Agenda

Greater Manchester People & Resource Committee (Public)

Date: 22 April 2026

Time: 14:00pm to 16:00pm

Venue: Teddy Webb Room, Manchester Deaf Centre

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:00	5 mins	Welcome, Introductions and purpose of first meeting	Verbal	Information	Kal Kay *Chair*
2.			Declarations of Interest	Paper	Noting	
3.			Minutes from Finance Sub-Committee meeting held on 25 March 2026	Paper	Approval	
Strategic Updates						
4.	14:05	15 mins	Terms of Reference – Update & Next Steps	Paper	Information / Discussion	Kal Kay *Chair*
5.	14:20	15 mins	Sub Groups & Draft Workplan – Introductory Discussion	Verbal	Discussion	Kal Kay *Chair*
6.	14:35	15 mins	Risk Report	Paper	Information	Nicola Hepburn, *Acting Chief Reform and Improvement Officer*
7.	14:50	30 mins	Chief Officers Update Reports	Paper	Discussion	Charlotte Bailey, *Chief Strategy, People and Partnerships Officer /* Nicola Hepburn *Acting Chief Reform and Improvement Officer /* Kathy Roe *Chief Finance Officer*
8.	15:20	15 mins	Finance Report – Month 12	Paper	Discussion	Kathy Roe *Chief Finance Officer*
9.	15:35	15 mins	NHS GM Financial Scheme of Delegation Amendments	Paper	Discussion	Kathy Roe *Chief Finance Officer*
For Information						
10.	15:50	0 mins	Performance Report	Paper	For Information	N/A
11.	15:50	10 mins	Any other business Board Paper Escalations	Verbal	Discussion / Noting	All

			Meeting Reflections			
Date and time of next meeting: **Wednesday 27 May 2026, 14:00pm – 16:00pm** **MS Teams**						

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To
Bailey, Ms. Charlotte Elizabeth	Y			Nil			
Kumar, Dr Manisha	Y	Financial Interest	Outside employment	Salaried GP at the Robert Darbishire Practice - 1 session per week		2004	Ongoing
Kumar, Dr Manisha	Y	Non-financial professional interest	Loyalty interests	Honorary Professor University of Salford		01/05/2023	Ongoing
Kumar, Dr Manisha	Y	Non-financial personal interest	Loyalty interests	Husband has the following roles: • Operations Director - Primary Eye Care Services LTD • Case Examiner – General Optical Council		2021 2019	Ongoing
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son works in the finance department at Tameside and Glossop NHS Foundation Trust.		14/10/2024	Ongoing
Hepburn, Mrs. Nicola	Y	Financial interests	Clinical private practice	From 29 April 2025 I have been an associate clinical nurse assessor for MHS clinical services. MHS often complete work for MIAA. I do not complete any work on behalf of MHS across Greater Manchester or work commissioned by NHS GM. I complete all work via my own personal company outside of my contracted substantive role.		29/04/2025	Ongoing
Hepburn, Mrs. Nicola	Y	Non-financial professional interest	Outside employment	I am a volunteer Clinical Board Advisor for Now Your Talking a talking based National therapy service.		07/10/2025	Ongoing
Scales, Mr. Colin	Y	I have no interests to declare		Honorary Professor at UCLan		2024	
Scales, Mr. Colin	Y	Indirect interests	Outside employment	Wife works at NCA as a nurse		19/09/2024	Ongoing
Sheerin, Mrs. Katherine Mary (Katherine)	Y	Non-financial professional interest	Loyalty interests	Trustee and Deputy Chair of the Board of the The Whitechapel Centre, a charity which works to prevent homelessness and support people who are homeless, operating across the Liverpool City Region.	This is a voluntary role with no remuneration or expenses paid.	01/01/2025	Ongoing
Non-Executive Directors	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**Col Date From**	**Col Date To**
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Outside employment	Interim FD Derian House Childrens Hospice			
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Shareholdings and other ownership interests	Director and Shareholder of GSD Financial Consulting Ltd	Set up my own consultancy firm		
Kay, Mrs. Khalida (Kal)	Y	Non-financial personal interests	Outside employment	Great Academies Education Trust	Trustee (non remunerated)		
Kay, Mrs. Khalida (Kal)	Y	Non-financial professional interest	Shareholdings and other ownership interests	Association of Camerados	Non Exec, non remunerated director		
Paver, Mr. Richard	Y	I have no interests to declare					
Njoroge, Jackie	Y	Financial professional interest	Outside employment	Chief Strategy & Data Officer University of Salford		2016	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	First Choice Homes Oldham (FCHO) Independent Non Exec		2025	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	GMCA Independent Audit Committee member		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Transforming Access & Student Outcome (TASO) Trustee		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Deputy Chair Higher Education Strategic Planning Association (HESPA)		2015	
Partner Members	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**Col Date From**	**Col Date To**
Williams, Dr Owen	Y	Non-financial professional interest	Loyalty interests	Co-Chair of the Chairs and CEO NHS Ethnic Minority Network		2021	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Loyalty interests	Acute Partner Member of the NHS Greater Manchester Integrated Care Board (ICB)		2022	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Loyalty interests	Chair - Yorkshire and Hmber PSRC Strategic Advisory Board		Jan-24	Ongoing
Williams, Dr Owen	Y	Financial interests	Loyalty interests	Chief Executive Officer – Northern Care Alliance NHS Foundation Trust		Nov-21	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Chief Medical Officer for Health Innovation Manchester	Ongoing	Dec-25	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Clinical Director, Gorton and Levenshulme Primary Care Network	Ongoing	Apr-19	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Executive Committee Member, Manchester Local medical Committee	Ongoing	Jan-26	Ongoing
Mehra, Dr Vishal	Y	Financial interests	Outside employment	Salaried GP, West Point Medical Centre	Ongoing	Apr-23	Ongoing

Minutes

NHS Greater Manchester Finance Sub-Committee – Public Meeting

Date: Wednesday 25 March 2026

Time: 14:00 – 16:00

Venue: Microsoft Teams

MEMBERS:		
Kal Kay	KK	Non-Executive Director, Finance Committee Chair
Kathy Roe	KR	Chief Finance Officer
Katherine Sheerin	KS	Chief Officer for Commissioning
Kenny Li	KL	Chief Pharmacist (deputising for MK)
IN ATTENDANCE:		
Stephen Downs	SD	Deputy Chief Finance Officer
Nicola Hepburn	NH	Acting
Jackie Gardiner	JG	Corporate Director of Operational Finance – Financial Management
Sam Evans	SE	Corporate Director of Finance – Commissioning & Financial Assurance
Gill Rowlands	GR	
Tori Quinn	TQ	
Ross Baxter	RB	Governance Advisor (Minutes)
APOLOGIES:		
Rachel Egan	RE	Non-Executive Director
Colin Scales	CS	Acting Chief Executive Officer
Manisha Kumar	MK	Chief Medical Officer
Vish Mehra	VM	GP/Partner Member

Item No	Item
	PUBLIC
1.	**Introductions and Apologies** KK welcomed everyone to the meeting and the apologies were noted. It was noted that the meeting was not quorate, and agreed that the meeting would progress as planned, with sign off and ratification of the February 2026 and March 2026 meeting decisions confirmed with CS following the meeting. **Attendance Matrix** The Attendance Matrix was shared for information.
2.	**Declarations of Interest** There were no declarations or conflicts of interest declared at the meeting. The Finance Sub-Committee Conflict of Interest Register was shared for information.

3.	**Minutes of the Last Meeting** The minutes of the last Finance Sub-Committee meetings were approved as an accurate record.
4.	**Action Log** There were no actions to be noted.
5.	**Advice & Guidance – Consultant Connect** This item was presented, with confirmation given that it had progressed through all required governance steps and had been discussed with Chief Officers earlier that morning, who were supportive of it. The request presented was for approval of a £1.65m cost, £0.65m higher than originally budgeted. It was explained that the additional pressure would not be added to the formal pressures list, and instead any slippage would be used to offset it, and the shortfall would be incorporated into the wider Cost Improvement Plan. A six-month review had been built in to ensure the programme stays within budget and to assess utilisation, which was currently not as strong as required to justify longer-term continuation. The review would inform decisions for the following year. **NHS GM Finance Sub-Committee approved the spend post-STAR process per the NHS GM Financial Scheme of Delegation.**
6.	**NHS 111** This item was presented, and it was confirmed that this was the same paper presented to all three ICBs and had been produced by the Regional Commissioner. The proposal involved an 18-month contract extension, largely to allow time for a full review of NHS 111 and associated Patient Transport Services, with the extension enabling the forthcoming PSR process to be followed appropriately. Members queried whether repeated extensions created procurement risks, and it was confirmed that previous challenges had delayed the full review and that this 18-month period was necessary to complete it. The Committee was given assurance that Lancashire, as lead commissioner, had provided assurance that the extension was compliant and low-risk, and that concerns raised by Greater Manchester had been acknowledged. The extension cannot go beyond 18 months, and it would be reported back if issues arose. Clarification was requested on whether the contract extension maintained current pricing despite provider-reported pressures, and it was confirmed that the extension holds pricing at current levels and does not incorporate additional provider pressure requests. **NHS GM Finance Sub-Committee;** • **Approved an urgent modification to the existing NHS 111 contract with NWAS for 18 months from April 2026** • **Approved migration of NWAS to the Integrated Urgent Care (IUC) national specification (not considered a significant contract change).**

7.	**HInM Pass Through Allocation** This item was presented, explaining that the accompanying Memorandum of Understanding had been circulated separately for information. The item concerned the pass-through of funding allocations received directly from NHS England, comprising two allocations: one of just over £2 million for innovation and life sciences, and another life sciences allocation issued in two parts. It was noted that the paper outlined in full how these monies would be deployed. As this was pass-through funding, the ICB simply transfers the allocations onward to Health Innovation Manchester, which is hosted by Manchester University NHS Foundation Trust. The proposal was described as straightforward and requiring formal approval. **NHS GM Finance Sub-Committee approved the three pass-through allocations from 2025/26 to Health Innovation Manchester totalling £4.6m.**
8.	**Salford CVS** This item was presented, outlining Salford's long-standing, well-evaluated relationship with Salford CVS and noting that the third sector fund has operated for over a decade and consistently shown value for money and return on investment. The service level agreement (SLA) covers multiple components: the Wellbeing Matters social prescribing programme delivered with Salford PCNs; the VCSE sector development work designed to maintain a healthy local voluntary sector; the Living Well mental health social prescriber interface role; and the VCSE Voices Matter model, which brings community insight into GM-wide and Salford-level discussions. It was emphasised that the proposed five-year term would offer stability, enable longer-term planning, reduce annual administrative burdens, and support staff recruitment and retention. Committee members discussed wider commissioning principles, with it being highlighted that this proposal pre-dated a new ICB position limiting contracts to 12 months during budget realignment, but agreed the timing meant this case had legitimately progressed. Members reflected on the balance between providing stability for the VCSE sector and ensuring the ICB has clear commissioning intentions, noting the need for coherent future planning, quality checks, and safeguards. It was added that the ICB's cost improvement programme includes work to consolidate multiple legacy contracts to strengthen outcomes and provide better long-term arrangements. **NHS GM Finance Sub-Committee approved a 5 year agreement (spanning 01/04/2026-31/03/2031) between NHS GM and Salford CVS for the delivery/management of a SLA which includes the Third Sector Fund £1m grants programme, VCSE Voices Matter, the Wellbeing Matters Social Prescribing Programme and a Living Well Coordinator.**
9.	**Outstanding Contracts Retrospective SORD Approval** This item was presented, acknowledging that this required retrospective approval and that the accompanying Chief Officer paper had not been fully adapted to make explicit

	what was being asked of the Finance Sub-Committee. It was explained that, as with the previous year, several contracts had not completed the full governance process in time, leaving the organisation in a position where approvals were needed retrospectively to ensure year-end compliance and audit assurance. Contracts valued under £5 million had already been approved by Chief Officers under delegated authority, but three contracts (Marie Stopes (£5.7m), Pennine MSK (£9.5m), and Specsavers Adult Hearing (£7.2m)) required approval from this Committee. It was confirmed that remaining governance checks, including STAR procurement and PSR requirements, would be completed in a batch and any breaches would be reported to the Audit Committee. The discussion focussed on the underlying structural issues with planned upcoming work to ensure every contract has a clearly assigned commissioning lead outlined, addressing longstanding ambiguity between locality and central roles. It was also noted that the new operating model would consolidate finance and contracting functions, ensuring dedicated finance and contracting leads for each agreement and helping prevent recurrence of similar delays. There was additionally a positive update from the DII team about developing improved contract reporting packs linking performance, outcomes, and financial data, which would be transformative for future governance and reduce rollover-driven risks. **NHS GM Finance Sub-Committee** • **Noted the unsigned contract position for 2025/26** • **Approved retrospectively, under the SoRD, the 3 contracts highlighted in red in Appendix A, which are above COs approval limit, namely Marie Stopes, Pennine MSK and SpecSavers.** • **Noted that retrospective STAR approval will be sought at scale where required to satisfy internal governance requirements.** • **Noted that the governance breaches will be reported, with remedial actions, to the Audit Committee.** • **Noted that approval is sought at this point in the year to enable the timely close-down of 2025/26, provide clarity for audit and year-end processes, and allow commissioning and contracting capacity to be redirected toward early and more proactive planning for 2026/27.**
10.	**Distribution of 2026/27 Pay Award Allocation** This item was presented as a straightforward item centred on the distribution of funding provided to the ICB to enable providers to implement the national Agenda for Change pay uplift. It was confirmed that the allocation received must be passed through to providers so they can apply the uplift to their staff, with the ICB retaining only the element necessary to fund its own internal pay award. This paper covered only the Agenda for Change uplift and further adjustments would follow once pay awards for other staff groups, typically including medical staff, are finalised, which often occurs later in the year. **NHS GM Finance Sub-Committee** • **Noted that NHS GM will receive a £51.1m allocation for 2026/27 AfC pay awards** • **Approved the proposed distribution of the GM NHS provider allocation in Table 3 and Appendix 1, noting that NHSE describes its guidance as**

	indicative. It is proposed that payments on account would then be agreed with NHS providers as necessary.
11.	**Risk Register** This report provided an update to the committee on the key significant risks identified for 2025/26, including the BAF risks and the risks relevant to this committee. Any changes to the risks were highlighted within the paper, with no new risks identified or any risks de-escalated. It was noted that the senior finance team had debated whether the current financial risk score should be reduced to 12 but it was agreed to retain the existing score until month-12 accounts were delivered, reflecting caution given ongoing year-end activity. Members acknowledged that recent improvements had reduced the risk somewhat but agreed that formal assurance was still required. It was highlighted that the likelihood of failing to meet the year-end position was diminishing, however lowering the score now would likely require it to be raised again on 1 April, as the underlying financial sustainability challenge for 2026/27 remains significant. This led to a broader discussion about whether the risk should reflect the ICB's position, the ICS system position, or both. The framing for future years was queried, recalling previous debates about responsibility for system-level outturn. It was clarified that the current performance framework assesses the system as a whole, but from 1 April the ICB will be judged on its own financial position, even though it will continue to support NHS England in resolving issues in struggling providers. Members reflected on the nuance between system accountability and direct ICB control of risk, with it noted that including risks the ICB cannot materially mitigate generates unhelpful, unmanageable risks. Members also stressed the need for narrative clarity so that future committees understand why risks are framed as they are. It was concluded that for 2026/27 the team will bring forward a clear ICB-specific financial risk, alongside a potential supplementary, softer system-related risk for discussion. **NHS GM Finance Sub-Committee:** • **Confirmed the updated BAF risks scores and assurance assessments as an accurate reflection of the current position** • **Confirmed the updated Committee risks scores and assurance assessments as an accurate reflection of the current position.**
12.	**GM Month 11 Financial Position** This report provided an update to the committee on the financial position for Greater Manchester as at 28 February 2026, with emerging context relevant to year-end also provided. It was reported that NHS GM continued to show a deficit against plan, with providers collectively reporting a £56.1m deficit, £27.4m worse than planned, though their run-rate was improving. System gross risk had reduced significantly, by £57.1m, indicating better confidence in the position as year-end approached. Key pressures remained, including under-delivery of provider CIPs, pressures in mental health linked to ADHD, autism and Section 117, continuing care cost pressures, and increased over-performance in independent sector activity. However, underspends in other areas and central slippage on allocations were helping to offset these pressures. It was confirmed NHS GM was forecasting delivery of its control total of a £7.5m deficit, and providers were collectively predicting a £10m surplus, £2.5m better than plan, driven largely by improvements at The Christie.

	A major development was the confirmation of an additional £21.3m DSF allocation for the system, dependent on all providers delivering year-end balance and agreeing balanced 2026/27 plans. This funding would be passed directly to providers to improve their bottom line and result in the system reporting an overall surplus of £23.8m against plan. It was clarified that the allocation was both revenue and cash, though the timing of the notification had created confusion. Further clarification was given, explaining that NHS England was redistributing unallocated DSF nationally and that providers must formally accept conditions before funds could flow. Because the allocation would likely arrive after the final March payment run, the ICB would need to record debtor/creditor entries at year end. It was noted that there had been a mismatch between this update and an update at Audit Committee due to the timing, as the DSF element had not yet been communicated, and it was agreed that a short briefing would be sent to the Chair of Audit Committee to resolve this. Remaining system risks were outlined and confirmation was given that the NHS GM element had reduced sharply because risks had crystallised into the position and been offset by underspends and slippage. Provider CIP remained the dominant residual risk, though all organisations had confirmed they would deliver by year end. Updates were also provided on agency spend, capital performance, MHIS targets, and cash management, noting that despite some provider-level concerns, additional cash allocated in Month 11 and drawn down in Month 12 had stabilised the position. It was emphasised that although pressures remained, the system was now confident of landing both the ICB and provider positions and delivering a significantly improved overall year-end outturn. **For the System Financial Position, NHS GM Finance Sub-Committee:** • **Noted the Month 11 year to date reported financial position for GM ICS of £63.0m deficit, against a planned deficit of £35.5m, resulting in a variance against plan of a £27.4m deficit.** • **Noted the in-month deterioration in the deficit position, however an improvement in the extrapolated run rate for the GM providers of £22.2m, a reduction in reported gross risk of £57.1m, a further reduction in net risk of £3.2m for NHS GM as a result of the on-going delivery of recovery plans.** • **Noted that whilst there has been an adverse performance against the in-month recovery plan for providers, all trusts have confirmed directly with NHSE they will deliver the plan and manage any remaining financial risk.** • **Noted the £2.5m surplus forecast outturn position.** • **Noted the year-to-date delivery of CIP as at Month 11 of £556.7m against a plan of £573.7m, an under delivery of £17.1m. (note rounding impact as the value is £0.065m which rounds to £0.1m)** • **Noted the forecast capital position is expected to deliver in line with allocation.** • **Noted the risk to the system wide cash position which continues to be closely monitored.** • **Noted that full DSF has been received, but there remains a risk that this is subject to clawback if a balanced position for the system is not delivered.** • **Noted the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP**

	delivery and monitor delivery of recovery plans to mitigate reported pressures. **For the NHS GM Financial position, NHS GM Finance Sub-Committee:** • **Noted the YTD position of £6.9m deficit, which is in line with the plan.** • **Noted the forecast outturn position of £7.5m deficit (after the technical adjustment, in line with the allocation of the Deficit Support Funding).** • **Noted the reduction in the gross reported risk of £49.1m, and the improved extrapolated forecast run rate.** • **Noted the key adverse variances in the position: ADHD/Autism, acute, all age continuing health care, and IS elective activity, and that associated Finance Recovery Plans are in place to reduce YTD and emerging pressures.** • **Noted the achievement on running costs both YTD and FOT.**
13.	**Medicines Horizon Scan Paper** This item was presented and an explanation given that two complementary papers had been produced, one outlining financial pressures and the other identifying opportunities, and that they should be read together to inform the medicines budget for the coming year. It was highlighted that 2025/26 had been a strong year, with the system expected to land close to balance and deliver around £40m in cash-releasing savings (rising to £60m when cost-avoidance is included), a level of performance not previously achieved in Greater Manchester. It was cautioned, however, that forecasting for 2026/27 remained extremely challenging due to delays in receiving complete data from providers. It was noted that GM's growth in prescribing cost and volume was lower than the national average but overall spend per head remained high due to population complexity. Members' attention was drawn to the pressure table in the paper, which breaks down baseline growth, tariff changes, patent expiries, and recognised risks, most notably NICE guideline NG28 on diabetes, which alone could create a pressure of at least £36m and potentially far higher. It was stressed that there was not an ask for that amount to be budgeted, recognising its impracticality, but emphasised that the ICB would need to create headroom and continue lobbying the national team. Based on the horizon scan and expected efficiency delivery, the assessment was that the medicines budget needed to increase to £605.9m, representing 4.3% growth, compared with national planning guidance allowing only 0.1% growth. It was explained that the team currently held £21m of identified CIP, with a risk-adjusted value of £16m, and further work was ongoing to bridge the gap. It was added that medicines and finance teams had worked closely throughout the planning cycle, using a detailed bottom-up approach to reconcile pressures with achievable efficiencies, noting that national assumptions about tariff benefits (e.g., around DAPA) did not fully reflect local pressures. Members then explored the wider implications, with a query on whether impact modelling could better reflect pathway redesign rather than simply drug-for-drug substitution. It was agreed that this would work, and ongoing work with long-term conditions groups, Health Innovation Manchester and SCN to redesign pathways was highlighted, such as optimising COPD management and case finding to reduce reliance on high-cost biologics. The Committee noted the significant risks, the strategic nature of the horizon scan, and the need for system-wide pathway design, and agreed the

	recommendations, acknowledging the importance of ongoing monitoring, headroom creation and national engagement. **NHS GM Finance Sub-Committee;** **1. Noted the savings opportunities around drugs available now and in the near future.** **2. Noted risks to delivery of such savings due to workforce constraints and other factors.** **3. Ensured all appropriate background work happens to maximise the speed of uptake of biosimilars.** **4. Noted the likely pressures on prescribing budgets which are expected in 2026/27 and acknowledge the risks of unforeseen developing pressures in 2026/27 which monitoring processes will escalate in-year.** **5. Noted the risks associated with primary care budget setting in 2026/27. The national assumption is of 0.1% growth, representing a £580k uplift.** **6. Noted the finance requests are calculated from the outturn of the main prescribing budget (£580.8m) plus specific items for 2026/27, such as anticipated growth, taking the minimum budget requirement to £605.9m. Additional 'risk' costs of £44.3m, including NICE guideline NG28's implementation are added, and finally an additional risk of the potential implementation of NICE ID 6441 for an implementation rate higher than that nationally assumed, presenting an additional £18.75m.** **7. Noted that the risks around not funding the pressures highlighted in this paper are inadequate investment for best evidence initiatives and poorer health outcomes for the GM population or a significant overspend on the main prescribing budget.** **8. Noted the risks associated with secondary care budget setting in 2026/27. A total growth of £8.4m, including pressures, savings and drugs moving into tariff is predicted – please see table 3.** **9. Noted that the proposed uplifts and risks are best estimates given the data available.** **10. Noted particularly the financial risks around drugs for treating diabetes and obesity, especially around the revised NICE guideline NG28 and other NICE Technology Appraisals (TA's) for GLP1 inhibitors. At full implementation these together would amount to a pressure of c£150m annually but this is way above anticipated levels of implementation for 2026/27.** **11. Noted that the revised reporting methodology for CIP will result in lower values as full-year effect from the previous year will no longer be reported as CIP.**
14.	**Performance Report** This report provided an update on key performance indicators for GM. The indicators included were those considered high risk and/or form part of the undertakings process. **NHS GM Finance Sub-Committee Noted the information provided.**
15.	**Any Other Business** Following the meeting, CS confirmed his approval of the decisions made at the February 2026 and March 2026. **NHS GM Finance Sub-Committee ratified the approval of the decisions made at**

	the February 2026 and March 2026 meetings.
16.	**Reflections of the Meeting and Items for Escalation to the Board** Members felt the meeting had been effective and useful, allowing respectful conversation about difficult issues.

NHS Greater Manchester

People and Resources Committee Terms of Reference

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester

NHS GM People and Resources Committee

22 April 2026

Report information.

Required information.	Details.
Title of report.	People and Resources Committee Terms of Reference
Author.	Chris Gaffey, Associate Director of Corporate Services
Presented by.	Kal Kay, Non-Executive Director and Chair of the People and Resources Committee Charlotte Bailey, Chief Strategy, People and Partnerships Officer
Contact for further information.	Chris Gaffey, Associate Director of Corporate Services chris.gaffey@nhs.net
Executive summary.	This report provides the Committee with Terms of Reference for the People and Resources Committee that were approved by the Board in March 2026. A three-month post-implementation review of the two newly established Committees will be conducted to further identify areas of potential improvement and amendment to the arrangements, which may include further changes to the Terms of Reference. Any changes will be considered by the Committee, before consideration by the Board for approval.

The benefits that the population of Greater Manchester will experience.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, which will benefit the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, which will support the delivery of the ICP Strategy, and in turn, reduce health inequalities in GM communities.
The decision to be made and/or input sought.	The Committee is asked to: 1. Note the Committee Terms of Reference (Appendix One).
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, and one of the objectives of moving to a new Committee structure is to ensure that the Board and its Committees have the required strategic focus. This will support the delivery of the ICP Strategy, as well as ensure focus on the Board Assurance Framework.
Key milestones.	17 December 2025 – Agreement of Transition Arrangements by Board 4 March 20026 – Consideration of proposals by Transition Committee 11 March 2026 – Further consideration and refinement by NEDs / Execs. 18 March 2026 – Board approval 1 April 2026 – Implementation

Leadership and governance arrangements.	The Chief Strategy, People and Partnerships Officer is responsible for Corporate Governance arrangements, supported by the Associate Director of Corporate Services. The People and Resources Committee will be chaired by Kal Kay, Non-Executive Director.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The Terms of Reference were drafted via working group meetings including officers from across functions, which were followed by working group meetings between NEDs and lead Chief Officers. Further discussions then took place at NEDs / Execs meeting on 11th March 2026, before final comments and views were incorporated into the proposals which were approved by Board on 18th March 2026.
Financial or Legal Implications	No formal legal or financial implications as part of this report.

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

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

Table 2: Assurance needed about the document.

NHS Greater Manchester

People and Resources Committee

Terms of Reference

<table>
<tr><td>Purpose</td><td>The purpose of the People and Resources Committee (‘the Committee’) is to obtain assurance, on behalf of the Board, that the ICB will achieve its statutory financial duties, and that the system is financially sustainable, by having the right financial strategy that results in the ICB meeting its financial targets and sustainability.

The Committee will also provide strategic oversight, assurance, and guidance on behalf of the Board on all matters relating to workforce, organisational culture, and staff experience across NHS GM. The Committee will ensure that through the delivery of our organisation’s People Plan, NHS GM fosters an inclusive, compassionate, and high-performing culture that supports the recruitment, retention, wellbeing, and development of its people.

The Committee will also provide strategic oversight and assurance on matters relating to estates and environmental sustainability across NHS GM, as well as receiving assurance and constructively challenging the operational resourcing and delivery in the areas of digital and IT infrastructure, and data and intelligence.

The Committee will operate within an agreed shared governance model with the Strategic Commissioning Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals and ensure delivery of investment standards.

The People and Resources and Strategic Commissioning Committees will collectively provide Board assurance across the end-to-end strategic commissioning cycle, from assessment of population need and outcomes, through prioritisation and design, to resource enablement, implementation, performance, value and learning.

Specifically, the People and Resources Committee leads on enabling delivery of agreed commissioning intent through workforce, finance, estates, IT, data and infrastructure, ensuring affordability, sustainability and value.

The Committees will share information, risks, and escalations in a systematic and timely way to support effective Board oversight.</td></tr>
<tr><td>Duties</td><td>The Committee will:

<u>Finance</u>

Financial strategy and planning

- Ensure delivery of the ICB financial plan / strategy and make recommendations to the Board</td></tr>
</table>

	- Have oversight of the ICS financial position - Where delivery of the financial plan is not assured, ensure the necessary actions are being taken to recover the position wherever possible - Apply constructive challenge to medium and long-term ICB financial plans and monitor their implementation. **Financial resource allocation** - Apply constructive challenge to proposals in line with Financial Scheme of Delegation. - Apply constructive challenge to business cases for major investments / disinvestments for material service change or efficiency schemes. - Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the People and Resources Committee will scrutinise financial implications and make relevant decisions, or where appropriate, escalate recommendations to the Board. **Financial performance** - Provide assurance in relation to the ICB achieving its statutory duties. People **Strategy and planning** - Review the NHS GM People, Culture and Organisational Development Plan and monitor progress with its implementation, through regular highlight reports. - Review delivery of the ICB workforce elements of the 10 Year Health Plan, with a focus on sustainability and effectiveness. - Oversee workforce planning, transformation and change programmes on behalf of the organisation. - Oversee our performance against CQC standards, with a focus on the 'well led' measure. **Statutory duties** - The approval of disciplinary process and arrangements for employees, including the accountable officer (where he/she is an employee of NHS GM)

	and for other persons working on behalf of NHS GM. - Making recommendations regarding the approval of arrangements for discharging NHS GM's statutory duties as an Employer and for staff appointments. - Making recommendations to the Remuneration Committee on items relating to the terms and conditions, remuneration and allowances for non-AfC employees. - Reviewing national policy and implementing accordingly, to ensure the organisation follows core employment legislation changes etc. - Provide system oversight of workforce efficiencies. **Workforce performance and experience** - To monitor and review workforce key performance indicators for the organisation, including sickness absence, training, appraisal, bank and agency usage and escalate any issues to the NHS GM Board. - Review the results of the annual staff survey and any other staff surveys and proposed organisation action plans. - Review reports from the Freedom to Speak Up Guardian regarding activity within the organisation, reflecting the updated national and regional models. - Review and approve partnership agreements with staff side. **Equality, diversity and inclusion** - Review workforce elements of the organisation's Equality, Diversity and Inclusion Implementation Plan prior to its submission to the Board, and monitor progress with delivery, including review of WRES, WDES, PSED, Gender, Disability and Ethnicity Pay Gap reports. - Oversee progress to act on the Anti-Racism Framework and the Sexual Safety Charter. Estates **Strategy** - To monitor implementation of the Infrastructure Strategy ensuring outcomes are achieved in line with required timescales - Apply constructive challenge whilst working collaboratively with Strategic Partners and Stakeholders to drive the development of a flexible, greener and cost-efficient estate, aligned with service transformation priorities Utilisation

	- Provide strategic direction and support in achieving realistic cost efficiencies and effective use of accommodation whilst ensuring optimum utilisation of retained estate - Ensure Department of Health Property Companies work in partnership with NHS GM to increase levels of utilisation; reduce void and subsidy costs; increase capital investment in the retained estate and to consider options at the end of the Local Improvement Finance Trust (LIFT) lease concessionary periods Primary Care - Review GP non mandatory occupational subsidies to reduce reimbursement costs and achieve an equitable outcome for all NHS GM practices - Ensure adherence to statutory requirements under the provisions of the Premises Cost Directions in relation to GP Practice new leases and lease renewals in order to achieve value for money in terms of rent reimbursement - Provide strategic advice and support to ensure primary care capital and revenue business case governance and approvals processes are followed **Corporate** - Review the corporate estate to establish strategic need and drive best practice in terms of provision and utilisation - Promote flexible access to accommodation throughout the corporate estate - Promote a robust Health & Safety culture ensuring compliance with statutory regulations and business policies Environmental Sustainability - Assurance of appropriate oversight for the implementation of the NHS Greater Manchester Green Plan - Assurance of appropriate oversight for NHS Greater Manchester's statutory responsibilities on environmental sustainability IT and Digital - Apply constructive challenge to the operational resourcing and delivery of digital and IT infrastructure. - Oversee and obtain assurance on resource planning and allocation for digital/IT.

	- Apply constructive challenge to evidence of deliverability, value creation integration with estates/workforce functions. <u>Data</u> - Manage corporate risks in relation to the maintenance and development of the ICB's data assets. This will involve recognising the centrality of the asset to the wider system, including the provision of a secure data environment to support Research and innovation. - Oversee and obtain assurance on data assets in respect of data governance, infrastructure investment, recognising that data costs are naturally inflationary and that the commercial value of data is being realised through partnership reimbursement (data is not a free good) - Oversee and obtain assurance that data and analytical skills are being developed and supported in accordance with professionalisation and the future requirements of the organisation and it's role in the system **Enabling strategies** - Provide assurance around any enabling strategies, e.g. capital, and monitor their implementation. **Strategic risks** - Monitor and provide assurance to the Board on <u>BAF risks</u> assigned to the committee, as well as relevant Corporate Risks. **Other Duties** - Review and recommend the ICB's Standing Financial Instructions to the ICB Board. - Apply constructive challenge to action taken in response to changes in relevant national policy. - Approve any business cases, procurements, non-healthcare contracts and expenditure and also be notified of any Individualised Commissioning healthcare placements or packages in line with the financial scheme of delegation.
Membership	The membership of the committee shall comprise of the following members: • Non-executive director (Chair) • Non-executive director (Deputy Chair) • Non-executive director • NHS GM Partner Member • NHS GM Partner Member

	• Chief Executive Officer • Chief Finance Officer • Chief Strategy, People and Partnerships Officer • Chief Reform and Improvement Officer
Attendees	Where any conflicts of interest arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting. Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter. The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.
Delegated authority	The Committee is established by the Board as a Committee of the Board in accordance with its constitution. The Committee has delegated responsibility by the Board to: • Investigate any activity within its terms of reference • Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference • Commission any reports it deems necessary to help fulfil its obligations • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • The Committee may establish a sub-committee and arrange for the functions exercisable by the Committee to be exercised by the sub-committee. For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. Members will be expected to conduct business in line with NHS GM values and behaviours, including demonstrably considering the equality and diversity implications of decisions they make.
Meeting management	**Frequency** The Committee shall meet monthly a minimum of 10 times per year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. Meetings will be held in public, however there may be occasions where items will

	need to be considered in private. And decisions to consider items in private will be evidenced, and be by agreement with the Chair. **Agenda and papers** The agenda and papers for meetings will be distributed five working days in advance of the meeting. **Attendance and Quorum** A quorum shall consist of 3 Committee members, including the Chair or Vice Chair, one other Non-Executive Director and the Chief Finance Officer (or Deputy Chief Finance Officer). Members should attend at least 75% of meetings within any calendar year. Members are expected to nominate a deputy to attend in their absence. Attendance will be monitored and addressed by the Chair, who will be responsible for discussing regular non-attendance with the relevant member. The Chair of the Committee will also be required to bring to the attention of the Chair of NHS GM if they feel that lack of attendance has not enabled adequate discussion or decision making. **Support** The Corporate Governance team will support the committee. **Conflict of interest** Conflicts of interest should be disclosed and managed in line with the NHS GM Conflict of Interest Policy. The chair is responsible for the management of all conflict of interest matters. **Reporting** The Committee Chair shall report to the Board on the Committee's activities by: • Providing a written update report following each meeting • The presentation of an annual report • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board of any issues that require disclosure to the full Board of Directors, or require action. **Annual self-assessment** The Committee shall undertake an annual self-assessment. It will report thereon to the Board. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Date agreed by the People and Resources Committee:	
Date approved by the Board:	
Review date:	

Appendix: Constructive challenge

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

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

NHS Greater Manchester

Board Assurance Framework and Risk Report

People & Resources Committee

22nd April 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

People & Resources Committee

22nd April 2026

Required information	Details
Title of report	Board Assurance Framework and Risk Report
Author	Chris Gaffey, Associate Director of Corporate Services Tom Conyers, Head of PMO and Risk
Presented by	Nicola Hepburn, Acting Chief Reform and Improvement Officer
Contact for further information	Tom Conyers, Head of Risk & PMO – tom.conyers1@nhs.net
Executive summary	This report confirms the BAF and Corporate Risks that will be considered by the newly established People and Resources Committee (PRC). As a new Committee of the Board, the PRC will be responsible for consideration and monitoring of these risks, and to provide the Board with the appropriate assurance that they are being appropriately managed. The relevant BAF risks are set out in Appendix One.
The benefits that the population of Greater Manchester will experience.	Effective risk management is essential. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation
How health inequalities will be reduced in Greater Manchester's communities.	The management of strategic risks will directly contribute to the delivery of the ICP strategy.
The decision to be made and/or input sought	The People and Resources Committee is asked to: • Consider the risks presented in this report
How this supports the delivery of the strategy and mitigates the BAF risks	This report is directly focused on Risk Management which includes the BAF risks.
Key milestones	People and Resources Committee – 22nd April 2026
Leadership and governance arrangements	Each strategic risk has an assigned risk owner,

	who is a Chief Officer of NHS GM. The BAF is reported to and considered by the Board at each of its meetings, with some strategic risks also considered at the People and Resources Committee and others at the Strategic Commissioning Committee. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The BAF and Corporate Risks are considered by the relevant Committee, as well as the NHS GM Chief Officers for management oversight.
Financial or Legal Implications	None.

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

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

1.0 Introduction

1.1 This report confirms the BAF and Corporate Risks that will be considered by the newly established People and Resources Committee (PRC).

2.0 Strategic Risks

2.1 The strategic risks for the PRC have been considered by the Executive Lead in partnership with their Non-Executive Director to finalise the risk descriptions and provide an update on the current risk positions. The assignment of these risks to the Committee have been considered and agreed by the now disestablished Transition Committee, as well as the Board at their March 2026 meeting.

2.2 Table 1 below shows the agreed strategic risks, aligned to the strategic objectives as well as the current risk score.

NHS GM Board Assurance Framework March 2026									
Strategic Objectives									
Strengthen our Communities	Recover core health and care services		Help people get into, and stay in, good work	Help people to stay well and detect illness earlier	Support our workforce and carers	Achieve financial sustainability	Meet our statutory obligations		
Strategic Risks									
SR1	**SR2**	**SR3**	**SR4**	**SR5**	**SR6**	**SR7**	**SR8**	**SR9**	**SR10**
Health of the Population	**Health Outcomes**	**Quality of Care**	**Good Employment**	**Health Inequalities**	**Workforce**	**Financial Sustainability**	**Cyber Security**	**Emergency Incident**	**NHS Reform**
Current Score 2 (L) x 5 (I) = **10**	Current Score 4 (L) x 5 (I) = **20**	Current Score 3 (L) x 5 (I) = **15**	Current Score 3 (L) x 4 (I) = **12**	Current Score 4 (L) x 4 (I) = **16**	Current Score 4 (L) x 4 (I) = **16**	Current Score 4 (L) x 4 (I) = **16**	Current Score 3 (L) x 4 (I) = **12**	Current Score 3 (L) x 3 (I) = 9	Current Score 4 (L) x 4 (I) = 16
Trend: ⇔	Trend: ⇔	Trend: ⇔	Trend: ⇩	Trend: ⇔	Trend: ⇧	Trend: ⇩	Trend: ⇔	Trend: ⇩	Trend: ⇔
Year End Target 2 (L) x 5 (I) = 10	Year End Target 4 (L) x 5 (I) = 20	Year End Target 3 (L) x 5 (I) = 15	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 3 (I) = 9	Year End Target 4 (L) x 3 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 3 (I) = 9	Year End Target 3 (L) x 3 (I) = 9
Final Target Score **5** (2028)	Final Target Score **10** (2028)	Final Target Score **10** (2028)	Final Target Score **8** (2029)	Final Target Score **4** (2028)	Final Target Score **9** (2028)	Final Target Score **12** (2025)	Final Target Score **8** (2028)	Final Target Score **6** (2028)	Final Target Score **4** (2026)
Risk Appetite: Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Cautious	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open
10 - 20	**5 - 15**	**5 - 15**	**10 - 20**	**10 - 20**	**10 - 20**	**10 - 20**	**5 -10**	**5 - 15**	**5 - 15**

3.0 Risk Update

3.1 The areas to report into each committee have been finalised and approved at the Board. The risks shown below are the BAF risks and corporate risks agreed to be considered by the People and Resources Committee.

3.2 It is important to note that a review of the BAF Risks is due to take place to ensure the risks are fully aligned to, and derived from, the Strategic Objectives.

3.3 The People and Resources Committee will consider the following BAF risks:

SR6	SR7	SR8	SR10
Workforce	**Financial Sustainability**	**Cyber Security**	**NHS Reform**

3.4 Appendix One contains the details for each of the risks but headline messages are identified below:

- BAF Risks SR6 (Workforce) is reporting an increased risk score for this return, with a current score of 16 - this is above the year-end target.
- SR7 (Finance) is reporting a reduced risk score for this quarter.
- All remaining risks are reporting a static risk score this quarter

3.5 Work towards a more dynamic way of reporting risks is ongoing, with a Deep Dive conducted on SR1 (Population Health) at the Audit Committee on 19 March 2026. The Committee discussed how lines of assurance may be presented more effectively, providing evidence to support assurance, including the use of data and intelligence; the need to be clear around ICB v system responsibilities in relation to mitigations; and developing the BAF to ensure it is an effective tool for driving agendas and prioritisation.

3.6 Learning from this deep dive will be incorporated into ongoing work on developing the BAF.

3.7 The corporate risks shown below are taken from the February 2026 Transition Committee Risk Report. The previous committee reference has been included to ensure members are clear where the corporate risks were previously reviewed.

People and Resources Committee Risks

Risk Number	Risk Description
Finance	
FIN2	Financial pressures may lead to a failure of NHS GM to meet NICE TA mandatory requirements which is work carried out by GMMMG.
FIN5	Significant increased or optimised utilisation in estate resource not achieved.
People & Culture	

PC001	**Workforce Integration** There is a risk that we do not have the resource, capacity or capability to adequately support the integration of our health and care workforce.
PC002	**Good Employment** There is a risk of being unable to uphold good employment practices across health and social care.
PC003	**Workforce Wellbeing** There is a significant risk that high levels of sickness absence will reduce workforce productivity across health and social care.
PC004	**Addressing Inequalities** There is a risk that financial challenges and NHS reform could impact on the resource allocated to ICB and organisation level activity to improve the experience of members of our workforce with protected characteristics.
PC005	**Growing and developing our workforce** There is a risk that the increasing headcount restrictions across the system could further prevent recruitment to key shortage areas.
PC006	**System Leadership Collaboration** There is a risk that there will be a reduced level of co-operation and collaboration between leaders across the system.
PC007	**Digital Readiness** There is a risk that low digital readiness will prevent successful implementation of the Transforming People Services Programme.
PC008	**Organisational Change Impact on P&C Teams** There is a risk that ongoing organisational change across NHS Greater Manchester driven by NHS Reform and financial pressures will lead to a reduction in the capacity and expertise of People and Culture teams.
PC009	**ICB Workforce Focus Loss** There is a risk that the remodelled ICBs may not retain a sufficient workforce focus, particularly in relation to People and Culture priorities.
PC010	**Loss of Talent Due to Reform** There is a risk that NHS and wider public sector reform will result in the displacement of staff, leading to the loss of valuable talent, experience, and knowledge across the GM health and care system. This risk is heightened by delays in national redundancy schemes, financial constraints, and ongoing organisational uncertainty.
PC011	**Changes to Immigration Rules** There is a risk that the recent UK immigration rule changes will impact individuals and their families (including ethical, safety and security, financial), colleagues, teams, and wider organisations, potentially patient care. The risk relates to Right to Work status of individuals affected.
Green Plan	
PH3	There is a risk a lack of capacity, funding and prioritisation will mean that NHS GM will fail deliver the requirements of the GM Green Plan including the required carbon emissions, and failure to fully prepare for the impacts of climate change.
Data, Insight & Intelligence	
DII039	Misalignment Between GM SDE and NW SDE Impacting Funding. There is a risk that a lack of alignment between the GM SDE and NW SDE programmes could result in reduced national funding, affecting both business-as-usual activities and the SDE programme.
DII058	Sustainability of New Commissioned Services. There is a risk that ongoing maintenance of newly commissioned services via DII cannot be sustained

DII068	NHS Reform Threatening Continuity of CSU Support. There is a risk that NHS reforms may lead to the dissolution or restructuring of Commissioning Support Units (CSUs), including Arden & GEM, threatening continuity of critical support services.
DII083	There is a risk that GP Data Controllers and Local Medical Committees (LMCs) do not agree to or sign the new Joint Data Controller Agreement for the GM Care Record / ADSP, particularly for secondary use and research purposes, resulting in data being unable to legally flow across the system.

3.10 In addition, this Committee will have responsibilities relating to some aspects of Digital and IT, and will therefore consider any related corporate risks. SCC will take the strategic view (i.e. Digital and IT strategy), whilst PRC will take a resource perspective (e.g. physical IT equipment, our IT and digital network and infrastructure etc.). All risks will need to be reviewed in line with the responsibilities of the new Committee structure, as well as the ICB's responsibilities under the ICB Model Blueprint as a Strategic Commissioner.

4.0 Recommendations

4.1 The People and Resources Committee is asked to:

- Consider the risks presented in this report

Strategic Risk **SR6**	There is a risk that existing workforce challenges are exacerbated due to the requirement for financial savings and the impact of NHS reforms. This will result in recruitment challenges to key areas, reduced staff wellbeing, lower morale and inequality of opportunity. This will further impact on service delivery and leadership capacity to manage change.		
Strategic Objective	Support our workforce and carers		
Chief Officer / Committee	Charlotte Bailey	People and Resources Committee	
Risk Appetite Level	Open	Risk Tolerance Range (e.g. 5 to 10)	10 to 20

Rationale for Risk Score and Progress made in the quarter

The current risk score has increased from 12 to 16 to reflect the cumulative impact of several escalating and interrelated pressures:

- Workforce cost pressures, with Trusts exceeding workforce cost plans by £51.3m at Month 6 and projections indicating a potential £100.3m year-end variance, despite progress in reducing bank and agency spend in line with national targets.
- Industrial action, including ongoing and planned doctor strikes, which continue to disrupt service delivery, increase pressure on remaining staff, and impact morale.
- Persistent workforce gaps, many of which are influenced by national supply issues and outside of local control.
- Increased reliance on migrant workers, combined with rising visa costs, tighter settlement and sponsorship rules, ethical recruitment requirements, and strong international competition, heightens recruitment and retention risks and may exacerbate workforce shortages. These pressures also carry delivery, skills dilution, and workforce wellbeing risks, particularly affecting a predominantly female and migrant workforce amid growing anti-migrant sentiment.
- Organisational change and turnover, particular within NHS GM following national VR announcement, resulting in loss of organisational memory, reduced continuity, and increased reliance on interim and agency staff.
- Financial constraints, including the requirement to reduce pay bills to achieve long-term sustainability, limiting flexibility to invest in workforce growth and development.
- Rising winter sickness absence, further constraining workforce capacity

Key Controls

- Direct reporting to NHS GM Board while Committee is stood down.
- P&C Governance and supporting TORs
- Committee working groups, focus on workforce efficiency, Transforming People Services, Leadership Culture & EDI
- Monthly workforce reports
- Operational planning rounds and provider oversight meetings, supporting pay bill reduction to support long term financial sustainability.
- Regular review of the P&C risk register
- Leadership, Culture and EDI; System-level equality impact assessment (EIA) risks noted at P&C; mitigation through electronic systems to increase visibility and assurance

Gaps in Control or Assurance

Some of the causes of this risks are outside of the control of our ICB e.g. national workforce shortages, training, social care rates of pay etc but mitigating actions put in place will help reduce the risk score.
No P&C Committee in January – stood down to support NHS GM to focus on business continuity. Mitigated by direct reporting to Board as necessary.
Increased requirements for the ICB to focus resources and capacity on statutory duties and leading NHS Provider and lack of full data sets for the entire health and care system is also a current gap that limits the ability to fully understand the position and impact of actions we are taking
Lack of additional funding such as HEE workforce development funding which previously supported transformation projects.

	Risk Scoring and Tolerance							
	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	4	4	4	3	3	March 2028
Impact	4	3	3	3	4	3	3	
Risk Level	16	12	12	12	16	9	9	

Number of Linked Risks on Corporate Risk Register		
Low (1 - 4)	**Mod (6 – 12)**	**High (15 – 25)**
0	1	5

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Bi-monthly workplan completed which aligns to priorities for the remainder of the financial year reported to SLT.	Partial
2nd Line	Regular reports provided to the; GM People & Culture Committee and ensuring oversight of progress against workforce priorities & delivery of agreed objectives. Contributions also feed into the ICB assurance process to demonstrate compliance & effective governance	Partial
3rd Line	Internal Audit Plans developed and delivered to provide evaluation of control effectiveness and management across key workforce areas	Partial

Action — Key: Complete/BAU; On Track; Delayed; Problematic

No	Action Required	Due Date	Progress	BRAG
1	Development of a Leadership Development approach including Board development and 360 feedback	Dec 2025	Board Development remains paused due to upcoming leadership changes	Delayed
2	Refresh of the P&C Strategy for 25-28 to support the 10 year plan for health and associated people plan - and extension of current strategy, with refined priority actions for the rest of 25/26.	March 2026	Development delayed due to NHS Reform.	Delayed
3	Implementation of digital EIA approach to increase system visibility.	Nov 2025	Proposed amended due date to Feb 2026. The platform is in it's final stages prior to testing. Implementation expected Early 2026.	On Track
4	Enhance individual and collective focus on workforce efficiency; reporting at POMs and HRDs, sharing good practice, improving quality of workforce data.	March 2026	NHS GM has introduced a more robust process of individualised provider workforce deep dives, enabling direct assurance-level discussions and promoting best practice sharing, with meeting frequency increasing in response to monthly performance trends and escalation needs.	On Track

			Working towards greater workforce focus through Provider Oversight Meetings in January. Increased scrutiny around annual planning round – and workforce affordability in preparation for restrictions on temporary staffing usage.	
5	Support all system boards to adopt and implement workforce delivery plans	Oct 2025	Collaborate with system programme leads to identify workforce challenges and develop responsive action plans, offering expert guidance, sharing best practice, and fostering peer support. Some plans are developed - some still emerging and meet quarterly to ensure progress.	
6	To widen the scope of Transforming people services beyond occupational health and policy, with an initial focus on recruitment	March 2026	Highlight reports to Committee	
7.	Deliver Careers Event, alongside other planned staff support offers, to support staff through organisational change by providing clear career pathways, retention support, skills development opportunities, and targeted guidance for affected and at-risk groups.	Early 2026	In Progress	
8.	Migrant Workers - joint working and sharing best practice		NHS trusts collaborating to understand scale of the issue and sharing best practice. NHS GM is also supporting the issue in primary care and social care.	

Strategic Risk **SR7**	There is a risk that the ICS does not achieve in-year and medium-term financial sustainability due to continued growth in demand, inflationary and cost pressures, inability to deliver CIPs in full and other identified causes such that the financial resources do not meet system needs. This will result in the inability to deliver on the ICP Strategy, reducing our ability to invest in preventative care which will drive demand, and continued inequalities and variation in health and care.		
Strategic Objective	Achieve financial sustainability		
Chief Officer / Committee	Kathy Roe	People and Resources Committee	
Risk Appetite Level	Level 3 - Open	Risk Tolerance Range (e.g. 5 to 10)	10 - 20

Rationale for Risk Score and Progress made in the quarter

The risk score is based on the financial plan submitted to NHSE for 2025/26, taking on board the financial grip and control measures currently in place and the financial risk associated with delivering financial balance over the medium term (2 to 5 years) which is rated as high, as there is a significant amount of work to do as an organisation and system to develop robust savings plans that deliver savings on a recurrent basis. A considerable amount of work has already been undertaken, savings plans are being further developed across the whole GM ICS over a medium-term basis to help ensure the ICS can move to an affordable and sustainable financial position within the overall financial resources available to it.
The sustainability plan is developed upon 5 pillars (cost improvement, system productivity, reducing prevalence, proactive care, and optimising care). The financials were developed through a review of all organisations financial sustainability plans to ensure consistency of assumptions and a system approach.
The risk score has decreased from 20 to 16 to reflect the reduced likelihood in not achieving the desired target, this is based on the current financial position and the remainder of the time left in the finical year to meet the required target.

Key Controls

- The enhanced levels of grip and control and financial assurance established during 2024/25 continue across the GM system, including CIP Governance, Provider Oversight.
- NHSE has undertaken a review of both ICB and Provider Trusts exit run rate modelling to ensure consistency and robustness as part of planning. ICB plans submitted to NHSE 12/2/26 showing achievement of plan in 2026/7,2027/8 and 2028/29.
- The medium-term financial plan and financial strategy will be further developed to identify key principles and robust CIPs to support financial sustainability.
- ICB has revised the reporting pack with a focus on run rate to allow identification of potential issues and mitigation plans have been implemented to address the risks on in year delivery. Run rates became a focus within the finance item of LAMs from July and are a key item within monthly monitoring for all ICB areas of expenditure.
- Recovery plans have been developed for the 4 key areas of overspend:
  - CIP
  - Independent Sector
  - IPoC
  - ADHD/Autism

Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and Board scrutiny.
The ICB Recovery plan is now being accelerated to evaluate and approve new options to mitigate the current risk level with appropriate Board governance. Further schemes were developed including:
  - Meds Optimisation stretch target
  - Additional IS contracts activity plans
  - Primary Care
  - Non Pay and Workforce

- All CIPs are subject to a quarterly deep dive to ensure they remain on track and determine if there is any opportunity for stretch.
- Productivity pack - GM to continue with the system developed productivity pack that is now used across the NW. This helps to inform opportunities for improved performance and will become part of POMs.
- Red lines - GM has developed trigger points that will require corrective actions. There will be clear agreement and a 'Golden thread' through POMs/LAMs, SIB and sub committees of Boards.

Medium- and long-term financial plans were approved by the Board on 11/2/26. Localities and system Boards were engaged in the process of developing commissioning intentions.

Gaps in Control or Assurance

- Areas of overspend/performance may not be picked up in a timely manner due to a time lag in information.
- Time lag in financial / performance (Acute activity and prescribing) information may lead to ineffective or delayed decision making.
- Savings plans are not fully developed in a timely manner or do not realise the necessary savings or on a recurrent basis.
- Planning does not adequately reflect growth and/or impact of strategic decisions, and prevention investments on all parts of the system or budgets.
- Impact of NHS Reforms may delay development of new control measures.
- Recovery plans once agreed take time to implement and provide evidence of success

	Risk Scoring and Tolerance							
	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	5	5	5	4	4	4	31/03/26
Impact	4	4	4	4	4	3	3	
Risk Level	20	20	20	20	16	12	12	

Number of Linked Risks on Corporate Risk Register		
Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	3	

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Contract meeting (Monthly) Executive Management Team (Weekly) Internal Finance and Governance meetings (Weekly)	Acceptable
2nd Line	Finance Committee (Monthly) Executive CIP Group (Weekly) NHS GM Board (Bi-Monthly) Audit Committee (Quarterly) Locality Assurance meetings (Quarterly) these move to monthly for those localities which are challenged. Provider Oversight Meetings (Monthly)	Acceptable
3rd Line	External Audit Reports Internal Audit Reports NHSE (Monthly)	Acceptable

Action — Complete/BAU | On Track | Delayed | Problematic

No	Action Required	Due Date	Progress	BRAG
1	Recovery plans have been developed for the 4 key areas of overspend: CIP Independent Sector IPoC	31/03/26	Regular updates will be provided to Finance Sub Committee	

	ADHD/Autism Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and Board scrutiny. The ICB Recovery plan is now being accelerated to evaluate and approve new options to mitigate the current risk level with appropriate Board governance. Further schemes have been developed including Meds Optimisation stretch target Additional IS contracts activity plans Primary Care Non Pay and Workforce Finance Recovery Group meets on a weekly basis to review progress and identify barriers to progress in delivery of all schemes. Additional resource has been identified and redirected from other areas to work on these priority areas.			
2	CIP plans are further being developed for 2026/27 and implemented to realise efficiencies along with commissioning intentions that will deliver efficiencies while improving services. Work ongoing through PMO. CIPs are being identified for 2026/27. All are subject to a quarterly deep dive to ensure they remain on track and determine if there is any opportunity for stretch.	31/03/26	Regular updates provided to Finance Sub Committee. As a consequence of continuous challenge and risk to full delivery some schemes may require a review of their original target. The schemes on the opportunities and difficult decisions list also need progressing at pace.	
3	Those localities who are forecasting a deficit are being offered additional support to identify and deliver further recovery plan schemes. Recovery plans must deliver sufficient opportunities to optimise 2025/26 financial plan delivery and retention of DSF.	31/03/26	Updates will be provided to Finance Sub Committee	

Strategic Risk **SR8**	Significant systemic service disruption occurs as a result of cyber-attack moving quickly across the GM health and care IT estate		
Strategic Objective	Meet our statutory obligations		
Chief Officer / Committee	Nicola Hepburn	People and Resources Committee	
Risk Appetite Level	Cautious	Risk Tolerance Range (e.g. 5 to 10)	5 – 10

Rationale for Risk Score and Progress made in the quarter
NHS GM do not have a defined approach to dealing with a significant cross-system cyber incident – though there is a Cyber Special Interest Group - but no defined path to identify the impact of a cyber incident and act as a system to report and manage the incident through initial containment and eventual resolution. Every NHS organisation has its own business continuity plan. As these are not consistent across the system, this leads to variation and inhibits swift movement to enable continuity of operation as a system. An NHS GM ICS cyber incident exercise was performed on the 9th of January with representative from the ICS member organisations, the exercise went well and identified a need to develop a high-level response plan. The aim of the plan will be to coordinate activities across the system to ensure a swift region wide response to a cyber incident. Work has started to develop the plan but is not in place currently.

Key Controls
Each part of the system (ICS) has their own security and protection measures in place. There is a GM NHS Cyber Security Special Interest Group in place. The results of the cyber maturity assessment conducted across all NHS GM ICS member organisations highlighted areas for improvement within each organisation. NHS England risk reduction funds are being utilised to address improvements including business continuity arrangements, system vulnerability management, Privileged access management, supply chain risk assessment and management NHS GM Cyber Security Strategy has been developed with an associated improvement plan and is progressing through the appropriate governance.

Gaps in Control or Assurance
Commitment to creating a single ICS oversight group for cyber security controls and management which can be linked to the EPRR process in the event of an incident with well-defined management and escalation processes in place – and a Business Continuity Plan that is regularly tested.

	Risk Scoring and Tolerance							
	Inherent risk score	Q1	Q2	Q3	Q4*	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	3	3	3	3	2	March 2028
Impact	4	4	4	4	4	4	4	
Risk Level	16	16	12	12	12	12	8	

Number of Linked Risks on Corporate Risk Register		
Low (1 - 4)	**Mod (6 – 12)**	**High (15 – 25)**
0	0	1

Lines of Defence	Sources of Assurance	Assurance Level
#1st Line	Monthly digital IT assurance group for ICB	Partial
2nd Line	Cyber security maturity assessments considered at monthly Special Interest Group attended by all heads of security across the ICS Trust CIO's weekly meeting (includes CIO for NHS GM and NHS E) GM ICS secure GM communication group that is not reliant on NHS Mail or Microsoft Teams which shares risks and issues across trusts, NHS E and GMCA and LA's and CIOs.	Acceptable
3rd Line	Regular Regional and National communication with NHSE and other NHS organisations. Annual Data Security Protection Toolkit (DSPT) carried out by each care setting, which is reviewed by NHS E. DSPT is carried out annually between January and June. Will more stringently review in 2025, based on national cyber security centre cyber assessment	Partial

Action	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	To develop the Cyber Security Strategy and implementation plan	Dec 2025 (Delayed)	The approval of the strategy and implementation plan is delayed until the new structure of the NHS GM ICB is published and the implications of the changes are understood and fed into the strategy	
2	An ICS system wide cyber incident response plan is being produced.	March 2026	Working group has been setup representing ICS member organisation to produce a coordinated response plan	
3	Utilise NHS England risk reduction funds to address areas for improvement identified during the cyber maturity assessment	March 2026	NHS England funds have been applied for addressing areas for improvement in NHS GM ICS member organisations. Currently waiting for funds to be approved by NHS E	
4	Implement system to address identified arras of weakness utilising approved NHSE funding.	March 2026	NHSE funds have been approved waiting for the transfer of funds to NHS GM ICS organisation.	
5	Implement solutions to remediate identified areas of	March 2026	NHS England Funding has now been received by NHS GM ICS member	

	weakness, utilising approved NHSE funding.		organisations. and work has started to procure and implement cyber security improvements across the ICS.	

Strategic Risk SR10	There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions. This will result in core ICB business being disrupted during the transition.		
Strategic Objective	Meet our statutory obligations		
Chief Officer / Committee	Colin Scales	Strategic Commissioning Committee & People and Resources Committee	
Risk Appetite Level	Cautious to Open	Risk Tolerance Range (e.g. 5 to 10)	5 to 15

Rationale for Risk Score and Progress made in the quarter

The risk score remains at 16 following a recommendation to reduce the score to 12 as new instructions have been received from NHS which has confirmed the reduction target of £19 p/h as described in the model ICB blueprint to be achieved from April 26. This has also resulted in Voluntary Redundancy being approved for implementation by the ICBs. This means the pace of the reform work will now increase at pace in order to achieve the targets set with high likelihood and impact to the disruption of core ICB business.

Key progress made this quarter:

- As a result of the Government announcement that all ICBs are expected to achieve their £19 per head target from April 2026, we have re-designed the Reform programme outcomes with the need to implement the organisational restructure now the key priority.
- Formal consultation on the structures was launched on 28th January and will run till the 27th February. We will utilise the feedback from staff to finalise the organisational structures with the aim of publishing the final structures on 11th March.
- VR Scheme (Phase 1) was successfully delivered with a number of staff opting for VR exiting the organisation on 31st January. VR Scheme (Phase 2) launched on 2nd February – staff opting for VR are due to exit the organisation by no later than 31st March.
- Regional Do Once programme is being progressed with formal governance now being stood up for OPIC and IFR. We are also progressing work on Pop Health and GP IT with the aim of transferring these services from April 2027.
- Continuing to work with Place stakeholders – through the Place mobilisation working group to progress work on key areas such as funding and options for transfer.

Key Controls

- The development of a business continuity framework to ensure work is managed through core organisational priorities.
- Programme dedicated resource in place (with additional resource recently agreed) in order to minimise capacity issues within current BAU programmes.
- Transition Risk Group established with key system stakeholders to ensure we have captured and mitigated against high-risk areas.
- These risks are also being escalated to Transition Operational Delivery Group from potential areas which the highest likelihood of impact to resource reductions with scenarios to be tested to ensure the programme is considering how to manage and mitigate the reductions.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In year Target	Long Term Target	Long Term Target Date
Likelihood	4	N/A	4	4	4	3	2	April 2026
Impact	4	N/A	4	4	4	3	2	
Risk Level	16	N/A	16	16	16	9	4	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Transition Programme Team- The team oversees management and updates of the risks for all component programme areas. Transition Operational Delivery Group - This group holds oversight on all the risks within the transition programme and component workstreams. Transition Risk Group – New group creates within the transition programme governance to have a grip and oversight over all programme risks. This group will monitor controls, actions and ensure that all work is being done to lower the risk	
2nd Line	**Chief Officers** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **ICB Board** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **Executive Committee** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **NEDs/Execs** – Assurance of the high-level risks within the transition programme with monitoring to ensure the risks are correctly being mitigated periodically.	
3rd Line	NHSE Oversight Meetings – Reporting on progress of the reform and any risks that need to be escalated.	

Action — Complete/BAU; On Track; Delayed; Problematic

No	Action Required	Due Date	Progress	BRAG
1	Organisational restructure implementation to ensure the organisation is meeting its £19ph obligations from April 2026.	June 2026	In the process of engaging with staff on new organisational structure - concurrently we are running Phase 2 VR scheme. We will then look to undertake filling of posts exercise (including any necessary compulsory redundancies) with the aim to complete by end of May 2026.	
2	Assurance Statement for Model Integrated Care Board	February 2026	GM ICB provided NHSE confirmation (through official correspondence) that we are developing our future operating structure in line with the £19 running cost allowance and the Model Integrated Care Board (ICB) Blueprint.	

NHS Greater Manchester

Chief Strategy, People and Partnerships Officer - Alert Report

April 2026

NHS
Greater Manchester

NHS Greater Manchester People and Resources Committee

22 April 2026

Required information	**Details**
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report
Author	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Presented by	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Contact for further information	Charlotte.bailey37@nhs.net
Executive summary	This paper alerts, assures and advises the People and Resources Committee regarding key people and culture priorities, risks and mitigations as overseen by the People and Culture Sub-Group.
The benefits that the population of Greater Manchester will experience.	To support our staff to be their best in order to deliver our ambitions for GM.
How health inequalities will be reduced in Greater Manchester's communities.	To support our staff to be their best in order to deliver our ambitions, including tackling health inequalities for GM and leading by example.
The decision to be made and/or input sought	The People and Resources Committee is asked to: • Note the report • Support the progress and direction of travel for establishing the new People and Culture Sub-Group
How this supports the delivery of the strategy and mitigates the BAF risks	Relates to the ability of our workforce to perform at their best and supports the organisation's ability to manage all BAF risks.
Key milestones	New model commenced in April 2026 – priorities and associated KPIs to be reviewed at Sub-Group in June.
Leadership and governance arrangements	This paper is produced for the People and Resource Committee and has not been

	elsewhere.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for The People and Resources Committee and has not been elsewhere.
Financial or Legal Implications;	n/a.

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

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

Report from:	People & Culture Sub-Group
Date of Meeting:	Thursday 16th April
Chair:	Charlotte Bailey
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert

- The Sub-Group reviewed the latest Gender Pay Gap Report and noted that progress has been limited, largely due to competing organisational pressures and capacity constraints. It was further acknowledged that, due to ongoing organisational reform and changes in staffing levels, the current data set is now out of date. The data will be revalidated once the organisation has reached a more stable position, after which key actions will be identified and implemented based on the most accurate and complete information available. Members were also advised that current capacity limitations have delayed the production of the Disability and Ethnicity Pay Gap analyses. A review will be undertaken to determine the future approach to pay gap reporting, ensuring alignment with statutory requirements, recognised best practice and team capacity.

- February MaST Compliance is at 94.60% (-0.40%) below the 95% national target Identified Risks: At present we have non-compliance identified with several Safeguarding & Information Governance MaST modules. This presents a significant organisational risk, including potential safeguarding breaches, regulatory and legal consequences, reputational damage, and corporate negligence. Sustained mandatory training compliance is essential to uphold our duty of care and maintain public trust. Action required includes all executives to review and address non-compliance with their teams as part of ongoing due diligence discussions.

Advise

- Sub-Group reviewed the Anti-Racism Plan, which brings together all related activity into a single framework, aligned to a 12-month delivery plan and linked to clear leadership objectives. The plan sets out the establishment of a new core group, comprising executive and non-executive members from a range of functions, alongside representatives from the Inclusion Staff Network. This group will focus on three key areas: the OD plan, culture, and inclusion. It was noted that delivery of this plan would form a key people and culture priority for 2026/27.

- Sub-Group considered draft Terms of Reference, priorities and a 2026/27 workplan (see Appendix One). Members supported the draft documents and will continue to review and finalise for the next meeting in June.

Assure

- The OD plan is now in delivery, following approvals. The P&C Sub-Group will consider the timeliness of delivery and how activity is managed alongside other factors, including organisational capacity, skills and experience. This will also include consideration of where specialist insight or expertise is required and how the plan is embedded as the organisation continues to develop. It was noted that delivery of this plan would also form a key people and culture priority for 2026/27.

- The latest Workforce Report was reviewed, and the current data did not highlight any areas for significant concern at this time.

Risks discussed and new risks identified

The Sub-Group reviewed and approved the newly developed dynamic risk log, including their status, and mitigations.

Current risks and updates:

- **Loss of talent and organisational knowledge** due to voluntary redundancies, restructures and staff departures. The group agreed to review and potentially reduce the risk score from 16, acknowledging the need to tolerate some loss and focus on further mitigation through organisational development.

- **Capacity constraints** were highlighted, reflecting both the impact of organisational change and a longer-term challenge. The discussion emphasised the importance of increased digitalisation and greater manager self-sufficiency going forward. Matrix working was also identified as a potential mitigating approach.

- **Uncertainty in P&C Responsibilities and impact on system commitments** discussions were held around working with partners to support the sustainability of priority projects as a mitigation.

- **Workforce wellbeing and leadership capacity** including interim leadership arrangements, wellbeing communications and sustaining the network of wellbeing champions. Mitigations identified included continued leadership development and the importance of maintaining and strengthening the wellbeing champion network.

- **Widening inequalities due to reduced organisational focus –** This risk is to be discussed outside of the P&C meeting.

- **Workforce Data** becomes inaccurate or misleading due to high turnover and limited capacity for ESR maintenance. Work will be undertaken to scope solutions and mitigations.
- **Mandatory training exposure**, particularly around IG and safeguarding, where compliance may fall due to inaccurate ESR data and reduced capacity. A decline in training compliance to 94.6% has been identified which directly correlates to staff departures and workload pressures. To address this, a data cleanse exercise is to be undertaken to ensure ESR records are updated to reflect accurate staff numbers.
- These dynamic risks will be monitored on an ongoing basis to ensure they remain responsive to the organisation and emerging people and culture risks.

Learning for sharing

- It was noted that as the new structure is introduced, the People and Culture offer to the organisation will change. Supporting both the team and the wider organisation to prepare for these changes and reduced offer will help enable a smooth transition and increase confidence in new ways of working.
- The ongoing contribution of the Wellbeing Champions should be recognised, with a focus on how this network and the support they provide can be supported in the future.

Achievements

- Teams across the Strategy, People and Partnerships portfolio have worked extensively to progress to the next stage of the transition journey, including the finalisation of structures, completion of VR2, and delivery of Filling of Posts Panels. This has been a collective effort, with colleagues proactively providing additional support where required, to continue to support our people first approach

Period: February 2026

NHS GM SUB-GROUP RISK REGISTER

Risk Number	Source	Risk Category	Risk Owner	Risk Description	Inherent Risk Score			Trend	Risk Proximity	Controls	Gaps in Controls	Current Risk Score			Rationale for current risk score	Actions	Action Owner	Completion Date for actions	Assurances	Gaps in Assurances	Target Risk Score (anticipated score when mitigation complete)			Functional Area (optional)	Geographical Location (optional)	Last reviewed	Risk Target Date	Open/ Closed	Date and Reasons for Closure	Date Reviewed	Status	Comments
Number to identify risk	*The source of the risk (e.g. Manager, Committee, Board meeting etc..)*	*Alignment to one of 13 risk categories (for GMPMO to complete)*	*Job title of the person responsible for the management, monitoring, control and escalation*	*A statement describing the risk event, cause and impact*	Likelihood	Impact	RAG Status	*The trend indicates any change in the current risk score in the form of an arrow*	*Timescale as to when the risk will occur*	*Please describe the controls in place to manage/reduce the risk*	*Please describe any gaps in controls to manage/reduce the risk*	Likelihood	Impact	RAG Status	*Please explain the rationale for the risk score since previousthe update, whether the risk score has increased, decreased or remained static*	*The actions and activities planned to take place that will when implemented or completed reduce, eliminate or minimise the risk*	*Job title of the person responsible for completing the action*	*Each action should have a completion date set*	*Please describe the assurance(s) in place to manage/reduce the risk*	*Please describe any gaps in the assurance(s) in place to manage/reduce the risk*	Likelihood	Impact	RAG Status	*A functional area within a regional team or a service area within a directorate*	*Where the risk is attributed to*	*Date when the risk was last reviewed and/or updated*	*Date risk will be mitigated by*	*Select Current Status of Risk*	*Reasons outlining why the risk was closed*	*Confirm the date of review*	*Select Update for risk e.g. escalation required*	*Any comments*
				PEOPLE AND CULTURE																												
26-001	P&C Sub-Group (05/02/26)			**Loss of talent, skills and organisational memory** **Risk:** There is a risk that the organisation loses critical skills, talent, and organisational memory during the transition, reducing our ability to sustain essential operational, analytical, planning and improvement functions across systems. **Cause:** Increased staff turnover across a range of specialist roles including programme delivery, intelligence, organisational development, data, operational and corporate functions combined with a high-pressure and fast-moving change environment is limiting retention and reducing opportunities for effective knowledge transfer before colleagues leave. **Impact:** Reduced accuracy and timeliness of key statutory, operational and programme	5	5	25			P&C Sub-Group (bi-monthly meeting) Plan to route workforce reporting to DII Wellbeing and retention support		4	4	16		001 - Implement consistent quality-handover processes, including documented handover notes and knowledge transfer sessions to ensure continuity of critical work when staff leave or transition roles. 002 – Transition Hub to support retention of talent			001 - Regular workforce insights provided through the monthly workforce report, including turnover, sickness, leaver trends and capacity pressures. 002 - People & Culture Sub-Group provides structured oversight, escalation and challenge, with risks reviewed bimonthly.		3	4	12			18/02/2026						
26-002	P&C Sub-Group (05/02/26)			**People & Culture teams lack capacity to deliver business-as-usual while managing major change** **Risk:** There is a risk that P&C teams will not have the capacity to deliver core functions while managing organisational change, resulting in reduced organisational compliance and workforce support. **Cause:** Teams are being stretched by high transition demands, reduced staffing and limited backfill, leaving critical gapsin workforce functions such as reporting, wellbeing support and data analysis. **Impact:** Critical workforce and People & Culture activities may be delayed, incomplete or inconsistently delivered, which reduces organisational assurance and increases the risk of errors in key workforce reports, metrics and compliance outputs. This reduced capacity also limits how quickly and effectively staff issues can be responded to, negatively affecting wellbeing, engagement and confidence in organisational support	5	5	25				Stop/Start Workplan	4	4	16		001 - Introduce “critical-only” prioritisation so BAU tasks linked to statutory duties, reporting and staff support take precedence over non-essential activity. 002 - Streamline workforce reporting by reducing the volume of requirements 003 - Pause, defer or de-scope non-urgent projects to balance workload with available capacity. 004 - Reassign colleagues to support prioriity tasks.			001 - People & Culture Sub-Group 002 - Monitoring of KPIs (sickness, annual leave utilisation, mandatory training, reporting timeliness)	001 - Prioritisation framework (Stop/Start/Continue)	3	4	12			18/02/2026						
26-003	P&C Sub-Group (05/02/26)			**Uncertainty in P&C Responsibilities and Impact on System Commitments** **Risk:** There is a risk that uncertainty around which core P&C functions will stop, change or transfer to regional or trust-level structures leads to gaps in delivery of statutory, workforce and system-wide responsibilities, resulting in reduced organisational readiness and reputational harm. **Cause:** Governance changes including the standing down of the People & Culture Committee combined with unclear future accountability routes and the absence of a defined roadmap for ownership of statutory duties, workforce reporting, OD and culture functions, create uncertainty about who is responsible for key activities from April onwards. This lack of clarity may lead to reduced capacity to deliver existing P&C and system commitments. **Impact:** This uncertainty increases the risk of essential workforce and statutory processes being duplicated, misaligned or missed altogether, reducing organisational assurance and readiness. It may also damage the organisation’s reputation with system partners if key system-wide workforce commitments are paused or weakened.	5	4	20			Committee/Sub-Group ToR and escalation routes Good Employment Charter Programmes	Decision Flow Map	4	4	16		001 - Develop and communicate a clear Day-1 function map outlining which statutory, reporting, OD, culture and system workforce duties sit with which part of the new structure. 002 - Maintain dialogue with system partners to provide assurance on continuity of key system-wide responsibilities during restructure. 003 - Develop clear handover documentation. 004 – NHS HRDs have secured interim funding to maintain some support for 12 months.			001 - Consultation documentation and subsequent feedback reports provide visibility of planned structural changes and expected future accountability 002 - Existing governance documents (ToR, committee structures, Sub-Group remit)		2	4	8			18/02/2026						
26-004	P&C Sub-Group (05/02/26)			**Workforce Wellbeing and Leadership Capacity** **Risk:** There is a risk that staff morale and wellbeing deteriorate during the transition, compounded by insufficient leadership capacity to provide appropriate support, supervision and escalation, resulting in increased safety, performance and retention risks. **Cause:** Staff are experiencing heightened anxiety due to rapid organisational change, high workloads, unclear priorities and reduced capacity. At the same time, leadership gaps caused by VR, role changes and stretched managers mean staff are receiving inconsistent support, delaying annual leave and working through health issues, which further increases strain and limits resilience. **Impact:** This leads to increased burnout, presenteeism and longer-term sickness, with wellbeing concerns more likely to go unnoticed. Morale, cohesion and trust in organisational processes decline, creating greater risk of errors, reduced quality, poorer delivery and higher turnover at a time when organisational stability is already vulnerable.	5	5	25			Wellbeing Support FTSU Networks Pulse Surveys Workforce Report		4	4	16		001 - Put in place interim leadership arrangements where managers have left or are stretched, ensuring every team has a named contact for support and escalation. 002 - Strengthen wellbeing communications and remind staff of supportive policies (wellbeing days, annual leave flexibilities, adjustments, OH access).			001 - Occupational Health usage, sickness absence trends and wellbeing indicators are monitored monthly through the workforce report. 002 - Staff networks, EDI groups and Freedom to Speak Up channels 003 - Keep Connected updates 004 - Line-manager check-ins and escalation routes		3	4	12			18/02/2026						
26-005	P&C Sub-Group (05/02/26)			**Widening inequalities due to reduced organisational focus** **Risk:** There is a risk that inequalities widen within the workforce as capacity to progress equalities and anti-racist work reduces. **Cause:** Capacity constraints during transition are reducing the organisation’s ability to progress equality, inclusion and anti-racist work. Limited staffing in key teams and delays in workforce and culture data mean emerging disparities are harder to identify and address. **Impact:** This creates a heightened risk of widening inequalities across the workforce, with potential negative impacts on protected groups, weakened inclusion culture and possible non-compliance with statutory equality and human rights duties.	4	5	20			WRES/WDES Reports		3	4	12		001 - Apply EHIA - Equality & Health Impact Assessments consistently to all restructure and workforce decisions to identify disproportionate impacts early. 002 - Maintain momentum on anti-racism, EDI action plans and staff networks by streamlining rather than pausing activity. 003 - Implement targeted interventions for groups most at risk of detriment during organisational change			001 - Statutory frameworks (WRES, WDES, Gender Pay Gap, anti-racism) 002 - EHIAs 003 - EDI Networks		2	4	8			18/02/2026						
26-006	P&C Sub-Group (05/02/26)			**Inaccurate Workforce Data** **Risk:** There is a risk that workforce data becomes inaccurate or misleading due to high turnover and limited capacity for ESR maintenance. **Cause:** ESR records are changing rapidly due to high staff turnover, while limited capacity for data maintenance means key informationsuch as mandatory training, sickness, headcount and vacancies quickly becomes outdated and misaligned with the organisation’s actual position. **Impact:** This leads to unreliable workforce metrics, increasing the risk of misinterpretation by leaders and weakening decision-making. Reporting accuracy is compromised, organisational assurance is reduced, and confidence in data integrity may decline.	5	4	20			Workforce Reports Digital Dashboard		4	4	16							2	3	6			18/02/2026						
26-007	P&C Sub-Group (05/02/26)			**Mandatory training compliance** **Risk:** There is a risk that mandatory training compliance and tracking become unreliable, exposing the organisation to statutory and safety risks. **Cause:** Reduced staffing capacity and inaccuracies within the workforce intelligence team limit the organisation’s ability to complete and accurately track mandatory training. Conflicting messages about prioritisation and delays in reporting further undermine the reliability of compliance data. **Impact:** This may result in non-compliance with statutory IG, safeguarding and other mandatory requirements, increasing organisational liability. Staff may become	5	4	20			Organisational Target for MT - 95%		4	3	12		001 - Provide protected time for staff to complete essential modules, particularly in teams experiencing high workload or leadership gaps. 002 - Implement temporary grace-period arrangements for low-risk modules to avoid unnecessary breaches.			001 - Monthly Reporting		2	3	6			18/02/2026						

NHS
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Acting Chief Reform & Improvement Officer Report

2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester People and Resources Committee

April 2026

Required information	**Details**
Title of report	Acting Chief Reform & Improvement Officer Report
Author	Gill Baker – GM UEC Programme Director Dan Gordon – Director of elective care Ed Dyson – Director of performance, improvement and assurance
Presented by	Nicola Hepburn Acting Chief Reform & Improvement Officer, NHS GM
Contact for further information	Nicola.Hepburn1@nhs.net
Executive summary	This report provides an analysis of assurance relating to NHS Greater Manchester Integrated Care Board discharging its statutory duties for performance. It follows the Alert, Advise, Assure framework. It brings together intelligence from established governance routes and illustrates examples of actions taking place to deliver performance. The report shows varying levels of assurance in delivery of standards. It demonstrates Greater Manchester continues to show continuous improvement against standards.
The benefits that the population of Greater Manchester will experience.	The Greater Manchester population will gain improved health outcomes and experience as the Greater Manchester system makes continuous improvement in key standards.
How health inequalities will be reduced in Greater Manchester's communities.	A focus on reducing variation in provision across Greater Manchester will narrow variation in outcomes across geographical boundaries. Deep dives take place to look at variation across protected characteristic groups.
The decision to be made and/or input sought	The Committee is asked to: • Receive and discuss the report. • Note scrutiny of performance takes place at the Strategic Commissioning Committee and is reported to Board.
How this supports the delivery of the strategy and mitigates the BAF risks	Performance is held within BAF risk SR2.
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	Performance reports to Strategic Commissioning Committee and Board.
Engagement* to date ***Engagement: public,**	Development of the operational plan and its work programmes incorporate these aspects of engagement.

clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report. Financial impacts are reported as required. Financial decisions are taken through the appropriate governance. There is a relationship between achievement of financial objectives and delivery of performance standards due to the required levels of funded activity to require standards.

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

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

Alert

The following national priority metrics are currently rated as Alert and continue to be monitored through established recovery and performance arrangements:

- Urgent and Emergency Care – A&E 4-hour performance (GM providers)
- Urgent and Emergency Care – A&E 12-hour waits
- Elective – Incomplete RTT pathways of 52 weeks or more
- Diagnostics – 6-week diagnostic wait performance
- Mental Health – Average length of stay in adult acute mental health beds
- Learning Disabilities – Inpatient care for autistic adults

Advise

The following metrics are rated as Advise, with improvement plans in place and ongoing system oversight:

- Elective – Incomplete RTT pathways within 18 weeks
- Elective – Pathways waiting over 18 weeks for a first appointment
- Cancer – Patients receiving treatment within 62 days
- Learning Disabilities – Inpatient care for adults with learning disabilities
- Primary Care – Appointments in general practice
- Primary Care – Population access to NHS dentistry

Urgent Care focused update:

- System pressures: The UEC system has remained stable month to date. Isolated escalations have been managed effectively through the System Control Centre (SCC) and local escalation arrangements, with no sustained system-wide pressures identified.
- NEPTS: Procurement activity has progressed in line with plan. The evaluation phase has concluded, with moderation scheduled to commence w/c 20 April.
- Winter review: System-wide input has been completed, engaging locality partners and acute providers. Learning is being consolidated and will be shared through the UEC Reform Board to inform future planning and improvement.
- UEC Capacity Fund: Evaluation of funded schemes is underway using a standardised methodology. Completed proformas are due by the end of April, with system-level review and reporting planned for May through agreed governance routes.
- UEC Capital: NHS England has provided an update on UEC capital bids submitted as part of the wider capital programme. Letters of Key Engagement (LKOEs) have been requested from providers, with decisions on progression expected by the end of April.

EPRR on-call model: A revised on-call model has been agreed, supported by a new Standard Operating Procedure (SOP) and engagement through the Partnership Forum. Phased implementation will commence from 20 April to support an orderly transition.

Elective care focused update:

- Q4 sprint ended 31st March demonstrating significant improvement in performance especially RTT 18 weeks and total list size - Trusts are validating March position to the end of April to ensure most accurate position possible is reported
- Through planning round trusts have been funded to deliver target RTT performance to March 27,

NCA were lagging but have had a significant investment and should continue to improve, improving overall GM position

- **Consultant Connect** platform continues to see strong growth (March 15% above February levels) and being extended to March 27 (current annualised activity is c24,000 which is 50% above 24/25 levels)
- **BeCCoR** scheme approved for 2nd year, with a focus on targeted reduction in new referral rates and increase use of Trust SPOAs and Advice and Guidance
- **Community services**: ENT business case approved and mobilisation underway, Gynaecology service provision

Assure

The following metrics remain rated as Assure and are performing within national expectations:

- Cancer – Patients receiving communication of diagnosis, or ruling cancer out, within 28 days
- Mental Health – Access to Children and Young People's Mental Health Services
- Prevention – Hypertension treated in line with NICE guidance
- Prevention – Cholesterol management for patients with recorded cardiovascular disease

Governance, escalation, and assurance arrangements across UEC remain robust. Key programmes and workstreams continue to progress as planned, and there are no issues requiring escalation to Chief Officers beyond routine reporting at this time.

Risk discussed and new risk identified

Focus is now turning to 27/28 delivery. Many of the core standards, including the four-hour target, 18 weeks and 62 day cancer, have had target extended. This means a similarly challenging year ahead in terms of operational focus, productivity and transformation. As with 26/27 there is friction between delivery of financial and performance objectives. Focus on demand management brings the opportunity to mitigate these in a mutually inclusive way in some instances.

This risk is set out in BAF risk SR2.

Achievements

GM has continued to show continuous improvement over the last three years in all key indicators. We expect to see an improvement in relative performance to other ICBs when March rankings are published. Other than the A&E 4 hour target all year end figures are currently forecast. Final published figures and national rankings can be between eight and ten weeks following the year end. A summary of key indicators is as follows.

Standard	**Target**	**Forecast achievement**	**Improvement from March '25**
A&E 4 hour	> 78%	74.1% (confirmed)	+2.9%
18 week RTT	> 60.7%	61.4%	+8%
52 week RTT	<1%	1.75%	-2%
Cancer 62 day	>75%	75.6%	+3.9%
Cancer FDS	>80%	82.3%	+2%

UEC Focus

System working and the UEC March Sprint processes supported the delivery of the 4hr standard of care in March achieving 74.1%. This is an almost 3% improvement on the previous year and the table below highlights that all but 1 provider delivered improvement on the previous year.

Provider	March 26	March 25 Actual	Difference
Bolton FT	68.1%	71.8%	--3.7%
MFT	77.2%	73.9%	+3.3%
NCA	73.6%	68.8%	+4.5%
Stockport	70.1%	69%	+2.1%
Tameside	68.9%	67.1%	+2.8%
Wigan (WWL FT)	78.1%	71.7%	+6.3%
GM Total	**74.1%**	71.2%	+2.9%

Ambulance performance and the delivery of the Cat 2 response time remains higher than national average and Ambulance handovers are delivered in a timely manner across the GM footprint.

Throughout 25/26 the GM UEC Reform Programme has worked with system partners to achieve a fully implemented single telephony platform for Integrated Care Coordination. A number of localities have implemented a true Single Point of Access model to support the redirection of patients to more appropriate urgent community services, with other localities working through phased implementation plans.

It is too early to provide Trust specific figures across other indicators. These will be provided when published data is available.

NHS Greater Manchester

Chief Finance Officer Report

April 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester People and Resources Committee

22nd April 2026

Required information	**Details**
Title of report	Chief Clinical Officer Report
Author	Stephen Downs, Deputy Chief Finance Office, NHS GM
Presented by	Kathy Roe, Chief Finance Officer, NHS GM
Contact for further information	Stephen.Downs1@nhs.net
Executive summary	This report provides assurance on how NHS Greater Manchester Integrated Care Board is discharging its statutory duties for finance across the organisation and the system as a whole. It brings together intelligence from a number of resources to provide the Committee with an update on current pertinent issues and updates. Alerts • The transfer of social care from Northern Care Alliance Advise • Transfer of estate from NHS Property Services to NHS Trusts • National Dental Contract Reform • Capital bids for return to Constitutional Standards Assure • 2026/27 financial plans • 2026/27 provider contracts New risks • No new risks highlighted. CIP delivery continues to be the main risk Achievements • Delivery of the 2025/26 financial plan
The benefits that the population of Greater Manchester will experience.	The ICB will operate within the resources available for the Greater Manchester population and deliver the best value possible.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy.
The decision to be made and/or input sought	No decisions are required
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk SR7
Key milestones	These are set out within the different sections of the report.

Leadership and governance arrangements	This paper is produced for the People and Resources Committee and covers the finance aspects of the Committee business. It has not been elsewhere but is formulated from intelligence gathered from various senior managers within the ICB.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper.
Financial or Legal Implications;	There are no direct new financial or legal implications arising from this report.

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

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

Alert

Transfer of Salford Social Care from Northern Care Alliance (NCA)

The Northern Care Alliance (NCA) has been the provider of Adult Social Care services in Salford since July 2016 and has recently given notice on the ten-year contract, which was held originally by NHS Salford CCG and now NHS GM. At the same time, Salford City Council (SCC) expressed an intention to in-house the provision of Adult Social Care and a project is underway to transfer both social work staff and responsibility for packages of care back to the council in two phases in 2026/27.

There are some health elements of the former contract that the NCA will continue to deliver and NHS GM has agreed a contract value of £5,455k for 2026/27, which will be added to the existing contract for community services with the NCA. These health elements include Learning Disability nursing costs, psychological therapies and psychiatry input, a high-cost hospital placement and some health-related intermediate care costs.

Advise

Transfer of properties from NHS Property Services (NHSPS) to NHS Providers

NHS Trusts have an opportunity to transfer NHSPS assets into their own estate. Initial expressions of interest have been submitted by six providers covering 54 properties.
A subsequent business case will be required for each asset transfer that the ICB will review and provide support. At this stage, Trusts are only submitting an expression of interest.

National Dental Contract Reform

There are significant changes to the national dental contract for 2026/27. This has been financially modelled and as a consequence a number of locally commissioned services have been decommissioned or reduced as these now form part of the national contract. Financial and contractual performance monitoring will continue throughout 2026/27.

Return to Constitutional Standards 4 Year Capital Allocation

Greater Manchester ICS has been allocated £300m Public Dividend Capital over 4 years across 5 separate programmes:

- Diagnostics £95m
- Urgent Emergency Care £107m
- Mental Health and Learning Disabilities £26m
- Community £15m
- Primary Care and Strategic ICB capital £57m

Bids have been submitted to NHS England which are now in the process of being approved. Schemes greater than £1m require a business case. The ICB will need to provide formal support for these business cases to NHS England.

Assure

2026/27 Financial Plans

All organisations apart from one provider have now submitted compliant financial plans to NHS England. The system is, however, considered compliant because there is an aggregate breakeven position. The one provider submitting a non-compliant plan is the in the national NHS England

"Challenge Provider Programme".

Agreement of 2026/27 Provider Contracts

The ICB has agreed contract values with all material NHS providers and is working through minor variances with a handful of providers outside the system. We are in the process of finalising the paperwork so contracts can be signed. This reflects a significant achievement given the delays in contract signatures in previous years.
In addition, contract values for delegated specialised commissioning and the independent sector have been agreed.

Risk discussed and new risk identified

Delivery of the 2026/27 CIP Programme

The risk to the ICB plan continues to be the delivery of the CIP programme for 2026/27 and for at least 65% to be recurrent, in line with the plan submitted to NHSE. This will continue to be a risk during 2026/27, and delivery will be tracked through the People and Resources Committee.

No new risks have been identified.

Achievements

Delivery of the 2025/26 financial plan

The ICB has successfully delivered the 2025/26 planned deficit target of £7.5m. In addition, all organisations in the system delivered at least their individual target, with six organisations delivering better than plan. Therefore, the overall aggregate system position was a £24.1m surplus.

The ICB is on target to submit the IFR to NHS England on 20th April 2026 and the draft accounts on 27th April 2026.

NHS Greater Manchester

Draft Month 12 Finance Report

2025-2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS GM People and Resource Committee

22nd April 2026

Required information	Details
Title of report	Draft Month 12 Finance Report
Author	Jackie Gardiner – Corporate Director of Operational Finance – Financial Management Sandra Davies – Interim Associate Director of Finance - Corporate & Reporting
Presented by	Jackie Gardiner – Corporate Director of Operational Finance – Financial Management
Contact for further information	Jackie Gardiner – Corporate Director of Operational Finance – Financial Management
Executive summary	The purpose of the report is to update the People and Resources Committee on the draft Month 12 ICS financial position for Greater Manchester as at 31st March 2026.
The benefits that the population of Greater Manchester will experience.	Effective financial management will contribute to the delivery of the ICP strategy and delivery of health and social care services to the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	Effective financial management will support the delivery of the ICP strategy and the focus on commissioning decisions to reduce health inequalities.
The decision to be made and/or input sought	For the System Financial position, the People and Resources Committee are asked to: 1. Note the draft outturn position of a £24.1m surplus following the receipt of additional deficit support funding by GM NHS Providers. 2. Note the delivery of CIP in full for NHS GM at £175.0m. 3. Note the achievement of the requirement to remain within the allowable cash balance at the end of the year for NHS GM, with a cash balance of £36k. 4. Note the delivery of the provider operational capital position in line with the allocation of £201m.
How this supports the delivery of the	The report provides an update aligned to the

strategy and mitigates the Board Assurance Framework (BAF) risks	strategic risk to ensure financial balance for GM ICS for 2025/26.
Key milestones	Monthly reporting within 2025/26 Financial Year.
Leadership and governance arrangements	Reviewed by senior finance leadership due to year-end timescales.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A, part of on-going monthly reporting.
Financial or Legal Implications	N/A as this is the monthly Finance Report.

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

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

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

NHS Greater Manchester

NHS Greater Manchester Finance Report DRAFT Month 12 – March 2026

Presented by: Jackie Gardiner
Date: 22nd April 2026

Part of Greater Manchester Integrated Care Partnership

The final outturn position for the ICS for 2025/26 is a surplus of £24.1m (M11: £2.5m surplus), which is an improvement of £21.6m on the forecast outturn position reported at M11.

2025/26 ICS Surplus/(Deficit) £m	Annual Plan	Actual Outturn	Variance
GM NHS Providers	£7.5	£31.6	£24.1
NHS GM	-£7.5	-£7.5	£0.0
ICS Total	**£0.0**	**£24.1**	**£24.1**

Key points of note for Month 12 are:

- This reported position is based on the draft submissions for NHS GM and the GM NHS Providers. Draft accounts are due for submission on 27th April 2026, which will be subject to external audit before the final accounts are submitted in June.
- All GM NHS Providers have delivered their plan or better, and the main reason for the further improvement relates to the majority of the GM NHS Providers meeting the eligibility criteria and therefore receiving additional Deficit Support Funding of £21.3m.
- In addition, The Christie, MFT and NCA have reported a further surplus above their plan.
- The final NHS GM position is a deficit of £7.5m which is in line with plan. Whilst the implementation of Finance Recovery Plans in the 4 key risk areas has resulted in reduced spend in comparison to the run rate earlier in the year, pressures relating to ADHD, Autism and s117 within Mental Health, All Age Continuing Care and the Independent Sector have not been fully mitigated. However, the CIP target of £175.0m has been delivered in full. The outturn position also reflects other areas of underspend including Prescribing, Primary Care, and Running Costs.
- The closing cash balance for NHS GM was £36k, which was well within the allowable cash balance at the end of the financial year.
- The GM system spend on operational capital was £201m, which was within the £201m operational capital envelope issued by NHS England.

NHS Greater Manchester

For the System Financial position, the People & Resource Committee is asked to:

- Note the draft outturn position of a £24.1m surplus following the receipt of additional deficit support funding by GM NHS Providers.
- Note the delivery of CIP in full for NHS GM at £175.0m.
- Note the achievement of the requirement to remain within the allowable cash balance at the end of the year for NHS GM, with a cash balance of £36k.
- Note the delivery of the provider operational capital position in line with the allocation of £201m.

NHS Greater Manchester

NHS GM Financial Scheme of Delegation Amendments

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

People and Resources Committee

Date 22/04/2026

Required information	**Details**
Title of report	NHS GM Financial Scheme of Delegation Amendments
Author	Izhar Chaudhary
Presented by	Kathy Roe & Sam Evans
Contact for further information	Izhar Chaudhary
Executive summary	The purpose of this paper is to propose a number of amendments to the current NHS GM Financial Scheme of Delegation. The changes are being proposed in light of the pending changes to the NHS GM governance and Committee structures. This will enable efficient and effective decision making while retaining the appropriate level of financial grip and control.
The benefits that the population of Greater Manchester will experience.	Timely and effective decision making.
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	Endorse the proposed amendments to the NHS GM Financial Scheme of Delegation.
How this supports the delivery of the strategy and mitigates the BAF risks	Ensures financial risks are mitigated when incurring expenditure.
Key milestones	N/A
Leadership and governance arrangements	Chief Officers (1/4/26) Audit Committee (23/4/26) Board (14/5/26)
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Senior Finance Team Chief Officers (1/4/26)

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

Introduction

The purpose of this paper is to propose a number of amendments to the current NHS GM Financial Scheme of Delegation (FSD). The changes are being proposed in light of the pending changes to the NHS GM governance and Committee structures. The changes will enable efficient and effective decision making whilst retaining the appropriate level of financial grip and control.

Rationale for Proposed Amendments

The changes being proposed are based on the current proposals for the revised NHS GM governance and Committee structures and recognising that budgets and contracts are being consolidated at a pan GM level rather than at 10 separate Places, and in the absence of formal terms of reference having been agreed for the Committees/ Sub Committees/ Groups. Once the revised governance structure is agreed there may be a requirement to make further changes to the Financial Scheme of Delegation to ensure it is fit for purpose.

For clarity all threshold values proposed include VAT where applicable and are for the full contract duration including any option to extend.

Appendix 1 Highlights the current NHS GM Financial Scheme of Delegation as approved by Board on the 26/03/25.

Appendix 2 Highlights the proposed NHS GM Financial Scheme of Delegation.

Financial Scheme of Delegation- Proposed Amendments

Summary of Key Changes

The FSD has been updated to reflect the changes in the rationalisation of the NHS GM Committee structure, the change of names for the replacement Committees and new officer titles. The level of financial approval permitted has been recalibrated to ensure business decision making is efficient and effective and also moves financial approval to budget holders in line with accountability and away from finance staff.

Further detail on the comparison of the changes has been provided below only where the financial authorisation level has been amended. Other changes in new officer titles and Committee name changes ***have not been illustrated***. Red font identifies where tables or text has been deleted, and green font reflects the updated text

The following Tables have been removed:

Table 6 Employee Costs now reflected in New Table 13 Payroll Financial Approval, which was previously Table 16.

Table 8 Procurements, now reflected in New Table 6 Health Care Business Cases and New Table 7 Non-Health Care Business Cases/ Proposals, Requests for Funding and Contracts.

Table 15 Legal Claims, now reflected in New Table 10 All Losses, Legal Claims, Special

Payments, Consolatory Payments.

Section 1 - Highlights the key changes proposed in respect of the Committees and Senior Officer financial delegations.

Amendment - Finance Committee

Delegation previously assigned to the Finance Committee to be removed as this will not function as a standalone Committee in the new governance structure post 31/03/26.

Table 2 Individualised Commissioning (LD, MH, CHC, Children)

Previous approval limit: Receive a report on packages greater than £300,000.

Table 7 Health Care Business Cases/ Proposals

Previous approval limit: £5m and up to £100m.

Table 8 Procurements

Previous approval limit: £5m and up to £100m.

Table 9 Non-Health Care Business Cases/ Proposals, Requests for Funding and Contracts

Previous approval limit: £1m and up to £10m.

Table 10 Consultancy Expenditure

Previous approval limit: £50,000 and up to £250,000.

Table 12 All Losses, Special Payments, Consolatory Payments

Previous approval limit: All losses up to £100,000. Receive a report on all losses.

Proposed Amendments:

People & Resources Committee – To be assigned higher threshold values than the financial delegation of the previous Finance Committee recognising the consolidation of budgets at a pan GM level.

New Table 2 Individualised Commissioning (LD, MH, CHC, Children's)

New 'Report packages greater than £350,000 (bi-annually)'.

New Table 6 Health Care Business Cases/ Proposals

New approval limit: '£15m and up to £100m'.

New Table 7 Non-Health Care Business Cases/ Proposals, Requests for Funding and Contracts

New approval limit: '£5m and up to £20m'.

New Table 8 Consultancy Expenditure

New approval limit: '£100,000 and up to £250,000'.

New Table 10 All Losses, Legal Claims, Special Payments, Consolatory Payments

New approval limit: '£50,000 to £100,000. Receive a report on all losses'.

(See Appendix 2 for the applicable New Tables 2, 6, 7, 8,10)

Rationale

The People & Resources Committee has been assigned financial delegations based on the anticipated approval values on the consolidated budgets, and the volume of approvals likely to be required.

Amendment – Locality Committee, Place Based Lead and Deputy Place Lead

Delegation previously assigned to the Locality Committee(s), Place Based Lead and Deputy Place Lead to be removed as the Locality Committee(s), the Place Based Lead and Deputy Place Lead will no longer have delegated budgets within the new operating model from the 1st April 2026.

Proposed Amendments:

Remove financial delegation from the Locality Committee(s), Place Based Lead and Deputy Place Lead.

Rationale

The ten Places will be given a Place fund that includes the Better Care Fund to be managed within the governance of the host organisation. This expenditure will be incurred and managed by each of the individual host organisations, likely to be the Local Authorities in line with the agreed Section 75 agreements.

Amendment – Strategic Commissioning Committee

The financial delegation to be assigned to the Strategic Commissioning Committee needs to be determined considering the proposed changes to the governance structure to ensure that commissioning decisions can be made in a timely manner.

Proposed Amendments:

The financial delegation for the Strategic Commissioning Committee will be determined once the full implications of the revised Committee structure and consolidation of existing budgets and contracts is fully understood.

Rationale

The ICB is required to have a greater focus on strategic commissioning and with the streamlining of the existing Committee structures, it is envisioned that the Strategic Commissioning Committee will need to make financial decisions. Therefore, financial delegations to this Committee will need revisiting within the first 3-6 months of operation.

Proposed Amendments – Chief Officers (Three Statutory Board Members)

New Table 6 Health Care Business Cases/ Proposals

To increase the delegation for a combination of three Chief Officers from the current levels of £150k - £5m to £500k - £15m and to remove the terminology of three statutory Board Members. This will now require approval by the Chief Executive and Chief Finance Officer and one other ICB Chief Officer.

(See Appendix 2 for the applicable New Table 6)

Rationale

Recognising the impact of consolidating budgets and contracts at a pan GM level and moving VCSFE to 3-year contracts rather than rolling 12-month awards.

Operational Leadership Group

The Operational Leadership Group will not have any delegated financial authority, however, the Group will make recommendations to the Chief Officers meeting for decisions to be formally approved in line with the agreed NHS GM Financial Scheme of Delegation.

Section 2 – Provides an overview of the key changes proposed across the different FSD Tables, taking into account the requirement to transfer financial responsibility to budget holders.

Proposed Amendments – Table 1 Health & Service Contracts

New Table 1 Non-Financial Contract Values approval for the SIRO 'Signing of Data Processing/Sharing Agreements (As nominated by the GMICB CFO)'.

Proposed Amendments – Table 2 Individualised Commissioning (LD, MH, CHC, Children's)

New Table 2 Individualised Commissioning, finance delegation has been removed from Finance officers at Band 8D and Band C 'Package agreed up to £300,000', and Other Officer VSM 'Package agreed up to £250,000', recognising that the appropriate levels now sit with those officers within the relevant portfolio

Proposed Amendments – Table 3 Individual Funding Requests

New Table 3 Individual Funding Requests financial delegation has been assigned to Deputy Chief Finance Officer, Chief Commissioning Officer and Director in Chief Commissioning Officer Portfolio 'Up to £100,000'.

Proposed Amendments – Table 4 Cash and Activity

Amend the approval threshold for the Sign Off Regular Contract Invoices:

Chief Finance Officer threshold amended from 'Greater than £125m' to 'Greater than £200m'.
Finance Officer Band 8D, Band 9 and Deputy Chief Finance Officer threshold amended from 'Up to £125m' to 'Up to £200m'.

Amend the approval threshold for Cash Draw Down:

Chief Finance Officer and Deputy Chief Finance Officer threshold amended from 'Greater than £700m' to 'Greater than £1bn'.
Director of Finance Band 9 threshold amended from 'Up to £700m' to 'Up to £1bn'.
Head of Statutory Reporting Band 8B, Associate Director of Finance Band 8D threshold amended from 'Up to £700m' to 'Up to £800m'.

Amend the approval threshold for Sign-Off Regular Contract Invoices:

Remove the financial delegation for Finance officers at Band 8A and Band 7 'Up to £100m'.

Amend the approval threshold for Petty Cash:

Remove the financial delegation for Finance officers at Band 8A and Band 7 'Up to £500'.

Rationale

Changes to the threshold values associated with New Table 4 are required to reflect the business operational needs and higher contract values for key NHS providers.

Proposed Amendments – Table 5 Invoice Payment

Amend the Invoice Authorisation Non-Contract:

Approval Values:
Finance officers Band 8D and Band 8C from 'Up to £500,000' to 'Up to £250,000'.

Finance Officer Band 8B from 'Up to £500,000' to 'Up to £100,000'.
Other Officer VSM & Band 9 from 'Up to £50,000' to VSM & Band 9 with budget responsibility 'Up to £250,000'.
Other Officer Band 8D 'Up to £50,000' to Other Officer Band 8D with budget holder responsibility 'Up to £200,000'.
Other Officer Band 8C 'Up to £50,000' to Other Officer Band 8C with budget holder responsibility 'Up to £150,000'.
Other Officer Band 8B 'Up to £50,000' to Other Officer Band 8B with budget holder responsibility 'Up to £100,000'.
Other Officer Band 8A 'Up to £50,000' to Other Officer Band 8A with budget holder responsibility 'Up to £50,000'.

Amend Approval of PO Without a Contract

Other Officer VSM & Band 9 from '£0' to VSM & Band 9 with budget responsibility 'Up to £250,000'.
Other Officer Band 8D '£0' to Other Officer Band 8D with budget holder responsibility 'Up to £200,000'.
Other Officer Band 8C '£0' to Other Officer Band 8C with budget holder responsibility 'Up to £150,000'.
Other Officer Band 8B '£0' to Other Officer Band 8B with budget holder responsibility 'Up to £100,000'.
Other Officer Band 8A '£0' to Other Officer Band 8A with budget holder responsibility 'Up to £50,000'.

Amend Approval of PO Variances

Finance delegation has been removed for Finance officers at Band 7 and Band 6 'Approval of PO variances Up to £200'.

Amend Non-Contracted Approval

Finance delegation has been removed for Finance officers at Band 7, Band 6 and Band 5 'Up to £10,000'.

Proposed Amendments – Table 6 Health Care Business Cases/ Proposals (Including Change in Clinical Policies)

Amend Business Case/ Proposal Approvals

Approval Values:

ICB Executive Director (Statutory Board Member), and Chief Finance Officer, and Chief Executive (All three signatories) from '£150,000 and up to £10m' to ICB Chief Officer, and Chief Finance Officer, and Chief Executive (All three signatories via appropriate meeting) '£500,000 and up to £15m'.
Chief Executive from '£150,000' (with CFO engagement) to 'Up to £500,000'. Noting there is no longer a requirement for with CFO engagement
Removed ICB Chief Officer & Chief Finance Officer or Chief Executive 'Up to £150,000'.
Chief Finance Officer from '£150,000' to 'Up to £500,000'.

Chief Officer with relevant budget responsibility from '£100,000' to 'Up to £250,000'.

Proposed Amendments – Table 7 Non-Health Care/ Request for Funding and Contracts (Including Corporate Expenditure)

Amend Business Case/ Proposal Approvals

Approval Values:

ICB Executive Director (Statutory Board Member), and Chief Finance Officer, and Chief Executive (All three signatories) from '£75,000 and up to £1m' to ICB Chief Officer, and Chief Finance Officer, and Chief Executive (All three signatories via appropriate meeting) '£150,000 and up to £5m'.
Chief Executive from 'Up to £75,000' (with CFO engagement) to 'Up to £150,000'. Noting there is no longer a requirement for with CFO engagement
Removed ICB Chief Officer & Chief Finance Officer or Chief Executive 'Up to £75,000'.
Chief Finance Officer from 'Up to £75,000' to 'Up to £150,000'.
Chief Officer with relevant budget responsibility from 'Up to £50,000' to 'Up to £100,000'.
Deputy Chief Finance Officer/ Finance Officer VSM from '£5,000' to 'Up to £50,000'.
Director of Finance Band 9 from '£5,000' to 'Up to £25,000'.
Associate Director of Finance Band 8D from '£5,000' to 'Up to £15,000'.
Assistant Director of Finance Band 8C from '£5,000' to 'Up to £15,000'.
Head of Finance Band 8B from '£5,000' to 'Up to £10,000'.
Finance Business Partner Band 8A from '£5,000' to 'Up to £10,000'.
Other Officer VSM '£0' to Other Officer VSM with relevant budget responsibility to 'Up to £25,000'.
Other Officer Band 9 '£25,000' to Other Officer Band 9 with relevant budget responsibility to 'Up to £25,000'.
Other Officer Band D & Band C from '£25,000' to Other Officer Band D & Band C with relevant budget responsibility 'Up to £15,000'.
Other Officer Band B & Band A from '£10,000' to Other Officer Band B & Band A with relevant budget responsibility 'Up to £10,000'.

Proposed Amendments – Table 8 Consultancy Expenditure

Amend Approval Value:

Approval Value:

Chief Executive 'Up to £49,999' (with CFO engagement) to 'Up to 50,000'. Noting there is no longer a requirement for with CFO engagement
Chief Finance Officer 'Up to £49,999' to 'Up to £50,000'.

Proposed Amendments – Table 9 Raise Sales Invoices

Amend Approval Value:

Approval Value:

Chief Finance Officer from 'Greater than £250,000' to 'Greater than £1m'.
Deputy Chief Finance Officer/ VSM from 'Greater than £250,000' to 'Greater than £1m'.
Director of Finance Band 9 from 'Greater than £250,000' to ' Greater than £1m'.
Associate Director of Finance Band 8D from 'Greater than £250,000' to 'Greater than £500,000'.
Assistant Director of Finance Band 8C from 'Greater than £250,000' to '£250,000 to £500,000'.

Proposed Amendments – Table 10 All Losses, Legal Claims Special Payments, Consolatory Payments

Amend Approval Value:

Approval Value:

GMICB Board Special Payments and Consolatory Payments from 'All' to 'Greater than £5,000'
Finance Committee 'All losses up to £100,000' to People and Resources Committee '£50,000 to £100,000'.
Chief Finance Officer Special Payments and Consolatory Payments from '£0' to 'Up to £5,000'.

Proposed Amendments – Table 11 Budget Virements

Amend Approval Value:

Approval Value:

Deputy Chief Finance Officer from 'Up to £50m' to '£75m to £100m'.
Director of Finance Band 9 from 'Up to £50m' to '£75m to £100m'.
Associate Director of Finance Band 8D from 'Up to £50m' to 'Up to £75m'.
Head of Finance Band 8B from 'Up to £50m' to 'Up to £25m'.
Finance Business Partner from 'Up to £50m' to 'Up to £15m'.

Proposed Amendments – Table 12 Authorisation- Waivers & Decision-Making Records Under (PSR)

Amend Approval:

Approval:

Chief Executive from 'All waivers' to 'All waivers & Decision-Making Records under PSR'.
Chief Finance Officer from 'All waivers' to 'All waivers & Decision-Making Records under PSR'.
Deputy Chief Finance Officer from 'All waivers (As nominated in writing by the GMICB CFO) to 'All waivers & Decision-Making Records under PSR (As nominated in writing by the GMICB CFO)'
Director of Finance Band 9 from 'All waivers (As nominated in writing by the GMICB CFO) to 'All waivers & Decision-Making Records under PSR (As nominated in writing by the GMICB CFO)'.

Associate Director of Contract Management & Procurement Band 8D from 'All waivers (As nominated in writing by the GMICB CFO) to 'All waivers & Decision-Making Records under PSR (As nominated in writing by the GMICB CFO)'.

Proposed Amendments – Table 14 Travel Expenses

Amend Approval:

Approval:

Removal of all financial values for all officers to be replaced with 'As permitted in line with the use of the Easy Expenses/ ESR approval processes'.

Appendix 3 provides guidance on using the Financial Scheme of Delegation, and guidance on the financial processes to follow when incurring expenditure.

Action Required

The People and Resources Committee is requested to:

1. Endorse the proposed amendments to the NHS GM Financial Scheme of Delegation.

Next Steps

Subject to the approval of the above recommendations the NHS GM Financial Scheme of Delegation will be amended accordingly, once approved by the Audit Committee (23/04/26) and Board (14/05/26).

NHS Greater Manchester Integrated Board

Financial Scheme of Delegation

NHS Greater Manchester

DOCUMENT CONTROL SHEET

Name of Document:	Financial Scheme of Delegation
Version:	15.0
File Location / Document Name:	
Date Of This Version:	26/03/2025
Produced By:	Izhar Chaudhary
Reviewed By:	N/A
Synopsis And Outcomes Of Equality and Diversity Impact Assessment:	N/A
Ratified By (Committee):	N/A
Date Ratified:	N/A
Distribute To:	N/A
Date Due For Review:	N/A
Enquiries To:	Izhar Chaudhary

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
08/05/24	Approval value increased from £120m to £125m (VSM & Band 9), approval value increased from £100m to £125m (Band 8D) for the approval of regular contract invoices as per Table 4. EMT/ Senior Management Team financial approval revoked, and assigned to CE, CFO and Executive Director(s) or nominated deputies, as per Table 7, Table 8 and Table 9. Remuneration Committee approval for pay and travel reflected as per the SORD in Table 16.	Izhar Chaudhary	V13
06/08/24	Consultancy, and Special Losses & Payments thresholds changed as agreed at the 15/05/24 Board meeting.	Izhar Chaudhary	V13.1
29/08/24	Changes to role names (ICB Executive Director -Statutory Board Member), Chief Officer and Deputy Chief Executive) and authorisation of Non Pay expenditure up to £50,000.	Izhar Chaudhary	V14.0
26/03/25	Amendments to Table 9 Non Pay/ Requests for Funding and Contracts, thresholds changed. Change of title from Place Based Delivery Lead to Deputy Place Lead. Changes enacted after NHS GM Board approval on the 26/03/25.	Izhar Chaudhary	V15.0

Approvals

This document requires approval at the GMIB Board

Committee	Date of Issue	Version Number
Board	October 2022	V12
Board Board	15 May 2024 15 May 2024	V13 V13.1
Board	18 September 2024	V14.0
Board	26 March 2025	V15.0

GMICB Financial Scheme of Delegation

The table below provides an outline of the different categories of approval along with table reference numbers.

Table Reference	Area of Approval
Table 1	Health Service Contracts
Table 2	Individualised Commissioning (LD, MH, CHC, Children's)
Table 3	Individual Funding Requests
Table 4	Cash and Activity
Table 5	Invoice Payment
Table 6	Employee Costs
Table 7	Business Cases/ Proposals (Including Change in Clinical Policies)
Table 8	Procurements
Table 9	Non-Pay / Request for Funding and Contracts (Including Corporate Expenditure)
Table 10	Consultancy Expenditure
Table 11	Raise Sales Invoices
Table 12	All Losses, Special Payments, Consolatory Payments
Table 13	Budget Virements Between Cost Centres
Table 14	Waiver Authorisation
Table 15	NHS Legal Claims
Table 16	Payroll Financial Approval
Table 17	Travel Expenses

Guidance

The column on the left indicates the Committee/Officer being granted authority, the column on the right indicates the category of expenditure/ authority along with the financial limit where appropriate.

If an officer is in doubt about the appropriate approval level or authority required the GMICB Finance directorate should be contacted in the first instance for clarification and guidance.

Table 1 -Health Service Contracts

Notes **** This section is associated with the signature on contractual documents. It assumes appropriate governance has been undertaken in respect of a business case, procurement exercise or waiver.

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning**	**Health Service Contracts (NHS and Non-NHS Providers)********		
Committee Name or Post	**Contract Sign off Value**	**All Contract Variations**	**Non Financial Cntract Values**
Chief Executive	All contracts (With CFO engagement)		
Chief Finance Officer	All contracts	All variations	
Finance Officer VSM	All contracts (As nominated in writing by the GMICB CFO)	All contracts (As nominated in writing by the GMICB CFO)	
Finance Officer Band 9	All contracts (As nominated in writing by the GMICB CFO)	All contracts (As nominated in writing by the GMICB CFO)	
Finance Officer Band 8D	All contracts (As nominated in writing by the GMICB CFO)	All contracts (As nominated in writing by the GMICB CFO)	
Other Officer VSM			Primary Care Contracts (Medical, Dentistry, Pharmacy, Optometry) Community Dental and Specialist Dental (As nominatied in writing by the GMICB CFO
Other Officer Band 9			Primary Care Contracts (Medical, Dentistry, Pharmacy, Optometry) Community Dental and Specialist Dental (As nominatied in writing by the GMICB CFO
Other Officer Band 8D			Primary Care Contracts (Medical, Dentistry, Pharmacy, Optometry) Community Dental and Specialist Dental (As nominatied in writing by the GMICB CFO

Table 2 -Individualised Commissioning

Notes * Any packages of care above this value would need to go through the normal commissioning process.
** Individualised commissioning limits are only applicable to designated managers / senior managers / executives with responsibility for MH, LD, CHC and Children's, including jointly funded packages. Individuals with this responsibility will be recorded (and reviewed periodically).

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Individualised Commissioning **** **(LD, MH, CHC, Children's)** **(Financial limits reflect the expected annual cost of the package)**	
Committee Name or Post	**Non Healthcare (e.g. supported living)**	**Healthcare Placements/ Packages**
Finance Committee		Report packages greater than £300,000
ICB Executive Director (Statutory Board Member) or Chief Finance Officer or Chief Executive (Two out of three signatures required)		*Package greater than £350,000
Chief Executive	Up to *£100,000 (With CFO engagement)	
Chief Finance Officer	Up to *£100,000	
ICB Executive Director (Statutory Board Member) or Place Based Lead or Deputy Place Lead or Chief Officer or Deputy Chief Executive (Only for responsible budget areas assigned)		*Package agreed up to £350,000
Placed Based Lead or Deputy Place Lead Deputy Place Lead/Deputy Place Lead (Deputy) or Locality Finance Lead (Two out of three signatures required) (Only for responsible budget areas assigned)		*Package greater than £350,000
Finance Officer VSM		*Package agreed up to £350,000
Finance Officer Band 9		*Package agreed up to £350,000
Finance Officer Band 8D		*Package agreed up to £300,000
Finance Officer Band 8C		*Package agreed up to £300,000
Other Officer VSM		Package agreed up to £250,000
Other Officer Band 9		Package agreed up to £250,000
Other Officer Band 8D		Package agreed up to £250,000
Other Officer Band 8C		Package agreed up to £150,000
Other Officer Band 8B		Package agreed up to £150,000
Other Officer Band 8A		Package agreed up to £80,000
Other Officer Band 7		Package agreed up to £80,000
On Call Managers	Up to £5,000	Up to £100,000

Table 3 -Individual Funding Requests

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Individual Funding Requests** **(Financial limits reflect the annual cost)**
Committee Name or Post	
GMICB Board	Greater than £250,000
Chief Executive	Up to £250,000 (With CFO engagement)
Chief Finance Officer	Up to £150,000
Other Officer VSM	Up to £100,000
Other Officer Band 9	Up to £100,000
Other Officer Band 8D	Up to £100,000

Table 4 -Cash and Activity

Approval Limits
With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.

General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.

Individualised commissioning
Limits reflect the expected annual cost of the package.

Cash and Activity			
Committee Name or Post	**Sign -Off Regular Contract Invoices**	**Petty Cash**	**Cash Draw Down**
Chief Finance Officer	Greater than £125m	Up to £1,000	Greater than £700m
Finance Officer VSM	Up to £125m	Up to £1,000	Greater than £700m
Finance Officer Band 9	Up to £125m	Up to £1,000	Up to £700m
Finance Officer Band 8D	Up to £125m	Up to £1,000	Up to £700m
Finance Officer Band 8C	Up to £100m	Up to £1,000	Up to £700m
Finance Officer Band 8B	Up to £100m	Up to £500	Up to £700m
Finance Officer Band 8A	Up to £100m	Up to £500	
Finance Officer Band 7	Up to £100m	Up to £500	

Greater Manchester

Table 5 -Invoice Payment

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Invoice Payment**			
Committee Name or Post	**Invoice Authorisation - Non Contract**	**Conversion of Requisitions**	**Approval of PO Variances**	**Non Contracted Activity Approval**
Chief Executive	Greater than £600,000 (With CFO engagement)			
Chief Finance Officer	Greater than £600,000			
ICB Executive Director (Statutory Board Member) or Place Based Lead or Deputy Place Lead or Chief Officer or Deputy Chief Executive	Up to £600,000			
Finance Officer VSM	Up to £600,000		Up to £5000	
Finance Officer Band 9	Up to £600,000	£999,999,999 (To include an ability to adjust the value up or	Up to £5000	
Finance Officer Band 8D	Up to £500,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5000	
Finance Officer Band 8C	Up to £500,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5000	Greater than £10,000
Finance Officer Band 8B	Up to £500,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5000	Greater than £10,000
Finance Officer Band 8A	Up to £50,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £200	Greater than £10,000
Finance Officer Band 7		£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £200	Up to £10,000
Finance Officer Band 6			Up to £200	Up to £10,000
Finance Officer Band 5				Up to £10,000
Other Officer VSM	Up to £50,000			
Other Officer Band 9	Up to £50,000			
Other Officer Band 8D	Up to £50,000			
Other Officer Band 8C	Up to £50,000			
Other Officer Band 8B	Up to £50,000			
Other Officer Band 8A	Up to £50,000			

Table 6 -Employee Costs

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Employee Costs**
Committee Name or Post	**Changes to Payroll details**
Chief Executive	Sign of changes to employee details
Chief Finance Officer	Sign of changes to employee details
Finance Officer VSM	Sign of changes to employee details
Finance Officer Band 9	Sign of changes to employee details
Finance Officer Band 8D	Sign of changes to employee details
Finance Officer Band 8C	Sign of changes to employee details
Finance Officer Band 8B	Sign of changes to employee details
Finance Officer Band 8A	Sign of changes to employee details

NHS Greater Manchester

Table 7 -Business Cases/ Proposals

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Business Cases / Proposals (Including Change in Clinical Policies)** **(Financial limits reflect total contract values, if recurrent funding, then 3 times the annual value should be used for the purpose of financial approval limits)**
Committee Name or Post	**To commit resources for commissioned healthcare services (including decommissioning & disinvestment decisions)**
GMICB Board	Greater than £100m
Finance Committee	£5m - and up to £100m
ICB Executive Director (Statutory Board Member) and Chief Finance Officer and Chief Executive (or nominated deputies) (All three signatures required)	£150,000 and up to £5m
Chief Executive	Up to £150,000 (With CFO engagement)
ICB Executive Director (Statutory Board Member) + Chief Finance Officer or Chief Executive	Up to £150,000
Chief Finance Officer	Up to £150,000
ICB Executive Director (Statutory Board Member) or Place Based Lead or Deputy Place Lead or Chief Officer or Deputy Chief Executive (Only for responsible budget areas assigned)	Up to £100,000
Placed Based Lead and Deputy Place Lead and Locality Finance Lead (All three signatures required) (Only for responsible budget areas assigned)	Up to £500,000
Locality Committee	Full approval of all budgets that have been delegated to the Locality up to the value of £5m.

Table 8 -Procurements

Notes
*** Procurements which do not result in any change of provider, are funded recurrently and there are no material variations do not need to go for approval, only information. This assumes that a procurement exercise is undertaken. Or alternatively the waiver process is followed.

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Procurements***** **(Financial limits reflect total contract values, if recurrent funding, then 3 times the annual value should be used for the purpose of financial approval limits)**	
Committee Name or Post	**To commit resources for healthcare services through launching a procurement exercise**	**To commit resources for healthcare services as a result of a procurement exercise which has already been approved as part of a recent business case, which is within the agreed funding levels**
GMICB Board	Greater than £100m	
Finance Committee	£5m and up to £100m	
ICB Executive Director (Statutory Board Member) and Chief Finance Officer and Chief Executive (or nominated deputies) (All three signatures required)	£500,000 and up to £5m	All procurements
Chief Executive	Up to £500,000 (With CFO engagement)	
ICB Executive Director (Statutory Board Member) + Chief Finance Officer or Chief Executive	Up to £500,000	
Chief Finance Officer	Up to £500,000	
ICB Executive Director (Statutory Board Member) or Place Based Lead or Deputy Place Lead or Chief Officer or Deputy Chief Executive (Only for responsible budget areas assigned)	Up to £100,000	
Placed Based Lead and Deputy Place Lead and Locality Finance Lead (All three signatures required) (Only for responsible budget areas assigned)	Up to £500,000	
Locality Committee	Full approval of all budgets that have been delegated to the Locality up to the value of £5m.	Full approval of all budgets that have been delegated to the Locality up to the value of £5m.

Table 9 -Non-Pay/ Requests for Funding and Contracts

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Non-Pay / Request for Funding and Contracts (Including Corporate Expenditure)** **(Financial limits reflect total contract values, if recurrent funding, then 3 times the annual value should be used for the purpose of financial approval limits)** **(All threshold values include VAT where applicable and are for the full contract duration including any option to extend)**
Committee Name or Post	**(To commit resources that are NOT service costs or staff costs, e.g. nonhealthcare contracts)**
GMICB Board	Greater than £10m
Finance Committee	Greater than £1m and up to £10m
ICB Executive Director (Statutory Board Member) and Chief Finance Officer and Chief Executive (or nominated deputies) (All three signatures required)	£75,000 and up to £1m
Chief Executive	Up to £75,000 (With CFO engagement)
ICB Executive Director (Statutory Board Member) + Chief Finance Officer or Chief Executive	Up to £75,000
Chief Finance Officer	Up to £75,000
ICB Executive Director (Statutory Board Member) or Place Based Lead or Deputy Place Lead or Chief Officer or Deputy Chief Executive (Only for responsible budget areas assigned)	Up to £50,000
Finance Officer VSM	Up to £5,000
Finance Officer Band 9	Up to £5,000
Finance Officer Band 8D	Up to £5,000
Finance Officer Band 8C	Up to £5,000
Finance Officer Band 8B	Up to £5,000
Finance Officer Band 8A	Up to £5,000
Other Officer Band 9	Up to £25,000
Other Officer Band 8D	Up to £25,000
Other Officer Band 8C	Up to £25,000
Other Officer Band 8B	Up to £10,000
Other Officer Band 8A	Up to £10,000
Locality Committee	Full approval of all budgets that have been delegated to the Locality up the value of £500,000.

Table 10 -Consultancy Expenditure

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Consultancy Expenditure** **(All expenditure to be approved must be in line with NHSE guidance)**
Committee Name or Post	
GMICB Board	Greater than £250,000
Finance Committee	£50,000 and up to £250,000
Chief Executive	Up to £49,999 (With CFO engagement)
Chief Finance Officer	Up to £49,999

Table 11 -Raise Sales Invoices

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Raise Sales Invoices**
Committee Name or Post	
Chief Finance Officer	Greater than £250,000
Finance Officer VSM	Greater than £250,000
Finance Officer Band 9	Greater than £250,000
Finance Officer Band 8D	Greater than £250,000
Finance Officer Band 8C	Greater than £250,000
Finance Officer Band 8B	£100,000 -£250,000
Finance Officer Band 8A	£100,000 or less

Table 12 -All Losses, Special Payments, Consolatory Payments

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**All Losses, Special Payments, Consolatory Payments** **(All expenditure to be approved must be in line with NHSE guidance and SFIs)**
Committee Name or Post	
GMICB Board	All Losses Greater than £100,000 All Special Payments All Consolatory Payments (Report All Losses, Special Payments, Consolatory Payments)
Audit Committee	(Report All Losses, Special Payments, Consolatory Payments)
Finance Committee	All Losses up to £100,000 (Report All Losses)
Chief Finance Officer	All Losses up to £50,000

Table 13 – Budget Virements Between Cost Centres

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Budget Virements Between Cost Centres**
Committee Name or Post	
Chief Finance Officer	Greater than £100m
Finance Officer VSM	Up to £50m
Finance Officer Band 9	Up to £50m
Finance Officer Band 8D	Up to £50m
Finance Officer Band 8C	Up to £50m
Finance Officer Band 8B	Up to £50m
Finance Officer Band 8A	Up to £50m

Table 14 -Waiver Authorisation

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Waiver Authorisation**
Committee Name or Post	
Audit Committee	All waivers to be reported to the Audit Committee
Chief Executive	All waivers
Chief Finance Officer	All waivers
Finance Officer VSM	All waivers (As nominated in writing by the GMICB CFO)
Finance Officer Band 9	All waivers (As nominated in writing by the GMICB CFO)
Finance Officer Band 8D	All waivers (As nominated in writing by the GMICB CFO)

Table 15 -NHS Legal Claims

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**NHS Legal Claims**
Committee Name or Post	
GMICB Board	All Legal Claims

Table 16 -Payroll Financial Approval

Approval Limits
With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.

General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.

Individualised commissioning
Limits reflect the expected annual cost of the package.

Payroll Financial Approval	
Committee Name or Post	**HR Forms**
Remuneration Committee	Financial Approval in relation to Chief Executive, Directors, Non Executive Directors and other VSM. All other duties as outlined in the SORD.
Chief Finance Officer	Authorise HR Forms for Financial Approval
Finance Officer VSM	Authorise HR Forms for Financial Approval
Finance Officer Band 9	Authorise HR Forms for Financial Approval
Finance Officer Band 8D	Authorise HR Forms for Financial Approval
Finance Officer Band 8C	Authorise HR Forms for Financial Approval
Finance Officer Band 8B	Authorise HR Forms for Financial Approval
Finance Officer Band 8A	Authorise HR Forms for Financial Approval

Table 17 -Travel Expenses

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Travel Expenses** **(Financial limit for an individual monthly claim)**
Committee Name or Post	
Chief Executive	Up to £1,000
Chief Finance Officer	Up to £1,000
ICB Executive Director (Statutory Board Member) or Place Based Lead or Deputy Place Lead or Chief Officer or Deputy Chief Executive (Only for responsible budget areas assigned)	Up to £1,000
Finance Officer VSM	Up to £1,000
Finance Officer Band 9	Up to £1,000
Finance Officer Band 8D	Up to £500
Finance Officer Band 8C	Up to £500
Finance Officer Band 8B	Up to £500
Finance Officer Band 8A	Up to £500
Finance Officer Band 7	Up to £500
Other Officer VSM	Up to £1,000
Other Officer Band 9	Up to £1,000
Other Officer Band 8D	Up to £500
Other Officer Band 8C	Up to £500
Other Officer Band 8B	Up to £500
Other Officer Band 8A	Up to £500
Other Officer Band 7	Up to £500

NHS Greater Manchester Integrated Board

Financial Scheme of Delegation

NHS Greater Manchester

DOCUMENT CONTROL SHEET

Name of Document:	Financial Scheme of Delegation
Version:	16.0
File Location / Document Name:	
Date Of This Version:	30/03/2026
Produced By:	Izhar Chaudhary
Reviewed By:	N/A
Synopsis And Outcomes Of Equality and Diversity Impact Assessment:	N/A
Ratified By (Committee):	N/A
Date Ratified:	N/A
Distribute To:	N/A
Date Due For Review:	N/A
Enquiries To:	Izhar Chaudhary

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
08/05/24	Approval value increased from £120m to £125m (VSM & Band 9), approval value increased from £100m to £125m (Band 8D) for the approval of regular contract invoices as per Table 4. EMT/ Senior Management Team financial approval revoked, and assigned to CE, CFO and Executive Director(s) or nominated deputies, as per Table 7, Table 8 and Table 9. Remuneration Committee approval for pay and travel reflected as per the SORD in Table 16.	Izhar Chaudhary	V13
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30/03/26	Changes to reflect revised NHS GM governance structure.	Izhar Chaudhary	V16.0

Approvals

This document requires approval at the GMIB Board

Committee	Date of Issue	Version Number
Board	October 2022	V12
Board Board	15 May 2024 15 May 2024	V13 V13.1
Board	18 September 2024	V14.0
Board	26 March 2025	V15.0

GMICB Financial Scheme of Delegation

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Table 11	Budget Virements Between Cost Centres
Table 12	Authorisation- Waivers & Decision Making Records Under (PSR)
Table 13	Payroll Financial Approval
Table 14	Travel Expenses

Guidance
The column on the left indicates the Committee/Officer being granted authority, the column on the right indicates the category of expenditure/ authority along with the financial limit where appropriate.

If an officer is in doubt about the appropriate approval level or authority required, the GMICB Finance directorate should be contacted in the first instance for clarification and guidance.

NHS Greater Manchester

Table 1 -Health Service Contracts

Notes **** This section is associated with the signature on contractual documents. It assumes appropriate governance has been undertaken in respect of a business case, procurement exercise or waiver.

	Health Service Contracts (NHS and Non-NHS Providers)****		
Committee Name or Post	**Contract Sign off Value**	**All Contract Variations**	**Non Financial Contract Values**
Chief Executive	All contracts (With CFO engagement)		
Chief Finance Officer (CFO)	All contracts	All variations	
Deputy Chief Finance Officer	All contracts (As nominated in writing by the GMICB CFO)	All contracts (As nominated in writing by the GMICB CFO)	
Director of Finance - Band 9	All contracts (As nominated in writing by the GMICB CFO)	All contracts (As nominated in writing by the GMICB CFO)	
Associate Director of Provider Finance & Insight - Band 8D	All contracts within their portfolio (As nominated in writing by the GMICB CFO)	All contracts within their portfolio (As nominated in writing by the GMICB CFO)	
Chief Commissioning Officer			Primary Care Contracts (Medical, Dentistry, Pharmacy, Optometry) Community Dental and Specialist Dental (As nominated by the GMICB CFO.
Director of Primary Care & Community Health Services - Band 9			Primary Care Contracts (Medical, Dentistry, Pharmacy, Optometry) Community Dental and Specialist Dental (As nominated by the GMICB CFO.
Associate Director of Primary Care - Band 8D			Primary Care Contracts (Medical, Dentistry, Pharmacy, Optometry) Community Dental and Specialist Dental (As nominated by the GMICB CFO.
SIRO			Signing of Data Processing/Sharing Agreements (As nominated by the GMICB CFO)

Table 2 -Individualised Commissioning

Notes * Any packages of care above this value would need to go through the normal commissioning process.
** Individualised commissioning limits are only applicable to designated managers / senior managers / executives with responsibility for MH, LD, CHC and Children's, including jointly funded packages. Individuals with this responsibility will be recorded (and reviewed periodically).

Approval Limits **With the exception of individualised commissioning, all limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** **General: All limits referred to are for those budgets delegated, with the exception of ICB Board members, where limits apply across all ICB budgets unless specified.** **Individualised commissioning** **Limits reflect the expected annual cost of the package.**	**Individualised Commissioning **** **(LD, MH, CHC, Children's)** **(Financial limits reflect the expected annual cost of the package)**	
Committee Name or Post	**Non Healthcare (e.g. supported living)**	**Healthcare Placements/ Packages**
People & Resources Committee bi-annually		Report packages greater than £350,000
ICB Chief Officer & either Chief Finance Officer or Chief Executive (Two out of three signatures required)		*Package greater than £350,000
Chief Executive	Up to *£150,000	
Chief Finance Officer	Up to *£150,000	
Chief Officer with relevant budget responsibility		*Package agreed up to £350,000
Deputy Chief Finance Officer - to cover in absence of Chief Officer		*Package agreed up to £350,000
Director of Finance - Band 9 to cover for absences		*Package agreed up to £350,000
Director in relevant Chief Officer Portfolio - Band 9		Package agreed up to £250,000
Associate Director in relevant Chief Officer Portfolio - Band 8D		Package agreed up to £250,000
Assistant Director in relevant Chief Officer portfolio - Band 8C		Package agreed up to £150,000
Other Officer in relevant Chief Officer Portfolio Band 8B		Package agreed up to £150,000
Other Officer in relevant Chief Officer portfolio - Band 8A		Package agreed up to £80,000
Other Officer in relevant Chief Officer portfolio - Band 7		Package agreed up to £80,000
On Call Managers	Up to £5,000	Up to £100,000

Table 3 -Individual Funding Requests

Approval Limits **All limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.**	**Individual Funding Requests** **(Financial limits reflect the annual cost)**
Committee Name or Post	
GMICB Board	Greater than £250,000
Chief Executive	Up to £250,000
Chief Finance Officer	Up to £150,000
Deputy Chief Finance Officer	Up to £100,000
Chief Commissioning Officer	Up to £100,000
Director in Chief Commissioning Officer Portfolio - Band 9	Up to £100,000

Table 4 -Cash and Activity

	Cash and Activity		
Committee Name or Post	**Sign -Off Regular Contract Invoices**	**Petty Cash**	**Cash Draw Down**
Chief Finance Officer	Greater than £200m	Up to £1,000	Greater than £1bn
Deputy Chief Finance Officer	Up to £200m	Up to £1,000	Greater than £1bn
Director of Finance Band 9	Up to £200m	Up to £1,000	Up to £1bn
Associate Director of Finance Band 8D	Up to £200m	Up to £1,000	Up to £800m
Assistant Director of Finance Band 8C	Up to £100m	Up to £1,000	
Head of Finance Band 8B	Up to £100m		
Head of Statutory Reporting Band 8B		Up to £500	Up to £800m

Table 5 -Invoice Payment

	Invoice Payment			
Committee Name or Post	**Invoice Authorisation - Non Contract**	**Approval of PO without a contract**	**Approval of PO Variances**	**Non Contracted Activity Approval**
Chief Executive	Greater than £600,000			
Chief Finance Officer	Greater than £600,000			
Chief Officer with relevant budget responsibility	Up to £600,000			
Deputy Chief Finance Officer	Up to £600,000		Up to £5000	
Director of Finance Band 9	Up to £500,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5000	
Associate Director of Finance Band 8D	Up to £250,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5000	
Assistant Director of Finance Band 8C	Up to £150,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5000	Greater than £10,000
Head of Finance Band 8B	Up to £100,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5000	Greater than £10,000
Head of Statutory Reporting Band 8B		£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £5001	
Finance Business Partner Band 8A	Up to £50,000	£999,999,999 (To include an ability to adjust the value up or down by £200)	Up to £200	Greater than £10,000
Other Officer VSM & Band 9 with budget responsibility	Up to £250,000	Up to £250,000		
Other Officer Band 8D with budget responsibility	Up to £200,000	Up to £200,000		
Other Officer Band 8C with budget responsibility	Up to £150,000	Up to £150,000		
Other Officer Band 8B with budget responsibility	Up to £100,000	Up to £100,000		
Other Officer Band 8A with budget responsibility	Up to £50,000	Up to £50,000		

Table 6 -Health Care Business Cases/ Proposals

Approval Limits **All limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.**	**Business Cases / Proposals for Healthcare prior to any Procurements Commencing (Including Change in Clinical Policies)** **(Financial limits reflect total contract values, if recurrent funding, then 3 times the annual value should be used for the purpose of financial approval limits)**
Committee Name or Post	**To commit resources for commissioned healthcare services (including decommissioning & disinvestment decisions)**
GMICB Board	Greater than £100m
People & Resources Committee	£15m - and up to £100m
Strategic Commissioning Committee	TBC
ICB Chief Officer and Chief Finance Officer and Chief Executive (or nominated deputies) (All three signatures required) via appropriate meeting	£500,000 and up to £15m
Chief Executive	Up to £500,000
Chief Finance Officer	Up to £500,000
Chief Officer with relevant budget responsibility	Up to £250,000

Table 7 -Non-Health Care/ Requests for Funding and Contracts

	Non-Pay / Request for Funding and Contracts for Non Healthcare prior to any Procurements Commencing (Financial limits reflect total contract values, if recurrent funding, then 3 times the annual value should be used for the purpose of financial approval limits) (All threshold values include VAT where applicable and are for the full contract duration including any option to extend)
Committee Name or Post	**(To commit resources that are NOT service costs or staff costs, e.g. nonhealthcare contracts)**
GMICB Board	Greater than £20m
People & Resources Committee	Greater than £5m and up to £20m
Strategic Commissioning Committee	TBC
ICB Chief Officer and Chief Finance Officer and Chief Executive (or nominated deputies) (All three signatures required) via appropriate meeting	£150,000 and up to £5m
Chief Executive	Up to £150,000
Chief Finance Officer	Up to £150,000
Chief Officer with relevant budget responsibility	Up to £100,000
Deputy Chief Finance Officer	Up to £50,000
Director of Finance Band 9	Up to £25,000
Associate Director of Finance Band 8D	Up to £15,000
Assistant Director of Finance Band 8C	Up to £15,000
Head of Finance Band 8B	Up to £10,000
Finance Business Partner Band 8A	Up to £10,000
Other Officer VSM & Band 9 with relevant budget responsibility	Up to £25,000
Other Officer Band 8C & 8D with relevant budget responsibility	Up to £15,000
Other Officer Band 8A & 8B with relevant budget responsibility	Up to £10,000

Table 8 -Consultancy Expenditure

	Consultancy Expenditure **(All expenditure to be approved must be in line with NHSE guidance)**
Committee Name or Post	
GMICB Board	Greater than £250,000
People & Resources Committee	£100,000 and up to £250,000
ICB Chief Officer & either Chief Finance Officer or Chief Executive (Two out of three signatures required)	£50,000 and up to £100,000
Chief Executive	Up to £50,000
Chief Finance Officer	Up to £50,000

Table 9 -Raise Sales Invoices

	Raise Sales Invoices
Committee Name or Post	
Chief Finance Officer	Greater than £1m
Deputy Chief Finance Officer	Greater than £1m
Director of Finance Band 9	Greater than £1m
Associate Director of Finance Band 8D	Greater than £500,000
Assistant Director of Finance Band 8C	£250,000- £500,000
Head of Finance Band 8B	£100,000 -£250,000
Finance Business Partner Band 8A	£100,000 or less

Table 10 -All Losses, Legal Claims, Special Payments, Consolatory Payments

	All Losses, Legal Claims, Special Payments, Consolatory Payments **(All expenditure to be approved must be in line with NHSE guidance and SFIs)**
Committee Name or Post	
GMICB Board	All Losses Greater than £100,000. All Legal Claims Special Payments & Consolatory Payments over £5,000 (Report All Losses, Special Payments, Consolatory Payments)
Audit Committee	(Report All Losses, Legal Claims, Special Payments, Consolatory Payments)
People & Resources Committee	£50,000 - £100,000 (Report All Losses)
Chief Finance Officer	All Losses up to £50,000 Special Payments & Consolatory Payments up to £5,000

Table 11 – Budget Virements Between Cost Centres

	Budget Virements Between Cost Centres
Committee Name or Post	
Chief Finance Officer	Greater than £100m
Deputy Chief Finance Officer	£75m - £100m
Director of Finance Band 9	£75m - £100m
Associate Director of Finance Band 8D	Up to £75m
Assistant Director of Finance Band 8C	Up to £50m
Head of Finance Band 8B	Up to £25m
Finance Business Partner Band 8A	Up to £15m

Table 12 -Authorisation - Waivers & Decision-Making Records Under (PSR)

	Authorisation - Waiver & Decision Making Records Under PSR
Committee Name or Post	
Audit Committee	All waivers to be reported to the Audit Committee
Chief Executive	All waivers- & Decision Making Records under PSR
Chief Finance Officer	All waivers- & Decision Making Records under PSR
Deputy Chief Finance Officer	All waivers & Decision Making Records under PSR (As nominated in writing by the GMICB CFO)
Director of Finance Band 9	All waivers & Decision Making Records under PSR (As nominated in writing by the GMICB CFO)
Associate Director of Contract Management & Procurement Band 8D	All waivers & Decision Making Records under PSR (As nominated in writing by the GMICB CFO)

Table 13 – Payroll Financial Approval

	Payroll Financial Approval
Committee Name or Post	HR Forms
Remuneration Committee	Financial Approval in relation to Chief Executive, Directors, Non Executive Directors and other VSM. All other duties as outlined in the SORD.
Chief Finance Officer	Authorise HR Forms for Financial Approval
Deputy Chief Finance Officer	Authorise HR Forms for Financial Approval
Director of Finance Band 9	Authorise HR Forms for Financial Approval
Associate Director of Finance - Operating Costs Band 8D	Authorise HR Forms for Financial Approval
Assistant Director of Finance - Operating Costs Band 8C	Authorise HR Forms for Financial Approval
Head of Finance - Operating Costs Band 8B	Authorise HR Forms for Financial Approval
Finance Business Partner - Operating Costs Band 8A	Authorise HR Forms for Financial Approval

Table 14 – Travel Expenses

	Travel Expenses (Financial limit for an individual monthly claim)
Committee Name or Post	
As permitted in line with the use of Easy Expenses/ ESR approval processes.	*

GUIDANCE IN APPLYING THE NHS GM FINANCIAL SCHEME OF DELEGATION

Date: April 2026

TABLE 6 (HEALTH CARE BUSINESS CASES AND PROPOSALS)
AND
TABLE 7 (NON HEALTH CARE/ REQUEST FOR FUNDING AND CONTRACTS)

NHS Greater Manchester

Overview

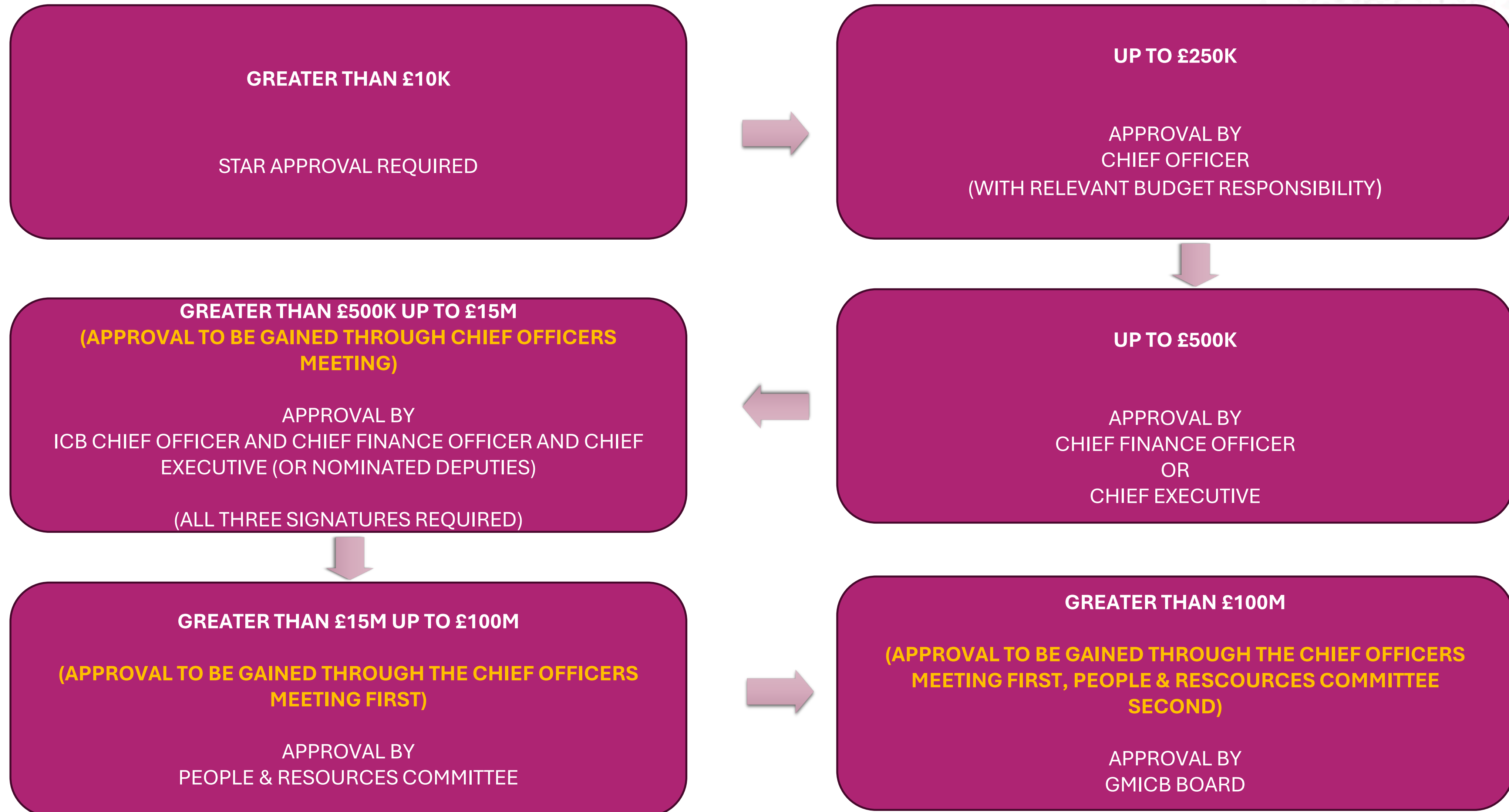
This guidance provides an overview in applying the NHS GM Financial Scheme of Delegation (FSD) for approving funding proposals for goods and services. The attached flow charts provide a step-by-step guide on the steps to follow when seeking approval for a financial decision.

This will ultimately depend on what is being purchased (healthcare or non-healthcare) and value.

There are two flow charts which highlight the steps to follow when procuring goods or services:

- Flow Chart 1 – Incurring healthcare expenditure.
- Flow Chart 2 – Incurring non-healthcare expenditure.

FLOWCHART 1: HEALTH CARE EXPENDITURE (FINANCIAL SCHEME OF DELEGATION TABLE 6)



FLOWCHART 2: NON-HEALTH CARE EXPENDITURE (FINANCIAL SCHEME OF DELEGATION TABLE 7)

UP TO £10K

APPROVAL BY
BUDGET HOLDERS BANDS 8A AND 8B
(WITH RELEVANT BUDGET RESPONSIBILITY)

→

GREATER THAN £10K

STAR APPROVAL REQUIRED

→

UP TO £15k

APPROVAL BY
BUDGET HOLDERS BANDS 8C AND 8D
(WITH RELEVANT BUDGET RESPONSIBILITY)

→

UP TO £25K

APPROVAL BY BUDGET HOLDERS
OTHER OFFICER VSM AND BAND 9
(WITH RELEVANT BUDGET RESPONSIBILITY)

↓

UP TO £100K

APPROVAL BY
CHIEF OFFICER
(WITH RELEVANT BUDGET RESPONSIBILITY)

←

UP TO £150K

APPROVAL BY
CHIEF FINANCE OFFICER
OR
CHIEF EXECUTIVE

←

GREATER THAN £150K AND UP TO £5M

(APPROVAL TO BE GAINED THROUGH THE CHIEF OFFICERS MEETING)

APPROVAL BY
ICB CHIEF OFFICER AND CHIEF FINANCE OFFICER AND CHIEF EXECUTIVE (OR NOMINATED DEPUTIES)
(ALL THREE SIGNATURES REQUIRED)

←

GREATER THAN £5M AND UP TO £20M
(APPROVAL TO BE GAINED THROUGH THE CHIEF OFFICERS MEETING FIRST)

APPROVAL BY
PEOPLE & RESOURCES COMMITTEE

↓

GREATER THAN £20M
(APPROVAL TO BE GAINED THROUGH THE CHIEF OFFICERS MEETING FIRST, PEOPLE & RESCOURCES COMMITTEE SECOND)

APPROVAL BY
GMICB BOARD

Other Key Considerations

NHS
Greater Manchester

Procurement

It is important to note that once financial approval has been gained, any goods and services must be procured in line with the NHS GM Procurement policy. There must be a clear audit trail on how any goods and services have been procured in line with the current procurement legislation.

If further support is required on procurement or on the classification of goods or services, then the Procurement and Market Management Team should be contacted.

NHS
Greater Manchester

Contract Agreement

Contracts for any goods and services procured must be agreed through the NHS GM Contracting team.

Contract Signature

Financial Value Contracts

Only the Chief Executive and the Chief Finance Officer, and those NHS GM Officers nominated by the Chief Finance Officer are authorised to sign contracts (i.e. those contracts that commit to expenditure) on behalf of NHS GM as outlined in the FSD. All contracts, Service Level Agreements, or Memorandum of Understanding (MOU's) that require signature must be presented for authorisation via the NHS GM Contracting team using the Contract Signature Request process.

Non-Financial Contracts

Non Financial contracts can only be authorised by NHS GM officers that have been nominated by the Chief Finance Officer. This will include Primary Care Contracts (Medical, Dentistry, Pharmacy, Optometry, Community Dental and Specialist Dental), Signing of data processing/ sharing agreements.

Planning Ahead

To ensure the timely approval of a proposal sufficient time should be factored into gaining approval through the NHS GM governance processes for financial approval, procurement compliance, and contract signature.

Financial Value

The financial value that will be taken into consideration for financial approval purposes in line with the FSD will be the total value that is being put forward in the proposal.

For example, if a proposal has an annual value of £1 million but requires a three year contract. The approval required will be for £3 million.

Alternatively, if there is a proposal that looks to gain approval for a number of providers for the same or similar services; but is captured in one proposal, the total value will require approval.

For example, Provider A annual value, £5 million and Provider B annual value, £1 million, then a combined approval will be required for £6 million.

Additional Support

Further support and guidance can be obtained from the Finance Team.

Greater Manchester

Performance Report People and Resources Committee

2026-27

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS GM People and Resources Committee

April 2026

Required information	Details
Title of report	Performance Report
Author	Alexandra Barber, Performance Manager
Presented by	
Contact for further information	Miladur.rahman@nhs.net
Executive summary	This paper updates the Committee on key performance indicators for Greater Manchester.
The benefits that the population of Greater Manchester will experience.	Achievement of performance objectives will improve access to services and drive-up standards of care for the Greater Manchester population.
How health inequalities will be reduced in Greater Manchester's communities.	Ensuring delivery of standards across Greater Manchester Trusts will equalise geographical variation.
The decision to be made and/or input sought	For information.
How this supports the delivery of the strategy and mitigates the BAF risks	Deliver key standards of care and operational plans.
Key milestones	Monthly and Quarterly milestones are in place.
Leadership and governance arrangements	The Performance and Quality Committee receive a more comprehensive performance report every month.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Not applicable

1. Introduction

1.1 For 25/26, the key high-level metrics have been categorised using the "Assure, Alert and Advise" approach

- ALERT: Alert to matters that require escalation for the board's attention or action
- ADVISE: Advise of areas of ongoing monitoring or development
- ASSURE: Inform the board where assurance has been achieved

1.2 The report advises the Committee on NHS Greater Manchester's (GM) performance focussing on high-risk areas for 25/26. It references the most recent published data but also highlights more up to date but unvalidated data or forecasts where we have it.

2. Key Messages

Alert

2.1 In March, 74.1% of patients attending A&E were admitted, transferred, or discharged within **four hours,** which was worse than the March plan of 78%, but a 2.9% improvement compared to the same period last year. More recent unvalidated data shows that between the 1st and 17th of April, performance was at 72.9%. Once data is validated, performance usually increases by an average of 1% - 1.5%.

2.2 In March, 8.3% of patients waited **over 12 hours** for admission or discharge from a type 1 emergency department, which was worse than the 7.5% plan, but a 1.3% improvement compared to the same period last year. GM ICB benchmarked at 15 out of 42 ICBs in March for this standard. More recent unvalidated data shows that between the 1st and 17th of April, performance was at 10.6%.

2.3 At the end of February, there were 51 patients across GM Trusts waiting **over 65 weeks** for treatment against a target of zero. At the end of March, the forecast (as of 14/04) is 24 patients and zero end of April.

2.4 The **average length of stay** in a mental health acute inpatient bed for adults and older adults discharged in the three months to February, remained high at 64.9 days for GM registered patients, which was worse than the February plan of 57.8 days. The plan is to reduce to 57 days by March 26.

2.5 At the end of February there were 50 adults with **autism** (with no learning disability) in an inpatient bed, this is not on-track to achieve the quarter four plan of no more than 39 adults. Published data for LDA metrics are rounded to nearest 5 prevent identification of vulnerable individuals. Larger numbers are also rounded to ensure uniformity across the national datasets.

Advise

2.6 In February, 2% of the patients in GM Trusts were waiting over **52 weeks** for treatment, worse than the February plan of 1.3%. Additional NHSE funding has been made available to Trusts in quarter four to support delivery of the end of March plan of no more than 1% over 52 weeks. However, GM providers as of 14/04 are forecasting to achieve 1.57%.

2.7 In February, 59% of GM Trust patients were waiting less **18 weeks for treatment,** which was worse than the February plan of 60%. Additional NHSE funding to Trust in quarter four will support delivery of the end of March plan of no less than 61%. GM providers as of 14/04 are forecasting to achieve 61.5% which is better than plan.

2.8 In February, 65.2% of elective patients in GM Acute Trusts were waiting less than **18 weeks for a first appointment**, which was worse than the February plan of 67.1%. The GM target is to increase to 68% by March 26. Unvalidated data from the 12th of April is at 68.3%.

2.9 In February, 10.2% of patients were waiting more than six weeks for a **diagnostic test** at GM NHS providers. GM benchmarks favourably in February compared to other ICBs, ranked 5th best performing out of the 42 ICBs. This metric is no longer an operational planning metric, but GM will continue to closely monitor.

2.10 At the end of February, there were 50 adults with a **learning disability** (and may also be autistic) in an inpatient bed, off plan to achieve the quarter four target of no more than 46 adults. Published data for LD metrics are rounded to nearest 5 prevent identification of vulnerable individuals. Larger numbers are also rounded to ensure uniformity across the national datasets.

Assure

2.11 GM continues to achieve the 30-minute target for **Category 2** ambulance calls. In March, the average response time was 20 minutes and 58 seconds. Unvalidated data show that between the 1st and 12th of April the average response time improved to 19 minutes and 21 seconds.

2.12 In February 74.3% of **cancer** patients received treatment within **62 days**, which was better than plan. Local data indicates that GM is forecast to achieve the 75% plan in March 26.

2.13 GM providers were better than plan for the **cancer faster diagnosis** with 83.6% diagnosed within 28 days in February 26. Local data indicates that GM is forecast to be better than the 80% plan in March 26.

2.14 The number of **children and young people accessing mental health services** in the 12 months to February 2026 was 55,770, which was better than the January plan of 55,000.

3. **Recommendation**

3.1 The Committee is asked to note the current and forecast position against these high-risk performance areas.