

Strategic Commissioning Plan

15th July 2026

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1. INTRODUCTION AND STRATEGIC CONTEXT

This is NHS Greater Manchester's Strategic Commissioning Plan covering the period from 1st April 2026 to 31st March 2031. This plan describes what and how we will commission over the next five years to ensure high-quality service provision and sustained improvement in the health of our population.

To deliver the expectations of the 10-year Health Plan and the Greater Manchester Strategy (GMS), we must transform the NHS in Greater Manchester to meet the needs of residents and patients in a different way.

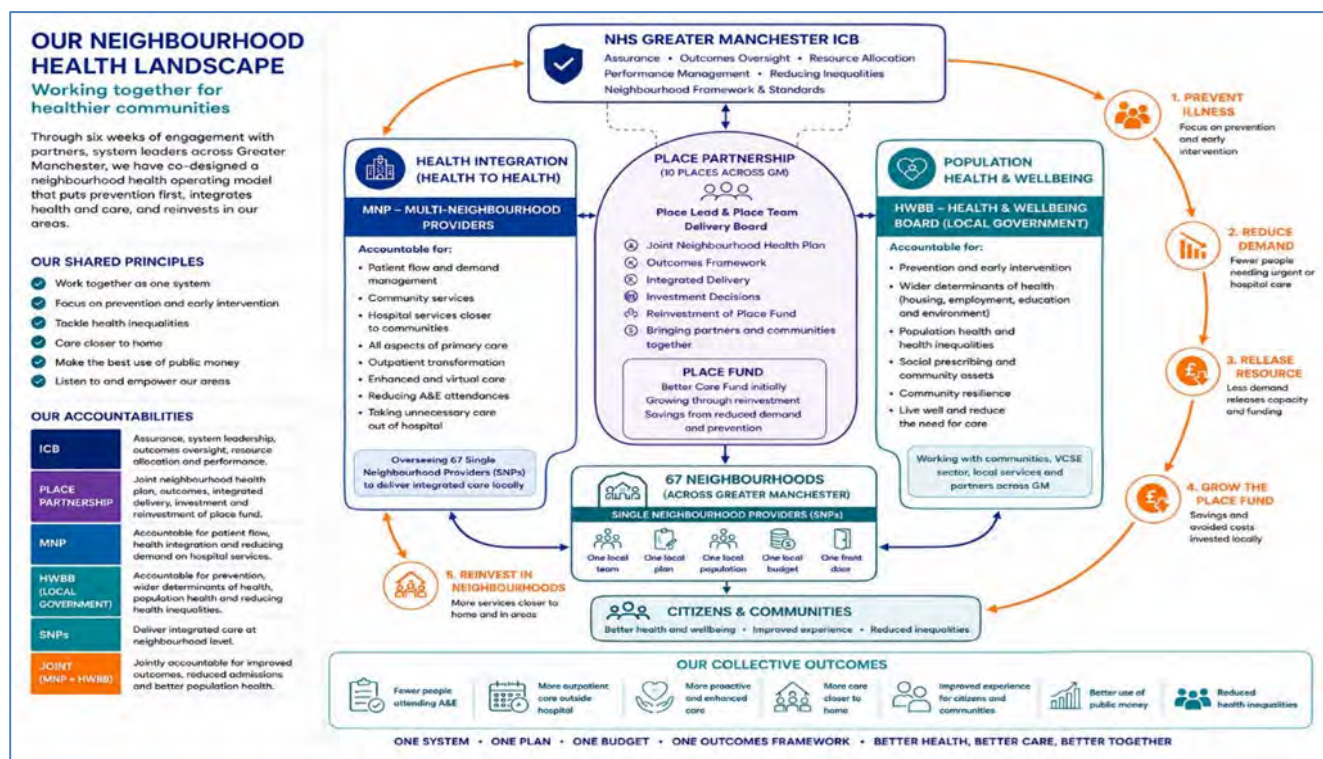
We must shift to a system that is routinely preventative and proactive – both to sustain good health and to prevent deterioration once people become unwell. We know that the NHS cannot do this alone. We must work with partners who can affect the social determinants of health and bring a diversity of skills and approach beyond that available within the NHS.

The 10 places in Greater Manchester, and the 67 neighbourhoods within them, are where we must start to meet need differently. To drive that change, the ICB has not only retained its commitment to place but strengthened it.

This begins with Live Well as the most significant commitment that Greater Manchester has ever made to addressing the social determinants of health that drive much of the pressure on NHS services. We expect that our neighbourhoods will increasingly become where services are delivered for our residents and patients with Live Well as the platform for NHS Transformation in Greater Manchester.

This is fully in line with the direction of travel across Greater Manchester – and nationally. Andy Burnham has set out his vision for strong neighbourhoods to be the foundation of economic growth, public service reform and better health.

Our plan is for our system to develop as illustrated in the diagram below:



Alongside this, we must transform our clinical models of care. We need to move to a care model which is not characterised by the referral of patients from one sector to another, but by coordinated care built around the needs of the individual with clinicians working as a single team.

This will include a fundamental redesign of how we operate outpatient services in the context of our neighbourhood model. A review of evidence indicates that c40% of new Outpatient demand from a primary care referral could be managed outside of hospital. We are developing a “neighbourhood” vision for transforming how we deliver elective care, comprising the high volume, very common conditions that can be managed as well if not better outside of hospital through a holistic primary care model

Through our neighbourhood model, we must break down the barriers that have long existed between physical and mental health; between the NHS and social care; and between the NHS and the wider offer from the public sector and the VCFSE. These must be all-age models with a radically different offer for our children and young people.

The initiatives we have described across prevention, neighbourhoods, Live Well, population health and primary care will contribute to health improvement across the population and reduce pressure on acute services giving us the headroom to develop new models of proactive, person-centred, digitally enabled care for our residents and patients. The ICB will increasingly commission these models and create the right conditions for providers to work together to deliver them. Our provider collaboratives, spanning all sectors of the system, have a vital role

to play in this.

Equally, our partnership with Health Innovation Manchester (HInM) will play a key role in how we scale and spread innovation and use digital and Artificial Intelligence (AI) to transform the way our care is delivered improving both population health outcomes and productivity. This is formalised in the Memorandum of Understanding (MOU) between our two organisations.

This plan makes reducing health inequalities a core commissioning test, not a separate workstream. Across all major programmes, NHS Greater Manchester will use strategic commissioning to shift resource, decision-making and delivery closer to neighbourhoods, communities and the VCFSE sector, using lived experience, co-design and evidence to shape priorities and evaluate impact.

Delivery will be supported through our refreshed operating model, strengthened place partnerships, provider collaboration and an outcomes framework that will track progress, impact and value over the life of the plan. In doing so, we will ensure that we continue to drive up our performance against NHS Constitutional Standards each year.

As we move to a system that is characterised by a much more preventative and proactive care model, we will, working with partners, develop our thinking on how we plan and model the impact of strategic change and how this will inform our commissioning practice – including, for example, through much greater use of health economics.

To deliver this plan will require transformational change at a significant pace and scale. This will require a step change in:

- Our leadership – our culture and the way we collaborate
- Our capability – on digital, analytics, finance and contracting
- On empowerment – creating the conditions for change across GM

Our expectation, through delivery of this plan, is that the health and care system in Greater Manchester will look very different, complementing the strategic outcomes we have set out in this Plan. Our aim is that by 2031:

Proactive and Preventative Care in Neighbourhoods

- Every Neighbourhood in Greater Manchester will have a fully integrated, prevention-led model of care that helps people stay well, access timely support close to home, and experience joined-up services built around local communities and shared partner accountability
- Through Live Well, Health and Care services are part of a joined-up model of public services so that people get the support they need at the right time without having to navigate complex systems or repeat their story. Services will work with people and communities, recognising strengths, lived experience and local leadership.

- Most outpatients and diagnostic appointments will be delivered in neighbourhood settings
- Our workforce will be working as integrated neighbourhood teams, supported by digital tools and empowered to deliver proactive, person-centred care across organisational boundaries
- Support for Mental Health and Emotional Well-Being will be fully integrated into our neighbourhood models of care

Targeted Action on Population Health and Inequalities

- Greater Manchester will be a national leader in reducing health inequalities and improving healthy life expectancy through targeted action on the drivers of poor population health
- A growing proportion of investment will be directed towards prevention, neighbourhoods, community services and VCFSE-delivered support, demonstrating a measurable left shift in resources
- Greater Manchester will be one of the best places in the country for babies, children and young people to grow up, with improved health, wellbeing and life chances
- Residents, communities and the VCFSE sector will routinely shape decisions, priorities and service redesign through co-production, Live Well and neighbourhood partnerships

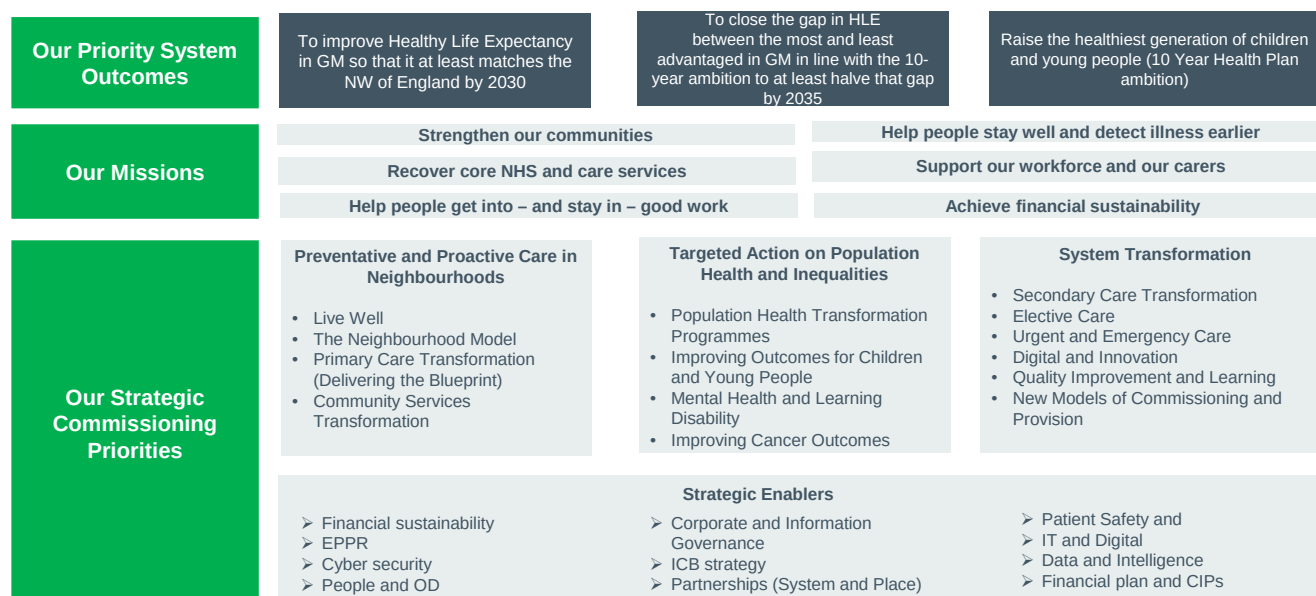
System Transformation

- We will have transformed our system so that services are more preventive, collaborative and digitally enabled, shifting care closer to home while improving outcomes and reducing pressure on acute services
- Our digital systems enable care to be delivered seamlessly across organisational boundaries with interoperability, shared records and real-time data enabled – and are used confidently by all those who work in the system
- With partners, we will have continued draw on Greater Manchester's global strengths in digital and innovation to design new care models, secure investment and build research capability – using AI to help us turn population health evidence into commissioning decisions
- Collaboration across organisations in GM is significant and systemic, creating the platform to optimize the opportunities afforded by further devolution

- Every person with one or more long term condition will have access to their own digitally accessible care plan which they have helped to design
- We will be consistently meeting the NHS Constitutional Standards and in financial balance
- Both attendances at A&E and non-elective admissions will have been on a downward path for three years
- For those who need clinical and specialist care, care received will be accessible, safe, effective and of high quality, leading to improved experiences of healthcare for our population
- Clinicians will have led change across major clinical pathways in ways which demonstrate better prevention, use of resources and patient experience

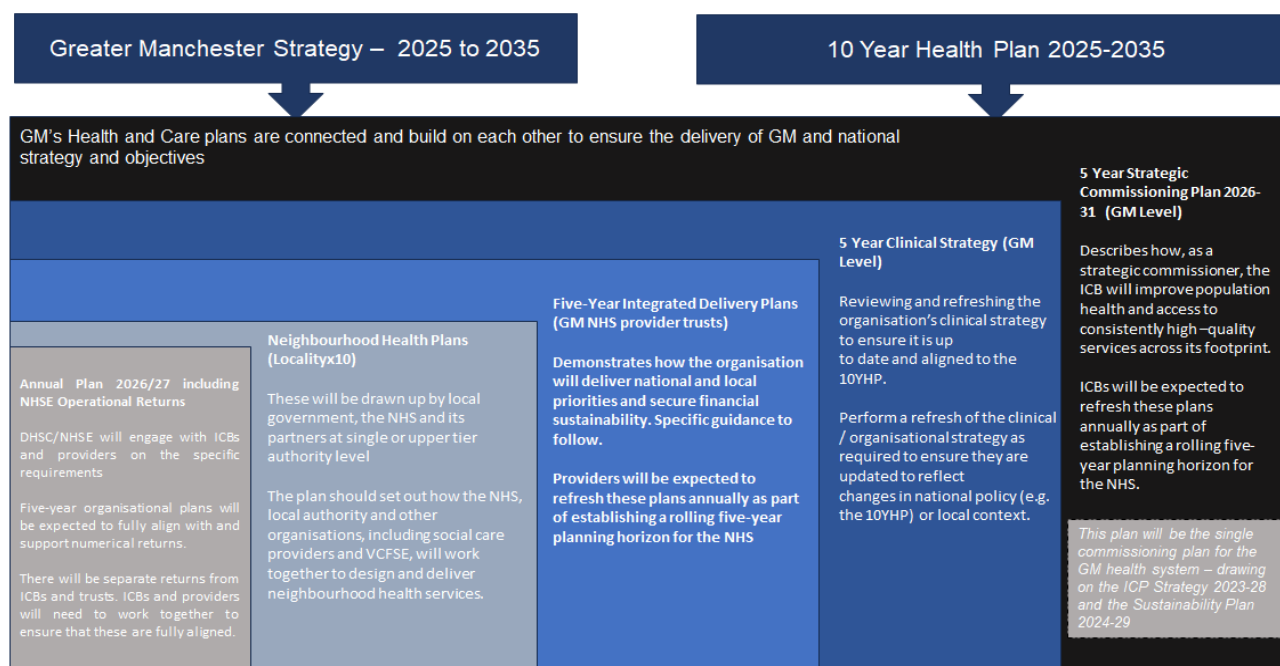
1.1. Plan on a Page

This plan sets out our core missions, the outcomes we will seek to change and our main programmes of work. This is summarised in our Plan on a Page.



We present this document alongside other key plans that are being developed in Greater Manchester ahead of 2026/27 – including our Clinical Strategy and our Neighbourhood Health Plans. The relationship between these plans is depicted below:

GM Strategy and Plan Alignment



Together, these plans set the context for NHS GM at both a national and a Greater Manchester city-region level. They inform how we will operate as a strategic commissioner within the new NHS landscape and improve outcomes. Our vision for health and care in Greater Manchester is the same as the vision for the overarching Greater Manchester Strategy:

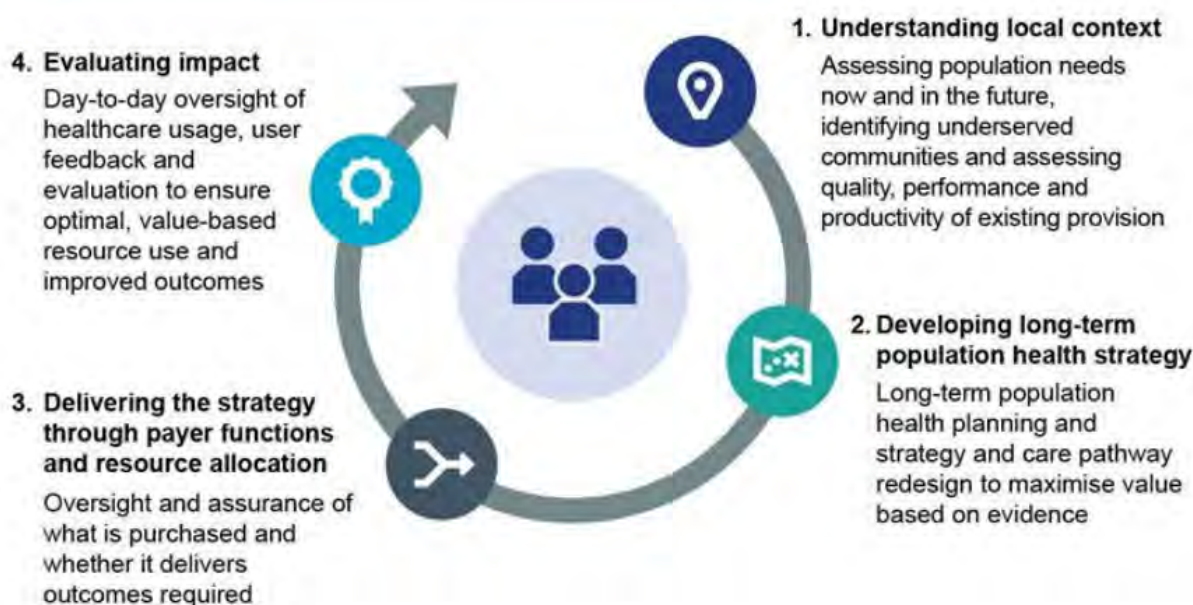
A Thriving City Region Where Everyone Can Live a Good Life

NHS Greater Manchester is also uniquely placed as a partnership operating in the city region with the most advanced set of devolved arrangements in the country. This advantage is not only institutional. Greater Manchester also benefits from strong place partnerships, deep civic relationships and a large, organised VCFSE ecosystem that can reach communities and support community-led prevention in ways that statutory services cannot achieve alone. This means that we can:

- Lead the way nationally in the delivery of the Three Shifts in the 10 Year Health Plan
- Contribute to the Greater Manchester Strategy (GMS) – through our concerted effort to improve health and health services, while also benefiting from the wider health gains created by safe, warm homes, good quality jobs and social support at every stage of life.

We will do this through leading the strategic commissioning cycle, as shown below:

Model ICB - System leadership for improved population health



1.2. Our Outcomes Framework

As a strategic commissioner, our focus is firmly on leading the system to deliver improved outcomes. Working with system partners, we have developed an Outcomes Framework with the following as our high-level outcomes.

Improved health outcomes

- To improve Healthy Life Expectancy (HLE) in GM so that it at least matches the North West of England level by 2030
- To reduce the gap in HLE between most and least advantaged areas in GM in line with a 10-year ambition to at least halve that gap by 2035 (10 Year Health Plan Ambition)
- Raise the healthiest generation of children and young people (10 Year Health Plan ambition). Measured through a CYP Core Indicator Set

Improved patient experience

- GP experience scores to be in best quartile
- Hospital experience scores to be in best quartile
- Mental Health services experience scores to be in best quartile

Improved effectiveness

- Average Length of Stay (physical and mental health) to be in best quartile in all

providers

- Non-elective bed days to be maintained at 2025/6 levels
- Outpatient rates (first and follow-ups) to be at or below England average
- All national targets to be met over the course of the Strategic Commissioning Plan

Improved efficiency

- Increase the share of overall spend directed to prevention, primary care, community services and VCFSE-delivered support, with a clear baseline and annual trajectory for funding
- To deliver the deficit reduction targets set by NHS England
- To move towards upper decile performance for nationally published efficiency metrics
- Deliver the corporate savings reduction targets

We will also develop supplementary indicators to track progress on the proportion of major programmes designed with residents and VCFSE partners; changes in investment reaching prevention and community-led support; and narrowing gaps in access, experience and outcomes for priority population groups

These supplementary indicators will be reported through annual refreshes of the Strategic Commissioning Plan and used to assess whether strategic commissioning is delivering the intended left shift. We have created a Performance Scorecard to track the delivery of this Strategic Commissioning Plan. We will use this Scorecard to report on our performance both to Board and Strategic Commissioning Committee.

1.3. Our Clinical Strategy

This Plan has been informed by NHS Greater Manchester's five-year Clinical Strategy – which has been developed alongside it. The full version of the Clinical Strategy can be found [here](#).

The Clinical Strategy describes the strategic clinical approach for the Greater Manchester system in the next five years. It is for all providers and partners across the GM system to guide commissioning decisions and service development and delivery.

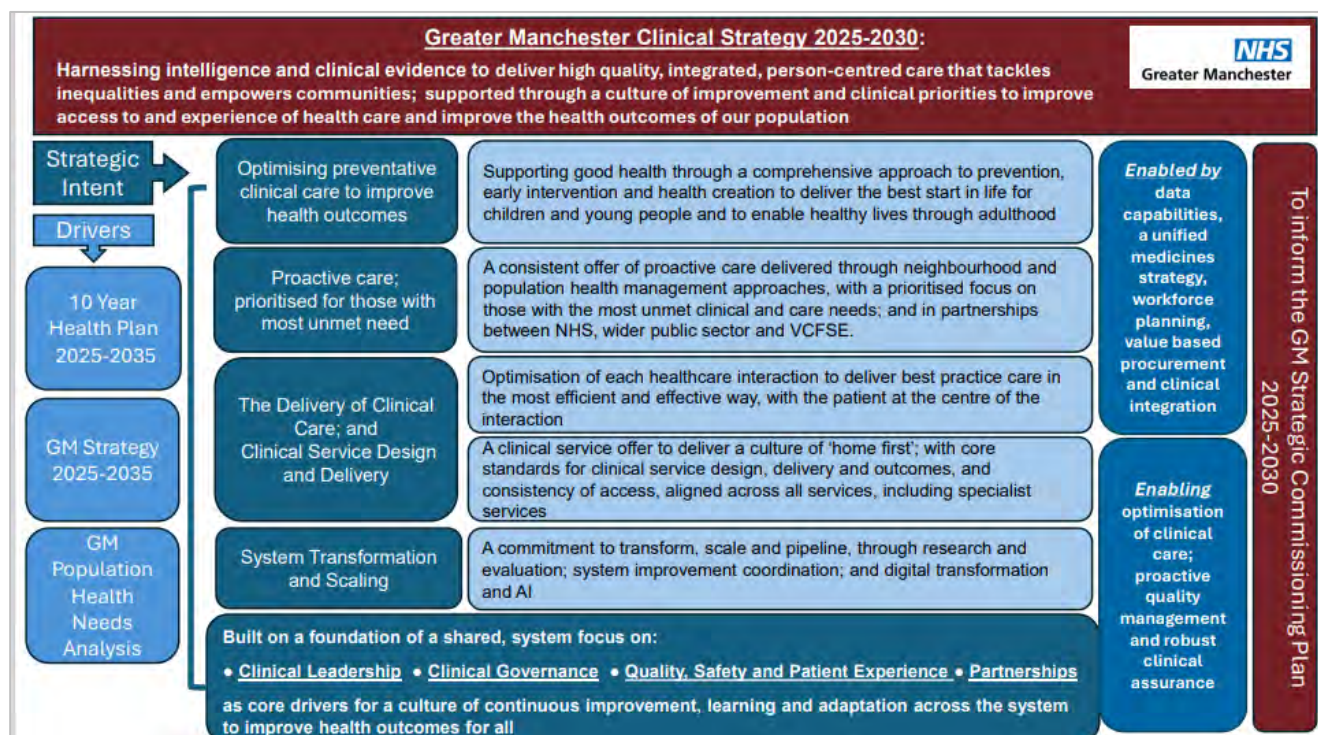
The Strategy is based on a strong foundation of patient safety, quality management and quality improvement, recognising that transformation needs to be underpinned by robust quality and clinical governance to drive system learning, ensure safe services, improved patient experience and reduction in unwarranted variation.

Partners in GM have agreed a vision for the Clinical Strategy:

To create a healthier and fairer Greater Manchester by delivering high quality, integrated, person-centred care that tackles inequalities and empowers communities; supported through a culture of prevention and improvement, alongside clinical priorities to improve the access to and experience of health care as well as the health outcomes of our population

The Clinical Strategy is accompanied by a delivery plan, which sets out clear and prioritised pathways for system focus and delivery. It is also underpinned by a measurable outcomes framework to demonstrate and evidence improvement and impact.

A summary of the Clinical Strategy is shown below:



1.4. Greater Manchester as the Prevention Demonstrator

In the 10 Year Health Plan, Greater Manchester was designated as the UK's first Prevention Demonstrator. This programme will support the implementation and spread of a preventative approach delivered in neighbourhoods via Live Well.

That means we have cross-Government backing to test the hypothesis that a scaled, system wide shift to prevention and early help can deliver better outcomes, reduce pressure on public services and provider better value for the public purse. The Demonstrator will be supported by increased autonomy, including exploring opportunities to pool budgets, and reprofile public service spending towards prevention.

Through the Prevention Demonstrator, GM will show how re-wiring the state improves decisions, connects public services to community strengths and leads to more preventative action.

This is the most significant public service reform programme in the UK and will guide how we reimagine the state both locally, in relation to how services and support are offered and

experienced, and nationally, to maximise the opportunity of deeper devolution and stronger local accountability.

As Live Well takes root and demonstrates impact, the work of the Prevention Demonstrator will be to blueprint what's changed and how the impacts are achieved. That means describing how our insight into emerging risk and better targeted support is improved through better data linkage; how teams work with communities and community-based organisations to take a name not numbers approach; and how investment and resources change to support earlier help and head off crisis before it occurs.

2. THE HEALTH OF THE POPULATION

2.1. Demographic Data

The number of people registered with a GP practice in Greater Manchester is just over 3.3 million (September 2025), with the number of people estimated to reside within the Greater Manchester area being slightly over 3 million. Since 2014, the resident population of Greater Manchester has increased by 10.1% over the 10-year period. In the same timeframe, the population in England increased at a slower rate, 7.8%¹.

The average (median) age of residents in Greater Manchester is 36 years, below the national average of 40 years. The proportion of people aged under 16 in Greater Manchester is 20.2%, higher than England (18.4%); whilst there are also a higher proportion of people of working age (16-64) in Greater Manchester than England – 64.2% vs 62.9% respectively. Conversely, the proportion of people aged 65 and over in Greater Manchester is 3% lower than England – 15.7% vs 18.7% respectively.

By 2030, the Greater Manchester population is projected to increase by 3.1%. Increasing the latest mid-year estimate by this amount would increase the population by 92,500 people which would put the Greater Manchester population in excess of 3.1 million residents. All 10 local authority areas are expected to show an increase in the period between 2024 and 2030; however, these increases vary from 0.8% in Bury to 7.4% in Salford.

The latest National Indices of Multiple Deprivation (IMD) - published in October 2025² confirm the extent of the health challenges facing Greater Manchester. For example, 25.3% of the GM population (737,780 residents) live in the most deprived decile for health and disability whereas only 1.8% (51,240) live in the least deprived decile³.

The IMD data highlights the deep inequalities we face within Greater Manchester. For example, both Manchester and Oldham have the highest proportions of their respective populations living within the top 10% most deprived areas nationally at 42.6% each (or 241,215 and 103,859 residents, respectively). In contrast, Trafford has the lowest proportion living within the most deprived areas nationally at 3.9% (9,200 residents)⁴.

¹

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationestimatesforenglandandwales/mid2024>

² <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025>

³ <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025>

⁴ <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025>

2.2 Quadrant Analysis

The Quadrant Analysis below (September 2025) of over 60 metrics illustrates that whilst GM has shown improvement in multiple areas, there are several metrics that reveal a worsening performance and widening gaps to the national average.

	Worse than Average or Target	Better than Average or Target	
Improved	• Life expectancy at birth (male) • Life expectancy at birth (female) • Life expectancy at 65 (Male) • Life expectancy at 65 (Female) • Under 75 avoidable mortality rate • Under 75 mortality rate from causes considered preventable • Smoking Prevalence in adults (aged 18 and over) (%) • % of children achieving a good level of development at the end of reception • Reception prevalence of overweight (including obesity) (%) • Year 6 prevalence of overweight (including obesity) (%) • Percentage of physically active children and young people (%) • Percentage of physically active adults (%) • Under 75 mortality from cancer • Percentage of cancers diagnosed at stages 1 and 2 • Cancer screening coverage: breast cancer • Cancer screening coverage: cervical cancer (25 to 49 years old) • % of 5-year-olds with experience of visually obvious dental decay • Under 75 mortality rate from liver disease	• Under 75 mortality rate from liver disease considered preventable • Hospital Admissions for violence (including sexual violence) offences per 1,000 population • Sexual offences per 1,000 population • Emergency Hospital Admissions for Intentional Self Harm • Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years) • Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years) • Abdominal Aortic Aneurysm Screening Coverage • Emergency hospital admissions due to falls in people aged 65+ • Air pollution: Estimated fraction of mortality attributable to particulate air pollution • Fuel poverty (low income, low energy efficiency methodology) • Total prescribed LARC excluding injections rate / 1,000 • Chlamydia detection rate per 100,000 aged 15 to 24 years • HIV late diagnosis in people first diagnosed with HIV in the UK • Proportion of drug sensitive TB notifications who had completed a full course of treatment by 12 months	• Smoking status at time of delivery (%) • Homelessness: households in temporary accommodation • Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15 to 24 years) • Estimated dementia diagnosis rate (aged 65 and older)
Worsened	• Under 75 mortality from cardiovascular disease • Under 75 mortality from respiratory disease • Under 75 treatable mortality rate • Low birth weight of term babies • Infant mortality rate • MMR (one does at 2 years) • MMR (two doses at 5 years) • Children in absolute low-income families (u16s) • Children in relative low-income families (u16s) • Under 18s conception rate • Overweight (including obesity) prevalence in adults (%) • Diabetes QOF Prevalence • Deaths from drug misuse • Alcohol Specific Mortality	• TB incidence (three-year average) • Cancer screening coverage: cervical cancer (50 to 64 years old) • Cancer screening coverage: bowel cancer • Percentage of people in employment (Male) • Percentage of people in employment (Female) • Homelessness: Households owed a duty under the Homelessness Reduction Act • Percentage reporting a long term Musculoskeletal (MSK) problem • Mortality rate from a range of specified communicable diseases, including influenza • Suicide rate • Sickness absence% of employees who had at least one day off in the previous week	• Hospital admissions for alcohol related conditions (Narrow) • Emergency readmissions within 30 days of discharge from hospital • Sickness absence: the percentage of working days lost due to sickness absence

Our population can expect to experience many poorer health outcomes and experiences compared to the national average or elsewhere in the country. Unfortunately, this experience is growing more acute as the gaps between the national average and GM are widening in many areas. These experiences include:

- Worsening infant mortality compared to the national average
- A higher likelihood to be diagnosed with a long term or chronic condition such as obesity and diabetes – recognising that identifying previously undiagnosed people has an impact on this data
- Higher levels of suicide compared to the national average and elsewhere in England
- Worsening levels of alcohol specific mortality
- Some of the lowest life expectancies in the country

Within the Quadrant Analysis, there are some clusters of metrics that point us towards areas that we need to focus on and require an integrated, system-wide approach through this

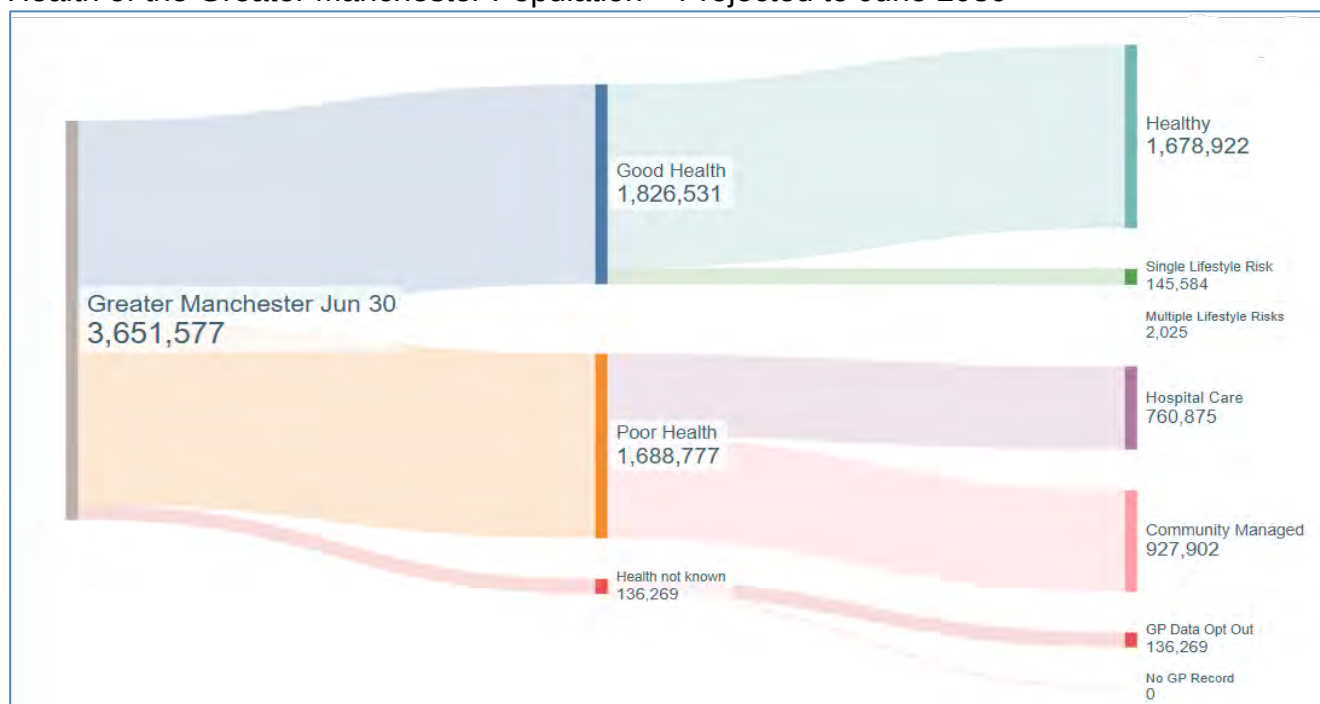
Commissioning Plan:

- Children and young people during pregnancy and early years, particularly in the context of increased exposure to poverty and deprivation. People who are experiencing “lives (and deaths) of despair” and the most significant inequalities characterised by alcohol harm; drug misuse, homelessness, communicable disease such as tuberculosis, financial hardship, and severe/multiple deprivation. For many of these groups, improvement will depend on relational, flexible and trauma-informed support delivered in partnership with trusted VCFSE and grassroots organisations, rather than statutory services acting alone.
- The opportunity to contribute more fully to economic growth and productivity in GM by addressing health-related barriers to employment and sickness absence, and with a particular emphasis on Musculoskeletal (MSK) conditions.

Whilst we face deep-rooted health challenges, we also know that where we have undertaken evidence-based and comprehensive system action, we can see a demonstrable improvement in key metrics – for example Smoking Reduction (Including at Time of Delivery); Dementia Diagnosis; CVD Prevention, Physical Activity; 0-5 Oral Health; Violence; antimicrobial and opioid stewardship; HIV; Fuel Poverty. This approach will guide our work through this Strategic Commissioning Plan.

Our access to the longitudinal patient record in Greater Manchester enables us to see the picture of the health of our population. The chart below shows the projected health status of the population in GM by 2030.

Health of the Greater Manchester Population – Projected to June 2030



2.3 What the People of Greater Manchester Told Us - Fit for the Future

Fit for the Future was an extensive programme of public engagement undertaken by NHS Greater Manchester between June 2024 and March 2025. The engagement has informed the development of this Strategic Commissioning Plan. The focus was on the following key system challenges:

- Great services (i.e. providing sufficient, high quality and timely care), and
- Happy Healthy Lives (i.e. the shift from treatment towards prevention)
- Achieving financial balance

This was multi-methodology work using a broad spectrum of comms and engagement approaches, including groups and meetings, public events, surveys and social media, newsletters etc. Overall, we had conversations with 2,413 people. 549 people took part in surveys and 146,649 were reached through social media.

3. RESPONDING TO THE CHALLENGES

The data, evidence, insight and engagement outlined in the previous section tell us that we need to bring about radical change in the health and care system in Greater Manchester. The Sustainability Plan (2024) set out, based on care data from the GM system, that we face c£600m of additional demand on the system over the next 5 years based on a projected deterioration in health.

This can only be addressed through a population health approach based on prevention and proactive care. This 5-year plan must enable us to meet both our current challenges and take the right actions to ensure a sustainable system in the longer-term.

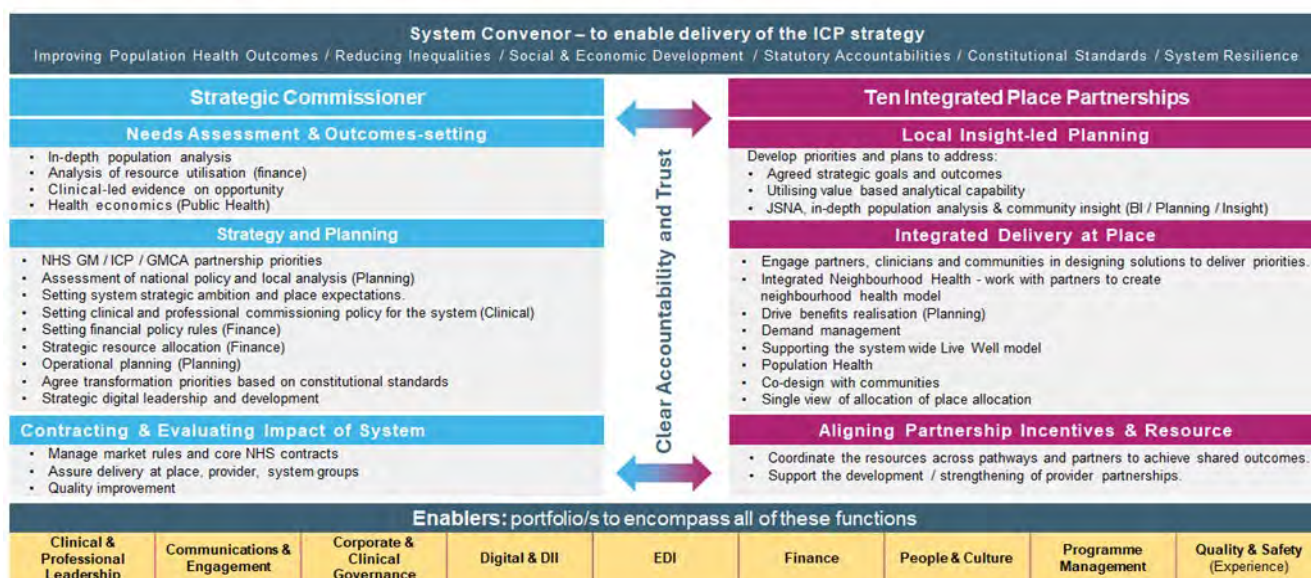
3.1. Delivery through our 10 Place Partnerships

Working with partners, NHS GM has developed a new Operating Model to put us in the best position to deliver both our strategy in Greater Manchester and the national changes to ICBs described in the ICB Blueprint.

As a strategic commissioner, our role will be to think ahead, to make sure the right services are in place to improve population health, tackle inequalities and meet people's needs, now and in the future. This will work in partnership with place, which will provide the local intelligence and insight, as well as the expert local knowledge to integrate delivery in the way that is best for the local population.

The relationship between strategic commissioning and place delivery is shown in the diagram below:

Integrated working between our Place Partnerships and Strategic Commissioning teams is at the heart of our new model



Place partnerships are integral to the delivery of neighbourhood working, prevention and Live Well. We recognised that we needed to strengthen our place partnerships so that they are equipped to drive the transformation in how we provide care and support to people in Greater Manchester. We have done so through a combination of:

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

A summary of each of these is described below:

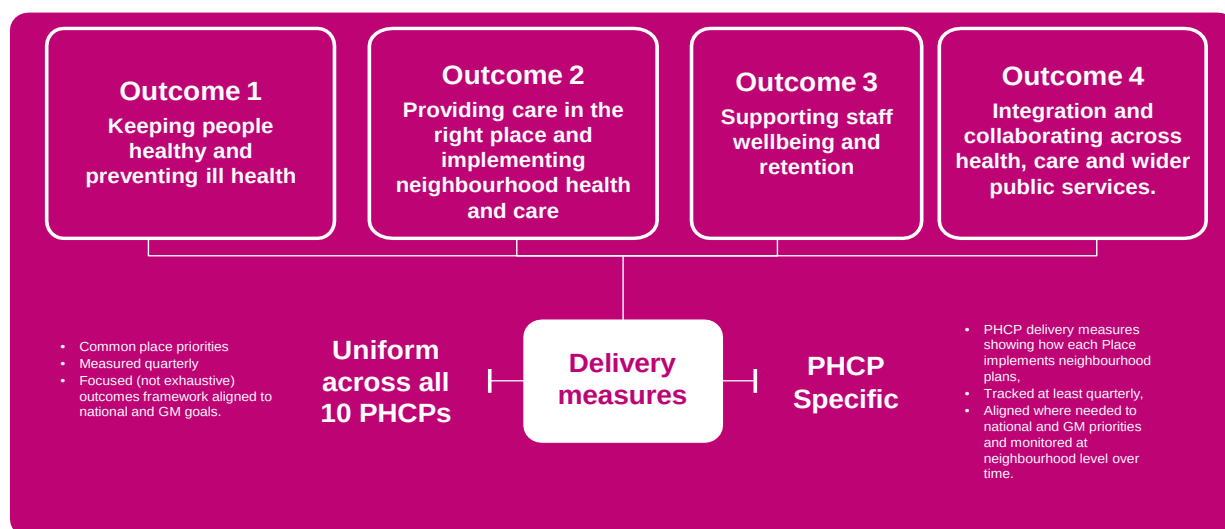
Place Partnership Agreement

Partnership Agreement: Structure by section

1	Purpose, Parties and agreement status Defines why the Place Health and Care Partnership exists, who is involved, and how Partners will work together under clear principles while retaining their statutory independence.	2	Commencement and Term Explains when the Agreement starts and ends, and how it will be reviewed, updated and kept relevant as national policy, GM arrangements and local priorities evolve.	3	Shared Vision, Purpose and Strategic Context Sets a shared vision and purpose for Place, aligning local priorities with Greater Manchester's wider health and care ambitions.
4	Strategic Priorities and Outcomes Framework Sets out the Place's agreed strategic priorities and establishes the Place Outcomes Framework as the main tool for measuring progress and accountability.	5	System Characteristics, Leadership and Culture Describes the leadership behaviours, culture and ways of working that enable Partners to act as one system while remaining sovereign organisations.	6	Roles, Responsibilities and Collective Capability Clarifies shared and individual responsibilities and explains how Partners will combine resources, skills and capacity to deliver outcomes effectively.
7	Place Funding Defines how Partners will align and steward financial resources through a shared Place Funding Framework focused on outcomes, prevention and neighbourhood delivery.	8	Governance and Decision Making Sets out the governance structure, decision making principles and accountability arrangements for Place Partnerships.	9	Transparency, Information and Learning Commits Partners to open information sharing, lawful data use and continuous system learning to support effective decision-making and improvement.
10	Clinical Strategy Explains how clinical leadership, quality, safety and medicines optimisation at Place align with NHS Greater Manchester clinical governance and strategy.	11	Problem Resolution and Escalation Provides a clear, proportionate process for resolving disagreements and escalating issues while protecting relationships and continuity of services.	12	Review, Variation and Evolution Confirms the Agreement as a living document, setting out how it will be reviewed, amended and evolved over time through collective stewardship.

Place Outcomes Framework

Place Outcomes Framework – Linking delivery measures to outcomes



Place Fund

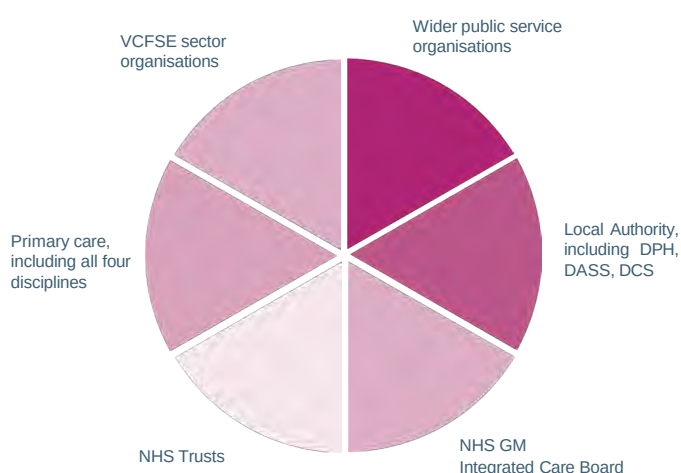
Place Fund



The Place Fund exists within a wider context featuring the totality of investment in Place and Neighbourhood Health through contracts such as primary care, VCFSE, Foundation Trusts etc.

Place Teams

A Place Team is a multidisciplinary team drawn from across Place partners, providing shared capacity to turn collective ambition into action by connecting strategy to neighbourhood-level delivery, connected through shared purpose and accountability to the Place Lead.



Creating success through:

1. System Leadership and Alignment
2. Frontline service integration and transformation
3. Place planning and resource allocation
4. Data, Intelligence and Improvement
5. Shared vision, goals and priorities
6. Collaborative Culture
7. Citizen and Community voice and co-design
8. Clear governance and accountability
9. Commitment of capacity

3.2. Shifting the Model of Care

The 10 Year Health Plan described the three shifts the NHS must make:

- Treatment to Prevention
- Hospital to Community
- Analogue to Digital

Making these three shifts will be built into each of the priority areas of focus in this Plan. We have developed a three-fold definition of the Left Shift for the way that we work in Greater Manchester. This is:

1. The shift in system conditions and culture towards prevention demonstrated by what we measure and how we commission
2. The shift in the model of care from treatment to prevention
3. The shift in the location of care from acute settings to community and neighbourhood settings – including through digital models

In practice, this means changing what we measure, what we fund, what we contract for and what we expect from providers and partners. It also means increasing the share of investment that supports prevention, neighbourhood care, VCFSE delivery and community capacity, rather than relying predominantly on reactive and hospital-based responses.

This needs to be underpinned by a firm commitment from the ICB and system partners to lead the cultural change required to achieve the Left Shift and how it leads to sustained change across Greater Manchester. This must start with us working with the VCFSE as equal partners as part of our approach to every area of commissioning policy.

A strong role for systems, consensus between clinical and managerial staff, flexible, imaginative financing, keeping patients at the heart of change, and the development of robust metrics to assess and demonstrate the benefits of the left shift are the key principles that underpin the shift's success. With support from the centre – such as via reformed payment mechanisms and improved data quality – NHS leaders can ensure the left shift runs right through the entire health system.

We know that major change is needed to our models of care so that we can better respond to the needs of our population. There are three areas, in particular, where we have the opportunity to change our care model radically:

The NHS contribution to Live Well - we need to mainstream Live Well, making it central to the NHS operating model in GM and ensuring that it matters to our clinicians. Focusing on population health will help ensure our services are increasingly preventative and proactive. This will both create and require further change to how services are delivered and organised in all sectors.

An equitable transformation of mental health and learning disability services - mental health services are improving in GM, but we need to step-up our GM-wide transformation efforts to ensure that service users in all parts of GM experience the very best in mental health care, children and adults, from emotional wellbeing through the treatment of severe illness.

NHS trusts reforming their care models and working together - demand for hospital care is high, occasionally overwhelmingly so. Hospital leaders are responding to the need to transform care models but recognise that much more needs to be done. As we move to a proactive, integrated, neighbourhood model of care – we will need to model the impact that this has on our acute sector and inform how our care models develop.

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

In making the left shift, we must support secondary care clinicians in making their contribution to Neighbourhood Health and Live Well. This is central to plans being developed in NHS trusts to deliver on the left shift and to transform the care offer from our hospitals. Whilst there are important bilateral relationships between the ICB and individual providers, there is more benefit to come from GM providers working as one on key service and delivery challenges. We will agree a workplan with TPC in Q2 of 2026/27 to describe how we will realise this opportunity.

Notwithstanding the pan-GM, regional or national services provided by some of our trusts,

there are opportunities for greater collaboration between trusts covering neighbouring geographies in GM:

- In the north of the conurbation between WWL FT, Bolton FT and Northern Care Alliance FT
- In the south of the conurbation between Stockport FT, Tameside and Glossop FT, East Cheshire NHS Trust and MFT
- Between the two largest, multi-site trusts – MFT and NCA
- Between the two mental health Foundation Trusts

Delivering on the three areas of the Left Shift as outlined above should enable us to reduce our cost base over time and increase the proportion of our budget earmarked for prevention. We will only be able to do this through a clear methodology that quantifies the impact of Left Shift programmes on finance, activity, performance and quality and population health.

To support this Strategic Commissioning Plan, we will establish an agreed system method for the modelling of the impact of the Left Shift in the longer-term. We will aim for this to be in operation during 2026/27 – the first year of this plan.

It will be based on these principles:

- The approach is detailed and systematic and allows NHS GM, as a strategic commissioner, to model the impact and make the appropriate adjustment to provider contracts to reflect the activity shift on both an annual and longer-term basis
- It utilises GM's data infrastructure to set out a longitudinal ROI for prevention programmes – drawing on the Sustainability Plan
- It requires system engagement and buy in – so there is a recognised method agreed by partners
- Utilises the real-time evaluation and learning from the Prevention Demonstrator
- It is aligned to the Outcomes Framework and Clinical Strategy
- Enables confidence so that we can increase the proportion of overall spend on prevention – and deploy new contracting and financial mechanisms that incentivise prevention

In parallel to this, we will continue with our delivery programmes where we already have evidence of impact and can project a strong return on investment.

4. STRATEGIC DELIVERY THEMES

As described in the first section of this document, the main aim of this Plan is to confirm our strategic commissioning intent for the next five years. We will do this through the key programmes articulated in this section. The themes and key programmes are summarised in the table below. A detailed Delivery Plan will support this document and will set out the key priorities for each of the programmes along with how impact will be measured.

Strategic Delivery Theme	Key Programmes
Preventative and Proactive Care in Neighbourhoods	Live Well
	The Neighbourhood Model
	Primary Care Transformation – Delivering the Blueprint
	Community Services Transformation
Targeted Action on Population Health and Inequalities	Population Health Transformation Programmes
	Improving Outcomes for Children and Young People
	Mental Health and Learning Disability
	Improving Cancer Outcomes
System Transformation	Secondary Care Transformation
	Elective Care Reform
	Urgent and Emergency Care Reform
	Digital and Innovation
	Quality Improvement and Learning
	New Models of Commissioning and Provision

4.1. Preventative and Proactive Care in Neighbourhoods

Improving the health of our population and providing alternatives to expensive, acute-based provision are the main ways in which we will secure a sustainable system in the next five years. This will be done through neighbourhood working – where the key partners who contribute to good health can come together to support people to be well at home and in their communities and reducing demand on acute, crisis-based services.

4.1.1. Neighbourhood Health and Live Well

Neighbourhood Health is at the forefront of the 10-year Health Plan published last summer, and this was reinforced through the NHS Neighbourhood Health Framework (March 2026). We have made clear that neighbourhood working will increasingly become our core business as a system in Greater Manchester.

Live Well is our model for Neighbourhood Health. It underpins our strategic shift towards preventative and proactive care by embedding holistic, non-clinical support within neighbourhoods alongside person-centred integrated public services. Through this we will deliver the ambition of the National Neighbourhood Health Framework – and go further through

Live Well.

Live Well is our approach to system and culture change in Greater Manchester. It represents the most significant commitment Greater Manchester has ever made in addressing the social determinants of health – which are driving ever-greater demand on services. Live Well centres, spaces and offers will work through, and alongside, neighbourhood teams in each locality and enable a better, more effective response to different communities' needs. Investment will be shifted into integrated support models, designed and delivered with communities, including sustainable VCFSE sector delivery.

This approach is already being developed and put into practice across Greater Manchester. All ten localities are developing Live Well approaches tailored to their communities, building on existing assets, networks and models of good practice.

Neighbourhood working in Greater Manchester is based on a different relationship between public services and residents. It brings together multi-agency teams working on geographical footprints of c30-50k population. These teams enable front-line public service staff to know each other, work collaboratively, and understand the strengths and assets of residents. We are planning not only to integrate health and social care but also to integrate health with broader public services.

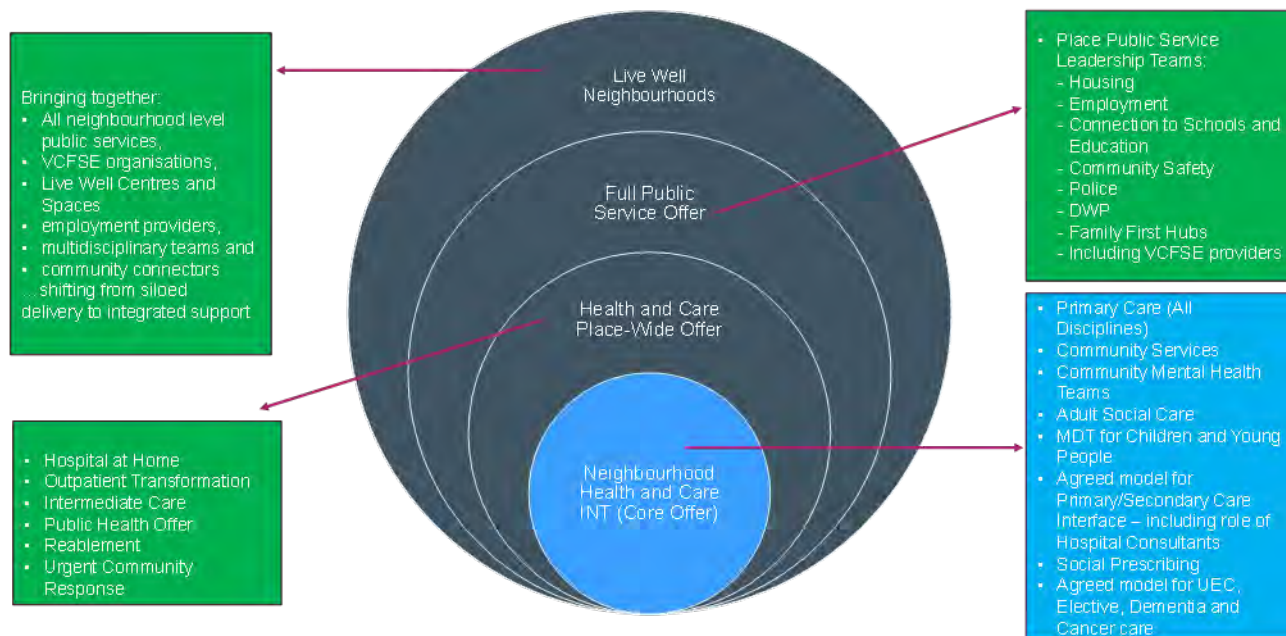
It is an all-age, all public and voluntary service model. Within the health system this includes integrated health and care teams such as primary care, community care, adult and children's social care, mental health services, and aspects of secondary care delivered in neighbourhoods.

We have described below how the range of offers across neighbourhoods comes together:

Primary Care (All

Neighbourhood Health as part of Live Well – Our Delivery Model

Primary Care (All



A critical part of this model will be how we strengthen the connection between Live Well and Neighbourhood Health and secondary care clinicians whose practice will be increasingly defined by population health rather than waiting lists and bed numbers.

In the first quarter of 2026/27, we carried out a full programme of engagement with system leaders to build a clear understanding of the expectations and opportunities for Neighbourhood Health. The primary output from this engagement will be a Strategic Commissioning Framework for Neighbourhood Health for Greater Manchester.

The Commissioning Framework will set out the core standards for Neighbourhood Health that people in Greater Manchester can expect no matter where they live. It will be published in September 2026. We have developed an outline of these core standards – which is shown below:

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

Alongside this system engagement, localities will continue to develop their neighbourhood plans. Across Greater Manchester, we will work together to:

- Align Place Health and Care Partnership Agreements, Place Outcomes Frameworks and Live Well metrics with neighbourhood plans
- Strengthen data capability to model the impact of neighbourhood working on activity, cost and population health improvement
- Embed NHS Neighbourhood Health Framework guidance (see Appendix A)
- Develop a clear description and roadmap for how GM-level programmes (e.g. mental health, housing and homelessness, SEND reform, dementia) connect to neighbourhood models
- Scope and mobilise GM-level enablers, including estates and digital, and work together on workforce and culture
- Clarify the role of Health and Wellbeing Boards, including how they relate to wider partnership governance and their role in approving neighbourhood health plans
- Continue to support the growth of community-led health and wellbeing, particularly to improve health equity.
- Further build and sustain non-clinical approaches that impact health outcomes (e.g. social prescribing, creative health, green and blue activities, social connection)

Our Outcomes:

Successful neighbourhood working will support the delivery of Place Partnership Outcomes. By year five, Our Live Well Neighbourhood Health delivery will have contributed to:

1. **Improved healthy life expectancy**, particularly in communities experiencing the poorest health outcomes, helping to narrow inequalities across Greater Manchester. [Priority system outcomes, measured through 5 Year Comm Plan reporting]
2. **Reduced demand on reactive health and care services**, including primary care, urgent care and emergency services, through earlier, preventative and community-based support.
3. **Increased access to and uptake of non-clinical support**, with more people supported through neighbourhood Live Well offers that address wellbeing, social connection and wider determinants of health. [Live Well metrics WOW1 and WOW2]
4. **Stronger community capacity, connection and resilience**, with communities better enabled to shape, deliver and sustain health and wellbeing activity. [Live Well metrics EX2 and WOW4]
5. **Reduced variation in preventative provision and outcomes across GM**, with a more consistent, high-quality Live Well offer available in every place while remaining rooted in local need. [Live Well metric WOW1 plus additional on outcomes?]

4.1.2. Primary Care Transformation (Delivering the Blueprint)

The Greater Manchester Primary Care Blueprint was published in October 2023. It is the five-year plan for primary care across our city-region and the changes that will be made to keep it sustainable for the future.

The core aims of the Blueprint remain valid and will continue to guide our work in the next five years. These are to:

- Provide timely appropriate access to care delivered by a system which has sufficient capacity to meet the needs of service users, where processes are simple and straight forward
- Form part of a wider neighbourhood team, where individuals and communities are supported to take more control over their own health and where providers work together with the shared aim of improving the health of the population
- Help to create fairer health and tackle the root causes of inequalities, working in partnership with our communities to create healthier, greener and fairer places
- Help people to stay well and focus on the prevention and early detection of ill health, and the effective management of long-term conditions
- Be viable for the long term, ensuring that services are available when and where needed
- Play a full part in achieving a Net Zero NHS GM Integrated Care Carbon Footprint by 2038
- Empower citizens and providers with high quality, digitally enabled Primary Care
- Be delivered from facilities which are appropriate for the provision of 21st century primary care
- Deliver safe, effective services, with a focus on quality improvement

- Be recognised as a career destination for a happy, healthy and engaged workforce, trained to a consistent standard with knowledge and expertise to meet the needs of our population and provide timely, exemplar services.

Over the course of this Strategic Commissioning Plan, we will accelerate delivery of the Primary Care Blueprint through a multi-year approach to our BeCCoR programme – building on the success of BeCCoR in 2024/25 and 2025/26.

We will put in place a multiyear GM GP Incentive scheme that will provide a core offer for all GM residents aligned to the three Darzi shifts and represents value for money with demonstrable return on investment.

The aim of BeCCoR is to deliver primary care transformation at an accelerated pace and at scale to improve population outcome and to unlock an increased and consistent investment in primary care.

BeCCoR delivers:

- Population Health Management Approach at Scale
- Risk stratification of unmet need – defined as gaps in good care – using an innovative digital tool: CVNeed

For 2026/27, we will take enhanced approach to identify unmet clinical need across the Long-Term Condition cohort ~ 500,000

- CVD – primary prevention (Qrisk) and secondary prevention
- Diabetes
- Chronic Kidney Disease
- COPD and Asthma (adults/children)
- Safer prescribing need (opiates and anticholinergic burden)
- Clinical care reviews to identify and address unmet clinical need/gaps in clinical care
- Strengthened neighbourhood working to improve engagement and non-clinical support for those with additional non-medical needs that impact health outcomes through LiveWell approaches

4.1.3. Community Services Transformation

The Community Services Transformation programme sets out a five-year ambition to deliver a consistent, proactive, preventative, neighbourhood-based community health and care offer across all ten Greater Manchester (GM) localities. The intention is that people receive the *right support, in the right place, at the right time*, enabling them to live well and independently at home, reducing avoidable hospital use, and narrowing inequalities.

Draft Priority Delivery Programmes / Actions (2026–2031)

Year 1 – Establish the Foundations

- GM-wide baselining: finance, workforce, activity, waiting times
- District Nursing Core Standards implementation
- Intermediate Care standards advancement
- Single Points of Access and care coordination in all localities
- Agreement on digital systems, analytics and naming conventions
- Establish frailty as the overarching GM priority for rising risk
- Prepare economic case to support left shift i.e. community investment to reduce upstream costs, and differential investment to reduce variation and inequalities
- Build on the children's 90-day plan to reduce community waiting times
- Develop and approach to community capital supporting left-shift capital pipeline (£14.4m window over 4 years)
- Develop support for carers in partnership with VCFSE carers' organisations and neighbourhood services and connect this more effectively with NHS community services and Live Well support.

Year 2 – Early Scaling

- GM Falls Prevention roll-out
- Expansion of community diagnostics (POCT, spirometry, monitoring)
- Begin MSK and continence pathway redesign
- Strengthen proactive neighbourhood care

Year 3 – Integrated Neighbourhood Model

- Live Well hubs operating in all neighbourhoods
- Full GM Care Record utilisation
- carers' support model connected to neighbourhood health
- Integrated children's community visibility and planning
- Consolidated frailty programme

Year 4 – Workforce Maturity and Productivity

- ACP and blended role expansion
- Community estates optimisation for diagnostics and clinics
- Year-on-year productivity improvement through sharing best practice

Year 5 – Optimisation and Evaluation

- Whole-system evaluation across outcomes, inequalities and left shift
- Refresh strategy for 2031–2036
- Demonstrate a fully mature, proactive, preventative community model
- Plan Capital and Estates Strategically
- Work with diagnostic network to support diagnostics in the community
- Influence the multiyear capital allocations to meet community needs
- Reframe community services as central to independence, prevention and population health
- Move the system beyond flow-driven thinking to “living well at home”

4.2. Targeted Action on Population Health Inequalities

4.2.1. Population Health

NHS GM has as a strong track record of acting across the breath of Population Health and is acknowledged as an exemplar nationally – for instance, by the King's Fund⁵. This is complemented by our data and analytical capability, which we can utilise to target interventions at specific cohorts/clinical groups through our Population Health Management (PHM) approach.

Our organisational approach to Population Health and Prevention is focused on pivoting the entirety of the system from treatment to prevention, which both 'hardwires' prevention into the NHS GM operating model and contributes to the wider pan-GM focus on a 'prevention first' approach to providing services for the public, and in partnership with people and communities.

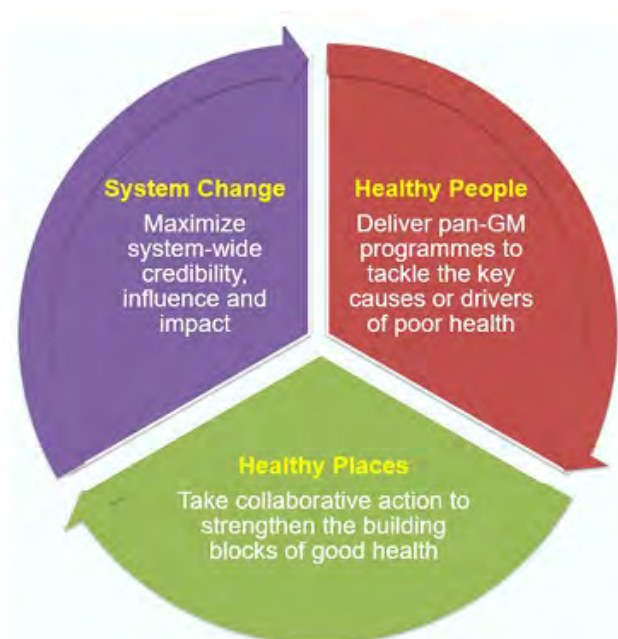
At the heart of the GM Population Health model is a recognition that most change is driven by activity that takes place in neighbourhoods and localities, and that the role of NHS GM as a strategic commissioner is to enable this to happen, and to provide pan-GM leadership.

This means that population health improvement will be delivered not only through public health programmes, but through commissioning, contracting, pathway redesign, provider collaboration and stronger partnership with local government, the VCFSE sector and communities.

The GM Public Health Network, of which NHS GM is a member and where transformation plans are set out in (3) has produced a wide-ranging and comprehensive Action Plan for 2026/27.

The plan focuses on 3 strategic priorities:

⁵ <https://www.kingsfund.org.uk/insight-and-analysis/reports/population-health-greater-manchester>



As part of the ICB's new Operating Model, we are taking a further, significant step towards this by NHS GM commissioning the GM Public Health Network to provide networked and distributed leadership for the ICB population health programme. This is a significant example of the Left Shift and a move to whole system collaboration over the long-term.

Over the course of this Strategic Commissioning Plan, we will seek to improve population health across three core themes.

- 1) Creating good health by acting on the wider, social and commercial determinants of health
- 2) Preventing non-communicable diseases through comprehensive action on the key modifiable / behavioural risk factors
- 3) Preventing communicable diseases through the design and delivery of evidence-based interventions

Our priorities for the next five years include:

- Work, Health and Growth – including the delivery of the GM WorkWell Partnership Vanguard; the Economic Inactivity Trailblazer; and the ongoing establishment of a GM Joint Inclusive Employment Unit
- Healthy Homes – the extension of the GM Tripartite Housing Agreement (between NHS GM, GMCA and GM Housing Providers) to 2029; make our full contribution to, and ensure the maximum health benefit from, the GM Housing First programme; transform our approach to falls prevention through a proof-of-concept on data driven home improvements and adaptations to reduce the prevalence of falls.
- Environmental Sustainability is a statutory duty under the Health and Care Act 2022.

NHS organisations meet these duties through delivery of a Board approved NHS Green Plan which we will focus on implementing.

- Tackling Poverty - through the voluntary adoption of the Socio-Economic Duty
- Giving Every Child the Best Start in Life (though a focus on Infant Mortality and School Readiness.
- Support the implementation of the Greater Manchester Age-Friendly Strategy 2024-2034.
- Commercial Determinants of Health - with a focus on regulating the use, environment and advertising of health-harming products

System approaches to tackling the key modifiable risk factors that influence health outcomes

Our main areas of work in the next five years will include:

- Tobacco - through the delivery of the GM Making Smoking History Strategic Framework and continued investment in Treating Tobacco Dependency provision
- Alcohol - through the implementation of the GM Alcohol Harm Strategy - and continued investment in hospital-based support to reduce alcohol Harm
- Physical Activity - through continued strategic co-investment in the GM Moving Strategy)
- Cross-risk factor approaches - by collaborating with GM stakeholders and national expert partners to co-design a coherent approach for Reducing Harm from Alcohol / Unhealthy Food and Drink and through GM delivery of a national prevention framework).

We will also continue to build on our progress on secondary prevention and optimising the management of Long-Term Conditions

- Scaling up evidenced based secondary prevention activities to reduce the prevalence of long-term conditions.
- Strengthening early detection and early intervention, to optimise care for those with existing Long-term conditions (LTCs), including reducing variation and inequalities in access, experience and outcomes
- Enabling those with an LTC to live in good health, and to slow the progression of those with a single LTC from developing multiple LTCs and Frailty
- Preventing over-treatment and inappropriate polypharmacy, to avoid unnecessary medicines use, reduce waste, and minimise the risk of harm to patients with LTCs.
- Embedding a personalised, preventative approach across the care pathway by redesigning models of care to reduce unplanned episodes of care.

Preventing communicable diseases through evidence-based interventions

- HIV - continue to deliver the pan-GM programme to end all new transmission of HIV by 2030, including continuing to fund existing multi-year grant agreements

- HIV / Viral Hepatitis - delivery, development and evaluation of the national blood borne virus (BBV) opt-out testing programme in emergency departments, covering nine sites across 7 GM localities, and assess the feasibility of pan-GM scale up from 2026/27.
- TB - work in partnership with stakeholders in the wider system to review current ICB TB commissioned services, risks and issues, with the aim of informing service transformation and ensuring services better meet the needs of the local population
- NHS Health Checks - work with local authority and clinical leads to improve the quality and uptake of NHS Health Checks, and address inequities

4.2.2. Long Term Conditions

We will also continue to build on our progress on secondary prevention and optimising the management of Long-Term Conditions via system wide integrated working, aligned to our GM clinical strategy.

We will focus on high priority, full pathway approaches to ensure that transformation achieves improvements in outcomes for people and our population (rather than improves the outcomes of services) and spans prevention-early intervention-proactive care-specialist care.

The identified high priority pathways include:

- CVRM-Brain Health (Cardiovascular, Renal, Metabolic) – which includes obesity, diabetes and dementia
- Frailty
- Palliative and End of Life Care
- Respiratory

To note, there is strong alignment of this LTC pathway approach with National Modern Service Frameworks. The CVD MSF was published 7th July 2026, with Dementia and Frailty MSF and Palliative and End of Life Care MSF expected by October 2026.

In addition, we will continue to build on our current approaches which include:

- Scaling up evidenced based secondary prevention activities to reduce the prevalence of long-term conditions.
- Strengthening early detection and early intervention, to optimise care for those with existing Long-term conditions (LTCs), including reducing variation and inequalities in access, experience and outcomes
- Enabling those with an LTC to live in good health, and to slow the progression of those with a single LTC from developing multiple LTCs and Frailty
- Preventing over-treatment and inappropriate polypharmacy, to avoid unnecessary medicines use, reduce waste, and minimise the risk of harm to patients with LTCs.
- Embedding a personalised, preventative approach across the care pathway by redesigning models of care to reduce unplanned episodes of care

4.2.3. Improving Outcomes for Babies, Children and Young People

Greater Manchester continues to experience rising demand for children's community health services, significant variation in waiting times, and persistent inequalities in access and outcomes. Alongside this, our maternity and neonatal services continue to focus on delivering consistently safe, personalised and equitable care to improve perinatal outcomes and experience, recognising the importance of maternity in the first 1,001 critical days.

We face several significant challenges:

- **Long waits:** GM has made significant reductions in long waits for community health services, although some pathways continue to exceed 18 and 52 weeks
- **Variation:** There remains variation between localities in access, capacity, and outcomes.
- **Demand growth:** Demand is increasing by an estimated 3% per year nationally, and GM is experiencing similar, and in some areas higher, growth
- **Workforce constraints:** Recruitment and retention challenges limit the ability to expand capacity.
- **Digital maturity:** Digital tools are not yet consistently available or used across all teams
- **Inequalities:** Children in more deprived areas experience poorer outcomes and longer waits, consistent with CORE20PLUS5 priorities.

Maternity and neonatal context

- Stillbirth rates, including termination of pregnancy, are currently 4.11 per 1,000 births, compared with 3.3 in England and 3.9 in the North West.
- Stillbirth rates, excluding termination of pregnancy, are currently 3.19 per 1,000 births, compared with 3.1 in England and 3.2 in the North West.
- Suspected hypoxic-ischaemic encephalopathy among neonates was 0.96 per 1,000 live births in 2025, compared with 1.2 in England and 1.6 in the North West.
- Smoking at time of delivery (SATOD) is at its lowest recorded rate this quarter, at 3.7%, tracking nearly half a percentage point below England.
- The current midwifery vacancy gap is 48.9 WTE, reduced from 102.6 WTE in 2024

Five-year outcomes (aligned to GM plan and national targets) By 2029, GM aims to:

CYP Community Health outcomes.

- Reduce unwarranted variation in access and outcomes across all localities.
- Ensure community health services deliver **at least 80% of activity within 18 weeks** (aligned to the 2028/29 national target).
- Reduce acute outpatient appointments for children under the age of 16 by 10%

- Eliminate all **52-week waits** in community services.
- Increase community capacity to meet **3% annual demand growth**.
- Improve digital maturity so all teams can work efficiently and connect remotely.
- Expand use of digital therapeutics where clinically appropriate.
- Standardise core community health service provision across GM.
- Reduce inequalities in access, experience and outcomes for children and young people.
- Improve the uptake of childhood immunisations and addressing health inequalities, to prevent illness and health consequences from preventable disease.

Maternity and neonatal outcomes

- Reduce avoidable harm, including stillbirth, neonatal death and brain injury.
- Reduce inequity in maternity and neonatal outcomes.
- Improve experience of maternity care.
- Support maternity services to maintain a safe, sustainable and skilled workforce.
- Strengthen seamless pathways across community and acute services.

We have a Greater Manchester Children and Young People Joint Forward Plan. This plan is underpinned by our commitment to put the voice of children and young people at the heart of the way we design and deliver services. Our Joint Forward Delivery Plan sets our commitments and shared ambitions under six themes:

- Child Development in the Early Years
- SEND and School-Age Children Wellbeing
- Long-Term Physical Conditions (CORE20PLUS5)
- Mental ill Health
- Risk and Complex Care
- Family help

4.2.4. Mental Health, Learning Disability and Autism (All Age)

The Greater Manchester Mental Health and Well-being Strategy is the overarching system plan for mental health service transformation and enabling the left shift. This is underpinned by the Mental Health Integrated Fund (MHIF) as the vehicle to enable the continued investment in early intervention and community service transformation through prevention of inpatient admissions.

2026/27 will focus on adult community crisis service expansion and enhancement including Assertive Outreach and EIP alongside planning for wider transformation of core adult community Mental Health services (from reinvestment from reductions in Independent Sector bed usage). We will implement the findings from the review of Children and Young People's crisis services across Greater Manchester and develop integrated service specifications for improved access, single front door and reduced admissions to inpatient facilities (24/7).

Mental health need across Greater Manchester is higher than the national average, shaped strongly by deprivation, demographic change and increasing demand across the life course. The Joint Strategic Needs Assessment (JSNA) indicates wide-ranging need across prevention, existing need and unmet need. Key indicators include:

- Severe mental illness: the number of patients registered with GPs with severe mental illness has shown a steady increase and is reported at around 37,000 patients in mid-2025.
- Neurodivergence and SEND: as of January 2024, there were 35,201 Education, Health and Care Plans held in Greater Manchester, representing a 16.8% increase from 2023; the rate per 10,000 CYP is reported as higher than England
- Emotional Wellbeing: around 4 in 10 residents report high anxiety across Greater Manchester, with higher levels among younger adults and those in the most deprived areas; 29% of residents report feeling lonely at least some of the time.
- Crisis and urgent care demand: mental health calls make up a material share of ambulance activity, with the JSNA summary indicating around 8.6% of emergency calls to NWAS in Greater Manchester (around 3,000 calls per month), and a clear deprivation gradient in incident rates.
- Suicide: 851 people in Greater Manchester died by suicide in the 3-year rolling period 2021–23, with a reported suicide rate of 12.5 per 100,000 people in that period.

The GM Mental Health and Wellbeing Plan sets out key system priorities. The strategic commissioning intentions focus on the transformation required to deliver the improved outcomes and reduce inequalities

Children and Young People

The MHLDA Plan highlights programmes including expansion of Mental Health Support Teams, perinatal mental health expansion, Parent Infant Mental Health redesign, implementation of Core CAMHS service specification (including neurodiversity triage and assessment), the cared for children and young people CAMHS service, digital early support in primary schools, neurodiversity model of care, and community eating disorders work including ARFID.

The strategy update also identifies CYP access and continued support as a core 2026/27 strategic priority, including MHST expansion and system action on neurodevelopmental waiting lists and pathways.

Adult community and prevention

The MHLDA Plan highlights adult ADHD and autism services reform, increased capacity in Talking Therapies, Individual Placement Support expansion, shared care test of change, complex emotional and relational needs (CERN) pathway implementation, rehabilitation service review with strengthening of community-based services, neighbourhood delivery models, and continued inpatient transformation and bed reduction.

The strategy update identifies community mental health and neighbourhood teams as a core 2026/27 priority, with emphasis on sustaining integrated community mental health models and VCSE integration to prevent escalation.

Learning Disability and Autism

The MHLDA Plan prioritises the development of a consistent all-age Learning Disability and Autism model across Greater Manchester, focused on reducing inequalities, improving access to community-based support and reducing reliance on inpatient care. Key priorities include implementation of the Learning Disability and Autism Lead Provider Collaborative, development of a single community Learning Disability service specification, strengthening Dynamic Support Registers and Care (Education) and Treatment Reviews, enhancing intensive support services and delivering improved pathways for adults and children with autism and learning disabilities.

A continued focus will be placed on admission avoidance, timely discharge, least restrictive care and ensuring that people with a learning disability and/or autism are supported to live well in their communities with access to the right support at the right time.

Crisis and inpatient care

The MHLDA Plan includes adult crisis services investment to ensure core fidelity across Crisis Response and Home Treatment Teams, a GM-wide CMHT service specification, strengthened gatekeeping and integrated discharge, health-based place of safety improvements, digital transformation including CPA replacement, liaison services and mental health provision in emergency settings, and implementation of NHS 111 and text service.

A key system priority is the delivery of a consistent and sustainable urgent and emergency care mental health crisis pathway, alongside continued improvement in clinically ready for discharge processes and acute interfaces.

triage, crisis alternatives and specialist services, where this supports agreed programme priorities and delivery.

In addition to the Lead Provider Collaboratives, there is a strategic ambition to maximise opportunities for economies of scale and to explore whether a greater number of specialised services could be commissioned and delivered once across Greater Manchester. Discussions are underway with providers to identify opportunities where a GM-wide approach could improve outcomes, reduce variation and deliver greater value.

The MH LDA transformation programme is underpinned by the Mental Health Integrated Fund (MHIF) as the vehicle to enable the continued investment in early intervention and community service transformation through prevention of inpatient admissions and reducing length of stay.

Mental Health Integrated Fund

In 2025/26, to support the 'Left Shift' in investment flow from hospital beds to community services, the Mental Health Integrated Fund (IF) was agreed and implemented.

This is our shared vehicle for significant investment to be made into resilient community mental health services, which align to the GM Live Well model and our shared strategic drive for prevention and early intervention to be at the heart of our neighbourhood model of care.

The MHIF has been very successful. We have seen a reduction in the use of Out of Area Placements (OAPs) and Local Spot Purchase Placements to less than 20 by end March 2026. This has resulted in recurrent savings for reinvestment of over £11m.

4.2.5. Improving Cancer Outcomes

The National Cancer Plan aims to ensure that by 2035, three in four people diagnosed with cancer survive for five years or more, transforming cancer care through earlier diagnosis, improved treatment, and innovation.

Cancer outcomes in Greater Manchester are improving, but variation persists and demand continues to rise. GM performs above national averages for staging and some waiting times, yet the system is not delivering fast enough or early enough for all residents.

The Medium-Term Planning Framework confirms the public ambition to return to meeting the Cancer Waiting Times Standards by March 2029. It also confirms the need to maintain attention on securing further improvements to early cancer diagnosis.

The 'National Cancer Plan for England: delivering world class cancer care' expands on these priorities and responds to the challenge to implement the three strategic shifts in the 10 Year Health Plan, in the context of cancer care. The plan highlights cancer performance and survival, outlines approaches to personalised and neighbourhood cancer care, describes the need for advances in cancer research, describes specific approaches to cancer in children and the need to address rare and less common cancers.

Diagnosing cancer earlier is the single biggest action that can improve survival. The 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.

Reducing inequalities in cancer outcomes will require targeted neighbourhood action, improved uptake of screening and earlier presentation in underserved groups, supported by community outreach, primary care and VCFSE partners where these routes are more trusted and effective.

Achievement of nationally set constitutional cancer waiting time standards will continue to be a priority and will be overseen by the GM Cancer Alliance on behalf of the GM system. Variation by pathway and provider will be identified and addressed via a programme of pathway improvement work and the reduction in treatment variation.

There will continue to be a focus on the delivery of personalised care for cancer patients, increasingly connecting with Neighbourhoods and the GM Live Well programme. National guidance will specify the interventions.

Headline performance at the end of 2025-6 against the 3 Cancer Waiting Time constitutional standards is as follows:

- Faster Diagnosis Standard (FDS): 82.18% (against an 80% year-end target)
- 31-day decision to treat: 96.38% (against a 96% year-end target)
- 62-day referral to treatment: 78.84% (against a 75% year-end target)

It's also worth highlighting the significant improvement in Greater Manchester's national ranking as an Alliance in comparison to the other 19 Cancer Alliances in England:

- FDS: improved from 15th to 8th
- 62-day: improved from 19th to 9th

All three standards are above target and performing above the national position providing a strong baseline for 2026-7. This represents a strong step forward for GM and reflects the collective effort across the system to drive improvement in cancer pathways.

The National Cancer Plan aims to ensure that 3 in every 4 people diagnosed in 2035 will be cancer-free or living well with cancer after 5 years. For Greater Manchester that translates to approximately 20,000 people.

There are approximately 17,000 cancers diagnosed in Greater Manchester every year. In the calendar year 2025, there were 16,443 cancers diagnosed with 60.3% diagnosed at stage 1 or 2. Increasing the proportion of cancers diagnosed at stage 1 and 2 is key to delivering the survival ambition and is premised on achieving at least a 20-percentage point increase in early diagnosis above the 2019 level by 2035. The Greater Manchester level in 2019 was 53.7% giving an ambition of 73.7% for Greater Manchester

4.3. System Transformation

The initiatives we have described across prevention, neighbourhoods, Live Well, population health and primary care will contribute to health improvement across the population and reduce pressure on acute services.

4.3.1. Reviewing our Care Model

This will need to be complemented by a review of our care models in Greater Manchester encompassing our full pathways of care extending into secondary care.

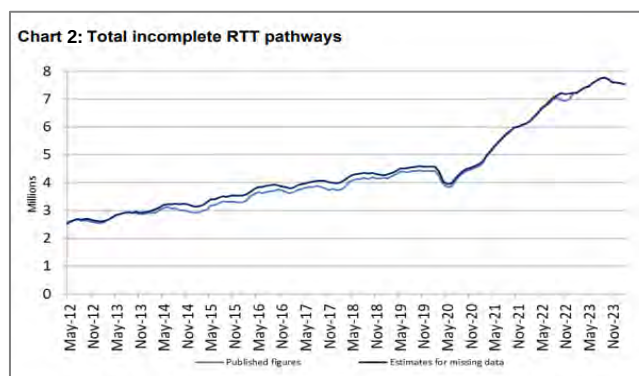
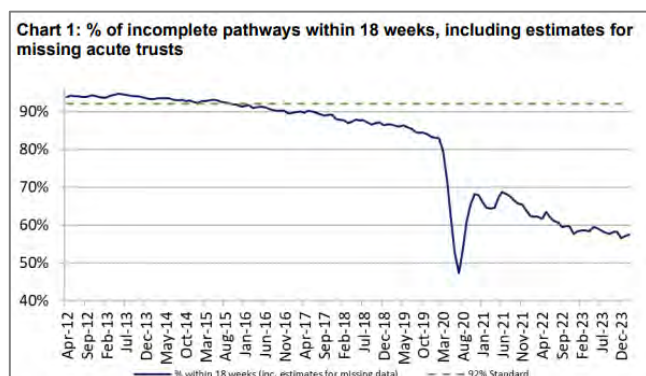
As we move to a proactive, integrated, neighbourhood model of care – enhanced by our Live Well approach in Greater Manchester – we need a robust, quantified plan for acute and non-acute delivery that commands confidence from the system. To inform this plan, we will carry out a review of our care models in 2026/27 to:

- Understand the likely growth in demand for acute care based on current care models and wait time requirements, year by year for the next ten years.
- Analyse the full extent of demand reduction opportunities based upon current clinical models and capacity, year by year for the next ten years.
- Design the clinical models and capacity that would need to operate outside of hospital to reduce demand by x% per year based upon the demand modelled above
- Quantify, by acute site, how much activity is being undertaken that would be amenable to being delivered in a non-acute setting.
- Model, by acute site, the impact on capacity that will come from the demand reduction using costs, bed numbers and theatre time as the currency - i.e. how much can we close and how much will be liberated for investment and to close our recurrent deficit?
- Identify cash releasing opportunities over the medium term related to each area of the review being considered

4.3.1.1. Elective Care Reform – including Outpatients

Prior to the COVID-19 pandemic, GM was able to operate with a materially smaller elective waiting list and RTT performance much closer to national standards. During the pandemic period, elective activity reduced significantly while demand continued to accrue, leading to a rapid expansion in the Patient Treatment List (PTL).

Decline in RTT Performance in GM and the corresponding rise in total waits since 2012



When addressing recovery, Greater Manchester's elective challenge is structural rather than episodic. While progress has been made in reducing the longest waits, the overall waiting list remains materially above a sustainable level.

The last time that GM was achieving the 18-week constitutional standard of 92% was December 2015, at which point the total waiting list was 194,000 patients waiting for treatment. NHS England expects ICBs to return to the 18-week constitutional standard by March 2029, requiring GM to remove approximately 60,000 net pathways per year and halve the waiting list over three years.

For 2026/27, GM is required to deliver a step-change improvement in RTT performance (c.11 percentage points) and a significant reduction in waiting list size. However, national funding allocations cover less than half of the required reduction. This means GM cannot rely on traditional hospital-led activity growth alone and must instead deliver a fundamental shift in how elective demand is managed, how patients enter pathways, and where care is delivered.

Over the last 12 months, Greater Manchester has made measurable progress in elective recovery, particularly in stabilising the waiting list and reducing the longest waits. During 2025/26, GM achieved exceeded plan with an 8-percentage point improvement in RTT performance, with all providers improving over the period.

Modelling demonstrates that current trajectories, even if sustained, will not deliver the required reduction in waiting list size or RTT performance. National elective funding covers only a proportion of the annual reduction required, creating a material delivery gap that must be addressed through transformation rather than activity growth alone.

Compared to high-performing systems, GM has clear headroom on pre-referral demand management and outpatient pathway efficiency. These areas represent the most credible opportunities to accelerate improvement beyond the current trajectory

OUTCOMES

1. Delivery of the 18-week constitutional standard - Greater Manchester will return to, and sustain, 92% of patients treated within 18 weeks by March 2029, with staged improvement milestones across the intervening years. This reflects national expectations and ensures GM is no longer an outlier on access to planned care.
2. A sustainable waiting list size - The GM waiting list will reduce from its current structurally inflated position to a level consistent with sustainable RTT delivery (circa 180,000–210,000 pathways). This represents a fundamental shift from managing long waits to controlling system inflow and flow.
3. Reduced growth in new elective demand - Growth in GP-initiated elective referrals will be moderated through consistent pre-referral clinical advice, peer-led variation

management and improved alternatives to acute care, ensuring consultant-led pathways are reserved for patients who genuinely need them.

4. Shorter, simpler elective pathways - Elective pathways will be redesigned to minimise unnecessary outpatient attendances, reduce follow-ups, and embed straight-to-test and protocol-driven care. This will improve patient experience while releasing clinical capacity.
5. Care delivered in the most appropriate setting - A significantly higher proportion of elective activity will be delivered in community and outpatient settings, with acute hospitals focused on complex care and high-value surgical activity delivered through optimised surgical hubs.
6. Reduced unwarranted variation and improved equity of access - Elective access and outcomes will be more consistent across GM localities, providers and population groups, supporting the wider population health and inequality objectives of the ICB strategy.

To return Greater Manchester to the constitutional standard of 92% of patients treated within 18 weeks by March 2029, the elective system must transition to a fundamentally different operating model. While long wait backlogs have reduced, the overall Patient Treatment List (PTL) remains significantly above sustainable levels. The next five years therefore require a deliberate, system-wide shift in how elective demand is managed, how patients are routed, and how capacity is deployed across acute, surgical hub and community settings.

Five-Year Strategic Delivery Expectations

Year	Commissioning Priorities	Key System Changes	Expected Outcome
2026/27	Establish foundations for PTL reduction	- Implement SPOA in priority specialties - Expand community pathways - Strengthen A&G with mandated turnaround - Strengthen referral variation management - Standardise outpatient templates - expand surgical hub optimisation - Embed digital and clinical validation	Early PTL stabilisation and initial reduction; 67% RTT
2027/28	Deliver material PTL reduction	- SPOA extended across all high-volume specialties - Implement new MSK model for GM - Expand HVLC hub activity - Increase community capacity - Sustained focus on paediatric waits	Significant PTL reduction; RTT 70–75%

2028/29	Consolidate transformed operating model	- Digital referral management system - Mandate straight to test / hub pathway - Full GIRFT compliant hub utilisation - Follow-up reductions embedded - Community pathway model fully mature	PTL reaches sustainable range; RTT 80-85%
2029/30	Achieve constitutional standard	- Load levelling and capacity optimisation - Hub capacity flex used to maintain performance	Delivery of 92% RTT
2030/31	Sustain and optimise	- Long-term sustainable delivery model - Embed continuous improvement (CI) methodology across all providers	Stable RTT

Outpatient Transformation

A review of evidence indicates that c40% of new Outpatient demand from a primary care referral could be managed outside of hospital. The share of referrals and primary mechanism for delivery varies across different specialties, as per the conditions being managed, and so left-shift needs to be planned within the scope of specific specialty footprints.

For new Outpatient demand there are working archetypes and relatively well-defined pathways that support quantification of the potential for left shift. Follow-up demand requires better definition. Certain cohorts of patients such as those living with Long-Term Conditions and multi-morbidity can be identified and potentially managed outside of hospital but these often reach across multiple specialties and require MDTs working together (such as being piloted in North London).

In GM, we have started with an expansion of Specialist Advice – making it easy to use, accessible and high-quality for all of primary care – and commissioning of community services in ENT and Gynaecology. A pan-GM programme of work supporting the elective Single Point of Access (SPoA) roll-out through development of GM pathways is focusing on these two specialties plus Cardiology and Gastroenterology, where the potential for virtual diagnostic and advice pathways is highest.

We are now developing a “neighbourhood” vision for transforming how we deliver elective care, comprising the high volume, very common conditions that can be managed as well if not better outside of hospital through a holistic primary care model

4.3.1.2. Urgent and Emergency Care Reform

Urgent and Emergency Care (UEC) remains the most visible indicator of whole-system effectiveness across Greater Manchester (GM), reflecting the degree to which health, care and wider partners operate as a single, integrated system. The GM approach continues to be explicitly system-wide, spanning acute, ambulance, community, primary care, mental health and adult social care services, delivered through a single system oversight framework.

The UEC programme is now organised around a small number of non-negotiable system

delivery priorities:

- Restoring flow and throughput across the acute pathway;
- Actively managing demand and reducing avoidable use of ED;
- Improving outcomes for high-impact population cohorts; and
- Scaling community-based alternatives to admission.

Despite progress during 2025/26, GM continues to face sustained pressure across urgent and emergency care, characterised by high demand, delays at the front door, and constrained discharge impacting overall system flow.

These pressures continue to manifest as long waits in emergency departments, ambulance handover delays and increasing length of stay for admitted patients, creating risks to patient safety, experience and system performance. The impact is not evenly distributed, with poorer access and outcomes for older adults, people experiencing mental health crisis, children and young people, and those living in areas of higher deprivation.

The system therefore requires a step change in delivery discipline, moving from reactive pressure management to a proactive, standardised and outcomes-focused approach that addresses both immediate performance recovery and longer-term demand reduction.

The primary system challenge is the persistent mismatch between demand and available capacity, compounded by variable performance across providers and places. This variation continues to limit the effectiveness of system-wide interventions and reinforces inequalities in access and outcomes.

The refreshed programme responds to this by strengthening GM-level grip and consistency, establishing common standards, clearer accountability and a more directive commissioning approach. Place-based delivery remains essential, but is now supported by mandated system expectations, trajectories and assurance mechanisms.

Outcomes and interventions

By 2030/31, Greater Manchester will deliver a resilient, integrated and prevention-led urgent and emergency care system that consistently meets national access standards through durable whole-system flow, enables timely access to appropriate care in community settings, and demonstrates measurable reductions in unwarranted variation and health inequalities.

This ambition is now explicitly linked to the system's commitment to eradicate the most harmful delays, including 12-hour waits, and to deliver a sustained shift in activity away from hospital-based care toward neighbourhood and community models.

Phase 1 (Years 1–2): Stabilisation and System Grip

The immediate priority is to restore flow across the system, with a focus on front-door

performance, discharge optimisation and reduction in long lengths of stay.

This phase will establish consistent GM standards for ED flow, ambulance handovers and discharge, supported by clear trajectories and regular system oversight. Success will be defined by the system operating within agreed performance thresholds, with sustained reductions in 12-hour waits, ambulance handover delays and long-stay patients.

Phase 2 (Years 2–4): Standardisation and Scale

Building on initial stabilisation, this phase will focus on scaling consistent pathways across GM, reducing unwarranted variation and embedding alternative models of care.

This includes the expansion of same-day urgent care, integrated frailty pathways, and crisis models for mental health and children and young people. Delivery will increasingly be driven through standardised models supported by evaluation and evidence-based investment decisions.

Phase 3 (Years 4–5): Transformation and Prevention

The final phase will deliver a structural shift in the model of care, with a measurable reduction in emergency demand and sustained improvement in outcomes.

By this stage, community-based alternatives, prevention and neighbourhood delivery models will be fully embedded, with commissioning and investment aligned to value and outcomes rather than activity.

4.3.2. Digital and Innovation

Greater Manchester is entering a decisive phase for digital transformation and innovation in health and care. National reform, financial pressure and rising population need are converging with rapid advances in data, digital and AI technologies. In response, Health Innovation Manchester (HInM) and the ICB will work in close partnership to deliver a focused set of digital and innovation priorities that accelerate population health impact, improve system productivity and position Greater Manchester as a globally recognised learning system for innovation at scale. This is described fully in the Health Innovation Manchester Strategy and supported by an MoU between the two organisations.

1. Optimising GM's core digital and data infrastructure as a live system asset

HInM and the ICB will continue to evolve Greater Manchester's foundational digital assets to support care delivery, planning, research and innovation. This includes the continued development of the GM Care Record as a live operational platform, sustained investment in the Advanced Data Science Platform and Secure Data Environment as a globally competitive real-world evidence and analytics capability, and stronger integration of data across health, care and prevention. The emphasis is on reliability, usability and value creation, ensuring these assets directly support clinical decision-making, productivity and system improvement, not just access and compliance.

2. Embedding AI-enabled transformation to improve productivity and workforce sustainability

The partnership will deliver a focused AI and digital transformation programme aligned to system priorities. This includes deploying AI to optimise pathways, reduce unwarranted variation, support clinical and operational productivity, and alleviate workforce pressures. HInM will provide the method, delivery assurance and industry interface, while the ICB anchors deployment within commissioning, clinical governance and operational delivery. The ambition is to move from fragmented experimentation to scaled, safe and trusted AI adoption across GM. Supported by strong governance, we will explore the opportunities for Agentic AI (autonomous AI systems that act independently to achieve specific aims) to improve the speed, quality and transparency of commissioning intelligence without displacing human judgement – enabling us to make better-informed, evidence-based commissioning decisions.

3. Using data and innovation to drive population health missions at scale

Digital and data capability will be tightly aligned to GM's priority population health missions - including cardiovascular, metabolic and renal disease, obesity and respiratory health. Advanced analytics, targeted case-finding, pathway optimisation and real-world evidence will be embedded into service design and delivery. This mission-led approach ensures innovation activity is driven by system need and population impact.

4. Positioning GM as a globally competitive learning system for innovation and real-world evidence

HInM and the ICB will jointly position Greater Manchester as a place of choice for industry-led innovation, trials and real-world evidence generation. By combining population-scale data, integrated pathways and credible delivery capability, GM will offer partners faster, lower-risk routes to evidence generation and adoption. Structured industry pipelines, co-investment models and value-sharing arrangements will ensure innovation delivers benefits for patients, the NHS and the GM economy.

5. Embedding innovation into system planning, commissioning and delivery

A core priority is to normalise innovation as part of “business as usual” system decision-making. HInM and the ICB will align innovation activity to commissioning intentions, financial planning and operational priorities, supported by shared governance, benefits realisation and delivery assurance. This ensures innovation is deployed where it delivers the greatest system value - improving outcomes, productivity and sustainability.

6. Strengthening citizen trust, governance and system capability

All activity will be underpinned by robust data governance, citizen involvement and system co-production. The partnership will continue to invest in leadership, skills and capability across the system, ensuring digital and innovation programmes are trusted, ethical and scalable. Citizen trust and transparency remain foundational to GM's ability to innovate at pace and at scale

Digital transformation must also support inclusion. This means designing services that reduce rather than widen digital exclusion and working with communities and VCFSE partners to

improve trust, uptake and accessibility for groups less well served by standard digital channels.

Core delivery projects include:

- 1) Population health innovation missions – focus on CVRM, obesity and respiratory, as well as driver of economic inactivity
- 2) Attracting industry partnerships and investment, aligned to addressing system challenges.
- 3) Contributing to the successful delivery of the Prevention Demonstrator
- 4) Optimising AI, digital & data transformation – linked with the GM Care Record, ADSP and SDE
- 5) Economic development & cluster growth – cementing health innovation and life sciences as part of the GMCA's good growth plan
- 6) Enabling work programmes including System adoption & sustained delivery, System-wide skills, capability & leadership for innovation and Academic Translation & evaluation

During 2026, we will refresh our Digital Strategy to cover the same period as this Strategic Commissioning Plan and will launch the Strategy in January 2027. Our approach will be guided by how we can we build digital capability that directly enables the delivery of this Strategic Commissioning Plan. We need to move away from seeing digital as a support function — it must become a core commissioning lever for integrated care, prevention, and neighbourhood models.

4.3.3. Quality Improvement and Learning

NHS Greater Manchester is committed to being a learning system and using quality improvement approaches and methodologies and system learning to drive change and yield impacts.

Over the course of this plan, we will:

- 1) Grow and embed quality improvement capacity, capability and tools across priority transformation programmes, supported by system-wide Learning and Improvement Networks (LINs) and the development of a GM improvement collaborative/community of practice to scale learning and accelerate impact
- 2) Adopt a systematic approach to clinical effectiveness encompassing the GIRFT programme, robust horizon scanning, national audit outputs, development of innovation/research to BAU pipeline to guide improvement, transformation and future commissioning
- 3) Embed nationally published Modern Service Frameworks to support local delivery of high quality, evidence-based and digitally enabled care for key conditions. For 2026/2027, these are expected to include:
 - a. Cardiovascular Disease (CVD) – published 7.7.26
 - b. Sepsis

- c. Mental Health (including SMI)
- d. Palliative and end of life care
- e. Dementia and Frailty

4.3.4. New Models of Commissioning and Provision

Over the course of this plan, NHS Greater Manchester will continue to build its capability as a strategic commissioner. This means making sure that all the enablers for successful strategic commissioning, as set out in the NHS Strategic Commissioning Framework, are in place:

- Capability in strategic leadership and partnership working with other commissioners, providers, local government, VCFSE and service users to co-design services and improve population outcomes
- Effective and broad multidisciplinary clinical and professional leadership embedded in how they work to drive cross-organisation improvements
- Access to high quality data analysis, sustained and meaningful engagement with people and expertise to inform decision-making and target interventions.
- An ability to involve people and diverse communities and understand their experiences through asset-based approaches that facilitate co-production and empower community-driven solutions
- An ability to use market management and development, contract management and procurement mechanisms to support a focus on quality, value for money and delivery of improved outcomes – including on specific areas of focus such as Continuing Health Care
- In practice, this means that major commissioning decisions should be able to show how evidence and lived experience have been used; how inequalities and anti-racism have been considered; how residents and VCFSE partners have shaped the design; and how the chosen model will support prevention, neighbourhood health and better long-term value.

As a strategic commissioner, NHS Greater Manchester will also act as an intelligent payer and market shaper. This includes:

- shaping the provider and partner landscape across NHS, local government and VCFSE
- using contracts and incentives to support prevention and neighbourhood models
- reducing fragmentation across pathways
- supporting innovation and new delivery models

We recognise that commissioning in the NHS has often been characterised by short-term approaches with narrow definitions of activity and cost rather than value and a focus on outputs rather than outcomes. As a result, we have seen ‘rightward drift’ in the NHS as opposed to ‘left shift’ as Lord Darzi commented in his 2024 report.⁶

⁶ <https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england>

This means that we must increase our focus on developing new commissioning models which incentivise providers across all sectors to maximise prevention and proactive care and reducing inequalities. This could include:

- Outcomes-based contracts
- Value-based payment mechanisms
- Contracts and payments that incentivise the three national shifts
- New models of provider partnership and collaboration
- A more comprehensive and innovative approach to market development strategy – with a focus on how we work differently with VCFSE partners.
- Applying the principles of the GM VCFSE Accord involving and devolving, resourcing and enabling, and recognising and valuing within commissioning and governance
- Reducing barriers for small and grassroots organisations to contribute to design, delivery, procurement and partnership working
- Using fair funding principles, including transparency, proportionality and wherever appropriate longer-term and more flexible approaches to community-based provision
- Building community engagement into our approach to commissioning and planning on both an annual and longer-term basis – working with the VCFSE to do this
- Embedding mechanisms to reduce inequalities firmly within the strategic commissioning cycle – with processes to monitor this
- Ensuring that a clear stance on anti-racism is built into the commissioning cycle and all commissioning decisions
- Use of new national contracting and payment mechanisms when they support the delivery of our strategy in Greater Manchester – for example, neighbourhood contracts, Integrated Health Organisations (IHOs).

4.3.5. Provider Collaboration

The GM Provider Collaboration is a maturing collaboration of the 3 healthcare delivery sectors of acute Trusts (Trust Provider Collaborative), the 4 Primary Care Provider disciplines (Primary Care Provider Board) and Social Business Providers (Alternative Provider Collaborative).

It has developed on the foundations of strong sector Collaboratives and has enabled at scale GM collaboration and joint working over the last 10 years. The Collaboration is in the early stages of developing how it best works together to add value. It is not a new formal structure, but an approach to working more closely together that can work towards and enable:

- 1. At scale delivery of the GM missions and Operating model and support / enhance work of Place Partnerships**
 - a. Supporting a convergence around shared purpose, messaging and coordinated communications across health and care providers

- b. Builds on existing cross-sector work i.e. elective reform, neighbourhood working to ensure we realise our ambitions in this and the GM Strategy i.e. GM Market Development Strategy
- c. This is a positive and supportive approach and should be recognised as a key part of the GM system infrastructure, providing support to:
 - i. buy the best
 - ii. model a range of scenarios to address challenges and opportunities
 - iii. lead on and enable integration and left shift
 - iv. a sounding board – what does good look like?
- d. At scale providers make it easier to contract with and / or work with Providers operating at scale and more importantly operating in our 10 Places; we know where the expertise is and can connect to that in a timely way

2. Contribute to / lead / support the delivery of key programmes:

Providers across GM bring clinical, professional and lived experiences of our residents, bringing challenges and opportunities to life using real examples. When this experience is brought together across Primary, Secondary and Specialist, Community and VCFSE sectors, it is greater than the sum of its parts. Areas of key contributions are:

- a. Live Well - realised through the Prevention Demonstrator – supporting the development and evaluation of a Blueprint.
- b. Service reconfiguration – supporting development of urgent and elective care and new models of commissioning
- c. Transformation and innovation – our collective workforce hold significant expertise and experience, but through this Collaboration will enable at scale testing and development of new roles in health and care. It also enables a more efficient use of our collective estate.
- d. Neighbourhood health –strengthening national contract and framework delivery
- e. Strengthen and expand Community care and services (PC - align to Blueprint delivery); VCFSE and community-based health and care services.

Key work areas that we will use to test this approach (working at Neighbourhood, Place and scale (GM)) are:

- 1) To develop a GM Market Development Strategy (commenced June 2026)
- 2) Support to the Prevention Demonstrator Blueprint development in Place; consistent standards and approach
- 3) Delivery of Neighbourhood models
- 4) Delegated Functions

The partnership between NHS Greater Manchester and the 10 local authorities as commissioners of social care provision is fundamental to this. We will accelerate our progress on social care transformation – with a particular focus on the role of social care as part of Integrated Neighbourhood Teams.

The Role of the VCFSE

The VCFSE in Greater Manchester makes a significant economic contribution, generating £1.2 billion in income each year (State of the Sector 2021). The sector is a critical part of the system, supporting prevention, reducing demand, strengthening communities, and reaching people and places statutory services cannot always reach.

The Greater Manchester VCFSE Accord is an agreement between Greater Manchester's ten local authorities, Greater Manchester Combined Authority, NHS GM, and the Greater Manchester voluntary, community, faith, and social enterprise sector (VCFSE) represented by the Greater Manchester VCFSE Leadership Group.

The first Accord ran from 2021 to 2026. This Accord was included in the recent Civil Society Covenant as an example of successful and effective partnership working with civil society. In March 2026, we created a new Accord to run for 10 years. This aligns with the timeline of other key strategies, notably the Greater Manchester Strategy and NHS 10 Year Plan for England.

For NHS Greater Manchester, the Accord is not only a statement of partnership but a framework for how strategic commissioning should work differently. This means strengthening the role of communities and VCFSE organisations in shaping decisions and investment; resourcing and enabling the sector to play a fuller role in prevention, neighbourhood health and tackling inequalities; and recognising and valuing VCFSE expertise as equal to other forms of system leadership and intelligence.

This Accord sets out three priority 'areas of change':

- **Involve and Devolve:** We commit to shifting power closer to communities by involving the VCFSE sector and people with lived experience earlier and more consistently in decision -making.
- **Resource and Enable:** Public sector partners will commit to fair, transparent and long -term investment in VCFSE organisations and to increase the total proportion of public sector funding invested in VCFSE
- **Recognise and Value:** Recognise the range of roles VCFSE organisations can play, and use VCFSE evidence, insight and community leadership in shaping policy, commissioning and service design.

A key part of implementing the Accord will be to uphold principles of financial fairness, transparency, and shared accountability through, for example, the Greater Manchester Fair Funding Protocol and the NHS GM Commissioning Principles signed off by the Integrated Care Board in July 2025.

Social Value

ICB's act as social and economic anchor institutions, using commissioning to influence the wider determinants of health and deliver social value. Social value ensures that public spending achieves the best possible outcomes for the local population by delivering additional

social, economic and environmental benefits alongside the core service.

Under the Social Value Act (2012) and subsequent policy updates, a minimum 10% weighting for social value is mandatory. The Social Value Model and accompanying guidance ([Procurement Policy Note \(PPN\) 002](#)) sets out a menu of options from which in scope organisations can select the most appropriate outcomes and criteria.

It was updated in 2025 to align with the Government Missions which include growing the economy, an NHS fit for the future, safer streets, opportunity for all, and making Britain a clean energy superpower. It focuses on three domains:

- Economic (employment, apprenticeships, training, skills)
- Social (community cohesion, health equity)
- Environmental (carbon reduction and climate resilience)

