GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Joint Health Scrutiny Committee

Date: 16 June 2026

Subject: Preparedness Post Winter (Outcomes and Lessons Learned)

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Purpose of Report

The purpose of this report is to provide the Joint Health Scrutiny Committee with an overview of system performance, delivery and learning from Winter 2025/26 across Greater Manchester.

The report draws on NHS provider and locality assessments, alongside programme-level insight and System Coordination Centre intelligence. It highlights key areas of effective delivery, identifies operational challenges and variation, and sets out the learning to inform planning for Winter 2026/27 and to support the continued delivery of the Greater Manchester Urgent and Emergency Care (UEC) Reform Programme.

Recommendations:

The Joint Health Scrutiny Committee is requested to:

1. Note the overall system performance and resilience demonstrated during Winter 2025/26.
2. Note the key challenges and areas of variation identified across localities.
3. Support the proposed strategic priorities to strengthen system flow, standardisation and operational coordination.
4. Endorse the transition of winter planning into a strategic commissioning framework for 2026/27, aligned to UEC Reform.

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Equalities Impact, Carbon and Sustainability Assessment:

Winter delivery demonstrated increasing alignment with population health approaches through community and preventative models, including neighbourhood-based services and falls prevention, supporting improved access and outcomes.

Variations in delivery across localities highlight a potential risk of inequity in access to services, reinforcing the need for greater standardisation in future planning.

Risk Management

Key risks identified include workforce constraints, reliance on non-recurrent funding and variation in delivery across localities. Additional risks relate to data quality limitations and the effectiveness of escalation processes in supporting system intervention.

Legal Considerations

There are no specific legal implications arising directly from this report. However, delivery of winter services continues to operate within existing statutory responsibilities across NHS and local authority partners.

Financial Consequences – Revenue

Winter delivery was supported in part by non-recurrent funding, creating a risk to the sustainability of high-impact interventions without longer-term financial certainty.

Financial Consequences – Capital

There are no direct capital implications arising from this report.

1. Introduction/Background

1.1. Winter 2025/26 demonstrated a resilient and well-coordinated system response, supported by strong partnership working, clear governance arrangements, and multi-agency engagement across health and social care partners. Delivery was underpinned by embedded winter planning at locality level and supported by strong partnership working across primary care, mental health, community services, adult social care, and the vaccination programmes.

1.2. This was delivered in the context of sustained system pressure, including high emergency demand, constrained discharge capacity and workforce challenges, consistent with the wider Greater Manchester UEC position.

1.3. Despite these pressures, the system-maintained stability through expansion of community-based alternatives, strengthened discharge arrangements, and improved real-time system visibility through the system coordination function. At place level, this was experienced as a shift towards more proactive and coordinated flow management, supported by earlier mobilisation of community capacity and increasing confidence in alternative pathways.

1.4. Importantly, Winter 2025/26 was delivered within the previous ICB operating model, characterised by a strong emphasis on system coordination, programme oversight and partnership-based delivery. The learning from this period provides an important foundation as the system continues to evolve its approach to commissioning and delivery.

1.5. Under this future model, NHS Greater Manchester ICB will increasingly focus on:

- Setting clear system outcomes and priorities
- Allocating resources based on population need and value
- Standardising service models across Greater Manchester
- Strengthening provider and partner accountability for delivery
- This transition sits alongside evolving national arrangements, with DHSC setting strategic and financial direction, and a reduced operational role for NHS England, requiring systems to operate with greater autonomy and accountability.

2. Key Areas of Delivery

2.1. Demand Management and Flow

2.1.1. Same Day Emergency Care, primary care streaming, Single Points of Access, and community-based alternatives were consistently implemented across localities and widely recognised as contributing to reduced pressure on acute services.

2.1.2. Services such as Urgent Community Response, Hospital at Home, and falls response services demonstrated clear value in admission avoidance and supporting care at home, with several now embedded as business-as-usual services rather than winter-specific interventions. There is clear shift towards proactive use of community pathways.

2.1.3. However, variation in design and implementation across localities limited the consistency of impact. For 2026/27, this creates a clear opportunity to standardise commissioning models and service specifications across Greater Manchester to reduce unwarranted variation.

2.2. Discharge and System Flow

2.2.1. Discharge remained the primary enabler of system performance, consistently identified by providers and localities as the key driver of resilience and improved flow. Strong collaboration with adult social care supported timely discharge, particularly for patients with complex needs.

2.2.2. System delivery included discharge-to-assess models, Integrated Model of Care approaches, repatriation processes, and targeted work on long length of stay cohorts, supported by improvement approaches such as MaDE and Perfect Week.

However, variation in implementation of Home First, Trusted Assessor and access to community capacity limited consistency, and reliance on spot purchasing constrained system-wide benefit. This reflects the need under the future model for consistent commissioning frameworks and embedded discharge standards across the system.

2.3. Community and Preventative Services

2.3.1. Community services were a core system strength, with Urgent Community Response embedded across Single Points of Access and delivering consistently against expected standards.

2.3.2. Preventative approaches, including falls prevention, Hospital at Home, and neighbourhood-based models aligned to Marmot principles, supported reduced demand and improved population health outcomes.

2.3.3. Early mobilisation of these services was identified as critical, reinforcing the need to position community and preventative capacity as year-round system infrastructure rather than seasonal response.

2.3.4. Learning for 2026/27 is the need to commission these services as core, year-round infrastructure rather than seasonal interventions, with consistent access and standards across GM.

2.4. Primary Care

2.4.1. Primary care surge capacity supported system resilience through additional appointments and improved access.

2.4.2. However, delivery varied significantly across localities due to differences in commissioning and reporting arrangements under the existing operating model, limiting the ability to assess impact consistently.

2.4.3. Transition to the new model will require greater consistency in commissioning approaches, clearer outcome measures, and stronger system-level oversight.

2.5. Mental Health

2.5.1. The NHS 111 First Response Service improved access to crisis support and represented a significant step forward.

2.5.2. However, wider crisis alternatives were only partially delivered due to funding and mobilisation constraints.

2.5.3. This also reflects limitations in commissioning clarity and alignment, highlighting the need for more consistent and integrated commissioning of mental health crisis pathways within UEC.

2.6. System Coordination

2.6.1. System coordination arrangements, including the System Coordination Centre (SCC), provided improved real-time visibility of system demand, capacity and flow, enabling a more proactive and coordinated response than in previous winters.

2.6.2. Compared to Winter 2024/25, the system demonstrated improved management of escalation, with fewer instances requiring the highest levels of escalation (including OPEL 4 and Business Critical incidents), reflecting a more mature and collaborative system response.

2.6.3. Escalation processes were more consistently understood across partners, with increasing confidence in system-led actions to mitigate pressure. Whilst there remains variation in the timeliness and consistency of escalation triggers, overall, the system demonstrated stronger alignment in responding to periods of pressure.

2.6.4. This reflects the benefits of strengthened partnership working, clearer system oversight and improved situational awareness. As the system transitions, there is an opportunity to further embed consistent escalation thresholds and ensure responses are increasingly focused on delivering timely operational intervention alongside assurance.

2.6.5. This reflects the characteristics of the previous operating model, where the ICB played a significant role in coordination.

2.6.6. As the system transitions, there is a need to move towards provider-led operational delivery, with the ICB focusing on assurance, insight and strategic intervention rather than direct coordination.

3. UEC Performance

3.1. At the start of the winter period, system performance was already under sustained pressure. In October 2025, Type 1 four-hour performance stood at 68.9%, below the planned trajectory of 72.8% for October 2025. This represented a modest improvement from October 2024 (66.5% against a 72.9% plan), indicating incremental progress in baseline performance entering Winter 2025/26, albeit still below both operational plans and constitutional expectations.

3.2. By the end of each respective winter period, further improvements were observed. In March 2026, four-hour performance reached 74.1%, compared to 71.2% in March 2025. Whilst both remain below the 78% national standard, the 2025/26 trajectory demonstrates a stronger rate of improvement across the winter period, alongside a narrower gap to plan (74.1% vs 78.0%) than in the prior year.

3.3. Twelve-hour waits remained a key indicator of system pressure. At the start of Winter 2025/26, waits stood at 10,268 in October 2025, an improvement on October 2024 (11,418), reducing further to 7,898 by March 2026 compared to 8,623 in March 2025. Although still above the system ambition to eliminate long waits, this represents a year-on-year reduction in both starting position and end-of-winter levels, alongside improved management of peak pressures.

3.4. Emergency department attendances totalled 127,590 in October 2025, increasing from 109,020 earlier in the year and confirming continued growth in underlying demand entering winter. Bed occupancy was recorded at 91.7%, within the acceptable operational threshold (≤92%) but with limited headroom to accommodate surges, reinforcing the system's exposure to flow constraints.

3.5 Ambulance handover performance also demonstrated measurable improvement. Average handover times reduced from 25 minutes 35 seconds in October 2024 to 22 minutes 27 seconds in October 2025, and further to 20 minutes 54 seconds by March 2026 (compared to 23 minutes 34 seconds in March 2025). Peak escalation pressures were also better contained, reducing from a peak of 30 minutes 50 seconds in December 2024 to 26 minutes in January 2026, indicating improved operational grip and responsiveness during periods of highest demand.

3.6 Non-Criteria to Reside (NCTR) levels remained a persistent system pressure across both winter periods, with performance broadly stable year-on-year but above optimal levels. In October 2024, NCTR was recorded at 837 patients, representing 15.0% of adult G&A beds, increasing to 920 (16.8%) by March 2025, reflecting a deterioration across the winter period.

3.7 In comparison, Winter 2025/26 demonstrated improved stability in NCTR levels. The starting position in October 2025 was 860 patients (15.8% of adult G&A beds), slightly higher than the previous year; however, by March 2026 this reduced marginally to 839 (15.9%), indicating that the system was able to prevent further escalation despite sustained demand pressures.

3.8 Across the winter period, performance remained below constitutional standards; however, system intelligence and provider feedback consistently indicate that Winter 2025/26 delivery was more stable than the previous year. This is evidenced by reduced volatility in key metrics, improved trajectories across the winter period, and stronger control of escalation. In particular:

- Four-hour performance remained below target but improved more consistently across the winter period, reflecting strengthened system flow and coordination.
- Twelve-hour waits, whilst still a significant challenge, reduced year-on-year and were better managed during peak pressure periods.
- Ambulance handover delays remained under pressure, in line with national trends; however, sustained reductions in average and peak delays demonstrate improved system responsiveness.
- Whilst NCTR levels remained above the level required to support optimal patient flow, the relative stability observed during Winter 2025/26compared to the increase seen in Winter 2024/25 suggests improved management of discharge pathways and system flow. This indicates stronger system grip on length of stay and discharge processes, contributing to the broader stabilisation seen across urgent and emergency care performance metrics.

Overall, these indicators point to a system that, while still operating above optimal levels of pressure, is increasingly able to manage sustained demand and mitigate the most severe impacts of winter.

4 Key Challenges

4.5 Many challenges observed during Winter 2025/26 reflect constraints within the previous operating model, including:

- Variation in commissioning approaches across localities
- Limited ability to enforce consistent system-wide standards
- Reliance on non-recurrent funding
- Blurred accountability between commissioner and provider roles
- Heavy reliance on coordination and escalation rather than commissioning levers
- Data and digital limitations affecting system intelligence

5 Strategic Insights

5.5 Winter resilience is increasingly delivered through year-round, embedded services, with many interventions now fully integrated into business-as-usual delivery.

5.6 Discharge and flow remain the primary drivers of system performance, supported by strong integration with adult social care and community capacity

5.7 Variation across localities remains a key barrier to consistent improvement and system-wide impact.

5.8 These insights provide a clear evidence base for the transition 2026/27 to a strategic commissioning model, where success will depend on:

- Clear commissioning intent and outcomes
- Standardised service models
- Stronger financial and contractual levers
- Clear accountability for delivery

6 Recommendations for Future Planning

6.5 Strengthen discharge processes and system flow

6.6 Improve consistency of escalation and operational response

6.7 Enhance data quality and system intelligence

6.8 Embed successful winter interventions into core delivery

7 Conclusion

7.5 Winter 2025/26 demonstrated a strong and resilient system response, supported by partnership working and increasingly mature models of care.

7.6 However, sustaining and accelerating improvement will require a shift in how the system operates, as the ICB transitions to its role as a strategic commissioner within a changing national framework.

7.7 This transition provides a clear opportunity to embed winter resilience within a longer-term programme of Urgent and Emergency Care reform, ensuring consistent, equitable, and sustainable service delivery across Greater Manchester.