparing the organisation and system partners for substantial change.

The NHS Reform and Transition Programme provided the framework through which NHS GM responded to the **Model ICB Blueprint**, re-defined its role as a strategic commissioner, and designed a future operating model capable of supporting delivery of national priorities, financial sustainability and improved population health outcomes for Greater Manchester.

Responding to the Model ICB Blueprint

Following publication of the Model ICB Blueprint, NHS GM undertook an early and structured assessment of the implications for its role, responsibilities and organisational configuration. This initial response focused on understanding the scale of change required, particularly the shift towards a more focused strategic commissioning role, the reduction in running costs, and the expectation that delivery activity would increasingly be undertaken through providers, places and collaborative arrangements.

The Board received regular updates and assurance during 2025/26 on the implications of the Blueprint, including risks to delivery, capacity and capability, and agreed that NHS GM would pursue a proactive, system-led approach to implementation, aligned to the Greater Manchester Integrated Care Strategy and the Sustainability Plan approved in September 2024.

Collaborative design and engagement

A formal design phase was undertaken throughout quarter 2 and 3 of 2025/26 to shape the future operating model for NHS GM. This phase was characterised by extensive engagement with staff, trade unions and system partners. The design approach was underpinned by a commitment to transparency, collaboration and co-production, recognising that successful reform would depend on collective ownership and understanding.

Staff and stakeholders were actively involved in shaping proposals through workshops, engagement sessions and structured feedback opportunities. This engagement informed both the design of the operating model and the approach to workforce change, and helped surface

key risks, dependencies and enablers for transition.

Development of a new organisational Operating Model

The design and engagement activity culminated in the development of a new organisational operating model for NHS GM, which was formally engaged upon with staff and stakeholders during November and December 2025. The operating model reflects the strategic intent of the Model ICB Blueprint and sets out how NHS GM will operate as a leaner, more focused strategic commissioner.

Key principles of the operating model include clarity of accountability, strengthened strategic commissioning capability, a clear principle of matrix working across the organisation and system, and greater use of collaborative and place-based arrangements to support population health improvement and service transformation.

Key elements of the Operating Model

The new operating model introduces several core changes designed to support delivery of national and local priorities:

1. **New financial approaches to support left shift**, including redesigned financial flows intended to enable earlier intervention, prevention and community-based models of care, and to support a reduction in avoidable demand for acute services.
2. **Strengthened place partnerships**, with a renewed focus on neighbourhood health and place-based delivery, enabling closer alignment between local government, NHS providers, primary care, the VCFSE sector and communities to improve outcomes and reduce inequalities.
3. **A clearer strategic commissioning cycle**, linking population health intelligence, prioritisation, design, resource allocation, oversight and learning, supported by streamlined governance arrangements.

System and regional collaboration

Alongside internal reform, NHS GM worked closely with other North West ICBs and the NHS England regional team during 2025/26 to identify opportunities to reduce duplication and scale delivery through ‘do once’ functions. This collaborative work recognised the benefits of shared

approaches where appropriate, while retaining local accountability for outcomes.

A key component of this collaboration was agreement on how to respond to the requirement to establish a new **Office for Pan-ICB Commissioning (OPIC)**, working across ICBs within the North West. During 2025/26, NHS GM contributed to the design of OPIC, with agreement that it will operate in shadow form during 2026/27, providing a platform for shared commissioning activity for defined functions and services.

Workforce change and operating cost reduction

Delivery of the Model ICB Blueprint required NHS GM to implement significant workforce change to achieve the required reduction in running costs. In November 2025, collective consultation was launched with new workforce structures aligned to the future operating model published for feedback from staff and trade unions in January 2026 and confirmed as final in March 2026.

A clear commitment was made to a **people-first approach**, with voluntary redundancy (VR) used as the primary mechanism for achieving organisational right-sizing and mitigating the need for compulsory redundancy. Two voluntary redundancy windows were delivered during quarter 3 and quarter 4, supported by enhanced workforce support, including careers advice, redeployment support and access to system-wide opportunities.

The Remuneration Committee and Board received regular assurance on the fairness, transparency and governance of these processes, ensuring alignment with organisational values, statutory requirements and best practice.

Board assurance and risk

During quarter 4, the Board provided formal assurance to NHS England that NHS Greater Manchester is capable of delivering the requirements of the Model ICB Blueprint. This assurance was given with clear acknowledgement of the **significant risks** associated with the scale and pace of change, particularly in relation to capacity, workforce resilience and the need to maintain operational delivery during transition.

NHS Reform remained a principal strategic risk on the Board Assurance Framework throughout the year, with mitigations focused on strong programme governance, phased implementation, engagement, and the development of transitional arrangements to manage risk into 2026/27.

Supporting organisational development and transition

Recognising that successful transition depends not only on structure, but on culture, capability and leadership, NHS GM developed a two-year Organisational Development (OD) plan to support the move to the new operating arrangements. The OD plan focuses on leadership development, culture and behaviours, ways of working, and supporting staff through change, ensuring that the organisation remains resilient, inclusive and effective during and beyond transition.

Performance analysis

Ensuring and driving quality, performance and improvement

In April 2025, a new NHS Oversight Framework (NOF) was published. The new framework builds upon the core principles of the previous framework, such as segmentation, but describes a more consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The main changes from 2024 / 25 are;

1. **A new objective and transparent approach to segmentation**: The existing judgement-based approach where regions allocate segments depending on support needs is replaced with 6 domains consisting of:

    - scoring metrics (focused on delivery priorities for 2025/26) and
    - contextual metrics which do not influence segmentation

2. **Clearer roles:** which align with the model ICB blueprint including an illustrative example
3. **Leadership capability assessments**: conducted alongside segmentation to inform NHS England's oversight response but will not influence scoring
4. **Financial override**: financial reset for 2025/26 is a priority, therefore segments 1 and 2 are limited to organisations achieving financial stability
5. **Incentives, consequences and performance improvement**: with high performers sharing good practice and receiving autonomy and poorer performers receiving more

intensive support from the provider improvement programme

All segmentations will be published, and this will include **“league tables”.**

Overview of the revised approach:

Scoring

Organisations will be measured based on their performance in metrics aligned to six domains which draw from ICS purposes;

- Access to services
- Effectiveness and experience of care
- Patient safety
- People and workforce
- Finance and Productivity
- Improving health and reducing inequality

Any organisation in financial deficit will be limited to a segment of 3 (but could be placed in 4 or 5).

Segmentation

- NHS England will segment providers into segments 1–5.
- The scoring process will give an outcome of a segment between 1 and 4
- The capability of organisations placed in segment 4 will be considered alongside their capability rating.
- Where capability and segment are low, they will be placed in segment 5.
- Providers in Segment 5 are considered our most challenged and will enter the Provider Improvement Programme which replaces the Recovery Support Programme.

Response

- NHS England’s response will account for the capability of the provider to improve
- High performing organisations in segment 1 may receive greater autonomy and will be expected to support others.
- NHS England will work with them to share learning and good practice.

- Organisations in segments 3 and 4 will receive greater scrutiny and interventions.
- Organisations in segment 5 will receive targeted support based on their needs
- Segments will be reviewed quarterly or when new information comes to light.

Performance monitoring

Providers

Throughout 2025/26, NHS GM and regional teams have worked together on providing oversight of NHS providers, assessing delivery against priority areas / NOF / Operational Plans and supporting improvement.

Trusts will develop actions plans and trajectories to recover their respective indicators for agreement with NHS GM. These plans are improvement focused and involve support from the ICB and other partners as appropriate.

The governance arrangements between NHS GM and Trusts are determined on an organisation-by-organisation basis based upon the type and materiality of risk. The key feature of our provider oversight model is three levels of meetings;

- **Level one - standard contract review meetings (CRM).** Cover the full scope of commissioned services and monitor achievement of all planning objectives, seeking action plans where any aspect of delivery is not in line with the plan. Meetings are focused on delivery of the contract in terms of outputs and outcomes. If there are any formal contract notices in place they are overseen by the contract meeting.
- **Level two - escalation meetings**. These are to address issues which have not been resolved through the contracting meeting; where there are immediate and material concerns; or where improvement in performance has not been demonstrated in accordance with the escalation framework. Both the contract meeting, the provider oversight meeting, ICB Chief Officers or a provider can request establishment of escalation meetings.
- **Level three - provider oversight meetings (POM).** These are the most senior point of escalation. They will also act a means of strategic engagement focused upon provider delivery, governance and system working. They will take a forward look at key delivery issues. The POM may choose to escalate provider risks to NHS England. NHSE will join POMs where appropriate.

ICB and regional teams have supported our providers, leading and coordinating improvement programmes.

In relation to segmentation, as at the end of Quarter 2 2025 / 26, of the 9 provider trusts;

- One was in Segment 1
- Five were in segment 3
- Three were in Segment 4

ICB's

ICB's were excluded from assessment against the new framework in 2025 / 26 as it was felt that there was already significant change for ICBs as they transform in line with the Model ICB Blueprint to focus on strategic commissioning and implement plans to meet the running cost reductions.

Consequently, the focus for 2025/26 has been on improving performance against the priority measures highlighted as part of undertakings as well as continuing to improve against the delivery metrics set out in the Planning Framework and NHS Contract.

Priority metrics

Key highlights against the priority metrics included in the undertaking process include:

- **Proportion of patients receiving a faster diagnosis of cancer within 28 days:** March 26 position is 82.1%, a +1.9% point change compared to March 2025 (80.2%). NHS GM is ranked 12th out of 42 nationally.
- **Proportion of patients receiving treatment within 62 days:** March 2026 position is 78.2%, a +6.7%-point change compared to March 2025 (71.5%). NHS GM is currently ranked 8th out of 42, nationally.
- **Number of patients waiting over 65 weeks for first definitive treatment:** the number of patients waiting over 65 weeks was 29 in March 2026, a reduction from 177 in March 2025 (84% reduction). The number of open 65-week pathways is 0.007% of the total waiting list, ranking NHS GM 7th out of 42, nationally.
- **Number of patients waiting over 52 weeks for first definitive treatment:** the number of patients waiting over 52 weeks was 5,763 in March 2026, a reduction from 15,147 (62%) in March 2025 (ICB position). The number of open 52-week pathways is 1.4% of

the total waiting list, ranking NHS GM 30th out of 42, nationally.

- **% of incomplete RTT pathways of 18 weeks or less:** the proportion of patients on the waiting list for treatment who had been waiting less than 18 weeks in March 26 was 63.8% an improvement from 55% in March 2025, ranking NHS GM 30th out of 42, nationally.
- **% of pathways waiting no longer than 18 weeks for a first appointment**: the proportion of patients who waited no longer than 18 weeks for a 1st appointment was 68.4% in March 2026, an improvement from 58% in March 2025.
- **Overall RTT waiting list size**; the overall RTT waiting list size was 402,771 in March 2026, a reduction from 432,101 in March 2025 (6.8%).
- **Proportion of patients waiting six weeks for a diagnostic test:** the proportion of patients waiting six weeks or more for a diagnostic test decreased from 10.5% in March 2025 to 10.2% in March 26. In the latest published data, NHS GM ranked 4th out of 42 nationally, a significant improvement from the same period in 2024, when it was ranked 20th.
- **Average response time for category 2 ambulance calls:** at the end of March 26, the year-to-date performance was 23 minutes and 29 seconds, better than the 30-minute operational target
- **Proportion of patients waiting less than 4 hours in A&E:** March 2026 position is 73.4%, a +3.2% point change compared to March 2025 (70.2%). NHS GM is currently ranked 28th out of 42 nationally, which is an improvement from the same period last year when it ranked 32nd out of 42.
- **Proportion of Type 1 patients waiting more than 12 hours in A&E:** 8.8% of patients waited more than 12 hours in A+E in March 2026, an improvement from 9.5% in March 2025. NHS GM is currently ranked 18th out of 42 nationally, which is a deterioration from the same period last year (16th).
- **Number of patients with a mental health condition in an inappropriate out of area placements:** significant improvement across the year falling from 19 from 1st April 2025 to 3 at end of March 26. Better than operational plan of 7
- **Average Length of Stay in Adult Acute, Older Adult Acute and Psychiatric Intensive Care beds: improvement** across the year falling from 73 days in March 2025 to 68.4 at the end of March 2026 – a 6.3% reduction.
- **Number of women accessing specialist community perinatal services:** as of March 26, 2,875 women accessed perinatal MH services, below year end plan of 3,131

Learning Difficulties (LD) / Autism inpatients: Inpatient numbers for children and young people and for adults with a learning disability (who may also be autistic) have reduced in line with plan; however, inpatient numbers for autistic adults without a learning disability remain above plan. Key highlights in other areas include:

- **Community Services waiting lists –** the number of people on the community services waiting list has risen from 53,639 in March2025 to 60,964 in March 2026. The number of people waiting more than 52 weeks has reduced by 67% between March 2025 and March 2026, falling from 1,334 to 445. Currently 85% of people are under 18 weeks, which is ahead of the soon-to-be introduced target for 2026 / 27 of 78%.
- **Urgent community response:** data forthe end of December 2025 shows referrals achie ving the 2-hour standard was 87.5%, better than the 70% national standard and England Average of 85.4%. NHS GM is ranked 19th out of 42 nationally.
- **Availability of GP appointments:** access has improved, with average monthly GP appointments increasing from 1.42 million in 2024/25 to 1.45 million in 2025/26. This is a year-on-year increase of 1.7%.
- **% of patients with hypertension treated according to NICE guidance**: the proportion of patients with hypertension treated to NICE guidance was 70.2% in Quarter 3 2025 / 26, an improvement from 67.7% in Quarter 3 2024 / 25.
- **% of patients with GP recorded CVD, who have their cholesterol levels, managed to NICE guidelines:** the proportion of patients with managed cholesterol levels was 52.3% in Quarter 3 2025 / 26, an improvement from 49.9% in Quarter 3 2024 / 25.
- **Access to dental services:** Access levels to dental services continue to improve. In the 24 months leading up to March 2026, 1,127,126 adults were seen, this represents 48.5% of the adult population. In the 24 months leading up to March 2026, 505,848 children were seen, this represents 73.9% of the child population
- **Dementia diagnosis rate:** As of March26, the dementia diagnosis rate was 73.9%, ahe ad of the local target of 73% and national target of 66.7%. NHS GM is ranked 3rd out of 42 nationally.
- **Access to children and young people (CYP) mental health services:** as of March 2026, the number of CYP receiving at least one co ntact was 56,370, better than the 2025/26 target of 55,000
- **SMI health check:** in December 2025, 62% of people with Severe Mental Illness (SMI) received a physical health check above the 2025/26 plan of 60%.
- **Babies born healthy:** 14 less stillbirths in 2025 and 25 less babies born with a brain

injury this year than 2 years ago

Performance challenges and improvement

GM has several performance challenges, some of which are a legacy from the COVID-19 pandemic. During this time, elective activity reduced and waiting lists for diagnostic tests and procedures increased as a result. There are also challenges with meeting the national cancer standards as demand for cancer services recovered and exceeded pre-pandemic levels.

As usual, the Urgent Care System was tested over winter and demand for health and care services significantly increased. Mental Health Out of Area placements were still stubbornly high at the beginning of the year and a key focus for action. This year there were additional pressures with peaks in flu activity, demand for children's services and industrial action.

GM has established a set of key programme areas to address its performance challenges and provide improvement support to GM providers where required. A summary of the key programme area follows, highlighting progress against key indicators and noting key achievements in 25/26.

Elective care

Overview and referral to treatment time (RTT) impact

During 2025 to 2026, the GM Elective Recovery and Reform Programme delivered a coordinated, system-wide response to sustained RTT pressure, combining targeted long-waiter clearance, productivity improvement and elective reform across providers. The programme focused on RTT performance, mobilised system funding and capacity, strengthened access and validation disciplines, and accelerated priority reforms including Advice and Guidance, surgical hubs and pathway standardisation.

RTT performance improved across the year, with 18-week performance increasing from 53.8% in March 2025 to 62.2% by March 2026, exceeding the 61.0% plan. Greater Manchester also delivered a significant reduction in long waits, maintaining low numbers of 65-week waiters and reducing 52-week waits from 18,000 to 6,700 over the same period. Key programme inputs and outcomes.

Targeted capacity and pathway delivery

Elective delivery was strengthened through focused use of protected elective capacity, particularly via the Surgical Hubs. A test of change at Leigh Surgical Hub to create paediatric operating lists meant paediatric surgery returned to Leigh for the first time in 30 years and enabled treatment of additional children across high-pressure specialties, contributing to improved access in ENT and paediatric dentistry. Trust activity for these specialties increased 15% year on year. Separately, additional capacity to treat cataract and hernia patients has been created, with a test of change single point of access for hernia patients to the west of the city meaning patients in Bury, Bolton and Wigan now have direct access to the surgical hub capacity at Leigh.

Waiting list validation and list size reduction

Significant system effort was directed toward improving waiting list accuracy. Supported by the national validation sprint an additional 17,000 pathways have been reviewed and closed compared with the previous year, contributing directly to reductions in overall waiting list size. The programme also piloted the use of automated chatbot technology to support validation activity of over 45,000 pathways, delivered in partnership with Midlands & Lancashire CSU. This approach improved the efficiency of validation activity and enabled Trust teams to focus capacity on patients who still required care.

Access consistency and referral quality

A system-wide approach to patient access was established through the agreement of a single Greater Manchester Access Policy, supported by standardised RTT and customer care training and shared key performance indicators. This work improved fairness and consistency in the application of RTT rules and underpinned more equitable access for patients across providers.

In parallel, the General Practice Elective Quality Improvement Scheme achieved near-universal engagement from practices, strengthening referral quality, increasing use of Advice and Guidance, and supporting diversion to appropriate community pathways, preventing long waits and contributed to better demand management upstream of secondary care.

Advice and guidance and clinical validation

Advice and Guidance was embedded as a core elective recovery lever through the launch of a pan-Greater Manchester service utilising Consultant Connect, enabling rapid specialist advice

and reducing avoidable referrals. Early usage demonstrates strong clinical adoption with requests for advice increasing 25% each month from launch in October through to the latest position in January, alongside this 90% of GP practices have now signed up to the platform.

The Clinical Validation Trial further showed the potential of specialist advice and enhanced community (Tier 2) services to reduce waiting lists, with clear opportunities identified to manage patients outside acute pathways. Learning from this work is now shaping system-wide approaches to specialist advice, community provision and referral management.

System productivity and theatre utilisation

Programme focus on theatre productivity delivered improved system oversight through a Greater Manchester theatres dashboard, enabling targeted improvement and sharing of best practice. Capital investment exceeding £6 million was secured to support theatre infrastructure, equipment replacement and technology adoption (such as Robot technology), strengthening elective efficiency, capacity and resilience.

Priorities for 2026 to 2027

Building on delivery and learning from 2025/2026, the programme will increasingly focus on transformation and demand management to support sustained RTT improvement. Key priorities include:

- Implementation of Single Point of Access alongside specialist advice to optimise patient pathways from the point of referral into secondary care – this includes the implementation of straight-to-test pathways and optimisation of Community Diagnostic Centres
- Development of Tier 2 community services and linking these to the single point of access to support direct to community pathways
- Expanding the direct to hub pilot from hernia to Leigh to other procedures and localities across GM
- Continued focus on appropriate deployment of RTT best practice, including regular waiting list validation and review These workstreams directly address the underlying drivers of RTT pressure and will form the core of the 2026 to 2027 Elective Recovery and Reform Programme as we focus on the return to NHS constitutional standards by 2029.

Diagnostics

Actions in 2025/26

The Diagnostic Network have been focused on the national targets within the operational plan and NHS Oversight Framework – these are the 6 weeks wait (6ww) target, achieving activity plans, driving improved productivity via both the digital programme, and through operational improvement initiatives, ensuring diagnostics activity is focused on supporting the elective and cancer programmes.

The system-wide approach to support this has included:

- Focus on reducing DNAs and delayed surveillance patients through close working with Trust operational teams – identifying best practice, support with operational improvement, enhancements in reporting.
- Improving the data quality of Greater Manchester's Waiting List Minimum Data Set (WLMDS), which is the national weekly data source for diagnostics. These improvements give the system a more accurate weekly dataset to support real-time performance improvement and management at system level, support shared capacity and planning discussions, and inform decision making around resource allocation.
- Ensuring capital programmes are focused on areas of greatest impact on 6wws and productivity improvements, in addition to the replacement of old equipment and, where possible, increasing capacity in challenged modalities
- Maximising the benefits of the THRIVE productivity tool within Endoscopy to target utilisation, DNAs, turnaround times with expansion into other modalities.
- Development of a new reporting dashboard - GM Diagnostics Reporting and Monitoring System (DiagRaMS) for diagnostics including waiting times and backlogs, weekly data, surveillance patients, productivity measures and pathology turnaround times.

Imaging

- Successful implementation of expansion of GP requesting portfolios to include MR Brain, with the development of a new pathway plus CT Thorax , Abdomen and Pelvis plus the deployment of the software associated with the Royal College of Radiologists (RCR) referral guidelines called ' IRefer' which is a clinical decision support tool to guide physicians to the most appropriate imaging examination, this has and is being delivered

to primary care services for 3 organisations in project scope within GM (NCA, MFT and WWL); others may follow in the next financial year.

- Successful implementation of a ‘shared capacity’ scheme between two GM member organisations for Non obstetric ultrasound. This scheme overcame technical and financial barriers to ensure completion.
- RIS (Radiology information system), re-procurement group set up to explore the possible options for a new GM wide RIS system.
- Successful sub-modality groups now in operation reporting to the GM Radiology Operations group, purpose to problem solve and share best practice for improved service delivery.
- Network, in partnership with University of Salford, helped coordinate stakeholder event to help co-design future courses at the university.
- Network partnerships with the North-West England Imaging academy with coordinated NHSE funding for upskilling and development of radiology staff, highest number of reporting radiographers’ trainees in NW.
- Undertaken a deep dive in ultrasound workforce, findings with recommendations now being actioned.
- Undertaken comprehensive deep dive into insourcing and outsourcing providing essential intelligence to inform future actions aimed at reducing outsourcing costs and improving system resilience.
- GM imaging workforce strategy re-written and up to date
- Successfully launched the new NW PACS Portal replacing the legacy system and enabling colleagues from 17 trusts across the Northwest to access GM Sectra PACS images and reports.

Physiological sciences

- Completed a system-wide review of sleep study services, achieving a 100% data collection response rate, which identified key challenges in referral pathways and enabled targeted support to trusts.
- Delivered a full programme of assurance visits for all GM trusts as part of the national paediatric audiology quality assurance programme which has led to an agreed assurance status.
- Conducted an ECHO pro-BNP audit demonstrating that all participating trusts now mandate pro-BNP results for ECHO referrals. A follow-up audit shows a substantial

reduction in inappropriate referrals, improving clinical quality and triage efficiency.

- Secured funding for system-wide implementation of the THRIVE productivity tool within echocardiology and sleep services at three trusts. This initiative enhances visibility of productivity, list utilisation, and DNA rates, and has attracted regional and national recognition.
- Delivered a GM-wide suite of careers videos for all physiological science disciplines, now actively shared across GM, regional, and national networks.

Pathology

- Delivered a GM-wide pilot introducing rapid MT-RNR1 genetic testing for newborns requiring urgent antibiotic treatment for suspected sepsis.
- Developed standardised validation processes and a POCT device procurement guide for use across GM, reducing validation times and prevented inappropriate device purchases, improving governance and reducing waste.
- Continued the rollout of digital pathology, with four GM sites now clinically live.
- Advanced implementation of the new Clinisys WinPath LIMS across GM, achieving several major go-lives including Bolton, Stockport (partial), NCA sites, and sustained progress at Tameside.
- Secured over £5m investment into histopathology automation at multiple trusts, modernising key sample workflows and strengthening future turnaround time performance.
- Agreed standardised PQAD histopathology metric definitions across GM, improving comparability and system assurance.
- Completed a blood sciences send-away review, identifying opportunities to repatriate test volumes and reduce out-of-area spend.
- Continued rollout of Profiler Live, now live at two sites, improving the quality and consistency of staff training and competency management.
- Delivered a highly successful student recruitment event—the second consecutive year - resulting in 34 students securing placements, an increase from the previous year.

Community Diagnostic Centres (CDC)

- Implementation of a ‘CDC First’ policy to ensure any available CDC capacity is fully utilised to support challenged performance – through the development of a CDC First

Opportunity Tool to identify cohorts of patients who would benefit from having their test moved to a closer site with lower waiting times.

- 6 of the 7 CDC sites are now fully open and delivering activity for our patients.
- For 25/26 we planned to deliver c. 443k tests out of our CDC sites and will achieve c. 97% of that plan by year end.
- CDCs continue to evolve with development of clinical pathways and one-stop-shops to improve the patient experience - work which will continue into 26/27.
- Sustainability assessment completed which evidences CDCs in Greater Manchester to be high-performing, efficient and financially sound system assets.

Cancer

The NHS England cancer programme issues annual guidance for the 20 Cancer Alliances in England which provides structure to Cancer Alliance delivery and therefore ICB plans for cancer service improvement, transformation and oversight.

The Cancer Alliance has 12 clinically led pathway boards who develop and deliver comprehensive annual work programmes aligned with the national cancer planning guidance and Greater Manchester population needs. These boards have system-wide membership and engagement across NHS and non-NHS organisations, including representation from many staff groups and with patient/carer involvement, working collaboratively to improve patient outcomes and experience. Focus is on the following thematic areas:

- Early diagnosis
- Faster diagnosis, operational performance and treatment variation
- Personalised care and experience of care
- Workforce and education

The work programmes are available to view on the Greater Manchester Cancer Alliance website: https://gmcancer.org.uk/

Actions in 2025/26

Greater Manchester Cancer Alliance is one of 20 Cancer Alliances in England, working in collaboration with organisations across GM to help people get diagnosed earlier, provide better treatment and support people to live well with and beyond cancer. In 2025-6 the Alliance have

focused on the delivery of a range of system-wide programmes of work to deliver against the targets in the national cancer planning guidance.

Early diagnosis and primary care

The national expectation is that more people have their cancer diagnosed at an early stage – stage 1 or 2. The standard set in the Long-Term Plan in 2019 was that 75% of cancers should be diagnosed at this stage. At the time of writing this report the latest data shows the level in Greater Manchester as 60.5%, 1.0% above the England average position of 59.5%. In early 2025, the Cancer Alliance published the Greater Manchester Early Cancer Diagnosis strategy, with the following vision:

Our vision for the people of Greater Manchester is a future where everyone with cancer receives equitable and timely early diagnosis. By raising public awareness, reducing health inequalities, and fostering collaboration and innovation, we aim for continuous improvement in the proportion of cancers diagnosed at an early stage.

Successes in 2025-6 have included:

- The launch of the Get Cancer Clever campaign and community outreach project, taking messages about cancer signs and symptoms into the parts of Greater Manchester where cancer late-stage diagnosis is highest.
- Roll out of the Lung Cancer Screening programme in GM, completing 75,000 lung health checks and 51,000 CT scans, diagnosing 425 lung cancers (80% early stage)
- Achievement of the national standard for the completion for FIT (Faecal Immunochemical Tests) in primary care – reaching 80% compliance before the end of Q3
- Delivery of early cancer diagnosis improvement plans in 95% of the Primary Care Networks in Greater Manchester, supporting delivery of the nationally commissioned Early Cancer Diagnosis Directed Enhanced Service.
- Delivery of an ovarian cancer awareness community outreach project in conjunction with the Diane Oxberry Trust and Target Ovarian Cancer.
- Heartburn Health Check provided capsule sponge to patients at highest risk of Barrett's oesophagus in the community. 60% of practices across GM actively participated in the project. Of those patients who completed the capsule sponge procedure, 75% had normal results and 25% had an abnormal result. This shows that a targeted approach to

identifying patients at highest risk of Barrett's Oesophagus increases the rate of-abnormal results. 3% of patients required investigation under the suspected cancer pathway.

- The Cancer Alliance was successful with an application to participate in the NHSE pancreatic cancer case finding pilot. The pilot went live in Greater Manchester in November 2025 across 6 PCNs, with a 7th PCN joining the pilot in April 2026
- GM's lung cancer symptom validation and patient activation tool, LungAware, has had 30,000 site visits since going live in November 2024 and has recently been shortlisted for 3 HSJ Partnership/Digital awards.

Operational performance and faster diagnosis

Cancer Alliances are required to develop and deliver an Operational Performance Improvement Plan which will contribute to an improvement in Cancer Waiting Times performance across the three standards: 28 days Faster Diagnosis, 31-day Decision to Treat to Treatment, and 62-day Urgent Referral to First Treatment Standards.

For 25/26, the national focus was on achieving the faster diagnosis standard by March 2026. Four priority pathways were identified which contribute high breach volumes and show significant local variation in performance. Some of these pathways also experience low 62-day performance, with poor FDS performance among patients who are diagnosed with cancer being a primary driver. As in 24/25, each priority pathways has a core intervention focused on where the case for change in strongest, alongside improvement focused on the lowest performing providers. Reducing the FDS gap between those who have cancer ruled out and those who are diagnosed with cancer was a new focus for 25/26.

Successes in 2025-6 for operational performance included:

- Completed 12-month breach reviews across prostate, bladder, head & neck and gynaecology, identifying pathway variation and setting targeted improvement actions for the next year.
- Implemented a Straight-to-Test gynaecology pathway at NCA, now expanded to Bolton and MFT, improving diagnostic timeliness and reducing unnecessary clinic steps.
- Developed a PMB self-referral tool for launch at NCA, enabling direct patient access into the gynaecology pathway and reducing delays to investigation.
- Ongoing collaborative work with the diagnostics programme to implement IOTA across

trusts, standardising gynaecology ultrasound reporting to improve patient experience and reduce duplication in the pathway.

- Rollout of training for non-medical LATP biopsy across all Trusts.
- Funded and supported the set up and delivery of the OG one stop model.
- Developed a GM pathway for Lung Small Cell patients to speed up diagnosis and subsequent treatment of small cell lung cancer which is a rapidly progressing cancer.
- Funded and supported the delivery of the Prostate AI pilot at hospitals in Wigan, Bolton, Stockport and Salford. The AI tool analyses prostate MRI scans using validated NHS data and flags scans that are most likely to show cancer, allowing radiologists to prioritise patients at highest risk.
- Supported the rollout of tele-dermatology across GM and delivered the evaluation of the AI pilots to inform the GM ICB Dermatology Board on next steps.
- Upkeep and training when requested on suite of curator dashboards used by Trusts and ICB to track cancer performance (50 different dashboards all with individual pages/views).
- Greater Manchester has pioneered ‘single queue diagnostics’ (SQD). The approach uses technology to identify the earliest appointment times across multiple providers, and to offer real-time booking into diagnostic tests. Building on this success, this approach is referenced in the NHS Cancer Plan as something which will be introduced across the NHS in 2026-7.

Personalised care

The national planning guidance ‘deliverables’ for cancer and personalised care for 2025-6 were: to embed personalised care interventions and Personalised Stratified Follow Up pathways; to deliver co-produced plans for psycho-social support, cancer prehabilitation and behaviour change.

Successes in 2025-6 for Personalised Care and cancer included:

Personalised care / live well with cancer

- Creation of a Health and Wellbeing Hub offering a range of resources and support services for individuals living with cancer and their families.
- Development of multiple animations covering psychosexual support, tumour-specific advice, and practical topics such as managing money.

- Creation of a multi-disciplinary steering group to improve prehabilitation/rehabilitation pathways and widen provision of physical activity, nutrition, and behaviour-change support.
- Development of a project with Prehab4Cancer and leisure centre colleagues to upskill exercise professionals to deliver rehabilitation in neighbourhood settings, increasing capacity within Prehab4Cancer prehabilitation teams.
- Creation of a service specification for inclusion in Trust contracts, enabling self-monitoring of holistic support performance via a locally developed dashboard.
- Co-production of a revised secondary care treatment summary to make it more primary-care-friendly and accessible for patients, enabling greater self-management.
- Worked with the national team on the transition to a nationally funded Digital Remote Monitoring System (DRMS) for patients on stratified follow-up pathways.

Genomics

- Genomics event for 200+ attendees, highlighting how genomic testing is being integrated into cancer care and improving earlier, fairer, and more personalised diagnosis and treatment.
- Mainstreaming and embedding of genomic and genetic (germline and somatic) testing pathways in line with the National Test Directory using a whole-system approach.

Psychological support and mental health

- Launch of an expedited talking therapies pathway for people affected by cancer in partnership with GMMH.
- Implemented associated staff supervision and education to support the wider system.

Cross cutting work programmes

The Cancer Alliance have 11 clinically led Pathway Boards who lead work across the cancer pathway for the following tumour sites:

- Brain & CNS
- Breast
- Colorectal (Lower GI)
- Gynaecology

- Haematology
- Head & neck
- Hepato Pancreatic Biliary
- Lung
- Oesophago-gastric
- Urology
- Skin

In 2025-6 the Cancer Alliance saw the high-profile launch of a patient and clinically led GM **Metastatic Cancer Strategy**, becoming the first Cancer Alliance to do so. This is a system-wide plan to transform outcomes and experiences for people living with metastatic cancer. Metastatic disease accounts for most cancer deaths, yet services and information remain fragmented, and patients frequently describe feeling “invisible” compared with those treated for primary cancer. In response, Greater Manchester Cancer Alliance has developed the first dedicated metastatic cancer strategy in the country, bringing together clinicians, service leads, researchers, and people with lived experience to create a comprehensive, practical plan for change.

The strategy sets out a clear vision to:

- drive earlier recognition and diagnosis of metastatic disease across all tumour sites.
- ensure equitable, patient-centred care through every stage of the pathway.
- strengthen and educate the multi-professional workforce, supporting lifelong learning and up-to-date practice across all care settings.
- embed innovation and data-driven improvement across our cancer system.

During August and September 2025, the Greater Manchester Cancer Alliance, with support from The Christie NHS Foundation Trust and the Urgent and Emergency Care Board, presented the Greater Manchester 5-Year **Acute Oncology** Transformation Plan to Provider Executive Groups. The initial paper described the growing demand for urgent and emergency cancer care and how a strengthened and more equitable acute oncology service could provide higher quality care through more efficient processes.

Urgent and emergency care (UEC)

During 2025/26, NHS GM continued to operate in a highly challenging UEC environment.

Demand remained high and volatile, workforce pressures persisted, and capacity constraints across the wider health and care system continued to impact flow. However, compared to 2024/25, the system entered 2025/26 with greater organisational grip, more mature system governance, and clearer alignment around shared priorities, enabling a more coordinated and resilient response to pressure.

While UEC performance continued to reflect systemic pressures across primary care, community services, mental health and adult social care, the year marked a shift from reactive stabilisation towards more deliberate consolidation and recovery. In contrast to 2024/25, when delivery was characterised by rapid mitigation and crisis response, 2025/26 focused on embedding agreed models, strengthening accountability, and improving system reliability.

GM UEC governance model

The GM governance model for UEC underwent significant strengthening and restructuring throughout 2025/26, driven by national UEC priorities, system-wide performance challenges, and the move toward a more unified, accountable operating model.

2025/26 saw the introduction of a new GM UEC Reform Board, established to provide strategic leadership and align GM UEC transformation with NHS England's national reform programmes. It is described as shaping and overseeing a single system plan, driving system-wide improvement, and ensuring alignment with GM's strategic vision. It formally sits within the GM ICS governance structure, replacing earlier fragmented arrangements and bringing together system partners to deliver improved UEC pathways and standards of care. This represented a key shift from operational oversight toward strategic system-wide accountability.

Then saw the formation of the GM UEC Development Group alongside the Reform Board, a new GM UEC Development Group was established as the "engine room" for service development, tasked with delivering priorities set by the GM UEC Reform Board and scaling learning across GM. The governance model also expanded to include dedicated pillar groups such as the Integrated Care Co-ordination Steering Group and Hospital Handover Improvement Group to tackle priority issues like flow, handover delays, and coordination across pathways.

Additionally, the GM UEC Provider Oversight meetings have become an important part of NHS GM's assurance and delivery framework, operating for more than a year to provide consistent, system-wide scrutiny of improvement and operational plans. These meetings bring together NHS providers and locality leadership to share intelligence, escalate risks, and provide

assurance on the delivery of each organisation's improvement and operational plan. They allow collectively to identify common issues and ensure alignment with regional and national expectations.

Delivery throughout the year was structured around four connected priorities, aligned to national expectations: Integrated Care co-ordination, Handover 45, improving the whole pathway flow, and diverting avoidable demand. These priorities remained consistent with 2024/25 but were pursued in 2025/26 with greater consistency, system ownership and collective delivery.

In addition to the above, to further strengthen operational winter management across GM, NHS GM introduced the Greater Manchester Escalation Framework 2025/26, designed to enable timely, coordinated, and proportionate responses to rising system pressures. The framework sets out clearly defined roles, responsibilities, and escalation actions for staff operating at provider, locality, and Integrated Care System (ICS) levels. It is underpinned by core principles that emphasise proactive rather than reactive management, real-time data to support informed decision-making, and a tiered intervention model that empowers local leadership. Escalation is positioned as a supportive mechanism facilitating collaborative problem-solving and alignment across clinical, operational, and system leaders while embedding continuous learning and improvement across all sectors.

The model enabled NHS GM to deploy a structured three-tier command and control system, ensuring that operational (provider), tactical (pillar), and strategic (ICS) levels of response were activated appropriately as pressures escalate. When required, escalation calls were convened to bring NHS GM leaders together at the right time, enabling collective decision-making and coordinated system-wide action. This approach ensured alignment to the national Operational Pressures Escalation Levels (OPEL) Framework 2024/26 and local escalation processes, supporting consistent responses and improved system resilience throughout the winter period.

Integrated care co-ordination (ICC/SPoA)

During 2025/26, NHS GM progressed the ICC pillar as a key enabler of GM UEC reform, strengthening front-door coordination through the development of more consistent Single Point of Access arrangements and the introduction of a single telephony access route to support clinical decision-making and appropriate use of alternatives to ED. Updates via formal governance noted that the telephony model that was launched in August 2025 has expanded in use, with growing call volumes and a majority of calls resulting in diversion to non-ED

alternatives, while recognising ongoing variation between localities and the need to align workforce and capacity to sustain delivery. The programme has increasingly focused on the practical enablers required for full implementation, including capacity and demand analysis, standardisation of access routes and integration of mental health triage within the coordinated offer.

Ambulance handover: Handover 45 (release to rescue)

NHS GM implemented the 45-minute ambulance handover standard (“Handover 45”) on 1st August 2025 as part of the national Release to Rescue programme, delivered through a coordinated North West regional rollout. From the outset, the standard was positioned as a whole-system measure, recognising that delays in handover reflected wider flow pressures rather than isolated hospital-level issues.

Throughout 2025/26, GM’s approach aligned closely with regional expectations, underpinned by mature UEC governance and established multi-agency escalation frameworks, enabling the standard to be embedded more rapidly into routine operational practice.

Performance across the North West varied due to differing levels of acute, community and discharge capacity; however, GM maintained a strong focus on shared accountability between acute providers and NWAS, with both monitored against their respective contributions to handover performance. The introduction of Handover 45 supported earlier escalation, clearer executive oversight, and improved visibility of system risk, while also reinforcing the shared regional understanding that sustained improvement depends on strengthening flow, inpatient capacity and discharge processes.

By March 2026, Handover 45 had become a core operational standard across GM, with clearer system-wide ownership and closer alignment with regional governance. Although performance continued to fluctuate with demand pressures, GM’s performance exceeded regional peers. Looking ahead to 2026/27, NHS Greater Manchester will continue to mature the implementation of Handover 45 as part of its wider UEC improvement programme, with a continued emphasis on improving flow, discharge and demand management as the key enablers of sustained performance.

Alternatives to emergency departments (ED) and the expansion of admission-avoidance pathways

During 2025/26, NHS GM continued to strengthen alternatives to ED and expand admission-avoidance pathways, significantly evolving the system's capacity to safely manage patients outside acute settings. Key programmes including Urgent Community Response (UCR), Same Day Emergency Care (SDEC), Hospital@Home, and ICC collectively reduced ED attendances and mitigated non-elective growth.

Updates across the year highlight marked progress: UCR consistently achieved over 70% of patients seen within two hours, SDEC expansion prevented an estimated 6,000 ED attendances, and increased Hospital@Home utilisation avoided further admissions by offering both step-up and step-down care alternatives. The strengthened SPOA approach also reduced ED conveyances, accounting for a significant proportion of activity deflection as identified in UEC improvement forecasting models.

Across GM's ten localities, enhanced primary and community-based alternatives further supported admission avoidance. Seasonal surge capacity such as extended GP and out-of-hours services, alongside locality-led Surge Hubs improved same-day access and reduced pressure on EDs, particularly during the high-demand festive period.

Additional mental health gatekeeping strengthened clinical streaming, improved falls-prevention models, and enhanced integration through the Live Well neighbourhood approach all contributed to fewer ambulance callouts, reduced ED presentations, and more timely onward referrals to the most appropriate non-ED services. Collectively, these developments demonstrate a maturing system-wide commitment to shifting care into the community, improving patient experience, and reducing reliance on hospital admissions during 2025/26.

Improving flow across the urgent care pathway

Improving flow remained a core priority in both 2024/25 and 2025/26; however, the latter year demonstrated stronger system coordination and learning. Compared to the previous year, providers were better supported through regular system wide operational forums, enabling shared situational awareness and more coordinated responses to escalation.

During 2025/26, there was a clearer focus on reducing internal delays, strengthening same day emergency care, and improving interfaces between emergency departments and inpatient

wards. While pressures persisted, the system's ability to anticipate and manage risk improved relative to 2024/25, reducing reliance on last minute escalation measures alone.

Particular attention continued to be paid to long waits and to patients with complex needs, including mental health and frailty related presentations. Compared to 2024/25, there was greater visibility and system ownership of these risks, supported by more consistent escalation processes and senior oversight.

Discharge improvement

Compared to the previous year, there was clearer executive-level leadership of discharge at both system and place level, with stronger alignment between acute, community and local authority partners.

In 2024/25, discharge improvement activity had focused heavily on escalation and short-term mitigations during periods of acute pressure. During 2025/26, this evolved into a more structured and routine approach, with improved daily grip on discharge processes, clearer expectations around shared responsibility, and greater consistency in senior clinical engagement.

Progress was made in embedding early discharge planning, improving identification and management of patients with no criteria to reside, and strengthening coordination between hospital and community services. Although constraints in community and social care capacity continued to limit the pace of improvement, the system's ability to work collectively across organisational boundaries improved compared to 2024/25, contributing to more effective pressure management during peak periods.

Position at the end of March 2026

By the end of March 2026, NHS GM was in a stronger and more stable position than at the end of 2024/25, with clearer system-wide ownership of UEC performance, better embedded front-door integration, and more consistent approaches to discharge and flow.

However, the system was also clear that significant challenges remained in delivery. Discharge continued to be constrained by community and social care capacity, variation persisted across places in access to alternative urgent care services, and workforce pressures remained a critical risk. The progress achieved during 2025/26 provided a more robust foundation for

continued improvement, but the system entered 2026/27 recognising that sustained delivery and further transformation would be required to achieve long-term resilience.

Looking ahead

The experience of 2025/26 demonstrated that Greater Manchester's urgent and emergency care system is better placed than in previous years to respond collectively to pressure, learn from experience and progress improvement at scale. As the system moves into 2026/27, the focus remains on deepening integration, reducing unwarranted variation and continuing the shift towards prevention and early intervention.

The improvements achieved relative to 2024/25 reflect the strength of partnership working across GM and provide confidence that, while the challenge remains significant, the system is moving in a positive and sustainable direction.

Mental health

Actions in 2025/26

Adult mental health crisis and urgent care transformation

There has been a significant level of transformation in mental health crisis and urgent pathways in Greater Manchester (GM) in 2025/26. These include:

- Mental Health 111 option 2 24/7 crisis helpline established and providing a single service for GM residents – combining existing Mental Health Trust crisis helplines into a single service.
- Mental Health Urgent Triage (MHUT) service established in GM, with MH practitioners based in and operating from NWAS Emergency Operations Centre, providing telephone triage and assessment to people who dial 999 in a mental health crisis who do not need an emergency response.
- Enhanced emergency services professionals' line as part of MHUT, single point of access for police officers and ambulance crew at scene to speak to a MH professional, providing support and advice when someone presents in potential MH crisis.
- Agreement for additional investment in 24/7 Crisis Resolution and Home-Based Treatment teams as key to delivering a sustainable alternative to Emergency Departments (EDs) and resilient community-based MH services.
- Significant investment in voluntary, community, faith and social enterprise (VCFSE)

sector partners embedded in MH crisis pathways – including integrated roles in 111 and MHUT, A&E and community-based crisis spaces.

- Delivery of a GM Improvement Plan for Health Based Places of Safety in GM
- Established MH Individual Escalation Process embedded in the GM System Control Centre for people experiencing long waits in E.Ds.
- Capital bid submitted for MH EDs, to support commitment as a system to develop the future model together, driven by our improved GM datasets.
- A VCFSE navigator pilot has been undertaken in MFT, as part of the S136 improvement plan with the data prospectively gathered from this to inform the MH ED models moving forward.

Right Care, Right Person (RCRP)

- It is universally agreed that RCRP Phase 1 (Concern for Welfare) was implemented successfully considering the challenging position of the mental health system, particularly over winter, with established pathways, for example, into 111 24/7 mental health crisis helplines. However there remain risks across several areas including clinical risk and definition of ‘immediate’ in respect to suicide risk and self-harm, and where attempts need to be made to locate an individual in person. Health and police continue to work in partnership to mitigate risks.
- Increased planning for Phase 2, related to improved handover times for police to health teams when someone is brought to a place of safety under section 136 of the Mental Health Act, is ongoing. There is a commitment to reducing handover times, evidenced through clear system-wide data and underpinned by improved joint protocols, and to addressing long-standing issues in S136 suite availability with additional workforce capacity, investment, and improved processes to improve outcomes for patients. A new GM interagency protocol for S136 has been developed and is being embedded within organisational processes.

Adult community mental health

Seamless GM community mental health pathway

- During 2025/26, Greater Manchester continued to make progress in transforming community mental health care through the delivery of the Neighbourhood Mental Health Team model across localities. This place-based approach is now embedded as the foundation of our community mental health offer, enabling earlier access to support for people with serious mental illness and complex needs.
- Neighbourhood Mental Health teams operate at Primary Care Network level and are closely connected with the VCFSE sector. These multidisciplinary teams bring together mental health practitioners, social care professionals, VCSE partners and peer support roles and deliver trauma-informed, person-centred, holistic support.
- Alongside the neighbourhood offer, redesigned specialist pathways continue to support people with more intensive or specific needs, including complex emotional and relational needs, eating disorders, and community rehabilitation. Both mental health trusts have also further strengthened pathways and are continuing to rollout redesigned specialist Community Mental Health Team (CMHT) functions ensuring a seamless pathway from early help to specialist care.
- Localities where the Neighbourhood Mental Health model is fully embedded continue to see improved access, reduced waits and decreased pressure on specialist services. Evaluation from Salford demonstrates that circa 80% of referrals previously directed to CMHTs were more appropriately supported within the Neighbourhood Mental Health Team model, avoiding escalation and reducing crisis presentations.
- In 2026/27, the alignment between Community Mental Health Transformation and GM Live Well will deepen further. Neighbourhood mental health teams will increasingly operate as part of the Live Well ecosystem, utilising Live Well Centres and Live Well Spaces as community access points, benefitting from strengthened VCFSE capacity, and contributing to a unified approach to prevention, early help and community wellbeing.
- This integration will help ensure that community mental health care in Greater Manchester is not only clinically effective, but also rooted in everyday, trusted community support, creating a seamless, compassionate and place-based offer for residents across all ten GM localities.

GM community mental health service specification

During 2025/26, NHS Greater Manchester has made substantial progress in the development of a new GM Community Mental Health Service Specification. The new specification sets out clear expectations for the NHS commissioned NHS Trusts services. Implementation of the new specification planned in April 2027, will align local delivery, with the specification setting out the required standards for high-quality, integrated community mental health care. The specification is derived from the NHS Long Term Plan and the Community Mental Health Framework and defines the core and developmental standards that all providers are expected to deliver.

The new specification will ensure / we are:

- Strengthening the Core Community Mental Health Offer.
- Reducing Fragmentation and Improving Pathway Consistency.
- Implementing Place-Based, Multidisciplinary Teams.
- Meeting National Activity and Quality Requirements.
- Meeting Workforce Development and Competency Requirements.
- Embedding the core principles of Co-Production and Lived Experience Leadership.

Performance and outcomes in 2025/26

- 31,960 people (adults and older adults with Severe Mental Illness (SMI)) accessed community mental health services and received 2 or more care contacts in the 12-months to November 2025.
- Localities report strengthened multidisciplinary working, deeper VCSE partnerships, and better service user involvement in care planning.
- Peer support and trauma-informed practice continue to expand, embedding recovery-focused approaches across neighbourhood teams.

Physical health severe mental illness (SMI)

- NHS Greater Manchester is prioritising the physical health of people with severe mental illness by supporting flexible, locally driven approaches across Primary Care Networks (PCNs). NHS GM is working with PCNs to design health-check processes that meet the needs of their local populations, including the use of holistic SMI health-check events. This approach recognises the importance of adapting delivery to local geography,

practice needs and existing relationships to improve engagement and outcomes.

- Alongside this, NHS GM is embedding the principles of Making Every Contact Count so that every interaction in primary or secondary care becomes an opportunity to consider and address physical health needs. By promoting this mindset and sharing examples of best practice across the system, NHS GM is helping services learn from one another and strengthen the overall support offered to people with SMI.

Performance and outcomes in 2025/26

- **SMI health check:** As at September 2025, 60% of people with Severe Mental Illness (SMI) received a physical health check, with GM on-track to exceed the 2025/26 plan of 60%. This metric measures the percentage of people with SMI on the General Practice (GP) SMI register that have had a full physical health check in the preceding 12 months - a full physical health check includes 6 components: a measurement of weight, a blood pressure and pulse check, a blood lipid including cholesterol test, a blood glucose test, an assessment of alcohol consumption, an assessment of smoking status.

CMHT independent review

- The final report for the CMHT Independent Review is due at the end of February 2026, and recommendations will be built into mental health programmes of work.

Children and young people (CYP)

Throughout 2025/26, Greater Manchester continued to demonstrate strong progress in improving access to community mental health services for children and young people, exceeding both the Long-Term Plan (LTP) target and the planned trajectory. As a result of this achievement, the access target for future years has been increased, and Greater Manchester remains committed to meeting this enhanced ambition.

Core child and adolescent mental health services (CAMHS)

- Across Greater Manchester, Autism and ADHD assessments for children and young people are primarily delivered through CAMHS (with some through Community Paediatric Services), with notable variation in service models between localities. The services are not able to meet the significant and rising demand for neurodevelopmental

assessments and waiting times and lists have grown exponentially.

- To address these challenges, the CAMHS specification has been refreshed, ensuring that CAMHS can focus on supporting children and young people with co-occurring mental health conditions. In addition, work is underway to ensure a consistent core CAMHS offer across all localities in line with the updated specification.
- Greater Manchester will also transform the current Mental Health Support Teams (MHST) model by adopting the national framework and expanding provision with eight new teams delivered in 2025/26. This forms part of our commitment to achieving 100% coverage by 2029/30, with an ambitious programme of work planned to accelerate progress.

Perinatal mental health

- Historically, Greater Manchester had not invested in specialist perinatal mental health services to the levels outlined in the Five Year Forward View or the Long-Term Plan. However, NHS GM has prioritised investment in Specialist Perinatal Mental Health Services for 2025/26. This funding will increase access, ensure timely assessment for those with the highest level of need, and support improvements in service quality.
- We are working closely with GM providers to address inequalities in access and ensure sustainable service expansion. A business case has been developed and funding secured, to increase reach in line with national Long-Term Plan targets of 10% coverage by 2029.

Neurodevelopmental transformation

In 2025/26, NHS Greater Manchester initiated a comprehensive transformation programme in response to national and local concerns regarding the significant increase in demand for Autism and ADHD diagnostic assessments, alongside growing waiting lists and extended waiting times. Recognising the need to shift away from a diagnosis-led model of support, Greater Manchester is committed to a needs-led approach.

Key developments include:

- A business case approved by NHS GM, securing investment for a new needs-led neurodevelopmental model of care across all 10 localities. This has enabled the establishment and mobilisation of early support offers, allowing children, young people,

and families to access help earlier and without requiring a diagnosis. GM has committed to recurrent investment of £3.6m per year to sustain these support pathways.

- Assessment prioritisation criteria, agreed by the GM Clinical Effectiveness Group in November 2025, with phased implementation beginning in January 2026 to ensure that children and young people with the highest needs are prioritised for earlier assessment.
- An additional £2m of funding secured to support waiting list recovery activity from January 2026

Out of area placements (OAPs) and local spot purchase placements (LSP)

- The GM system is committed to improving mental health services by reducing the number of inappropriate out of area placements (OAPs) throughout 2025/26. The aim was to reduce OAPs to 2 and the number of LSP beds to 14 by the end of March 2026. To achieve this goal, specific locality and provider action plans were developed and implemented, and a Greater Manchester wide oversight process was established to monitor progress and ensure delivery.
- Significant performance improvement throughout 2025/26 demonstrates the effectiveness of this collaborative approach. A substantial reduction in average daily OAP usage has been achieved, falling from 17 in April 2025 to just 4 in December 2025 (the average was between 1-3 from August to November 2026). In addition, a substantial reduction in LSP has also been achieved, falling from 68 in April 2025 to 15 in December 2025. Plans are in place to further improve performance in this area into 2026/27 and beyond.
- Targets were also set for Clinically Ready for Discharge – a target of a 25% reduction ‘bed days lost’ due to beds being occupied by people who are CRFD. There has been variance in localities and providers ability to meet these targets, but Salford, Wigan, Oldham, Tameside and Bury are all currently (as at December 2025) exceeding this target. PCFT as a provider is also exceeding this target.
- The mechanism which has ensured that the above targets are met and sustained is the Mental Health Integrated Fund (MHIF). This is a purposeful and sequenced shift in how public money is used. The MHIF was set up to mitigate the increasing costs of OAPs and local spot placements with the aim of reducing spend in inpatient facilities and investing instead in left shift and community developments.
- The MHIF operates between NHS GM and its 2 main NHS MH providers. The fund has

adopted a risk/gain share principle to manage placements and costs within an agreed budget and to agreed reducing trajectories. The initial model was based on average costs per bed night and then superseded by actual costs during the year. The fund is covered by a Memorandum of Understanding (MOU) which agreed the % shares in advance, with NHS GM holding 50% and the 2 MH Trusts 25% each.

Learning disability and autism

Actions in 2025/26

People with a learning disability and autistic people experience avoidable health inequalities and can also be inappropriately admitted to mental health hospitals for long periods. To improve health outcomes and access to and experience of care, ICBs and providers are working to:

- reduce the longest lengths of stay in mental health hospitals.
- reduce admission rates to mental health hospitals for people with a learning disability and autistic people.
- optimise existing resources to reduce long waits for autism and ADHD assessments and improve the quality of assessments by implementing existing and new guidance, as published.

Allocation of funding for this program to support these targets includes:

- Work with CYP services to standardise the clinical criteria for requests for Autism and ADHD assessments for Children and Young People to support consistent and transparent implementation across GM in relation to new requests for assessments and existing waiting lists. These criteria have been developed as part of NHS Greater Manchester's transformation program focused on implementing a new, needs led model of care for Neurodiverse CYP which includes the establishment of local, and GM early support offers which will be available to families without the need for a diagnosis.
- Investment in intensive, crisis and forensic community teams to support people to live in the community and reduce admissions. This includes intensive support (Ealing model teams for children and young people) and admission alternative provision such as Radcliffe Place.
- Work to tackle the causes of morbidity and preventable deaths in people with a learning

disability and for autistic people, through work on reducing health inequalities.

- Reduce the number of learning disabled and/or autistic people detained in mental health hospitals through admission avoidance and discharge support including the GM Complex Needs Project, investment in community services and support, Dynamic Support Registers and provision of Care, Education, Treatment Reviews. This has included mobilization of GM CETR 'hub' capacity to support compliance as well as digitization of Dynamic Support Registers.
- Improve the quality of care provided across the NHS and reduce the use of restrictive practices team.
- Designated key workers for children and young people with the most complex needs
- Increasing the number of people with a learning disability who receive an annual health check.
- Delivery of the Partnership for the Inclusion of Neurodiversity in Schools project (PINS) and GM continuation of the Autism in schools project, now known in GM as Neurodiversity in Schools. This programme has, to date, worked into 200 primary and secondary schools.

People and culture

Actions in 2025/26

Health and Care Champion Awards

- Successful delivery of the 2025 GM Health and Care Champion Awards, with exceptionally high-quality nominations (almost 700), strong social media and media engagement, and all three Lifetime Achievement finalists recognised as joint winners, celebrating a combined 120 years of service across cancer care, social care and children's nursing. 14 award categories, including the new Green Initiative of the Year category was also launched.

Workforce efficiency

- Progress made across the system to strengthen workforce efficiency, including a £22.7m reduction in bank spend (11.3%) and a £14.2m reduction in agency spend (28.6%) compared with the previous year, keeping GM on track to meet national targets in 2025/26

Equalities and inclusion

- The Equalities Professionals Network (EPN) continued to develop, creating a platform for sharing best practice and driving collaborative system action, alongside ongoing delivery of the Supporting Our Workforce campaign to improve support for carers and disabled staff across GM. Also advanced GM's EDI priorities, including disability inclusion frameworks, anti-racism masterclasses, and addressing inequalities highlighted in staff surveys.

Good Employment Charter

- Continued progress against the Greater Manchester Good Employment Charter, reaching 170 supporters and 22 full members across health and care organisations participating and aligning with Charter standards. It also means over 93,000 employees are experiencing the benefit of charter membership and the health and social care sector is also the largest business sector in the GM Good Employment Charter.
- The mayor's recognition during the Workforce Summit reinforced system-wide commitment to fair pay, secure work, and excellent employment practices. Also celebrated Good Employment Week 2025, raising awareness of fair employment across the system and aligning with upcoming Employment Rights Bill priorities.

T-Levels

- 100% of GM Health T-Level learners secured an industry placement; 14 new employers onboarded; 2,262 young people engaged through careers/technical pathway events; five learning webinars delivered (200+ attendees). 160 stakeholders are now part of the growing T-Level Network.

Careers fair

- Delivered the GM Workforce Transition Hub Careers Fairs, connecting hundreds of colleagues with new opportunities during reform and workforce change. November's fair hosted nearly 130 attendees and showcased a marketplace of employers, support organisations, and masterclasses.

Multiple disadvantage framework

- Developed and launched the Greater Manchester Multiple Disadvantage Framework,

providing clear recommendations for recruitment, retention, and improved workplace experience for employees experiencing multiple disadvantages.

Transforming People Services

- Transforming People Services made major progress in 2025, positioning GM as a national Vanguard site and driving modernisation through digital recruitment improvements, chatbot and ID-check innovation, and Occupational Health redesign. The programme broadened significantly in scope, becoming a core strategic priority embedded into governance, reform planning and the future People & Culture operating model.

WorkWell Partnership Vanguard

- NHS GM selected as one of only 15 national WorkWell Vanguard sites.

Learning and development

- Delivered an extensive annual Bitesize Learning Programme with sessions on Good Employment Charter, Social Care Clinical Learning, Host-a-T-Level guidance, Adult Social Care Workforce Strategy, Kooth & Qwell mental health services, GM Bereavement Service, Portfolio career development, Digital insights & employment law updates.

Health and care service review

The Health and Care Service Review (formerly named Sustainable Services) programme was originally established to focus on acute service fragility. Our Health and Care Service review is clinically led, designed and delivered with our Integrated Care Partnership (ICP). The co-production ensures its success ensuring that consideration is given to all parts of our system, so we have a truly joined up, voluntary, primary, community, secondary and tertiary care provision that delivers value for money, improved patient experience and outcomes.

The Health and Care Service Review assess services through the lens of redesign, quality improvement and transformation with the core objectives of:

- Co-designing seamless pathways of care for those using services that provide high quality and safe care

- Improving equity and integration in terms of access and outcome
- Making best use of resources to create long term financial and clinical sustainability.

2025/26 has seen the programme focusing on the following areas, to quantify the challenges, understand the pathways and how service users access care and plan end to end pathway change to ensure long term sustainability.

- Dermatology Transformation
- Neurorehabilitation
- Gynaecology Transformation
- Ophthalmology
- Community Service Review
- Musculoskeletal (MSK) Transformation
- Oral and Maxillofacial (OMFS) Surgery
- Children's Transformation

Dermatology transformation

Actions in 2025/26

- Launched the procurement of new Community Dermatology Services across all ten localities in GM. Once mobilised, all GM patients will have equal access to high quality community dermatology services.
- As some Independent Sector (IS) dermatology providers exited the market during 2025/26, we have mobilised additional capacity to ensure that GM patients continue to have access to both community and secondary care dermatology services. A safe transition from the previous services was integral to the mobilisation.
- Implemented and evaluated tele-dermatology / artificial intelligence (AI) pilots across GM, funded by NHS England.
- Implemented a Single Point of Access (SPoA) for dermatology referrals on both general dermatology and suspected cancer pathways as a test of change to ensure high quality referrals and to ensure patients are directed to the most appropriate service.
- Implementation of high-cost drugs pathways, aligned to national guidance, to ensure that patients, where appropriate, are treated in their local acute Trust. This development increases equity in access and helps to reduce waiting lists on these pathways.
- Developed a GM Strategic Direction for a Lead Provider Dermatology Model which will

be instrumental in ensuring sustainable dermatology services in the future.

Neurorehabilitation transformation

Actions in 2025/26

- Established a collaborative Task and Finish group dedicated to implementing a Single Provider Model.
- The first step of the model is to transfer Stockport NHS Foundation Trust's Devonshire Centre to the Northern Care Alliance NHS Foundation Trust (NCA). Phase 1 of the transfer was concluded during Quarter 4 of 2024/25; Phase 2 was concluded in Q4 of 2025/26, and Phase 3 will be concluded in Q1 of 2026/27.
- NHS GM investment in the Devonshire Centre to increase staffing and increase the bed base from 15 to 19 beds.
- Comprehensive review of the financial spend for Independent Sector Neuro Rehabilitation and gain an understanding of the historical use of the NR coding.
- Delivered a centralised provision for Extended Independent Sector Neuro Rehabilitation placements. Streamlined the pathway ensuring single point of referral and standardised reviews.
- Develop a Standard Operating Procedure for the Case Management Team and the Independent Sector Neuro Rehabilitation Pathway.
- Work in collaboration with Local Authority, Continuing Health Care and Mental Health colleagues to develop Principles Documents to support the discharge pathway into long-term funding stream.
- Implement contracts with Independent Sector Neuro Rehabilitation providers, first step to exploring block bed contracting in the future.
- Understand the variance of bed pricing in the Independent Sector Neuro Rehabilitation provider placements depending on the provider, acuity and expertise required.
- Business Case for continuation of the Neuro Rehabilitation Case Management Team completed and submitted to Chief Officers January 2026.

Gynaecology transformation

Actions in 2025/26

- Development and mobilisation of a Community Gynaecology Service model in

collaboration with the GP Provider Board building upon learning from the Women's Health Hub programme.

- Agreement of a GM Gynaecology service specification including KPIs and referral thresholds

Ophthalmology transformation

Actions in 2025/26

- Development, ratification and implementation of a GM wide ophthalmology service specification
- Roll out of an Ophthalmology audit programme across our Independent Sector Providers to ensure adherence to pathways
- Managed the safe transfer of displaced patients from Tameside Hospital to an alternative provider following the service coming to an end
- Extension of the scope of the Eye Care Navigation Referral System (EeRS) contract to include clinical triage, informed CHOICE for patients, GP referrals and completion of a GM wide patient engagement project and following this a self-assessment check list for Providers.
- Undertaken a GM workforce review with all providers to understand workforce capacity, issues and training gaps. Further work will take place with provider in 2026/27 to develop a strategy to resolve.

Community services review

Actions in 2025/26

- Further development of the transformation programme, focusing on two initial key areas: District Nursing and Intermediate Care. The aim is to develop a core service offer across both areas.
- Development of a GM-wide IMC data dashboard, bringing together data from all ten localities, with the aim of improving data quality.
- Worked with system partners to focus on the longest waiters for community services, with the aim of reducing waiting times.
- Worked with system partners to develop a core GM standard and align services to the neighbourhood model.

- Held a further workshop for Intermediate Care (IMC), with representation from all ten localities and system-wide colleagues.
- Developed financial flows and baseline templates aligned to the new “categories of community services” to understand the position across the system.

Paediatric audiology

Actions in 2025/26

- NHS GM has visited each Paediatric Audiology site; comprehensive reports have been issued with a clear set of recommendations.
- The Paediatric Audiology Oversight Group has reviewed individual and collective action plans based on initial PASQAT and subsequent ICB QA visit recommendations.
- A stakeholder event was held on 12th September to consider a new model of care based on site visit thematic analysis and the national service specification and oversight group recommendations.
- A full action plan against relevant themes (estates, equipment, quality, data, workforce and progress towards a new model of care) has been developed.
- Due to lack of mutual aid an independent sector offer has been commissioned by NHS GM to serve Stockport Foundation Trust following a pause in service.

Musculoskeletal (MSK)

Actions in 2025/26

- Developed the MSK strategy, engaging system partners to enable implementation and delivery at scale.
- Convened a system wide ‘Think Tank’ with representation across the MSK pathway to shape the future model of care for Greater Manchester. This catalysed three priority transformation workstreams: Model of Care, Self-Care Digital Innovation, and Workforce.
- Established a GM-wide Model of Care group to lead the co-design and standardisation of a redesigned MSK pathway, driving consistency, quality, and improved patient outcomes across Greater Manchester.
- Mobilised the Self-Care Digital Innovation and Workforce workstreams to accelerate transformation, strengthen capability, and embed sustainable change.
- Secured governance approval for the Independent Sector Orthopaedic specification,

positioning it for incorporation into 2026/27 contracts and supporting improved oversight, quality, and value.
- Strengthened the cMSK Community of Practice through delivery of a system benchmarking exercise to inform pathway standardisation, alongside a patient engagement survey to capture lived experience, embed patient voice, and establish a clear service baseline for improvement.

Oral and maxillofacial surgery (OMFS)

Actions in 2025/26

- Completion of the first phase of the OMFS Lead Provider model, including the transfer of services from Tameside & Glossop Integrated Care NHS Foundation Trust (T&GICFT) to Manchester University NHS Foundation Trust (MFT).
- Ongoing work throughout Quarter 4 to develop and refine the proposed Lead Provider model.
- During 2026/27, focused planning and stakeholder engagement will be undertaken on the preferred model, with the aim of establishing an MFT delivered Lead Provider model for implementation in 2027/28.

Children and young people

Actions in 2025/26

- Ensure clear accountability and oversight for CYP transformation programmes through re-established governance mechanisms (e.g. via Health and Care Service Review Programme Board or equivalent reporting).
- Align delivery of SDF-funded schemes with the GM ICP strategy, CYP Joint Forward Plan and national priorities.
- Prioritise delivery of Integrated Neighbourhood Teams (MDTs)
- Accelerate mobilisation of at least one fully operational CYP Integrated Neighbourhood Team in line with NHS England requirements.
- Integrate planning with Families First Pathfinder Programme and Best Start for Life (Family Hubs) to maximise system resources and avoid duplication.
- Secure project management support to coordinate locality roll-out.
- Progress commissioning reviews and intentions for paediatric audiology, CEW clinics

(for 2027/28), and specialised neonatal services.

- Ensure links with safeguarding reforms, SEND reforms, and ND hubs are explicit in commissioning intentions.
- Support the CYP data dashboard subgroup to deliver the quarter 3 roadshow and ensure dashboards are embedded into decision-making.
- Use emerging operational insights to strengthen planning and reduce fragmentation across localities.
- Support the 2025/26 Service Development Fund allocation and confirm continuity of existing commitments (leadership, CEW clinic, youth worker pilot, Balanced System, CYP voice).
- Ensure robust outcome monitoring and reporting to NHS England against all deliverables.
- Undertake a Complications of Excess Weight Clinics service review to determine sustainability beyond 2027/28, including prescribing costs and adding social work input to MDT model and align with national Obesity Pathway Innovation Programme funding opportunities.
- Actively participate in the national Cerebral Palsy Commissioning Framework baselining exercise and use findings to address inequities (e.g. tone management) across GM.
- Maintain collaboration via the GM Cerebral Palsy Network and feed back into national learning.
- Monitor risks relating to CYP delivery through the health and care service review programme board and ensure escalation mechanisms to the ICB executive committee.
- Maintain focused oversight on paediatric audiology as a known system risk.

Mental health expenditure

NHS GM has invested in mental health services in line with the requirements of the Mental Health Investment Standard and in line with national guidance, focusing on children and young people, mentally healthy schools, crisis, community services and learning disabilities and autism. NHS GM has been able to demonstrate robust plans for delivering the mental health standards and has mitigated one of the main risks relating to out of area placements, by implementing successfully an Integrated Fund.

The NHS GM set a clear ambition to eliminate inappropriate adult acute Out of Area Placements (OAPSs), reduce avoidable lengths of stay and return people closer to home. The

Integrated Fund functioned as a shared mechanism with NHS Providers. It is a gainshare based model that released funding from the reduction in independent sector inpatient capacity usage on OAPs and spot placements and reinvested funding supporting ‘left shift’ towards prevention and early intervention via investment in community mental health services.

The table below discloses the proportion of expenditure incurred by the ICB for Core Mental Health spend, excluding specialised commissioning, for 2025/26 and 2024/25.

Financial Years	**2025/26 (£000)**	**2024/25 (£000)**
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	£829,128	£722,852
Eligible Mental Health expenditure	£829,214	£741,763
Mental Health expenditure above / (below) minimum investment required	£86	£18,911
Mental Health expenditure as a proportion of total expenditure (%)	9.82%	8.48%

From 1st April 2025 NHS GM became the responsible commissioner for Mental Health Specialised commissioning, with the ICB allocations increasing by £119.1m including the pay award. Please note there are no comparative numbers for the prior financial year for these services.

The table below discloses the proportion of expenditure incurred by the ICB for Specialised Commissioning Mental Health for 2025/26.

Financial Years	2025/26 (£000)
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	£109,428
Eligible Mental Health expenditure	£119,161
Mental Health expenditure above / (below) minimum investment required	£9,733
Mental Health expenditure as a proportion of total expenditure (%)	11.97%

Please note that the mental health overachievement is purely due to the target of £109,428k not being increased for in year allocations. This will be aligned nationally for 2026/27 reporting.

The total eligible mental health spend in year across Core and Specialised Commissioning is £948,375k, which equates to 10.04% of total expenditure.

Despite the issue identified relating to the specialised commissioning target, NHS GM has achieved the Mental Health Investment Standard (MHIS) for both core and specialised commissioning mental health services in 2025/26.

Children and young people (CYP) safeguarding

During 2025-26 NHS GM continued to safely discharge its statutory duties in relation to the safeguarding of children, young people and adults as outlined in national guidance. The Chief Executive holds organisational safeguarding accountability and is supported by our Executive

Lead who was the Chief Nursing Officer until 1st January 2026 when, as part of the ongoing NHS Reforms, this formally transferred to the Chief Clinical Officer. The organisational leads were supported by the Deputy Chief Nurse and the Associate Director of Safeguarding, who provided strategic system leadership and oversight of safeguarding assurance. Statutory safeguarding delivery continued to be supported through the locality Associate Directors of Quality and Safety and delivered by Designated Safeguarding Teams in each of the ten GM localities.

NHS GM continued to embed and deliver the NHSE Safeguarding and Accountability and Assurance Framework (SAAF 2024) strengthening our approach to governance, assurance and improvement. SAAF implementation audits and the NHSE Safeguarding Clinical Audit Tool (SCAT) were routinely reviewed through internal governance structures and informed provider assurance, risk identification, strategic commissioning and improvement planning.

This year, NHS GM also contributed to the Northwest Department for Education (DfE) Regional Improvement Pilot, working collaboratively with Local Authorities, Police and regional ICBs to support shared learning and more consistent safeguarding standards across the Northwest. Through this work, NHS GM strengthened its relationships with statutory safeguarding partners and reinforced a collective health and care system voice within multi agency safeguarding arrangements.

NHS GM has established infrastructures to support learning from Safeguarding Adult Reviews, Child Safeguarding Practice Reviews (CSPRs) and Domestic Homicide Reviews and has continued to draw upon national learning, reviewing relevant findings from national panel reports, and independent inquiries. Key themes have been used to support system assurance and learning such as extra familial harm, neglect, sexual abuse and the impact of parental vulnerabilities. These have informed local safeguarding discussions and improvement actions with providers and partners. NHS GM supported system learning and improvement across partnership arrangements.

NHS GM continued to undertake and assure its statutory responsibilities across child safeguarding functions. This included participation in the Child Death Overview Panel (CDOP) processes; oversight of Looked After Children and Care Leavers' health pathways; scrutiny of Section 47 child protection activity; safeguarding and health responses for unaccompanied asylum seeking children (UASC); monitoring and reporting of Female Genital Mutilation (FGM); assurance around use of the Child Protection – Information Sharing (CP IS) system; and

responses to children affected by domestic abuse. Through these mechanisms, NHS GM maintained visibility of pressures, emerging issues and the effectiveness of local safeguarding arrangements.

Strengthening the voice and lived experience of children and young people remained a priority. NHS GM continued to embed the Child's Voice Strategy through 2025/26, including supporting the establishment and early development of the Youth Shadow Board. The Youth Shadow Board worked alongside the Children and Young People's (CYP) System Group to support meaningful participation in shaping commissioning priorities, service accessibility and improvement work across mental health, physical health and public health pathways.

NHS GM has maintained their statutory duties as an equal statutory safeguarding partner across all ten GM localities, working jointly with Local Authorities and the Police as required by Working Together to Safeguard Children (2023) for our Safeguarding Children Partnerships. Our Chief Executive is the Lead Safeguarding Partner (LSP) and our Chief Clinical Officer is the Delegated Safeguarding Partner (DSP).

The Multi Agency Safeguarding Arrangements (MASA) for each locality were published in 2024 and included in the NHS GM 2024/25 Annual Report (nhs-gm-safeguarding-annual-report-2024-25-final-v2.pptx). MASA arrangements do not require annual republication unless substantively revised, and as two localities refreshed them in 2025/26, MASA links are not included in this year's report. This approach remains fully compliant with statutory expectations.

NHS GM is a statutory partner for the GM Adult Safeguarding Boards across our localities working with statutory partners to deliver our statutory safeguarding adult duties.

In line with *Working Together to Safeguard Children (2023)*, each Safeguarding Children Partnership published an annual report outlining local safeguarding activity, learning from CSPRs and rapid reviews, and an assessment of system effectiveness.

NHS GM contributed to the preparation of these reports across all ten GM localities, ensuring that health safeguarding issues, risks and learning were fully represented. The ICB reviewed each published report and used the learning to inform commissioning assurance, internal risk oversight and system-wide improvement work.

Links to the most recent Safeguarding Children Partnership Annual Reports for all GM localities are included below. Annual reports for 2025-26 will be produced in September 2026.

Table 1 - Links to Safeguarding Children Partnership Annual Reports 2024-25

Locality	Link to Safeguarding Children Partnership Annual Reports, 2024-25
Bolton	Bolton SCP Annual Report 2024–25
Bury	Bury SCP Annual Report 2024–25
Rochdale	Manchester SCP Annual Report 2024–25
Manchester	Oldham SCP Annual Report 2024–25
Oldham	Rochdale SCP Annual Report 2024–25
Salford	Salford SCP Annual Report 2024–25
Stockport	Stockport SCP Annual Report 2024–25
Tameside	Tameside SCP Annual Report 2024–25
Trafford	Trafford SCP Annual Report 2024-25
Wigan	Wigan SCP Annual Report 2024–25

The ICB has maintained robust strategic, clinical and professional leadership during 2025-26 which has continued during the formal transition of the Executive Lead for Safeguarding from the Chief Nursing Officer to the Chief Clinical Officer in January 2026. NHS GM has upheld robust statutory safeguarding assurance processes across all commissioned and independent providers, monitored safeguarding risks through established governance structures, and contributed proportionately to multi agency safeguarding arrangements. This demonstrates that NHS GM continues to fulfil its statutory duties and support safe, effective and collaborative clinical safeguarding practice across the Integrated Care System.

Environmental matters

The UK's climate in 2025 was one of the warmest on record, with the warmest summer ever observed, an event made 70 times more likely due to human-induced climate change. The Climate Change Committee's 2025 Report to Parliament stated that whilst national emissions are steadily decreasing, without deep reductions the UK will face increasingly extreme weather, rising energy insecurity and escalating climate risks. In September 2025, NHSE published 'Five years of a greener NHS: progress and forward look' report, highlighting that reductions of 14% in emissions have been made since the publication of the original net zero strategy, as well as

demonstrating clear co-benefits including improvements in patient care, cost savings and estates efficiencies.

Climate change is a major public health threat, which disproportionately impacts people living in deprived communities, as highlighted in Manchester's Public Health Annual Report 2025. Climate related hazards are interconnected, influencing food security, physical and mental health and reinforcing health inequalities. These interconnected risks highlight the need for a place-based and system-led approach to address the impact on the healthcare system.

In July 2025 NHS GM approved a new Green Plan for 2025-2028, setting out progress to date and key priorities for reducing emissions, preparing for the impacts of climate change, and helping shape the conditions that support good health, including nature recovery. The plan aligns with national NHS requirements, and the GMCA's 5 Year Environment Plan, which sets out ambitions for cleaner air, nature recovery and a low carbon city region. The new Greater Manchester Strategy, also published in July 2025, includes 'a greener and more equal place' as a cross-cutting priority, reinforcing the importance of a healthy, low carbon and nature-rich environment that is resilient to climate change for everyone to live well and thrive.

Following the government decisions on NHS structural reform in March 2025, it has been confirmed that ICB's retain a core leadership role in environmental sustainability. As Greater Manchester continues its devolution journey, our system wide partnerships will strengthen further to deliver the Green Plan commitments, particularly in areas where climate action aligns closely with the three shifts outlined in the 10 Year Health Plan, such as improving air quality, supporting housing retrofit, enabling low carbon transport, ensuring sustainable food systems and restoring nature. These priorities are central to our purpose to improve population health and reduce socioeconomic inequalities, as part of our strategic commissioning role.

The following narrative provides key highlights from the work programme in 2025-2026, quantitative updates on our progress, and outlines high-level priorities for 2026-2027.

Workforce, networks and system leadership

During June 2025, we contributed to Northern Greener NHS week by delivering four sessions designed to strengthen capability and confidence in the NHS workforce. We also partnered with Pixel Fountain, and two GM NHS trusts to update Planit Sustainability, an immersive simulation for senior leaders. The refreshed version, now tailored to the NHS has since been rolled out to eight staff cohorts across NHS GM and three GM NHS trusts, supporting leaders to embed

environmental sustainability into broader decision making. We also finalised an environmental sustainability impact assessment tool in December 2025 to help staff assess the environmental impact of their proposals and business cases, and plan to migrate to a digital platform in 2026/27 to improve accessibility and holistic decision making. Following publication of the new Green Plan we updated the supporting web content, strengthening signposting to resources. Over the past 12 months the landing page has received 1,109 visits from 673 users, demonstrating broad engagement from staff and partners.

Net zero clinical transformation

Environmental sustainability is embedded within the service specification for the Primary Care Tirzepatide Weight Management Service 2025 - 2028, following the work led by our Chief Sustainability Officers Clinical Fellow which utilised the STEPS to Low Carbon Care framework tool. Our clinical sustainability lead supported updating the Adult & Children Asthma guidelines and the new COPD clinical pathway to ensure environmental sustainability is fully considered in new clinical guideline development. We continued to work in close partnership with GMCA to boost healthcare-related referrals into the ECO4 Flex (Flexible Eligibility) programme through targeted engagement and promotions, enabling fully funded, whole house energy efficient retrofit for eligible residents. In 2025, over 1,071 NHS referrals led to 757 completed home retrofits, representing £6 million of investment. These improvements generated savings of over 2,770 tonnes of CO_2e with residents reducing their energy bills by £590 per year, delivering carbon reduction alongside tangible financial and health benefits.

Climate change adaptation

We continued to provide healthcare sector input into the GMCA's Adaptation Steering Group, supporting the development of the city-region's Adaptation Strategy and Action Plan following the publication of the risk assessment in 2024. This helps ensure that the specific vulnerabilities, service pressures and population health needs of the NHS are fully reflected.

In parallel, we have refined the climate change adaptation plan for the NHS in GM, working closely with trust sustainability and emergency planning leads to produce a single, system-wide plan. This shared plan sets out common priorities, whilst enabling trusts to add site or organisation-specific risks, actions and governance arrangements to ensure the plan is meaningful and proportionate for each organisation. This consolidated plan will progress through formal governance and approval processes in early 26/27, strengthening a co-

ordinated and collaborative approach that makes best use of available resources. As part of strengthening preparedness, we have promoted the uptake of weather and health-alert systems across providers, supporting early and targeted action on heat and cold-related weather events to mitigate the impact on vulnerable groups.

Digital transformation, research, and innovation

Work on greener digital has progressed at modest pace this year, reflecting staffing constraints and the need to formally embed responsibility within the functions that are best placed to make change. A session on greener digital was held with the Digital Transformation Delivery Group, and they were briefed on the new Green Plan. We have continued to amplify NHSE greener digital resources and produced a targeted briefing on AI and environmental sustainability, in response to an increasing number of queries.

We have also contributed to discussions within the NW Public Health and Sustainability Network, including emerging emerging evidence on the environmental, social and health impacts of data centres. These conversations will help shape future digital planning and commissioning expectations, particularly as data-driven and AI-enabled models of care continue to expand. The introduction of the GM Care Record brings together information from NHS and care services across all 10 GM boroughs into one joined up record, this has indirect environmental sustainability benefits as it improves coordination and communication, as well as reducing duplication, for example in investigations. The roll out of electronic palliative care plans (ePaCCS), which captures and shares patients advanced care plans and can be updated by different professionals has similar benefits.

Travel, transport, and air quality

In autumn 2025, a Sustainable Travel Manager joined NHS GM on secondment from Transport for Greater Manchester (TfGM), the first arrangement of its kind for an ICB. This has significantly strengthened collaboration between the two organisations, providing dedicated capacity to maximise the opportunities presented by system-wide working and the Bee Network. One practical outcome has been the removal of the 9.30am restrictions on concessionary bus passes, reducing transport barriers for people accessing healthcare appointments and supporting more equitable access to services.

A baseline assessment of current modal split and supporting infrastructure across the

secondary care healthcare estate across GM has been completed, giving the system a clear understanding of travel patterns and the evidence needed to prioritise interventions. Bespoke active travel maps have also been produced for trust sites, building on similar work delivered across schools and colleges and supporting staff and visitors to make informed travel choices.

We have contributed to a newly formed GM air quality and health group, helping to develop a clearer picture of the city-region's air quality challenges and shaping how the health system can support targeted messaging for vulnerable groups. This work strengthens the links between clean air, sustainable travel and population health, and reinforces the role of the ICB in supporting system-wide action on environmental determinants of health.

During 2025/26 GM trusts secured over £284,000 of funding from NHSE to provide charging infrastructure for NHS owned and leased electric vehicles, supporting the decarbonisation of the fleet.

Estates and facilities

Following the launch of GMCA's Public Building Retrofit fund, we supported the two mental health trusts to access funding for feasibility assessments, helping them to prepare for future capital bids. Trusts across Greater Manchester secured £21M of national funding in 2025/2026 through schemes such as Public Sector Decarbonisation Fund, GB Energy and the NHS Decarbonisation Fund, enabling delivery of energy efficiency measures including solar PV, LED lighting, improved submetering and building management systems. Total funding for estates decarbonisation secured over the past six financial years now exceeds £70M.

The NW Net Zero Hub has provided additional technical support, including solar feasibility assessments and collating information on green financing options to help address capital gaps. We continue to work closely with GMCA colleagues on major strategic initiatives such as Heat Networks, maintaining high-level strategic oversight and facilitating sector engagement as needed.

To strengthen system readiness, we commissioned an assessment of maturity and readiness for estates decarbonisation across GM trusts and shared the findings with estates and energy leads to support local planning. We established a task and finish group on waste efficiencies and have been collaborating with waste leads to identify and deliver opportunities for waste reduction, improved segregation and more consistent practices across the system leading to reduced financial costs and carbon emissions. Baseline data on estates-related sustainability

projects and interventions was gathered from 137 participating GP practices to identify opportunities for sustainability projects.

Medicines

Our clinical lead has continued to contribute to the cross-sector collaborative on high quality, low carbon respiratory care. A key output from this year has been the development of new e-learning for healthcare professionals, building on earlier work from Manchester University NHS FT. Year on year total inhaler carbon emissions have reduced by 1,742 tCO_2e, (24/25 data) representing a 3% reduction. A GM-wide initiative for patient led ordering was introduced in early 2025, giving patients control to order their own repeat medication using the NHS app. This avoids unnecessary stockpiling and wastage of medication by ensuring patients only order what they need.

The GM Pharmacy Sustainability collaborative has rolled out dedicated training for pharmacists, with 109 staff completing the training to date. Eight NHS trusts are now registered with the Royal Pharmaceutical Society Greener Pharmacy Toolkit, providing a structured framework for tracking and improving sustainable pharmacy practice, with Christie NHS FT and Pennine Care NHS FT achieving bronze accreditation in 2025. Work to tackle nitrous oxide emissions has continued, with emissions reducing by 9%, or 1,119 tCO_2e (24/25 data), supported by funding from NHSE and close collaboration across pharmacy, estates and clinical teams. Another initiative that went live this year in GM was patient-led ordering of repeat prescriptions through the NHS App or directly from their GP practice. This avoids the automatic renewal of unwanted prescriptions by giving patients back control of their own medication and reduces the associated waste.

Supply chain and procurement

Delivery against the related Green Plan actions is led through the GM Sustainability and Social Value Procurement Forum. Nine GM trust procurement leads have taken part in the Planit training to build their capacity and understanding of this agenda.

The Forum is actively engaging with NHS Supply Chain to apply learning from national best practice and avoid duplication of effort, including a dedicated session facilitated by their Sustainability Manager in November 2025. All GM NHS trust tender exercises now include signposting to the national Evergreen sustainable supplier assessment, a self-assessment and

reporting tool for suppliers to share sustainability information with the NHS. Of the 30 top suppliers in GM, sixteen have completed an assessment with eight reaching maturity level 1 (lowest), seven reaching maturity level 2 and one reaching maturity level 3 (second highest). 9 of the top 30 suppliers have a published Carbon Reduction Plan in place.

Additionally, the NHS GM Sustainability team supported 2 large-scale procurements regarding environmental sustainability and social value considerations, in line with the minimum 10% social value weighting requirement.

Low carbon food

This remains an important area of work that requires a system-led approach, particularly as NHS GM does not directly procure or commission food services and therefore has limited operational influence. Current data shows significant variation in reported food-waste levels across trusts with 8.4 tonnes of food waste reported in 2024/25, a 1% increase, and six out of nine trusts indicating that they regularly review patient and retail menus to identify options that are both low carbon and healthier. This variation highlights the need for shared standards and accountability for accurate reporting and action.

We continue to play an active role in the GM Food Partnership, supporting a coordinated approach to sustainable food across the city region. At the 2026 GM Green Summit, a public commitment was made for all ten boroughs to become Sustainable Food Places, embedding healthier, fairer and more sustainable food across communities. One of the six core areas in this framework focuses specifically on tackling the climate and nature emergency through sustainable food and farming practices and reducing waste. This provides a clear platform for aligning NHS GM’s priorities on prevention, population health and environmental sustainability with wider action on food systems.

Nature for health

Nature-based approaches continue to be an important area where our role is to enable and support system-led collaboration, particularly around the health-relevant priorities within the Local Nature Recovery Strategy (LNRS). Over the past year we have supported partnership activity by commissioning and sharing a practical, policy-aligned guide on Biodiversity Net Gain (BNG) for NHS estates. This work followed an engagement workshop facilitated by GMCA and Natural England and provides trusts with clear guidance on meeting BNG requirements for

developments over 0.2 hectares where planning applications are submitted after 12 February 2024. The guide is designed to support consistent, proportionate and effective approaches across the system.

We also continued to promote the Green Space and Biodiversity Toolkit, which helps healthcare sites of all sizes to make measurable improvements to their outdoor environments. These resources support healthcare sites to enhance biodiversity, create restorative and therapeutic spaces, and align with wider system priorities on nature recovery and population health.

Performance Update

Although the publication of performance data in the annual report is not mandated, it is regarded as good practice and continues to evolve. As system-wide data for 2025/26 will not be available until late 2026, the summary below provides an overview of 2024/25 carbon footprint performance. This reflects emissions for which trusts hold direct responsibility, with the exception of inhaler emissions, which are reported for Primary Care only. All figures are drawn from the Greener NHS national dashboards.

The data reflects the wider healthcare system across Greater Manchester, rather than NHS GM's own organisational emissions. The majority of NHS GM's carbon footprint arises from commissioned services rather than from our own operations, as our activities are primarily office-based and do not have the carbon intensity associated with direct clinical service delivery. The reported emissions are therefore not within our direct control but are central to the performance of the wider GM healthcare system.

Table x: Trust Carbon Footprint and Primary Care Carbon Footprint (inhaler component only) (national dashboard)

	Baseline 2019/20	**2022/23**	**2023/24**	**2024/25**	**Change (2023/24 to 2024/25)**
Trust Estate Carbon footprint (tCO_2e)	179,858	169,704	175,159	178,301	2% increase
Energy	171,639	164,989	170,577	174,565	2% increase

(tCO_2e)					
Water (tCO_2e)	1,938	802	871	673	23% reduction
Waste (tCO_2e)	6,280	3,912	3,710	3,063	17% reduction
Medical Gases (Nitrous oxide and Entonox) (tCO_2e)	17,670	14,284	12,732	11,613	9% reduction
Anaesthetic Gases (tCO_2e)	3,650	862	752	800	5% increase
Inhalers (tCO_2e) Primary Care prescribed data only	58,890	51,365	45,007	43,265	3% reduction

- Clinical waste segregation and correct disposal have increased between the two reporting years from 26% to 43% of clinical waste now disposed via the lower cost and carbon offensive waste stream. Overall waste volumes have decreased by 7%.
- Electricity consumption reduced by 6% showing the impact of energy efficiency projects, however gas consumption went up by 6%. The carbon footprint of energy consumption increased by 2% between the last two reporting years.
- The carbon footprint of medical gases decreased by 9% between the last two reporting years, showing the impact of continued nitrous oxide manifold decommissioning taking effect.
- The carbon footprint of anaesthetic gases increased by 5% between the two reporting years, with continued minimal use of desflurane.
- The carbon footprint of inhalers prescribed in Primary Care decreased by 3%, due to ongoing changes in prescribing following the high quality, low carbon respiratory care approach.

Priorities for 2026/27

The following high-level priorities have been identified for 2026/27.

- Review priorities following the completion of NHS reform for the ICB: Align sustainability priorities with the new organisational operating model and capacity, using this as an opportunity to increasingly embed accountability and responsibility within the relevant parts of the organisation.
- Implement the GM-wide Climate Change Adaptation Plan: Move into the delivery phase of the healthcare sector adaptation plan, whilst continuing to support the broader development and implementation of GMCA's city region strategy and approach.
- Strengthen active and sustainable travel: Maximise the impact of the embedded Sustainable Travel Manager by progressing system-wide priorities on active and sustainable travel, supporting development of a healthy travel strategy, and working closely with TfGM on bus network reviews and the infrastructure strategy.
- Embed environmental sustainability through strategic commissioning: Use commissioning levers and contracting processes to embed sustainability expectations, drive increased adoption of the Environmental Sustainability Impact Assessment, and signpost staff to relevant training, guidance and tools.
- Build leadership and delivery capacity across the system: Continue developing leadership capability and organisational understanding of sustainability through training, resources and support progress against trust level Green Plans through our system convenor role.
- Advance NHS estates decarbonisation: Collaborate with GMCA, the North West Net Zero Hub and NHSE to secure and signpost to support and financing for decarbonisation, whilst maintaining high-level oversight of the pipeline and key strategic initiatives such as heat networks.
- Support system wide priorities on environmental determinants of health: Work collaboratively with system partners to influence, inform and support city-region strategy and approaches to sustainable food, domestic energy efficiency retrofit, greenspace and air quality.

Task force on climate-related financial disclosures (TCFD)

Climate change is assessed as a principal strategic risk for NHS GM when viewed through the

TCFD framework. NHS GM does not experience the direct operational impacts associated with delivering clinical services or managing a large estate, but it holds a system-wide remit for planning, commissioning and coordinating care across Greater Manchester. This creates a prospective organisational exposure in managing compounding climate risks, including the effects of extreme weather on service continuity, the disproportionate impacts on communities with existing socio-economic disadvantage and the implications for financial sustainability across the provider landscape. Whilst climate change is already impacting Greater Manchester more broadly, the effect on the healthcare system has not yet materialised at a scale that threatens stability. Transition-related risks such as evolving national decarbonisation requirements, and supply chain pressures influence the resilience of commissioned services. The ICB continues to work with providers, the GMCA and national teams to strengthen climate risk assessment and adaptation activity, and to align governance and decision-making processes with emerging TCFD-aligned methodologies as they become available nationally.

As set out in the GAM (Group Accounting Manual), NHS GM has adopted a phased approach to implementing the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, in line with HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. 2025-2026 is the final year of a three-year phased implementation of the requirements, with reporting against all four pillars of governance, risk management, metrics and targets and strategy now required. The NHS GM Green Plan 2025-2028 includes a TCFD chapter therefore this section focuses on changes since its publication in July 2025 and areas that will be strengthened in the next refresh.

Governance

The Net Zero Lead role is held by the Chief Officer for Strategy, People and Partnerships. During 2025/26, organisational change has affected the progression of several governance tasks, including formal approval of the Sustainability Policy and full implementation of the Environmental Sustainability Impact Assessment (ESIA) tool. Although the ESIA is finalised, it is not yet mandated across programmes or commissioning pathways.

The Board receives a formal annual update on Green Plan performance, the most recent being in July 2025, coinciding with approval of the Green Plan 2025–2028. As part of transitioning to the new organisational operating model, a comprehensive review of governance arrangements for climate-related issues will take place in early 2026/27 to ensure appropriate oversight, clear accountability and integration into mainstream assurance processes. This review will include

where climate governance sits within Board and committee structures, how responsibilities flow through the organisation, and how sustainability requirements are embedded into decision-making.

Risk management

Following changes to the Board Assurance Framework (BAF) in 2025/26, risks are now aligned directly to Integrated Care Partnership (ICP) strategic objectives. As a result, the previous climate-related BAF risk was retired, and Board papers are no longer required to demonstrate mitigation of a climate-specific risk. A climate change risk remained within the Population Health Committee (PHC) risk register, although PHC meetings were temporarily stood down in late 2025/26 due to the impact of organisational reform.

Operational oversight of climate-related risks continues through the Green Plan Oversight Group (GPOG), which maintains a live risk register and reviews it quarterly. Climate-related risks at system level have been identified within the draft NHS GM Climate Change Adaptation Plan, reflecting risks set out in the UK Climate Change Risk Assessment and GMCA's regional assessment. The GMCA undertook a stakeholder exercise using the 61 risks within the national Climate Change Risk Assessment (CCRA) and assessed against GM specific climate projections in the context of a 2O and 4O warming scenario. Two additional health-related risks were added. The NHS GM Climate Change Adaptation Plan outlines the risks and opportunities most relevant to the healthcare system which are indicated as high or very high magnitude in GM in the present day and/or in 2050. These include increased risks of conditions such as heart attacks and strokes in high temperatures, physical and mental health impacts from flooding, risks to food security and new and emerging vector-borne diseases. This plan will progress through formal governance processes in early 2026/27, strengthening system-wide ownership of climate-related risks and actions. Future improvements will include clarifying links between climate adaptation risks and service commissioning.

Metrics

Whilst reporting of Scope 1 (direct emissions from owned or controlled sources), 2 (indirect emissions from the generation of purchased energy) and relevant Scope 3 emissions (all indirect emissions not included in scope 2 that occur in the value chain) is not yet mandatory for NHS bodies, it remains best practice. NHS GM currently reports Scope 1 and 2 emissions, but does not have an established methodology, data flow or governance arrangements for

reporting Scope 3 emissions. Given that the majority of NHS GM's footprint arises from commissioned services rather than direct operations, the development of an approach to measuring and reporting scope 3 emissions is reliant on nationally led approaches, tools and datasets. NHS GM will incorporate these into future reporting cycles as they become available.

Carbon footprint data included in the Environmental Matters section reflects the definition set out in Delivering a Net Zero NHS, currently limited to trust-level emissions and inhaler emissions from Primary Care. Work to strengthen data quality, consistency and completeness will continue through 2026/27. Metrics and targets are detailed in the Green Plan and associated documents, including the Climate Change Adaptation Plan, with statutory responsibilities framed through national NHS net-zero requirements.

Strategy

The draft Climate Change Adaptation Plan sets out high-level climate risks to the health sector, based on the UK Government's Climate Change Risk Assessment and informed by extensive GMCA-led stakeholder engagement. NHS GM occupies a small footprint within leased assets, meaning responsibility for physical adaptation measures sits largely with building owners. The most material physical risks, such as service disruption during extreme weather primarily affect providers and the wider healthcare system, while the main transitional risk for NHS GM relates to the exacerbation of existing health inequalities among vulnerable populations.

NHS GM contributes to GMCA climate adaptation activity, supporting development of the city-region Adaptation Strategy and Action Plan.

Improve quality

System quality, safety and clinical governance

During 2025/26, NHS Greater Manchester strengthened clinical governance arrangements through the development and socialisation of the new GM Clinical Governance Framework for Improvement and Assurance, establishing a consistent system-wide approach to quality, risk management, and effectiveness. The framework reinforces system accountability, supports implementation of the Seven Pillars of Clinical Governance, and enhances visibility of clinical risk, learning and assurance across organisational boundaries. It places clinical effectiveness, standards-based care, equitable access, and workforce development at the centre of the governance model, ensuring that services are safe, evidence-based and consistently delivered

across all settings.

Over the year, governance structures such as NHS GM Clinical Effectiveness and Governance Groups, Quality and Performance Committee, and their associated subgroups have continued to provide robust oversight of assurance, audit, escalation and improvement activities. This included implementation planning for a GM Clinical Governance Assurance Framework; strengthening connections with the Board Assurance Framework; and embedding patient and public involvement within governance processes. The emphasis on system risk identification, escalation, and mitigation has proven central to navigating operational pressures, NHS reform activity and rising demand.

Patient safety

The NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF) are key components of ICB patient safety initiatives. These frameworks aim to improve patient safety by addressing the causes of harm and ensuring that healthcare providers respond effectively to incidents. The PSIRF replaces the Serious Incident Framework and requires providers to develop and submit a Patient Safety Incident Response Plan (PSIRP) and a policy to the ICB for agreement and signoff. This plan outlines how the organisation will respond to incidents requiring investigation, including priority incidents for a full Patient Safety Incident Investigation (PSII) and meeting national requirements for investigation.

The PSIRF emphasises systems thinking, human factors understanding, and just culture principles in all patient safety processes. It also supports the development and maintenance of an effective patient safety incident response system that integrates four key aims: strengthening response system functioning and improvement, supportive oversight, and learning from patient safety events.

Overall, ICB patient safety initiatives are designed to create a culture of safety, minimise patient safety incidents, and drive improvements in safety and quality across the NHS.

Actions in 2025/26

- Collaboration with providers across Greater Manchester (NHS Trusts and Independent Sector providers) to support development and refresh of Patient Safety Incident Response Framework (PSIRF) Policies and Plans.
- Completion and sign-off of ICB actions and recommendations following Mersey Internal

Audit Agency (MIAA) audit of PSIRF Implementation (overall rating of ‘substantial assurance).

- Roll out of the Learn From Patient Safety Events (LFPSE) service within Primary Care following LFPSE registration becoming part of core contractual requirements for GP Practices.
- Use of Patient Safety Specialist network across GM to share patient safety learning, insights and information.
- Planning and engagement work to consider oversight of patient safety in the ICB’s role as a Strategic Commissioner post NHS-Reform.
- Embedding of patient safety within provider oversight framework to ensure that any emerging safety concerns are escalated in a timely and appropriate manner.
- Support and input to ICB Winter Planning including increased oversight of incidents / patient harm related to urgent care.
- Use of Artificial Intelligence to support insight and thematic analysis of patient safety data.

Cardiovascular disease (CVD), long-term conditions and prevention

Partners across Greater Manchester advanced the delivery of the Multi-Year Prevention Plan through system wide collaboration. Work on CVD prevention, lipid optimisation, hypertension management, and secondary prevention following stroke was supported by shared data, collective clinical leadership, and coordinated pathway improvement.

Achievements included exceeding national ambitions for lipid-lowering prescriptions, narrowing inequality gaps, and implementing innovative programmes such as rapid access valve assessment clinics and risk-stratification tools like CVDNeed, the National CVD risk-stratification tool.

Strategic Clinical Networks brought together expertise from across providers and localities to deliver clinically led improvements in diabetes, respiratory disease and multimorbidity. These cross-system programmes strengthened prevention, early intervention and personalised care ensuring consistency and reducing unwarranted variation.

Clinical and care professional leadership

Clinical leadership across Greater Manchester continued to mature through the distributed system wide model, strengthened engagement of clinical leads, and expansion of senior clinical roles across networks, governance groups and clinical programmes.

Leaders from multiple sectors contributed to major transformation programmes, digital safety oversight, commissioning processes and quality improvement work. This included Community Mental Health transformation, Antimicrobial Resistance response, CVD prevention, SCN portfolio delivery, digital safety oversight, and clinical governance reform.

Clinical leadership has been pivotal in delivering statutory duties around quality, research, innovation and effectiveness, ensuring that system decisions remain grounded in evidence and professional standards

Dementia and brain health

Through the Dementia United partnership and programme, all ten Greater Manchester localities used the GM Dementia Quality Standards to benchmark and improve care. Locality self-assessments, assurance meetings and collaborative planning strengthened consistency and transparency across the system.

Development of the extended GM Dementia and Brain Health Plan (2025–2028) was undertaken through wide system partnership, reflecting a shared commitment to high-quality, coproduced and equitable dementia care across GM.

Greater Manchester continues to exceed national performance for dementia diagnosis, with a dementia diagnosis rate (over 65s) of 74.3%, compared with 65.7% nationally, and all localities surpassing the national ambition of 66.7%. As national emphasis shifts from diagnosis rates toward broader indicators of timely access, waiting times and lived experience, NHS Greater Manchester is actively developing the GM Dementia Dashboard to enable more comprehensive reporting. This reflects a wider system commitment to high-quality, co-produced dementia care that reduces inequalities and strengthens community-based support.

BeCCoR (beyond core contract review)

The BeCCoR programme continued to drive major improvements in primary care quality,

access and outcomes during 2025/26. Through targeted risk stratification tools, enhanced data capability and proactive care modelling, practices were supported to identify patients with greatest need—particularly those with cardiovascular risk, multimorbidity or complex long-term conditions. This work aligned directly with changes to the 2025/26 GP Contract, which redesignated Quality and Outcomes Framework indicators and increased investment into CVD prevention, childhood immunisation and workforce flexibility, reinforcing alignment between national ambition and GM-wide transformation.

BeCCoR also underpinned improvements in medicines optimisation, antimicrobial stewardship incentives, and primary care pathways for conditions such as obesity, hypertension, diabetes and respiratory disease. The focus on consistent use of the Primary Care Quality Data Framework, launched in June 2025, ensured that commissioners and providers used the same intelligence to drive improvement, reduce unwarranted variation and target support. These developments strengthened the clinical-operational interface between primary and secondary care, supporting the left shift and improving population health outcomes.

Antimicrobial stewardship (AMS)

Antimicrobial stewardship and IPC improvement continued to be delivered through coordinated system partnerships across microbiology, pharmacy, informatics and primary care. These collaborations strengthened surveillance, supported delivery of national AMR requirements and enabled development of shared system tools such as the GM AMR dashboard. This collective approach drove sustained reductions in overall antibiotic prescribing, maintained road-spectrum prescribing below national thresholds, and increased adherence to recommended 5-day courses for key respiratory infections. The GM Primary Care Incentive Scheme further strengthened stewardship culture by supporting leadership, improving coding of indications, reducing unnecessary prescribing and promoting appropriate duration of treatment.

Greater Manchester’s participation in the Improving Prescribing and Antimicrobial Practices in Urinary Tract Infections (national research trial), one of only a small number of system-level sites chosen, demonstrated leadership in tackling antimicrobial resistance linked to urinary infections—a key driver of Clostridium difficile (C.diff) infection risk. Collaboration across microbiology, pharmacy, informatics and primary care accelerated development of dashboards, prompts, education sessions and co-designed interventions. Strengthened IPC governance, improved surveillance of priority infection risks ensured system readiness and compliance with legal requirements. These efforts collectively contributed to improved safety, reduced variation

and more sustainable use of antimicrobial therapies.

Frailty, deterioration and community-based care

NHS Greater Manchester continued to strengthen system approaches to frailty through improved recognition, integrated care pathways and cross-sector working. Frailty featured prominently within both long-term conditions and urgent care programmes, particularly in relation to delirium, dementia, deterioration and prevention of infection.

The GM Deterioration Group advanced priorities to standardise best practice in sepsis, delirium care, innovation spread and learning from incidents. This included implementation of Martha's Rule expanded Paediatric Early Warning Score coverage, and cross-system escalation processes designed to improve early identification and response for deteriorating adults and older people.

As frailty continues to grow in prevalence across GM's ageing population, NHS Greater Manchester focus on integrated, proactive, community-based models of care remained central to achieving system ambitions around population health, inequalities and sustainability.

Medicines optimisation

NHS Greater Manchester's Medicines Optimisation (MO) function delivered one of its strongest performances to date. Enhanced partnership working across the system improved consistency, strengthened collaboration, and enabled delivery at pace across priority programmes.

As a result, the system is on track to achieve £40 million in prescribing cost improvements by the end of 2025/26, a substantial increase from £25 million in 2024/25. This will mark the first year we end with a projected prescribing budget underspend of £2.7 million and up to £60 million in total system savings when cost avoidance is included. These outcomes were underpinned by robust, joint horizon scanning by finance and system pharmacy teams, enabling accurate forecasting of savings and spend and strengthening system governance through the Greater Manchester Medicines Management Group (GMMMG). Furthermore, through GMMMG, the system also supported the managed entry of new medicines, ensuring their timely, safe, and affordable implementation, this includes working in close collaboration with the National Institute for Health and Care Excellence (NICE) to enable effective planning of more expensive technology appraisals, including medicines for weight management, ensuring rollout remains clinically appropriate, financially sustainable, and aligned with national and local

pathways.

Operational performance across community pharmacy also remained strong, with NHS GM maintaining its position as the highest-performing ICB nationally for Pharmacy First activity, reflecting effective system coordination and engagement with primary care.

System-wide collaboration continued to strengthen medicines safety and antimicrobial resistance (AMR) priorities. The antimicrobial stewardship (AMS) quality scheme supported a sustained reduction in antibiotic prescribing volumes, close to the national target, alongside reduced antibiotic expenditure. Progress in opioid stewardship was also maintained through a coordinated, system-wide approach, reflecting greater consistency in prescribing practice and a more mature, data-driven approach to medicines safety.

Alongside continued progress on national MO priorities, biosimilar uptake, and quality improvement programmes, these achievements demonstrate a system increasingly aligned around reducing unwarranted variation, improving patient outcomes, and ensuring the safe and effective use of medicines.

Research and innovation

Research and innovation has continued to expand across GM, aligned to our statutory duties. Through shared governance we have improved links with our regional research infrastructure to support strategic alignment of research delivery and allow for more rapid translation of findings into practice. NHS Greater Manchester made progress developing a Collaborative Framework for Research, supporting broader system partnerships, enhancing primary care research capability, and embedding research insights into strategic commissioning. Priorities included improving research participation as an active supporter of the Research Engagement Network, strengthening infrastructure, and using innovations such as digitally enabled pathways, AI oversight mechanisms, and new clinical technologies wherever appropriate. At a regional level, we have provided consistent scrutiny and oversight of applications to use data within the GM component of the sub-regional secure data environment. This clinical and Caldicott oversight is vital to maintain the trust of General Practice and the public in how their data are used to deliver improvements in care.

Innovation also directly supported clinical quality programmes—for example, genomic testing pilots for the treatment of stroke, adoption of remote monitoring for heart failure (TriageHF+), and development of digital dashboards driving clinical decision-making in AMR, IPC, and

sepsis. These initiatives demonstrated NHS Greater Manchester ongoing commitment to evidence-led, technology-enabled improvement.

Primary care and primary–secondary care interface

Work to strengthen the primary-secondary interface included managing GP collective action, enhancing shared care arrangements, refining referral and onward referral pathways, and improving communication between services. The impact of this work is seen in improved scores on the regional interface maturity assessment and has contributed to creating more collaborative working relationships, increasing consistency of working, strengthened safety processes and readiness for future structural and contractual reforms.

Digital

Digital transformation remained a high priority to help support productivity, collaboration and clinical pathway redesign. Active promotion of the Greater Manchester Shared Care Record has been continued growth in use, with access being made more broadly into primary care through community pharmacy access. To support safe transformation and align change with national safety standards, a system-wide AI policy and oversight group has been established. Addressing gaps in digital clinical safety capacity was a recurring theme in CMO reports, alongside work to integrate digital solutions within pathways such as crisis response, stroke imaging, and IPC/AMS dashboards.

Digital innovations also supported operational improvements, including online stroke referral systems (Patient Pass), improved data quality for mental health escalation pathways, and the growth of digital self-management platforms across long-term conditions. These developments contributed to safer, more efficient care aligned to national reform expectations.

Mental health

Adult mental health crisis and urgent care transformation

There has been a significant level of transformation in mental health crisis and urgent pathways in Greater Manchester (GM) in 2025/26. These include:

Mental Health 111 option 2 24/7 crisis helpline established and providing a single service for GM residents – combining existing Mental Health Trust crisis helplines into a single service.

- Mental Health Urgent Triage (MHUT) service established in GM, with MH practitioners based in and operating from NWAS Emergency Operations Centre, providing telephone triage and assessment to people who dial 999 in a mental health crisis who do not need an emergency response.
- Enhanced emergency services professionals' line as part of MHUT, single point of access for police officers and ambulance crew at scene to speak to a MH professional, providing support and advice when someone presents in potential MH crisis.
- Agreement for additional investment in 24/7 Crisis Resolution and Home-Based Treatment teams as key to delivering a sustainable alternative to Emergency Departments (EDs) and resilient community-based MH services
- Significant investment in voluntary, community, faith and social enterprise (VCFSE) sector partners embedded in MH crisis pathways – including integrated roles in 111 and MHUT, A&E and community-based crisis spaces.
- Delivery of a GM Improvement Plan for Health Based Places of Safety in GM
- Established MH Individual Escalation Process embedded in the GM System Control Centre for people experiencing long waits in EDs.
- Capital bid submitted for MH EDs, to support commitment as a system to develop the future model together, driven by our improved GM datasets
- A VCFSE navigator pilot has been undertaken in MFT, as part of the S136 improvement plan with the data prospectively gathered from this to inform the MH ED models moving forward

Right Care, Right Person (RCRP)

It is broadly agreed that RCRP Phase 1 (Concern for Welfare) was implemented relatively successfully considering the challenging position of the mental health system, particularly over winter, with established pathways, for example, into 111 24/7 mental health crisis helplines. However there remain risks across a number of areas including clinical risk and definition of 'immediate' in respect to suicide risk and self-harm, and where attempts need to be made to locate an individual in person. Health and police continue to work in partnership to mitigate risks.

Increased planning for Phase 2, related to improved handover times for police to health teams when someone is brought to a place of safety under section 136 of the Mental Health Act, is ongoing. There is a commitment to reducing handover times, evidenced through clear system-wide data and underpinned by improved joint protocols, and to addressing long-standing issues

in S136 suite availability with additional workforce capacity, investment, and improved processes to improve outcomes for patients. A new GM interagency protocol for S136 has been developed and is being embedded within organisational processes.

Adult community mental health

Seamless GM community mental health pathway

- During 2025/26, Greater Manchester continued to make progress in transforming community mental health care through the delivery of the Neighbourhood Mental Health Team model across localities. This place based approach is now embedded as the foundation of our community mental health offer, enabling earlier access to support for people with serious mental illness and complex needs.
- Neighbourhood Mental Health teams operate at Primary Care Network level and are closely connected with the VCFSE sector. These multidisciplinary teams bring together mental health practitioners, social care professionals, VCSE partners and peer support roles and deliver trauma informed, person centred, holistic support.
- Alongside the neighbourhood offer, redesigned specialist pathways continue to support people with more intensive or specific needs, including complex emotional and relational needs, eating disorders, and community rehabilitation. Both mental health trusts have also further strengthened pathways and are continuing to rollout redesigned specialist Community Mental Health Team (CMHT) functions ensuring a seamless pathway from early help to specialist care.
- Localities where the Neighbourhood Mental Health model is fully embedded continue to see improved access, reduced waits and decreased pressure on specialist services. Evaluation from Salford demonstrates that circa 80% of referrals previously directed to CMHTs were more appropriately supported within the Neighbourhood Mental Health Team model, avoiding escalation and reducing crisis presentations.
- In 2026/27, the alignment between Community Mental Health Transformation and GM Live Well will deepen further. Neighbourhood mental health teams will increasingly operate as part of the Live Well ecosystem, utilising Live Well Centres and Live Well Spaces as community access points, benefitting from strengthened VCFSE capacity, and contributing to a unified approach to prevention, early help and community wellbeing.
- This integration will help ensure that community mental health care in Greater Manchester is not only clinically effective, but also rooted in everyday, trusted

community support, creating a seamless, compassionate and place based offer for residents across all ten GM localities.

GM community mental health service specification

During 2025/26, NHS Greater Manchester has made substantial progress in the development of a new GM Community Mental Health Service Specification. The new specification sets out clear expectations for the NHS commissioned NHS Trusts services. Implementation of the new specification planned in April 2027, will align local delivery, with the specification setting out the required standards for high quality, integrated community mental health care. The specification is derived from the NHS Long Term Plan and the Community Mental Health Framework and defines the core and developmental standards that all providers are expected to deliver.

The new specification will ensure / we are:

- Strengthening the Core Community Mental Health Offer
- Reducing Fragmentation and Improving Pathway Consistency
- Implementing Place Based, Multidisciplinary Teams
- Meeting National Activity and Quality Requirements
- Meeting Workforce Development and Competency Requirements
- Embedding the core principles of Co Production and Lived Experience Leadership

Performance and Outcomes in 2025/26

- 31,960 people (adults and older adults with Severe Mental Illness (SMI)) accessed community mental health services and received 2 or more care contacts in the 12-months to November 2025.
- Localities report strengthened multidisciplinary working, deeper VCSE partnerships, and better service user involvement in care planning.
- Peer support and trauma informed practice continue to expand, embedding recovery-focused approaches across neighbourhood teams.

Physical health severe mental illness (SMI)

NHS Greater Manchester is prioritising the physical health of people with severe mental illness by supporting flexible, locally driven approaches across Primary Care Networks (PCNs). NHS GM is working with PCNs to design health check processes that meet the needs of their local

populations, including the use of holistic SMI health check events. This approach recognises the importance of adapting delivery to local geography, practice needs and existing relationships to improve engagement and outcomes.

Alongside this, NHS GM is embedding the principles of Making Every Contact Count so that every interaction in primary or secondary care becomes an opportunity to consider and address physical health needs. By promoting this mindset and sharing examples of best practice across the system, NHS GM is helping services learn from one another and strengthen the overall support offered to people with SMI.

Performance and outcomes in 2025/26

SMI health check: As at September 2025, 60% of people with Severe Mental Illness (SMI) received a physical health check, with GM on-track to exceed the 2025/26 plan of 60%. This metric measures the percentage of people with SMI on the General Practice (GP) SMI register that have had a full physical health check in the preceding 12 months - a full physical health check includes 6 components: a measurement of weight, a blood pressure and pulse check, a blood lipid including cholesterol test, a blood glucose test, an assessment of alcohol consumption, an assessment of smoking status.

CMHT independent review

The final report for the CMHT Independent Review is due at the end of February 2026, and recommendations will be built into mental health programmes of work.

Children and young people (CYP)

Throughout 2025/26, Greater Manchester continued to demonstrate strong progress in improving access to community mental health services for children and young people, exceeding both the Long-Term Plan (LTP) target and the planned trajectory. As a result of this achievement, the access target for future years has been increased, and Greater Manchester remains committed to meeting this enhanced ambition.

Core child and adolescent mental health services (CAMHS)

Across Greater Manchester, Autism and ADHD assessments for children and young people are primarily delivered through CAMHS (with some through Community Paediatric Services), with

notable variation in service models between localities. The services are not able to meet the significant and rising demand for neurodevelopmental assessments and waiting times and lists have grown exponentially.

To address these challenges, the CAMHS specification has been refreshed, ensuring that CAMHS can focus on supporting children and young people with co-occurring mental health conditions. In addition, work is underway to ensure a consistent core CAMHS offer across all localities in line with the updated specification.

Greater Manchester will also transform the current Mental Health Support Teams (MHST) model by adopting the national framework and expanding provision with eight new teams delivered in 2025/26. This forms part of our commitment to achieving 100% coverage by 2029/30, with an ambitious programme of work planned to accelerate progress.

Perinatal mental health

Historically, Greater Manchester had not invested in specialist perinatal mental health services to the levels outlined in the Five Year Forward View or the Long-Term Plan. However, NHS GM has prioritised investment in Specialist Perinatal Mental Health Services for 2025/26. This funding will increase access, ensure timely assessment for those with the highest level of need, and support improvements in service quality.

We are working closely with GM providers to address inequalities in access and ensure sustainable service expansion. A business case has been developed and funding secured, to increase reach in line with national Long-Term Plan targets of 10% coverage by 2029.

Neurodevelopmental transformation

In 2024/25, NHS Greater Manchester initiated a comprehensive transformation programme in response to national and local concerns regarding the significant increase in demand for Autism and ADHD diagnostic assessments, alongside growing waiting lists and extended waiting times. Recognising the need to shift away from a diagnosis-led model of support, Greater Manchester is committed to a needs-led approach.

Key developments include:

- A business case approved by NHS GM, securing investment for a needs-led

neurodevelopmental new model of care across all 10 localities. This has enabled the establishment and mobilisation of early support offers, allowing children, young people, and families to access help earlier and without requiring a diagnosis. GM has committed to recurrent investment of £3.6m per year to sustain these support pathways.

- Assessment prioritisation criteria, agreed by the GM Clinical Effectiveness Group in November 2025, with phased implementation beginning in January 2026 to ensure that children and young people with the highest needs are prioritised for earlier assessment.
- An additional £2m of funding secured to support waiting list recovery activity from January 2026

Out of area placements (OAPs) and local spot purchase placements (LSP)

The GM system is committed to improving mental health services by reducing the number of inappropriate out of area placements (OAPs) throughout 2025/26. The aim was to reduce OAPs to 2 and the number of LSP beds to 14 by the end of March 2026. To achieve this goal, specific locality and provider action plans were developed and implemented, and a Greater Manchester wide oversight process was established to monitor progress and ensure delivery.

Significant performance improvement throughout 2025/26 demonstrates the effectiveness of this collaborative approach. A substantial reduction in average daily OAP usage has been achieved, falling from 17 in April 2025 to just 4 in December 2025 (the average was between 1-3 from August to November 2026). In addition, a substantial reduction in LSP has also been achieved, falling from 68 in April 2025 to 15 in December 2025. Plans are in place to further improve performance in this area into 2026/27 and beyond.

Targets were also set for Clinically Ready for Discharge – a target of a 25% reduction ‘bed days lost’ due to beds being occupied by people who are CRFD. There has been variance in localities and providers ability to meet these targets, but Salford, Wigan, Oldham, Tameside and Bury are all currently (as at December 2025) exceeding this target. PCFT as a provider is also exceeding this target.

The mechanism which has ensured that the above targets are met and sustained is the Mental Health Integrated Fund (MHIF). This is a purposeful and sequenced shift in how public money is used. The MHIF was set up to mitigate the increasing costs of OAPs and local spot placements with the aim of reducing spend in inpatient facilities and investing instead in left

shift and community developments.

The MHIF operates between NHS GM and its 2 main NHS MH providers. The fund has adopted a risk/gain share principle to manage placements and costs within an agreed budget and to agreed reducing trajectories. The initial model was based on average costs per bed night and then superseded by actual costs during the year. The fund is covered by an MOU which agreed the % shares in advance, with NHS GM holding 50% and the 2 MH Trusts 25% each.

Learning disability and autism

People with a learning disability and autistic people experience avoidable health inequalities and can also be inappropriately admitted to mental health hospitals for long periods. To improve health outcomes and access to and experience of care, ICBs and providers are working to:

reduce the longest lengths of stay in mental health hospitals

- reduce admission rates to mental health hospitals for people with a learning disability and autistic people
- optimise existing resources to reduce long waits for autism and ADHD assessments and improve the quality of assessments by implementing existing and new guidance, as published

Allocation of funding for this program to support these targets includes:

- Work with CYP services to standardise the clinical criteria for requests for Autism and ADHD assessments for Children and Young People to support consistent and transparent implementation across GM in relation to new requests for assessments and existing waiting lists. These criteria have been developed as part of NHS Greater Manchester’s transformation program focused on implementing a new, needs led model of care for Neurodiverse CYP which includes the establishment of local, and GM early support offers which will be available to families without the need for a diagnosis.
- Investment in intensive, crisis and forensic community teams to support people to live in the community and reduce admissions. This includes intensive support (Ealing model teams for children and young people) and admission alternative provision such as Radcliffe Place.

- Work to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people, through work on reducing health inequalities.
- Reduce the number of learning disabled and/or autistic people detained in mental health hospitals through admission avoidance and discharge support including the GM Complex Needs Project, investment in community services and support, Dynamic Support Registers and provision of Care, Education, Treatment Reviews. This has included mobilization of GM CETR 'hub' capacity to support compliance as well as digitization of Dynamic Support Registers.
- Improve the quality of care provided across the NHS and reduce the use of restrictive practices team
- Designated key workers for children and young people with the most complex needs
- Increasing the number of people with a learning disability who receive an annual health check
- Delivery of the Partnership for the Inclusion of Neurodiversity in Schools project (PINS) and GM continuation of the Autism in schools project, now known in GM as Neurodiversity in Schools. This programme has, to date, worked into 200 primary and secondary schools.

Engaging people and communities

During the last 12 months we have continued to deliver our People and Communities Participation Strategy, relationships with people, communities and our partners to foster an environment of participation and collaboration.

We have strengthened engagement centrally and at place to ensure that people and communities have been truly involved at the beginning of our commissioning plans and have been contributed to the development of local and system wide engagement plans via the Locality Participation Groups.

This year we have undertaken two major pieces of consultation to support our reconfiguration of IVF and Adults ADHD services across Greater Manchester. This has included the views of more than 4000 people.

In 2024/25 we committed to amplifying the voice of vulnerable communities and developing closer links with the VCSE sector to support and enable this to happen. We are proud to have worked in partnership with 10GM and local infrastructure organisations to make this happen.

The Community Voices Model supports the development of locality networks for engagement reaching those who are least likely to have their voice heard and is led by communities at place.

People and communities participation strategy

We have continued to uphold the principles in our People and Communities Strategy and have worked with system wide health and care partners to deliver the commitments in the strategy.

People and community strategy, key principles

This group has been pivotal in the development of the Community Voices Model and the Locality Participation Groups (LPGs).

LPGs are made up of engagement leads and practitioners in each of the ten localities. The diversity of localities means that each group is set up and works in a different way but primarily their role is to plan, support, deliver and oversee engagement at place, enabling a coordinated approach, avoiding duplication and ensuring the voices of people and communities are central to place based plans.

System participation group

The GM SPG mirrors the LPGs for work which is at a scale of more than one locality and it consists of representatives from all of the NHS providers, the ICB and the VCSE sector. Work

this year has included a focus on health literacy and the development of a GM Readers' Panel.

Delivering our statutory duties

Involving people and communities is important to us as we know that health and care decisions that take into account people's needs are more likely to support people to live well and reduce inequalities. At the same time we are more able to meet our statutory duties and evidence that involvement has influenced health and care plans.

This year we have carried out two statutory consultations for IVF and Adults ADHD. Extensive engagement was carried out to shape the preferred models for reconfiguration of these two services and a wider public consultation exercise involving the views of over 4000 people.

Case study 1 – Adults ADHD

What we did

Following previous engagement with people with lived experience and a review of Adult ADHD services, an 8-week consultation was held to seek feedback on 2 proposed options for how services can be improved, proposed referral criteria, and ideas and feedback on what support would be helpful to people with ADHD.

Who we involved

We engaged over 2,500 people across Greater Manchester in a variety of ways, including: focus groups, community group workshops, online survey, texts, phonecalls, emails, voicenotes, and pop-up stalls across Greater Manchester.

What we heard

People told us that they agree with the proposed new model of care, with reducing waiting times being their biggest priority. They also agreed with the preferred option out of the 2 options we presented. People also on the whole agreed with the referral criteria, but raised concerns that they would be too exclusionary, and potentially increase health inequalities, particularly for women and non-binary genders.

What we did

We are implementing the preferred model which aims to reduce waiting times and prioritises those most in need. We have listened to the views about support services and referral criteria and have responded by offering a wider range of support with a range of ways to access these services so it isn't 'one size fits all'. We have also amended the referral criteria to ensure that people with diverse needs are not left behind.

Case study 2 – In vitro fertilisation (IVF)

We held a public consultation to seek feedback from residents, communities, stakeholders, and staff about the number of In vitro fertilisation (IVF) cycles, eligible people should be offered across Greater Manchester.

Due to differing legacy policies from the previous ten Clinical Commissioning Groups, depending on where a person lives, they are offered a different number of cycles – from 1 cycle to 3 cycles. We believed that this isn't fair and needs to change.

We held a 6-week consultation to ask if people agreed with the proposal to move to a 1 cycle, plus an additional attempt should this be cancelled or abandoned (referred to as 1+) offer, to eligible women aged 39 and under.

Who we involved

Over 2,200 people engaged with us in lots of different ways, including via an online survey, in focus groups, at community pop up events and as part of a Lived Experience Advisory Group.

What we heard

There was significant support from respondents for the number of NHS funded IVF cycles to be standardised across Greater Manchester. Despite this, most respondents strongly oppose the change to a 1+ cycle offer, citing clinical evidence, personal experiences, and concerns about "real equity" and the impact any change could have on individuals' mental health. Almost all supported maintaining the current higher offers in those localities which offer 2 or 3 cycles, with many also wanting to see an increase in the number of funded cycles, in line with NICE guidelines.

People felt that the policy should be applied fairly and consistently, however there were

different reasons for what people thought was a fair application.

The majority of people felt that any negative change should only apply to people who had not yet been approved for IVF and that applying it to people mid-journey would be emotionally and financially damaging and break a “promise”.

What we did

We will now be standardising the offer across Greater Manchester with implementation of the preferred option after April 2026. We have anyone listened to people about the need to support those currently on the pathway and referred to an IVF clinic before 1st April 2026 will continue under the current policy.

Reaching underserved communities

Understanding the views and experiences of underserved communities is central to all our engagement activities. This year we have developed tools to help track and evaluate engagement and ensure that we target those identified by equality impact assessments.

When undertaking engagement we have a range of ways to ensure our engagement is accessible including developing easy read information, interpreters, BSL films, information in different languages and we will provide support for people to get involved should they need it.

Community voices

This year we have funded the VSFSE sector to develop a community engagement model amplifying the voices of underserved and marginalised communities including; new and emerging communities, women and girls, mental health, the Jewish community, people living in poverty, the travelling community and refugee and asylum seekers.

Communities will be supported to give their views on priorities that are important to them and also to be involved in shaping local plans and GM strategies.

This is an innovative and exciting model that shifts the balance of power into the hands of the VCFSE sector and communities themselves meaning that they are more able to have their voices heard by decision makers.

Governance and assurance

NHS Greater Manchester's Involvement and Assurance Group (IAG) provides assurance to the Board for the delivery of the statutory duties. It will provide oversight of all participation and involvement work, with a focus on delivering the statutory duties.

The IAG is a sub-group of NHS GM's Quality and Performance committee, which receives patient complaints and experience information, giving a place to triangulate this insight and feedback.

Further information

This year, we have taken the decision to publish a People and Communities Engagement Annual Report describing more fully how we have discharged our legal duties which will be available on our website shortly.

Complaints

Patient feedback provides an invaluable insight into the patient experience, quality and safety of the services NHS GM commissions. NHS GM manages patients enquires, MP letters and complaints within its GM-wide Patient Services team. Enquiries and complaints are triaged at first point of contact to decide whether the case is appropriate for NHS GM to deal with. Of those cases accepted, some are resolved informally (through a Patient Advice and Liaison (PALS) approach) and where informal resolution is not possible, they are managed via the NHS complaints process. Complaint themes, trends, outcomes and learning is reported through the NHS GM Quality and Performance Committee and for primary care complaints, through NHS England's quarterly oversight meeting.

For the year 2025/2026, there are a number of cases where wider learning for the system was identified through the investigations NHS GM undertook. For primary care complaints, there were the following five recurrent themes:

Clinical Care – These varied significantly where patients felt their care had gone wrong. Where these cases were upheld and fitness to practice issues were identified by our clinical advisers, they were referred to NHS England North West's Performance Standards Group (PSG) for further action outside of the complaints process.

Removal from GP practice list – This was a common theme where patients were removed for their behaviour, but due process had not been followed. The practices were reminded of the process to follow. In one case, the Primary Care Network refused to accept a patient to any of their practices as a patient had been removed from one of them for their behaviour, using a loophole in the wording of the GP contract. This resulted in our Primary Care Contracting Team working with NHS England to ensure that this loophole was closed in the new contract for 2026/27.

Communication – This is a regular theme that resulted in complaints, where GPs, Dentists and Pharmacists had not clearly explained a situation to patients. This led to misunderstandings and a subsequent complaint. Clearer explanation of treatment prior to this commencing would have prevented these complaints and feedback was given to the providers concerned.

GP Registration – This was another common theme where patients were incorrectly asked for ID, proof of address or immigration status before a practice would register them. All practices were reminded that these are not required for a patient to be registered.

EPS Nominations – Another primary theme related to pharmacies changing a patient's nomination to themselves without consent. Documented consent (paper/electronic) was recommended to prevent this from happening again.

Within the non-primary care complaints received, the main underlying cause related to the funding and commissioning decisions of NHS GM. Whilst these complaints were upheld in terms of the concerns raised and experiences described by patients, there was no learning identified as due process had been followed through the implementation of the funding and commissioning decisions.

Reducing health inequalities

Fairer Health for All is our system-wide commitment and framework for reducing health inequalities in Greater Manchester (GM). The framework sets out our collaborative approach and priority action across the city-region to reduce health inequalities and ensure people have the best possible health and wellbeing, no matter who they are or where they live. It outlines key principles, alongside tools and resources for how we can monitor progress and learn through system wide outcome and assurance targets and metrics. It sets out how we will work collaboratively to:

- Fulfil statutory NHS responsibilities such as unlocking social and economic potential and delivering against Core20PLUS5 inequalities targets
- Enhance and embed prevention, equality, and environmental sustainability into everything we do as a health and care system
- Tackle the discrimination, injustice and prejudice that lead to health and care inequalities
- Create more opportunities for people to lead healthy lives wherever they live, work and play in our city-region

The Fairer Health for All Ambitions and Goals for 2030 are to:

- **Improve health and wellbeing to narrow the gap in life expectancy and healthy life expectancy:** narrow the gap by at least 15% between men and women living in GM between all 10 localities in GM, as well as between GM and England average.
- **Reduce unwarranted variation in health outcomes and experiences:** eliminate the difference between the highest and lowest social groups in the experience of having two or more multiple health harming behaviours.
- **Increase social and economic activity because of reduced ill health:** narrow the 15 year gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population to five years.
- **Reduce preventable or unmet health and care needs leading to reductions in health and care demand:** close the health inequalities gap in smoking prevalence with England. Reduce avoidable mortality rates by 40%.
- **Reduce the difference in life expectancy and the incidence of physical health conditions for people with SMI:** narrow the gap with England by 15%.
- **Reduce infant Mortality:** narrow the gap in infant mortality with England by 15% and close the school readiness gap.

This chapter summarises the progress of our system wide action on prevention and proactive care, it demonstrates approaches to reducing inequalities in 2025/26 and that equality and inclusion is embedded as a golden thread in all areas of work. This should be read alongside the full Health Inequality Statement and the Public Sector Equality Duty report which highlight the breadth of work to tackle inequalities happening across our neighbourhoods and localities. Further examples of Fairer Health for All in action are also on the Academy website, with links to training and development opportunities and shared learning resources that capture ‘stories of change’ describing how we are enhancing:

- Community-led health and wellbeing
- Health creating places.
- Prevention and proactive care
- Access, experience and outcomes of care

Community-led health and wellbeing

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

- **GM Live Well** - Greater Manchester's commitment to ensure everyone can access great everyday support in every neighbourhood. It aims to tackle health, social and economic inequalities by changing how we work with people and communities, and in public services. Live Well is nationally recognised as part of Greater Manchester's status as a 'Prevention Demonstrator', as outlined in the 10-year Plan for Health, attracting significant interest from various government departments.
- Over the last 12 months, Live Well has transformed from an ambitious manifesto pledge into our collective programme for public service reform. Live Well is now the main mechanism for embedding prevention, integration, and community empowerment across GM's neighbourhoods. The GM programme has also introduced the "Live Well Hallmarks" – a developing, collaboratively designed framework for Live Well centres, spaces, and offers, co-created with localities and community groups to ensure consistent, values-driven delivery.
- In the past 12 months Live Well has convened over 2,000 stakeholders in high-profile community-based events, growing a bottom-up movement to reduce inequality and further enhance collaboration between communities and the local public services that serve them. A new Live Well Communities Fund was prototyped, and funded community led health and wellbeing work of 400 community groups, reaching over 13000 in deciding and or benefitting from grants.
- **Immunisations and Vaccinations:** Greater Manchester ICB invested more than £450,000 to support underserved groups in accessing vaccinations throughout the winter period. Uptake of the Covid19 vaccine has met the NHS England aspirational

targets for 2025/26, with more than 155,000 vaccinations administered. Delivery of flu vaccinations has also improved during the 2025/26 period, with over 886,000 doses given to help protect those most at risk. The RSV vaccination programme is now established as a year-round offer.

- **Cardiovascular disease (CVD) prevention:** The Beyond Core Contract Reviews (BeCCoR) quality standards for CVD and Diabetes included as part of the GM-wide GP incentivisation programme have been shown in the year one evaluation (2024/25) to have performed very well, with an estimated 380 catastrophic events prevented (equivalent to one heart attack every other day and one stroke every two days across GM). GM ICB has also this year been involved in the national 'long-term conditions hypertension pilot' programme – with the largest number of GP practices of any ICB selected to take part. This work is benefitting those at greater risk of CVD within GM and helping to address existing health inequalities.
- **GM Creative Health Place Partnership** is a three-year programme (2024–2027) led by NHS GM and pioneering ways to embed creative health approaches into a more preventative, equitable and community driven health and care system across Greater Manchester. The programme brings together more than 30 partners from across health, care, VCFSE, culture and higher education sectors.
- Over its first year, the programme has developed and tested creative approaches to early years speech, language and communication; community based mental health for global majority communities and adults living with COPD and asthma. The programme is also building systemwide infrastructure to support activity including practitioner support, leadership development and the publication of evidence and research to support commissioning.
- **GM's Nature for Health 'Test and Learn' programme** (led by NHS GM 2021–2025) has concluded after formally engaging over 1,550 residents in nature-based activities and delivering a peak net economic benefit of £4,933 per person. The evaluation demonstrated statistically significant mental wellbeing improvements, with 83% of participants residing in the city-region's most deprived areas and 76% from ethnic minority backgrounds. The programme proved the value-for-money of nature-based interventions by specifically targeting individuals with serious mental illness and communities experiencing the most entrenched health inequalities. Furthermore, the programme has a proven, neighbourhood-based care model that supports the shift from sickness to prevention. This work helps contribute to the Live Well movement, with Green Health principles firmly embedded in the Greater Manchester Strategy and the

NHS GM Green Plan 2025–28 to ensure a sustainable, low-carbon legacy for regional health.

Best start

We have seen positive progress on improving maternal health and the health of children in their first 1000 days. Key highlights include:

- **Smoking in pregnancy**: Since 2018, the Greater Manchester Smokefree Pregnancy Programme has transformed maternity care across the region, GM has achieved their lowest ever recorded SATOD rate at 3.7% (Dec 2025). This demonstrates a significant reduction throughout the Saving Babies Lives Programme and also places GM below the England rate, supporting more than 7,000 additional babies to be born smokefree. Through early intervention, universal carbon monoxide screening, specialist midwifery-led stop smoking support, and a new digital platform that streamlines care (which received Health Service Journal commendation), the programme has created a consistent, evidence-based model now adopted nationally.
- **School readiness**: the proportion of children in Greater Manchester achieving a good level of development by the end of reception increased slightly, from 63.6% in academic year 2023/24 to 64.2% in 2024-2025. However, this figure still lags behind the England average of 68.3%. The proportion of children achieving a good level of development decreased to 50.4% when considering eligibility for Free School Meals and to 17.3% for children with SEN.
- **Preventing Fetal Alcohol Spectrum Disorder (FASD):** In 2025/26, NHS GM has continued to be recognised as a national exemplar of ICB action to prevent diagnose and treat FASD. National FASD charity have named their annual lecture after one of the NHS GM leads pioneering work. The Reynolds Lecture will highlight innovative work being done at a local, regional or national level to help improve services for and/or understanding of the risks of alcohol in pregnancy, the importance of diagnosis and support for those with FASD.
- **Food and Healthy Weight:** Following the successful Childhood Obesity consultation, *The Real Picture*, partners across Greater Manchester have continued to collaborate on opportunities, programmes and projects to reduce childhood obesity. This includes the establishment of a new GM Food Partnership Board, led by the Combined Authority; a review of current school food standards and Holiday Activities and Food (HAF) provision; and continued cross-system work to implement restrictions on out-of-home junk food

advertising. In addition, plans are in development to introduce a GM-wide approach to reducing both childhood and adult obesity from 2026–2027.

Prevention and proactive care

Continuation of system-wide programmes to positively shape the building blocks for health and to address the key behavioural risk factors driving poor health. Highlights include:

- **Work and health:** Delivery of the GM WorkWell Partnership Vanguard has resulted in over 4800 GM residents who are experiencing a health condition to start, stay and succeed in work, acknowledging work and poverty are key social determinants of health. Mental health conditions are primary health barriers identified, followed by musculoskeletal conditions. The success of the GM WorkWell Partnership has contributed to the Government's decision to roll out across England.
- **Housing and health:** Further developed ECO4 pathways delivered fully funded whole-house energy efficiency interventions for patients with specified health conditions that are exacerbated by living in cold homes. In 2025, over 1,071 NHS referrals into the ECO4 Flex scheme led to 757 completed home retrofits, representing £6 million of investment. This resulted in more than 2,770 tonnes of carbon dioxide equivalent emissions saved, with residents saving an average of £590 per year on their energy bills.
- **Making Smoking History:** Smoking at time of delivery rates are the lowest recorded in the city region and we have also seen a decrease in smoking prevalence in adults, which now stands at 11.7%. More public spaces than ever are going smokefree, with all Trusts mobilising a smokefree approach across their sites, community spaces supported to go smokefree with a new toolkit and ways to support housing tenants to quit smoking being tested across GM.
- An innovative digital platform to support transfer of care and give robust end-to-end data about smokers' journeys to quit, has been rolled out across all of GM's smoking cessation support offers. Smoking cessation pathways have implemented through the Prehab4 cancer wellbeing scheme are available in all localities. Pilots offering patients attending A&E and their friends and families brief advice, an e-cigarette starter kit (vape) and referral to stop smoking services have been launched - early predictions estimate over 100,000 people a year could be offered support.
- **Ending all new transmissions of HIV:** NHS Greater Manchester (GM), working alongside system partners, continues to invest in and deliver a comprehensive

programme to eliminate all new HIV transmissions by 2030, in line with GM's Fast Track City commitments. GM continues to exceed the Fast Track Cities 95–95–95 targets, with 95% of people living with HIV aware of their status, 99% of those diagnosed receiving treatment, and 97% of those on treatment achieving an undetectable viral load. Key activities include the expansion of the national Blood Borne Virus Emergency Department Opt-Out testing programme, now live across nine trust sites, alongside the extension of peer support services. Since the programme began, over 1.1 million people have been tested for HIV, Hepatitis B and Hepatitis C in emergency departments. Manchester University NHS Foundation Trust has also become the first trust nationally to mandate HIV stigma e-learning for all staff. Through the Passionate About Sexual Health Service, voluntary sector partners continue to deliver a multi-component approach to reducing HIV stigma, including a positive speaker programme and an intensive support service.

Reducing variation in access, experience and outcomes of care

We have continued to embed a culture of inclusion health and person-centred practice across care pathways, using intelligence (data and insight) and VCFSE partnerships to inform:

- **'Where' care is delivered** e.g. we are improving mental wellbeing and enabling access to mental health services for children and young people via the Mental Health Schools Teams programme and collaborative VCFSE projects. NHS GM have co-produced a new needs-led Neurodevelopmental (ND) Early Help Model of Care to create a more sustainable system that supports CYP and their families without requiring a formal diagnosis. A universal GM offer is being developed, and mobilisation has started including a new website, sensory toolkit, chat messaging service, peer support and a neuro-profiling toolkit. Mental Health Support Teams (MHSTs) continue to expand across education settings with a maintained focus on meeting diverse needs and addressing inequalities. Work has progressed locally with Equality, Diversity and Inclusion (EDI) practitioners, Special Educational Needs and Disabilities (SEND) teams, and youth services to reach underserved communities.

- **How we prioritise and target care** for particular communities and neighbourhoods by aligning NHS intelligence and community insight to develop quality and incentives schemes. Work has progressed embedding deprivation, ethnicity and gender into

dashboards. Additionally supporting the National Neighbourhood Health Implementation Programme in Stockport and Rochdale, providing data and insight at a population level with a focus on health inequalities to show gaps in age, ethnicity and deprivation for adults with long term conditions and high or rising risk of hospital admission.

- Furthermore, collaborative working with GMCA to implement a neighbourhood geography to allow further detailed analysis at a resident level which links to Live Well, Prevention Demonstrator and Neighbourhood working. Prioritisation of care via the continued delivery of the GM Dental Quality Access Scheme with priority given to key cohorts of military Veterans, Care Leavers, and people living with Cancer has continued. Progress has also been made to reduce the gap between adult and children long waits (elective care). Since June 2025, the percentage of 0–18-year-old over 52 week waiters has reduced from 5.2% to 3.7% (compared with 3.9% to 3.2% for 19–64-year-olds and 3% to 2.4% for 65+ year olds).
- **'How' care is delivered:** we are co-designing culturally appropriate and accessible services that also mitigate against the impact of poverty on health. The Bowel Screening Programme has implemented Learning Disability (LD) flagging, which ensures extra clinic time is given to patients attending with a LD. The Stockport Diabetes Transition Young Adult pilot report has shown significant positive impact on clinical outcomes and engagement with the cohort accessing the service and particularly targeting clinics in community settings in more deprived areas. Targeted engagement with schools serving high numbers of Black, Asian and Minority Ethnic students, including Islamic faith schools, is improving access and participation to mental health support. Further examples mental health tailored support for Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning) and other sexual identities (LGBTQ+) young people from faith backgrounds.

  To build more capacity and capability in the system NHS GM Staff have undertaken training and webinars including trauma informed care awareness raising sessions, adoption of the socio-economic duty and poverty awareness raising sessions (since poverty awareness training began, over 1,500 healthcare professionals have been trained, with attendees showing increased confidence in how to support people struggling financially). Health literacy awareness training has commenced to become a more health literate organisation in how we design and deliver care to mitigate any barriers of access.

  NHS GM has commenced implementation of a systemwide anti-racism programme to

tackle rising racist abuse towards staff and patients and to embed anti-racist practice into everyday culture, governance and commissioning. Additionally, NHS GM has continued to develop a system wide equality impact assessment online platform to better enable a read across of cumulative equality impact assessment.

Health and wellbeing strategy

The Health and Wellbeing plans for each locality informed the development of the ICP strategy (2023-28) and we listed each plan within the strategy itself. The strategy was reviewed and commented on by Locality Boards and Health and Wellbeing Boards and their feedback informed the final version.

Elected members from each Health and Well Being Board play a pivotal role in the continuing development and implementation of the ICP Strategy. Greater Manchester has a strong Integrated Care Partnership Board, which meets every two months in public and is jointly chaired by the Mayor of Greater Manchester and the Chair of the ICB. Representation on the ICP is made up of Portfolio Leads for Health and Care from our 10 localities – and these representatives bring the voice of local Health and Well Being Boards into the development of GM-wide strategy through these meetings. These are complemented by private ICP Board Strategy meetings, where local Health and Well-Being Board members meet to develop the programme for the public ICP and discuss key policy issues.

Each of our 10 localities has a Neighbourhood Health Plan and Locality Plan and these are informed on an ongoing basis by local JSNAs and discussion at Health and Well Being Boards. In turn, these plans were taken into account when developing the new Five Year Strategic Commissioning Plan for GM – which will be finalised in July 2026. All of the local JSNAs are made available on our Tableau information system for users across GM. The insight from the JSNAs will be a key part of the workplan of the newly strengthened GM Public Health Network – where the 10 GM Directors of Public Health come together.

Each Health and Well Being Board in Greater Manchester will be responsible for approving the Neighbourhood Health plans for their respective localities. This is a new NHS requirement. We are engaging with the GM system on the new National Neighbourhood Health Framework in the first quarter of 2026/27 – and this will include the role of the Health and Well Being Boards.

Financial Review

Delivery of financial duties

The initial system plan for 2025/26 was a deficit financial position of £200m, which was split £50m deficit in NHS GM and £150m within the provider sector. During the planning process and the agreement to submit a compliant plan, additional NHSE funding of £200m was agreed which was split £42.5m to NHS GM and £157.5m to providers.

The final agreed plan for the GM system (including deficit support funding) was a balanced compliant plan, with NHS GM reflecting a £7.5m deficit and providers a £7.5m surplus. The plan required a total efficiency saving of £656.0m, of which £175.0m related to NHS GM and £481.0m to GM NHS provider organisation efficiency schemes.

2025/26 has been another challenging year for NHS GM and the wider NHS, with higher than anticipated inflation continuing to increase prices and continued demographic growth increasing demand for services, alongside collective action undertaken by resident doctors, all leading to heavy impacts on service costs and productivity.

Due to the on-going economic climate, NHS GM continued with the measures introduced in previous financial years to manage pressures. The enhanced grip and control measures remained in place, including internal and system vacancy control, internal governance process for all expenditure before business case production (referenced locally as STAR process), and investment slippage. The previous scrutiny of both organisational positions and internal locality positions continued under a regime of Provider Oversight Meetings and Locality Assurance Meetings, with reviews being escalated if the financial positions were deteriorating. These meetings were chaired by the NHS GM CEO/Deputy CEO with equivalent colleagues from the provider trusts and locality leadership teams attending.

Where appropriate these meetings were stepped down as part of the organisational response to the Reform programme which required ICBs to reduce headcount by 50% by the 1 April 2026, with a number of redundancy programmes being run to facilitate this. The redundancy programme was partially funded by the national team.

During 2025/26, NHS GM continued to lead the local implementation of national NHS reform, building on the established integrated care model to strengthen collaboration across health, local government and the voluntary sector. This approach has supported a shift towards

prevention and community-based care, while maintaining a strong focus on system performance and financial sustainability to deliver improved outcomes for residents.

From 1st April 2025, NHS GM also took on additional delegated responsibility for mental health specialised commissioned services (the core specialised commissioning contracts were delegated from 1st April 2024), which equated to an additional £119m of funding compared to 2024/25.

Statutory duties

The table below demonstrates that NHS GM has not delivered all its statutory financial duties during 2025/26, with the failure to deliver the duty "Expenditure not to exceed Revenue Resource Limit". The organisation delivered a £7.5m deficit in year, which was in line with the 2025/26 plan agreed with NHS England. This has resulted in a Section 30 letter from the external auditors to the Secretary of State confirming that the organisation has not managed costs within the funding available. This will be the same process for all organisations who fail to meet this duty. This will also generate a regulatory opinion at the conclusion of the audit process. The ICB has commenced repayment of previous financial year deficits from 2025/26 in line with national guidance.

	Duty	**Target (£k)**	**Actual (£k)**	**Variance (£k)**	**Duty Met?**
Expenditure not to exceed Revenue Resource Limit*	Statutory	9,432,074	9,439,567	(7,493)	N
Expenditure not to exceed income	Statutory	9,543,247	9,550,740	(7,493)	N
Expenditure not to exceed Capital Resource Limit	Statutory	-	-	-	N/a
To remain within its Cash Limit	Admin	9,497,061	9,497,061	0	Y
To remain within the running cost target*	Admin	74,036	69,251	4,785	Y

** In addition to the core allocation of £46,047k, this also includes allocations for Redundancy costs (£20,467k),*

pension 9.4% uplift (£7,194k) and pay award (£328k).

The following table provides the key performance metrics over the last three financial years since NHS GM was formed.

	Duty	Variance 2022/23 (£k)	Variance 2023/24 (£k)	Variance 2024/25 (£k)
Expenditure not to exceed Revenue Resource Limit	Statutory	(2)	(38,108)	(55,976)
Expenditure not to exceed income	Statutory	(2)	(38,108)	(55.976)
Expenditure not to exceed Capital Resource Limit	Statutory	0	0	0
To remain within its Cash Limit	Admin	0	0	0
To remain within the running cost target*	Admin	(172)	3,696	1,093

Please note that figures in brackets denotes overspends, with positive figures reflecting underspends.

Expenditure not to exceed revenue resource limit

Limits are set by NHS England for integrated care boards, within which they must contain net expenditure for the year. These are termed “resource limits” and there are separate limits issued for revenue and capital.

NHS GM’s in-year revenue resource limit for 2025/26 was £9,432.1m. Against this, costs amounted to £9,439.6m and therefore the organisation has delivered a deficit of £7.5m, which is in line with the 2025/26 plan agreed with NHS England.

The overall ICS system has delivered a £24.1m surplus against a planned breakeven position, with providers delivering the surplus position, which is due to the receipt of £21.3m relating to additional deficit support funding and a number of providers delivering a further £2.8m improvement above plan.

2025/26 NHS England business rules require that system overspends are subject to repayment, starting in the second year following the year in which the overspend first arose. Cumulative overspends are repaid over a 3-year period subject to an annual cap of 0.5% of the ICB's allocation. NHS GM's overspend repayment in 2025/26 was £31.7m.

NHS England published updated business rules guidance as part of 2026/27 planning, to support the new NHS Operating model set out in the 10 Year Health Plan. ICB repayment of cumulative system deficits will be paused for 2026/27 and 2027/28. Where an ICB delivers a breakeven revenue position in both years, NHS England will consider eliminating the cumulative system deficit. Where an ICB does not deliver a breakeven revenue position in both years, NHS England reserves the right to carry forward the deficit, adjusted to include the 2026/27 and 2027/28 ICB positions.

To remain within cash limit

All ICBs are set a limit on the amount of cash they can spend in a financial year. The 2025/26 cash limit for NHS GM was £9,497.1m and the organisation fully drew down this cash from the government. During the 2025/26 year end processes, NHS GM was able to access £58.6m additional cash compared to the revenue funding (adjusted for cash backed agreed deficit and closing bank balance at 31st March 2025). From the total cash drawn down, there was a £36k balance in the bank at 31st March 2026 after the last payment run, which was within the 1.25% allowable limit (£9.3m).

To remain within the running costs target

The ICB receives an allocation for running costs or administrative expenditure. The target limits the amount the organisation can spend on administrative functions, such as support functions, headquarters, training. The total running cost allocation for NHS GM for 2025/26 was £74.0m, which included an extra £20.5m of in year allocations relating to redundancies due to the national reform programme and £7.2m of pension costs which are transferred annually. During the period, the organisation spent £69.3m on administrative expenditure (including £1.3m of income), generating an underspend against the allocation of £4.8m.

The accounting treatment of the Redundancy Costs is in line with the guidance issued by NHS England, whereby the actual costs should be assigned to either running costs or programmes depending on where the substantive costs are charged, whereas the full allocation was

reflected in the running cost target. This is the main reason why there has been an underspend against the running cost target. In addition, NHS GM maintained the grip and control measures in place, in particular, vacancy control around non-business critical roles and enhanced controls on non-pay expenditure.

Better payment practice code

In addition to the financial duties, NHS GM should comply with the national Better Payment Practice Code. The code is summarised as:

Target: to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Compliance: at least 95% of invoices paid (by the bank automated credit system or date and issue of cheque) within 30 days or within agreed contract terms.

The following table highlights the performance both in terms of the number and value for non-NHS and NHS invoices.

Measure of compliance	2025/26 Number	2025/26 £000
Non-NHS Payables		
Total non-NHS trade invoices paid in the year	155,226	2,133,081
Total non-NHS Trade invoices paid within target	150,845	1,983,849
Percentage of non-NHS trade invoices paid within target	**97.18%**	**93.00%**
NHS Payables		
Total NHS Trade invoices paid in the year	2,777	6,672,585
Total NHS Trade invoices paid within target	2,678	6,669,876
Percentage of NHS trade invoices paid within target	**96.44%**	**99.96%**

The above table shows that the performance measure has been met for three of the metrics, with NHS GM failing on non-NHS by value.

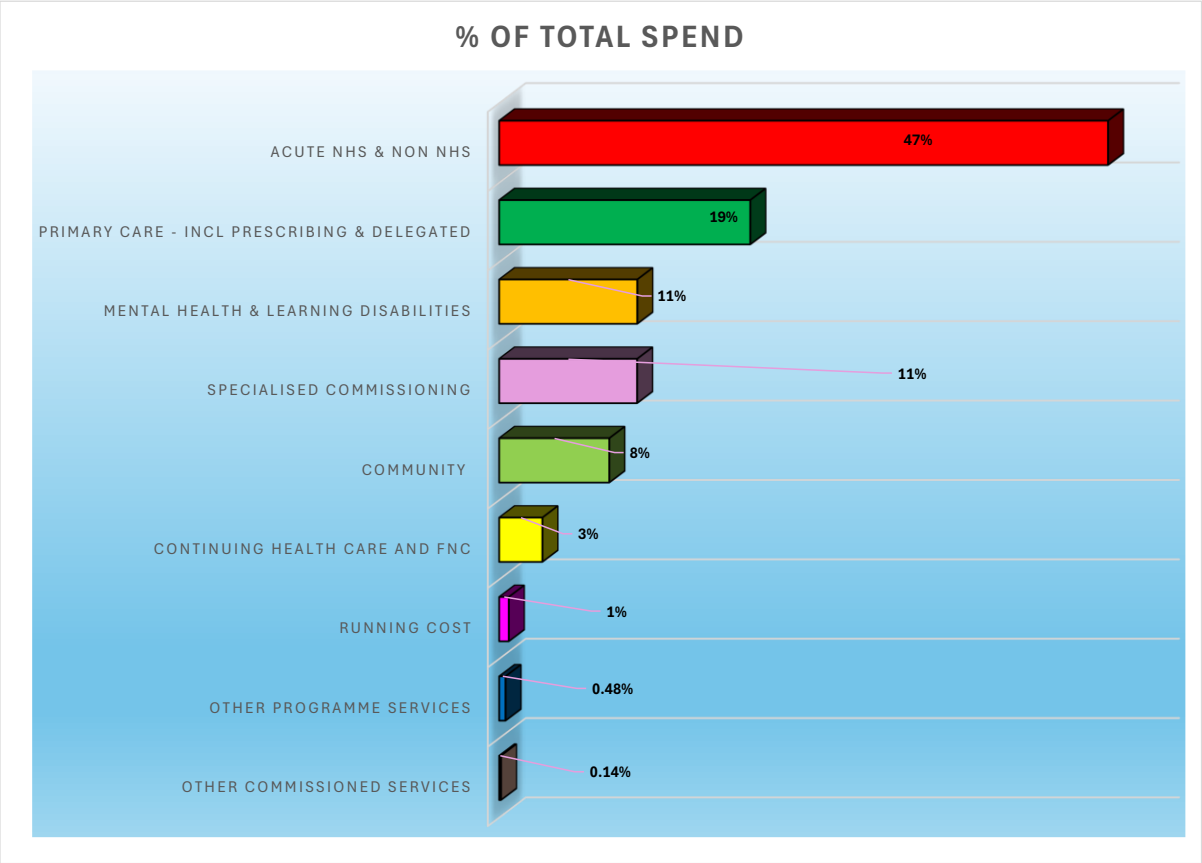
Income

In total NHS GM received funding of £9,543.2m in 2025/26. Most of this funding (£9,432.1m) is received directly from NHS England in the form of allocations. Other income of £111.1m has been received in the year, of which £93.9m relates to prescriptions and dental fees and charges, with the balance received from other organisations.

Expenditure

The total costs within 2025/26 are £9,550.7m, of which £70.5m (gross costs excluding income) relates to administrative/running costs expenditure and £9,480.2m to healthcare (programme) spend. The numbers quoted are gross expenditure and exclude any income.

The following chart details a breakdown of expenditure for NHS GM in 2025/26:



Investments

The ICB has increased funding for some key services to improve patient outcomes, in many cases these were based on additional allocations received from NHS England with specific conditions attached. Some examples of the programmes invested in are:

Mental health services: In 2025/26 the ICB prioritised its MH and LDA expenditure in order to deliver key priorities.

The main areas of increases were:

1. **Integrated Fund for OAPs and Spot placements –** During the year the ICB implemented a Mental Health Integrated Fund. This was based on a risk and gain share model across the system for the care of adult MH patients with acute needs. The Integrated Fund involved aligned budgets for acute placements with the ICB's main NHS providers and then worked closely with them to more effectively manage the placement of patients with acute needs. This necessitated additional investment in management and operational teams to ensure patient flows were appropriately managed collectively across organisational boundaries. This enabled improved data sharing across the ICB to monitor patient placements and their pathways, and to ensure that patient discharges

were better managed. This has resulted in a reduction in the number of patients treated and a consequent reduction in cost with the independent sector. The resulting financial gainshare was shared amongst partners for investment in improving 'left shift' community services.

2. **Children and Young People (CYP) –** Increased investments have continued in children's services in both NHS Providers and in partnership with the voluntary sector, local authority, and other non-NHS stakeholders. This also includes further investments within Mental Health Support Teams (MHST) in schools, targeted intensive support teams Learning Disabilities and Autism (LDA) and those experiencing care), crisis mental health care pathways as well as core Child & Adolescent Mental Health Services (CAMHS).
3. **Mental Health Act and S117 Aftercare –** As reported during the financial year, the ICB has experienced pressures in the cost of complex MH placements for patients who are in longer term as opposed to acute care. To try and mitigate this pressure the Place based teams developed recovery plans to mitigate these increased costs, part of which was to negotiate price increases across the ICB for all localities rather than in different localities. This approach has also been adopted for acute episodes in independent hospitals so that cost pressures can be managed. The ICB has recognised the success of dealing with the major OAPs pressure in previous years by developing a gain share approach as outlined above and is in the process of adopting a similar approach for rehabilitation packages which form part of this cost pressure. This should generate savings during 2026/27.
4. **Community Mental Health –** In line with the national expectations, the ICB has invested into "Left Shift" community initiatives in mental health to improve the service offer to patients and to prevent hospital admissions. The gainshare from the Integrated Fund paid to NHS provider partners facilitated such investments and strengthened community services. The aim of such investments is to provide better access to care and support in community settings. This timelier access means that patients can be seen quicker in the community, so that their mental health conditions are managed in the community, closer to home.

Cancer (national funding): NHS GM received System Development Funding (SDF) for cancer, which supported the Greater Manchester Cancer Alliance delivery plan to:

- Improve performance against the headline 62-day standard to reach 75% and achieve the Faster Diagnosis Standard performance of 80% by March 2026, ensuring that

resource is allocated to adequately support the most challenged areas for meeting these standards.

- Diagnose cancer earlier through: public and patient facing engagement and awareness raising, primary care engagement, testing and implementing innovations, locally developed interventions underpinned by data-led assessment of local priority needs, and through the transfer of NHS-wide initiatives into mainstream commissioning and/or service provision.
- Take forward locally tailored initiatives which contribute to the Long-Term Plan ambitions, including Personalised Care and Treatment programmes.

Additional targeted funding was received to deliver various programmes as detailed below:

- **Lung Cancer Screening Programme:** the lung cancer screening programme offers lung health checks and CT scans to participants aged 55 to 74 who are current or former smokers. The programme aims to improve earlier diagnosis of lung cancer, at a stage when it is much more treatable. The current position in GM is that 80% of cancers diagnosed through this route have been identified at stage 1 or 2.
- **Liver Surveillance:** the aim of the liver surveillance programme is to detect liver cancer early by identify people at higher risk of liver cancer and invite them to attend 6-monthly surveillance.
- **Pancreatic Case Finding Pilot:** the aim of the pilot is to improve early diagnosis and treatment outcomes. This pilot involves GP practices across England reviewing patient records to identify individuals at higher risk of pancreatic cancer. The initiative targets patients aged 60 and over who have recently been diagnosed with diabetes or show signs of unintentional weight loss. The pilot aims to offer diagnostic tests such as blood tests and CT scans to rule out cancer.
- **Cancer Performance Improvement Funding:** Additional funding to improve cancer constitutional standard performance.

Primary care: within primary care the key investments have been:

- **Dental Patient Access Quality Scheme**: to stabilise services and secure ongoing NHS commitment from dental practices and support recovery of access to dental services for patients. This scheme secured
    - New patients seen: 100,197
    - Urgent patient seen: 78,897

    - Cancer patients seen: 828
- In addition to the increased numbers of patients being able to access NHS dental services, there has been a marked decrease in the number of patient complaints and MP inquiries.
- **Beyond Core Contract investment (BeCCoR):** As part of addressing prevention and impact NHS GM worked hard to include an additional of £7.2 million in 2025/26 as phased, additional investment into primary medical care services. This is considered to *start* the levelling up process and consistent resourcing of primary care to achieve system benefit and deliver prevention and health improvement for the population. This investment has delivered in-year improvements to a range of system priorities and challenges, including elective and non-elective admissions for CVD. Evaluation of the scheme has presented an estimate that around **180 heart attacks** and **200 strokes** have been prevented – that's **one heart attack every other day and one stroke every two days across GM –** saving lives and reducing pressure on hospitals.
- **Additional Role Reimbursement (ARRs)**: The ARRS scheme is a primary care investment scheme introduced in 2019 as a key part of the government's manifesto commitment to improve access to general practice by further investment in primary care services. Through the scheme, primary care networks (PCNs) can claim reimbursement for the salaries of primary care roles within a multidisciplinary team selected to meet the needs of the local population, by expanding general practice capacity. The scheme improves access for patients, supports the delivery of new services and widens the range of offers available in primary care. Last year PCNs were permitted more flexibility with regards ARRS funding in that the funding allowed recruitment of other direct patient care roles, non-nurse and non-GP MDT roles , NHSE removed caps on all other direct patient care roles and as a result PCNs utilized 98% of the PCN maximum entitlement (£90.8m) recruiting 2.050.74 WTE's across GM.

Elective Activity: During the year, Greater Manchester received additional non-recurrent national funding to support elective recovery, targeted at areas of greatest need and aligned to national priorities. The investment supported additional capacity and targeted system-wide initiatives to increase activity, reduce waiting times and improve access to planned care, with impact reflected in improved throughput and delivery against recovery plans across the system.

Population Health: During 2025/26, the NHS GM Population Health function delivered prevention and population health activity covering a wide range and activity aimed at improving health outcomes and reducing health inequalities. This was across the breadth of the domains

within the GM Population Health Model and the GM Prevention and Early Intervention Framework and included a continuation of the 2024/25 investment focus on the following:

- Addressing the wider, social, and commercial determinants of health such as early years and school readiness, work and health, good housing and tackling poverty.
- Tackling the key modifiable risk factors for poor health including Making Smoking History, delivery of the GM Moving Strategy to reduce physical inactivity, preventing alcohol harm (with a specific focus on alcohol in pregnancy), and undertaking a wide-ranging programme of public engagement in relation to healthy weight.
- Shaping GM as a Population Health System through the Fairer Health for All (FHfA) Framework, including the development of the GM Health intelligence Hub, FHfA Academy, and FHfA Fellowships.
- Preventing new cases of HIV and Hepatitis.
- Net Zero, Sustainability and NHS Green Plan.
- Person and Community Centred Approaches, including Social Prescribing, Live Well, Personal Health Budgets, Personalisation.
- Delivering the statutory public health requirements of NHS GM including those related to screening, immunisation, and health & justice.

Digital: investments were made during 2025/26 on a range of capabilities to improve the use of technology across primary care. This included the support for our award winning digital first primary care programme enabled through our digital facilitators. Some of the key investments in 2025/26 were:

- Continuation of digital first primary care to deliver the support for digital triage, expanded use of NHS App, and delivery of the primary care recovery plan.
- Rollout of GM care record to community pharmacy, development of Single Sign on for regional access, design of national care record access, expansion to over 25,000 clinicians in all care settings.
- Further strategic cyber security improvements together with draft GM cyber strategy.
- Developed network strategy for replacement of aging network.
- Strategic procurement of OCVC tools for general practice.
- Development and agreement of primary care workspace strategy.
- Development of Primary care digital strategy.
- Definition and tool out of AI policy for primary care.
- Copilot pilot for 200 plus non clinical staff.

Community Diagnostics Centres: the £48.6m investment covers seven Community Diagnostic Centre sites, which have delivered 447,096 tests in 2025/26, with the top disciplines being:

- Imaging 222,454 tests,
- Physiological Sciences 123,234 tests,
- Pathology 77,592 tests.

Financial Sustainability Plans. The planning guidance for 2025/26 asked organisations to look at efficiency delivery in order to deliver financial balance. At the start of the financial year a system wide savings target of £656.0m was set. This efficiency target was split as follows:

- £175.0m NHS GM
- £481.0m GM Providers

At the end of 2025/26, the performance was:

- £175.0m NHS GM efficiency target delivered in full.
- £460.4m of savings were delivered by the GM Providers, which equates to an under delivery of £20.6m.

Review of the financial position

NHS GM's financial health is reviewed monthly at NHS GM's Board meeting. The role of detailed scrutiny is delegated to the monthly Finance Committee, which is a formal committee of the Board and is chaired by a Non-Executive Director and has representation from the other non-executive and partner Members. Due to changes in governance in year, the Finance Committee operated until December 2025 and was then replaced by the Transition Committee and Finance Sub Committee until March 2026. From April 2026, this responsibility is now delegated to the People and Resources Committee.

Independent assurance is provided to NHS GM by External Audit as follows:

- An opinion on the accounts
- A "Regularity" opinion on whether the expenditure has been incurred as intended by Parliament. Failure to meet statutory financial targets automatically results in a qualified regularity assertion, which will be the case in 2025/26, and the two previous financial

years, due to the deficit position reported.

- A report from the auditor on whether they are satisfied that the ICB has made “proper arrangements for securing economy, efficiency and effectiveness in its use of resources.” This is included as a commentary within the Auditor’s Annual Report.

Additional independent assurance is also provided to the Board by NHS GM’s internal auditors, and this is covered within the Head of Internal Audit Opinion within the Corporate Governance section.

The External Audit work programme is supported by the Internal Audit work programme, both of which are monitored by the Audit Committee. External Audit take assurance from this work programme within the statutory audit processes.

2026/27 Financial landscape

On 12 February 2026, NHS GM submitted a financial plan for 2026/27 which was for the organisation and no longer a system / ICS plan. The plan was a medium-term plan covering the three-year period 2026/29.

The plan submission aligns all aspects of planning and how these interrelate to deliver the strategy and the key missions, which are:

- Strengthen our communities.
- Help people get into – and stay in – good work
- Recover core NHS and care services.
- Help people stay well and detect illness earlier.
- Support our workforce and our carers.
- Achieve financial sustainability

The plan is structured around the five pillars of sustainability described in the Sustainability Plan approved by the Board in September 2024 (https://gmintegratedcare.org.uk/wp-content/uploads/2024/08/board-papers-public.pdf).

The longer-term planning and the organisational strategy, highlights the ambition to increase the proportion of expenditure over the longer term to support population health and prevention in line with the 10 Year NHS plan and with focus on the three national shifts, preventing ill health sooner, increasing care in the community, and moving from analogue to digital.

NHS GM has undertaken a challenging and detailed planning process, with high levels of engagement with Chief Officers to ensure robust budgets have been set. There has also been targeted review of allocations, pressures and expenditure run rates in accordance with affordability. The plan does not include a deficit repayment in 2026/27, as this has been paused based on NHS GM delivering to plan, with the balance written off if the plan is achieved.

The final plan submission reflected a revenue allocation of £9,246.0m, with NHS GM submitting a breakeven plan after the receipt of £17.7m deficit support funding. The plan also reflects a capital resource limit of £20.1m. The running cost allocation of £47.4m is broadly in line with previous years plus growth, but in addition, a notified £42.3m allocation reduction for ICB Cost of Commissioning has been applied as a direct result of the national Reform programme, which required ICBs to reduce admin costs to £19 per head.

The NHS GM exit run rate reflected a £155.0m deficit, which has been offset by the following:

- £41.0m surplus balance after applying 2026/27 growth and the allowable organisational deficit
- £62.0m commitments against growth (e.g. MHIS, BCF, CHC, prescribing and elective growth)
- £129.0m of additional pressures for example prescribing horizon scanning, Tier 2 deflection schemes, Live Well (left shift) and elective contract issues above funding available

In order to manage all the above, NHS GM needs to deliver a £150.0m CIP, of which £96.0m has been identified, with £54.0m still to be identified.

As a result of the deficit planning gap being submitted, a number of key priorities for the ICS to continue financial recovery in 2026/27 have been identified:

- The continuation of enhanced grip and control
- A systematic reduction in the dependency on the independent sector
- A commitment to continue the reviews commenced of every commissioned service
- Restrictions on further service growth to fund the left shift into prevention
- An expectation of challenging savings programmes for NHS GM, with 65% of these values delivered recurrently as a minimum

Capital

There are a number of capital funding streams available in 2026/27:

- **Primary care BAU capital** – a core allocation of £6.6m has been received to support investments including premises improvement grants and ICB capital requirements. This funding is administered by NHS England and paid to Primary Care GP practices, NHS PS or CHP based on the recommendations of NHS GM.
- **Strategic Capital –** NHSE have introduced strategic capital totalling £10.5m to develop neighbourhood health hubs prioritised based on deprivation indices within GM.
- **Utilisation & Modernisation funding** continues in 2026/27 with an allocation of £3.0m which will be subject to bids and prioritisation, which is also administered by NHS England, based on recommendations from NHS GM.

There a number of key risks associated with delivery against the 2026/27 financial plan, including:

- **CIP efficiency savings:** the financial plans include £150.0m of savings in NHS GM, with £54m currently unidentified.
- **ICB Reforms:** new operating model to be embedded from 1 April could impact on the operational capacity to deliver CIP and actions taken to minimise emerging pressures in year.
- **Exit Run Rate:** the exit run rate in 2025/26 could worsen from the assumptions made within the February plan.
- **Cost Pressures:** these could be over and above levels funded by NHS England within the national allocation growth assumptions.

ACCOUNTABILITY REPORT

Colin Scales

Acting Accountable Officer

17 June 2026

Accountability report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate governance report

Members report

Composition of the Integrated Care Board (ICB)

Members	
Sir Richard Leese	Chair, NHS GM
Richard Paver	Non-Executive Director and Chair of Audit Committee
Professor Dame Sue Bailey	Non-Executive Director and Chair of the Quality & Performance Committee
Kal Kay	Non-Executive Director and Chair of the Finance Committee
Rachel Egan	Non-Executive Director and Chair of the Remuneration and Population Health Committees
Sheena McDonnell (until 31 May 2025)	Non-Executive Director and Chair of the People & Culture Committee/Senior Independent Director

Jackie Njoroge (from 1 January 2026)	Deputy Chair/Senior Independent Director
Dr Owen Williams	Board Member bringing the perspective of Acute Providers, Chief Executive of Northern Care Alliance (NCA) NHS Foundation Trust
Sean Fielding (from 1 January 2025 until 18 March 2026)	Board Member bringing the perspective of Local Authorities, GM Integrated Care Partnership Board (Committee Member) Bolton Council
Dr Vish Mehra	Board Member bringing the perspective of Primary Care, General Practitioner (GP)
Leigh Vallance	Board Member bringing the perspective of the Voluntary Community and Social Enterprise (VCFSE) Sector, Chief Executive of Bolton Hospice
Anthony Hassall	Board Member bringing the perspective of Mental Health, Chief Executive of Pennine Care NHS Foundation Trust
Mark Fisher	Chief Executive, NHS GM
Kathy Roe	Chief Finance Officer, NHS GM
Mandy Philbin (until 31 December 2025)	Chief Nursing Officer, NHS GM
Professor Manisha Kumar	Chief Clinical Officer, NHS GM
Colin Scales	Deputy Chief Executive, NHS GM / Acting Chief Executive (from 9 December 2025)
Charlotte Bailey	Chief Strategy, People and Partnerships Officer, NHS GM
Katherine Sheerin	Chief Commissioning Officer, NHS GM
Attendees	
Alison McKenzie-Folan	Chief Executive of Wigan Council, Health and Care Portfolio Lead
Warren Heppolette (until 10 October 2025)	Chief Officer for Strategy, Innovation & Population Health
Gareth Robinson (until 9 September 2025)	Interim Chief Officer for System Improvement / Acting Chief Officer for System Reform (from 9 January 2026 until 9 March 2026)
Nicola Hepburn (from 1 March 2026)	Acting Chief Reform & Improvement Officer

Committee(s), including Audit Committee

All of the NHS GM ICB Committee Terms of Reference can be found in the Governance Handbook on the NHS GM Integrated Care Partnership website.

Audit Committee

The Audit Committee is accountable to the Board and provides an independent and objective view of the level of assurance that the ICB holds regarding its compliance with statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit. The Audit Committee is chaired by Richard Paver, Non-Executive Director.

During 2025/26, the Committee met to discharge its delegated functions in line with its Terms of Reference.

Some of the key business of the Committee for the period was as follows:

- Considered the Audit Committee work plan for the year
- Received Policies for consideration including the Conflict of Interest, Freedom of Information and Health and Safety Policies.
- Considered risk management arrangements for the organisation, including a review of the Board Assurance Framework
- Agreed the Internal Audit and Anti-Fraud Plans for 2025/26, whilst also considering plans for 2026/27
- Received summaries of Internal Audit reports and following up implementation of recommendations
- Approved the Annual Report and Accounts process for the period 2024/25 and the final post-audit documents on behalf of the Board
- Received reports relating to corporate governance processes, including Counter Fraud, Whistleblowing, Information Governance, Health & Safety, IT Security / Resilience and EPRR Arrangements.

Members	
Richard Paver (Chair)	Non-Executive Director / Audit Committee Chair

Sheena McDonnell (Vice Chair) (until May 2025)	Non-Executive Director / Chair of the People & Culture Committee
Jackie Njoroge (Vice Chair) (from January 2026)	Deputy Chair / Senior Independent Director
Anthony Hassall	Board Member bringing the perspective of Mental Health / Chief Executive, Pennine Care NHS Foundation Trust
Sue Greenhill	Independent Member
David Hopewell (until January 2026)	Independent Partner Member bringing perspective of GM NHS Provider

The process to replace David as Independent Partner Member is currently underway.

Remuneration Committee

The Remuneration Committee plays a critical role in ensuring that NHS GM maintains fair, transparent, and accountable remuneration practices. Reporting directly to the Board, the Committee oversees decisions related to salaries, fees, allowances, and pension schemes for employees and individuals providing services to the ICB. The Committee is chaired by Rachel Egan, who also serves as the Chair of the Population Health Committee.

The Committee is responsible for all pay and terms and conditions outside of the Agenda for Change pay framework, ensuring appropriate governance and oversight of remuneration arrangements for senior leaders, clinical leads, and other relevant roles within NHS GM.

Throughout 2025, the Committee has fulfilled its responsibilities in accordance with its Terms of Reference. Key areas of focus during this period have included:

- Supporting the implementation of the National Pay Award 25/26 for staff under the remit of the NHS Pay Review Body (NHS PRB) and the Senior Salaries Review Body (SSRB).
- Assessing and approving the agreed actions and recommendations for the launch of the VSM pay framework.
- Supporting the permanent appointment of the Chief Finance Officer for NHS Greater Manchester Board (ICB), aligning with the parameters of VSM framework.
- Reviewing the proposed process for the reappointment of Partner Members and Non-

Executive Directors, including Chair to Board.

- Reviewing the assurance processes in place for the two Voluntary Redundancy Schemes, to ensure fairness, transparency and organisational values and statutory requirements are aligned.

The Committee remains committed to maintaining robust governance and fair pay structures, ensuring that remuneration policies support the organisation's strategic objectives while remaining aligned with national frameworks and financial sustainability.

Members	
Rachel Egan (Chair)	Non-Executive Director / Chair of the Remuneration Committee
Sir Richard Leese	Chair of the ICB
Professor Dame Sue Bailey (Vice Chair)	Non-Executive Director / Chair of the Quality & Performance Committee
Kal Kay	Non-Executive Director / Chair of the Finance Committee Chair
Richard Paver	Non-Executive Director / Audit Committee Chair
Sheena McDonnell (until May 2025)	Non-Executive Director / Chair of the People & Culture Committee
Jackie Njoroge (from January 2026)	Deputy Chair / Senior Indepenent Director

Finance Committee

The purpose of the Finance Committee (Finance Sub-Committee from January 2026) is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

1. Financial performance of the ICB
2. Financial performance of NHS organisations within the ICB footprint

The Finance Committee meets monthly.

During 2025/26, the Committee met to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

1. Monitored delivery of the 2025/26 ICB and Provider financial plans
2. Monitoring and gaining assurance of both ICB and Providers cost improvement plan delivery
3. Monitor the delivery of the ICB recovery plan
4. Approved/recommended relevant allocation of funding, including for Virtual Wards, Discharge and Capacity funds, Winter Plans, and allocations to providers in line with the Financial Scheme of Delegation
5. Reviewed and approved the ICB 2026/27-2028/29 financial plan
6. Provided ongoing review and assurance of system financial performance through the receipt and scrutiny of monthly finance reports
7. Procurement oversight including the review of the new PSR regime and tenders
8. Approved primary care capital allocations and those to GM NHS providers
9. Endorsed and approved relevant business cases in line with the Financial Scheme of Delegation
10. Reviewed the proposed GM Digital Transformation Strategy and progress to date
11. Considered the Finance Committee's corporate risks as part of the Committee risk register

Members	
Kal Kay (Chair)	Non-Executive Director / Chair of the Finance Committee
Kathy Roe	Chief Finance Officer
Professor Manisha Kumar	Chief Medical Officer
Dr Vish Mehra	Board Member bringing the perspective of Primary Care, GP
Mandy Philbin (until	Chief Nurse

December 2025)	
Mark Fisher	Chief Executive
Rachel Egan (Vice Chair)	Non-Executive Director / Chair of the Remuneration and Population Health Committees

People and Culture Committee

The People and Culture Committee oversee the implementation of the Greater Manchester People and Culture Strategy for our health and care workforce across a number of levels:

1. NHS GM as an employing organisation
2. Our ten localities
3. Our NHS system
4. Across our health and care system.

Its purpose is to provide assurance to the NHS GM Board in relation to workforce matters.

Through oversight of the implementation of our strategy, the Committee provides assurance to NHS GM Board to ensure the Integrated Care Board is:

- Meeting its responsibilities under the NHS Oversight Framework: a) People b) Leadership and Capability
- Delivering the NHS Long Term Workforce Plan and People Plan
- Compliant with statutory duties and requirements regarding staff employment and equality and diversity requirements
- Delivering the workforce elements within the broader Integrated Care Strategy

Following governance changes introduced in 2025/26, the Committee operated in two parts:

- Part 1 (System): providing oversight of the system-wide People & Culture agenda across the Greater Manchester Integrated Care System (ICS), including workforce strategy, sector-wide risks, system performance, leadership development and equality, diversity & inclusion.
- Part 2 (ICB internal): providing assurance on the NHS GM organisational workforce, including workforce performance, mandatory training, appraisals, inclusion metrics, organisational risks, compliance, and development plans for the ICB workforce.

This structure has enabled the Committee to maintain strategic oversight of system-wide

workforce challenges, while ensuring appropriate assurance related to the NHS GM workforce during a period of significant organisational reform.

Across the year, meetings were held consistently, with strengthened assurance mechanisms including Working Group updates, BAF and risk management reviews, workforce performance monitoring, Freedom to Speak Up reporting, and deep dives on priority themes.

The Committee reviewed delivery against three system wide priorities agreed through streamlined governance arrangements:

1. Workforce Efficiency
2. Transforming People Services
3. Leadership, Culture & EDI

Key business of the Committee for the period was as follows:

- Oversaw delivery of the People & Culture Strategy and associated Delivery Plan.
- Reviewed system and organisational workforce performance, including recruitment, retention, sickness absence, capability, and temporary staffing usage.
- Reviewed workforce equality, diversity and inclusion (EDI) across GM, including WRES/WDES, equality objectives and pay gap reporting.
- Oversaw workforce elements of the NHS System Oversight Framework, People Plan and Long-Term Workforce Plan.
- Provided oversight of system leadership development, culture, OD, wellbeing and staff experience.
- Ensured that the workforce implications of NHS Reform, operational planning and system transformation were fully considered.
- Monitored and reviewed refreshed risk registers to reflect system reform, changes to working group structures and emerging risks such as conflicts of interest, immigration changes, talent retention, maternity and migrant workers.

The People & Culture Committee met bi-monthly until it was formally stood down in early January 2026, with its final meeting held on 4 November 2025.

Members	
Sheena McDonnell (Chair until May 2025)	Non-Executive Director / Chair of the People and Culture Committee

Kal Kay (Vice Chair April 2025 - May 2025 – Chair from June 2025)	Non-Executive Director / Chair of the Finance Committee
Charlotte Bailey	Chief People Officer, NHS GM and Chair of Sub-Committee
Hannah Dobrowolska	Deputy Place Based Lead, NHS GM
Steve Voyse	Staff Side Chair, NHS GM
Jane Seddon	Director of People Services, NHS GM
John Herring	Director of OD and Good Employment, NHS GM
Andy Brass	GM Universities Rep
James Bull	Regional Organiser, UNISON/ WEF Co-Chair
Jo Chilton	Director of Social Care NHS GM
Nicky Clarke	Chief of People, Northern Care Alliance
Majid Hussain	Director of Inclusion, NHS GM
Karen James	Chief Exec, Stockport and Tameside & Glossop NHS FTs and Chair of Health and Care Group
Professor Manisha Kumar	Chief Medical Officer, NHS GM
Mandy Philbin (until December 2025)	Chief Nursing Officer, NHS GM
Amanda Bromley	GM NHS HRD Network Chair
Luvjit Kandula	Primary Care Board representative
Katherine Sheerin	Chief Officer for Commissioning
Nicky Littler	Mental Health Provider representative
Owen Williams	Partner member
Michelle Hill	Voluntary, Community and Social Enterprise representative
Jackie Gardiner	Corporate Director of Operational Finance

Quality and Performance Committee

The Quality and Performance Committee (QPC) provided rigorous, independent assurance to the NHS Greater Manchester (NHS GM) Board throughout 2025 until its planned closure in January 2026 as part of NHS Reform. Operating within its delegated authority, the Committee oversaw the delivery of NHS GM's statutory duties for quality, patient safety, clinical governance, safeguarding, patient experience, and performance, ensuring that risks to safety, effectiveness, experience, and operational standards were clearly identified, triangulated, and addressed.

Across the reporting year, the Committee scrutinised a comprehensive cycle of assurance reports from the Chief Nursing Officer, Chief Medical Officer and Chief Operating Officer, alongside statutory annual reports, and thematic deep-dives. This enabled strong oversight of several high-risk areas, including urgent and emergency care, maternity safety, mental health, neurodevelopmental services, learning disability and autism, and paediatric audiology. The Committee's scrutiny contributed to strengthened mitigations, improved visibility of risk and clearer escalation into Board governance.

The Committee maintained oversight of the extensive work of GM Local Maternity & Neonatal System (LMNS) and GM Strategic Clinical Network (SCN) which has supported all maternity providers within GM to achieve full compliance with all ten safety actions in the Maternity Incentive Scheme National CNST year 7 programme. The GM SCN have actively supported all providers to reach 99% compliance with their adoption of Saving Babies Lives with all providers demonstrating deeper analysis of their data, demographics, ethnicity, complexity and understanding of gaps in pathways. The GM Maternity and Neonatal Equity and Equality Plan is in year 4 of delivery. A key outcome of the plan has been the establishment of a more mature, system-wide approach to equity, with considerations embedded across governance, commissioning and service delivery. Since implementation went live in 2024, delivery momentum has been very positive, with activity spanning the system, provider and third-sector partners. An example of impact includes The **Greater Manchester Maternity Action Health Justice Partnership** which has delivered benefits equating to over £3 million annually, by increasing women's incomes, helping retain employment, and securing settlements whilst also improving awareness of rights and reducing stress. The Enhanced GM Maternity & Neonatal Voices Partnership (MNVP) Model is now embedded across Greater Manchester, with local delivery models established in all areas and continuing to mature through ongoing refinement and continuous improvement. As the model becomes more established, its impact is becoming more visible, alongside continued development of key programmes including Induction of Labour, continuity models and co-production work. MNVP have been actively involved in all Provider assurance visits and completed 15 steps in all Providers. Quarterly feedback is shared with the Providers and at ICB system level to inform quality overview.

2025/26 has seen the culmination of 3 years work on the National Maternity & Neonatal Delivery Plan, specific ICB/LMNS achievements have included :

- **Personalised care strengthened**: supporting providers to standardise the offer for personalised care training; GM LMNS produced and shared a GM training package

(including trauma-informed care), plus resources and an audit template to monitor PCSP offers.

- **Key services in place**: Perinatal Pelvic Health Services and Enhanced Continuity of Care Services are commissioned and implemented.
- **Workforce deliverables completed**: commissioning/funding for safe staffing, agreement of staffing levels, aligning commissioning ambitions with workforce capacity.
    - Workforce planning is aligned to national standards
    - All providers funded establishments meet or exceed Birth Rate Plus recommendations
    - Increase in overall midwifery establishment from 1611wte (Jan ‘23) to 1796wte (Jan ’26)
    - Reduction in midwifery vacancy rate from 135wte/8.4% (Jan ’23) to 11wte/0.6% (Jan ’26)
    - Reduction in midwifery turnover rate from 15.5% (Jan ’23) to 8.2% (Jan ’26)

The Committee oversaw significant progress in key areas of statutory responsibility. This included: a reduction in Mental Health 12-hour ED waits supported by GM’s nationally recognised Safety Siren model; a 70-case reduction in the complaints backlog; and continued safeguarding assurance through approval of the 2024/25 NHS GM Safeguarding Annual report and the GM Safeguarding Children Partnerships Annual Reports. The Committee also received the Annual Medicines Management Report, Patient Safety Annual Report, SEND Annual Report, and Prevention of Future Deaths Report, ensuring full visibility of statutory performance and areas requiring further action.

Performance oversight remained central to the Committee’s work. The Committee examined delivery against the 2025/26 planning objectives, including urgent care, elective recovery, cancer, long-term conditions, and diagnostics. Although Improvement was noted in several areas—including strong performance on cancer 28-day and 62-day standards—the Committee recognised significant continuing pressures across urgent care, elective pathways, and diagnostics. These insights informed risk escalations to the Board and supported system-wide recovery planning.

The Committee also provided strategic oversight of transformation programmes critical to system resilience and quality outcomes. These included the GM Dermatology Transformation Programme, which achieved a reduction of over 5,500 patients on the waiting list and halved 52-week waits, and the Learning Disability and Autism programme, which continued the

downward trajectory of inpatient numbers. Additional assurance was secured across neurorehabilitation, stroke services and inequalities-focused workstreams, including the GM-wide health inequalities deep-dive.

Risk management capability strengthened significantly during the year. The Committee critically reviewed Board Assurance Framework risks and Committee-level risks at each meeting, driving refinements to scoring, mitigations, and clarity of ownership. A notable development was the integration of health inequalities into risk descriptions, templates, and training, enhancing the organisation's approach to inclusive risk assessment. The Committee also provided oversight of increasing risks associated with NHS Reform, including clinical leadership capacity, EPRR resilience, workforce fragility, and pathway sustainability.

The Committee placed particular emphasis on lived experience and patient voice. Quarterly Healthwatch reports provided system-wide insight into access, quality, equity and communication, prompting NHS GM to embed new feedback loops and strengthen relationships with VCSE and local Healthwatch bodies. The Committee championed this work, ensuring learning from experience directly informed commissioning and quality improvement.

In conclusion, the Quality and Performance Committee provided substantial assurance to the Board that NHS GM maintained robust arrangements for quality, performance and patient safety during a period of significant operational pressure and structural transition. Through its oversight of statutory duties, triangulation of intelligence, strengthening of risk management and focus on improvement, the Committee ensured the Board was well sighted on areas of achievement, areas of concern and the actions required to maintain safe, high-quality care for the population of Greater Manchester.

Members	
Professor Dame Sue Bailey (Chair)	Non-Executive Director / Chair of the Quality and Performance Committee
Leigh Vallance	Board Member bringing the perspective of the Voluntary Community and Social Enterprise (VCFSE) Sector / Chief Executive of Bolton Hospice
Mandy Philbin (until December 2025)	Chief Nursing Officer
Professor Manisha Kumar	Chief Medical Officer

Nicola Firth	Member bringing the perspective of Acute Providers
Richard Paver (Vice Chair)	Non-Executive Director / Audit Committee Chair
Colin Scales	Deputy Chief Executive Officer
Danielle Ruane (until June 2025)	Patient Representative (Healthwatch)
Luvjit Kandula	Member bringing the perspective of Primary Care

Population Health Committee

The Population Health Committee was formally established by NHS GM in January 2024 to:

- Ensure the effective implementation of agreed areas of the GM Joint Forward Plan and NHS GM Strategic Financial framework, and through this, contribute to the delivery of the GM Integrated Care Partnership Strategy
- Ensure population health intelligence and analytical capabilities to generate insight on variable population needs across the system and ensure the existence and utilisation of a population health management approach
- Oversee and agree strategy, plans and expenditure of the work programme of the NHS GM Population Health functions (including those responsibilities discharged through localities) that meets the health and healthcare needs of the Greater Manchester population, within the context of national strategy, the Partnership integrated care strategy and place health and wellbeing strategies
- Interpret and respond to strategic population health performance indicators, identifying areas of poor performance and agreeing remedial action, and identifying strong performance and opportunities to share best practice.

During 2025/26, the Committee met on four occasions to discharge its delegated functions in line with its Terms of Reference, before being paused in December 2025 due to organisational change.

Some of the key business of the Committee for the period was as follows:

- Shaped the development of the NHS GM Annual Plan 2025/26, particularly the sections focused on ‘Reducing Prevalence’ and ‘Proactive Care’, and received updates on delivery, risks, and achievements
- Reviewed the NHS GM Annual Plan 2025/26, NHS 10-Year Plan, Greater Manchester

Strategy, and the Get GM Working Plan to identify and advance system Population Health opportunities

- Oversaw the development of a Population Health Management roadmap and approved the final version
- Received updates on ICB Reform
- Reviewed and approved the GM Alcohol Harm Strategy,
- Reviewed and endorsed the GM Infant Feeding Plan
- Reviewed the work undertaken to reduce the impact of poverty on health service access, experience and outcomes and endorsed the voluntary adoption of the socio-economic duty, which was later approved by the ICB - the first ICB in the country to do so.
- Reviewed the work undertaken in GM to end all new cases of HIV by 2030.
- Received updates on the progress of the green plan / sustainability agenda across the system, including collaborative opportunities that exist with partners such as TfGM
- Oversaw the management of risk through the strategic Risk Register and Board Assurance Framework reports, which are reported into the ICB and reviewed at each Committee meeting, escalating risks where appropriate.
- Oversaw and gained assurance on NHS GM Population Health business case approvals, Scheme of Delegation Approvals and Expenditure
- Regularly discussed relevant Statutory Public Health Responsibilities of NHS GM

Members	
Rachel Egan (Chair)	Non-Executive Director / Chair of the Population Health Committee
Professor Dame Sue Bailey (Vice Chair)	Non-Executive Member / Quality and Performance Committee Chair
Katherine Sheerin	Chief Officer for Commissioning – NHS GM
Warren Heppolette (until October 2025)	Chief Officer for Strategy, Innovation and Population Health – NHS GM
Professor Manisha Kumar	Chief Medical Officer, NHS GM
Majid Hussain	Director of EDI – NHS GM
Will Blandamer	Representative of NHS GM Deputy Place-Based Leads
Andrew Lightfoot	Deputy Chief Executive – GMCA
Helen Gollins	Chair of the GM Public Health Leadership Network

Liz Windsor-Welsh	Representatives of GM VCFSE Leadership Group
Charles Kwaku-Odoi	Representatives of GM VCFSE Leadership Group
Emma Ansell-Meehan	Representatives of GM VCFSE Leadership Group

Primary Care Commissioning Committee

The Greater Manchester Primary Care Commissioning Committee provides the regulatory assurances as part of the matrix for primary care governance within NHS GM, working alongside the Primary Care System Board and the Primary Care Provider Board to support development and delivery of primary care across Greater Manchester.

The Committee holds the responsibility for discharging the duties delegated by NHS England to NHS GM regarding commissioning of primary care services. Explicitly this is in respect of:

- Primary Medical Services
- Primary Dental Services and Prescribed Dental Services
- Primary Ophthalmic Services
- Pharmaceutical Services and Local Pharmaceutical Services

The Committee also has held responsibility for the commissioning and contractual oversight for delegated statutory Public Health requirements as set out in the annual S7A Public Health Functions Agreement as this relates to Greater Manchester

Primary care in Greater Manchester has continued to evolve throughout 2025–26, and the Committee has continued to meet to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

- Maintaining oversight and assurance across the 10 Greater Manchester place-based committees managing local arrangements, specifically in respect to general practice and Primary Care Networks, but also developing local arrangements for engagement and delivery of the rest of primary care services
- Upholding the national regulatory frameworks and ensuring that commissioning of services is in accordance with NHS GM governance as well as the expectations and requirements of NHS England. This includes the local assurance of existing national contracting with primary care providers and the commissioning determination of new contracts, including determining the contracting specifications to meet population needs and procurement of those contracts. This has included oversight of national directives

and contract changes pertaining to primary care, such as delivery of additional 700,000 urgent dental appointments nationally, and new GP contractual requirements in October 2025. Furthermore, the Committee has overseen the preparation for announced national contract changes in General Practice and Dentistry for 2026/27.

- As part of driving forward quality improvement and demonstrating the impact and benefit primary care brings to the health of the population, the BeCCoR (Beyond Core Contract Review) programme has been commissioned, committing additional investment into evidence-based delivery through general practice.
- Supporting the NHS's transition from analogue to digital, the Committee has received assurances of the digital telephony rollout in general practice, NHS App functionality, and enhanced triage models as part of Modern General Practice. These collective developments support more responsive access pathways and improved care navigation.
- In supporting improved equity of access to care, the Committee has supported service reviews for pan-GM consistent local services such as Minor Ailments Scheme from community pharmacies and the sustained Dental Patient Access Quality Scheme.
- The Committee continues to hold responsibility of delivery of the Primary Care Blueprint, supported by the GM Blueprint Implementation Group

The Committee Terms of Reference were last reviewed in June 2025. The membership of the Committee during 2025/26 was as follows:

Members	
Katherine Sheerin, Chief Commissioning Officer (Chair)	Chief Commissioning Officer
Professor Manisha Kumar, Chief Medical Officer, NHS GM (Vice Chair)	Chief Medical Officer (or suitable nominated deputy)
Kathy Roe, Chief Finance Officer	Chief Finance Officer (or suitable nominated deputy)
Mandy Philbin, Chief Nurse	Chief Nursing Officer (or suitable nominated deputy with responsibility for primary care quality)
Ben Squires, Director of Primary Care	Director of Primary Care (or suitable nominated deputy)
Will Blandemer, Deputy Place Based Lead for Health and Care, NHS GM (Bury)	Chair of Place Based Primary Care Commissioning Committee (or suitable nominated deputy)

Martin Ashton, Deputy Director of Delivery, NHS GM (Bolton)	Chair of Place Based Primary Care Commissioning Committee (or suitable nominated deputy)
Janna Rigby, Assistant Director of Primary Care (Operations), NHS GM	Assistant Director of Primary Care (Operations), NHS GM
Stephanie Fernley, Assistant Director of Primary Care (Development), NHS GM	Assistant Director of Primary Care (Development), NHS GM
Jane Brooks, Assistant Director of Finance (Primary Care), NHS GM	Assistant Director of Finance (Primary Care), NHS GM
Dr Tracey Vell, GM Primary Care Provider Board Chief Officer	Primary Care Provider Representative - General Practice
Don McGrath, GM Dental Provider Board Chair	Primary Care Provider Representative - Dentistry
Luvjit Kandula, GM Community Pharmacy Provider Board Chair	Primary Care Provider Representative – Community Pharmacy
Dharmesh Patel, GM Optometry Provider Board Chair	Primary Care Provider Representative - Optometry

Transition arrangements

In December 2025, in response to the ongoing NHS Reform Programme and to manage organisational capacity, the Board agreed to implement transitional arrangements for the final quarter of the financial year. As of 1 January 2026, the Finance, Population Health, People and Culture, and Quality and Performance Committees were all disestablished, and replaced by a Transition Committee, and a Finance Sub-Committee. The Transition Committee, consisting of the membership of the Board, took on the responsibilities of the disestablished Committees for the remainder of the year whilst new Committee arrangements were developed for the new financial year. The Primary Care Commissioning Committee was renamed the Primary Care Commissioning Group, but retained its membership and responsibilities. The Audit Committee and Remuneration Committees remained in place with the same scope and responsibilities.

The Transition Committee met three times between January and March 2026, and considered the following business:

- Transition Committee Purpose and Closedown Arrangements for Abolished Committees

- BAF and Corporate Risks Reports
- Finance Reports
- Performance Reports
- Committee Work Plans
- Alert & Assurance Reports from each function area
- Preparations for New Governance

New committee arrangements for 2026/27

In March 2026, in response to the ICB Model Blueprint and the implementation of a new Operating Model for NHS GM, the Board agreed to the establishment of two new Committees from 1 April 2026: The Strategic Commissioning Committee, and the People and Resources Committee.

The purpose of the Strategic Commissioning Committee will be to obtain assurance, on behalf of the Board, that the ICB has the right commissioning strategy and approach, supported by intelligence, which is delivering its quality, performance, population health, and oversight functions in a way that secures continuous improvement, whilst ensuring that the ICB operates as a strategic commissioner. The Committee will have a strong focus on improvement, prevention, population health and the left-shift as set out in the 10-Year Health Plan.

The purpose of the People and Resources Committee (‘the Committee’) is to obtain assurance, on behalf of the Board, that the ICB will achieve its statutory financial duties, and that the system is financially sustainable, by having the right financial strategy that results in the ICB meeting its financial targets and sustainability. The Committee will also provide strategic oversight, assurance, and guidance on behalf of the Board on all matters relating to workforce, organisational culture, and staff experience across NHS GM. The Committee will ensure that through the delivery of our organisation’s People Plan, NHS GM fosters an inclusive, compassionate, and high-performing culture that supports the recruitment, retention, wellbeing, and development of its people. The Committee will also provide strategic oversight and assurance on matters relating to estates and environmental sustainability across NHS GM, as well as receiving assurance and constructively challenging the operational resourcing and delivery in the areas of digital and IT infrastructure, and data and intelligence.

The two newly established Committees will operate within an agreed shared governance model to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals.

Whilst having their own specific responsibilities, the 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.

The Audit and Remuneration Committees will continue in their current form, with the same role, scope, and responsibilities.

North-West Specialised Services Joint Committee

Under s65Z5 of the Act, ICBs are able to jointly exercise its functions with other relevant bodies, and in 2024/25 NHS GM, together with Lancashire and South Cumbria and Cheshire and Merseyside ICBs established the North-West Specialised Services Joint Committee.

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. The North-West was one of three regions in England where NHSE approved plans to delegate the commissioning of a number of specialised services, to ICBs, from 1 April 2024. These arrangements are underpinned by a Delegation Agreement.

These services consist of ‘delegate 1’ services which are planned at a single-ICB level with decision being taken by the ICB, and ‘delegate 2’ services which are planned and commissioned jointly at a multi-ICB level.

In order to facilitate the delegate 2 decision making, a Specialised Services Joint Committee was established between the three North West ICBs (Lancashire and South Cumbria, Cheshire and Merseyside, and Greater Manchester).

The role of the Joint Committee is to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified Delegated Services as set out in the NHSE Delegation Agreement.

As a Joint Committee of the three ICBs, the Joint Committee is accountable to the respective Boards of NHS Lancashire and South Cumbria ICB, NHS Cheshire and Merseyside ICB and NHS Greater Manchester ICB.

The terms of reference for this joint committee were ratified by the NHS GM Board in April 2024.

Delegate 1 services

NHS GM has established a Specialised Commissioning Oversight Group to oversee the commissioning and delivery of the 59 single-ICB Specialised services that have been delegated from NHSE to NHS GM from 1 April 2024.

The group brings together the relevant NHS GM Officers with the NHSE Nort West hub, and subject matter experts from across the GM system with a commitment to ensure that we commission effective, high-quality care in relation to delegated specialised commissioning functions within the resources available.

Register of Interests

The Register of Interests for Board Members is available on NHS GM Integrated Care Partnership's website. This was updated in October 2024 and a refresh is currently underway. The register will be refreshed at least annually in line with NHSE requirements, however the register is published more regularly to reflect changes in interests throughout the year. The register of interests of all staff, Board and Committee Members is updated on a regular basis as interests arose (or ceased) and when other opportunities present themselves to update.

Personal data related incidents

There were no Serious Untoward Incidents relating to the data security breaches and no data security incidents have been reported to the ICO within NHS GM for between 1 April 2025 and 31 March 2026.

Modern Slavery Act

NHS GM fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2026 is published on our website published on our website.

Statement of accountable officer's responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS GM and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

1. Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
2. Make judgements and estimates on a reasonable basis;
3. State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
4. Prepare the accounts on a going concern basis; and
5. Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS GM. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding NHS GM's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself

aware of any relevant audit information and to establish that NHS GM's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Colin Scales
Acting Accountable Officer
17 June 2026

Governance statement

Introduction and context

NHS GM is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2025 and 31 March 2026 the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

However, enforcement undertakings were agreed between NHS GM and NHS England (as set out and agreed at the NHS GM Board meeting on 17 July 2024) as NHS England had identified reasonable grounds to suspect NHS GM was failing or had failed to discharge some of the ICB functions as set out in the Health and Care Act 2006. Some of these undertakings remained in place during 2025/26, and delivery against these are referred to within sections of the Performance Report. Further detail on these enforcement undertakings are set out later in this governance statement.

In addition, NHS GM incurred a £7.5m overspend (as part of its agreed financial plan with NHSE) which has resulted in the issuing of a Section 30 referral to the Secretary of State for Health and Social Care.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS GM's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in

accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in NHS GM's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS GM is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the ICB is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB consists of: a Chair; a Chief Executive; and at least three Ordinary Members. In addition, NHS England Policy, requires the ICB to appoint the following additional Ordinary Members: three executive members, namely: Director of Finance, Medical Director and Director of Nursing (these roles are now covered by the portfolios of the Executive roles referenced in clause 2.2.3 of the constitution); and at least two Non-executive Members.

Furthermore, the ICB has four partner members and has also appointed one Ordinary Member bringing the perspective of the Voluntary, Community and Social Enterprise (VCFSE) sector to the Board.

The Board (i.e. the governing body) is therefore composed of the following members:

a. Chair
b. Chief Executive
c. two Partner Members NHS and foundation trusts
d. one Partner Member primary medical services
e. one Partner Member local authorities
f. five Non-executive Members

g. Chief Finance Officer
h. Chief Clinical Officer
i. one Ordinary Member VCFSE
j. Deputy Chief Executive
k. Chief Strategy, People and Partnerships Officer
l. Chief Commissioning Officer.

The Board specifically invites the GMCA Health and Care Portfolio Lead Officer, Alison McKenzie-Folan, as a participant at meetings.

The Board met formally eight times between April 2025 and March 2026 plus an extraordinary meeting in April 2025. Meetings are usually held in person and are open to the public. Members of the public are able to join via a link provided or additionally in person. The quorum was achieved at each meeting.

To support the successful delivery of its functions and activities, NHS GM has several Committees, each accountable to the ICB. Committee meetings are also usually held in person and are open to the public. Comprehensive highlights of the work led by the Committees of the ICB are set out in the Members Report of this Accountability Report. All terms of reference are published in the Governance Handbook on the NHS GM Integrated Care Partnership website.

10 Integrated Partnership Committees / Locality Boards covering the 10 GM localities operate as committees / joint committees of the ICB. Meetings are routinely be held in public and papers including minutes are published on the NHS GM Integrated Care Partnership website.

In addition to the Integrated Care Partnership (ICP) Board, several GM System Groups operated during 2025/26, including:

- GM People Group
- GM Digital Group
- GM Urgent and Emergency Care System Group
- GM Maternity and Neonatal group
- GM Children and Young People's Group
- GM Mental Health Group

- GM Specialised Commissioning Oversight Group

The GM ICP is a joint committee created by the 10 Greater Manchester local authorities and the Greater Manchester Integrated Care Board under s.116ZA into the Local Government and Public Involvement in Health Act 2007. Its role is to enable the discharge of the ICP's functions under the Local Government and Public Involvement in Health Act 2007 and any related guidance concerning the role of integrated care partnerships. ICPs have a statutory duty to create an integrated care strategy to address the assessed needs, such as health and care needs of the population within the ICB's area, including determinants of health and wellbeing such as employment, environment, and housing. All Health and Wellbeing Boards in Greater Manchester are involved in the preparation of the ICP Strategy.

Membership of the organisation's Audit Committee is included as part of the Member's Report.

The Good Governance Institute

During 2024/25, the Good Governance Institute (GGI) supported NHS GM in reviewing its arrangements against the system well-led assessment of the CQC, allowing for the organisation to identify its strengths and any gaps in system effectiveness. The initial diagnostic work identified four key areas for further development:

- System strategy and risks
- System Oversight
- System Learning
- Systems values and behaviours

The output of the work supported improvements in governance processes, as well as supporting NHS GM's delivery against the undertakings and Single Improvement Plan. This included the resetting of Board priorities, as well as the priorities of the key committees and localities to support the delivery of the ICP strategy.

The review found that the ICS has a well-regarded strategy and sustainability plan that addresses the triple deficit challenge (finance, performance and population health), and that the Board and its committees have improved their working with use of the system

effectiveness packs.

A further review conducted at the end of 2024 found that significant improvements had been made in system well-led arrangements, noting that this would not be a one-off piece of work, and a continuous improvement approach would be used for meeting effectiveness as well as CQC readiness. In addition to meeting-specific improvements, the review identified opportunities to learn from each other and numerous examples of areas of strength across the system well-led framework, which continued to be developed throughout 2025/26.

A recent reviewed conducted at the end of 2025 found that further improvements had been made in addressing the governance hygiene factors.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, the disclosures relating to risk, governance and internal controls within this statement are consistent with, and comply with, the main principles of The Orange Book: Management of Risk (with no departures to report).

Discharge of statutory functions

NHS GM has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICBs is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB’s statutory duties.

Risk management arrangements and effectiveness

NHS GM recognises that effective risk management processes are essential to the achievement and delivery of NHS GM’s strategic priorities/objectives and are central to

providing the assurance that all required activities are taking place to ensure the compliance with all legislation, regulatory frameworks, national guidance and risk management standards.

NHS GM accepts that risk is an inherent part of health care and maintains a system of internal control which is designed to identified and manage risk to a reasonable level rather than to eliminate it completely. Therefore, it is not practical to aim for a risk-free or risk-averse environment as the system of internal control can only ever provide reasonable and not absolute assurance of effectiveness.

NHS GM cannot manage its risks effectively unless it knows what the risks are. Risk identification, management and reporting is therefore vital to the organisational success. In order to ensure that NHS GM operates in a way that minimises risk the intention is to:

- Adopt a robust approach to risk identification, assessment and management
- Seek to effectively embed risk management across the organisation
- Seek to improve and inform decision-making, planning and prioritisation
- Seek to anticipate what may go wrong, minimising the amount of reactive work needed

In particular, the approach to risk is to:

- Understand the risks we face, their causes and control
- Ensure risks are recorded and assessed appropriately ensuring due regard is given to the possible consequence, likelihood and resource costs associated with mitigation
- Ensure action plans are robust and implemented in a timely manner
- Significantly improve the probability that the strategic objectives of NHS GM will be delivered
- Ensure lessons learned are disseminated as appropriate
- Ensure staff understand their roles in risk management
- Ensure the health, safety and welfare of patients, visitors and staff
- Prevent wherever possible the exposure to a risk which has not been identified Allocate capital and resources more efficiently

Risk management arrangements are set out in NHS GM’s Risk Management Policy,

which was last agreed by the Board in July 2025. NHS GM has a Board Assurance Framework (BAF) that enables Board members to understand the internal and external environment within which they operate and ensure that risk capture processes are in place to provide confidence that the Board is fully sighted on its key strategic risks and challenges. NHS GM's risk appetite statements were last reviewed and approved by the Board in September 2025. These statements have been in place since and up to the date of approval of the annual report and accounts.

NHS GM will assess its risks against the agreed strategic objectives as we strive to achieve these as a system.

Capacity to handle risk

Risk Management is recognised as an integral part of good management practice. The Board Assurance Framework, Corporate risk report and other risk reports are used by the Board and its committees to identify, assess, monitor and evaluate risks to the achievement of NHS GM's strategic objectives

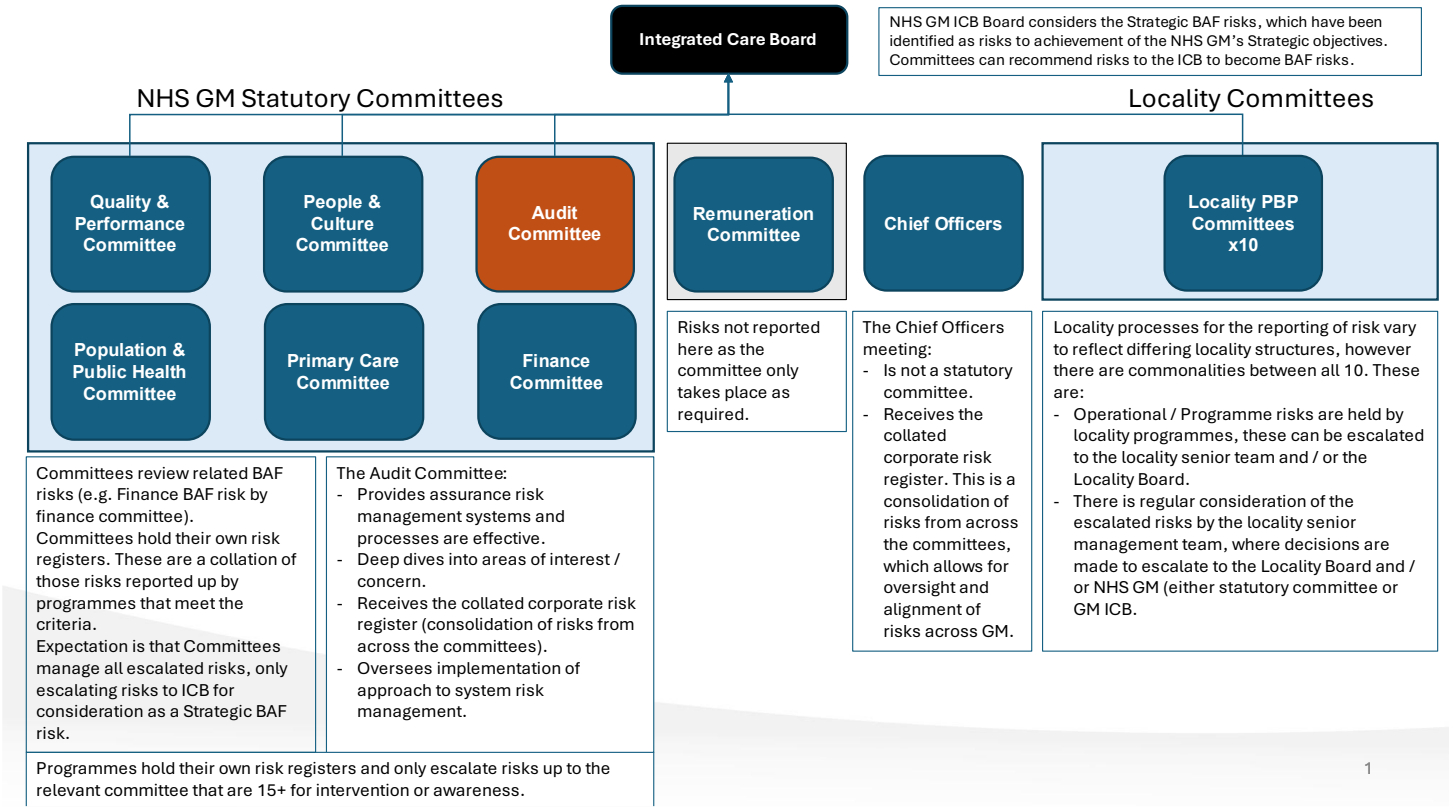
The risk reports are used alongside other key management tools, such as performance and quality dashboards and financial reports, to give the Board a comprehensive picture of the organisation's risk profile.

The diagram below shows the flow of risk reporting information and recognises the numerous routes for risk information to be gathered from during 2025/26

The Risk Reporting Committees shown in the diagram all have Committee Risk Registers that captures the key risks for that area, which are reviewed regularly in line with meeting frequency.

The ten Place Based Partnership (PBP) Committees are all required to have PBP Risk Registers that captures key risks to the delivery of PBP's Locality Objectives. The registers are reviewed regularly in line with meeting frequency.

Following the NHS reforms and restructure of NHS GM the risk reporting and governance will be reviewed and refreshed during 2026/27.



As referred to earlier in the Accountability Report, NHS GM's Committee structure operated under transitional arrangements during Q4 of the reporting period. During the quarter, risks that were previously held by the Quality and Performance, People and Culture, Population Health, and Primary Care Committees were reported via the Transition Committee.

The table below describes where risks are considered to support the Risk Management approach:

NHS GM Integrated Care Board	The Board Assurance Framework (BAF) which contains strategic risks against NHS GM's strategic objectives.
Chief Officers (governing body members)	Chief Officers receive the Corporate Risk Report which is a consolidation of all risks from the committees/boards of the ICB, providing an opportunity to review the current risk position across NHS GM and identify any new risks that may be considered significant enough to be escalated to the Board Assurance Framework (via the relevant Committee).
Audit Committee	Responsible on behalf of the Board for reviewing the adequacy and

	effectiveness of: all risk and control related disclosure statements (the Annual Governance Statement), prior to endorsement by the Board the underlying assurance processes that indicate the degree of achievement of strategic objectives and the effectiveness of the management of risks risk related documents, policies and procedures review the corporate risks, controls, and in relation to those risks which are outside the risk appetite of the organisation, recommend appropriate action to the Board Escalate to the Board any matters of significance which require Board attention
ICB Locality Committees (Place Based Partnerships)	Responsible for the management of risks for all functions and duties within the scope of their defined committee responsibility. Responsible for: Regular consideration of all corporate risks reported to the committee Discussion and agreement on the effectiveness of the controls and actions in place to manage the risks To provide clear oversight of the development and actions associated with place-based risks in keeping with the current assurance framework to present local reporting via current tool to relevant committee, with support from the NHS GM Risk Team to populate and update the local risk registers to identify appropriate mitigations and actions to manage local risks to map all risks across to the statutory functions and NHS GM

	objectives to align risks to delivery priorities
Committee Meetings	All Committee/Board level risks that have been identified from Operational/Programme Risk Registers and then escalated to the Committee. This will include all locality risks that have been identified from the locality operational risk registers and then agreed to be escalated Locality Senior Management Team. Corporate Risks can be escalated from committees/boards to the ICB if they are significant enough to be added to the Board Assurance Framework.
Programme Meetings	All risks identified by the team or service - required to maintain risk registers, with risks escalated up to the committees and boards where needed (by agreement with Senior Managers).

Risk assessment

The summary Board Assurance Framework (BAF) below shows NHS GM's strategic risk profile at the end of the 2025/26 financial year.

No	Strategic Risk Title	Risk Change from Quarter 3	Q4			In Year Target			Final Year Target	Final Year Target Date
			Likelihood	Impact	Score	Likelihood	Impact	Score		
SR1	Health of the Population	→	3	5	15	2	5	10	5	March 2028
SR2	Health Outcomes	→	4	5	20	4	5	20	10	March 2028
SR3	Quality of Care	→	3	5	15	3	5	15	10	March 2028
SR4	Good Employment	↓	3	4	12	3	4	12	8	March 2029
SR5	Health Inequalities	↓	3	4	12	3	4	12	4	March 2028
SR6	Workforce	→	4	4	16	3	3	9	9	March 2028
SR7	Financial Sustainability	↓	2	4	8	3	4	12	12	April 2026
SR8	Cyber Security	→	3	4	12	3	4	12	8	March 2028
SR9	Emergency Incident	↓	3	3	9	3	3	9	6	March 2028
SR10	NHS Reform	→	4	4	16	3	3	9	4	March 2026

The risks included within the BAF, as well as the organisation's risk appetite statement were developed by the NHS GM Executive Management Team, and are considered by the Board to present the most significant risk to achieving NHS GM's strategic objectives.

The ongoing assessment of controls and the mitigating actions to address these risks will continue in 2026/27 to ensure these are appropriate and implemented, as well as a review of the organisation's risk appetite statement.

Other sources of assurance

Internal control framework

A system of internal control is the set of processes and procedures in place in NHS GM, to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Committee and reporting structures of NHS GM provides the basis of the framework and process that maintains, monitors and reviews the effectiveness of the system of internal control and risk management. The Board and Committees comprised of a mix of senior managers, clinical professionals, independent contractors and internal audit representation to provide an effective balance between the Board, executive and audit functions and furthermore to ensure that decision making is effectively triangulated.

The Board's role is to provide active leadership of NHS GM within a framework of prudent and effective controls that enable risk to be managed. NHS GM's Risk Management Policy aims to provide the Board with the relevant assurance of the progress of achievement of NHS GM's aims, objectives and priorities within a robust risk-based framework. Further work on risk management arrangements has taken place during 2025/26 to ensure these are strengthened in line with the recommendations made by internal audit.

The Board receives regular minutes and reports from its Committees to provide internal assurances on financial, organisational and quality performance.

The Audit Committee specifically advised the Board on the effectiveness of the system of internal control by the review of the internal audit report, external audit report and the Risk Assurance Framework. Any significant control issues would be reported to the Board by the Audit Committee.

The Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own Conflict of Interest policy, which is included in NHS GM's governance handbook. NHS England has provided updated a national e-learning module on managing conflicts of interest in the context of the new ICB arrangements which have been rolled out to all staff, with a further two training modules provided to decision making staff only.

The most recent audit of conflicts of interest management (conducted during the 2023/24 financial year) received substantial assurance that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

Data quality

NHS GM recognises that high quality intelligence is essential for effective decision making across the health and care system. We continue to strengthen our secure data environment, enhance cyber and data security, and make full use of our longitudinal linked dataset to validate completeness, accuracy and timeliness across key datasets. Consistent demographic information is now drawn from our Master Patient Index, supporting alignment across all DII outputs.

National data standards are applied to all data collected, stored and processed by NHS GM, with local standards agreed through provider contracts where required. Our Data Quality Policy is being refined through governance, alongside a new User Access Policy that strengthens data stewardship.

Known areas of data quality challenge, including SDEC reporting and Community Services data, are being actively managed through the Data Quality Improvement Plan and supported by validation through the longitudinal record.

Based on the data submitted to and reviewed by the Board, I am assured that the information is of sufficient quality for the ICB to discharge its statutory duties.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

NHS GM submitted the organisations Cyber Assessment Framework (CAF) Data Security & Protection Toolkit Initial Assessment Submission on 31st December 2025 and will be submitting the final submission of the organisations CAF Data Security & Protection Toolkit by 30th June 2026. Phase One of the internal audit review took place at the beginning of 9th February 2026, with Phase Two of the audit is scheduled for 8th May 2026.

NHS GM places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established the NHS GM Data Security Protection Framework and have developed information governance processes and procedures in line with the CAF Data Security Protection & Toolkit. We have ensured all staff undertake annual Mandatory Data Security training and NHS GM is in the process of implementing a Data Security (IG) Staff Handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of data security breaches and incidents which is detailed in the NHS GM Data Security Breach & Incident Policy.

The NHS GM Information Risk Policy was reviewed and updated during the year. Work continues to take place to fully embed an information risk culture throughout the organisation against identified information risks

Business critical models

Due to the organisational restructure, NHS GM is also undertaking a review to identify any Information Asset Owners (IAOs) and Information Asset Administrators (IAAs) who have left the organisation, ensuring replacements are assigned where required and that appropriate training is completed.

IARs are in the process of being populated. Once complete, data flows for every information asset containing either patient confidential data or business confidential data will be documented to enable a better understanding of the information asset. Risk reviews will then take place, and any information risks will be reported to the Senior Information Risk Owner (SIRO). The SIRO is responsible for identifying and managing information risks, and regular reports will therefore be provided.

NHS GM has identified a defined list of essential functions. These are functions that are necessary to deliver NHS GM services. Work is being undertaken to ensure that appropriate Business Continuity Plans (BCPs), contracts, and Data Protection Impact Assessments (DPIAs) are in place for each. This work is being progressed with input from the Data Protection Officer to ensure that key data

and systems are captured within planning for potential disruption. NHS GM continues to operate a two-tier on-call system that provides a route of escalation from locality on-call staff to executive level.

Third party assurances

NHS England has procured a number of Service Auditor Reports to provide third party evidence on the effectiveness of controls within the organisation providing the service to NHS GM, for which NHS GM can rely on or would need to have in place compensating controls to deal with the weakness. These are evidenced as part of the external audit process. The organisations and status of the reports are summarised in the table below:

Service Provider	Status of Service Auditor Report	ICB has compensating controls to mitigate risks?	ICB can place reliance on entries / processes?
NHS Shared Business Services Ltd: Finance and Accounting Services	The 2025/26 service auditor report has not been qualified and assurance is gained from its findings.	Not applicable,	Yes
East Lancashire Financial Services – Payroll processing	The 2025/26 service auditor report has not been qualified and assurance is gained from its findings.	Not applicable	Yes
Electronic Staff Record Programme – Payroll System	The 2025/26 service auditor report has not been qualified and assurance is gained from its findings.	Not applicable	Yes
NHS Business Services Authority: Prescription payments	The 2025/26 service auditor report has not been qualified and assurance is gained from its findings.	Not applicable.	Yes

NHS Business Services Authority: Dental payments	The 2025/26 service auditor report has not been qualified and assurance is gained from its findings	Not applicable.	Yes.
CSW CSU CQRS processing	The 2025/26 service auditor report has not been qualified and assurance is gained from its findings	Not applicable.	Yes.
NHS England : Extraction and Processing of GP Data Services	The 2025/26 service auditor report has been qualified.	Yes.	Yes.
Capita Primary Care Support Services	The 2025/26 service auditor report has been qualified.	Yes.	Yes

Control issues

As described in the opening part of this governance statement, enforcement undertakings were agreed between NHS GM and NHS England (as set out at the NHS GM Board meeting on 17 July 2024) as NHS England had identified reasonable grounds to suspect NHS GM was failing or had failed to discharge some of the ICB functions as set out in the Health and Care Act 2006. The undertakings highlighted four key areas where action was required to be taken:

- Leadership and governance
- Financial planning
- Performance

Quality of care

In response, NHS GM developed a comprehensive Single Improvement Plan to address these concerns, detailing the position against the grounds for the undertakings and identifying actions to address the gaps and drive the required improvements.

During 2025/26, following significant progress made against the initial concerns raised, NHS England lifted the Enforcement Undertaking in the following areas:

- Leadership and Governance
- Performance
- Quality of Care

At year-end, enforcement undertakings remained in place for:

- Financial Planning

The Financial Planning undertaking has nine elements, and NHS England has confirmed that seven elements had been met during the year. The two outstanding elements that were not being met at the time were:

- Delivery of the 2025/26 plan
- Develop a medium-term financial plan which demonstrates how the ICS will be entering 2026/27 in an underlying breakeven position.

The ICB delivered the agreed financial plan with NHS England for 2025/26 so this criteria should be met when NHS England review compliance.

The ICB has submitted a medium-term financial plan for the period 2026/27-2028/29 that demonstrates break-even for each year. The system is not yet in an underlying breakeven position which has been recognised in the deficit targets set for the ICB for 2026/27 and a number of NHS Providers in the system. Given the progress made and the submission of a compliant medium-term plan, the ICB is confident this criteria will be lifted, which will enable a compliance notification to be issued for Financial Planning.

NHS GM incurred a £7.5m overspend (as part of its agreed financial plan with NHSE) which has resulted in the issuing of a Section 30 referral to the Secretary of State for Health and Social Care.

Review of economy, efficiency & effectiveness of the use of resources

NHS GM is responsible for commissioning all services for the population of Greater

Manchester, including pharmacy, optometry and dental under delegation from NHS England. From the 1st April 2024, the organisation became responsible for Specialised Commissioning under delegation from NHS England, with the further delegation of specialised mental health services from 1st April 2025.

NHS GM has an obligation to use its resources efficiently, effectively and economically. In addition, it must meet financial requirements as set out by NHS England, which includes delivering a breakeven financial position.

During 2025/26, NHS England lifted the Enforcement Undertaking in the following areas:

- Paragraph 1. Future Operating Model and Governance Arrangements
- Paragraph 3. Performance
- Paragraph 4. Quality of Care, Access and Outcomes and Leadership and Capability
- Paragraph 5. Programme Management

Enforcement undertakings remain place in:

- Paragraph 2: Financial Planning, with seven of nine elements met.

The two outstanding elements that were not being met at the time were:

- Delivery of the 2025/26 plan
- Develop a medium-term financial plan which demonstrates how the ICS will be entering 2026/27 in an underlying breakeven position.

The ICB delivered the agreed financial plan with NHS England for 2025/26, so this criteria should be met when NHS England review compliance.

The ICB has submitted a medium-term financial plan for the period 2026/27-2028/29 that demonstrates break-even for each year. The system is not yet in an underlying breakeven position which has been recognised in the deficit targets set for the ICB for 2026/27 and a number of NHS Providers in the system. Given the progress made and the submission of a compliant medium-term plan, the ICB is confident that this criterion will be lifted, which will enable a compliance notification to be issued for Paragraph 2:

Financial Planning.

During 2025/26, NHS GM continued to lead the local implementation of national NHS reform, building on the established integrated care model to strengthen collaboration across health, local government and the voluntary sector. This approach has supported a shift towards prevention and community-based care, while maintaining a strong focus on system performance and financial sustainability to delivery improved outcome for residents.

In terms of the financial position and approach there is more information detailed within the Finance Review detailed on page 102.

The key headlines are:

The final plan submission for 2025/26 was a deficit of £200m, which was split £150.0m within the provider sector and the balance in NHS GM. This plan was agreed with NHSE, and deficit support allocation was received for £200.0m giving a compliant balanced plan, with efficiency savings of £656.0m, of which £175.0m related to NHS GM and £481.0m to GM NHS provider organisation efficiency schemes.

Overall, the system did deliver £635.4m of efficiency savings, £175.0m relating to NHS GM was delivered in full (£108.6m recurrently and £66.4m non-recurrently) and £460.4m delivered by providers (£278.0m recurrently and £182.4m non-recurrently), which was a £20.6m under delivery.

To mitigate and control risks associated with NHS GM's use of resources, organisational financial health is checked and reported to the Board monthly. The Board also continues to delegate responsibility for some aspects of financial internal control to the Finance Committee until December 2025, replaced by the Transition Committee and Finance Sub Committee from January 2026 to March 2026, and from April 2026 this responsibility is delegated to the People and Resources Committee.

Due to the on-going economic climate, NHS GM continued with the measures introduced in previous financial years and expanded these to manage pressures, these included:

- Enhanced grip and control measures, including internal and system vacancy

control.

- Challenging efficiency programmes to manage overall pressures.
- Internal governance process for all expenditure before business case production (referenced locally as STAR process).
- Investment slippage.
- NHS GM set a clear ambition to eliminate inappropriate adult acute Out of Area Placements (OAPSs), reduce avoidable lengths of stay and return people closer to home. The Integrated Fund functioned as a shared mechanism with NHS Providers. It is a gainshare based model that released funding from the reduction in independent sector inpatient capacity usage on OAPs and spot placements and reinvested funding supporting 'left shift' towards prevention and early intervention via investment in community mental health services.
- Introduced Activity Management Plans across the Independent Sector to control activity and costs. The ICB introduced minimum waiting times down to 12 weeks for all non-urgent specialities, with the exception to a few such as ophthalmology for example and was prioritised through strategic elective care commissioning leads working with providers to manage within financial envelopes whilst maintaining Referral to Treatment (RTT) performance.
- NHS GM ICB launched a transformation programme for ADHD and ASD services. A central component of this work involved managing the provider market by collaborating with Right to Choose (RTC) providers to develop activity plans, while also consolidating locality budgets across Greater Manchester into a single central system. This approach reduced invoice volumes, improve oversight of future demand, and ensure services are delivered within available resources. This work has been underpinned by a centrally driven, cross-functional approach, with colleagues from finance, commissioning, data, and contracts working closely together to create a highly productive team environment that has adapted rapidly to change.

The previous scrutiny of both organisational positions and internal locality positions continued under a regime of Provider Oversight Meetings and Locality Assurance Meetings, with reviews being escalated if the financial positions were deteriorating. These meeting were chaired by the NHS GM CEO/Deputy CEO with equivalent colleagues from the provider Trusts and locality leadership teams. Where appropriate these were stood down during 2025/26.

A number of processes remained in place in 2025/26, with a key change moving away from ERF and its ceiling in 2024/25 to agreed Indicative Activity Plans (IAPs):

- Calculated block contracts payable to NHS bodies, adjusted for local agreements, which ceased the majority of inter-NHS invoicing. Work continues to progress for deconstructing of the blocks with significant changes relating to legacy payment agreements and the understanding of contract values down to specific services delivered. In 2025/26 the ICB had more control over elective performance and moving away from previous ERF arrangements and agreeing IAPs. More local agreements facilitated baseline plans for drugs and devices and unbundled diagnostics that could be monitored against performance and variable payments direct to Trusts. Sprint funding received from NHSE throughout the year supported with additional payments above IAPs, allowing Trusts to delivery and improve against RTT performance targets.
- Nationally calculated LVA (Low Value Activity) for NHS providers outside of the GM system have remained in place.
- Contracts for 2025/26 were agreed at system level, with CQUIN remaining suspended.
- Mental Health Investment Standard delivery was supported.

NHS England has a legal duty to annually assess the performance of each ICB. The assessment must consider the duties of ICBs to improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The latest available information in relation to this assessment can be found starting on page 16 of this report.

Commissioning of delegated services (primary care services and specialised services)

NHS GM has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service

specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

The Board retains accountability for the delivery of all of NHS GM functions. The Board has established a number of formal Committees with delegated authority to appropriately manage some of its functions. The Committees established are:

- Audit Committee
- Remuneration Committee
- Finance Committee (Finance Sub-Committee from January to March 2026)
- Quality and Performance Committee (formal Committee of the Board until December 2025)
- People and Culture Committee (formal Committee of the Board until December 2025)
- Population Health Committee (formal Committee of the Board until December 2025)
- Primary Care Commissioning Committee (changed to Primary Care Commissioning Group from January 2026)
- Transition Committee (from January 2026)

As described earlier in this report, transition arrangements were in place between January and March 2026 until new Committee arrangements were established from 1st April 2026.

In addition, the Board has established Integrated Partnership Committees / Locality Boards (as formal Committees of the Board with delegated budgets and functions) for each of the 10 localities within Greater Manchester (Bolton, Bury, Heywood, Middleton and Rochdale; Manchester, Oldham, Salford, Stockport, Tameside, Trafford, and Wigan). Integrated Partnership Committees / Locality Boards bring together senior

leaders for the NHS (primary, secondary, community and mental health), local authority and the VCFSE (Voluntary, Community, Faith and Social Enterprise), with their role to focus on the shared priorities within their respective Locality Plans and, by working together, improve health, wellbeing and care for the population of each locality.

The ICB's constitution and Governance Handbook sets out the arrangements under which the ICB and its Committees operate, with each of the Committees' Terms of Reference setting out their agreed delegations and responsibilities. The ICB receives the minutes and regular reports from each of its Committees detailing the delivery of work, and associated risks, within their specific remit. Risks are escalated by Committees to be included in the Board Assurance Framework if appropriate.

The internal audit process was used to provide an in-depth examination of any areas of concern, and the Audit Committee provides assurance that the statutory duties of the ICB are being managed appropriately at the different levels of the organisation.

The organisation has a Freedom to Speak Up Policy in place, and a separate Whistleblowing Policy has been developed to ensure relevant information is available to both internal and external stakeholders. The Freedom to Speak Up Policy is available to all staff and confirms the organisation's Freedom to Speak Up Guardian and how they can be contacted and identifies how issues may be raised and addressed, with the Whistleblowing Policy available on the organisation's website. An annual report on Whistleblowing is presented to Audit Committee as part of the workplan.

Counter fraud arrangements

NHS GM made the following arrangements regarding its managing of counter-fraud:

- An Accredited Counter Fraud Specialist (ACFS) was contracted, through Mersey Internal Audit Agency (MIAA) (NHS GM's Internal Audit service provider), to undertake counter fraud work at NHS GM proportionate to identified risks. The ACFS is supported by several nominated colleagues, a number of who specifically deal with any referrals and investigations. The ACFS participates in the national Counter Fraud Managers' Group, which shares good practices, and is also a member of that group's specialist ICB working group. The ACFS also actively participates in several of the NHSCFA's stakeholder working groups.

- An annual risk-based counter fraud proactive work plan was agreed and signed off by the Audit Committee. This was developed primarily by the Accredited Counter Fraud Specialist and the Chief Finance Officer (supported by colleagues including the Counter Fraud Champion and the Corporate Director of Finance), taking into consideration the Government Functional Counter Fraud Standard GovS013 (NHS Requirements), the NHS Counter Fraud Authority's National Strategic Priorities, as well as consideration of national, regional and locally identified fraud risks and intelligence (as captured in the Fraud Risk Assessment).
- All fraud referrals received by the ACFS during the course of the year have been responded to appropriately, in accordance with the NHS counter Fraud Authority's Fraud Manual. The Audit Committee has been kept continually informed about these during the year.
- The NHS GM Audit Committee received, through regular LCFS reporting, an indication as to the levels of compliance with the requirements set out in Government Functional Standard 013 for Counter Fraud. Work has been undertaken during the year to ensure that an annual self-assessment against the requirements of the standard can be submitted to the NHS Counter Fraud Authority in May 2026. There is an ongoing commitment from NHS GM to provide appropriate executive support and direction proportionate to the identified fraud risk profile of the ICB.
- The Chief Finance Officer is the executive board member proactively and demonstrably responsible for tackling fraud, bribery and corruption. Periodic liaison takes place between the ACFS, Chief Finance Officer (and their deputies), Counter Fraud Champion (and Counter Fraud 'Ambassadors') and other key stakeholders as appropriate to ensure the effective delivery and embedding of anti-fraud messaging across the organisation. A new Counter Fraud Champion for NHS GM was appointed during the year and has received the relevant training from NHSCFA.
- There were no NHS quality assurance recommendations issued during the year which required review and/or action. The ACFS regularly distributed NHS Counter Fraud Authority (NHSCFA) Fraud Prevention Notices and Intelligence Bulletins to relevant staff, as appropriate, which were actioned accordingly. Anti-fraud alerts, advice and guidance was also shared throughout the year with all

NHS GM's primary care providers. NHSCFA have not conducted any engagement visit during the year. The Anti-Fraud Specialist has also maintained regular liaison with members of the NHSE NW counter fraud team during the year, particularly with regard to primary care fraud risks.

Head of internal audit opinion

Following completion of the planned audit work for the period 1 April 2025 to 31 March 2026 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Substantial assurance can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. During the period, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Assurance Framework	N/A
Risk Management Core Controls	Substantial
Primary Care Commissioning Assurance Framework (POD Delegation)	Substantial
Key Financial Transactional Processing Controls	Moderate
Financial Recovery Programme	Substantial
Financial Reporting	Substantial
Mental Health	Substantial
Community Pharmacy Advances Services	Moderate
Continuing Healthcare (CHC)	Moderate

Training and Development	Substantial
ESR Payroll	Substantial
IT Supplier Management Review (Draft)	Limited
Contingency – NEPTS Procurement (Draft)	No overall assurance rating
Specialised Commissioning	Substantial

Follow up

During the course of the year, follow up reviews concluded that the organisation had made some progress with regards to the implementation of recommendations. Further progress would be required to reduce the number of outstanding recommendations. Internal Audit would continue to track and follow up outstanding actions.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board
- The audit committee
- The quality and performance committee
- Internal audit

The role and conclusions of each were described previously in the governance statement.

Conclusion

In the period 01 April 2025 to 31 March 2026, some internal control issues remained from the previous year relating to the NHSE Enforcement Undertakings, which have been described earlier in this Accountability Report (see “Control Issues” section). However, as mentioned earlier in this report, at the end of the reporting period NHS GM had made significant progress in delivering against these undertakings. Of the 36 initial undertakings in place, 34 were now fully compliant and had been formally lifted, with two, relating to financial planning, remaining in place (however at the end of the reporting period, it was expected that these would also be formally lifted following the successful delivery of the 202/25 financial plan (noting the issuing of a Section 30 referral to the Secretary of State for Health and Social Care as a result of the £7.5m overspend (as part of its agreed financial plan with NHSE)), and the submission of a medium-term financial plan for the period 2026/27-2028/29, that demonstrates break-even for each year).

Since its establishment, NHS GM has continued to work on strengthening its governance structures and financial controls. The Head of Internal Audit Opinion states that the ICB can take ‘substantial assurance’, demonstrating that there is a good system of internal control designed to meet the organisation’s objectives, and that controls are generally applied consistently. This level of assurance is an improved position from the previous reporting year (where the opinion provided ‘moderate assurance’), demonstrating the positive progress made by the organisation during 2025/26.

Remuneration and staff report

Remuneration report

Remuneration committee

The Remuneration Committee is a committee of NHS Greater Manchester Integrated Care Board. It has those executive powers, delegated to it by the ICB within the NHS GM scheme of delegation contained in its terms of reference, which are reviewed on an annual basis. Remuneration for Non-executive Members will be set by the Remuneration Committee with the addition of further members so that conflicted Non-executive Members can be excluded from discussion and decision.

Information on the Committee's membership can be found in the Members Report (under the heading 'Committee(s), including Audit Committee').

Only members have the right to attend Remuneration Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Remuneration Committee. Meetings may also be attended by the following individuals who are not members of the Remuneration Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- Chief Executive or their nominated deputy.
- Chief Strategy, People and Partnership Officer or nominated deputy.
- Other senior officer as requested by the Chair of the committee.
- Board and Committee secretary.

The Remuneration Committee's main purpose is to make recommendations to NHS GM on:

- Newly established or new appointments to senior NHS GM posts
- NHS GM pay policy including adoption of any pay frameworks and salaries for new director appointments (including but not limited to board members).
- NHS GM pay policy including adoption of any pay frameworks and remuneration for new nonexecutive director appointments
- The approval of any exit payments for VSM employees, including the issue of

associated contractual and non-contractual payments and referral into the national approvals process.

- The approval of any non-contractual exit payments for Agenda for Change (AfC) employees

The Remuneration Committee will exercise delegated authority on behalf of NHS GM to set remuneration, fees and other allowances for employees and for other people working for NHS GM who are not employed on Agenda for Change (AfC) terms and conditions of service which includes clinical leads, contracts for services or office holder arrangements.

Percentage change in remuneration of highest paid director (subject to audit)

The table below highlights the percentage change for the remuneration of the highest paid director, along with prior year comparators. The reduction between 2024/25 and 2025/26 for the highest paid director relates to differential national pay awards between the comparative years. The pay award differential also applies the employees as a whole, as well as the impact of a Mutually Acceptable Redundancy scheme which was run in 2024/25 which has impacted on the overall staff numbers,

	Percentage Change for Highest Paid Director (change from 2024/25 to 2025/26)	**Percentage Change for Employees as a Whole (change from 2024/25 to 2025/26)**
Salary and Allowances	3.3%	4.3%
Performance Pay/ Bonuses	n/a	n/a

	Percentage Change for Highest Paid Director (change from 2023/24 to 2024/25)	**Percentage Change for Employees as a Whole (change from 2023/24 to 2024/25)**
Salary and Allowances	5.0%	5.8%

Performance Pay/ Bonuses	n/a	n/a

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

2025/26 disclosure

The banded remuneration of the highest paid director in NHS Greater Manchester ICB was £290.0k - £295.0k (2024/25: £280.0k – £285.0k).

2025/26	**25th percentile**	**Median pay ratio**	**75th percentile pay ratio**
Total remuneration (£)	£39k	£55k	£69k
Salary component of total remuneration (£)	£39k	£55k	£69k
Remuneration ratio information	7.56:1	5.35:1	4.26:1
Salary ratio information	7.56:1	5.35:1	4.26:1

During the reporting period 2025/26, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £2,166 - £293,120.

Total remuneration includes salary costs, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

2024/25 disclosure

The banded remuneration of the highest paid director in NHS Greater Manchester ICB was £280.0k - £285.0k (2023/24: £270.0k – £275.0k).

2024/25	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£37k	£53k	£62k
Salary component of total remuneration (£)	£37k	£53k	£62k
Remuneration ratio information	7.57:1	5.35:1	4.54:1
Salary ratio information	7.57:1	5.35:1	4.54:1

Please note the 2024/25 calculations above include non-executive directors, but the 2025/26 comparators exclude these as per national guidance included within the Fair Pay Guidance included in the Group Accounting Manual 2025/26 (Section 3.109)

During the reporting period 2024/25, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £2,166-£283,894.

Total remuneration includes salary costs, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

NHS Greater Manchester ICB applies the NHS Very Senior Managers Pay Framework in respect of relevant Very Senior Manager roles. Remuneration decisions for Very Senior Managers are considered through the ICB's Remuneration Committee governance arrangements, with reference to the national framework, relevant NHS England guidance, internal governance requirements and the need to ensure appropriate, fair and proportionate use of public funds.

The ICB confirms that it complied with the NHS Very Senior Managers Pay Framework during 2025/26. There were no departures from the NHS Very Senior Managers Pay Framework during the reporting year.

The ICB's Remuneration Committee meets on a regular basis and provides formal oversight of relevant Very Senior Manager remuneration matters, including appointments, acting-up arrangements, salary changes and other pay-related decisions

within its remit.

Contractual Implications for Senior Managers

The contract for senior managers states that:

If the employee wishes to terminate their employment, they must give the organisation an appropriate period of notice in writing – a minimum of six months. The organisation will give a period of six months' notice.

NHS GM shall be entitled to terminate the individual's employment summarily, i.e. without notice or pay in lieu of notice, without prejudice to any rights or claims it may have against them, if at any time they are guilty of gross misconduct or if they commit any serious breach of a material term of their contract of employment.

If the individual is employed on a fixed term contract, their employment will terminate on the expiry of the fixed term without the need for NHS GM to give any additional notice.

NHS GM may require an individual to take any outstanding annual leave entitlement during their notice period, whether notice to terminate is given by them or by the ICB.

NHS GM has the discretion to terminate employment lawfully without any notice by paying a payment in lieu of notice. Once notice has been given by either party the employer reserves the right to do any of all of the following:

- Exclude an employee from its premises.
- Require an employee to carry out alternative duties or such specific duties as the organisation may specify or no duties.
- Revoke or suspend any powers the employee may have as a Board member or require the employee to refrain from attending meetings of the Board or any of its committees.
- Announce to other employees that an employee has given or received notice.
- Require the employee to delivery to the Employer any of its property in their possession
- Pay the employee in lieu of notice.

There are no special provisions for termination due to redundancy other than those

stated for all employees in NHS GM Organisational Change Framework and legacy Organisational Change Policies.

Service contracts of other board members (non-management)

There are members of the Board whose services are via a Contract for Services. The termination arrangements for these individuals are as follows:

- Continuation of their appointment is contingent on their continued satisfactory performance and re-election/selection by the members as required by the Constitution.
- The individual may resign from NHS Greater Manchester Integrated Care Board at any time by giving written notice to the Chair.
- The organisation reserves the right to terminate their appointment with immediate effect and without payment of compensation by written notice.
- On termination of the appointment, the individual shall only be entitled to accrued fees as at the date of termination, together with the reimbursement of any expenses properly incurred prior to that date.

Due to the terms in the contract for service there is no liability to the organisation in the event of early termination.

Remuneration of very senior managers

In 2025/26 NHS GM has seven senior leaders (2024/25: nine senior leaders) who would have been paid more than £170,000 per annum had they worked on a full-time basis. All NHS GM senior leaders were appointed within the parameters of the ICB national pay framework. NHS GM has satisfied itself that the remuneration is reasonable through the application of its remuneration policy.

2025/26 senior manager remuneration (including salary and pension entitlements) (subject to audit)

The following tables and the associated financial values are subject to validation by

external audit.

Name and Title		1 April 2025 to 31 March 2026					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Other (bands of £5,000)	(g) TOTAL (a to f) (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
Executive members							
Mark Fisher (Chief Executive)	290-295	0	0	0	75-77.5	5-10	375-380
Colin Scales (Deputy Chief Executive, Acting Chief Executive from 12th December)	215-220	0	0	0	210-212.5	0	430-435
Kathy Roe (Chief Finance Officer)	185-190	0	0	0	97.5-100	0	285-290
Charlotte Bailey (Chief Strategy,	170-175	0	0	0	47.5-50	0	220-225

Name and Title		1 April 2025 to 31 March 2026					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Other (bands of £5,000)	(g) TOTAL (a to f) (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
People & Partnerships)							
Warren Heppolette (Chief Officer for Strategy & Innovation until 12th October 2025)	80-85	0	0	0	32.5 - 35	0	115-120
Dr Manisha Kumar (Chief Medical Officer)	195-200	0	0	0	60-62.5	0	260-265
Mandy Philbin (Chief Nursing Officer until 31st	135-140	0	0	0	55-57.5	0	190-195

Name and Title		1 April 2025 to 31 March 2026					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Other (bands of £5,000)	(g) TOTAL (a to f) (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
December 2025)							
Katherine Sheerin (Chief Commissioning Officer)	160-165	0	0	0	40-42.5	0	200-205
Gareth Robinson (Chief Interim Officer for System Improvement until 8th September 2025)	65-70	0	0	0	22.5-25	0	90 – 95
Gareth Robinson (Acting Chief Officer for System	25-30	0	0	0	0	0	25-30

Name and Title		1 April 2025 to 31 March 2026					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Other (bands of £5,000)	(g) TOTAL (a to f) (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
Reform from 12th January 2026 until 9h March 2026)							
Nicola Hepburn (Acting Chief Reform & Improvement Officer from 9th March 2026)	10-15	0	0	0	2.5-5	0	10-15
	Non-Executive Members						
Sir Richard Leese (Chair)	70-75	0	0	0	0	0	70-75
Richard Paver (Audit & Transition	15-20	0	0	0	0	0	15-20

Name and Title		1 April 2025 to 31 March 2026					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Other (bands of £5,000)	(g) TOTAL (a to f) (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
Committees)							
Rachel Egan (Remuneration, Transition & Population Health Committees)	15-20	0	0	0	0	0	15-20
Sheena McDonnell (People & Culture Committee until 31st May 2025)	0-5	0	0	0	0	0	0-5
Professor Dame Sue Bailey (Quality & Transition	15-20	0	0	0	0	0	15-20

Name and Title		1 April 2025 to 31 March 2026					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Other (bands of £5,000)	(g) TOTAL (a to f) (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
Committees)							
Khalida Kay (Finance & Transition Committee)	15-20	0	0	0	0	0	15-20
Jacqueline Njoroge (Deputy Chair/Senior Independent Director from 1st January 2026 – attends all Committees)	0-5	0	0	0	0	0	0-5
	Partner Members (where remunerated)						
Dr Vishal Mehra	20-25	0	0	0	0	0	20-25

Name and Title		1 April 2025 to 31 March 2026					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Other (bands of £5,000)	(g) TOTAL (a to f) (bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
(Partner - Primary Care)							

**Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Column e, the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual or cost to NHS GM. It is a calculation that is intended to convey an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

The following information is presented to assist the understanding of the information contained within the table on pages 173-179.

Executive members

- Mark Fisher was absent from his role from 12th December and Colin Scales covered the responsibilities of the Chief Executive on an acting basis from this date. The remuneration disclosed reflects these temporary acting arrangements. The payments capture in the (f) Other relate to payments in lieu of annual leave.
- Mandy Philbin was in her Chief Officer role until 31st December 2025. As part of the NHS Reform programme, the Chief Nurse post was dis-established, with

clinical leadership responsibilities incorporated into the Chief Clinical Officer portfolio within the new structure. The postholder supported national programmes of work during the period 1st January to 31st March 2026. The annual salary for this role was £182,000.

- Warren Heppolette went on secondment on 13th October 2025. The annual salary associated with his substantive Chief Officer role is £158,000.
- Gareth Robinson appears twice in the table as he covered two periods / roles which are disclosable. The annual salary associated for these roles was £126,000.
- Nicola Hepburn became Acting Chief Reform & Improvement Officer on 9th March 2026. The annual salary associated with this role is £126,000.

Where the real value of pension related benefits is calculated to be negative (as the value of the in-year pension benefit is not as large as the inflation assumption of 1.7% that has been applied) the negative real benefit has been replaced by a zero, as required by the Department of Health and Social Care Group Accounting Manual.

Where an individual has been in post for less than the full twelve months, the value of pension benefits has been apportioned in line with the period of their employment.

Place based leads

Each of the ten localities have a place-based lead but due to decision making Committee changes from May 2024, these roles are considered out of scope of the Remuneration Report for 2025/26.

Non-executive members

Sheena McDonnell left her role as People & Culture Committee NED on 31st May 2025. The annual salary associated with this role is £16,000.

Jacqueline Njoroge became Deputy Chair & Senior Independent Director on 1st January 2026. The annual salary associated with this role is £16,000.

No pension benefits are disclosed in respect of Non-Executive Members, as they are not permitted to become members of the NHS Pensions Scheme in respect of their

roles with NHS GM.

Partner members

The following Partner members are not remunerated by NHS GM for their roles within the organisation, being paid instead by the bodies they represent as part of their role; Sean Fielding (Local Authority Partner Member), Leigh Vallance (VCFSE), Dr Owen Williams (Acute Sector), and Anthony Hassall (Mental Health Sector).

Dr Vishal Mehra's annual salary for his role as a Partner (Primary Care) is £21,709. In addition to this, Dr Mehra is remunerated by NHS GM for the role of Chair of the Manchester GP Board, which equated to £36,453 in 2025/26.

2024/25 senior manager remuneration (including salary and pension entitlements) (subject to audit)

The following tables and the associated financial values have been validated by external audit.

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Executive members						
Mark Fisher (Chief Executive)	280-285	0	0	0	72.5-75	355-360

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Colin Scales (Deputy Chief Executive – started 8th September 2024)	100-105	0	0	0	37.5-40	140-145
Kathy Roe (Interim Chief Finance Officer)	180-185	0	0	0	365-367.5	545-550
Janet Wilkinson (Chief People Officer until 31st March 2025)	160-165	0	0	0	0	160-165
Charlotte Bailey (Chief People Officer from 24th March 2025)	0-5	0	0	0	0	0-5
Warren Heppolette	150-155	0	0	0	22.5-25	175-180

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
(Chief Officer for Strategy & Innovation)						
Dr Manisha Kumar (Chief Medical Officer)	190-195	0	0	0	40-42.5	230-235
Mandy Philbin (Chief Nursing Officer & Acting Deputy Chief Executive)	180-185	0	0	0	20-22.5	200-205
Rob Bellingham (Chief Commissioning Officer – until 31st January 2025)	125-130	0	0	0	55.0-57.5	180-185
Katherine Sheerin (Chief Commissioning	35-40	0	0	0	0	35-40

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Officer started 1st January 2025)						
Gareth Robinson (Chief Interim Officer for System Improvement started 9th September 2024)	80-85	0	0	0	20-22.5	100-105
Martyn Pritchard (Interim Chief Operating Officer – until 18th July 2024)	45-50	0	0	0	0	45-50
Place Based Leads						
Steve Rumbelow (Heywood, Middleton &	5-10	0	0	0	0	5-10

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Rochdale Place Based Lead)						
Mike Barker (Oldham Place Based Lead)	15-20	0	0	0	0	15-20
Non-Executive Members						
Sir Richard Leese (Chair)	70-75	0	0	0	0	70-75
Richard Paver (Audit)	15-20	0	0	0	0	15-20
Rachel Egan (Remuneration Committee & Population Health Committee)	15-20	0	0	0	0	15-20
Sheena McDonnell (People & Culture	15-20	0	0	0	0	15-20

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Committee)						
Dame Professor Dame Sue Bailey (Quality Committee)	15-20	0	0	0	0	15-20
Khalida Kay (Finance Committee)	15-20	0	0	0	0	15-20
Partner Members (where remunerated)						
Dr Vishal Mehra (Partner - Primary Care)	20-25	0	0	0	0	20-25

**Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Column e, the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual or cost to NHS GM. It is a calculation that is intended to convey an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

The following information is presented to assist the understanding of the information contained within the table on pages 181-186.

Executive members

- Colin Scales joined NHS GM on 18th September 2024. The annual salary associated with this role is £192,178.
- Janet Wilkinson left her role with NHS GM on 31st March 2025.
- Charlotte Bailey commenced her Chief Officer role on 24th March 2025.
- Mandy Philbin held the post of Chief Nursing Officer and Acting Deputy Chief Executive until the appointment of Colin Scales. The acting up allowance for her role as interim Deputy Chief Executive was £10,000 per annum. The annual salary associated with the Chief Nursing Officer role is £176,014.
- Rob Bellingham left his Executive role with NHS GM on 31st January 2025. The annual salary associated with that role was £153,300. Following this, Rob continued with NHS GM as a part time Programme Director. From 1st February 2025, Rob earned £5,110 in this role, working 1 day per week. The annual salary for this role was £30,660 (full time equivalent £153,300). The total gross pay earned by Rob in the 2024/25 financial year was £132,860.
- Katherine Sheerin joined NHS GM on 1st January 2025. The annual salary associated with this role is £158,000.
- Gareth Robinson joined NHS GM on 9th September 2024. The annual salary associated with this role is £149,000.
- Martyn Pritchard was seconded to NHS GM as interim Chief Operating Officer until 18th July 2024. His annual equivalent salary in this role was £157,500.

Where the real value of pension related benefits is calculated to be negative (as the value of the in-year pension benefit is not as large as the inflation assumption of 6.7% that has been applied) the negative real benefit has been replaced by a zero, as required by the Department of Health and Social Care Group Accounting Manual.

Where an individual has been in post for less than the full twelve months, the value of pension benefits has been apportioned in line with the period of their employment.

Place based leads

In 2023/24 NHS GM established an Executive Committee to include the Place Based Leads for each of the 10 localities, which had decision making responsibility across the organisation. From 15th May 2024 this Committee was no longer able to make decisions on behalf of the organisation and as a result these roles are considered outside the scope of the Remuneration Report, due to this change (Department of Health and Social Care Group Accounting Manual section 3.72).

In many instances, the role of Place Based Lead is performed by an individual employed by a partner organisation of NHS GM, including Local Authorities and NHS Foundation Trusts. Different financial arrangements exist with each locality placed based lead. Where NHS GM does make a contribution to the host organisation relating to salary, on costs and administration expenses, these are not considered as remuneration as they are paid to the organisation not the individual.

The financial arrangements of the two place-based leads who are employed by NHS GM and disclosed within the table on pages 184-185 are:

- The annual equivalent salary in respect of Steve Rumbelow's role as HMR Place Based Lead is £52,447.
- Mike Barker is employed by NHS GM on an annual equivalent salary of £149,896. As part of his role, he is also an Executive Director for Oldham Metropolitan Borough Council.

For the following individuals, in the reportable period to 15th May 2024, a contribution was made by NHS GM to the host organisation. Details of the individual's remuneration are available in the Annual Report and Accounts of the host organisation.

- Fiona Noden, Bolton Place Based Lead (NHS Bolton Foundation Trust).
- Lynne Ridsdale, Bury Place Based Lead (Bury Council).
- Tom Stannard, Salford Place Based Lead (Salford Council).
- Caroline Simpson, Stockport Place Based Lead (Stockport Council).
- Sandra Stewart, Tameside Place Based Lead (Tameside Council).
- Sara Todd, Trafford Place Based Lead (Trafford Council).

For the following individuals, no contribution is made to the host organisation.

- Joanne Roney, Manchester Place Based Lead (Manchester City Council).
- Alison Mckenzie-Folan, Wigan Placed Based Lead (Wigan Council).

Non-executive members

All Non-Executive Members were in post for the duration of the financial year 2024/25.

No pension benefits are disclosed in respect of Non-Executive Members, as they are not permitted to become members of the NHS Pensions Scheme in respect of their roles with NHS GM.

Partner members

The following Partner members are not remunerated by NHS GM for their roles within the organisation, being paid instead by the bodies they represent as part of their role; Paul Dennett (Local Authority Partner Member, until October 2024), Sean Fielding (Local Authority Partner Member, from January 2025), Leigh Vallance (VCFSE), Dr Owen Williams (Acute Sector), and Anthony Hassall (Mental Health Sector).

Dr Vishal Mehra’s annual salary for his role as a Partner (Primary Care) is £21,885. In addition to this, Dr Mehra is remunerated by NHS GM for the role of Chair of the Manchester GP Board, which equated to £36,453 in 2024/25.

Pension benefits 2025/26 (subject to audit)

Name and Title	(a) Real increase in pension at pension age	(b) Real increase in pension lump sum at pension age	(c) Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2026	(e) Cash Equivalent Transfer Value at 1 April 2025	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2026	(h) Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mark Fisher (Chief Executive)	5-7.5	0	20-25	0	268	73	384	0
Colin Scales (Deputy Chief Executive became Acting Chief Executive from 12th December 2025)	10-12.5	20-22.5	65-70	160-165	1,244	219	1,511	0
Kathy Roe (Chief Finance Officer)	5-7.5	5-7.5	90-95	245-250	2,091	122	2,273	0
Charlotte Bailey (Chief Strategy, People and Partnership Officer)	2.5-5	0	25-30	0	338	35	400	0
Warren Heppolette (Chief Officer for Strategy & Innovation until 12th October 2025)	0-2.5	0	75-80	0	1,260	35	1,368	0
Dr Manisha Kumar (Chief Medical Officer)	2.5-5	0-2.5	40-45	85-90	813	56	908	0
Mandy Philbin (Chief Nursing Officer until 31st December 2025)	2.5-5	2.5-5	90-95	230-235	2,028	73	2,182	0
Katherine Sheerin (Chief	2.5-5	0	65-70	190-195	1,542	51	1,640	0

Commissioning Officer)								
Gareth Robinson (Interim Chief Officer for System Improvement until 8th September, and Acting Chief Officer for System Reform from 12th January 2026 until 9th March 2026)	0-2.5	0	20-25	10-15	320	17	372	0
Nicola Hepburn (Acting Chief Reform and Improvement Officer from 9th March 2026)	0-2.5	0-2.5	25-30	55-60	477	20	536	0

Non-executive Directors are not permitted to become members of the NHS Pensions Scheme in respect of their roles with the ICB.

The pensions table above should be read in conjunction with the notes to the pay table earlier in this section.

- Warren Heppolette's real increase in cash equivalent transfer values during the 7-month period is represented in the table above.
- Gareth Robinson's real increase in cash equivalent transfer values during the 9-month period (across two roles) is represented in the table above.
- Mandy Philbin's real increase in cash equivalent transfer values during the 9-month period is represented in the table above.
- Nicola Hepburn's real increase in cash equivalent transfer value during the 1-month period is represented in the table above.

Pension benefits 2024/25 (subject to audit)

Name and Title	(a) Real increase in pension at pension age	(b) Real increase in pension lump sum at pension age	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025	(e) Cash Equivalent Transfer Value at 31	(f) Real Increase in Cash Equivalent	(g) Cash Equivalent Transfer Value at 31	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mark Fisher (Chief Executive)	5-7.5	0	10-15	0	157	66	268	0
Colin Scales (Deputy Chief Executive)	2.5-5	2.5-5	55-60	135-140	1,066	40	1,244	0
Mandy Philbin (Chief Nursing Officer & Acting Deputy Chief Executive)	0-2.5	0	85-90	225-230	1,846	36	2,028	0
Dr Manisha Kumar (Chief Medical Officer)	2.5-5	0	35-40	85-90	709	32	813	0
Warren Heppolette (Chief Officer for Strategy & Innovation)	0-2.5	0	70-75	0	1,133	32	1,260	0
Rob Bellingham (Chief Commissioning Officer)	2.5-5	2.5-5	65-70	170-175	1,429	71	1,629	0
Martyn Pritchard (Former Interim) Chief Operating Officer	0	0	55-60	125-130	1,299	0	0	0
Mike Barker (Oldham Place Based Lead)	0-2.5	0	35-40	90-95	787	0	842	0
Kathy Roe (Interim Chief Finance Officer)	15-17.5	40-42.5	85-90	235-240	1,563	401	2,091	0
Katherine Sheerin (Chief Commissioning Officer)	0-2.5	0	60-65	185-190	1,411	4	1,542	0

Charlotte Bailey (Chief People Officer)	-	-	-	-	-	-	-	-
Gareth Robinson (Chief Interim Officer for System Improvement)	0-2.5	0	15-20	10-15	253	14	320	0

Non-executive Directors are not permitted to become members of the NHS Pensions Scheme in respect of their roles with the ICB.

The pensions table above should be read in conjunction with the notes to the pay table earlier in this section.

- Colin Scales' real increase in cash equivalent transfer values during the 6-month period is represented in the table above.
- Mike Barker's real increase in cash equivalent transfer value during the one and a half-month period is represented in the table above. The closing CETV value as at 31st March 2025 includes the impact of benefits earned for the full year, rather than only the one-and-a-half-month period.
- Katherine Sheerin's real increase in cash equivalent transfer value during the 3-month period is represented in the table above.
- Gareth Robinson's real increase in cash equivalent transfer value during the 7-month period is represented in the table above.
- There is no disclosure related to Charlotte Bailey as the information is not available.

Cash equivalent transfer values (subject to audit)

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which

disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office (subject to audit)

Note 4 to the accounts discloses the Termination Benefits payable by NHS GM in the 12-month period to 31 March 2026.

There are two packages agreed as compensation for loss of office within 2025/26 relating to:

- Charlotte Bailey (Chief Strategy, People and Partnership Officer) – exit package agreed in the financial year, but due to leave the organisation at the start of 2027/28
- Mandy Philbin (Former Chief Nurse) – exit package agreed in the financial year and paid in early 2026/27.

Both packages noted above have not been paid in 2025/26 and therefore have not been included within the Senior Manager Remuneration Salary and Pension Entitlement Disclosures on pages 173-179 of the annual report.

Section 16 of the Agenda for Change Handbook (Redundancy) was applied for individuals who had been displaced as a result of organisational change, for whom suitable alternative

employment could not be found. The numbers and values of payments associated with these cases are disclosed in note 4.

Payments to past directors (subject to audit)

NHS GM has made no payments to past directors in 2025/26 (2024/25: £nil). This is subject to validation by external audit.

Staff report

Number of senior managers

The information on the number of senior managers is presented in the table below for the 12-month period to the 31st March 2026.

Pay Grade	Headcount	FTE
Band 8 - Range C	63	60.79
Band 8 - Range D	52	50.80
Band 9	25	23.23
Other	39	25.71
Grand Total	179	160.53

Staff numbers and costs (subject to audit)

The staff numbers and cost information disclosed in the following two tables (staff costs and average staff numbers) are subject to validation by external audit.

	Permanent £000s	Others £000s	Total £000s
Salaries & Wages	84,460	3,564	88,024
Social Security costs	13,215	263	13,478
Employer Contribution to the NHS Pension Scheme	17,999	223	18,222
Other Pension Costs	4	-	4
Apprenticeship Levy	401	-	401

Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination Benefits	23,863	-	23,863
Less Recoveries in respect of employee benefits	(5,211)	-	(5,211)
Staff Costs 2025/26	**134,731**	**4,050**	**138,781**

	Permanent Number	Other Number	Total Number
Average Number of people employed (FTE)	1,472.48	41.22	1,513.70

Staff composition

The numbers in the staff composition table are as of 31 March 2026.

Pay Band	Female	Male	Total
All Senior Managers	106	73	179
Comprising:			
Executive Team	10	4	14
Senior Managers	96	69	165
Other Employees	935	419	1,354
Total	1,041	492	1,533

Staff numbers presented by Occupation Code

Pay Band	Medical & Dental	Admin & Clerical	Nursing & Midwifery	Add Prof & Pharmacy	Allied Health Professionals	Total
All Senior Managers Comprising:						
Executive Team	1	12	1	0	0	14
Senior Managers	14	126	15	10	0	165
Other Employees	79	941	194	139	1	1,354

Total	94	1,079	210	149	1	1,533

Sickness absence data

The numbers contained in the sickness absence data cover 12 months (calendar year) of data for NHS GM.

Figures Converted by DH to Best Estimates of Required Data Items				Statistics Published by NHS Digital from ESR Data Warehouse	
Months	Average FTE for 2025	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
12	1,523	10,658	7	556,016	17,290

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse
Period covered: January to December 2025

Ill-health retirements

During the year 2025-26, two members of staff retired on ill-health grounds (2024-25: none). The pension costs of these early retirements are incurred by the NHS Pensions Scheme, rather than NHS GM. These ill-health retirements costs were £236,180 in 2025-26 (£nil in 2024-25).

Staff turnover percentages

The turnover figure for the ICB is 19.95% (293.82 FTE Leavers / 1,472.48 FTE average staff in post over the period April 2025 to March 2026).

Please note that due to the required reporting date of '31st March 2026' not all NHS GM Reform Voluntary Redundancy leavers will be recorded as exiting the organisation in ESR, due to leaving dates of the 31st March, and are classed as employed on the date of the report.

Colleague experience and staff survey approach

Following the 2024 National Staff Survey (NSS), NHSGM developed an action plan focused on key themes from the survey findings, including leadership, appraisal quality, communication and teamworking. Early action included targeted appraisals training and support for line managers, recognising the importance of consistent, high quality development conversations.

As NHS Reform activity accelerated during 2025/26, priorities were necessarily refocused to support colleagues through transition, and some planned activity was paused to redirect capacity to reform related support. However, work continued throughout the year in several key areas, including the focused support for line managers and senior leaders, leadership circles, an internal coaching network, and ongoing system-level investment through Partnership and Assurance Team (PAT).

In this context, NHSGM took a deliberate decision not to participate in the NSS in 2025/26. The nationally mandated timetable and format offered limited flexibility at a time of significant organisational change, and Chief Officers agreed that proceeding risked additional burden and data that would be difficult to interpret or act upon meaningfully while structures and accountabilities were still evolving.

To ensure colleague voice continued to be heard, regular pulse surveys were introduced; delivered bi-monthly at the height of reform and quarterly from January 2026 - focused on core themes aligned to the NHS People Promise. This provided timely insight into colleague experience and enabled trends to be tracked alongside wider workforce intelligence.

The findings described below draw on four pulse surveys conducted between May 2025 and January 2026. From May to December 2025, surveys were delivered during Live Leadership Briefings, enabling collective participation and transparent sharing of aggregated results to support shared understanding of workforce sentiment.

Response rates and headline findings

- During 2025, participation with the pulse remained relatively strong, with 34 - 48% of organisational headcount responding.
- In January 2026, participation reduced to 21% of organisational headcount (this reduction coincided with a change in survey delivery, with responses submitted after,

rather than live during LLBs, to allow greater space for discussion and to support psychological safety at a particularly challenging point in the reform journey).

At an organisation wide level, the pulse surveys highlighted consistent themes over an extended period of organisational change and uncertainty. Although these trends cannot be attributed to any single cause, the wider context of NHS Reform formed an important backdrop to colleagues' experiences during this time:

- High levels of exhaustion and burnout, with a majority of respondents reporting that they feel worn out at the end of the working day - the lowest scoring theme across all survey rounds.
- Declining motivation and optimism, with increasing numbers of colleagues reporting that they do not look forward to going to work as organisational uncertainty continued.
- A gradual decline in psychological safety, with fewer colleagues reporting that they feel safe to speak up about concerns.
- In contrast, day-to-day relationships between colleagues remained a strength, with kindness, respect and civility consistently rated higher than other areas, providing an important source of stability during transition.

Use of insight and leadership action

- Pulse survey findings were consolidated at a NHS GM organisational level and broken down into functional and locality reports and shared with Executive Leadership Team members to allow for local action to be taken by leaders.
- Insights were considered alongside wider workforce intelligence, including culture work, engagement feedback and wellbeing data to inform decision making as the organisation navigated the NHS Reform.

Supporting colleagues through NHS Reform

Since April 2025, NHS GM has had a workforce support offer in place to support colleagues' wellbeing and development during a period of sustained pressure and organisational change. The offer was designed to provide accessible, timely and practical support for colleagues, complementing existing wellbeing provision, leadership engagement and wider listening activity. The support offer covered a range of topic areas reflecting the diverse

needs of colleagues during reform, including:

- Navigating change: Supporting colleagues to understand, process and adapt to uncertainty and transition
- Career development and planning: Guidance on career pathways, skills development, and practical support with CVs and interviews
- Financial planning and pensions: Access to information and advice on financial wellbeing and retirement planning
- Personal development: Opportunities to reflect, build confidence and strengthen professional capability
- Personal wellbeing support: Space to focus on health and wellbeing, with additional support addressing stress and burnout informed by pulse survey data
- Line manager and senior leader support: Helping leaders support others while managing change themselves
- HR essentials: Access to clear, practical information on key people policies and processes during transition

Targeted support linked to reform outcomes

Alongside the organisation wide support offer, NHS GM also put in place more targeted and responsive support for colleagues directly impacted by NHS reform. This support recognised that colleagues experienced change in different ways and at different points, and was therefore tailored to individual circumstances and specific reform outcomes, this included:

- *Support for colleagues leaving under voluntary redundancy (VR)*
  All colleagues leaving under voluntary redundancy were provided with access to an online Virtual Career Centre, offering structured support to help them plan next steps beyond NHS GM and included guidance on career planning and job search preparation. Colleagues were also invited to debrief sessions with a Chief Officer (in addition to the standard exit process), providing space to reflect on their experience and share feedback. Organisational learning from these conversations will be considered to inform future improvement and culture development.
- *Support for colleagues progressing through expressions of interest (EOIs)*
  Colleagues participating in expressions of interest were offered targeted support,

including practical guidance such as interview preparation, to help them feel prepared during a competitive and uncertain process.

- *Support for colleagues displaced through SAE processes*
  Colleagues displaced through formal selection and assessment (SAE) processes received bespoke, individualised support, tailored to personal circumstances and focused on navigating uncertainty, exploring options and accessing appropriate follow-on support.

Impact

The figures below demonstrate the scale and cumulative reach of both organisation wide workforce support and targeted interventions.

Between 5 June 2025 and 31 March 2026, this included:

- 132 facilitated support sessions delivered
- 1,423 places taken up
- Approximately 39% of the workforce attended an average of 3 facilitated sessions each

Colleague feedback captured from the sessions provided was very positive:

- Average score of 4.3/5 for the usefulness of sessions
- 87% of colleagues satisfied or very satisfied with the support provided.

Together, these organisation wide and targeted interventions ensured that workforce support was visible, consistent and available throughout a challenging period, reinforcing NHS GM's commitment to supporting colleagues alongside delivering reform.

Management development pilot

In 2025, NHS GM piloted the 'Values Led Manager' programme to strengthen the capability, confidence and consistency of people management across the system. The programme was designed to embed collaborative, compassionate and inclusive leadership behaviours aligned to organisational values, while equipping managers with practical tools for effective day-to-day management.

The programme was designed by the Organisational Development team and co delivered with an external provider, Delve as a blended offer combining facilitated workshops, practical tools and peer learning. Twenty three managers enrolled in the first cohort and twenty two completed the programme, which ran from May to September 2025.

Outcomes

Evaluation evidence demonstrated a clear and significant improvement in managers' confidence and capability. Participants reported improvements across all measured leadership and people management behaviours, with average self-assessment scores increasing from 3.34 to 4.55 out of 5. The greatest gains were seen in giving feedback, taking a coaching approach, and building trust and psychological safety within teams.

By the end of the programme:

- Participants felt significantly better equipped to manage people, with confidence ratings increasing from 5.6 to 8.5 out of 10.
- Confidence in sustaining new behaviours after the programme averaged 4.6 out of 5.
- Likelihood of recommending the programme to others averaged 4.8 out of 5.

Qualitative feedback indicated that managers were more confident in holding difficult and compassionate conversations, providing timely and constructive feedback, and adopting a coaching approach.

The programme has had a positive impact on how managers lead their teams, with reported benefits including more open communication, earlier resolution of issues, improved engagement, and a stronger sense of trust and inclusion within teams. Participants also highlighted the value of peer learning and networking, creating informal support networks that extend beyond the programme itself.

The decision to extend the programme has been deferred as the organisation continues to go through a period of significant change.

NHS GM's approach to Board level appraisals

The Chair, Chief Executive, Executive Directors and Non-Executive Directors completed an appraisal in spring / summer 2025. All appraisals included an EDI objective.

All members of the Board completed 360 feedback in 2024/25 (excluding Partner Members) and received their individual reports to inform their 2025 appraisals. A Board development session took place on 16th April 2025 to share the Board's group 360 report and further sessions were arranged for the Chief Officers to understand their group 360 report and the same for NEDs but the Board development programme has largely been on hold due to reform and transition arrangements.

Learning and development activity

2025/26 had been a year full of reform activities and the impacts the requirements to respond to the blue print have created.

NHS GM were proactive to respond very quickly at the start of the year to ensure funded development and support opportunities were in place, including the allocation of dedicated resources for access to a range of early reform support opportunities.

The budget has continued to be used to create access to a range of memberships and subscriptions to training and development providers, securing best value licenses and passes and a wide range of individual as well as team-based requests for specific development opportunities. At all times, the L&D function consider the effective use of resources in addition to the quality and relevance of development opportunities.

In addition to the substantive range of freely available resources already linked via the intranet or ESR portals, a range of activity has continued through the established skills group and panel.

During 2025/26, the number of funding applications has increased by over 50% from 2024/25 reaching over 160 funding applications. Combined, the resources commissioned for staff development and reform support have seen an investment from the L&D budget o over £650k. In a marked development, the policy was revised during the year, removing the contribution scheme from staff and confirming 100% funding support for all applications under the revised policy. In addition, the revisions specifically enhanced support for development during times of organisational change and built in a provision to support staff to "leave well" or "stay well".

NHS GM has continued steadily to draw on the use of the apprenticeship levy resources. There have been another 11 successful applications for apprenticeships during the 2025/26

year. As at the end of 2025/26, in real terms this means there are 17 live apprentices with 3 applications endorsed and in commissioning.

In addition to that, 2 individuals successfully completed their apprenticeships during 2025/26. Collectively, these pathways are making use of the now single source levy resources the organisation is required to pay.

NHS GM's Workforce Development Team has led the regional work for organisations to support T Levels, which include a 10 week on the job placement, present an opportunity for young people to gain a technical career pathway qualification. As part of the broadening of programmes and the organisation's own participation, the year saw NHS GM's first T level placement in business admin in a joint arrangement with the GMCA.

Beyond NHS GM's own workforce, 2025/26 saw the organisation confirm its first levy transfer arrangement to allocate £108k of the resources up upcoming primary care development.

As NHS GM developed its proposed operating model in response to the model ICB blueprint, to support the resultant new ways of working, extensive work has been put in to developing a skills mapping methodology, including a risk assessed prioritisation matrix; when coupled with the proposed skills scan, this will provide a robust and prioritised training needs analysis of developments needed to enable the transition in to the new operating models across the organisation. This will also reflect the national developments for the Management and Leadership Framework.

The national activity to rationalise, optimise and reform Mandatory training has progressed through the year; whilst that continues, NHS GM has retained its substantive core catalogue of modules plus, in response to audit recommendations, L&D have worked with the Governance Team to roll out Conflicts of Interest as a new mandatory requirement.

The mandatory training policy has been revised to introduce the national requirement for a Mandatory Local Oversight Group (MLOG). A Subject Matter Experts (SMEs) network has been formed to engage SMEs with both the national and local developments in support of activities that will follow, ready for the new national framework to take effect from April 2027.

Developments in role specific mandatory training have been adapted during the year in response to the revised national direction of travel, further revisions to intercollegiate

guidance and also reflecting the timescales and implications of reform outcomes anticipated to affect module requirements.

Safeguarding requirement reviews have been paused in agreement with the SME; based on the new structures, a further review of the TNA will be carried out and implemented.

In addition to our system responsibilities to support Trusts in their attainment and sustainability plans for Oliver McGowan Mandatory Training in Learning Disabilities and Autism, NHS GM has further progressed compliance in this requirement. By the end of year, 1,442 staff have completed the e-learning module, 955 staff have completed the tier 1 webinar and 286 staff have attended the tier 2 training day.

The 2025/26 internal audit plan for People & Culture included an audit with the overall objective to review and assess the effectiveness of completion of mandatory training and the approach taken to staff development.

This audit was conducted in Q3 of the year and resulted in an overall rating of substantial assurance.

The intranet remains a key resource for staff to start their search for L&D opportunities, including access to support and providing easy access links to forms, guides and policies.

Staff health and wellbeing

NHS GM has maintained a two-fold approach to the wellbeing of our health and care workforce across the GM system:

- Design and delivery of the wellbeing support and provision for NHS GM, as a response to embed good wellbeing cultures, and the insights from data and themes indicating the areas that need focused consideration.
- Support delivery of the GM system (ICS) wellbeing provision with system wide partners, and where possible, extended to the wider health and care workforce across GM ICS, to continue building great wellbeing cultures across the Greater Manchester footprint

The **practical, physical** and **psychological** pillars of wellbeing have a spotlight on provision and support that responds to the emerging wellbeing challenges. This includes a

series of focused approaches to improve the access and equity of health and wellbeing provision. This includes:

- **A focus on wellbeing themes** that support colleagues across key areas responding to absence data and survey insights: mental health, including stress and burnout; neurodiversity; the impacts of poor sleep; socio-economic inequities; musculoskeletal; menopause; and the onward impact of poor workplace cultures, such as incivility and bullying, alongside the overall demands and pace of the workplace.
- Supporting the network of approx. 70 **Wellbeing Champions** across the NHS GM footprint, including 50 Mental Health First Aiders.
- Delivery of the **employee benefits** to support colleagues across NHS GM by providing products and services to improve wellbeing provision.

This includes:

- Cycle to Work scheme
- Car Lease provision
- Credit Union access via direct debit for greater equity to direct loans and savings.
- Enhanced wellbeing provision to access Employers for Carers UK provision.

Currently the Car Lease & Cycle to Work scheme is restricted to existing lease holders only, and no new arrangements are possible whilst we navigate this period of organisational change. This is to ensure we take an equitable approach for all colleagues, and prevent any colleagues from entering into financial arrangements whilst there may be uncertainty with individual roles.

The Credit Union provision remains accessible for all health and care colleagues across the GM footprint under the ‘common bond’ arrangement for GM ICP. In addition, the *Employers for Carers* access is also open to all NHS organisations across the GM footprint with the ICB as the lead across our system.

- NHS GM continues its commitment to the **Wellbeing Day** and **Pay It Forward Volunteer Days** to enhance the wellbeing provision; as well as support a series of **peer led networks** – Neurodiversity, DisAbility, Working Carers, LGBTQIA+, and the Ethnic Minority Voices Alliance (EMVA) networks - to enhance wellbeing levels and

social connection. This sits alongside the engagement and governance focused **Inclusion Staff Network**, to ensure that the provision is transparent and clear about the need for the organisation, and ensure engagement and governance has a clear route through the ISN, and the Peer Networks are focused on the support required by individuals.

- The **advice and guidance** across a number of workplace needs, including signposting to support provision; regular newsletters and updates through engagement networks and channels; risk assessments; support workplace cultures for good conversations; process and policy development; and flexible working approaches to create a work life balance to suit individual needs. This has been demonstrable in the launch of the *Workplace Adjustment Passport*.
- This is underpinned by the established **Occupational Health** provision with improved online referral processes to support wellbeing and absence in the workplace, and wider **Employee Assistance Programme** for enhanced access to services 24 hrs a day.

This work is extended to the wider region where possible, including the Good Wellbeing Cultures work to improve the prevention support for workforce in the workplace, as well as routes in to support provision such as Occupational Health.

The regional working group have been recognised with a national **NHS Health at Work award** for the innovative development of the Good Wellbeing Cultures activity, including the digital improvements and efficiencies; whilst equitable and timely access to employer led – and system wide support provision are captured in the ***Mental Health & Wellbeing Support*** documents.

The impacts of organisational change

As part of the organisational change and Reform implementation, much of the work has been focused on the support required to help colleagues navigate through this change process, and help mitigate and respond to the onward impacts of uncertainty and change.

Increasingly the impact on mental wellbeing, financial provision and onward has been apparent in the last year. An increase in activities relating to planning for retirement, pensions or financial management have been consistently programmed to capacity; as well as the increase in complex demands for mental health support and intervention.

Some of the provision is scheduled to be driven from a regional approach, reflecting the future of service provision for our workforce, and some of the GM system based activities have been stood down, including:

- The system wide ***Wellbeing & Good Employment Network***, with the sub-group who have stood down from January 2026.
- The **bi-monthly network bulletin** circulated to approx 250 Wellbeing Guardians and leads across the GM system has ceased since February 2026.
- And the refresh and development of the **GM Wellbeing Toolkit** and **Wellbeing Engagement Quiz**, as resource for all health and care colleagues across GM ICP, and Integrated Care Board in on hold – discussions with the regional team are underway.

Staff policies

Following the formation of NHS Greater Manchester, we have been aligning new and existing people policies to ensure consistency across the organisation. This process incorporates legacy expiry dates, updated legislation, national NHSE guidance and user feedback. Our aim is to create a positive workplace environment while supporting the organisations goals.

Based on feedback from key stakeholders, we have refined existing policies and introduced new ones to enhance engagement with colleagues, line managers, and staff side representatives. These updates also reinforce our organisational culture, support employee development, ensure legislative compliance, align expectations, manage risk effectively, and promote a consistent and robust approach to policy management.

Phase 1 and 2 policies have now been published and are readily accessible to all employees. These policies were co-produced with the People Team, Organisational Development, Equality and Inclusion, staff side representatives, place based and functional leads and senior managers.

A structured people policy schedule has also been established, with a further set to be co-produced by the end of 2026.

All policies will undergo a rigorous governance process before ratification. Once approved,

they will continue to be widely publicised and easily accessible with dedicated support provided to line managers to ensure fair, equitable, and inclusive implementation across the organisation.

NHS GM retains its commitment to becoming a Disability Confident employer, which will support the Government's commitment to halve the employment gap between disabled and non-disabled people by focusing on the role of employers, who have a crucial role to play in ensuring disabled people are recruited, retained and developed in their careers. Disability Confident is about creating a movement for change - getting employers to think differently about disability and to take positive action to improve how they attract, recruit and retain disabled workers. NHS GM has the Two Tick scheme, where applicants with a disability who meet the essential criteria, will be included in the shortlisted candidates pool in most cases. The principle of the guaranteed interview scheme continues to be a core commitment of NHS GM.

Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) data is not available for the 2025/26 collection period, as NHS GM did not participate in the annual NHS Staff Survey. This was due to the period of organisational reform, including restructuring and changes to portfolios, which impacted the ability to undertake the survey. NHS GM continued to maintain oversight of the WRES and WDES through reporting of monthly workforce data to the People and Culture Committee (as referred to earlier within the Accountability Report).

Expenditure on consultancy

In the 2025/26 financial year, NHS GM spent £90k on consultancy (2024/25: £1.2m). This spend is not expected to be consistent year on year and is typically a one off expense.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31st March 2026 for more than £245* per day. This includes all staff engaged through either agency or with the individual directly.

	Number

Number of existing engagements as at 31st March 2026	8
Of which, the number that have existed:	
for less than one year at the time of reporting	7
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

**The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.*

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1st April 2025 and 31st March 2026, for NHS Greater Manchester Integrated Care Board of more than £245* per day. This summarises only the individuals engaged directly, which aligns with 2024/25 reporting.

	Number
No. of temporary off-payroll workers engaged between 1st April 2025 and 31st March 2026	0
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

**The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.*

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1st April 2025 and 31st March 2026:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	0

Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	10

Exit packages, including special (non-contractual) payments (subject to audit)

Table 1: Exit packages 2025/26

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	20	136,631	**20**	**136,631**	**-**	**-**
£10,000 - £25,000	24	473,338	72	1,222,037	**96**	**1,695,375**	**-**	**-**
£25,001 - £50,000	5	144,115	70	2,574,230	**75**	**2,718,345**	**-**	**-**
£50,001 - £100,000	16	1,136,898	92	6,709,205	**108**	**7,846,103**	**-**	**-**
£100,001 - £150,000	5	626,667	60	7,362,253	**65**	**7,988,919**	**-**	**-**
£150,001 – £200,000	2	320,000	20	3,158,245	**22**	**3,478,245**	**-**	**-**
>£200,000	-	-	-	-	**-**	**-**	**-**	**-**
TOTALS	**52**	**2,701,017**	**334**	**21,162,331**	**386**	**23,863,348**	**-**	**-**

386 exit packages were agreed in the 2025/26 financial year with 2 individuals leaving April to December 2025, 136 in January 2026, 6 in February and 153 in March. Following the year end, a further 89 will leave during 2026/27. Within this disclosure, there are two exit packages relating to very senior managers who are Charlotte Bailey and Mandy Philbin.

Compulsory redundancy and other departures reported in 2025-26 will be paid in accordance with the provisions of the redundancy scheme as agreed with NHS England. Actual payments will be across financial years and will align to exit dates. The costs have increased significantly in 2025-26 due to the national NHS Reform programme which reduced ICB running costs to £19 per head from 1st April 2026.

The costs reported in 2024-25 were paid in accordance with the provisions of a Mutually Agreed Resignation Scheme, as agreed with NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

No Special Payments have been made associated with any of the departures included in the tables above.

Exit packages, including special (non-contractual) payments (subject to audit)

Table 1: Exit packages 2024/25

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	1	4,206	-	-	**1**	**4,206**	**-**	**-**
£10,000 - £25,000	-	-	-	-	**-**	**-**	**-**	**-**
£25,001 - £50,000	-	-	-	-	**-**	**-**	**-**	**-**
£50,001 - £100,000	-	-	-		**-**	**-**	**-**	**-**
£100,001 - £150,000	1	121,008	-	-	**1**	**121,008**	**-**	**-**
£150,001 – £200,000	-	-	-	-	**-**	**-**	**-**	**-**
>£200,000	-	-	-	-	**-**	**-**	**-**	**-**
TOTALS	**2**	**125,214**	**-**	**-**	**2**	**125,214**	**-**	**-**

No departures have occurred in the period to 31 March 2025 where special payments have been made.

No other departures have occurred in the period to 31 March 2025.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the period of departure.

Analysis of Other Agreed Departures

Analysis of Other Agreed Departures	**2025-26**		2024-25	
	Other agreed departures		Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	334	21,162,331	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**334**	**21,162,331**	**-**	**-**

Parliamentary accountability and audit report

NHS GM is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at 218. An audit certificate and report are also included in this Annual Report at page 264.

ANNUAL ACCOUNTS 202526

NHS Greater Manchester ICB

Colin Scales
Acting Accountable Officer
17 June 2026

Contents

Statement of Comprehensive Net Expenditure for the year ended 31st March 2026

Statement of Comprehensive Net Expenditure for the year ended 31st March 2026		**2025-26**	2024-25
	Note	**£'000**	£'000
Income from sale of goods and services	2	(109,757)	(108,569)
Other operating income	2	(1,415)	(2,670)
Total operating income		**(111,172)**	**(111,239)**
Staff costs	4	138,781	108,503
Purchase of goods and services	5	9,407,671	8,740,527
Depreciation and impairment charges	5	1,056	1,096
Provision expense	5	1,892	1,706
Other operating expenditure	5	1,243	1,994
Total operating expenditure		**9,550,643**	**8,853,826**
Net Operating Expenditure		**9,439,471**	**8,742,587**
Finance income		-	-
Finance expense		97	83
Other Gains & Losses		-	(7)
Net expenditure for the Year		**9,439,568**	**8,742,663**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**9,439,568**	**8,742,663**

During the current and previous financial years, there were no items of Other Comprehensive Income or Expenditure.

Statement of Financial Position as at 31 March 2026

Statement of Financial Position as at 31 March 2026	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Right-of-use assets	7.1	6,667	7,724
Other financial assets	9	1,106	1,106
Total non-current assets		**7,773**	8,830
Current assets:			
Trade and other receivables	8	42,292	34,006
Cash and cash equivalents	10	36	1,112
Total current assets		**42,328**	35,118
Total assets		**50,101**	43,948
Current liabilities			
Trade and other payables	12	(394,139)	(444,636)
Lease liabilities	7.2	(1,041)	(1,028)
Provisions	13	(2,692)	(2,315)
Total current liabilities		**(397,872)**	(447,979)
Non-Current Assets less Net Current Liabilities		**(347,771)**	(404,031)
Non-current liabilities			
Lease liabilities	7.2	(5,764)	(6,805)
Provisions	13	(202)	(202)
Total non-current liabilities		**(5,966)**	**(7,007)**
Assets less Liabilities		**(353,737)**	(411,038)
Financed by Taxpayers' Equity			
General fund		(353,737)	(411,038)
Total taxpayers' equity:		**(353,737)**	(411,038)

The notes on pages 223 to 263 form part of this statement.

The financial statements on pages 219 to 263 were approved by the Audit Committee on the 17 June 2026 and signed on behalf of the Board by

Colin Scales
Acting Accountable Officer
17 June 2026

Statement of Changes In Taxpayers' Equity for the year ended 31st March 2026

Statement of Changes In Taxpayers' Equity for the year ended 31st March 2026	General fund
	£'000
Changes in taxpayers' equity for 2025-26	
Balance at 01 April 2025	(411,038)
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26	
Net expenditure for the financial year	(9,439,568)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(9,439,568)**
Net funding	9,496,869
Balance at 31 March 2026	**(353,737)**

	General fund £'000
Changes in taxpayers' equity for 2024-25	
Balance at 01 April 2024	(356,817)
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25	
Net expenditure for the financial year	(8,742,663)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(8,742,663)**
Net funding	8,688,442
Balance at 31 March 2025	**(411,038)**

The notes on pages 223 to 263 form part of this statement.

Statement of Cash Flows for the year ended 31st March 2026

Statement of Cash Flows for the year ended 31st March 2026	Note	**2025-26** **£'000**	2024-25 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(9,439,568)	(8,742,663)
Depreciation and amortisation	5	1,056	1,096
Interest paid / received		97	83
Other Gains & Losses		-	(7)
(Increase)/decrease in trade & other receivables	8	(8,285)	13,116
Increase/(decrease) in trade & other payables	12	(50,497)	40,097
Provisions utilised	13	(1,515)	-
Increase/(decrease) in provisions	5	1,892	1,706
Net Cash Inflow (Outflow) from Operating Activities		**(9,496,820)**	(8,686,572)
Cash Flows from Investing Activities			
Interest paid / received		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(9,496,820)**	(8,686,572)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		9,496,869	8,688,442
Repayment of lease liabilities		(1,125)	(1,152)
Net Cash Inflow (Outflow) from Financing Activities		**9,495,744**	8,687,290
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(1,076)**	718
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,112**	394
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**36**	1,112

The notes on pages 223 to 263 form part of this statement.

Notes to the Financial Statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts

1.1 Going Concern

These accounts have been prepared on a going concern basis, despite the 2025-26 deficit position and the referral to the Secretary of State for Health & Social Care under Section 30 of the Local Audit and Accountability Act 2014.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, inventories and certain financial assets and financial liabilities.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

From 1st April 2025, NHS GM gained commissioning responsibility for certain additional Specialised Commissioning services, previously commissioned by NHS England, in addition to those which had transferred in previous years. Whilst commissioning

responsibility transferred, no assets or liabilities associated with the services transferred, therefore no restatement of performance is required. The additional expenditure in 2025-26 is reflected in Note 5.

1.4 Pooled Budgets

NHS GM has entered into pooled budget arrangements with each of the 10 local authorities in Greater Manchester in accordance with Section 75 of the NHS Act 2006. Under these arrangements, funds are pooled for the purpose of improving the commissioning of health and social care and Note 16 to the accounts provides details of the income and expenditure. The operating arrangements relating to each pooled budget are specific to that arrangement and are further discussed in Note 16 to these accounts.

1.5 Revenue

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when NHS GM accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify

their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Property, Plant & Equipment

1.8.1 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
NHS GM assesses whether a contract is or contains a lease, at inception of the contract.

1.8.2 NHS GM as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their operational capacity and are in use are subsequently measured at their current value in existing use.

1.9 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Cash, bank and overdraft balances are recorded at current values.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of NHS GM's cash management.

1.10 Provisions

Provisions are recognised when NHS GM has a present legal or constructive obligation as a result of a past event, it is probable that NHS GM will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.11 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which NHS GM pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with NHS GM.

1.12 Financial Assets

Financial assets are recognised when NHS GM becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired, or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.12.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The

effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.12.2 Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, NHS GM recognises a loss allowance representing the expected credit losses on the financial asset.

NHS GM adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. NHS GM therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies, and NHS GM does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.13 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when NHS GM becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.14 Value Added Tax

Most of the activities of NHS GM are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.16 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS GM not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.17 Critical accounting judgements and key sources of estimation uncertainty

In the application of NHS GM's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.17.1 Critical accounting judgements in applying accounting policies

NHS GM has reviewed the judgements that management has made in the process of applying its accounting policies and concluded that there are no critical accounting judgements made which have a material impact on these financial statements.

1.17.2 Sources of estimation uncertainty

NHS GM has considered the areas where it makes significant estimates in preparing these accounts. On review of the estimates, NHS GM has concluded that there are no estimates made which are subject to material uncertainty.

1.18 New and revised IFRS Standards in issue but not yet effective

- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

NHS GM has considered the potential impact of the above new standards on its accounts and concluded that it does not expect them to have a material impact on NHS GM’s financial statements.

2 Revenue

Revenue	2025-26	2024-25
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	75	67
Non-patient care services to other bodies	8,746	14,045
Prescription fees and charges	42,456	4,753
Dental fees and charges	51,425	48,852
Other Contract income	6,877	3,675
Recoveries in respect of employee benefits	178	177
Total Income from sale of goods and services	**109,757**	**108,569**
Other operating income		
Non cash apprenticeship training grants revenue	97	65
Other non-contract revenue	1,318	2,605
Total Other operating income	**1,415**	**2,670**
Total Operating Income	**111,172**	**111,239**

3 Disaggregation of Income - Income from sale of good and services (contracts)

2025-26

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	8	2,166	-	-	654	178
Non-NHS	67	6,580	42,456	51,425	6,223	-
Total	**75**	**8,746**	**42,456**	**51,425**	**6,877**	**178**

2024-25

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	64	2,896	-	-	359	169
Non-NHS	3	11,149	41,753	48,852	3,316	8
Total	**67**	**14,045**	**41,753**	**48,852**	**3,675**	**177**

NHS GM has no contract revenue expected to be recognised in future periods related to contract performance obligations not yet completed at either the current or previous reporting dates.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

Employee benefits	Total		2025-26
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	84,460	3,564	88,024
Social security costs	13,215	263	13,478
Employer Contributions to NHS Pension scheme	17,999	223	18,222
Other pension costs	4	-	4
Apprenticeship Levy	401	-	401
Termination benefits	23,863	-	23,863
Gross employee benefits expenditure	**139,942**	**4,050**	**143,992**
Less recoveries in respect of employee benefits (note 4.1.2)	(5,211)	-	(5,211)
Total - Net admin employee benefits including capitalised costs	**134,731**	**4,050**	**138,781**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**134,731**	**4,050**	**138,781**

In 2024-25, the recoveries in respect of employee benefits line within Note 4 disclosed only the total value of recoveries were accounted for on a gross accounting basis, which matched the revenue shown in Note 2. The impact of net recoveries was instead shown net, within the salaries and wages, social security costs and employer contributions to pensions schemes in Note 4.1.1. In 2025-26, the recoveries line also includes the value of net recoveries in respect of employee benefits, rather than these being shown in the relevant lines above.

Employee benefits	Total		2024-25
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	77,226	4,306	81,532
Social security costs	8,833	175	9,008
Employer Contributions to NHS Pension scheme	17,230	213	17,443
Other pension costs	4	-	4
Apprenticeship Levy	391	-	391
Termination benefits	125	-	125
Gross employee benefits expenditure	**103,809**	**4,694**	**108,503**
Less recoveries in respect of employee benefits (note 4.1.2)	(177)	-	(177)
Total - Net admin employee benefits including capitalised costs	**103,632**	**4,694**	**108,326**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**103,632**	**4,694**	**108,326**

4.1.2 Recoveries in respect of employee benefits

Recoveries in respect of employee benefits	2025-26			2024-25
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(5,211)	0	(5,211)	(177)
Total recoveries in respect of employee benefits	**(5,211)**	**0**	**(5,211)**	**(177)**

As described above in respect of Note 4.1.1, the recoveries in respect of employee benefits caption now includes the disclosure of net recoveries, which had previously been shown within the relevant lines in Note 4.1.1.

4.2 Average number of people employed

Average number of people employed	2025-26			2024-25		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	1,472.48	41.22	**1,513.70**	1,502.01	48.19	1,550.20
Of the above:						
Number of whole time equivalent people engaged on capital projects	-	-	**-**	-	-	-

4.3 Exit packages agreed in the financial year

Exit packages agreed in the financial year	2025-26 Compulsory redundancies Number	2025-26 Compulsory redundancies £	2025-26 Other agreed departures Number	2025-26 Other agreed departures £	2025-26 Total Number	2025-26 Total £
Less than £10,000	-	-	20	136,361	20	136,361
£10,001 to £25,000	24	473,338	72	1,222,037	96	1,695,375
£25,001 to £50,000	5	144,115	70	2,574,230	75	2,718,345
£50,001 to £100,000	16	1,136,897	92	6,709,205	108	7,846,102
£100,001 to £150,000	5	626,667	60	7,362,253	65	7,988,920
£150,001 to £200,000	2	320,000	20	3,158,245	22	3,478,245
Over £200,001	-	-	-	-	-	-
Total	**52**	**2,701,017**	**334**	**21,162,331**	**386**	**23,863,348**

	2024-25 Compulsory redundancies Number	2024-25 Compulsory redundancies £	2024-25 Other agreed departures Number	2024-25 Other agreed departures £	2024-25 Total Number	2024-25 Total £
Less than £10,000	1	4,206	-	-	1	4,206
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	121,008	-	-	1	121,008
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**125,214**	**-**	**-**	**2**	**125,214**

386 exit packages were agreed in the 2025/26 financial year with 2 individuals leaving April to December 2025, 136 in January 2026, 6 in February and 153 in March. Following the year end, a further 88 are expected to leave during 2026/27 and 1 in 2027/28. Within this disclosure, there are two exit packages relating to very senior managers who are Charlotte Bailey and Mandy Philbin.

Analysis of Other Agreed Departures

Analysis of Other Agreed Departures	2025-26		2024-25	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	334	21,162,331	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**334**	**21,162,331**	**-**	**-**

Compulsory redundancy and other departures reported in 2025-26 will be paid in accordance with the provisions of the redundancy scheme as agreed with NHS England. Actual payments will be across financial years and will align to exit dates. The costs have increased significantly in 2025-26 due to the national NHS Reform programme which reduced ICB running costs to £19 per head from 1st April 2026.

The costs reported in 2024-25 were paid in accordance with the provisions of a Mutually Agreed Resignation Scheme, as agreed with NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

No Special Payments have been made associated with any of the departures included in the tables above.

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31st March 2026, is based on valuation data as at 31st March 2024, updated to 31st March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31st March 2020. The results of this valuation set the employer contribution rate payable from 1st April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31st March 2020. However, when the wider economic situation was taken into account through the economic cost cap

cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

5. Operating expenses

Operating expenses	2025-26	2024-25
	Total £'000	Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	1,071	969
Services from foundation trusts	6,240,101	5,757,538
Services from other NHS trusts	212,421	204,387
Services from Other WGA bodies	718	261
Purchase of healthcare from non-NHS bodies	1,000,078	932,628
Purchase of social care	140,543	136,840
General Dental services and personal dental services	210,704	201,965
Prescribing costs	590,895	579,540
Pharmaceutical services	138,945	119,709
General Ophthalmic services	47,174	44,156
GPMS/APMS and PCTMS	714,238	649,685
Supplies and services – clinical	8,949	4,839
Supplies and services – general	38,825	41,474
Consultancy services	90	1,197
Establishment	24,261	24,086
Transport	199	539
Premises	33,101	32,893
Audit fees	290	276
Other non-statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	140
Other professional fees	3,448	5,303
Legal fees	1,251	1,713
Education, training and conferences	272	324
Non cash apprenticeship training grants	97	65
Total Purchase of goods and services	**9,407,671**	**8,740,527**
Depreciation and impairment charges		
Depreciation	1,056	1,096
Total Depreciation and impairment charges	**1,056**	**1,096**
Provision expense		
Provisions	1,892	1,706
Total Provision expense	**1,892**	**1,706**
Other Operating Expenditure		
Chair and Non-Executive Members	198	178
Grants to Other bodies	848	1,282
Clinical negligence	34	33
Expected credit loss on receivables	110	(34)
Other expenditure	53	535
Total Other Operating Expenditure	**1,243**	**1,994**
Total operating expenditure	**9,411,862**	**8,745,323**

In accordance with Statutory Instrument 2008 non.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, NHS GM's contract with its auditors provides for the limitation of the auditor's liability to a maximum of £3m.

The other non-statutory audit fees disclosed in 2024-25 related to certification of NHS GM's Mental Health Investment Standard Compliance Statement. For 2025-26 this is not mandated nationally as a separate audit service and is instead consolidated within the 2025-26 audit processes. Please note the audit fees in the note above include VAT that is not recoverable by NHS GM (£241.5k+ VAT)

Prescribing costs include £95.660m of accrued expenditure in the year to 31st March 2026.

On 1st April 2025, NHS GM became the responsible commissioner for various aspects of Mental Health Specialised Commissioning, which had previously been commissioned by NHS England. This spend totalled £119.2m and is included in the above note This includes £86.9m included as services from Foundation Trusts, and £31.4m included within Purchase of healthcare from non-NHS bodies, with immaterial balances distributed across other lines as appropriate. Comparators have not been restated for the equivalent expenditure incurred by NHS England in 2024-25.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	**2025-26 Number**	**2025-26 £'000**	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	155,226	2,133,081	158,447	2,025,867
Total Non-NHS Trade Invoices paid within target	150,845	1,983,849	153,450	1,932,153
Percentage of Non-NHS Trade invoices paid within target	**97.18%**	**93.00%**	**96.85%**	**95.37%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,777	6,672,585	2,790	6,050,793
Total NHS Trade Invoices Paid within target	2,678	6,669,876	2,663	6,048,276
Percentage of NHS Trade Invoices paid within target	**96.44%**	**99.96%**	**95.45%**	**99.96%**

The target for NHS Greater Manchester ICB is to pay 95% of NHS and Non-NHS invoices within 30 days of receipt of a valid invoice, measured both by volume of invoices and value of invoices received.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

NHS GM incurred no costs under the Late Payment of Commercial Debts (Interest) Act 1998 in either the current or previous financial years.

7 Leases

7.1 Right-of-use assets

Right-of-use assets 2025-26	Land	Buildings excluding dwellings	Total
	£'000	£'000	£'000
Cost or valuation at 01 April 2025	640	10,206	10,846
Additions	-	-	-
Derecognition for early terminations	-	-	-
Impairments charged	-	-	-
Reversal of impairments	-	-	-
Cost/Valuation at 31 March 2026	**640**	**10,206**	**10,846**
Depreciation 01 April 2025	240	2,883	3,123
Charged during the year	80	976	1,056
Impairments charged	-	-	-
Reversal of impairments	-	-	-
Derecognition for early terminations	-	-	-
Depreciation at 31 March 2026	**320**	**3,859**	**4,179**
Net Book Value at 31 March 2026	**320**	**6,347**	**6,667**

7.2 Lease liabilities

Lease liabilities 2025-26	2025-26	2024-25
	£'000	£'000
Lease liabilities at 01 April 2025	(7,833)	(8,767)
Additions purchased	-	(878)
Interest expense relating to lease liabilities	(97)	(83)
Repayment of lease liabilities (including interest)	1,125	1,152
Derecognition for early terminations	-	742
Other	-	1
Lease liabilities at 31 March 2026	**(6,805)**	**(7,833)**

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

Lease liabilities - Maturity analysis of undiscounted future lease payments	2025-26	Of which: leased from DHSC group bodies	2024-25	Of which: leased from DHSC group bodies
	£'000	£'000	£'000	£'000
Within one year	(1,126)	(827)	(1,125)	(826)
Between one and five years	(3,671)	(2,790)	(4,213)	(3,192)
After five years	(2,392)	(2,233)	(2,976)	(2,658)
Balance at 31 March 2026	**(7,189)**	**(5,850)**	**(8,314)**	**(6,676)**

8 Trade and other receivables

8.1 Trade and other receivables

Trade and other receivables	Current	Non-current	Current	Non-current
	2025-26 £'000	2025-26 £'000	2024-25 £'000	2024-25 £'000
NHS receivables: Revenue	2,581	-	2,169	-
NHS prepayments	3,679	-	2,458	-
NHS accrued income	634	-	177	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	15,264	-	11,926	-
Non-NHS and Other WGA prepayments	17,088	-	15,452	-
Non-NHS and Other WGA accrued income	2,957	-	1,120	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(1,008)	-	(898)	-
VAT	1,075	-	1,545	-
Other receivables and accruals	22	-	57	-
Total Trade & other receivables	**42,292**	**-**	**34,006**	**-**
Total current and non-current	**42,292**		**34,006**	
Included above:				
Prepaid pensions contributions		-		-

8.2 Receivables past their due date but not impaired

Receivables past their due date but not impaired	2025-26	2025-26	2024-25	2024-25
	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	159	651	557	-
By three to six months	4	336	33	-
By more than six months	34	355	24	-
Total	**197**	**1,342**	**614**	**-**

8.3 Loss allowance on asset classes

Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2025	**(898)**
Lifetime expected credit loss on credit impaired financial assets	**-**
Lifetime expected credit losses on trade and other receivables- Stage 2	(110)
Amounts written off	**-**
Total	**(1,008)**

9 Other financial assets

9.1 non-current

Other financial assets Non-current	**2025-26**	2024-25
	£'000	£'000
Balance at 01 April 2025	1,106	1,106
Additions	-	-
Impairments	-	-
Impairment reversals	-	-
Transfer (to) from other public sector body	-	-
Balance at 31 March 2026	**1,106**	**1,106**

The balance represents NHS GM's minority interest in North West E-Health.

10 Cash and cash equivalents

Cash and cash equivalents	**2025-26**	2024-25
	£'000	£'000
Balance at 01 April 2025	1,112	394
Net change in year	(1,076)	718
Balance at 31 March 2026	**36**	**1,112**
Made up of:		
Cash with the Government Banking Service	36	1,112
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**36**	**1,112**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2026	**36**	**1,112**

NHS GM does not money on behalf of patients,

11 Mental Health expenditure

Mental Health expenditure	**2025-26**			2024-25
	£'000 Core ICB Commissioned	**£'000 Specialised Commissioning**	**NHS GM total**	£'000 NHS GM Total
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	829,128	109,428	**938,556**	722,852
Eligible mental health expenditure	829,214	119,161	**948,375**	741,763
Mental health expenditure above/(below) minimum investment required	86	9,733	**9,819**	18,911
NHS GM total expenditure	8,443,854	995,713	**9,439,568**	8,742,663
Mental health expenditure as a proportion of total expenditure	9.82%	11.97%	**10.05%**	8.48%

NHS GM is measured in terms of its compliance with the Mental Health Investment Standard. This requires that NHS GM spends in excess of the core allocation growth on Mental Health services within the financial year.

On 1st April 2025, NHS GM became responsible for commissioning various elements of Specialised Commissioning services for Mental Health. These are separately identified by NHS GM, and a separate analysis has been provided above.

Please note that the specialised commissioning mental health overachievement is purely due to the target of £109,428k not being increased for in year allocations. This will be aligned nationally for 2026-27 reporting.

Please note that the 2024-25 comparator relates to Core ICB Commissioned expenditure only.

Despite the issue identified relating to the specialised commissioning target, NHS GM has achieved the Mental Health Investment Standard (MHIS) for both core and specialised commissioning mental health services in 2025/26.

12 Trade and other payables

Trade and other payables	Current	Non-current	Current	Non-current
	2025-26 £'000	**2025-26 £'000**	2024-25 £'000	2024-25 £'000
NHS payables: Revenue	23,622	-	17,546	-
NHS accruals	29,679	-	82,462	-
NHS deferred income	2	-	-	-
Non-NHS and Other WGA payables: Revenue	83,002	-	90,654	-
Non-NHS and Other WGA accruals	182,490	-	189,681	-
Non-NHS and Other WGA deferred income	137	-	293	-
Social security costs	1,242	-	1,127	-
VAT	-	-	-	-
Tax	1,218	-	1,139	-
Other payables and accruals	72,747	-	61,734	-
Total Trade & Other Payables	**394,139**	**-**	**444,636**	**-**
Total current and non-current	**394,139**		**444,636**	

Other payables and accruals include payments to General Practitioners under GP contracts.
Other payables include £5.555m outstanding pension contributions at 31 March 2026 (2024-25: £5.426m).
Other payables includes accrued exit costs of £17.051m as at 31st March 2026 (2024-25: £nil).

13 Provisions

Provisions	Current	Non-current	Current	Non-current
	2025-26 £'000	2025-26 £'000	2024-25 £'000	2024-25 £'000
Continuing care	2,137	-	1,760	-
Other	555	202	555	202
Total	2,692	202	2,315	202
Total current and non-current	2,894		2,517	

	Redundancy	Continuing Care	Other	Total
	£'000	£'000	£'000	£'000
Balance at 01 April 2025	-	1,760	757	2,517
Arising during the year	-	1,892	-	1,892
Utilised during the year	-	(1,515)	-	(1,515)
Reversed unused	-	-	-	-
Unwinding of discount	-	-	-	-
Change in discount rate	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-
Transfer (to) from other public sector body under absorption	-	-	-	-
Balance at 31 March 2026	**-**	**2,137**	**757**	**2,894**
Expected timing of cash flows:				
Within one year	-	2,137	555	**2,692**
Between one and five years	-	-	202	**202**
After five years	-	-		-
Balance at 31 March 2026	**-**	**2,137**	**757**	**2,894**

Other provisions include dilapidations costs associated with NHS GM's estate.

14 Commitments

14.1 Other financial commitments

The NHS GM has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

Other financial commitments	**2025-26**	2024-25
	£'000	£'000
In not more than one year	611	702
In more than one year but not more than five years	2,443	2,807
In more than five years	10,688	12,980
Total	**13,742**	**16,489**

In addition to the above, NHS GM is committed to funding the cost of the estate with NHS Property Services and Community Health Partnerships inherited from the former NHS Primary Care Trusts within Greater Manchester. NHS GM works with the property companies to maximise utilisation, but where the property companies do not recover the full costs of the estate, NHS GM is chargeable. The amount which NHS GM is charged varies each year dependent upon occupation and value of the future liability cannot be reliably estimated. These assets are not considered to be leased, as NHS GM does not have control of a defined space, which rests with the relevant property company.

15 Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS GM is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

Working capital management is carried out by the finance department, within parameters defined formally within NHS GM's standing financial instructions and policies agreed by the Board.

15.1.1 Currency risk

NHS GM is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. NHS GM has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

Where NHS GM borrows, it does so from government for capital expenditure, subject to affordability as confirmed by NHS England. NHS GM therefore has low exposure to interest rate fluctuations.

15.2 Financial assets

Financial Assets	**Financial Assets measured at amortised cost 31 March 2026 £'000**	Financial Assets measured at amortised cost 31 March 2025 £'000
Loans receivable with group bodies	-	-
Loans receivable with external bodies	-	-
Trade and other receivables with NHSE bodies	2,809	1,093
Trade and other receivables with other DHSC group bodies	407	1,254
Trade and other receivables with external bodies	18,242	13,103
Other financial assets	1,106	1,106
Cash and cash equivalents	36	1,112
Total	**22,600**	**17,668**
Items not classified as financial assets	20,834	18,556
Total	**43,434**	**36,224**
Relevant items as per Statement of Financial Position		
Other Financial Assets	1,106	1,106
Trade and Other Receivables	42,292	34,006
Cash and Cash Equivalents	36	1,112
Total	**43,434**	**36,224**

15.3 Financial liabilities

Financial liabilities	Financial Liabilities measured at amortised cost 31 March 2026 £'000	Financial Liabilities measured at amortised cost 31 March 2025 £'000
Loans with group bodies	-	-
Loans with external bodies	-	-
Trade and other payables with NHSE bodies	574	1,431
Trade and other payables with other DHSC group bodies	52,727	102,448
Trade and other payables with external bodies	338,239	338,198
Other financial liabilities	-	-
Finance lease obligations	6,805	7,833
Total	**398,345**	**449,910**
Items not classified as financial liabilities	2,599	2,559
Total	**400,944**	**452,469**
Relevant items as per Statement of Financial Position		
Trade and Other Payables	394,139	444,636
Current Lease Liabilities	1,041	1,028
Non-Current Lease Liabilities	5,764	6,805
Total	**400,944**	**452,469**

16 Joint arrangements - interests in joint operations

NHS Greater Manchester ICB has entered in to Pooled Budget arrangements with each of the local authorities within Greater Manchester under the provisions of Section 75 of the NHS Act 2006.

A pooled budget allows the ICB and the local authority to co-ordinate expenditure to maximise the benefit of that spend to patients and residents, allowing for joined up services to be commissioned and provided.

Each of the pooled budgets are different, and this is reflected in the pooling agreement (the "Section 75 Agreement") between the ICB and each individual Local Authority. The scope of each pooled budget is as agreed with each Local Authority, but all agreements include for the pooling of resources through the Better Care Fund as mandated by NHS England.

The common objectives of the pooled budgets are to promote joint and co-ordinated working between the ICB and the relevant Local Authority.

The ICB's share of expenditure of the pooled funds is recorded in Note 5 (operational expenditure) to these financial statements.

This includes where funding is provided to a Local Authority to deliver services within a Local Authority hosted element of a pooled budget, which is also shown as expenditure in Note 5.

Where the ICB administers a pooled budget on behalf of the partners, net accounting is adopted, meaning Note 5 to these accounts only shows the expenditure of the ICB, and excludes expenditure formally incurred by the Local Authority, but hosted by the ICB.

More details on the Local Authority's share of expenditure from the pooled funds can be found in the annual accounts of each local authority.

2025-26	Bolton MBC	Bury MBC	Rochdale MBC	Manchester City Council	Oldham MBC	Salford City Council	Stockport MBC	Tameside MBC	Trafford MBC	Wigan MBC
Host of pool	Both	Both	Both	Both	Both	NHS GM	Both	Both	Both	Both
Gross or Net Accounting	Net	Net	Net	Net	Net	Net	Net	Net	Net	Net
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ICB contributions to pooled budget recorded in ICB accounts	35,659	80,090	57,842	66,784	26,096	91,399	29,794	24,530	25,460	35,917
ICB expenditure from pooled budget recorded in ICB accounts	35,659	80,090	57,842	66,784	26,096	91,399	29,794	24,530	25,460	35,917
Total contributions to pooled budget	62,532	226,235	259,461	117,218	42,377	363,452	45,660	43,841	73,601	62,,646
Total expenditure from pooled budget	62,532	226,235	259,461	117,218	42,377	363,452	45,660	43,841	73,601	62,646
Amounts owed to/(by) ICB in respect of pooled budget	-	-	-	-	-	(653)	-	-	-	-

2024-25	Bolton MBC	Bury MBC	Rochdale MBC	Manchester City Council	Oldham MBC	Salford City Council	Stockport MBC	Tameside MBC	Trafford MBC	Wigan MBC
Host of pool	Both	Both	Both	Both	Both	NHS GM	Both	Both	Both	Both
Gross or Net Accounting	Net	Net	Net	Net	Net	Net	Net	Net	Net	Net
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ICB contributions to pooled budget recorded in ICB accounts	35,650	78,380	60,355	65,295	25,537	91,180	29,892	24,076	25,860	35,062
ICB expenditure from pooled budget recorded in ICB accounts	35,650	78,380	60,355	65,295	25,537	91,180	29,892	24,076	25,860	35,062
Total contributions to pooled budget	61,715	217,522	244,409	113,716	44,079	343,234	45,530	42,710	73,678	60,710
Total expenditure from pooled budget	61,715	217,522	244,409	113,716	44,079	343,234	45,530	42,710	73,678	60,710
Amounts owed to/(by) ICB in respect of pooled budget	-	-	-	-	-	(860)	-	-	-	-

The subsequent notes provide detail of expenditure of the ICB from the pooled budgets with each local authority.

16.1 Pooled Budget arrangements with Bolton Metropolitan Borough Council

A pooled budget exists between NHS GM and Bolton MBC known as the Bolton Better Care Fund (BCF). The pooled budget covers both health care spend (hosted by NHS GM), and social care spend (hosted by the Council).

The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 arrangements do not provide for risk sharing between the organisations. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM ICB incurred expenditure of £35.659m (2024-25: £35.650m), of the total value of the pool of £62.532m (2024-25: £61.715m).

16.2 Pooled Budget arrangements with Bury Metropolitan Borough Council

A pooled budget exists between NHS GM and Bury MBC known as the Bury Integrated Commissioning Fund (ICF) pooled budget.

The purpose of the pool is to support integrated health and social care. Commissioning decisions are made by the Bury Locality Board whose voting rights on matters pertaining to the pooled budget are made up of equal numbers of NHS and Council representatives.

The pooled budget covers services under the headings of Primary Care Services, Secondary Care Services (where expenditure is incurred by NHS GM) and Communities & Adult Social Care (where expenditure is incurred by the Council). The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis.

Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner. The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM ICB incurred expenditure of £80.090m (2024-25: £78.380m), of the total value of the pool of £226.235m (2024-25: £217.522m).

16.3 Pooled Budget arrangements with Rochdale Metropolitan Borough Council

There are two pooled budgets between NHS GM and Rochdale Borough Council known as the Rochdale Health & Social Care Pooled Fund, and the Rochdale Health & Social Care Better Care Fund.

These are both governed by Rochdale's Integrated Care Partnership Committee.

Firstly, the Rochdale Health & Social Care Better Care Fund relating to the Commissioning of Integrated Health and Social Care Services. The purpose of this arrangement is to enable joint design, development, procurement and monitoring of services for local people. This pool contains expenditure relating to services covered by the Better Care Fund. The fund is hosted by the Council and monitored through regular reports to the Locality Board.

Each organisation is responsible for over or underspends in respect of services where it has commissioning responsibility. The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

There are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM ICB incurred expenditure of £25.006m (2024-25: £22.262m), of the total value of the pool of £44.152m (2024-25: £34.917m).

Secondly, a pooled budget exists between NHS GM and Rochdale MBC known as the pooled budget for the provision of All Age Health and Social Care Services.

The purpose of this arrangement is to enable joint design, development, procurement and monitoring of services for local people. This pool contains expenditure relating to services in addition to those covered by the Better Care Fund. The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM ICB incurred expenditure of £32.836m (2024-25: £38.093m), of the total value of the pool of £215.309m (2024-25: £209.5m).

From 2025-26 onwards, the commissioning responsibility for Mental Health Out of Area Hospital Placements and ADHD/Autism assessments were undertaken at an ICB level rather than at locality, and therefore these are no longer included in the pool. The 2024-25 figure for these elements was £3.567m. It should also be noted that Discharge funding was formally moved into the BCF fund from 2025-26 which was previously within the All-Age Pool, the figure being £2.248m.

16.4 Pooled Budget arrangements with Manchester City Council

A pooled budget exists between NHS GM and Manchester City Council covering the Better Care Fund pooled budget for Manchester. The Manchester Health and Wellbeing Board has strategic oversight of the pooled budget.

The aims and benefits of the partners in entering into this agreement are to:

- improve the quality and efficiency of the services in scope;
- meet the Local Objectives and the National Conditions which are as follows:
    - delivers a jointly agreed plan between the partners, signed off by the Health and Wellbeing Board;
    - ensures that NHS GM's financial contribution to adult social care is maintained in line with the uplift to the ICB minimum contribution;
    - investing in NHS-commissioned out-of-hospital services, and
    - delivering a plan for improving outcomes for people being discharged from hospital.
- make more effective use of resources through the establishment and maintenance of the BCF Pooled Fund for revenue expenditure on the Services.

The pooled budget covers both health care spend (commissioned by NHS GM), and social care spend (commissioned by the Council). The fund is jointly managed by the parties on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM ICB incurred expenditure of £66.784m (2024-25: £65.295m), of the total value of the pool of £117.218m (2024-25: £113.716m).

16.5 Pooled Budget arrangements with Oldham Metropolitan Borough Council

A pooled budget exists between the ICB and Oldham MBC with the decision-making body being the Oldham Integrated Care Partnership Committee.

The purpose of the pool is to ensure the provision of services to support reduced hospital admissions and length of stay, building on the aims and objectives of the Partners in entering the Agreement to:

improve the quality and efficiency of service provision;

- meet the National Conditions of funding streams, such as the Better Care Fund and Local Objectives;
- make more effective use of resources through the establishment and maintenance of an aligned fund for revenue expenditure on services;

- ensure that people in Oldham will be independent, resilient and self-caring so fewer people reach crisis point, and
- to develop an integrated health and care system, for those that need it, that enables people to proactively manage their own care with the support of their family, community and the right professionals at the right time in a joined-up system.

The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM ICB incurred expenditure of £26.096m (2024-25: £25.537m), of the total value of the pool of £42.377m (2024-25: £44.079m).

16.6 Pooled Budget arrangements with Salford City Council

NHS GM and Salford City Council have an integrated fund for health and social care services in Salford. NHS GM administers the integrated fund, which covers Adults Services, Public Health Services, Children's Services, and Primary Care Services. The Integrated Fund focuses on improving population health and inequalities along with improving outcomes and delivering safe, effective and efficient services for the Salford population.

The Salford Integrated Care Partnership Committee governs the use of the pooled fund. A risk share exists between NHS GM and Salford City Council which covers all expenditure within the Integrated Fund. The partners have agreed that any under or overspends of the fund are apportioned between them for 2024-25 in line with planned contribution levels.

As at 31st March 2026, the net balance on the fund resulted in a creditor of £0.653m being owed to Salford City Council (2024-25: creditor of £0.860m recorded to Salford City Council).

During the year to 31st March 2026, NHS GM incurred expenditure of £91.399m (2024-25: £91.180m), of the total value of the pool of £363.452m (2024-25: £343.234m).

16.7 Pooled Budget arrangements with Stockport Metropolitan Borough Council

A pooled budget exists between NHS GM and Stockport Metropolitan Borough Council, known as the Stockport Better Care Fund. This pooled funding aims to enhance partnership working between the organisations and deliver integrated and improved services for patients.

While the provisions within the Section 75 agreement establish joint control, the fund operates under lead commissioner arrangements. Under this structure, the nominated lead commissioner enters into legal contracts with providers, and the non-lead commissioner cedes control over the resulting contracts. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to or from the pool at the balance sheet date. Each organisation is responsible for any over or underspends related to the services it oversees as the lead commissioner.
For the year ending 31st March 2026, NHS GM incurred expenditure of £29.794m (2024-25: £29.892m). This includes £20.077m contributed by NHS GM to support the Council in fulfilling its role as lead commissioner (2024-25: £19.616m), from a total pool value of £45.660m (2024-25: £45.530m).

16.8 Pooled Budget arrangements with Tameside Metropolitan Borough Council

A pooled budget exists between NHS GM and Tameside MBC known as the Tameside Better Care Fund. The fund is jointly hosted by NHS GM and Tameside Council on a lead commissioner basis.

Each organisation is responsible for any over or under spends in respect of services where it is lead commissioner. The Section 75 agreement provides for risk sharing between the organisations, via mutual agreement, to manage pressures in either the health or care position.

During the year to 31st March 2026, NHS GM incurred expenditure of £24.530m (2024-25: £24.076m), of the total value of the pool of £43.841m (2024-25: £42.710m).

16.9 Pooled Budget arrangements with Trafford Metropolitan Borough Council

A pooled budget exists between NHS GM and Trafford Metropolitan Borough Council, incorporating the Better Care Fund, the Learning Difficulties (LD) Fund and the Discharge to Assess fund. The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well and independent and in control of their own care.

As per the Section 75 agreement, the Trafford Health & Wellbeing Board (H&WB), made up of Council and NHS GM locality representatives, is the group that governs the fund. The fund is jointly hosted by NHS GM and Trafford Council on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure

on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM incurred expenditure of £25.460m (2024-25: £25.860m), of the total value of the pool of £73.601m (2024-25: £73.678m).

16.10 Pooled Budget arrangements with Wigan Metropolitan Borough Council

A pooled budget exists between NHS GM and Wigan Metropolitan Borough Council known as the Wigan Better Care Fund pooled budget. The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well and independent and in control of their own care.

The Wigan Health and Wellbeing Board, made up of Wigan Council and NHS GM representatives, govern the use of the fund. The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis.

Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner. The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2026, NHS GM incurred expenditure of £35.917m (2024-25: £35.062m), of the total value of the pool of £62.646m (2024-25: £60.710m).

17 Related party transactions

Details of related party transactions with individuals are as follows:

Details of related party transactions with individuals are as follows:	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Dr Leigh Vallance (Bolton Hospice)	1,626	-	96	-
Dr Vishral Mehra (Gorton Medical Centre)	1,792	-	-	-

The Department of Health and Social Care is regarded as a related party. During the period, NHS GM has had a number of material transactions for which the Department is regarded as the parent Department, including with:

Bolton NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Manchester University NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
North West Ambulance NHS Foundation Trust
Pennine Care NHS Foundation Trust
Stockport NHS Foundation Trust
Tameside & Glossop Integrated Care NHS Foundation Trust
The Christie NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
NHS England
NHS Pensions

Similarly, NHS GM considers to the following Local Authorities to be related parties, on the grounds that they are under the common control of the UK Government. Further details of the pooled budget arrangements with these Local Authorities are included in Note 16 to these accounts.

Bolton Metropolitan Borough Council
Bury Metropolitan Borough Council
Manchester City Council
Oldham Metropolitan Borough Council
Rochdale Metropolitan Borough Council
Salford City Council
Stockport Metropolitan Borough Council
Tameside Metropolitan Borough Council
Trafford Metropolitan Borough Council
Wigan Metropolitan Borough Council

18 Events after the end of the reporting period

NHS GM has reviewed the events occurring after the end of the reporting period to the date of approval of these accounts. No matters are noted which are reportable as events after the end of the reporting period.

19 Financial performance targets

NHS GM have a number of financial duties under the NHS Act 2006 (as amended).

NHS GM's performance against those duties was as follows:

Financial performance targets	**2025-26 Target**	**2025-26 Performance**	**2025-26 Target met?**	2024-25 Target	2024-25 Performance	2024-25 Target met?
	£'000	**£'000**		£'000	£'000	
Expenditure not to exceed income	9,543,247	9,550,740	No	8,797,933	8,853,909	No
Capital resource use does not exceed the amount specified in Directions	-	-	N/a	143	143	Yes
Revenue resource use does not exceed the amount specified in Directions	9,432,074	9,439,568	No	8,686,687	8,742,663	No
Revenue administration resource use does not exceed the amount specified in Directions	74,036	69,251	Yes	56,045	54,952	Yes

Whilst NHS GM did not achieve two performance targets listed above, it did deliver performance against its planned £7.5m deficit position.

Due to the failure of the two statutory duties on maintaining costs within the funding available, this has resulted in a Section 30 letter being issued by external audit to the Secretary of State.

20 Operating Segments

NHS GM has reviewed its operations and concluded that it has one operating segment, for the commissioning of healthcare, therefore a segmental reporting analysis is not provided.

21 Losses and Special Payments

21.1 Losses

In 2025-26, NHS GM incurred no losses, (2024-25: 5 losses totalling £13k).

21.2 Special Payments

In 2025-26, NHS GM made one special payment, totalling £1.5k (2024-25: no special payments).

Independent auditor's report to the members of the Board of NHS Greater Manchester Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Greater Manchester Integrated Care Board (the 'ICB') for the year ended 31 March 2026, which comprise the statement of comprehensive net expenditure, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The ICB reported an overspend of £7.493 million against its revenue resource limit of £9,432.1 million in its financial statements for the year ended 31 March 2026. The ICB thereby breached its duty under section 223GC (1) of the National Health Service Act 2006, as amended, to ensure that expenditure it incurred in a financial year does not exceed the sums received by it in that year. Under sections 223GB and 272(7) and (8) of the National Health Service Act 2006, as amended, NHS England directed that revenue resource use for the ICB in 2025-26 should not exceed £9,432.1 million. The ICB's revenue resource use for 2025-26 was £9,439.6 million, thereby breaching the direction given to it by NHS England.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 12 May 2026 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the ICB's breach of its revenue resource limit for the year ending 31 March 2026.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - Management override of controls through inappropriate journal entry.

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals over performance materiality, post year end journals, journals relating to year end accruals, journals posted by senior managers and self-authorised journals;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members including the fraud risk relating to management override of controls. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter except the following.

On 17 June 2026 we identified one significant weakness in respect of the ICB's arrangements to secure financial sustainability in how the ICB plans and manages its resources to ensure it can continue to deliver services.

The ICB has made significant progress in delivering its in-year financial plan and developing a coherent medium-term financial plan. However, there is an ongoing significant risk to delivering the required investment in transformation and prevention and realising the benefits, indicating a significant weakness in arrangements for financial sustainability.

We recommended that the ICB must strengthen its medium-term financial arrangements to support delivery of the 2026/27 plan. The Board and its Committees must receive appropriate oversight and assurance to enable effective and timely decision making, ensuring transformation and prevention investment is sustained and aligned to the plan.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Greater Manchester Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester
17 June 2026