Minutes of the Meeting of the Greater Manchester Joint Health Scrutiny Committee held on 17 March 2026 at 10.00 am at Greater Manchester Combined Authority, Tootal Buildings, 56 Oxford Street, Manchester M1 6EU

Present:

Councillor Liz FitzGerald	Bury Council (Chair)
Councillor Colin McLaren	Oldham Council
Councillor Basil Curley	Manchester City Council
Councillor Pat Dale	Rochdale Council
Councillor Sanjita Patel	Tameside Council
Councillor Ifran Syed	Salford City Council
Councillor Ron Conway	Wigan Council

Officers in Attendance:

Leonard E Barr	Medical Director, Manchester Royal Infirmary
Sandy Bering	Strategic Lead Clinical Commissioner/ Consultant (Mental Health & Disabilities, NHS Greater Manchester (NHS GM)
Jacob Botham	Children & Young People Lead, GMCA
Claire Connor	Director of Communications and Engagement, NHS GM
Anna Cooper-Shepherd	Head of Strategy & Business for the Chief People Officer, NHS GM
Dan Gordon	Programme Director, Elective Recovery & Reform, NHS GM
Jenny Hollamby	Senior Governance and Scrutiny Officer, GMCA
Waseem Khan	ICB Head of Oversight & Governance
Melissa Maguiness	Programme Director, Commissioning Development, NHS GM
Diane Norburn	Special Education Needs & Disabilities (SEND) Project Manager, GMCA

Louise Rule	Associate Programme Director Transformation, NHS GM
Katherin Sheerin	ICB Executive Lead for Children & Young People and SEND
Claire Smith	Associate Director, Nursing & Quality, NHS GM
Louise Sinnott	Head of Placed Based Commissioning, NHS GM
Emma Storer	Senior Project Manager, Nursing & Quality, NHS GM

JHSC/71/26 Welcome & Apologies

Apologies for absence were received and noted from Councillors Pat Dale, Emma Hirst, Debbie Newall (Substitute), Ayyub Patel, and Joseph Turrell.

An apology was also received from Councillor Sean Fielding, Local Authority (LA) Integrated Care Board (ICB) Representative.

JHSC/72/26 Chair's Announcements and Urgent Business

It was noted that Members were provided with a Supplementary Agenda on 11 March 2026, which contained Item 6 – GM Cardiac Surgery and Arterial Vascular Surgery Services Review.

JHSC/73/26 Declarations of Interest

No declarations of interest were received.

JHSC/74/26 To approve the minutes dated 17 February 2026

Resolved/-

That the minutes of the meeting held on 17 February 2026 be approved as a correct record.

JHSC/75/26 Elective Care Update

Dan Gordon, Programme Director Elective Recovery & Reform, NHS GM presented a report that provided an update on the current position across GM, described the performance of the system in terms of data and trends, highlighted driving factors for current challenges and described the key components of the GM Elective Recovery Plan.

The Director drew out the following highlights:

- Referral to Treatment (RTT) performance had improved over the last year, with a significant reduction in long waits.
- GM's share of patients waiting over 65 weeks had reduced from around one in 25 nationally to around 30–40 patients, effectively eliminating the longest waits.
- Patients in GM were no longer more likely to wait over 52 weeks for elective care, representing a major improvement for patients.
- GM's rate of improvement was faster than the rest of England, even where overall RTT performance remained challenging.
- A medium-term plan was outlined to return to the 92% RTT standard by March 2029, requiring around a ten percentage-point improvement each year over the next three years.
- Progress would rely on increasing treatment capacity and transforming outpatient pathways, including single points of access, earlier clinical review of referrals and expanded community-based services, with roll-out across up to ten specialties.

The main points referred:

A Member queried whether recent reductions in waiting lists were partly due to patients leaving the NHS pathway, including going private or abroad. NHS GM did not hold specific data on patients travelling abroad or complete data on private treatment. During waiting-list validation, around 8–10% of patients typically came off lists for a range of reasons, with only around 1–2% estimated to opt for private care. It was emphasised that the primary driver of waiting-list reductions had been increased elective, outpatient and diagnostic activity, with referral rates remaining broadly stable.

A Member enquired how NHS GM planned to improve communication with patients and communities, noting that elective care improvements were not always well understood locally, and queried how changes to care pathways and patient expectations would be better explained. It was agreed that clearer and more consistent communication was needed. Outlined was ongoing work with primary care, trusts and local partners to share key messages more widely. Members were encouraged to help cascade information locally, while Officers highlighted existing campaigns and committed to strengthening communication to help patients better understand changes to elective care pathways and what those changes would mean in practice. The Director agreed to share locality information for Members to circulate.

A Member asked when the changes would be implemented. A pan-GM advice and guidance service was live, and that a single point of access for elective referrals would begin rollout from April/May 2026, with full coverage expected by October 2026. It was clarified that this applied to elective referrals only, with urgent and inpatient cases continuing to follow existing pathways.

In response to a question about the impact of the Federated Data Platform could have in helping to better balance demand and capacity across the system, it was reported that the platform was an NHS England initiative and it was too early to assess its full impact. The platform would bring hospital waiting-list data together to provide a system-wide view, helping to identify variation in waiting times between providers and support better use of capacity, including offering patients alternative locations where waiting times were shorter.

A Member noted that 18-week performance had been 52% at the same time last year and had increased to around 60%, towards a target of 61%. Some funding had been provided by NHS England, with the remainder supported through existing funding and transformation work.

A Member asked whether patients could be offered treatment outside GM where another provider had shorter waiting times. This could be considered in some circumstances, although overall capacity within GM was generally sufficient. Use of alternative providers, including the independent sector or providers outside GM, would depend on the specialty, procedure and available funding.

Resolved/-

1. That the Committee noted the improvement in reducing long waits in GM over the last 12 months, plans for improving access to elective care and how this would help reduce waiting times across GM over the next two to three years.
2. That the Committee considered how to better communicate with patients around the changes to elective care and management of expectations and Dan Gordon agreed to provide Members with further locality-level data to share.
3. That the Committee considered any practical solutions to support the left-shift, especially primary care integration with community-based models of elective care and the use of specialist advice in GP-patient interactions.

JHSC/76/26 Specialised Commissioning: Cardiac and Arterial Vascular Surgery

Members considered a report presented by Katherine Sheerin, ICB Chief Commissioning Officer, Louise Sinnott, Head of Place Based Commissioning, NHS GM, and Leonard E Barr, Medical Director, Manchester Royal Infirmary which set out NHS GM's case for change in relation to cardiac surgery and arterial vascular surgery services. It explained why the current arrangements were no longer considered sustainable, highlighted the clinical, workforce and patient-safety drivers for change, and outlined the proposed approach to centralising cardiac surgery and arterial vascular surgery. The presentation also summarised the proposed engagement, consultation and decision-making process, including the role of scrutiny and the key milestones leading to a final decision.

Officers drew Member's attention to:

- The services related to very rare and complex conditions and were planned for large populations, often exceeding one million people.
- These were highly specialised tertiary or quaternary services, requiring consultant-to-consultant referrals, specialist skills, equipment and clinical co-dependencies.

- Cardiac surgery and arterial vascular surgery were being considered in parallel due to shared workforce, infrastructure and site dependencies.
- National data showed a reduction in demand for arterial vascular surgery, alongside increasing patient complexity and the need for 24/7 specialist cover.
- Workforce shortages, particularly in specialist roles, required greater service resilience, centralisation and critical mass to support recruitment and sustainability. Vascular services were currently delivered through two arterial hubs, while cardiac surgery demand had increased but resilience challenges remained across two centres.
- The emerging case for change proposed greater centralisation to address variation, improve safety and ensured long-term sustainability, with further detail to be brought to the Committee in June 2026 ahead of planned public engagement and a subsequent ICB decision.
- That references to scrutiny in the next steps be amended to reflect the appropriate Joint Health Scrutiny Committee, rather than Overview and Scrutiny.

The main points referred:

A Member asked what engagement had taken place with staff and patients in developing the proposals. Both schemes were clinically led, with sustained engagement involving clinical networks across GM, and that staff had been involved throughout the option development process. patients and user groups had been engaged through focus groups, surveys and workshops, with lived experience informing the long-listing and short-listing of options. Officers provided further reassurance that extensive public engagement was being planned to inform the forthcoming consultation, with a detailed communications and engagement plan to be brought back to the Committee in June 2026.

A Member enquired how the proposals would support workforce retention given national shortages in specialist staff. It was reported that centralising services would provide greater workforce resilience, sustainable rotas and opportunities for sub-specialisation, research and training, making GM a more attractive place to work and supporting recruitment and retention across cardiac and vascular services.

In terms of recruiting highly specialised staff, a Member asked why recruitment appeared quicker in the private sector. It was reported that recruitment could take several months due to safety requirements, workforce rotation cycles and notice periods, but that improving retention through a resilient, attractive service model was key to strengthening recruitment and long-term workforce sustainability.

A Member asked whether the proposals would make GM attractive enough to recruit and retain highly skilled staff. Early indicators were positive, with interest in specialist roles increasing as service plans became clearer, particularly for hard-to-recruit specialties where centralisation would improve resilience, training and retention.

The Chair advised that June 2026 would be the Committee's first meeting of the new municipal year and noted the potential for a full agenda. Officers were therefore asked to liaise with the Governance and Scrutiny Officer in advance if they wished to bring an item to the June 2026 meeting, to support effective planning and scheduling.

Resolved/-

1. That the presentation be received and noted.
2. That the Committee noted the emerging case for change, and that further detail might be brought to the Committee in June 2026 (to be confirmed) ahead of planned public engagement and a subsequent ICB decision.

JHSC/77/26 NHS Greater Manchester Children and Young People's Mental Health Programme Update

Consideration was given to a report presented by Sandy Bering, Strategic Lead Clinical Commissioner/Consultant (Mental Health & Disabilities), NHS GM, which had been prepared at the request of the Committee to provide an update and assurance on the system-wide direction, priorities and progress of the Children and Young People's Mental Health Programme.

The following highlights were noted:

- Children and young people were experiencing increased stress and a broader range of needs, with greater understanding of mental health and neurodevelopmental issues.
- The distinction between mental health and mental illness was emphasised, alongside the need for continued investment.
- GM had increased investment over the past ten years, including strengthened crisis services, resulting in fewer children and young people being treated in hospital.
- Reducing out-of-area placements had enabled funding to be ring-fenced for mental health and shifted earlier into prevention and early intervention.
- Despite progress, demand continued to rise, particularly in relation to neurodevelopmental needs, which were not mental illnesses but required appropriate support.
- Unwarranted variation across GM was acknowledged, with work ongoing to improve consistency through a core service specification.
- Significant investment was being directed into Mental Health Support Teams in schools, reflecting what families had asked for.
- Key priorities included core services, specialist provision, neurodevelopmental pathways and crisis support, with targeted investment in priority groups and spreading expertise across GM.
- While progress was welcomed, there was still work to do, and that this represented progress rather than the end of the journey.

The main points referred:

A discussion took place about working with schools, particularly given the challenges of academisation, and whether this affected communication and delivery of support. Mental Health Support Teams and wider support would be applied across all education settings, including academies, independent schools, colleges and universities. Officers reported no resistance from schools and noted strong engagement, supported by a Mental Health and Education Board, with coverage spanning early years through to higher education. Ongoing alignment with wider reforms, including the Schools White Paper, was also highlighted.

A Member sought clarification on how to distinguish between anxiety, stress and mental illness, noting that these were often unclear to families and schools. It was explained that common mental health difficulties such as anxiety, stress and depression were widespread and often influenced by life circumstances, while severe mental illness had a clinical basis and required specialist treatment. Officers emphasised the importance of early support, understanding neurodiversity and avoiding unnecessary medicalisation, and it was agreed that clear, plain-English information should be cascaded to LAs, schools and partners to support consistent communication with families and communities.

Concerns about variation in mental health provision across LAs and the need for a more coordinated system-wide approach to make best use of available resources were raised. Improving coordination and understanding the starting position across the system was important, alongside addressing wider pressures impacting mental health.
A suggestion was made to consider a GM-wide discussion to support a more joined-up approach.

A Member raised concerns about variation in access to mental health appointments across localities and asked about coordination of engagement and communications.
Services should operate to national standards, that differences reflected historical investment decisions, and that close joint working was in place between clinical and communications teams, supported by dedicated communications capacity.

The Chair summarised that the update had been noted, including planned next steps and investment priorities, and welcomed confirmation that structural savings had been reinvested into children's services and prevention.

The Chair highlighted the importance of future updates focusing on outcomes and impact, noted concerns regarding reductions in LA and public health funding in some areas, and emphasised the value of more joined-up discussion across health, education and LAs, including consideration of joint scrutiny or governance sessions.

Resolved/-

1. That the Committee noted the update on the system-wide direction, priorities and planned developments for the Children and Young People's Mental Health Programme.
2. That Members acknowledged the planned next steps and investment priorities, including the use of structural savings to support children's services and prevention.
3. That future updates include a clearer focus on outcomes and impact across localities as system plans progressed.
4. That concerns regarding reductions in LA and public health funding be noted, and that opportunities for more joined-up discussion across health, education and LAs, including joint scrutiny or governance sessions, be explored.
5. That clear, plain-English information should be cascaded to LAs, schools and partners to support consistent communication with families and communities.

JHSC/78/26 NHS Greater Manchester Care Quality Commission (CQC) Inspections and Quality Oversight

The Chair introduced the item, presented by Claire Smith, Associate Director for Nursing & Quality, NHS GM, and Wasseem Khan, ICB Head of Oversight and Governance, as an overview of NHS GM Care Quality Commission (CQC) inspections and quality oversight. The report outlined NHS GM's quality oversight arrangements, how CQC intelligence informed local assurance processes, and summarised current ratings and recent inspection findings across providers and was noted as a baseline for potential future scrutiny.

Officers highlighted the following points:

- ICBs had a statutory duty to assure the quality and safety of the services commissioned, with a focus on population experience across GM.
- A Quality Assurance and Escalation Framework aligned to the National Quality Board's Single View of Quality, was in place, which continued to be developed with regional and national partners.

- CQC ratings were an important element of quality oversight but formed part of a wider intelligence set, including patient experience, complaints, compliments and partnership working with LAs and the voluntary sector.
- NHS GM held regular meetings with CQC inspectors to share intelligence, including early intelligence and whistleblowing information, supporting a shared system narrative.
- The scale and complexity of the provider landscape across GM, including NHS, independent, GP and dental providers, not all of which were directly commissioned by NHS GM was acknowledged.
- The report set out current CQC ratings alongside NHS Oversight Framework segmentation, and that further consideration of independent sector providers was suggested for future discussions.

The main points referred:

A Member asked what action was taken where services remained rated Requires Improvement or Inadequate, and when escalation would occur if improvement did not take place. Inadequate ratings triggered formal NHS England-led improvement arrangements, and that proactive oversight activity, including regular engagement with providers and early intervention, was used to address issues before further deterioration, with improvements often evidenced ahead of any change to published CQC ratings.

A Member asked how standards were monitored and maintained between CQC inspections to prevent deterioration. This was overseen through regular contract and quality review meetings, with formal governance and escalation in place where concerns arose.

A Member noted the high number of action plans associated with Requires Improvement ratings and raised concerns about ongoing workforce pressures and system capacity. It was asked how the system was managing these pressures while maintaining quality and avoiding the displacement of risk between providers. Commissioning and quality assurance arrangements were designed to minimise duplication and take a system-wide view, with oversight focused at trust level. The ICB’s strategic commissioning role

supported coordinated working across the system to balance pressures and target improvement activity.

A Member queried commissioning arrangements such as social care and asked how quality was overseen where responsibilities sat across different organisations. Commissioning arrangements varied and that collaborative working with partners at place level supported appropriate oversight and improvement across services.

While the presentation was helpful, it a Member asked whether a wider, more up-to-date picture could be provided. It was suggested that additional context on progress, timescales and recent improvement activity would support clearer understanding of current performance and direction of travel.

In response to a question about collaboration across trusts, it was reported that the ICB supported system-wide working through established quality and patient safety forums, using central governance to share learning and support improvement.

Resolved/-

1. That Members noted the current CQC ratings and recent inspection outcomes for GM Trusts.
2. That Officers share the wider narrative, including evidence of improvement activity, indicators of progress and examples of good practice, to support future scrutiny and be programmed into the Committee's work programme.

JHSC/79/26 Special Educational Needs and Disabilities (SEND)

The Committee considered a report presented by Jacob Botham, Children & Young People Lead, and Diane Norburn, SEND Project Manager, GMCA, Louise Rule, Associate Programme Director Transformation, and Emma Storer, Senior Project Manager – Nursing & Quality, NHS GM that provided an overview of the GM SEND position, including current governance and assurance arrangements, partnership networks and the Schools White Paper and SEND reforms.

The following highlights were noted:

- SEND was governed by the Children and Families Act 2014, supported by the SEND Code of Practice and underpinned by the Equality Act, with education as the primary focus.
- SEND applied to children and young people aged 0–25 with significant learning difficulty or disability affecting access to mainstream education.
- Support was delivered through a graduated approach, including inclusive provision, SEN support and Education, Health and Care Plans for those with complex needs.
- Local authorities held statutory responsibility for SEND planning and commissioning, with the NHS operating under a duty to cooperate.
- Governance operated through locality SEND partnerships and a GM-wide SEND partnership, supporting joined-up system leadership.
- National SEND and education reforms had been published and were subject to consultation, with a GM response in development.

The main points referred:

The Chair returned to an earlier point, asking whether current partnership structures were engaging the right groups and supporting effective outcomes. SEND partnership arrangements reflected a whole-system approach with appropriate stakeholder representation, and that current inspection feedback provided assurance that the right groups were engaged, while noting that forthcoming reforms would require further review of governance arrangements.

A Member asked whether Members could visit locality SEND partnerships or services to support scrutiny and understanding of current arrangements. Partner organisations would welcome Member engagement, and that visits to local SEND partnerships or services would be appropriate and beneficial given current inspection activity and system pressures.

Officers suggested that the Committee would benefit from a future update on the implementation of the Schools White Paper and SEND reforms, potentially through a joint session with Overview and Scrutiny.

Concerns were raised about families' experience of fragmentation within SEND services and emphasised the need to demonstrate measurable improvement in waiting times, assessments and support over time. Officers acknowledged the complexity of the system and highlighted existing improvement activity and whole-system engagement, noting that clearer, outcomes-focused updates would support future scrutiny.

Resolved/-

1. That the Committee received and noted the report.
2. That Members be supported to undertake visits or engagement activity with locality SEND partnerships or services, as appropriate, to inform future scrutiny.
3. That a future update on the implementation of the Schools White Paper and SEND reforms, potentially through a joint session with Overview and Scrutiny be considered.
4. That future SEND updates include a clear focus on outcomes and progress over time, including waiting times, assessments and support.

JHSC/80/26 Reconfiguration Progress Report and Forward Look

Claire Connor, Director of Communications and Engagement, NHS GM presented a report that set out the service reconfigurations planned or undertaking engagement and/or consultation. The report also included additional information on any engagement.

The main points referred:

Members were asked to support promotion of the current public engagement on shoulder pain and impingement procedures within their local areas.

A Member asked about ambulance handover experiences in Tameside, and it was reported that patient feedback on the 45-minute handover standard was informing wider review work.

A Member advised that they had invited representatives from Salford Royal to their local scrutiny committee and had gathered feedback from local residents and asked how this could be shared. It was agreed that the information should be sent directly to Claire Connor to inform the findings.

Resolved/-

1. That the Committee received and noted the report.
2. That Members support the promotion of the current public engagement on shoulder pain and impingement procedures within their local areas and Claire Connor share the relevant website link.

JHSC/81/26 Work Programme for the 2025/26 Municipal Year and Draft Work Programme for the 2026/27 Municipal Year

Resolved/-

1. That the Committee noted the Draft Work Programme 2026/27.
2. That Members noted the reports to be considered at the June 2026 Annual Meeting.
3. It was agreed that Members and Officers take part in an online poll to help determine agenda item preferences ahead of an April 2026 planning session focused on population health data and inequalities as requested by the Chair at the last meeting.
4. That the Committee agreed that the Annual Meeting in June 2026 would commence with a 30-minute Induction session at 9.30 am in person prior to the meeting, including the VCSFE sector.
5. That CQC assessments for adult social care be added to the Work Programme.

JHSC/82/26 Date and Time of Next Meeting

It was noted that a schedule of meetings was being developed for the 2026/27 Municipal Year.