**On May 31st, Richard Leese, the Chair of Greater Manchester Integrated Care Board, will be running the Manchester 10k, aiming to raise money for the British Heart Foundation. For more information and how to donate, please click on the link. https://ajbellgreatmanchesterrun2026.enthuse.com/pf/richard-leese**

# Agenda

## Greater Manchester Integrated Care Board (Public)

Date: 20th May 2026

Time: 2.00pm to 3.45pm

Venue: Boardroom, Tootal Buildings

| Item No. | Time | Duration | Subject | Paper/ Verbal | For Approval/ Discussion/ Information | By Whom |
|---|---|---|---|---|---|---|
| 1. | 2.00 | 5 mins | Welcome, Introductions and Apologies:<br><br>Richard Paver<br>Anthony Hassall | Verbal | - | Sir Richard Leese, Chair |
| 2. | 2.00 | | Declarations of Interest | Verbal | - | Sir Richard Leese, Chair |
| 3. | 2.05 | 5 mins | Minutes of previous meetings and matters arising | Paper | Approval | Sir Richard Leese, Chair |
| **Actions: Log attached** | | | | | | |
| **Leadership Reports** | | | | | | |
| 4. | 2.10 | 5 mins | Chair's Briefing | Verbal | Information | Sir Richard Leese, Chair |
| 5. | 2.15 | 10 mins | Acting Chief Executive's Update including Reform | Paper | Discussion | Colin Scales, Acting Chief Executive |
| **Strategic Updates** | | | | | | |
| 6. | 2.25 | 10 mins | Financial Scheme of Delegation Amendments | Paper | Decision | Kathy Roe, Chief Finance Officer |
| 7. | 2.35 | 10 mins | Board Assurance Framework | Paper | Discussion / Approval | Nicola Hepburn, Acting Chief Reform & Improvement Officer |
| 8. | 2.45 | 10 mins | Cardiac and Vascular Surgery | Paper | Decision | Katherine Sheerin, Chief Commissioning Officer |

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| **5 MIN BREAK**<br><br>**Assurance Reports and Updates** | | | | | | |
| 9. | 3.00 | 15 mins | People and Resources:<br>• Committee Report<br><br>• Finance Report | Paper<br><br>Paper | Information<br><br>Discussion | Kal Kay, Non-Executive Director / Chair of the People & Resources Committee<br><br>Kathy Roe, Chief Finance Officer |
| 10. | 3.15 | 15 mins | Strategic Commissioning:<br>• Committee Report<br><br>• Quality & Performance Report | Paper<br><br>Paper | Information<br><br>Approval / Discussion / Information | Sue Bailey, Non-Executive Director / Chair of the Strategic Commissioning Committee<br><br>Manisha Kumar, Chief Clinical Officer |
| 11. | 3.30 | 5 mins | Audit Committee:<br><br>Audit Committee Report including Terms of Reference | Paper | Approval | Jackie Njoroge, Deputy Chair / Senior Independent Director |
| 12. | 3.35 | 5 mins | Remuneration Committee | Verbal | Information | Rachel Egan, Non-Executive Director / Chair of the Remuneration Committee |
| 13. | 3.40 | 5 mins | North West Specialised Commissioning Committee | Paper | Information | Katherine Sheerin, Chief Commissioning Officer |
| **For Information** | | | | | | |
| 14. | 3.45 | 5 mins | Approved minutes of Committees:<br>• Transition Committee<br>• Strategic Commissioning Committee<br>• Audit Committee | Paper | Information | - |
| 15. | | | Any other business | Verbal | - | Sir Richard Leese, Chair |
| 16. | | | Date and time of next meeting:<br><br>15th July 2026, 2-4pm | Verbal | Information | |

*Please note that due to the limited time we have we cannot respond to public questions within the Board meeting. We will acknowledge all the questions we get and will respond to them formally within 20 days. The questions and answers will also be published on our website.*

| Chair, NHS Greater Manchester | Interest Declared | Interest Category | Interest Situation | Interest Description | Comments | CoI Date From | CoI Date To |
|---|---|---|---|---|---|---|---|
| Leese, Sir Richard Charles | Y | Financial interests | Outside employment | Board Member, West Coast Development Partnership Independent Advisory Board | | 30/03/2025 | 31/10/2026 |
| Leese, Sir Richard Charles | Y | Indirect interests | Outside employment | Daughter works for a training company that provides training inter alia to NHS organisations | | 01/11/2011 | |
| Leese, Sir Richard Charles | Y | Non-financial personal interest | Loyalty interests | Honorary President, Manchester City Football Club | | 01/12/2021 | |
| Leese, Sir Richard Charles | Y | Non-financial professional interest | Outside employment | Honorary Professor, Chair in Integrated Care and Population Health, University of Manchester | | 01/08/2022 | 31/07/2025 |
| **Employee Name** | **Interest Declared** | **Interest Category** | **Interest Situation** | **Interest Description** | **Comments** | **CoI Date From** | **CoI Date To** |
| Bailey, Ms. Charlotte Elizabeth | | | | 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:<br>• Operations Director - Primary Eye Care Services LTD<br>• Case Examiner – General Optical Council | | 2021<br>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 |
| Scales, Mr. Colin | Y | Non-financial professional interest | Loyalty interests | Honorary Professor of 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** | **CoI Date From** | **CoI Date To** |
| Bailey, Dr Susan Mary | | Financial interest | Outside employment | Independent NED on the board of KOOTH PLC, a mental health online digital platform. I am remunerated for this work. Neither any members of my family or I hold shares in this PLC | | 2022 | Ongoing |
| Bailey, Dr Susan Mary | Y | Non-financial professional interest | Loyalty Interests | Chair of Centre for Mental Health. The centre and myself advocate for better mental health outcomes for all through the delivery of evidenced based policy briefings and lobbying at a national and Regional level | | 2018 | Ongoing |
| Bailey, Dr Susan Mary | Y | Non-financial professional interest | Outside employment | Council member university of Salford | | 2016 | |
| Bailey, Dr Susan Mary | Y | Non-financial professional interest | Loyalty Interests | ex-VfM commissioner - began through evidence base support improved health and social care outcomes For the population of Wales. | | 2014 | Ongoing |
| Egan, Rachel Mrs | Y | | | Nil | | | |
| Kay, Mrs. Khalida (Kal) | Y | Financial interests | Outside employment | Interim FD Derian House Childrens Hospice | | 06/10/2025 | |
| 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 | 01/04/2025 | |
| Kay, Mrs. Khalida (Kal) | Y | Non-financial personal interests | Outside employment | Great Academies Education Trust | Trustee (non remunerated) | 20/04/2020 | |
| Kay, Mrs. Khalida (Kal) | Y | Non-financial professional interest | Shareholdings and other ownership interests | Association of Camerados | Non Exec, non remunerated director | 22/10/2018 | |
| Paver, Mr. Richard | Y | | | Nil | | | |
| 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** | **CoI Date From** | **CoI Date To** |
| Mehra, Dr Vishal | Y | Financial interest | Outside employment | Chief Medical Officer for Health Innovation Manchester | | Dec-25 | Ongoing |
| Mehra, Dr Vishal | Y | Financial interest | Outside employment | Clinical Director, Gorton and Levenshulme Primary Care Network | | Apr-19 | Ongoing |
| Mehra, Dr Vishal | Y | Financial interest | Outside employment | Executive Committee Member, Manchester Local medical Committee | | Jan-26 | Ongoing |
| Mehra, Dr Vishal | Y | Financial interest | Outside employment | Salaried GP, West Point Medical Centre | | Apr-23 | Ongoing |
| Hassall, Anthony | Y | Financial interest | Outside employment | Chief Executive, Pennine Care NHS Foundation Trust | | 2022 | Ongoing |
| Vallance, Leigh | Y | Financial interest | Outside employment | CEO of Bolton Hospice which is part funded by an NHS Grant | | 2023 | Ongoing |
| Vallance, Leigh | Y | Financial interest | Outside employment | As Chair of Bolton CVS, (a voluntary sector infrastructure body) who are in receipt of NHS funding | | Ongoing | |
| Williams, Dr Owen | Y | Non-financial professional interest | Outside employment | Co-Chair of the Chairs and CEO Ethnic Minority Network | | 2021 | Ongoing |
| Williams, Dr Owen | Y | Non-financial professional interest | Outside employment | Acute Partner Member of the NHS Greater Manchester Integrated Care Board (ICB) | | 2022 | Ongoing |
| Williams, Dr Owen | Y | Non-financial professional interest | Outside employment | Chair - Yorkshire and Humber PSRC Strategic Advisory Board | | Jan-24 | Ongoing |
| Williams, Dr Owen | Y | Financial interest | Loyalty Interests | Chief Executive Officer – Northern Care Alliance NHS Foundation Trust | | Nov-21 | Ongoing |
| McKenzie Folan, Alison | Y | Financial interest | Outside employment | Chief Executive at Wigan Council | | 2019 | Ongoing |

| Actions Log: ICB Board | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **No** | **Date** | **Item** | **Details of action agreed** | **Action Lead** | **Deadline** | **Status** | **Further Detail** | |
| **19** | 19/11/2026 | 10. Major Trauma | Assurance on compliance, clinical safety and long-term sustainability including timescales for the NHS GM Major Trauma model to be provided to QPC. | KS | 15/07/2026 | | Proposal to update the new Committee in June then back to Board in July as part of our undertakings. | |
| **6** | 18/03/2026 | 6. Governance and SORD update including new committee structures | CG to check primary care delegations and report back to Board | CG | 20/05/2026 | | | |
| | | | | | | | | |
| Completed at Previous Meeting (Audit Trail) | | | | | | | | |
| **1** | 17/07/2024 | 4. Chair's Briefing | WH to meet with members of the KONP group to discuss the petition and agree next steps | WH | 18/09/2024 | | The meeting went ahead on the 20th August, and the group submitted questions back to WH which the Communication Team are collating the answers. | |
| **2** | 17/07/2024 | 6. Single Improvement Plan | Single Improvement Plan should be shared with members of the board as soon as it is available showing progress against the plan. | MF | 18/09/2024 | | The plan was shared with members at the Board strategy session on 21st August and updates will be provided. | |
| **3** | 18/09/2024 | 3. Matters arising | The Chair to meet with MP and team regarding the data in the performance report following concerns raised at the previous meeting | MP/CS | 20/11/2024 | | The performance matrix is still under review and discussed at QPC. Meeting with the Chair has taken place. | |
| **4** | 18/09/2024 | 4. CEO Report | RB to provide update on Health and Care Review at next meeting in November. | RB | 20/11/2024 | | On agenda for November meeting | |
| **8** | 19/02/2025 | 4. 2025/26 operational plan | Board meeting to be reconvened prior to final submission of the draft plan on 27th February which would be held in public. | JN | 27/02/2025 | | Meeting reconvened on 26th February | |
| **9** | 26/02/2025 | 4. Annual plan 25/26 update | Board seminar to be arranged prior to formal meeting. | JN | 26/03/2025 | | Seminar held on 19th March and formal meeting moved to the 26th | |
| **6** | 15/01/2025 | 7. Board Assurance Framework | Risk appetite to be discussed as part of operational planning at February Board. | CS | 05/02/2025 | | Deferred to June Board development session. Complete | |
| **7** | 15/01/2025 | 13. Quality and Performance | MP and JW to meet with SMc and SB to discuss maternity workforce issues. | MP/JW | 05/02/2025 | | Meeting took place on 7th April | |
| **10** | 26/03/2025 | 7. Baord Assurance Framework | CS to meet with Committee Chairs in April prior to Board Seminar. | CS | 16/04/2025 | | Meeting took place on 14th April | |
| **11** | 21/05/2025 | 7. Committee ToR | JN to amend the Quality and Performance TOR after the meeting. | JN | 16/07/2025 | | Complete | |
| **14** | 16/07/2025 | 6. NHS Reform | MP to meet with RE to discuss the process and decision behind the safeguarding as part of the reform agenda | MP/RE | 17/09/2025 | | Complete | |
| **15** | 16/07/2025 | 6. VR Scheme | CB to share the EIA that had been to the T&F Group. | CB | 17/09/2025 | | Complete | |
| **16** | 16/07/2025 | 16. GM Alcohol Harm Strategy | WH to share map of drug and alcohol services in GM. | WH | 19/08/2025 | | Info can be found here: https://gmintegratedcare.org.uk/find-a-service/type/alcohol-and-drug-support/ | |
| **5** | 17/07/2024 | 12. Primary Care Blueprint Delivery Update | RB to work with John Herring and his team to provide a briefing to the People and Culture Committee and bring a position statement back to Board at a future meeting. | RB | 20/11/2024 | | A paper has been prepared and presented to the PC Blueprint Group. This is in respect to FTSU for Primary Care. We have a proposed model , with delivery through PCB but delivery resource dependent. Update on Primary Care Blueprint provided in Sep 25 | |
| **13** | 21/05/2025 | 10. Assertive outreach | To share report with AMK and other place leads via the Exec Committee | MK | TBC | | Complete | |
| **17** | 17/09/2025 | 3. Matters arising | MK to provide update on the ADHD consultation after the meeting | MK | ASAP | | Update provided and paper on agenda for November meeting | |
| **12** | 21/05/2025 | 9. Federated Data Platform (FDP) | To bring FDP back to Board at later date. | WH | 19/11/2025 | | Paper to come back to the board 6 months following the last meeting. Update provided in CEO report | |
| **18** | 19/11/2026 | 8. Draft Clinical Strategy | Commissioning intentions including plan to be presented to Board at strategy session in December. | KS | 17/12/2025 | | Presented at December meeting | |
| **20** | 19/11/2026 | 15 People and Culture Report | Freedom to Speak Up report to be shared with RP. | CB | 21/01/2026 | | Sent to RP on the 21/11/25 | |
| **21** | 17/12/2026 | 3. Approval of 2026/7 planning submission | JN to reschedule February Board meeting from the 18th to the 11th and arrange seminar in January. | JN | 11/02/2026 | | Complete | |

NHS Greater Manchester

# Minutes

## Greater Manchester Integrated Care Board (Public)

Date: Wednesday 18th March 2026

Time: 2.00pm to 4.15pm

Venue: Boardroom, Tootal Buildings

| Present | | |
|---|---|---|
| **Members:** | | |
| Sir Richard Leese | RL | Chair, NHS Greater Manchester |
| Richard Paver | RP | Non-Executive Director and Chair of Audit Committee, NHS GM |
| Dame Sue Bailey | SB | Non-Executive Director and Chair of the Performance & Quality Committee, NHS GM (Items 1-9 only) |
| Kal Kay | KK | Non-Executive Director and Chair of the Finance Committee, NHS GM |
| Rachel Egan | RE | Non-Executive Director and Chair of the Remuneration and Population Health Committees, NHS GM |
| Jackie Njoroge | JNo | Deputy Chair/Senior Independent Director, NHS GM |
| Dr Owen Williams | OW | Board Member bringing the perspective of Acute Providers, Chief Executive of Northern Care Alliance (NCA) NHS Foundation Trust |
| Dr Vish Mehra | VM | Board Member bringing the perspective of Primary Care, General Practitioner |
| Leigh Vallance | LV | Board Member bringing the perspective of the Voluntary Community, Faith and Social Enterprise (VCFSE) Sector, Chief Executive of Bolton Hospice |
| Colin Scales | CS | Acting CEO, NHS GM |
| Kathy Roe | KR | Chief Finance Officer, NHS GM |
| Professor Manisha Kumar | MK | Chief Clinical Officer, NHS GM |
| Charlotte Bailey | CB | Chief Strategy, People and Partnerships Officer, NHS GM |
| Katherine Sheerin | KS | Chief Commissioning Officer, NHS GM |
| **Executives:** | | |
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| **Attendees / Participants:** | | |
| Jenny Noble | JN | Board Secretary, NHS GM |

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| Lucy Cunliffe | LC | Governance Manager, NHS GM |
| Faye Vaughan | FV | Governance Advisor, NHS GM |
| Claire Connor | CC | Director of Communications and Engagement, NHS GM |
| Chris Gaffey | CG | Associate Director of Corporate Services, NHS GM (Items 1-6 only) |
| Paul Lynch | PL | Director of Strategy, NHS GM (Item 10 only) |
| Charlene Mulhern | CM | Assistant Director Mental Health, NHS GM (Items 1-8 only) |
| Sandeep Ranote | SR | Medical Exec Lead Mental Health, NHS GM (Items 1-8 only) |
| Rena Kaur | RK | Lead Analyst (Mental Health) – Public Service Reform, GMCA (Items 1-8 only) |
| Mel Maguiness | MM | Director of Integrated Clinical Strategy and Transformation, NHS GM (Items 1-8 only) |
| **Apologies:** | | |
| Anthony Hassall | AH | Board Member bringing the perspective of Mental Health, Chief Executive of Pennine Care NHS Foundation Trust |
| Alison McKenzie-Folan | AMK | Chief Executive Wigan Council, Place Based Lead Health & Care for Integrated Care Partnership |
| Nicola Hepburn | NH | Acting Chief Reform & Improvement Officer, NHS GM |
| Cllr Sean Fielding | SF | Board Member bringing the perspective of Local Authorities, Bolton Council |

| | Topic | Action |
|---|---|---|
| 1. | <u>Welcome, Introductions and Apologies</u><br><br>RL welcomed attendees and members of the public to the Board meeting. Apologies were noted.<br><br>He announced that Cllr Sean Fielding was standing down as Partner Member on the Board due to work commitments. The ICB would work with GMCA colleagues to seek a replacement in due course. | |
| 2. | <u>Declarations of Interest (DOI)</u><br><br>RL reminded board members of their obligation to declare any interest relating to items on the public part of the agenda. | |
| 3. | <u>Minutes of previous meetings</u><br><br>The minutes of the public Board meeting on Wednesday 11 February were approved. | |


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| | Matters Arising<br><br>There were none. | |
| 4. | Chair's Briefing<br><br>The Chair advised that a lot of his time in the last month had been taken up with the operational, planning and budgetary process including a series of meetings with region looking at the ICB's own plan as well as plans for providers with the final date for submission of plans being today. The ICB would be delivering a complaint plan noting the Chair's ambition to submit this before the start of the financial year had been met. All providers except one were expected to submit a compliant plan, with some work remaining before the end of March. The ICB would keep working with all providers.<br><br>Other things he had been involved with included the NHS Leaders' Summit. The NHS Confederation would merge with NHS Providers to become NHS Alliance and within this the ICS network would become the ICB network.<br><br>He had met with the Mayor of Salford and other political leaders to look at some of big challenges coming up including strategic commissioning noting that CS was already in discussion with Caroline Simpson, CEO of the GMCA, on how to take forward some of these conversations including a Health and Care Conference to take place in the autumn.<br><br>He was also meeting with Penny Dash, NHSE Chair, and other ICB Chairs and CEOs to discuss some of the big issues around the table including neighbourhood health.<br><br>He noted his continued involvement in CyanLines in and around Greater Manchester which was an interesting piece of work, and a presentation by the English National Opera on their Breathe programme designed for adults recovering from COVID-19 who continue experience breathlessness and associated anxiety. Board members noted that there were lots of other groups doing great things which need to be working together including Creative Health.<br><br>**The Board noted the verbal update provided.** | |
| 5. | Acting Chief Executive's Update<br><br>CS highlighted section 1.4 of the report regarding enforcement undertakings, noting that only area of financial oversight remains which would be reviewed at the end of the financial year with a view to removing this. Thanks were noted to colleagues who had worked with system partners.<br><br>Just over 12 months since the announcement was made, the organisational change process was still underway. It had been a tumultuous year with a lot still do in terms of transition over the next 12 months. Board members would continue to receive regular updates.<br><br>He reflected on the launch of the Neighbourhood Health Framework published | |

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| | yesterday, noting this was a generational opportunity for NHS to deliver something fundamentally different which would be brought back to a future meeting.<br><br>He also reflected on PCFT being the first mental health provider in England to offer appointment notifications through the NHS App.<br><br>He highlighted Jess's Rule, which was welcomed by GPs making it easier for clinicians to follow. Need to keep this in mind with work happening around referral pathways.<br><br>The Chair acknowledged the work done in producing the operating model on top of transformation and everything else. He thanked colleagues for their hard work and quality of work during this time.<br><br>Board members asked for an update following the outbreak of meningitis in Kent and MK confirmed that guidance had been shared with GPs but there was no impact on the NW. A further update would be provided if required but there was no known supply issue as reported in the news.<br><br>**The Board:**<br>• **Noted the contents of the CEO's Report to the Board.**<br>• **Disseminated and cascaded the necessary key messages and information as appropriate.** | |
| 6. | <u>Governance and SORD update including new committee structures</u><br><br>CB introduced CG who provided the Board with proposals on the new NHS GM Committee structure, and revised Scheme of Reservation and Delegation (SORD) for approval.<br><br>The new Committee structure would see two new Committees established – the Strategic Commissioning Committee, chaired by Sue Bailey, and the People and Resources Committee, chaired by Kal Kay. The scope and remit of the two statutory Committees, Audit and Remuneration, were not affected nor that of the Place-Based Partnership Committees which were under review. The two new Committees would provide end-to-end oversight of the strategic commissioning cycle on behalf of the Board.<br><br>It was noted that there was still work to do including establishing working groups, a rapid review of transition arrangements and reaffirming governance hygiene factors. The Financial Scheme of Delegation was currently being reviewed to ensure alignment with the new Committee Structure and SORD.<br><br>There followed a discussion regarding delegated authority and primary care which had been left in the SORD as part of transition arrangements and may need to be kept in place as NHSE had delegated it to the ICB.<br><br>ACTION: CG to check primary care delegations and report back to Board.<br><br>Following queries regarding the workplans, CG confirmed that work was in progress including feedback from committee chairs. | |

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| | The Chair welcomed learning from the Transition Committee, including Chief Officer reports.<br><br>**The Board**:<br>• **Considered and approved the Committee Terms of Reference (Appendices One and Two) and the Scheme of Reservation and Delegation (Appendix Three) presented with this report to enable the establishment of the new Committees from 1 April 2026.**<br>• **Noted the next steps and actions required to further develop and embed these new arrangements, as set out from paragraph 1.14 onwards.** | |
| 7. | <u>Board Assurance Framework (BAF)</u><br><br>On behalf of NH, CG provided an update to the Board on the Strategic Risks following their development and revisions at their relevant committee(s), noting that the BAF risks had been reviewed by Chief Officers following discussion at Transition Committee.<br><br>Headline messages were identified below:<br>• BAF Risk SR6 (Workforce) were reporting an increased risk score for this return, with a current score of 16 - this is above the year-end target.<br>• Risks SR4 (Good Employment), SR7 (Finance) and SR9 (Emergency Incident) were reporting a reduced risk score for this quarter. Additional information had been provided below to fully explain the rationale for these reductions.<br>• All remaining risks were reporting a static risk score this quarter<br>• Risks SR1 (Population Health), SR5 (Health Inequalities), SR6 (Workforce), SR7 (Finance) and SR10 (NHS Reform were all showing a variation between current score and year-end target score. A full analysis of the variation between final yearend scores and the target scores would be provided in the May report and risk leads would be asked to provide an explanation of any variations. This analysis would also include an analysis of the position between the year-end score and the agreed risk appetite.<br><br>It was noted that Audit Committee was doing a deep dive into BAF Risk SR1 (Population Health) at its meeting tomorrow.<br><br>The Board were asked to consider the assignment of BAF risks to the new Committees now they had been established.<br><br>Members queried the assignment of SR5 (Health Inequalities) to the Strategic Commissioning Committee, but it was agreed to leave as is for now. They also queried SR7 (Financial Sustainability) and whether this should be reduced which would be reviewed by the People and Resources Committee.<br><br>A conversation took place about dynamic risk reporting and its associated deadlines. It was agreed that the review would occur this month and results would be provided at the next report.<br><br>**The Board:**<br>• **Considered and approved the updated strategic risk descriptions and** | |

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| | **scores**<br>• **Confirmed the assignment of BAF risks to the relevant Committees (if approved and established) from April 2026, as set out in section three of the report.** | |
| 8. | <u>GM MH & Wellbeing Strategy Update</u><br><br>MK was pleased to welcome key members of the MH team to the meeting. She and the team provided a progress update two years on, highlighting what had been achieved, where challenges remain, and what was needed next in GM acknowledging that AH not here today.<br><br>SR set the context and what we believe we had been doing differently in GM. Year one focused on building shared governance, establishing new cross sector groups, and embedding links across neighbourhood, place and GM level programmes. Year two marks the start of measurable progress across our five strategic missions, supported by the first baseline metrics for GM.<br><br>RK presented a snapshot of the dashboard including the landing page which brings together the strategy work into one easy to navigate page which operationalises the strategy itself.<br><br>MK thanked the team for bringing this to life and invited questions from members.<br><br>Members appreciated the update and recognised the effort involved but emphasised the need to link it with physical health. While data and health checks were included, there was a need for self-accountability. Personalised care plans remain crucial, and the neighbourhood model of care was a strong case study in the pack.<br><br>CC provided the Board with reassurance that MH was a priority for the system as well as the communications and engagement team.<br><br>Members noted challenges in navigating the system and identified concerns regarding interactions among providers. LV observed that the sector has been encouraged to collaborate with renewed confidence and trust, aiming to enhance patient outcomes. She commended the progress thus far and recognised the role of Mental Health Integrated Fund to enable this to happen.<br><br>CM responded to a query about the strategy's impact, noting fewer Out of Area Placements (OAPS) across GM as a major achievement, but acknowledged more progress was needed in other areas. In terms of lessons learnt, the wider sector would like to be more involved including patients notwithstanding the complexities of the system.<br><br>The CEO welcomed the update and subsequent discussion, emphasising the importance of learning from it and highlighting key metrics on page 102. Both qualitative and quantitative data were needed for the next phase balanced with the patient experience. RK confirmed the strategy prioritises leading indicators and CM advised the establishment of a lived experience mental health hub to complement the data.<br>Members queried the ask of the Board highlighting the need to keep the momentum | |

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| | going.<br><br>OW emphasised the value of patient stories and asked how those who were less articulate were picked up. MM explained that they listened to individuals with lived experience, highlighting the importance of mental health and emotional wellbeing as central to the neighbourhood health model. MM also stressed the need to hold system partners accountable. Each system and organisation could provide feedback as well as smaller groups. Although stigma surrounding mental health remains, organised groups were enabling more voices to be heard.<br><br>Members asked about our efforts regarding online harm and social media platforms, noting ongoing government initiatives with schools, parents, and end-of-life care.<br><br>The Chair acknowledged that this was an excellent piece of work and expressed appreciation for the progress made to date including assertive outreach. MK, speaking on behalf of the team, thanked the Board members for their valuable feedback.<br><br>**The Board:**<br>• **Endorsed the pace and direction of travel, recognising both progress and complexity.**<br>• **Supported the system to unblock cross-cutting issues (workforce, digital, finance, estates).**<br>• **Backed a whole system approach that enabled GM to improve outcomes, deliver equity, and maximise the impact of mental health investment for our population.** | |
| 9. | <u>Clinical Strategy</u><br><br>MK presented the Greater Manchester Clinical Strategy, developed through extensive engagement with clinical leaders, stakeholders, and partners, following feedback from Board in November.<br><br>It focuses on three key areas:<br>• Digital Transformation<br>• Care Closer to Home<br>• Prevention and Proactive Care<br><br>MK highlighted the prioritisation framework on slide 13 (page 194 in the pack) which had been added and asked the Board to endorse the Clinical Strategy.<br><br>Members were supportive of the strategy but queried the plans underpinning it noting that the primary care blueprint was not a strategy. It was confirmed that the new Neighbourhood Health Framework would not change our plans but would give us momentum on how and when we do things. Progress would be shared with the Board.<br><br>**The Board:**<br>• **Approved the Clinical Strategy** | |
| 10. | <u>VCFSE Accord Refresh</u> | |

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| | PL presented the final draft of the Greater Manchester VCFSE Accord Agreement 2026–2035 for Board Approval, following which the Agreement would proceed to formal signing.<br><br>The refreshed Accord sets out a shared framework for partnership working between NHS Greater Manchester, Greater Manchester Combined Authority, local authorities and the voluntary, community, faith and social enterprise (VCFSE) sector. It replaces the current Accord (2021–26), which concludes on 31 March 2026.<br><br>He highlighted some of the notable successes of the first Accord including some fantastic examples of what the sector can bring and asked Board members to approve the final draft, noting that funding arrangements would be presented separately.<br><br>This was welcomed by the sector subject to clarity regarding NHS providers signing up. OW confirmed he was happy to sponsor this and work with TPC and the Primary Care Board.<br><br>**The Board:**<br>• **Reviewed and approved the final draft of the GM VCFSE Accord Agreement 2026–2035**<br>• **Noted that associated funding arrangements were presented in a separate paper** | |
| 11. | <u>Finance</u><br><br><u>Finance Sub-Committee Report</u><br><br>KK presented the summary report following the last Finance Committee meeting taking it as read noting that on refection financial planning should be on alert rather than assure. This was symptomatic of the need of reform, and an update would be provided to the next meeting.<br><br>**The Board:**<br>• **Noted the contents of the report.**<br><br><u>Finance Report</u><br><br>The Board was updated on the financial position for Greater Manchester as at 31st January 2026. As at Month 10 the ICS deficit plan is £50.9m, with an actual deficit of £75.7m, which equates to a £24.8m adverse variance to plan, a deterioration of £14.8m compared to last month.<br><br>KR reported we were still aiming to deliver our financial targets by the end of the financial year. However, if we were unable to deliver this, we would have to forfeit the Deficit Support Funding received. Board recognised and appreciated all the efforts being taken to deliver the plan. Some of which would be discussed at Audit Committee tomorrow which would then support the subsequent approval of the annual report and accounts over the coming weeks.<br>. | |

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| | **For the System Financial position, the Board:**<br>• **Noted the Month 10 year to date reported financial position for GM ICS of £75.7m deficit, against a planned deficit of £50.9m, resulting in a variance against plan of a £24.8m deficit.**<br>• **Noted the in-month deterioration in the deficit position, however a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs), a reduction in reported gross risk of £18.4m, a further reduction in net risk of £8.4m for NHS GM as a result of the on-going delivery of recovery plans continue to be reported.**<br>• **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.**<br>• **Noted the breakeven forecast outturn position in line with NHSE reporting requirements.**<br>• **Noted the year-to-date delivery of CIP as at Month 10 of £500.8m against a plan of £496.6m, an over delivery of £4.1m.**<br>• **Noted the forecast capital position is expected to deliver in line with allocation.**<br>• **Noted the risk to the system wide cash position which continues to be closely monitored.**<br>• **Noted that full DSF has been received, and whilst there remains a risk that this is subject to clawback if a balanced position for the system is not delivered, this is low as the system has confirmed that it will deliver the recovery plans and an overall balanced system position.**<br>• **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.** | |
| 12. | <u>Quality and Performance</u><br><br><u>Quality & Performance Report</u><br><br>MK advised the Board on the levels of assurance regarding performance and quality and the report was taken as read. She highlighted the number of alerts which the system was trying to recover. Quality oversight continues and the ICB was working closely with GMMH.<br><br>Paediatric Audiology remains a concern for NHS GM, but progress was expected within the next 12 months.<br><br>**The Board discussed and agreed levels of assurance set out in this report.** | |
| 13. | <u>Audit Committee</u><br><br><u>Audit Committee Report</u><br><br>It was noted that the Audit Committee was not meeting until tmrw and would do a deep dive into Population Health. The report would be presented next time. | |



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www.gmintegratedcare.org.uk

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| | **The Board:**<br>• **Noted the contents of the report** | |
| 14. | Remuneration Committee<br><br>RE provided a verbal update from the February meeting including the Voluntary Redundancy (VR) Ratification Panel, noting that the second round of VR was nearing completion.<br><br>**The Board:**<br>• **Noted the contents of the verbal report.** | |
| 15. | Primary Care Commissioning Committee<br><br>The summary report following the last Primary Care Commissioning Committee meeting was noted.<br><br>KS highlighted the national dental contract reforms to be introduced on 1st April 2026 noting a high degree of risk within the contract which need to be reviewed to understand the<br><br>VM added that the referendum regarding the GP contract may lead to collective action. The changes to the contact would make contracting more difficult.<br><br>**The Board:**<br>• **Noted the contents of the report** | |
| 16. | Specialised Commissioning Committee<br><br>The NW Specialised Commissioning Committee report was taken as read noting there had been an additional meeting since then.<br><br>**The Board:**<br>• **Noted the contents of the report.** | |
| 17. | Transition Committee<br><br>The overview of discussions at the February and March Transition Committee was taken as read. The Chair thanked everyone who had participated moving towards new structures noting that learning was underway.<br><br>**The Board:**<br>• **Noted the contents of the report** | |
| 18. | Approved Minutes of Committees<br><br>The following minutes were shared for information:<br>• Transition Committee | |
| 19. | Any Other Business including reflections of the meeting<br><br>Thanks were noted to Gareth Robinson who had left NHS GM and welcome to Nicola Hepburn as Acting Chief Reform & Improvement Officer. | |

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| | The Chair also thanked Lucy Cunliffe for her support to the Board who leaves the organisation in the coming weeks. | |
| 20. | <u>Date and time of next meeting:</u><br><br>Wednesday 20th May 2026, 2pm – 4pm, Tootal Buildings. | |

NHS
Greater Manchester

# Acting CEO's Report to the Board 2026-2027

**Part of** Greater Manchester
Integrated Care Partnership

# Board

## 20 May 2026

### Report for Information

| Required information. | Details. |
|---|---|
| **Title of report.** | Acting CEO's Report to the Board |
| **Author.** | Professor Colin Scales |
| **Presented by.** | Professor Colin Scales |
| **Contact for further information.** | gmhscp.gmicb.corporate@nhs.net |
| **Executive summary.** | The paper details updates from the Acting CEO with reference to the national, regional and local system positions. |
| **The benefits that the population of Greater Manchester will experience.** | The NHS Greater Manchester (GM) response to NHS Reform, with consideration being made through the necessary due diligence.<br><br>The importance of Martha's Rule, which recognises that those who know the patient best may be the first to notice changes.<br><br>Investing £3.2 million to improve support for children and young people (CYP) under 18, with suspected attention deficit hyperactivity disorder (ADHD) and autism. |
| **How health inequalities will be reduced in Greater Manchester's communities.** | Proactively responding to Martha's Rule. |

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| **The decision to be made and/or input sought.** | The Board is asked to note the contents of the CEO's Report to the Board. Also, disseminate and cascade the necessary key messages and information as appropriate. |
| **How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.** | Delivering key messages in the context of NHS Reform which is BAF SR10. Specifically for the quality of care BAF SR3, in response to Martha's Rule. Radcliffe Primary Care Centre being selected as a neighbourhood health centre aiming to reduce health inequalities, which is BAF SR5. |
| **Key milestones.** | Key messages in the context of NHS Reform. |
| **Leadership and governance arrangements.** | For consideration and dissemination by the Board. |
| **Engagement* to date.**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | Engagement has already commenced with the GM system's key stakeholders and NHS GM staff in response to NHS Reform. Any formal decisions to be taken, will proceed through the necessary governance routes. |
| **Financial or Legal Implications** | NHS GM proceeding with the organisational change programme in response to NHS Reform. |

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

# Introduction

1.1. The paper details updates from the Acting CEO with reference to the national, regional and local system positions.

## National and Regional Updates

1.2. This section of my report is aimed to update the Board on the key areas of development from a national and regional position, since the last Acting CEO's Report to the Board in March.

1.3. Board members will be aware of the organisational change process currently underway across all Integrated Care Boards (ICBs) since the respective announcements made by the Prime Minister and Secretary of State for Health and Social Care in 2025. Moreover, a further announcement was made by the Secretary of State for Health and Social Care on 25th March 2026 regarding the health devolution arrangements which will come into place here in GM, as well as South Yorkshire.

1.4. This will mean that the communities here in GM and South Yorkshire will benefit from a greater focus on preventative healthcare. Also, the two respective ICB Chairs will report to NHS leaders and Mayors, putting democratically elected Mayors at the heart of local health services. This trial is a first of its kind to shift local decision-making out of Whitehall into regions, which is part of the Government's landmark 10 Year Health Plan and devolution bill. Under the plans, NHS England (NHSE) will appoint a new NHS ICB Chair, who will also serve as the Mayor's Health Commissioner. I have provided the link to the Government's press release for further information: Health devolution in Greater Manchester and South Yorkshire - GOV.UK

1.5. Staying with NHSE, I would like to congratulate and acknowledge the appointment of Kathy Cowell CBE as the new NHSE North West Regional Chair, who took up this post on 1st May. The new NHSE Regional Chair roles will provide visible, independent leadership across the regions, supporting the delivery of the NHS 10-Year Plan and working with provider and system Chairs to drive improvement, strengthen governance and help reduce health inequalities across the North West. Board members will be well aware of Kathy's previous role as Chair of Manchester University NHS Foundation Trust (MFT).

1.6. At the point of writing my Acting CEO's Report to the Board, we are still progressing the formalities of the consultation process. Where possible, and if necessary, I can verbally update the Board during the meeting itself.

# Greater Manchester (GM) System Updates

**2.0** This section of my CEO Report is specifically focussed on what is happening here within the GM system.

## The NHS GM Board

2.1. Within March's Acting CEO Report to the Board, I referred to the formal advertisement of the substantive CEO role with our recruitment partner Alumni Global. I have been asked to report to the Board of the agreement which has been reached by Sir Richard and Louise Shepherd – NHSE's North West Regional Director, who have decided to pause the CEO recruitment, until the new Chair has been appointed. Therefore, Sir Richard has asked that I remain as Acting CEO, until the new Chair has been appointed and the CEO recruitment process is relaunched and subsequently concludes. I will appraise the Board, as required, on behalf of Louise Shepherd with any necessary updates.

2.2. It would be remiss of me, not to highlight that May's meeting with be Sir Richard's last formal NHS GM Board. Sir Richard will be retiring on 30th June having served a term as NHS GM's first Chair. I am sure Board members will be individually reaching out to Sir Richard to pass on their own thanks, but I would like the minutes to reflect Sir Richard's dedication to public and civic service over many decades. I would like to also thank Sir Richard personally for the support he has given me during my time as Deputy CEO and now as Acting CEO.

2.3. Also, since the last Board meeting in March, Mark Fisher has retired as the CEO of NHS GM. On 27th March Mark confirmed to Board Members and wider GM system colleagues that following a whistleblowing concern, he was pleased to announce that the process had concluded, and he was free to return to work. However, given the close proximity to his retirement date of 31st March, he would not be resuming his substantive duties. Mark will be moving onto a portfolio of non-executive work and other interests. I am sure the Board will join me in wishing Mark the very best for the future.

2.4. There is another change to notify the Board of, which is in relation to Dr Owen Williams, who is our Board member representing acute and community services, as well as being the Northern Care Alliance NHS Foundation Trust (NCA) CEO. Owen has announced he will be leaving the NCA in September. Owen's departure has implications for our Board, which myself and Sir Richard will discuss with the GM Trust Provider Collaborative (TPC).

2.5. Since the Board last met, there have been key governance milestones achieved, with new Board and Committee arrangements now operational. These changes strengthen assurance, support effective strategic commissioning and improve decision making as NHS GM transitions fully to its role as a strategic commissioner. Workforce transition activity is progressing in a controlled and compliant manner. The new staffing structures have also now been finalised. The filling of posts panels are imminent, and tailored transition and wellbeing support remains in place to support staff through change, mitigating risk to organisational stability and delivery.

## Industrial Action

2.6. Board members will be aware that resident doctors in GM took part in the industrial action between 7th April through to 13th April. The GM system has worked collectively to support and mitigate the risk, with all urgent care services continuing to be delivered and no immediate patient safety risks were experienced. The wider workforce acted collaboratively to cover any rota gaps and initial intelligence shows that around 50% of the resident doctor workforce took part in the action. Patients were supported through communications and engagement processes to ensure they knew how to access the most appropriate services to meet their needs.

## National spotlight on Martha's Rule

2.7. Martha's Rule has received significant national media attention in recent weeks following its phased rollout across acute hospitals in England. Martha's Rule recognises that those who know the patient best may be the first to notice changes that could be an early sign of deterioration and actively encourages patients, families and carers to tell staff if they are worried a health condition is getting worse. If, after speaking to the care team, they remain worried and feel their concerns are not being addressed, Martha's Rule means that they can call a dedicated number to request a rapid review from a different team. It also empowers staff to call for a rapid review if they feel their concerns about a patient are not being responded to.

2.8. Early evidence suggests Martha's Rule, which is led by the National Director of Patient Safety in NHSE, is saving lives and helping thousands of patients benefit from changes to their care. Data from September 2024 to February 2026 shows 12,301 Martha's Rule calls were made, with the highest proportion of calls being 72%, made via the family and carer escalation process. About one in three, 4,047, helped to identify a patient whose health was getting worse.

## ADHD and autism support – children and young people (CYP)

2.9. NHS GM is investing £3.2 million to improve support for CYP under 18 with suspected ADHD and autism. From April 2026, a new needs-led model will be implemented across all of GM to address long waits and inequity in the current diagnosis-led system. The new approach prioritises CYP with the highest levels of need, enables access to support with or without a formal diagnosis, and ensures earlier intervention. All children and families will receive a personalised offer of support based on assessed need, including advice, practical tools, workshops for parents, and access to enhanced online resources.

2.10. CYP currently on waiting lists will be reviewed under the new process and contacted where their care pathway changes. The programme aims to reduce delays, prevent avoidable harm, and ensure timely access to specialist support for those who need it

most. I have provided a useful link as follows: Changes to Autism and ADHD support in Greater Manchester | Greater Manchester Integrated Care Partnership

## Radcliffe Primary Care Centre to be transformed into one of the country's first neighbourhood health centres

2.11. I am pleased that Radcliffe Primary Care Centre in Bury has been selected as one of the first 27 sites nationally to be developed as a neighbourhood health centre. The scheme will refurbish existing NHS estate to support more integrated, community-based services by bringing a wider range of care and support together in one location. The model places greater emphasis on prevention, early intervention and personalised support. Radcliffe is one of 27 centres selected in areas with higher levels of deprivation, forming part of an initial cohort of 50 neighbourhood health centres supported through a £200 million national capital investment, with further rollouts planned through to 2036.

2.12. The centre currently hosts two GP practices and a range of health and wellbeing services. A £2.74 million capital investment will be used to convert under-used clinical space into flexible, multi-use areas to support outreach, diagnostics and additional community health services. The Work is expected to be completed by 2027. The aim is to make it easier for everyone to access the health care they need and to reduce the inequality. We believe that turning Radcliffe Primary Care Centre into a neighbourhood health centre will do just that, and will have a hugely positive impact on the local community.

## Health Innovation Manchester (HInM) Update

2.13. In obesity care, discussions are ongoing in relation to the potential future commissioning opportunities. In the meantime, HInM have won a bid to lead the UK-wide learning system for the 12 sites involved in the £85 million Obesity Pathway Innovation Programme. The 'Impact Collaborative' will enable the projects to collaborate effectively, share actionable insights, and accelerate the delivery of sustainable impact across NHS systems. This is a strong example of GM leading the way in this high-profile space.

2.14. The HInM Strategy has recently been refreshed to respond to national and local strategic drivers in health and life sciences. Our relationship with HInM continues to mature, with the recent agreement of an ICB-HInM partnership memorandum of understanding (MOU), and oversight via a Partnership Steering Group. This is to ensure alignment and effective working across our respective portfolios.

## Health and Safety Oversight

2.15. I have previously committed to update the Board on all matters relating to health and safety, with a standing item within my report to the Board. In my previous update, I advised

the Board that the last meeting of the Health and Safety Oversight Group had been stood down as part of the response to NHS Reform and the associated organisational change pressures. I am happy to report that the quarter one (Q1) meeting of the group took place on 12th May. The meeting focussed on key health and safety related areas, and drew out risks the organisation is currently facing in this respect.

2.16. The oversight arrangements for health and safety, as well as security continue to be reviewed as part of the organisational change programme, including revieing the need to provide additional Health and Safety Management Training to all managers across the organisation, as well as the Leading for Safety Training for Executives of the organisation. As reported to the Audit Committee in March, progress in respect of the Mersey Internal Audit Agency (MIAA) Health and Safety Audit recommendations has not been as swift as we would have hoped due to ongoing pressures linked to organisational change. However, addressing these recommendations remains important, and will be progressed over the coming months. I will appraise the Board on progress at the next meeting in July.

## Greater Manchester celebrates success at the first NHS Excellence Awards

2.17. I am delighted that GM secured five regional wins at the NHS Excellence Awards 2026, showcasing innovation and collaboration across health services. The NHS Excellence Awards 2026 are run by, and for, the NHS, shining a light on local projects and teams who are making a real difference to patients and communities, delivering on the ambitions of the 10 Year Health Plan and inspiring others to adopt innovative approaches in their local area.

2.18. The ECO4 Flex Health Referral Pathways funded by NHS GM was named the regional winner for the North West in the Sustainable Healthcare category. The Working in Partnership Award was awarded to the Greater Manchester Urgent Primary Care Alliance, while Greater Manchester Mental Health NHS Foundation Trust (GMMH), MFT and Pennine Care NHS Foundation Trust (PCFT) were also crowned regional champions. More information on the award winners are on our website via the following link: Greater Manchester wins five NHS awards 2026

2.19. It is fantastic to see the outstanding work taking place across GM being recognised through these regional awards. I believe that the power of collaboration is essential in improving health outcomes and reducing inequalities. These projects show how innovation and sustainability can deliver real benefits, more joined-up care for patients whilst making the best possible use of public resources.

## Award Winning Hospital Catering Team

2.20. Earlier this month, I was informed about Stockport NHS Foundation Trust's Catering Team picking up awards in recognition of their 'excellent' standards. The Catering Team came first in the 'Hospital Catering' category at this year's Public Sector Catering Awards and Support Services Manager Erica Bell, was named 'Caterer of the Year' at the Annual

Hospital Catering Association awards. I am sure the Board will join me in passing on our congratulations in recognition of providing this important service to patients, when they are unwell in hospital.

## Recommendations

**3.0** The NHS GM Board is asked to:

3.1. Note the contents of the Acting CEO's Report to the Board.

3.2. Provider feedback on any future topics they wish to be covered within the Acting CEO's Report to the Board in July 2026.

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# NHS GM Financial Scheme of Delegation Amendments

**Part of** Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

# NHS GM Board

## Date 14/05/2026

| 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 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** | Approve 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)<br>People & Resources Committee (22/4/26)<br>Audit Committee (23/4/26)<br>Board (14/5/26) |
| **Engagement* to date**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | Senior Finance Team<br>Chief Officers (1/4/26)<br>People & Resources Committee (22/4/26)<br>Audit Committee (23/4/26) |

| 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 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 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 all the Committees/ Sub Committees/ Groups. Once the revised governance structure is embedded 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’.

All expenditure above £50,000 will still be required to be approved by NHS England in line with current guidance. All consultancy expenditure approved by NHSE will be reported to the People and Resources Committee.

**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 Board is requested to:

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

## 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.<br><br>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.<br><br>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<br>Board | 15 May 2024<br>15 May 2024 | V13<br>V13.1 |
| Board | 18 September 2024 | V14.0 |
| Board | 26 March 2025 | V15.0 |

NHS
Greater Manchester

## 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**<br>**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.**<br><br>**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.**<br><br>**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<br><br>(With CFO engagement) | | |
| Chief Finance Officer | All contracts | All variations | |
| Finance Officer VSM | All contracts<br><br>(As nominated in writing by the GMICB CFO) | All contracts<br><br>(As nominated in writing by the GMICB CFO) | |
| Finance Officer Band 9 | All contracts<br><br>(As nominated in writing by the GMICB CFO) | All contracts<br><br>(As nominated in writing by the GMICB CFO) | |
| Finance Officer Band 8D | All contracts<br><br>(As nominated in writing by the GMICB CFO) | All contracts<br><br>(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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Individualised Commissioning ****<br>**(LD, MH, CHC, Children's)**<br><br>**(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)<br>or Chief Finance Officer<br>or Chief Executive<br><br>(Two out of three signatures required) | | *Package greater than £350,000 |
| Chief Executive | Up to *£100,000<br><br>(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<br><br>(Only for responsible budget areas assigned) | | *Package agreed up to £350,000 |
| Placed Based Lead or Deputy Place Lead<br>Deputy Place Lead/Deputy Place Lead (Deputy) or<br>Locality Finance Lead<br><br>(Two out of three signatures required)<br><br>(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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Individual Funding Requests**<br><br>**(Financial limits reflect the annual cost)** |
|---|---|
| **Committee Name or Post** | |
| GMICB Board | Greater than £250,000 |
| Chief Executive | Up to £250,000<br><br>(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 | |

## Table 5 -Invoice Payment

| **Approval Limits**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**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<br><br>(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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**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 |

## Table 7 -Business Cases/ Proposals

| **Approval Limits**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Business Cases / Proposals (Including Change in Clinical Policies)**<br><br>**(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)<br>and Chief Finance Officer<br>and Chief Executive<br>(or nominated deputies)<br><br>(All three signatures required) | £150,000 and up to £5m |
| Chief Executive | Up to £150,000<br><br>(With CFO engagement) |
| ICB Executive Director (Statutory Board Member)<br>+ 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<br><br>(Only for responsible budget areas assigned) | Up to £100,000 |
| Placed Based Lead and<br>Deputy Place Lead and<br>Locality Finance Lead<br><br>(All three signatures required)<br><br>(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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Procurements*****<br><br>**(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)<br>and Chief Finance Officer<br>and Chief Executive<br>(or nominated deputies)<br><br>(All three signatures required) | £500,000 and up to £5m | All procurements |
| Chief Executive | Up to £500,000<br><br>(With CFO engagement) | |
| ICB Executive Director (Statutory Board Member)<br>+ 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<br><br>(Only for responsible budget areas assigned) | Up to £100,000 | |
| Placed Based Lead and<br>Deputy Place Lead and<br>Locality Finance Lead<br><br>(All three signatures required)<br><br>(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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Non-Pay / Request for Funding and Contracts (Including Corporate Expenditure)**<br><br>**(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)**<br><br>**(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)<br>and Chief Finance Officer<br>and Chief Executive<br>(or nominated deputies)<br><br>(All three signatures required) | £75,000 and up to £1m |
| Chief Executive | Up to £75,000<br><br>(With CFO engagement) |
| ICB Executive Director (Statutory Board Member)<br>+ 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<br><br>(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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Consultancy Expenditure**<br><br>**(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<br><br>(With CFO engagement) |
| Chief Finance Officer | Up to £49,999 |

Table 11 -Raise Sales Invoices

| **Approval Limits**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **All Losses, Special Payments, Consolatory Payments**<br><br>**(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<br>All Special Payments<br>All Consolatory Payments<br><br>(Report All Losses, Special Payments, Consolatory Payments) |
| Audit Committee | (Report All Losses, Special Payments, Consolatory Payments) |
| Finance Committee | All Losses up to £100,000<br><br>(Report All Losses) |
| Chief Finance Officer | All Losses up to £50,000 |

Table 13 – Budget Virements Between Cost Centres

| **Approval Limits**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**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<br><br>(As nominated in writing by the GMICB CFO) |
| Finance Officer Band 9 | All waivers<br><br>(As nominated in writing by the GMICB CFO) |
| Finance Officer Band 8D | All waivers<br><br>(As nominated in writing by the GMICB CFO) |

Table 15 -NHS Legal Claims

| | |
|---|---|
| **Approval Limits**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Travel Expenses**<br><br>**(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<br><br>(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.<br><br>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.<br><br>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 |
| 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<br>Board | 15 May 2024<br>15 May 2024 | V13<br>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 | Health Care Business Cases/ Proposals (Including Change in Clinical Policies) |
| Table 7 | Non-Health Care / Request for Funding and Contracts (Including Corporate Expenditure) |
| Table 8 | Consultancy Expenditure |
| Table 9 | Raise Sales Invoices |
| Table 10 | All Losses, Legal Claims, Special Payments, Consolatory Payments |
| 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.**

## 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<br><br>(With CFO engagement) | | |
| Chief Finance Officer (CFO) | All contracts | All variations | |
| Deputy Chief Finance Officer | All contracts<br><br>(As nominated in writing by the GMICB CFO) | All contracts<br><br>(As nominated in writing by the GMICB CFO) | |
| Director of Finance - Band 9 | All contracts<br><br>(As nominated in writing by the GMICB CFO) | All contracts<br><br>(As nominated in writing by the GMICB CFO) | |
| Associate Director of Provider Finance & Insight - Band 8D | All contracts within their portfolio<br><br>(As nominated in writing by the GMICB CFO) | All contracts within their portfolio<br><br>(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**<br>**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.**<br><br>**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.**<br><br>**Individualised commissioning**<br>**Limits reflect the expected annual cost of the package.** | **Individualised Commissioning ****<br>**(LD, MH, CHC, Children's)**<br><br>**(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<br>& either Chief Finance Officer<br>or Chief Executive<br><br>(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**<br>**All limits reflect the total expected cost of the decision, regardless of which financial year the costs will be incurred.** | **Individual Funding Requests**<br><br>**(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**<br>**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)**<br><br>**(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<br>and Chief Finance Officer<br>and Chief Executive<br>(or nominated deputies)<br><br>(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**<br><br>**(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)**<br><br>**(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<br>and Chief Finance Officer<br>and Chief Executive<br>(or nominated deputies)<br><br>(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

All expenditure above £50,000 will still be required to be approved by NHS England in line with current guidance. All consultancy expenditure approved by NHSE will be reported to the People and Resources Committee.

| | **Consultancy Expenditure**<br><br>**(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<br>& either Chief Finance Officer<br>or Chief Executive<br><br>(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**<br><br>**(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.<br>All Legal Claims<br>Special Payments & Consolatory Payments over £5,000<br><br>(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<br><br>(Report All Losses) |
| Chief Finance Officer | All Losses up to £50,000<br>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<br><br>(As nominated in writing by the GMICB CFO) |
| Director of Finance Band 9 | All waivers & Decision Making Records under PSR<br><br>(As nominated in writing by the GMICB CFO) |
| Associate Director of Contract Management & Procurement Band 8D | All waivers & Decision Making Records under PSR<br><br>(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<br><br>(Financial limit for an individual monthly claim) |
|---|---|
| **Committee Name or Post** | |
| As permitted in line with the use of Easy Expenses/ ESR approval processes. | * |

NHS
Greater Manchester

# GUIDANCE IN APPLYING THE NHS GM FINANCIAL SCHEME OF DELEGATION

Part of Greater Manchester Integrated Care Partnership

Date: April 2026

NHS
Greater Manchester

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

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# 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)

NHS Greater Manchester

**GREATER THAN £10K**

STAR APPROVAL REQUIRED

**UP TO £250K**

APPROVAL BY
CHIEF OFFICER
(WITH RELEVANT BUDGET RESPONSIBILITY)

**UP TO £500K**

APPROVAL BY
CHIEF FINANCE OFFICER
OR
CHIEF EXECUTIVE

**GREATER THAN £500K UP TO £15M**
**(APPROVAL TO BE GAINED THROUGH CHIEF OFFICERS MEETING)**

APPROVAL BY
ICB CHIEF OFFICER AND CHIEF FINANCE OFFICER AND CHIEF EXECUTIVE (OR NOMINATED DEPUTIES)

(ALL THREE SIGNATURES REQUIRED)

**GREATER THAN £15M UP TO £100M**

**(APPROVAL TO BE GAINED THROUGH THE CHIEF OFFICERS MEETING FIRST)**

APPROVAL BY
PEOPLE & RESOURCES COMMITTEE

**GREATER THAN £100M**

**(APPROVAL TO BE GAINED THROUGH THE CHIEF OFFICERS MEETING FIRST, PEOPLE & RESCOURCES COMMITTEE SECOND)**

APPROVAL BY
GMICB BOARD

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

NHS Greater Manchester

**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

NHS
Greater Manchester

# Other Key Considerations

# 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.

# 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.

NHS
Greater Manchester

# Board Assurance Framework Report – 2025/26 Closedown and Refresh Plans

20th May 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

# Integrated Care Board

## 20th May 2026

| Required information | Details |
|---|---|
| **Title of report** | Board Assurance Framework Report – 2025/26 Closedown and Refresh Plans |
| **Author** | Chris Gaffey, Associate Director of Corporate Services<br>Tom Conyers, Head of Risk and PMO |
| **Presented by** | Nicola Hepburn, Interim Chief Reform and Improvement Officer |
| **Contact for further information** | Tom Conyers, Head of Risk & PMO – tom.conyers1@nhs.net |
| **Executive summary** | This report provides the Board with a final position for the organisation's strategic risks for 2025/26 (the BAF is set out in Appendix One).<br><br>The report also sets out the proposed process for reviewing and refreshing the BAF for 2026/27, ensuring the organisation's strategic risks are aligned to its strategic objectives, and that these accurately reflect the ICB's new responsibilities as a strategic commissioner in line with the ICB Model Blueprint and new Operating Model. |
| **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 Integrated Care Board is asked to:<br><br>• Review and reflect on the year-end position for the 2025/26 BAF risks.<br><br>• Note and provide any comments on the proposed plans for the BAF refresh for 2026/27, including the learning from the recent Deep Dive. |
| **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** | None |
| **Leadership and governance arrangements** | Each strategic risk has an assigned risk owner, who is a Chief Officer of NHS GM.<br><br>The BAF is reported to and considered by the Board at each of its meetings, with the strategic risks also considered at the responsible committee.<br><br>The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation |
| **Engagement* to date**<br><br>***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 provides the Board with the final position of the organisation's Strategic Risks for 2025/2026. In addition, following the NHS reforms and organisational restructure, there is a need for the BAF to be refreshed to align with the new organisational arrangements and change in responsibilities, so the process and timeline for the BAF refresh is also detailed within the report.

## 2.0 Strategic Risks

2.1 Since the March meeting, the strategic risks 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 risk positions.

2.2 Table 1 below shows the agreed strategic risks, aligned to the strategic objectives as well as the final Q4 risk scores.

# NHS GM Board Assurance Framework
# Year End 2025/2026

## 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** |
| Year End Score 3 (L) x 5 (I) = **15** | Year End Score 4 (L) x 5 (I) = **20** | Year End Score 3 (L) x 5 (I) = **15** | Year End Score 3 (L) x 4 (I) = **12** | Year End Score 2 (L) x 4 (I) = **12** | Year End Score 4 (L) x 4 (I) = **16** | Year End Score 2 (L) x 4 (I) = **8** | Year End Score 3 (L) x 4 (I) = **12** | Year End Score 3 (L) x 3 (I) = 9 | Year End 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** |

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

- Four areas showed reductions in risk scores from Q3 to Q4 (SR4 Good Employment, SR5 Health Inequalities, SR7 Financial Sustainability and SR9 Emergency Incident). Additional information has been provided below to explain these reductions.

- SR4 Good Employment: This risk score has been reduced to reflect the significant work that has taken place over the past 12 months in GM, between NHS GM and key partners. The Get GM Working Plan has been approved, and GM is a named Keep Britain Working vanguard area. The GM WorkWell Partnership vanguard supported almost 7000 people over the first 18months of delivery and a further 3 years funding has been included in the Integrated Settlement which has a strong focus on ensuring all GM residents have line of sight to Good Employment, as per the ambition set out in the GM Strategy.

- SR5 Health Inequalities: This risk score has been reduced because whilst NHS GM remains an organisation facing significant financial challenges and comprehensive organisational change, there is a heightened emphasis on prevention and 'left shift' within the new operating models and ICB Chief Officers have confirmed plan with the 10 LA Directors of Public Health (DsPH) to create an integrated GM Public Health Network with a pooled budget, integrated team, and shared plan under the leadership of the DsPH. This will be operating in shadow form from 1/5/26 and fully operational from 1/4/27.

- SR7 Financial Sustainability: Following the submission of the ICB and all GM Trusts draft accounts the risk score has further decreased from 16 to 8 to reflect the reduced likelihood in not achieving the desired target. These draft accounts are still subject to external audit, and the final outcome will not be known until June.

- SR9 Emergency Preparedness: The risk score for the end of 2025/26 reflects a Likelihood of 3 that is related to the EPRR team staffing position. The team had longstanding gaps in its structure and has recently recruited to two full time posts. There will be a period of transition as the two individuals settle into their new roles and there is one further post to be filled as part of the organisational change process.

- All remaining strategic risks reported a static score in Q4.

2.4 Comparison of the Q4 risk scores with their Year End Targets shows three areas where the Q4 score exceeds the Year End Target:

- SR1 Health of the Population (Q4 score: 15, Year End Target: 10), although this is within the agreed risk appetite (Open – range 10 to 20)

- SR6 Workforce (Q4 score: 16, Year End Target: 9) although this is within the agreed risk appetite (Open – range 10 to 20)

- SR10 NHS Reform (Q4 score: 16, Year End Target: 9). The Q4 is outside the agreed risk appetite (Cautious to Open – range 5 to 15)

Three Strategic Risk year-end scores are above their agreed risk appetite. These are: Q2 Health Outcomes, SR8 Cyber Security and SR10 NHS Reform.

- The Health Outcomes year-end risk score is outside the agreed risk tolerance range (Cautious to open 5 to 15), though the final target score for 2028 is 10.

- The Cyber Security year-end risk score is above the agreed risk appetite range (Cautious 5 to 10), though the final target score for 20228 is 8.

- The NHS Reform year-end score is above the agreed risk tolerance range (Cautious to Open 5 to 15). The final target score for 2026 is 4, which is below the range.

- All other Strategic Risks year-end scores are in line with the Year End Targets.

2.5 All of the above will be considered within the context of the upcoming refresh of the BAF (see section three), but also within the framework of moving towards a more dynamic way of reporting risk for the organisation. Feedback from a recent deep dive on SR1 conducted by the Audit Committee (further information later in this report) set out a number of key areas to enhance reporting, focusing on outcomes, impact and risk movement.

## 3.0 2026/27 BAF Refresh

3.1 Following the closedown of the 2025/26 BAF, a formal review of NHS GM's BAF risks for the coming period will be conducted to ensure the organisation's strategic risks are aligned to its strategic objectives, and that these accurately reflect the ICB's new responsibilities as a strategic commissioner in line with the ICB Model Blueprint and new Operating Model.

3.2 Work is ongoing to develop a list of strategic risks for the coming year, based on the 5-Year Commissioning Plan, which will be considered by Chief Officers at a planned away day in May. Following this, proposals will be presented to the Board at their informal meeting in June, before the BAF is then finalised and presented at the formal Board meeting in July for consideration and approval.

3.3 As part of this process, the learning from the recent Deep Dive on SR1, conducted by the Audit Committee at their meeting in March, will be applied to new risks to move towards the more dynamic way of risk reporting.

3.4 The learning was presented back to the Committee at their meeting in April, which was well received, and the Committee requested that the summary of the learning be shared with the Board. The summary of the learning is as follows:

**a) The need to move beyond "process assurance" to impact and outcomes**

Audit Committee members consistently emphasised the importance of answering the "so what?" in relation to strategic risks.

- BAF risks currently place significant emphasis on controls, processes and narrative assurance, but insufficiently demonstrate whether mitigations are changing the level of risk.

- Assurance statements can appear reassuring (including Three Lines of Defence assessments) without clear evidence, data or metrics to justify those judgements. In particular, the three lines of defence ratings can appear "all green" without measurable evidence to justify that judgement.

- Members noted that it is often difficult to tell whether progress is being made quickly enough, or at all.

Expectation:
Risk reports should explicitly describe what has changed since the previous review, how we know, whether the risk trajectory is improving, worsening or static, and have clearer evidence and rationale behind any assurance ratings related to the three lines of defence.

**b) Ambiguity over ownership of system-level risks**

The Committee highlighted persistent uncertainty around ownership and accountability for risks that are system wide.

- Strategic risks frequently extend beyond the direct control of the ICB, with mitigation dependent on wider system partners.
- Current reports do not always make clear:
    - who is accountable for the overall management of the risk.
    - or how assurance is obtained that partner actions are being delivered.

Expectation:
For each strategic risk, there should be explicit distinction between ICB-owned mitigations and system dependencies, and clarity on how the ICB is holding the ring on system coordination and escalation (where possible and appropriate).

**c) Strategic risks may be too broad without clear prioritisation**

Members observed that several BAF risks are extremely broad, in some cases underpinned by a large number of other risks.

- This breadth makes it difficult to demonstrate progress or apply meaningful metrics.
- There was concern that the BAF is not always being used as a prioritisation tool, including to inform resource and financial decisions.

Expectation:
The BAF should operate as a living document, supporting prioritisation of executive focus and capacity, targeted deep dive scrutiny on the most material risks, and explicit decisions about where effort and investment are, or are not, justified.

**d) Stronger use of data, metrics and evaluation**

The Committee acknowledged that measuring strategic risks is complex, and that progress may be long term. However, members stressed that:

- absence of perfect measures should not default to absence of measures.
- some meaningful indicators are preferable to none.
- evaluation must be honest and enable stopping or adapting interventions that are not working.
- Positive examples (e.g. outcomes frameworks and data-led strategy packs) were cited as

models to build upon.

Expectation:
Each strategic risk should be supported by aligned metrics or indicators, narrative interpretation of what the data shows, and explicit consideration of whether mitigations remain appropriate.

**e). Proportionate improvement – not creating an "industry"**

Members were clear that improvements should not result in over-engineering or excessively burdensome processes.

Expectation:
The focus should be on better quality thinking and decision-making, clearer information flow, and a virtuous cycle of insight, action and review.

The Committee's discussion signals a shift from asking *"do we have mitigations in place?"* to *"are our actions having an impact on the risk, and how do we know?"*. Applying this learning consistently will strengthen strategic risk management and the Board's ability to take confident, informed decisions.

Proposed actions to strengthen the BAF approach

As a result of the discussion, the following actions should be applied across all strategic risks:

1. Refresh the BAF approach to focus more on outcomes, impact and risk movement.
2. Separate system risk from ICB-specific mitigations, with a distinct section on dependencies and influence.
3. Introduce a small number of meaningful indicators for each strategic risk.
4. Use the BAF more explicitly as a prioritisation tool, including to inform resource and financial decisions.
5. Embed learning and adaptation, including stopping or reshaping mitigations where evidence suggests limited impact.

## 4.0 Recommendations

4.1 The Board is asked to:

- Review and reflect on the year-end position for the 2025/26 BAF risks.
- Note and provide any comments on the proposed plans for the BAF refresh for 2026/27, including the learning from the recent Deep Dive.

| | |
|---|---|
| Strategic Risk<br><br>**SR1** | There is a risk that the health of the population will worsen due to wider economic and social conditions deteriorating. This could include societal challenges and structural inequalities that relate to poverty / socio-economic disadvantage, housing and local infrastructure, early years experiences and educational attainment, access to good employment, crime and safety, air quality and transport. This will result in poorer health, unsustainable demand on health and care services and will impede economic growth. |
| Strategic Objective | Strengthen our communities |
| Chief Officer / Committee | Charlotte Bailey Strategic Commissioning Committee |

| | | | |
|---|---|---|---|
| Risk Appetite Level | 3 - Open | Risk Tolerance Range (e.g. 5 to 10) | 10 - 20 |

**Rationale for Risk Score and Progress made in the quarter**

The health of the population is primarily determined by the wider, social and commercial determinants of health ("building blocks of health") and structural inequalities / discrimination. This includes determinants such as housing, poverty, educational attainment, air quality, good employment, transport. Building upon significant progress over recent years in areas such as growth, early years and transport, the ambitions set out within the new Greater Manchester Strategy 2025-35 provide the framework upon which the system will take action to influence these risk factors and improve health outcomes, including through Live Well.

**Key Controls**

The Greater Manchester Strategy is the main control measure and the deliverability of the strategy including the extent to which the ICB can act as a system influencer and strategic investor is key to mitigating this risk. In the current landscape of NHS reform, it is crucial that the ICB retains the capacity, expertise and ability to act as a collaborative system influencer and co-investor in relation to the building blocks of health which the strategy covers.

Alongside the GMS, another key control is the development of a comprehensive strategic approach to NHS 'left shift' which builds upon our GM Population Health Model and comprehensive Prevention and Early Intervention Framework and underpins ICB reform and future transformational operating model.

The ICB 5-year strategic commissioning plan is nearing completion and will set out how the ICB will improve the health of the population.

An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care.

A Fairer Health for All Framework has been agreed by the Integrated Care Board and implementation plans are in place for 2025/26 which will seek to embed tacking inequalities as a focus of the system.

The GM Housing Tripartite Agreement ensures a collaborative approach to healthy homes across NHS GM, GMCA and Housing Providers.

Equality & Health Impact Assessments of all ICB plans and proposals.

**Gaps in Control or Assurance**

Current reforms have and likely will continue to significantly impact any proactive NHS system involvement in delivery of the various strategic ambitions. Continuation of this will mean programmes develop without relevant health system influence and opportunities are missed to improve the health of the population.

The NHS Reform could impact on the capability of the ICB to provide the resource, skills, expert knowledge and capacity to effectively work across multiple systems in order to fulfil our role in driving the delivery of the GMS. A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel.

The delay in organisational 'left shift' activity and investment will impact progress of prevention and early intervention opportunities and transformation propositions.

| | Risk Scoring and Tolerance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Inherent risk score | Q1 | Q2 | Q3 | Q4 | Year-end Target | Long Term Target | Long Term Target Date |
| Likelihood | 3 | 3 | 3 | 3 | 3 | 2 | 1 | 2028 |
| Impact | 5 | 5 | 5 | 5 | 5 | 5 | 5 | |
| Risk Level | 15 | 15 | 15 | 15 | 15 | 10 | 5 | |

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

| Lines of Defence | Sources of Assurance | Assurance Level |
|---|---|---|
| 1st Line | ICB twice weekly Chief Officers meetings; Strategy People & Partnership directorate SLT meetings; Weekly Population Health function SMT; SPP Chief Officer is a member of NHS GM Chief Officers Group; GM Tripartite Agreement Core Group; GM Housing First Board; GM Strategy governance in place. This risk has been subject to an Audit Committee deep dive in March 2026 | Acceptable |
| 2nd Line | Population Health Committee currently stood down and replacement not yet in place. Maintenance of Strategic Risk Register and collation of the strategic risks into the Board Assurance Framework. | Partial |
| 3rd Line | GM Public Health Network which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny - includes an articulation of key risks and issues. Health and Wellbeing Boards | Acceptable |
| Action | Complete/BAU | On Track |
| | Delayed | Problematic |

| No | Action Required | Due Date | Progress | BRAG |
|---|---|---|---|---|
| 1 | Delivery of GMS under a new delivery framework | Ongoing | The delivery plans and associated governance are now well advanced and provide confidence around delivery of the strategy | |
| 2 | Development of refreshed Tripartite Agreement document (completed in October) and delivery plan to continue best practice work across NHS GM and GMCA re: housing | March 2026 | Tripartite Agreement signed off by GMCA on 28th Nov 2025. And ICB in Jan 2026 Action to be replaced in Q1 2026/27. | |
| 3 | Ensure the NHS Reform programme maintains the "left shift" priority and can provide the capability required from NHS GM to continue as a system influencer and strategic investor across the GMS building blocks for health, including through greater collaboration with key partners such as the GM Directors of Public Health and the GMCA. | March 2026 | Programme of ICB Reform is ongoing and the draft Strategic Commissioning Plan has a strong focus on Population Health and Prevention. Final implementation of the reform programme and operating model will be completed later than planned so now classes as delayed | |
| 4 | Development and design of an integrated GM Public Health Network which brings together the existing GMPHN resources with the ICB resources into a single integrated function under a s75 agreement. | June 2026 | On track for the implementation of Phase 1 of the transformation during Q1 2026/27, and for full implementation from 1 April 2027. | |

| | |
|---|---|
| Strategic Risk<br><br>**SR2** | There is a risk that key health and care services become unsafe and unstable due to growing and changing demand, pressures faced by other sectors and workforce, estates and technology gaps.<br>This will result in poorer health outcomes for the GM population and a reduction in quality of care and patient safety and an inability to deliver operational delivery standards. |
| Strategic Objective | Recover core health and care services |
| Chief Officer / Committee | Nicola Hepburn — Strategic Commissioning Committee |

| | | | |
|---|---|---|---|
| Risk Appetite Level | Cautious to Open | Risk Tolerance Range (e.g. 5 to 10) | 5 – 15 |

**Rationale for Risk Score and Progress made in the quarter**

All organisations have submitted plans for 26/27. Areas highlighted as high risk are considered such because of the scale of the 26/27 challenge or historical non-achievement. Current plans include significant levels of mitigations and NHS GM is committed to meet its planning objectives. This risk is currently outside of the risk appetite of the organisation. The target risk score moves within risk appetite by March '28. It is important to note that national guidance will require a continued incremental improvement back toward constitutional standards over several years which will mean a continued pressure against these standards. High risk areas continue to be A&E 4 and 12 hour waits; Long waits for elective care; Waiting times for Children's and adolescent mental health services including ADHD/ASD and reducing mental health inpatient LOS. Work has progressed to refresh oversight arrangements in line with ICB reform requirements and further development of the function will continue in 26/27. Financial constraints remain a contributory factor.

**Key Controls**

Weekly, and daily as required, tracking of activity and operational planning objectives and/or constitutional standards.
Daily monitoring of A&E activity and breaches.
GM system control centre oversees operational activities and escalation of UEC.
Mutual aid for elective, cancer and diagnostic care is in place.
Use of independent sector support for elective care, where this is within budget.
Improvement plans refreshed (or in the process of being refreshed) for all high-risk areas, including individual Trust and/or locality level where needed. (UEC, elective, cancer, mental health, diagnostics and inpatients for people with a learning disability).
Provider oversight meetings in place to gain assurance regarding delivery. Escalation meetings in place for Trusts which provider clearer tracking of action plans at senior level.
Additional internal ICB performance group in place from April 26 to bring together provider intelligence across teams and agree actions in line with the ICB escalation process, which includes more robust use of contract levers and contract meetings.

**Gaps in Control or Assurance**

Limited scope for additional investment in mitigating actions, such as investing to support additional activity.
Locality assurance meetings stepped down in late 2025. New arrangements focussing on the Place and delivery of their plans are in developments but don't expect to be in place until Q2.
Specific challenges within specialties/sub-specialities which have limiting factors such as available workforce. Some specialty areas where there are workforce shortages nationally. Terms of refence for contract meetings with NHS and Independent sector providers will be refreshed in Q1 and implemented following sign off through correct governance routes.

**Risk Scoring and Tolerance**

| | Inherent risk score | Q1 | Q2 | Q3 | Q4 | Year-end Target | Long Term Target | Long Term Target Date |
|---|---|---|---|---|---|---|---|---|
| Likelihood | 5 | 4 | 4 | 4 | 4 | 4 | 2 | March 2028 |
| Impact | 5 | 5 | 5 | 5 | 5 | 5 | 5 | |
| Risk Level | 25 | 20 | 20 | 20 | 20 | 20 | 10 | |

Number of Linked Risks on Corporate Risk Register

| Low (1 - 4) | Mod (6 – 12) | High (15 – 25) |
|---|---|---|
| 2 | 25 | 19 |

| Lines of Defence | Sources of Assurance | Assurance Level |
|---|---|---|
| 1st Line | Weekly review of key metrics Executive Committee / Chief Officers review key metrics weekly<br>121s with programme directors (elective, cancer, urgent care, mental health, diagnostics) | Partial |
| 2nd Line | System Group meetings to review operational performance for their respective thematic area; provider contract meetings; provider oversight meetings; | Partial |
| 3rd Line | NHS GM is part of various NHSE (regional and national) oversight relating to elective; urgent and emergency care; and cancer care. Provides access to various external support offers including GIRFT and ECIST | Acceptable |

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

| No | Action Required | Due Date | Progress | BRAG |
|---|---|---|---|---|
| 1 | Refresh the framework for Place and Provider Oversight arrangements in line with the new operating model and implementation thereafter | July 2026 | Teams across the organisation are working on new oversight arrangements in line with the refreshed operation model. As the timelines for implementation of the model have been delayed it is recommended the due date is changed to July2026. | |

| | | | |
|---|---|---|---|
| Strategic Risk<br><br>**SR3** | There is a risk that the quality of care, patient safety and care experience will decline if the ICB fail to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system.<br>This may lead to poorer health outcomes for the GM population. | | |
| Strategic Objective | Recover core health and care services | | |
| Chief Officer / Committee | Manisha Kumar | Strategic Commissioning Committee | |
| Risk Appetite Level | Cautious to Open | Risk Tolerance Range (e.g. 5 to 10) | 5 – 15 |

**Rationale for Risk Score and Progress made in the quarter**

The NHS GM provider oversight model is now well embedded with regular review of providers in line with NHS England guidance which provides significant mitigation, however some quality oversight processes are currently paused whilst current models and mechanisms for escalation are being reviewed in light of model ICB and model region guidance. Following the system wide recommendations from the Independent Assurance Review into GMMH (The Shanley Review), the ICB has responded to NICHE with evidence of its progress in the identified areas and the final report has now been published, with concerns highlighted in relation to the independent review of community mental health and also the level of mental health expertise within the ICB to provide effective oversight of mental health organisations. Whilst delayed from the original timescale due to data sharing issues, the independent review into community mental health has now been undertaken, with the findings and actions being finalised.

NHS Reforms have impacted on the delivery of our statutory duties following a reduction in resource and loss of organisational memory, however transition of quality functions to a single clinical portfolio and a matrix-working approach alongside performance and contract colleagues has partly mitigated this. Risk stratification methodology is in place to focus a more limited resource in the most appropriate way to mitigate risk whilst still providing early warning of lapses in quality & safety. Work is ongoing to undertake Quality Impact Assessments against proposed changes in each statutory function. Engagement work has been undertaken to develop the new organisational/operating model for the ICB which includes review of oversight of quality and patient safety as a Strategic Commissioner. Development of new ways of working to strengthen contractual oversight is ongoing. Filling of organisational structure work continues and a Nurse Advisor to the Board has been confirmed to ensure Nursing influence through to Board Level.

**Key Controls**

| | |
|---|---|
| • NHS trust provider oversight (POM) in place and well established with plans to further develop and further strengthen. • Exec to exec meetings now a regular occurrence, with Quality KLOES identified. • ICB Provider Oversight Framework established in line with National Guidance. • Quality Assurance Framework established/aligned to meet the National Quality Board Standards. • Work underway to strengthen quality in contractual mechanisms to align with the strategic commissioner aim. | • Quality Impact Assessment processes established – • GM System Quality Group currently being reviewed in line with wider governance work underway at the ICB). • Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy). • MIAA Audit findings/actions • Annual reports (Quality Accounts / Safeguarding Report). • Assurance meetings with NHSE. • Submission to RSQG with escalations as part of business as usual. • External audits. • External inspections by regulators |

**Gaps in Control or Assurance**

Gaps in Assurance whilst organisational structures are being confirmed.
Compliance with the statutory assurance frameworks.

**Risk Scoring and Tolerance**

| | Inherent risk score | Q1 | Q2 | Q3 | Q4 | Year-end Target | Long Term Target | Long Term Target Date |
|---|---|---|---|---|---|---|---|---|
| Likelihood | 4 | 3 | 3 | 3 | 3 | 3 | 2 | March 2028 |
| Impact | 5 | 5 | 5 | 5 | 5 | 5 | 5 | |
| Risk Level | 20 | 15 | 15 | 15 | 15 | 15 | 10 | |

**Number of Linked Risks on Corporate Risk Register**

| Low (1 - 4) | Mod (6 – 12) | High (15 – 25) |
|---|---|---|
| 0 | 9 | 1 |

| Lines of Defence | Sources of Assurance | Assurance Level |
|---|---|---|
| 1st Line | Quality Impact Assessment Process; Reporting via appropriate governance arrangements; Self-assessment process; Annual reports (Quality Accounts /Safeguarding Report); Statutory functions oversight group; Reporting into locality Quality meeting | Acceptable |
| 2nd Line | Strategic Commissioning Committee; Greater Manchester System Quality Group; Provider Oversight Sub-committee; Reporting into locality board; External assurance via statutory bodies; ICB System improvement board | Acceptable |
| 3rd Line | Regional SQG; Single Improvement Plan responding to Enforced Undertakings<br>Assurance meetings with NHSE; Internal Audit | Acceptable |

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

| No | Action Required | Due Date | Progress | BRAG |
|---|---|---|---|---|
| 1 | Co-Design of a future Clinical Leadership Model and Strategy across GM | Sept 2026<br>Due date extended to align with the revised ICB reform timetable | Clinical Strategy agreed. Outcomes Framework under development with engagement event in May 26. Work ongoing on Clinical Leadership | |
| 2 | Development of the new operating model to clearly define roles and responsibilities for oversight of quality and patient safety within the context of the ICB as a Strategic Commissioner. This should also consider the role of place vs centralised work. | June 2026<br><br>Due date extended to align with the revised ICB reform timetable | Engagement work undertaken to identify high-level structures. Further development work required to establish clear roles and responsibilities and governance arrangements. | |
| 3 | Development of new ways of working within the new operating model to strengthen contractual oversight of providers. | June 2026 | Ongoing engagement work to define how quality assurance/oversight will feed into contractual oversight | |

| | | | |
|---|---|---|---|
| Strategic Risk<br><br>**SR4** | There is a risk that the GM position on good employment will deteriorate without an increased emphasis on tackling the health barriers to employment and improving the quality of employment that is available. This will lead to an increase in poor health attributable to economic inactivity or poor-quality employment (driving up health service utilization and cost), have an adverse impact on the NHS as a major employer in GM, and inhibit city-regional growth and productivity. | | |
| Strategic Objective | Help people get into, and stay in, good work | | |
| Chief Officer / Committee | Charlotte Bailey Strategic Commissioning Committee | | |
| Risk Appetite Level | 3 – Open | Risk Tolerance Range (e.g. 5 to 10) | 10 – 20 |

**Rationale for Risk Score and Progress made in the quarter**

The health impact of economic inactivity or poor quality of employment is widely recognised and as such is one of the key building blocks of health which is outlined as a priority in the GM strategy (Greater Manchester Strategy). Reciprocally, poor health is a contributor to economic inactivity and low productivity. There are several opportunities across the ICB and partners to positively address good employment and increase economic activity, primarily driven through the Get GM Working Plan, Working Well and as part of Live Well. Effective collaboration and integration are key to the delivery of the Get GM Working Plan with a strong connectivity and joint working between several NHS GM's partners, notably GMCA, DWP, LA's and VCSFE sector. The scale up of Health and Growth Accelerators has been included in the 10 Year Plan and GM could be a health and growth accelerator site Phase 2 (April 2026), as well as further extension for the successful WorkWell partnership Vanguard which is currently being jointly led by NHS GM and GMCA. GM continues to experience economic growth that is outwith the national average, but faces significant economic headwinds due to global factors.

**Key Controls**

There are key drivers within the Get GM Working Strategy which will have a significant impact on employment as a determinant of health and poor health as a contributor to economic inactivity. During the NHS Reform process, NHS GM will need to ensure that the ICB can continue to be a strategic investor and system influencer to reduce economic inactivity and improve health outcomes by supporting people in work and to be in good employment. The Get GM Working Collaborative has oversight of Get GM working Plan which is nationally required and signed off by DWP. Examples of these key activities where the ICB has a specific involvement are:

• WorkWell Partnership which supported over 6000 people in GM over 18 months and has now been rolled out nationally
• Additional funding for Primary Care innovation funding – sick note reform
• Adults Skills and Employment thematic panel – examine themes, share good practice
* Keep Britain Working vanguard
• Collaborative Work ongoing between NHS GM & GMCA, DWB to integrate and share work, health and skills data GM has an existing and mature Good Employment Charter to drive up employment standards in GM and ensure that employment is conducive to good health.

**Gaps in Control or Assurance**

The ICB transformation and response to the NHS reform needs to ensure NHS GM has the capacity, expertise and ability to influence the wider determinants of health and create opportunities to improve the building blocks of health in partnership with other key partners. The new Operating Model will need to ensure that this is possible.

The NHS reform could also have a potential negative impact on NHSE colleagues to shape the GM approach to the Health and Growth accelerator site Phase 2. Delays in future funding could cause financial difficulties for VCSFE partners and other short term staffing groups within the programme. Trailblazer funding is required to be utilized and evaluations by April 2026.

A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel.

| | 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 | 3 | 3 | 2 | March 2029 |
| Impact | 4 | 4 | 4 | 4 | 4 | 4 | 4 | |
| Risk Level | 16 | 16 | 16 | 16 | 12 | 12 | 8 | |

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

| Lines of Defence | Sources of Assurance | Assurance Level |
|---|---|---|
| 1st Line | Employment, Work and Skills Executive Group with LA CX leadership; Workwell steering group, Get GM Working Collaborative Weekly; ICB twice weekly Chief Officers meetings; Strategy People and Partnership directorate SLT meetings; Weekly Population Health function SMT; Strategy, people and Partnerships is a member of NHS GM Chief Officers Group. | Acceptable |
| 2nd Line | The Population Health Committee remains paused and replacement governance has not yet been mobilised. Maintenance of Strategic Risk Register and collation of the strategic risks into the Board Assurance Framework. | Partial |
| 3rd Line | GM Public Health Network which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny; local Health & Wellbeing Boards | Acceptable |

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

| No | Action Required | Due Date | Progress | BRAG |
|---|---|---|---|---|
| 1 | Completion and launch of Get GM Working Plan with accompanying implementation plan. | February 2026 | Get GM Working Plan formally approved by the CA in December 2025 and agreement to a GM Integrated Settlement with a strong focus on work and health. Delay to Implementation plan due to staff shortages – now expected June 2026. | |
| 2 | Confirmation of future funding for WWP, Primary Care Innovation Fund and Health and Growth Accelerator | March 2026 | Funding confirmed. From 2026/7 they will form part of the GM Integrated Settlement provided greater GM-level flexibility and accountability for delivery and improved outcomes | |
| 3 | Delivery of GMS under a new delivery framework | Ongoing throughout 26/27 | The delivery plans and associated governance are now well advanced and provide confidence around delivery of the strategy | |
| 4 | ICB reform and transition process to ensure new Operating Model is capable of mitigating BAF risk | March 2026 | Structures and capacity/capability to deliver controls still being established | |

| | | | |
|---|---|---|---|
| Strategic Risk<br>**SR5** | There is a risk that health inequalities are widened, and health outcomes are reduced to due to a lack of sustained investment in preventive, proactive and evidence-based services. This will result in increased demand and cost of health and care services and impede economic growth. | | |
| Strategic Objective | Help people to stay well and detect illness earlier | | |
| Chief Officer / Committee | Charlotte Bailey | Strategic Commissioning Committee | |
| Risk Appetite Level | 3 - Open | Risk Tolerance Range (e.g. 5 to 10) | 10 – 20 |

## Rationale for Risk Score and Progress made in the quarter

The GM system has a strong track record of building upon existing strengths to expand on relationships between partners such as GMCA, DPH's, other system infrastructure. Integration and collaboration will be key to driving forwards prevention and early intervention work in order to effectively address health inequalities across the GM footprint. Whilst there are several key controls in place to mitigate this risk, there remains a high degree of uncertainty about the extent to which these controls can be fully realised and of the impact this will have. There are challenges at present in relation to: translating planned investment into actual expenditure against agreed priorities in the context of the sustained financial challenges facing the system; agreeing an overarching and comprehensive left shift strategy; the impact of NHS reform (including the model ICB blueprint). NHS GM remains an organisational facing significant financial challenges and comprehensive organisational change. ICB Chief Officers have reaffirmed to work with DsPH to create an integrated GM Public Health Network with a pooled budget, integrated team, and shared plan under the leadership of the DsPH. Will be operating in shadow form from 1/5/26 and fully operational from 1/4/27.

## Key Controls

Development of a comprehensive strategic approach to NHS 'left shift' which underpins ICB reform and future operating model. Inclusion of 'left shift' investments in the annual plan and budget for 2025/26.
Strong oversight of the risk and mitigations through the Population Health Committee (chaired by an NHS GM NED) which has a risk register in place which is reviewed as a standing item at every committee meeting. An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care.
A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant implementation plans in place for 2025/26 which will seek to embed tacking inequalities as a focus of the system. The ICP Strategy and NHS GM Sustainability Plan both have a strong emphasis on improving health and reducing inequalities through prevention. NHS GM has agreed a comprehensive, whole system model for improving health and reducing inequalities in the form of the GM Prevention and Early Intervention Framework and co-produced GM Population Health Model. Refresh of the GM Strategy which has a significant impact on the wider determinants of health.
Equality & Health Impact Assessments of all ICB plans and proposals.
GM participation in NW anti-racist framework and board oversight of the plan,

## Gaps in Control or Assurance

Whilst the organisation has committed to a "left-shift" approach, the exact detail of the approach and how it will strategically develop and lead on a more preventative and early intervention approach across NHS GM is still under development.
The pausing of funding for 2025/26 due to the potential for further financial challenges in future years, prevents the delivery of flagship programmes of work included in the Annual Plan which in turn diminishes the likely impact of activity and creates uncertainty amongst providers (particularly those within the VCFSE sector).
The NHS reform could have a significant impact on the resource, capacity, expertise and knowledge across the building blocks of health programme areas which may impact the delivery of the organisational left shift. A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel.

| | 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 | 3 | 3 | 2 | March 2029 |
| Impact | 4 | 4 | 4 | 4 | 4 | 4 | 4 | |
| Risk Level | 16 | 16 | 16 | 16 | 12 | 12 | 8 | |

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

| Lines of Defence | Sources of Assurance | Assurance Level |
|---|---|---|
| 1st Line | Employment, Work and Skills Executive Group with LA CX leadership; Workwell steering group, Get GM Working Collaborative Weekly; ICB twice weekly Chief Officers meetings; Strategy People and Partnership directorate SLT meetings; Weekly Population Health function SMT; Strategy People and Partnership Chief Officer is a member of NHS GM Chief Officers Group. | Acceptable |
| 2nd Line | Population Health Committee remained paused and proposed future arrangements are not yet in place. Maintenance of Strategic Risk Register and collation of the strategic risks into the Board Assurance Framework. | Partial |
| 3rd Line | GM Public Health Network which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny; LA oversight through Health & Wellbeing Boards | Acceptable |

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

| No | Action Required | Due Date | Progress | BRAG |
|---|---|---|---|---|
| 1 | Development and approval of an ICB Left Shift Strategy | June 2025 | Draft 5-year strategic commissioning plan has a strong focus on left shift, population health and prevention. Action to be removed in Q1 26/27 | |
| 2 | Confirmation of future funding for WWP, Primary Care Innovation Fund and Health and Growth Accelerator | June 2025 | From 2026/7 they will form part of the GM Integrated Settlement provided greater GM-level flexibility and accountability for delivery and improved outcomes | |
| 3 | Development of Integrated GM Public Health Network strategic priorities and allocation of resource | June 2026 | Plan for 2026/27 finalised. Q1 priorities (smoking, alcohol, poverty, HIV, obesity) to be progressed through ICB financial governance for approval. S75 on track for completion by Sept 2026 | |
| 4 | Model ICB Transformation that incorporates Left Shift focus and ensures capacity, expertise and ability to influence is retained to effectively deliver strategic aims and objectives designed to improve the health of the population and reduce inequalities | March 2026 | Programme of ICB Reform is ongoing. However, the focus on a left shift strategic approach has remained a priority with the ambition to sustain and grow investment in prevention through Place Partnerships, at a pan-GM level, and through greater integration with the GM Public Health Network. The completion of the reform work will now be within Q1 2026/27 | |

| | | | |
|---|---|---|---|
| Strategic Risk<br>**SR6** | There is a risk that existing workforce challenges are exacerbated due to the requirement for financial savings and the impact of NHS reforms.<br>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 | Strategic Commissioning 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 | 4 | 4 | 3 | 3 | |
| Risk Level | 16 | 12 | 12 | 16 | 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 | | | 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 | |
| 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. | |
| 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. | |
| **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. 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<br>**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 & 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.

Following the submission of the ICB and all GM Trusts draft accounts the risk score has further decreased from 16 (provisional Q4 score) to 8 to reflect the reduced likelihood in not achieving the desired target. These draft accounts are still subject to external audit, and the final outcome will not be known until June

## 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 was 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, with a year-end overarching lessons learnt review.
- 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 | 2 | 4 | 4 | 31/03/26 |
| Impact | 4 | 4 | 4 | 4 | 4 | 3 | 3 | |
| Risk Level | 20 | 20 | 20 | 20 | 8 | 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)<br>Executive Management Team (Weekly)<br>Internal Finance and Governance meetings (Weekly) | Acceptable |
| 2nd Line | Finance Committee (Monthly)<br>Executive CIP Group (Weekly)<br>NHS GM Board (Bi-Monthly)<br>Audit Committee (Quarterly)<br>Locality Assurance meetings (Quarterly) these move to monthly for those localities which are challenged.<br>Provider Oversight Meetings (Monthly) | Acceptable |
| 3rd Line | External Audit Reports<br>Internal Audit Reports<br>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:<br>CIP<br>Independent Sector<br>IPoC<br>ADHD/Autism<br>Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and | 31/03/26 | Regular updates will be provided to Finance Sub Committee | |

| | | | | |
|---|---|---|---|---|
| | Board scrutiny.<br><br>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<br>Meds Optimisation stretch target<br>Additional IS contracts activity plans<br>Primary Care<br>Non Pay and Workforce<br>Finance Recovery Group meets on a weekly basis to review progress and identify barriers to progress in delivery of all schemes.<br>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.<br>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 have been offered additional support to identify and deliver further recovery plan schemes, and whilst this has not delivered in year savings for the Manchester locality there is a much clearer position on the cost drivers and an action plan being enacted which will continue into the next financial year. | 31/03/26 | Updates will be provided to Finance Sub Committee | |

| | | | |
|---|---|---|---|
| Strategic Risk<br><br>**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 & 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 2025 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.

Another NHS GM ICS cyber incident response exercise was completed on 4 February 2026, with outcomes to be confirmed.

**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 | 3 | 3 | 3 | 3 | 3 | 2 | March 2028 |
| Impact | 4 | 4 | 4 | 4 | 4 | 4 | 4 | |
| Risk Level | 16 | 12 | 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<br>Trust CIO's weekly meeting (includes CIO for NHS GM and NHS E)<br>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.<br>Annual Data Security Protection Toolkit (DSPT) carried out by each care setting, which is reviewed by NHS E.<br>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 | The NHS GM ICS Cyber Strategy and its implementation plan are being reviewed and will be presented for approval following completion of the review. | |
| 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 NHSE | |
| 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 weakness, utilising approved NHSE funding. | April 2026 | As part of the NHS England risk reduction programme, NHS GM successfully applied for and secured funding for a network monitoring and defence system aimed at significantly enhancing our cyber security capabilities. However, the expenditure has been paused pending completion of a full review, to support spend governance and the presentation of the associated paper. | |

| | |
|---|---|
| Strategic Risk **SR9** | There is a risk that the ICS system is significantly disrupted due to an emergency e.g. pandemic, major incident, etc.<br>This could result in health services becoming overwhelmed. |
| Strategic Objective | Meet our statutory obligations |
| Chief Officer / Committee | Nicola Hepburn — Strategic Commissioning Committee |
| Risk Appetite Level | Cautious to Open |

| | | | |
|---|---|---|---|
| Risk Appetite Level Rationale for Risk Score and Progress made in the quarter | Cautious to Open | Risk Tolerance Range (e.g. 5 to 10) | 5 – 15 |

**Rationale for Risk Score and Progress made in the quarter**

The risk score for Q4 25/26 reflects a Likelihood of 3 that is related to the EPRR team staffing position. The team had longstanding gaps in its structure and has recently recruited to two full time posts.
There will be a period of transition as the two individuals settle into their new roles and there is one further post to be filled as part of the organisational change process.
The team will ensure that the delivery of training and exercising for NHS GM staff with a potential incident response role continues.
The consultation process has provided an opportunity to review the on-call arrangements for NHS GM, to ensure adequate tactical and strategic cover is in place to respond to incidents and emergencies. The new model has been designed and is aiming to be implemented in June 2026.
NHS GM and partner agencies continue to plan, train and exercise for emergencies, which provides a level of mitigation for the risk to the GM system of disruption due to an incident.

**Key Controls**

- In light of the EPRR team's staffing position, support for NHS GM's EPRR work has been sought from Lancashire and South Cumbria ICB EPRR team. A 2 day a week secondment is currently in place.
- Existing training delivery and ongoing exercise participation for NHS GM staff with an incident response role.
- Ongoing liaison with key stakeholders and partners to ensure NHS GM is linked in with multi-agency planning for major incidents, including liaison with GM NHS providers, GM Category 1 responders, other ICBs in the Northwest and NHS England Northwest EPRR team.
- Regular updates are provided to Chief Officers on the progress of the recruitment and the risks in the workload.

**Gaps in Control or Assurance**

Reporting on progress with delivery of EPRR training and exercising. This will be monitored going forward as part of the EPRR core standards process.

| | Inherent risk score | Q1 | Q2 | Q3 | Q4 | Year-end Target | Long Term Target | Long Term Target Date |
|---|---|---|---|---|---|---|---|---|
| Likelihood | 4 | 3 | 3 | 4 | 3 | 3 | 2 | TBC |
| Impact | 4 | 4 | 4 | 4 | 3 | 3 | 3 | |
| Risk Level | 16 | 12 | 12 | 16 | 9 | 9 | 6 | |

| 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 | Meetings within the EPRR team and with the NHS GM Accountable Emergency Officer. | Partial |
| 2nd Line | Meetings and workshops with NHS GM staff with a potential incident response role. | Partial |
| 3rd Line | Meetings and collaboration with NHS EPRR colleagues across GM and from neighbouring ICBs as well as NHS England North West | Partial |

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

| No | Action Required | Due Date | Progress | BRAG |
|---|---|---|---|---|
| 1 | Ongoing review of team staffing and workload to ensure optimal use of team capacity for mitigation of identified risk | June 2026 | Successfully recruited to posts, full recruitment will be complete following Organisational Change. | |
| 2 | Delivery of EPRR training and exercising for NHS GM staff with a potential incident response role (more trained staff provides increased organisation resilience in the face of intense and/or prolonged emergencies requiring GM heath system incident coordination) | June 2026 | Progress is delayed due to the staffing gaps in the team | |
| 3 | Maintain oversight of the ICB transition process so that impacts for EPRR are assessed and factored into team activities | June 2026 | | |

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|---|---|
| Strategic Risk<br><br>**SR10** | There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions.<br>This will result in core ICB business being disrupted during the transition. |
| Strategic Objective | Meet our statutory obligations |
| Chief Officer / Committee | Charlotte Bailey — Strategic Commissioning Committee and 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 - whilst stabilisation activity is underway the likelihood remains high due to capacity pressure and unfilled posts. A future reduction may be considered once structures are fully populated and operations stabilise.

Key progress made this quarter:

- Formal consultation on the structures was launched on 28th January with feedback of the consultation and publication of the final structures launched on 11th March.
- VR Scheme (Phase 1 & Phase 2) were successfully delivered with staff exiting the organisation on 31st January (Phase 1) and 31st March (Phase 2). A small number of staff have had their exit dates extended into 2026/27 due to the business-critical nature of their work and business continuity.
- Filling of Post Panels (FOPPs) have been conducted with outcome of the panel communicated to all staff. The next stage will include allocation panels following the closure of the expression of interest window with ringfenced interviews (as required) to follow.
- 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 with the aim of transferring these services during 2026/27.
- Continuing to work with Place stakeholders – through the Place mobilisation working group to progress work on key areas such as funding, governance, place partnership agreement 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 Executive Committee 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 2027 |
| 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 | OLG (Operational Leadership Group) – Primary escalation and first line of defence for managing service disruption and business-critical capacity gaps.<br>Transition Programme Team - The team oversees management and updates of the risks for all component programme areas.<br>Transition Risk Group – Has grip and oversight over all programme risks. This group monitors 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.<br>**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.<br>**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.<br>**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 — Delayed — On Track — Problematic

| No | Action Required | Due Date | Progress | BRAG |
|---|---|---|---|---|
| 1 | Organisational restructure implementation to ensure the organisation is meeting its £19ph obligations from April 2026. | Sept 2026 | • We have completed both phase 1 and 2 of VR.<br>• The filling of posts panel has also been concluded with outcomes communicated to all staff.<br>• The next phase will include allocation panels and where required, ringfenced interviews will take place.<br>• Staff who are made compulsory redundant as a result of this process will leave the | |

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| 2 | Transition and stabilisation planning is taking place across organisational functions to manage and mitigate disruption risks. | | organisation by no later than September 2026.<br><br>Each function lead will work with respective CO to develop plans to ensure teams and staff are in place to safely deliver services. n | |

NHS
Greater Manchester

# Greater Manchester Cardiac and Vascular Service Reconfiguration Pre-Consultation Business Cases

Part of Greater Manchester Integrated Care Partnership

| Required information. | Details. |
|---|---|
| **Title of report.** | Greater Manchester Cardiac and Vascular Service Reconfiguration – Pre-Consultation Business Cases |
| **Author.** | Louise Sinnott, Head of Scute Strategy and Transformation, NW Specialised Commissioning Team<br><br>Claire Connor, Director of Communications and Engagement, NHS GM |
| **Presented by.** | Katherine Sheerin, Chief Commissioning Officer, NHS GM |
| **Contact for further information.** | Louise Sinnott, Head of Scute Strategy and Transformation, NW Specialised Commissioning Team<br><br>louisesinnott@nhs.net |

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|---|---|
| **Executive summary.** | This paper seeks Board support to progress the Greater Manchester and East Cheshire (GMEC) Cardiac and Vascular Service Reconfiguration proposals to formal public consultation, subject to NHS England Stage 2 assurance and completion of the vascular financial case. The proposals respond to clear clinical, workforce and sustainability challenges and recommend single-centre models for both adult cardiac surgery (at Wythenshawe Hospital) and specialised arterial vascular surgery (at Manchester Royal Infirmary), supported by strengthened hub-and-spoke networks to maintain care closer to home. Evidence from the interim cardiac model and clinical reviews demonstrates improved resilience, outcomes and service stability through consolidation of expertise. Taken together, the schemes deliver a coordinated, system-wide approach to clinically interdependent services, improving quality, reducing unwarranted variation and supporting equitable access for the GMEC population. The programme includes robust governance, assurance and engagement processes, with public consultation planned for summer 2026 and final decisions expected by December 2026, subject to addressing key risks and dependencies. |

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| **The benefits that the population of Greater Manchester will experience.** | The proposed reconfiguration of cardiac and vascular surgery across Greater Manchester and East Cheshire is expected to deliver significant population benefits by centralising highly complex procedures into single specialist centres, improving clinical outcomes, safety and service resilience through concentrated expertise and 24/7 consultant-led care. The model supports faster access to treatment and reduced waiting times, while addressing current workforce and sustainability challenges and ensuring compliance with national standards. At the same time, a strengthened hub-and-spoke approach maintains care closer to home for diagnostics, outpatient care and recovery, reducing unwarranted variation and improving equity of access across the population. Overall, the proposals provide a more reliable, efficient and future-proofed system, capable of meeting growing demand while delivering consistently high-quality care. |

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| **How health inequalities will be reduced in Greater Manchester's communities.** | The proposals are expected to reduce health inequalities by standardising access to high-quality specialist care across Greater Manchester and East Cheshire, addressing current variation in outcomes and service provision between different areas and hospitals. By centralising complex surgery into high-performing centres, all patients—regardless of where they live—will receive care that meets consistent national standards, supported by experienced multidisciplinary teams. The strengthened hub-and-spoke model ensures that most elements of care, including diagnostics, outpatient appointments and follow-up, remain available locally, reducing barriers to access and travel burden, particularly for more deprived communities. In addition, more reliable services, shorter waiting times and improved emergency pathways will disproportionately benefit groups who currently experience delayed access or poorer outcomes, helping to narrow existing gaps in cardiovascular health across the population. |

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| **The decision to be made and/or input sought.** | The purpose of this paper is to seek support in principle for the proposed reconfiguration of specialised arterial vascular surgery and adult cardiac surgery services in Greater Manchester and East Cheshire (GMEC), and specifically to approve the progression of both Pre-Consultation Business Cases (PCBCs) – Vascular PCBC v2.0 and Cardiac PCBC v2.0 – to formal public consultation, subject to the conditions set out below.<br><br>Members are asked to:<br><br>• Support proceeding to public consultation on the proposals set out in the GMEC Vascular and Cardiac Surgery PCBCs (v2.0), which each recommend a single-centre model as the preferred way forward, subject to:<br><br>o NHS England Stage 2 Assurance being achieved for both PCBCs (scheduled for 22 June 2026); and<br><br>o Finalisation and assurance of the Vascular Surgery financial case, which is explicitly identified within the Vascular PCBC as still under development.<br><br>This conditional approval enables timely progression to consultation (targeted from July 2026) while ensuring that all outstanding assurance requirements are met prior to any final decision on implementation. |

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| **How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.** | The proposed cardiac and vascular reconfiguration strongly supports delivery of the NHS GM strategy by improving clinical outcomes, reducing unwarranted variation and strengthening equitable access to high-quality care through consistent, standards-compliant pathways. The model also underpins system sustainability and performance recovery by addressing workforce fragility, increasing capacity and reducing waiting times, while maintaining care closer to home through a hub-and-spoke approach. In doing so, it mitigates key BAF risks, particularly those relating to patient safety and quality, workforce resilience, elective recovery and health inequalities, by creating more robust, high-volume specialist services, improving timely access to treatment, and ensuring a coordinated, system-wide approach to clinically interdependent services. |

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| **Key milestones.** | The key programme milestones are:<br>• **June 2026 – Joint Health Overview and Scrutiny Committee (JHOSC):** Formal consideration of the PCBCs by local authority scrutiny<br>• **22 June 2026 – NHS England Stage 2 Assurance:** National assurance review to confirm readiness for consultation<br>• **1 July 2026 (planned) – Public Consultation Launch:** Start of a 10-week public consultation with patients, staff and stakeholders<br>• **October–November 2026 – Decision-Making Business Cases (DMBCs):** Final business cases developed, incorporating consultation feedback and full financial detail<br>• **By December 2026 – Final Decision:** GM Integrated Care Board decision on future service configuration |

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| **Leadership and governance arrangements.** | The programme is governed through a formal, integrated GM Cardiac and Vascular Programme structure, providing system-wide oversight across both reconfiguration schemes in recognition of their clinical and operational interdependencies. Strategic leadership is provided through GM ICB governance routes, with regular reporting into senior executive and Board forums, ensuring alignment with GM priorities and accountability for decision-making. Robust assurance processes are in place, including Clinical Senate review, NHS England Stage 2 assurance and local authority scrutiny via the Joint Health Overview and Scrutiny Committee. This is complemented by a structured engagement and consultation approach, ensuring transparency and stakeholder involvement ahead of final decision-making by the GM ICB. |

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| **Engagement* to date.**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | Extensive engagement has been undertaken to inform the development of both PCBCs, including clinical engagement across cardiac and vascular networks to co-design safe, sustainable service models, alongside early public and patient engagement to understand priorities such as access, travel and quality of care. Feedback has shaped the preferred options, particularly the balance between centralisation and maintaining local services. Supporting analysis has been completed across key domains, including Equality Impact Assessments to identify and mitigate potential disproportionate impacts on protected and deprived groups, travel and access analysis, sustainability considerations, and ongoing financial modelling (with the vascular financial case nearing completion). The proposals and supporting evidence have been reviewed through formal governance routes, including Clinical Senate review, programme boards and senior system groups, with scrutiny engagement planned via the Joint Health Overview and Scrutiny Committee. Collectively, this provides assurance that the proposals are clinically led, analytically robust, and have been subject to appropriate system oversight ahead of public consultation. |

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|---|---|
| **Financial or Legal Implications** | The proposals have important financial and legal implications. Financially, the reconfiguration is expected to improve efficiency and long-term sustainability by reducing duplication of highly specialised services, optimising use of estates, theatres and workforce, and increasing throughput to support elective recovery; however, delivery is dependent on completion and assurance of the vascular financial case, alongside managing transition costs, capital investment (e.g. theatre capacity) and affordability within system resources.<br><br>Legally, the programme must comply with statutory duties for service change, including robust public consultation, equality duties under the Equality Act 2010, and demonstrating that decisions are evidence-based, clinically justified and in the best interests of patients. Engagement with the Joint Health Overview and Scrutiny Committee, adherence to NHS England assurance processes, and maintenance of transparent, well-documented decision-making will be critical to mitigate the risk of legal challenge and ensure lawful implementation. |

*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** | **EHIA** |
|---|---|---|---|---|---|---|---|
| *Yes* | *Yes* | *Yes* | *Yes* | *No* | *No* | *No* | *Yes* |

*Table 2: Assurance needed about the document. * If yes, then please include narrative in the report itself*

# Introduction

The Cardiac and Vascular surgery service reconfiguration schemes are being progressed together because of significant clinical, workforce and infrastructure interdependencies. A small number of highly complex cases (notably specific aortic procedures) require joint working between cardiac and vascular surgical teams, meaning that the location and configuration of each service must be aligned to ensure safe delivery.

In addition, temporary operational changes during the COVID 19 pandemic resulted in the relocation of key theatre and critical care capacity from Manchester Royal Infirmary (MRI) to Wythenshawe Hospital. Decisions relating to the permanent configuration of vascular and cardiac surgery services are therefore closely linked, particularly given planned investment in new theatre capacity at MRI and the established cardiothoracic infrastructure at Wythenshawe.

Considering both services together enables a coordinated, system-wide approach that avoids fragmented decision-making and ensures the final recommendations are aligned, sustainable, and clinically coherent for the GMEC population.

## Adult cardiac surgery

### Case for change

Historically, GMEC operated a two-site adult cardiac surgery service. Workforce pressures, particularly in cardiac anaesthesia, resulted in the temporary centralisation of all urgent and emergency cardiac surgery at Wythenshawe Hospital from April 2024. This interim model has now been operating successfully for an extended period and has demonstrated improved service stability and resilience.

### Preferred option

The Cardiac PCBCconfirms permanent consolidation of adult cardiac surgery at Wythenshawe Hospital as the preferred option. All elective, urgent and emergency adult cardiac surgery would be delivered from a single centre supported by five cardiac theatres and dedicated cardiothoracic critical care. A network model would continue, with diagnostics, outpatient activity and follow-up delivered locally across GMEC, and formal in-reach arrangements providing support to dependent services at MRI.

### Benefits

The single-centre model optimises patient outcomes through concentration of expertise, improves waiting times and throughput, and ensures ongoing compliance with national service standards. Evidence in the PCBC demonstrates that the interim consolidated model has delivered benefits without adverse impact on patient safety or outcomes.

### Status and assurance

The Cardiac PCBC has been updated following Clinical Senate review and is considered fully

ready for NHS England Stage 2 assurance.

## Adult arterial vascular surgery

### Case for change

Specialised arterial vascular surgery is a complex, high-risk service requiring 24/7 access to experienced vascular surgeons, interventional radiology, critical care and a range of co-dependent services. Currently, inpatient arterial vascular surgery is delivered from two arterial centres within GMEC. Evidence set out in the PCBC demonstrates that this configuration does not fully meet national standards, particularly in relation to minimum caseloads, workforce sustainability and resilience of interdependent services.

### Preferred option

The Vascular PCBC recommends a single arterial hub at Manchester Royal Infirmary, supported by a strengthened hub-and-spoke network. Under this model, all complex inpatient arterial surgery would be consolidated at MRI, with local hospitals continuing to provide outpatient care, diagnostics, day-case procedures and elements such as diabetic foot services. Emergency pathways would ensure timely transfer to the hub, with repatriation to local sites as soon as clinically appropriate.

### Benefits

The single-hub model is expected to improve clinical outcomes, reduce unwarranted variation, strengthen workforce resilience and deliver more equitable access to high-quality vascular care across GMEC. Concentration of expertise at MRI supports compliance with national standards while maintaining local access wherever inpatient admission is not required.

### Status and assurance

The Vascular PCBC incorporates feedback from the Clinical Senate review and has been prepared explicitly for NHS England Stage 2 assurance. The PCBC transparently identifies that the detailed financial case remains under development; completion and assurance of this element is required prior to consultation and final decision-making.

# Programme timeline and next steps

Subject to Board support and the assurance conditions set out above, the indicative programme timeline is:

- **Joint Health Overview and Scrutiny Committee – June 2026:** Formal consideration of the consultation plans by the GM Joint Health Overview and Scrutiny Commitee.

- **NHS England Stage 2 Assurance – 22 June 2026:** Formal assurance review of both PCBC documents to confirm readiness for public consultation.
- **Public consultation – Summer 2026:** A 10 week public consultation is planned from 1st July 2026, engaging patients, the public, staff and stakeholders.
- **Decision-Making Business Cases – Oct-Nov 2026:** Development of DMBCs incorporating consultation feedback and finalised financial information.
- **Final decision – by December 2026:** GM ICB to consider DMBCs and make final decisions on future service configurations.

## 6. Key risks and dependencies

Key programme risks include completion of the vascular financial case, outcomes of NHS England Stage 2 assurance, interdependencies between cardiac and vascular schemes, and public response to consultation. These risks are actively managed through integrated programme governance, close engagement with NHS England, and a comprehensive communications and engagement approach. The conditional nature of the recommendation to consult provides a key mitigation.

## Recommendations

Support in principle is sought for the proposed reconfiguration of specialised arterial vascular surgery and adult cardiac surgery services in Greater Manchester and East Cheshire (GMEC), and specifically to approve the progression of both Pre-Consultation Business Cases (PCBCs) – to formal public consultation, subject to the conditions set out below.

Members are asked to:

- Support proceeding to public consultation on the proposals set out in the GMEC Vascular and Cardiac Surgery PCBCs (v2.0), which each recommend a single-centre model as the preferred way forward, subject to:
    - NHS England Stage 2 Assurance being achieved for both PCBCs (scheduled for 22 June 2026); and
    - Finalisation and assurance of the Vascular Surgery financial case, which is explicitly identified within the Vascular PCBC as still under development.

This conditional approval enables timely progression to consultation (targeted from July 2026) while ensuring that all outstanding assurance requirements are met prior to any final decision on implementation.

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Greater Manchester

# People & Resource Committee Report

22 April 2026

Part of Greater Manchester Integrated Care Partnership

# Integrated Care Board

## 22 April 2026

| Required information | Details |
|---|---|
| **Title of report** | People & Resource Committee Report |
| **Author** | Ross Baxter, Governance Advisor |
| **Presented by** | Kal Kay, Non-Executive Director/ Chair of People & Resource Committee |
| **Contact for further information** | Kal Kay, Non-Executive Director/ Chair of People & Resource Committee |
| **Executive summary** | To highlight key issues and provide assurance to the Board. |
| **The benefits that the population of Greater Manchester will experience.** | N/A |
| **How health inequalities will be reduced in Greater Manchester's communities.** | N/A |
| **The decision to be made and/or input sought** | The Board is asked to:<br>• Note the contents of the report and provide feedback to the Committee Chair. |
| **How this supports the delivery of the strategy and mitigates the BAF risks** | N/A |
| **Key milestones** | N/A |
| **Leadership and governance arrangements** | Overview of discussions at the People & Resource Committee |
| **Engagement* to date**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | N/A |
| **Financial or Legal Implications** | N/A |

*Table 1 - core information relating to the content and creation of paper*

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

*Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report*

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| | |
|---|---|
| **Report from:** | **People & Resource Committee** |
| **Date of Meeting:** | April 2026 |
| **Chair:** | Kal Kay |
| **Quoracy Achieved:** | Yes |

Key escalations and discussion points from the meeting:

| **Alert** |
|---|
| **GM Month 12 Financial Position** - The Committee received the Month 12 Finance Report setting out the year-end financial position for 2025/26 and noted that, subject to final audit confirmation and ongoing discussions with NHS England regarding the treatment of late year allocations, the organisation had delivered its financial plan. Members acknowledged that the year-end position had been achieved through a range of mitigations that differed from original assumptions and that not all planned recovery actions had been fully implemented, with a number of underlying pressures remaining unresolved, including those relating to elective activity, independent sector arrangements and wider system challenges. While some late-year activity growth was recognised as operationally necessary to address backlogs, the Committee noted that this increased financial risk entering 2026/27 and emphasised the importance of clearly understanding and reflecting residual pressures within future planning, contracting and risk management arrangements, particularly in the context of delayed national guidance. The Committee welcomed the improved financial stability compared with previous years and recognised the collective effort required to achieve the position, while stressing that the position remained fragile and sensitive to relatively small changes in delivery assumptions. Members requested additional clarity on the scale and nature of key risks, including worked examples of potential financial impact, further explanation on the treatment and effect of additional deficit support funding, and continued transparency on the sustainability of year-end actions and their implications for delivery in 2026/27. |
| **Advise** |
| **Terms of Reference** – The Terms of Reference for the Committee were noted, highlighting minor, non-material amendments that had been made since Board approval, primarily typographical corrections and minor clarifications. Members felt that further clarity may be required in certain areas, including ambiguity on the membership with regards to who the deputy was. It was agreed that this would be reviewed as part of the planned review, and monitored in the meantime. |

**Sub Groups & Draft Workplan** – The Committee received an update on the proposed sub group structure and the development of the draft workplan. It was noted that discussions had taken place with Committee Chairs at the end of March, ahead of the Strategic Commissioning Committee, with a focus on establishing clear principles rather than revisiting the overall governance model. April and May were described as transitional months, during which a pragmatic approach would be taken while arrangements were embedded.

**Assure**

**Chief Officers' Update Reports** – The Committee received reports from the three portfolios, namely Strategy, People & Partnerships, Reform and Improvement, and Finance. Members were given the opportunity to discuss, with focussed discussion happening on;

- Freedom to Speak Up arrangements
- Cost Improvement Programme
- Overall Finance performance
- Estates and capital

**Financial Scheme of Delegation Amendments** - The Committee considered proposed amendments to the Financial Scheme of Delegation, which had been brought forward to reflect the implementation of the new operating model, revised committee structures and changes to delegated budgets across the system. Members discussed application of delegation thresholds and raised concerns that proposed delegation limits should remain aligned with NHS England approval thresholds. Overall, the Committee supported the direction of travel and endorsed the proposed amendments.

**Risks discussed and new risks identified**

The Committee received the Risk Report, which was presented as a landing report for the Committee's first meeting, intended to set out the scope of risks falling within the Committee's remit. It was explained that the report outlined, in Section 3, the Board Assurance Framework (BAF) risks and corporate risks that the Committee would be responsible for overseeing. Members were reminded that the allocation of BAF risks to committees had previously been considered by the Transition Committee in March and subsequently discussed and agreed by the Board. The risks presented reflected those already approved by the Board, with an updated position scheduled to be reported to the May Board. It was noted that, due to transition timing, the usual process of Committee consideration of BAF risks ahead of Board review had not been fully implemented for this meeting; however, it was confirmed that this process would be reinstated going forward, with BAF risks being reviewed by the Committee prior to consideration by the Board.

| Learning for sharing |
| --- |
| There were no specific points of learning from the April 2026 meeting. |

NHS
Greater Manchester

# Month 12 Finance Report

2025-2026

**Part of** Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

# NHS GM Integrated Care Board

## 20th May 2026

| Required information | Details |
|---|---|
| **Title of report** | Month 12 Finance Report |
| **Author** | Jackie Gardiner – Corporate Director of Operational Finance – Financial Management |
| **Presented by** | Kathy Roe – Chief Finance Officer |
| **Contact for further information** | Jackie Gardiner – Corporate Director of Operational Finance – Financial Management |
| **Executive summary** | The purpose of the report is to update the Board on the Month 12 ICS financial position for Greater Manchester as at 31st March 2026 (subject to external audit). |
| **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 Board is asked to:<br>1. Note the outturn position of a £24.1m surplus following the receipt of additional deficit support funding by GM NHS Providers of £21.3m.<br>2. Note that all organisations have delivered either in line or better than plan.<br>3. Note that NHS GM delivered an outturn position of a deficit of £7.5m in line with plan, with GM Providers delivering a surplus of £24.1m.<br>4. Note the delivery of CIP of £635.6m, a shortfall of £20.4m against the system target of £656.0m, with NHS GM delivering the CIP savings target of £175.0m in full.<br>5. Note the delivery of the provider operational capital position in line with the allocation of £200.9m. |

| | |
|---|---|
| | 6. Note that NHS GM achieved the requirement to remain within the allowable cash balance at the end of the year, with a cash balance of £36k.<br>7. Note that the provider cash balance at the end of the financial year was £428.9m, £1.0m above the planned level of £427.9m.<br>8. Note the achievement of the running costs allowance target for NHS GM. |
| **How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks** | The report provides an update aligned to the 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.<br>Presented to People & Resources Committee (Private) on 22nd April 2026.<br>Updated position presented to the NHS GM Integrated Care Board on 20th May 2026. |
| **Engagement* to date**<br>***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*

# 1. Introduction

1.1 The purpose of the report is to update the Board on the outturn financial position for Greater Manchester as at 31st March 2026.

# 2. Key Messages

2.1 Plan

The 2025/26 Greater Manchester ICS final plan following the receipt of Deficit Support Funding (DSF) is breakeven, and as previously reported is split £7.5m deficit for NHS GM and a £7.5m surplus for GM providers.

2.2 Month 12 reported position

At Month 12 the final outturn position for the ICS is a surplus of £24.1m, which is an improvement of £21.6m compared to 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 messages of the overall position are:

- The reported position reflects the draft submissions for NHS GM and the GM NHS Providers (updated by providers in their latest PFRs). Draft accounts were submitted 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, with other smaller surpluses reported by Bolton and Tameside.
- 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, and the GM NHS Providers ended up with a cash balance of £1.0m above plan.
- The GM system spend on operational capital was £200.9m, which is consistent with the £200.9m operational capital envelope issued by NHS England.

2.3 Efficiencies / CIP

For Greater Manchester ICS, total savings of £635.6m have been delivered against a plan of £656.0m, a shortfall of £20.4m. NHS GM has delivered the target of £175.0m in full, whilst GM providers have delivered £460.6m.

2.4 Risk and Mitigations

Previously reported risks where mitigations or finance recovery plans have been unable to reduce costs have now materialised in the reported position. However, these have been mitigated through other reductions in spend or increased CIP delivery, resulting in the delivery of the overall balanced position, with the additional DSF allocation allowing a further surplus being reported.

2.5 NHS GM Finance Recovery Plans

At Month 12 the following is noted as the final delivery against the individual Finance Recovery Plans for NHS GM:

- AACC is reporting further increased spend in M12 against the trajectory and overall is reporting a deterioration of £1.2m compared to M11, due to a continuation of increased cases and high-cost placements including some backdated invoices from LAs.
- ADHD is reporting a further deterioration in M12, as a result of further backdated invoices under Right to Choose, with a final outturn position of an £11.2m overspend.
- Independent Sector activity whilst still behind the recovery plan and impacted by the Q4 Sprint programme, the final position indicates a reduction to a £9.9m overspend.
- CIP is the only area of the finance recovery plans to have delivered in full, albeit through stretch in other schemes.

Focus in now on the identification of the detailed plans to deliver the 2026/27 savings target of £150.0m.

2.6 Capital

Overall, GM Providers have overspent against the capital plan of £396.0m by £0.5m. However, within this total, a breakeven outturn position has been delivered against the system allocation of £200.9m for internally generated and IFRS 16 capital expenditure.

The final NHS GM capital outturn spend is £13.9m, an increase of £0.5m since M11 due to additional Utilisation and Modernisation fund schemes approved in M12.

2.7 Cash

On 31st March, NHS GM had a closing cash balance of £36k, which was well within the allowable cash balance of £9.3m. NHS GM had been able to drawdown all of its allocation, including the cash associated with the allocations received in M12, and was also able to access supplementary cash of c£58.6m, which has allowed the ICB to reduce the cash liabilities moving into 2026/27.

The final GM provider cash position at 31st March 2026 was £428.9m, which was £1.0m above the planned level. NHS GM was able to flow the cash in M12 associated with surge and Q4 Sprint, with just the additional DSF to flow in the new financial year.

## 3. Recommendations

3.1 For the System Financial position, the Board is asked to:

- Note the outturn position of a £24.1m surplus following the receipt of additional deficit support funding by GM NHS Providers of £21.3m.
- Note that all organisations have delivered either in line or better than plan.

- Note that NHS GM delivered an outturn position of a deficit of £7.5m in line with plan, with GM Providers delivering a surplus of £24.1m.
- Note the delivery of CIP of £635.6m, a shortfall of £20.4m against the system target of £656.0m, with NHS GM delivering the CIP savings target of £175.0m in full.
- Note the delivery of the provider operational capital position in line with the allocation of £200.9m.
- Note that NHS GM achieved the requirement to remain within the allowable cash balance at the end of the year, with a cash balance of £36k.
- Note that the provider cash balance at the end of the financial year was £428.9m, £1.0m above the planned level of £427.9m.
- Note the achievement of the running costs allowance target for NHS GM.

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# NHS Greater Manchester Finance Slide Pack Month 12 – March 2026

Part of Greater Manchester Integrated Care Partnership

Presented by: Kathy Roe
Date: 20th May 2026

# System Financial Position Overview

NHS Greater Manchester

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:

- The reported position reflects the draft submissions for NHS GM and the GM NHS Providers (updated by providers in their latest PFRs). Draft accounts were submitted 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, with other smaller surpluses reported by Bolton and Tameside.
- 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, and the GM NHS Providers ended up with a cash balance of £1.0m above plan.
- The GM system spend on operational capital was £200.9m, which is consistent with the £200.9m operational capital envelope issued by NHS England.

# Key Metrics Dashboard

NHS Greater Manchester

| 2025/26 ICS Key metrics £m | Annual Plan | Actual Outturn | Variance | RAG |
|---|---|---|---|---|
| Financial position - NHS GM | -£7.5 | -£7.5 | £0.0 | G |
| Financial position - Provider | £7.5 | £31.6 | £24.1 | G |
| **Financial position - ICS** | **£0.0** | **£24.1** | **£24.1** | G |
| CIP | £656.0 | £635.6 | -£20.4 | A |
| Agency (provider) * | £55.7 | £61.9 | -£6.2 | G |
| Capital - NHS GM | £13.9 | £13.9 | £0.0 | G |
| Capital - Provider (CDEL) ** | £396.0 | £396.4 | -£0.4 | G |
| **Capital - ICS** | **£409.8** | **£410.3** | **-£0.4** | G |
| Cash (provider) | £427.9 | £428.9 | £1.0 | G |
| **Key metrics - ICB only** | | | | |
| MHIS (excluding LD & Dementia) | £829.2 | £829.2 | £0.0 | G |
| Delegated Specialised Commissioning MHIS *** | £119.2 | £119.2 | £0.0 | G |
| Running costs | £74.0 | £69.3 | £4.7 | G |

| | NHS | Non NHS |
|---|---|---|
| BPPC Target Achieved (out of 10 ICS organisations) | 6 | 7 |

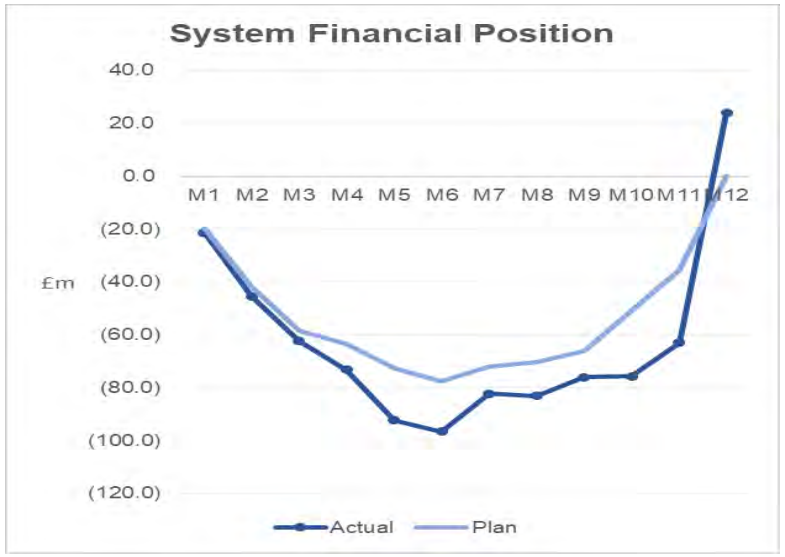
* Whilst agency (provider) spend is above plan, this is within the Agency Ceiling Cap
** The Capital Departmental Expenditure Limit (CDEL) includes both Operational Capital and nationally funded PDC.
*** NHSE have confirmed that the SCMHIS target will remain at £109.4m and will not be updated to £119.2m to reflect the additional allocations in year, the table above is reflective of the allocations received and forecast spend.

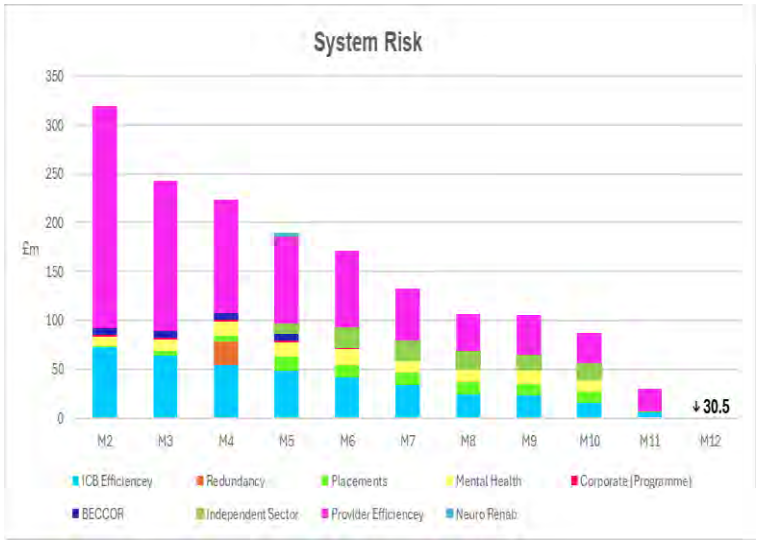
***Note:*** *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are* calculated using precise values, before rounding is applied.

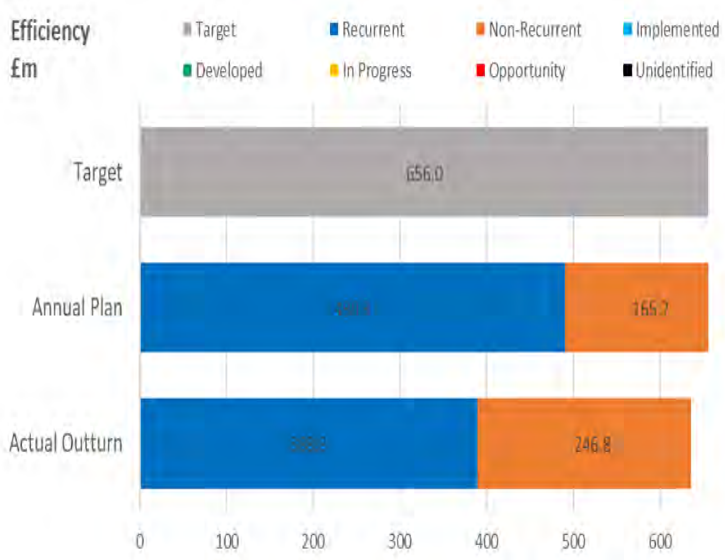
# Key Metrics

# Analysis

NHS Greater Manchester




**System Financial Position**

- The Actual Outturn position for the GM NHS System is a £24.1m surplus against the breakeven plan, and improvement of £21.6m and is split as follows:
  - £0.0m NHS GM (Month 11: £0.0m)
  - £24.1m GM Providers (Month 11: -£27.4m)
- The main reason for the increased surplus relates to the receipt of additional DSF funding of £21.3m.

**System Risk**

- The GM system has reported a fully mitigated risk position at M12
- This is a decrease of £30.5m from M11.

**System Efficiency**

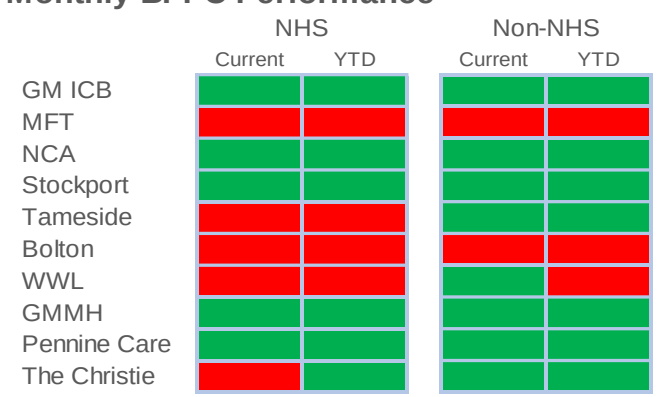
- The chart above details the savings delivered against an overall system savings target of £656.0m
- Total savings of £635.6m have been delivered against the target of £656.0m, of which 61.2% has been delivered recurrently.
- Overall, for the year delivery was £20.6m below plan, all relating to the GM Providers.

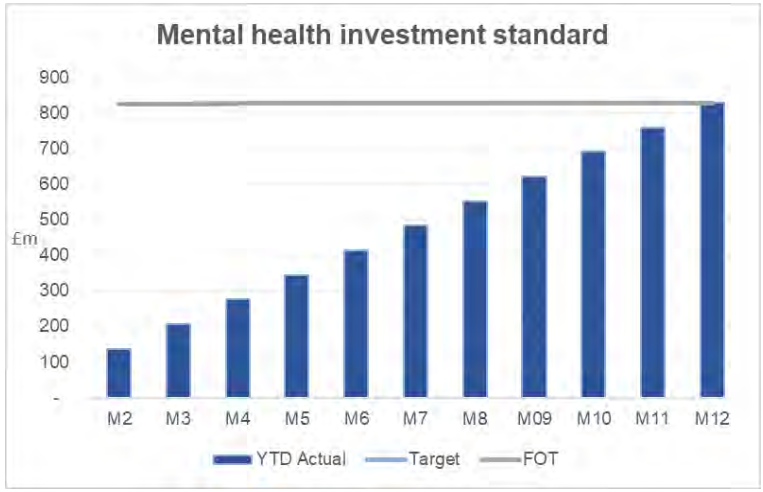
***Note:*** *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when reviewing. All values presented are calculated using precise values, before rounding is applied.*

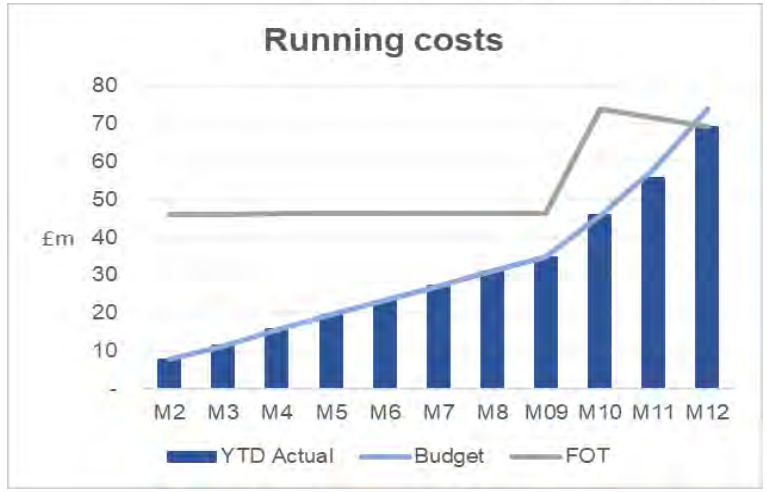
# Key Metrics

# Analysis

NHS Greater Manchester




**System Better Payment Practice Code**

- BPPC is monitored on the YTD performance, and at M12 5 organisations have met the target relating to NHS organisations.
- Out of the 5 organisations not meeting the NHS target in M12, all have slightly worsened their performance from the previous month.
- 7 organisations are meeting the target for YTD achievement for Non-NHS organisations.
- For the remaining 3 organisations not achieving the Non-NHS target, WWL have reported an improvement of 0.4% since M11.

**Mental Health Investment Standard**

- There are 2 targets relating to the Mental Health Investment Standard (MHIS) which are reported and monitored separately and not combined.
- The core MHIS target requires NHS GM to spend £829.1m on mental health provision in 2025/26.
- In addition, there is a Specialised Commissioning MHIS (SCMHIS) target of £109.4m. This target has not been updated by NHSE to reflect the additional allocations received in-year, which now totals £119.2m.
- At Month 12 NHS GM has delivered both targets (i.e. minimum spend) with core MHIS at £829.2m and Specialised at £119.2m.

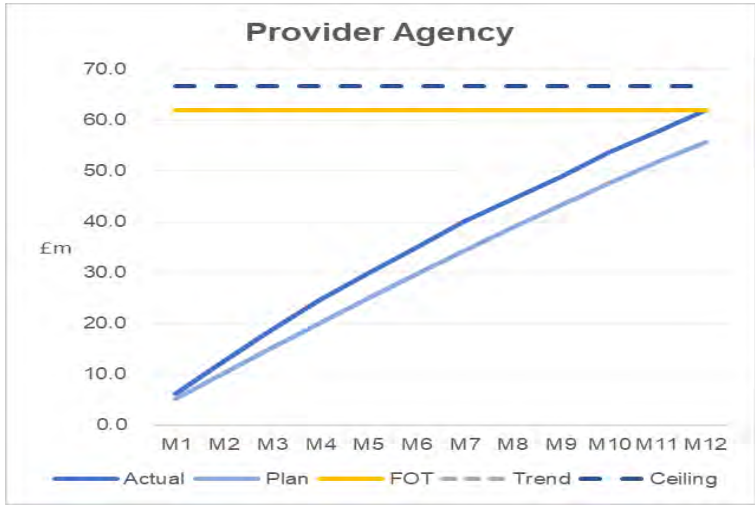
**NHS GM Running costs**

- The running cost allowance for NHS GM for 2025/26 is £74.0m with actual spend of £69.3m.
- NHS GM has achieved the running cost target.
- The main reason for this relates to the allowance reflecting the full allocation received for Redundancy Costs, whereas the guidance stipulated that actual costs should be assigned to running costs or programmes depending on where the substantive costs are charged.

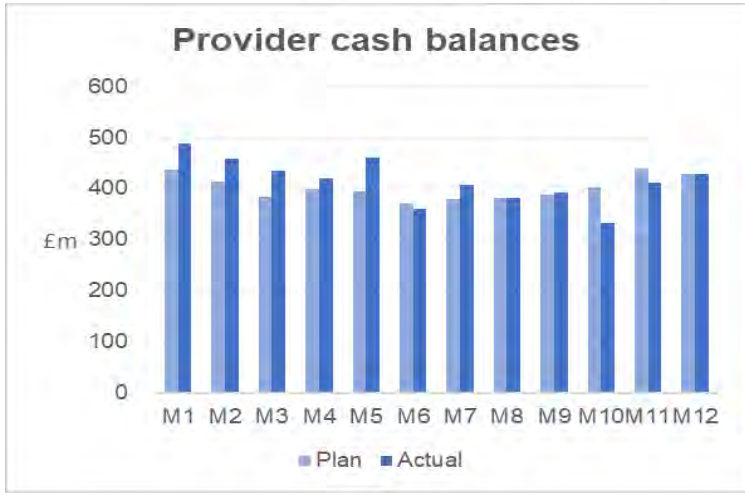
# Key Metrics

# Analysis

NHS Greater Manchester








**Provider Agency**

- The Actual Outturn agency spend for GM providers is £61.9m which is £6.2m above the plan of £55.7m.
- However, this remains under the 2025/26 agency ceiling set at £66.7m at the end of the year.

**Capital**

- The chart above shows the entirety of the provider plan for the Capital Departmental Expenditure Limit (CDEL) including internally generated, IFRS 16 (leases) and PDC which totals £396.0m. Actual capital expenditure is £396.4m.
- Within this total there is a system allocation of £200.9m issued to GM providers for both internally generated and IFRS 16 capital expenditure. Actual spend of £200.9m is reported.
- The NHS GM annual capital allocation was £13.8m, all of which was fully utilised in year.

**Cash**

- At the end of the financial year, GM providers (as shown in the chart above) are £1.0m above the planned cash balance (plan: £427.9m, actual: £428.9m).
- At M12 NHS GM has drawn down £9,497.1m, which was £58.6m higher than the M12 allocations (adjusted for deficit funding of £7.5m less the closing cash balance in 2024/25 of £1.1m).
- The allowable cash balance at the end of M12 equated to £9.3m, with an actual closing balance of £36k.

# System Financial Position

# System Efficiencies

NHS Greater Manchester

| 2025/26 System CIP Savings March 2026 £m | Actual Outturn Recurrent/Non Recurrent Split | | Annual Plan | Actual Outturn | Variance |
|---|---|---|---|---|---|
| | Recurrent | Non Recurrent | | | |
| **ICB Savings** | 62% | 38% | £175.0 | £175.0 | £0.0 |
| **Breakdown by Provider** | | | | | |
| Manchester University NHS Foundation Trust | 60% | 40% | £165.8 | £158.5 | -£7.3 |
| Northern Care Alliance NHS Foundation Trust | 52% | 48% | £110.0 | £112.4 | £2.4 |
| Stockport NHS Foundation Trust | 79% | 21% | £29.2 | £29.2 | £0.0 |
| Tameside and Glossop Integrated Care NHS Foundation Trust | 64% | 36% | £25.3 | £25.3 | £0.0 |
| Bolton NHS Foundation Trust | 85% | 15% | £36.9 | £20.1 | -£16.8 |
| Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust | 52% | 48% | £38.4 | £39.1 | £0.7 |
| Greater Manchester Mental Health NHS Foundation Trust | 87% | 13% | £32.5 | £32.5 | £0.0 |
| Pennine Care NHS Foundation Trust | 57% | 43% | £17.5 | £18.2 | £0.7 |
| The Christie NHS Foundation Trust | 45% | 55% | £25.3 | £25.3 | £0.0 |
| **GM Provider Savings** | 61% | 39% | £481.0 | £460.6 | -£20.4 |
| **Total Efficiencies** | 61% | 39% | £656.0 | £635.6 | -£20.4 |

- The final position for CIP delivery is £20.4m below the target as a system:
  - NHS GM delivering in line with plan, and
  - £20.4m adverse provider variance

***Note:*** *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are calculated using precise values, before rounding is applied.*

# System Financial Position

## Recommendations

NHS Greater Manchester

For the System Financial position, the Board is asked to:

- Note the outturn position of a £24.1m surplus following the receipt of additional deficit support funding by GM NHS Providers of £21.3m.
- Note that all organisations have delivered either in line or better than plan.
- Note that NHS GM delivered an outturn position of a deficit of £7.5m in line with plan, with GM Providers delivering a surplus of £24.1m.
- Note the delivery of CIP of £635.6m, a shortfall of £20.4m against the system target of £656.0m, with NHS GM delivering the CIP savings target of £175.0m in full.
- Note the delivery of the provider operational capital position in line with the allocation of £200.9m.
- Note that NHS GM achieved the requirement to remain within the allowable cash balance at the end of the year, with a cash balance of £36k.
- Note that the provider cash balance at the end of the financial year was £428.9m, £1.0m above the planned level of £427.9m.
- Note the achievement of the running costs allowance target for NHS GM.

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# Appendix – Individual Organisation Reported Positions

# NHS GM Financial Position

# Month 12

NHS Greater Manchester

The financial summary for NHS GM by expenditure type as at Month 12 is shown in the table below:

| NHS GM Financial Position £m | In Month Plan | In Month Actual | In Month Variance | In Month Variance % | Annual Plan | Actual Outturn | Variance | Variance % | Change in Var - Outturn var vs M11 FOT var |
|---|---|---|---|---|---|---|---|---|---|
| Allocations | £897.7 | £897.7 | £0.0 | 0.0% | £9,432.1 | £9,432.1 | £0.0 | 0.0% | £0.0 |
| Admin | | | | | | | | | |
| Running Costs | £15.9 | £13.7 | £2.1 | 13.5% | £74.0 | £69.3 | £4.8 | 6.5% | £2.5 |
| Total Admin | £15.9 | £13.7 | £2.1 | 13.5% | £74.0 | £69.3 | £4.8 | 6.5% | £2.5 |
| Programme | | | | | | | | | |
| Mental Health | £88.2 | £86.1 | £2.2 | 2.4% | £990.4 | £996.9 | -£6.5 | -0.7% | £3.0 |
| Acute | £441.0 | £446.7 | -£5.7 | -1.3% | £4,353.0 | £4,395.8 | -£42.9 | -1.0% | -£4.1 |
| Specialised Commissioning | £86.0 | £85.7 | £0.3 | 0.3% | £999.2 | £995.7 | £3.5 | 0.3% | -£0.1 |
| Primary Care | £9.2 | £8.4 | £0.8 | 9.1% | £104.2 | £100.6 | £3.6 | 3.5% | £0.3 |
| GP Medical, Pharmacy, Dental and Optometry | £92.2 | £92.7 | -£0.5 | -0.5% | £1,079.0 | £1,078.8 | £0.1 | 0.0% | -£0.5 |
| Prescribing | £50.1 | £48.1 | £2.0 | 4.0% | £599.1 | £593.8 | £5.3 | 0.9% | £0.8 |
| All Age Continuing Healthcare | £24.4 | £27.2 | -£2.8 | -11.3% | £289.2 | £299.6 | -£10.4 | -3.6% | -£1.2 |
| Community Health Services | £64.8 | £65.1 | -£0.3 | -0.4% | £793.3 | £794.7 | -£1.4 | -0.2% | -£0.5 |
| Programme Operating Costs | £15.0 | £19.6 | -£4.6 | -30.6% | £102.4 | £109.6 | -£7.2 | -7.0% | -£5.1 |
| Other expenditure | £0.8 | £0.6 | £0.2 | 29.0% | -£0.1 | £0.2 | -£0.3 | 372.3% | £0.5 |
| Earmarked commitments | £10.7 | £4.6 | £6.2 | 57.3% | £55.9 | £4.6 | £51.3 | 91.8% | £4.3 |
| Total Programme | £882.5 | £884.6 | -£2.1 | -0.2% | £9,365.5 | £9,370.3 | -£4.8 | -0.1% | -£2.5 |
| **Total Expenditure** | **£898.4** | **£898.4** | **£0.0** | **0.0%** | **£9,439.6** | **£9,439.6** | **£0.0** | **0.0%** | **£0.0** |
| | | | | | | | | | |
| **Surplus / (Deficit)** | **-£0.6** | **-£0.6** | **£0.0** | | **-£7.5** | **-£7.5** | **£0.0** | | **£0.0** |

- In the final month of the year, a number of allocations have been received, with a significant proportion flowing out to GM NHS Providers as part of the Acute category of spend in relation to surge funding and for the Q4 Sprint programme (net nil impact as budget and spend matched).
- The end column in the table above details the movement in the position compared to M11, with key movements explained as:
  - Acute – reflecting increased contract over performance, both NHS and in the Independent Sector.
  - A continuation of increased costs associated with All Age Continuing Care, including backdated invoices from LAs.
  - Mental health pressures relating to ADHD, Autism and s117, offset by the benefits from the MH Integrated Fund gainshare.
  - Programme Operating Costs – reflecting the additional cost of VR and CR above the allocation received, offset partially by the underspend in Running Costs
  - Offset with other areas of improvement in the overall position, and the release of slippage from centrally held allocations.

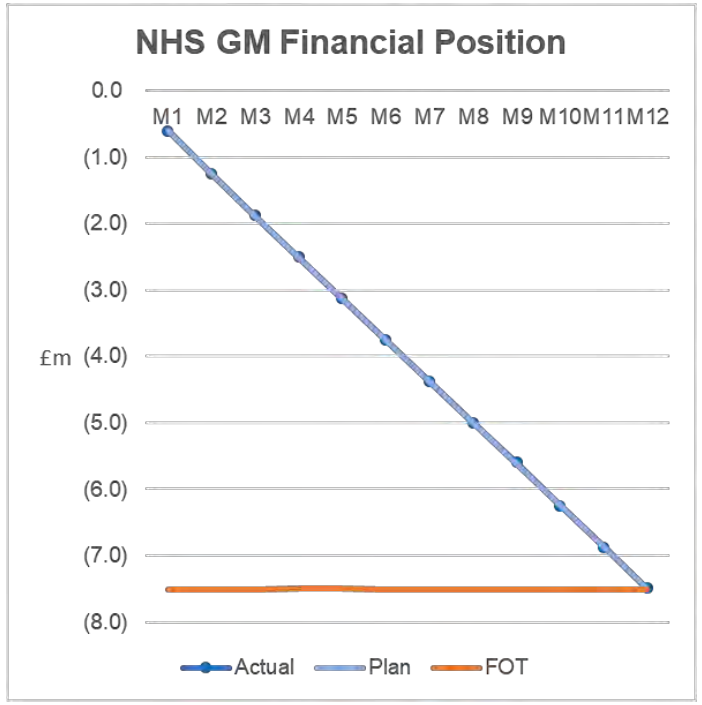
# NHS GM Key Messages

## Month 12

NHS Greater Manchester

| Key Area | Month 12 Overview |
|---|---|
| Financial position | NHS GM is reporting a £7.5m deficit which is in line with the plan. |
| Risk | At M12 the reported gross risk relating to NHS GM has been fully mitigated. |
| CIP | The CIP plan of £175.0 has been fully delivered. The annual plan was split 80.0% recurrent, 20.0% non recurrent achievement. Of this CIP delivery 62.1% has been delivered recurrently, 37.9% non recurrently. |
| Key variance: Acute | The M12 overspend is £42.9m, which is mainly as a result of the impact of both NHS contract over performance and Independent Sector Elective Activity overperformance. |
| Key variance: Mental Health | The outturn M12 overspend is £6.5m which reflects an improvement on the position reported at M11 of £3.0m. Pressures still remain regarding ADHD, Autism and s117, although improvements realised through the gainshare for the integrated fund have partially offset these. |
| Key variance: All Age Continuing Healthcare | All Age Continuing Healthcare is overspending by £10.4m, which is a combination of further increases in the number of high-cost cases, fast tracks and fully funded cases. |

The chart below shows the changes in position for NHS GM:



# GM NHS Provider Financial Position | Month 12

NHS Greater Manchester

An actual outturn surplus of £31.6m is reported at M12, which is a £24.1m favourable variance against plan. £21.3m additional Deficit Support Funding (DSF) was issued in M12 and is the main reason for the outturn surplus and favourable variance from plan.

| 2025/26 GM Providers Income Statement £m | Including DSF | | | Excluding DSF | | |
|---|---|---|---|---|---|---|
| | Annual Plan | Actual Outturn | Variance | Plan DSF | Additional DSF | Actual Outturn excluding DSF |
| Income | £8,700.6 | £9,012.6 | £312.0 | £157.5 | £21.3 | £8,833.8 |
| Pay | -£5,668.1 | -£5,854.1 | -£185.9 | | | -£5,854.1 |
| Non-Pay | -£2,900.4 | -£3,033.5 | -£133.0 | | | -£3,033.5 |
| Non Operating Items | -£124.5 | -£93.5 | £31.0 | | | -£93.5 |
| **TOTAL Provider Surplus/(Deficit)** | **£7.5** | **£31.6** | **£24.1** | **£157.5** | **£21.3** | **-£147.2** |
| Surplus/Deficit Breakdown | | | | | | |
| Manchester University NHS Foundation Trust | £0.0 | £5.0 | £5.0 | £0.0 | £4.9 | £0.1 |
| Northern Care Alliance NHS Foundation Trust | £0.0 | £5.1 | £5.1 | £57.9 | £4.9 | -£57.7 |
| Stockport NHS Foundation Trust | £0.0 | £0.0 | £0.0 | £43.2 | £0.0 | -£43.2 |
| Tameside NHS Foundation Trust | £0.0 | £0.0 | £0.0 | £31.8 | £0.0 | -£31.8 |
| Bolton NHS Foundation Trust | £0.0 | £0.0 | £0.0 | £6.5 | £0.0 | -£6.5 |
| Wrightington, Wigan and Leigh NHS Foundation Trust | £0.0 | £3.3 | £3.3 | £8.9 | £3.3 | -£8.9 |
| Greater Manchester Mental Health Foundation Trust | £0.0 | £3.3 | £3.3 | £9.2 | £3.3 | -£9.2 |
| Pennine Care NHS Foundation Trust | £0.0 | £1.6 | £1.6 | £0.0 | £1.6 | £0.0 |
| The Christie NHS Foundation Trust | £7.5 | £13.3 | £5.8 | £0.0 | £3.3 | £10.0 |
| **Provider Surplus/(Deficit)** | **£7.5** | **£31.6** | **£24.1** | **£157.5** | **£21.3** | **-£147.2** |

**Key messages:**

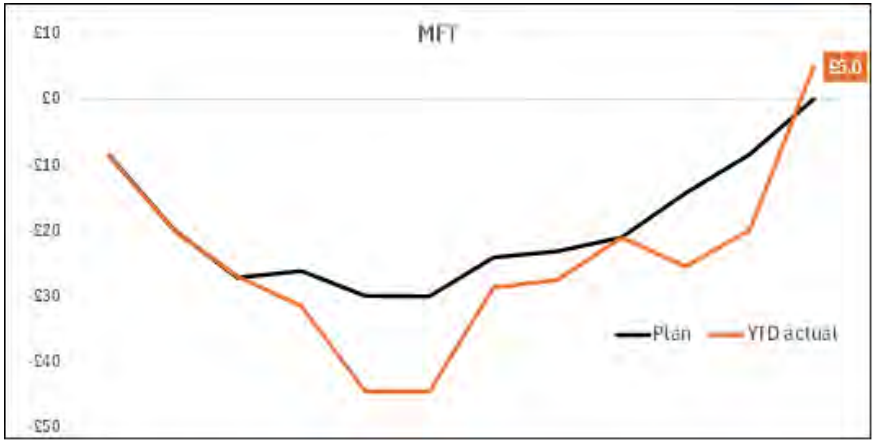
- All providers have reported either a breakeven or favourable position against plan.
- The £24.1m favourable variance from plan comprises:
  - Christie – additional £2.5m surplus, first reported in M11
  - £21.3m DSF issued in M12
  - A balance of £0.3m surplus spread across five providers

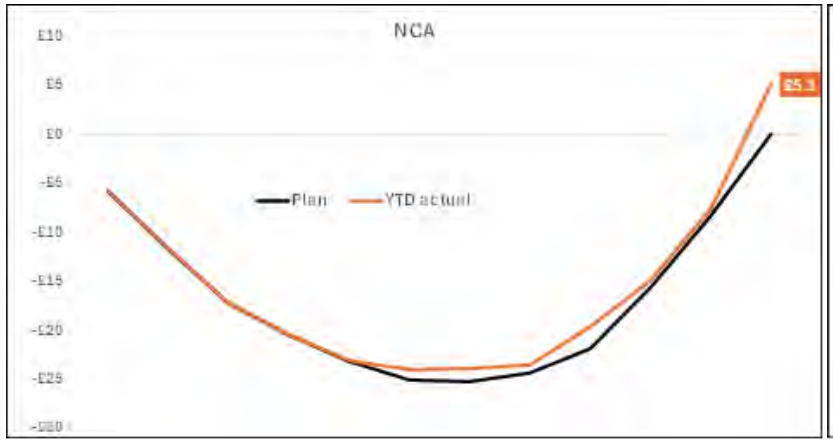
# GM NHS Provider Position

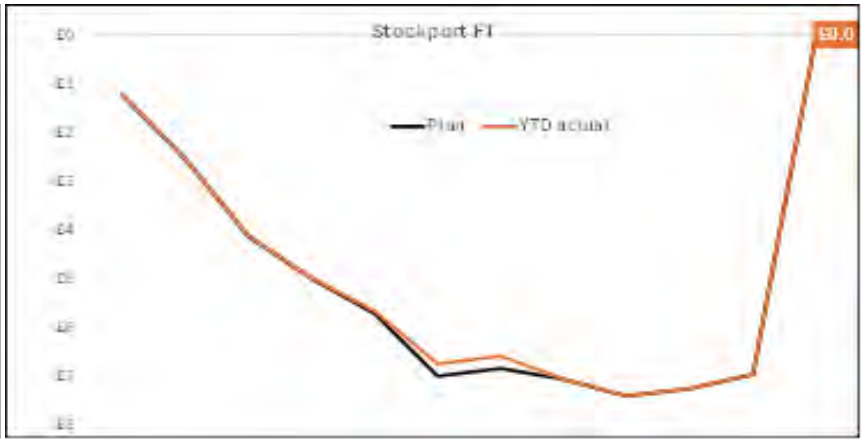
## Month 12

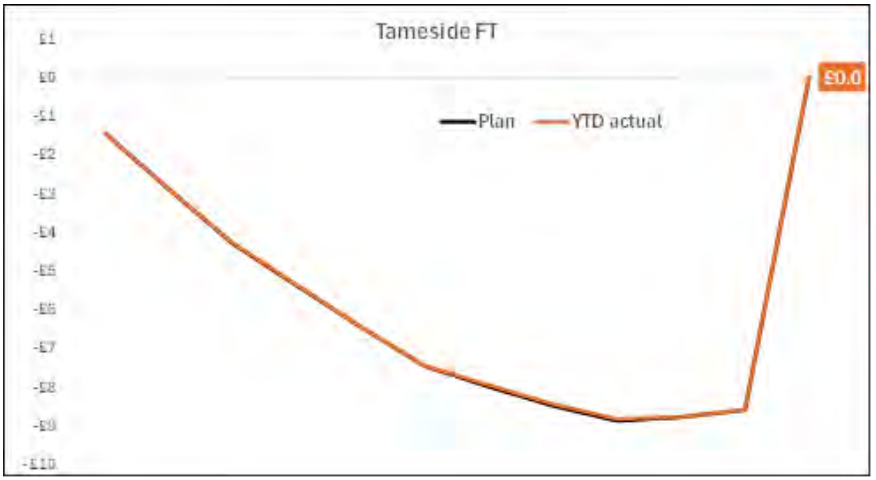
NHS Greater Manchester

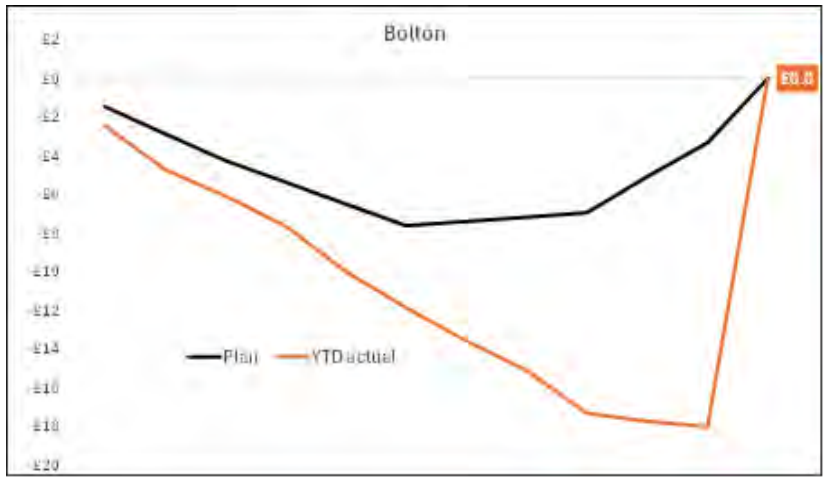
The following slides show the monthly I&E position by GM NHS provider (Slide 1 of 2)

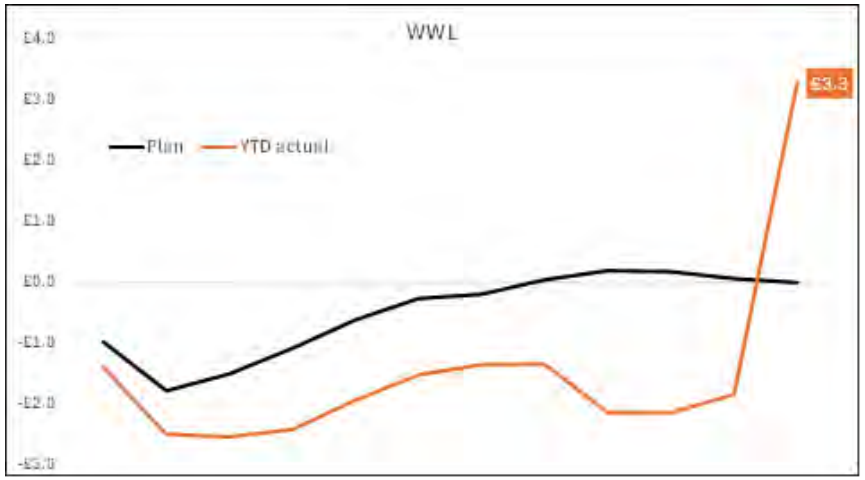


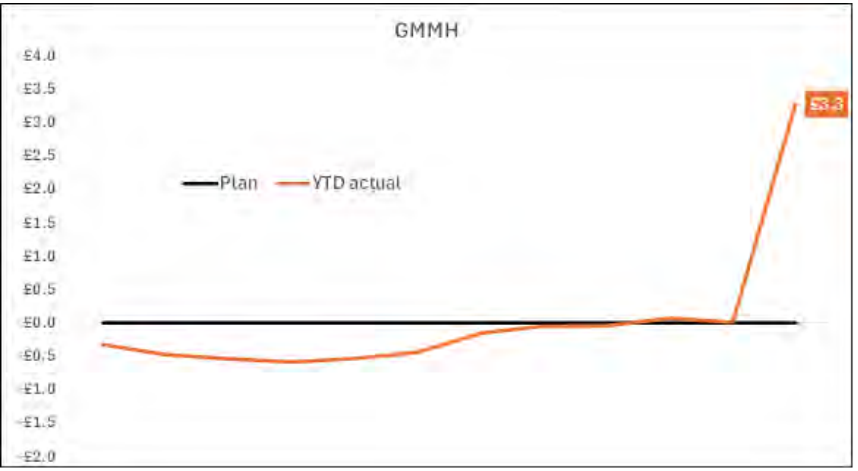



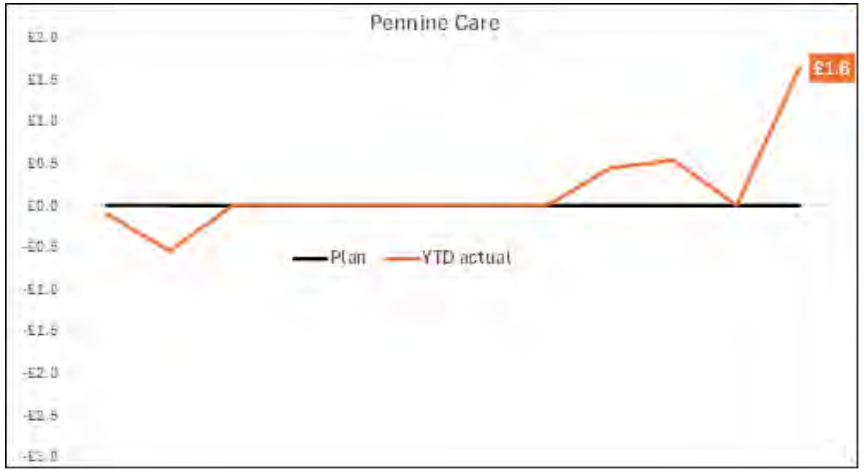
# GM NHS Provider Position

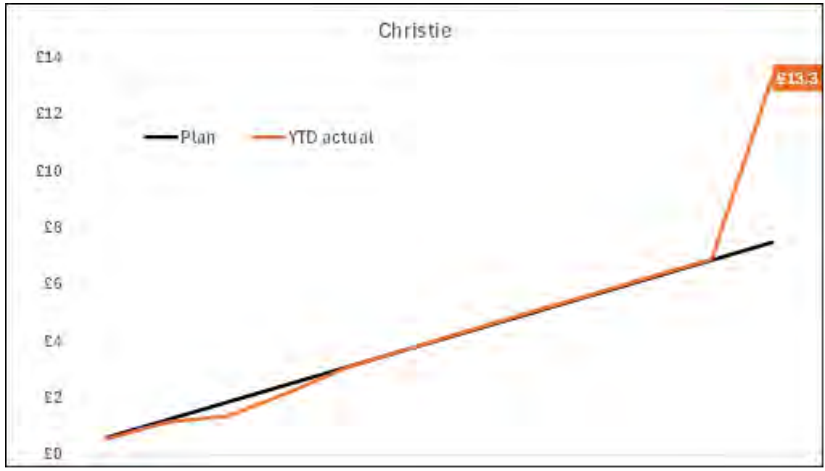
Month 12

NHS Greater Manchester

I&E monthly position by GM NHS provider (Slide 2 of 2)



NHS
Greater Manchester

# Strategic Commissioning Committee Report

20 May 2026

**Part of** Greater Manchester Integrated Care Partnership

NHS Greater Manchester

# Integrated Care Board

## 20 May 2026

| Required information | Details |
|---|---|
| **Title of report** | Strategic Commissioning Committee Report |
| **Author** | Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee |
| **Presented by** | Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee |
| **Contact for further information** | Sue Bailey, Non-Executive Director/ Chair of Strategic Commissioning Committee |
| **Executive summary** | To highlight key issues and provide assurance to the Board. |
| **The benefits that the population of Greater Manchester will experience.** | N/A |
| **How health inequalities will be reduced in Greater Manchester's communities.** | N/A |
| **The decision to be made and/or input sought** | The Board is asked to:<br>• Note the contents of the report and provide feedback to the Committee Chair. |
| **How this supports the delivery of the strategy and mitigates the BAF risks** | N/A |
| **Key milestones** | N/A |
| **Leadership and governance arrangements** | Overview of discussions at the Strategic Commissioning Committee |
| **Engagement* to date**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | N/A |
| **Financial or Legal Implications** | N/A |

*Table 1 - core information relating to the content and creation of paper*

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

*Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report*

NHS Greater Manchester

| | |
|---|---|
| **Report from:** | **Strategic Commissioning Committee** |
| **Date of Meeting:** | 1 April 2026 |
| **Chair:** | Dame Sue Bailey |
| **Quoracy Achieved:** | Yes |

Key escalations and discussion points from the meeting:

Discussion held regarding key timelines to be confirmed and in place in the finalised forward plan for the newly established committee, ensuring key priorities are discussed and linked across to future deep dives. Timelines will be revisited at next committee meeting.

**Alert**

No alerts were raised.

**Advise**

- **Strategic Commissioning Plan – Assurance Approach & Reporting Cycle:** The committee suggested escalating positive stories to Board, incorporating lived experience and alternative reporting formats such as videos and community stories to provide assurance on outcomes with support from the voluntary sector to help facilitate.
- **Sub Groups & Draft Workplan – Introductory Discussion:** Suggestion raised to carry out a review of the committee effectiveness in the summer to ensure the business had aligned with the committees strategic positioning.
- **Strategic Commissioning Plan – Assurance Approach & Reporting Cycle:** The committee considered and confirmed the proposal for how the Strategic Commissioning Committee receives assurances regarding progresses being made towards the delivery of the Strategic Commissioning Plan. A suggestion was raised to sub-segment large programmes such as Mental Health for more detailed work plans.

**Assure**

- **Terms of Reference – Update & Next Steps:** The committee noted the Terms of Reference and supported the three-month post-implementation review of the two newly established Committees.
- **Chief Officers Update – Chief Clinical Officer Report:** The committee were informed of the key areas of assurance and oversight in the report, including medicines optimisation decisions endorsed by CEG, clinical policy and audit assurance, progress on mental health quality improvement, and the system response to nationally significant patient safety issues such as

corridor care. The report also draws attention to specific risks requiring continued oversight, including paediatric audiology, specialised renal services and organisational capacity within mental health governance.

- **Chief Officers Update – Chief Commissioning Officer Report:** The committee were made aware of the positive review by the Northeast Clinical Senate of arterial, vascular and cardiac surgery reconfiguration. The committee were also informed that ICB would be an early adopter for SEND Reform.
- **Performance Report:** The Committee were provided with the year-end updates and agreed the recommended status of partial assurance.
- **Winter Vaccination Update:** The committee were informed of the high uptake in flu and maternal vaccinations and the successful Covid delivery.

**Risks discussed and new risks identified**

Risks scoring above 16 that are monitored via the Strategic Commissioning Committee:

- **BAF and Risks Report:** The committee considered the risks **SR4** (Good Employment) and **SR9** (Emergency Incident) reporting a reduced risk score for this quarter. All remaining risks were reporting a static risk score this quarter. The committee supported maintaining deep dives at the Audit Committee, however, emphasised open communication regarding resource impacts.

**Learning for sharing**

Summary of learning points to share from the Strategic Commissioning Committee April meeting.

- **Place Outcomes Framework / Outcomes Driven Commissioning:** LV and CB to meet to discuss guidance on co-production principles for place-based partnerships and health and wellbeing board and connect this with the newly agreed Accord.

**Appreciative**

Summary of the appreciation shared from the Strategic Commissioning Committee April meeting.

- Non-Executive Directors and Partner Members thanked all involved for the work that had taken place to establish the new committee and creation of papers during this challenging period.

NHS Greater Manchester

| | |
|---|---|
| **Report from:** | **Strategic Commissioning Committee** |
| **Date of Meeting:** | 6 May 2026 |
| **Chair:** | Dame Sue Bailey |
| **Quoracy Achieved:** | Yes |

Key escalations and discussion points from the meeting:

None were raised.

| **Alert** |
|---|
| No alerts were raised. |
| **Advise** |
| • **Chief Commissioning Officer Report:** The committee were made aware of the ongoing difficulties in securing a provider for adult critical care transport due to capital investment constraints, with interim arrangements in place and efforts underway to unblock capital issues following discussions at the Northwest Specialised Commissioning Committee.<br>• **Oldham SEND Inspection Outcome:** The committee reviewed the outcomes of the Oldham SEND re-inspection, highlighting improvements in waiting lists and partnership working and discussed ongoing efforts to embed needs-led, co-produced approaches across GM, with emphasis on system-wide commissioning and parent/carer involvement.<br>• **Mental Health Productivity: Inpatient Reduction, Flow and Commissioning Decisions:** The report outlined progress in mental health inpatient transformation, including significant reductions in non-commissioned and rehab beds, investment in community alternatives and a system ambition to eliminate block contracted beds by March 2027, while addressing workforce challenges and the importance of place-based discharge planning.<br>• **Frailty Update:** The committee were made aware of the initial approach to frailty as a system-wide priority, emphasising integrated pathways, collaboration with GMCA and a focus on prevention, end-of-life care and alignment with neighbourhood health models. |
| **Assure** |
| • **Update on Sub Groups & Draft Workplan Discussions:** The committee were updated on the development of a new substructure for committee support, focusing on refining work plans, ensuring alignment across |

committees and establishing a consistent framework for thematic deep dives and reporting.

- **Chief Strategy, People and Partnerships Report:** The committee were updated on the detailed finalisation of the place outcomes framework, integration of neighbourhood health initiatives and the development of consistent yet locally tailored approaches to address population health and health inequalities**.**
- **Chief Clinical Officer Report:** The committee were informed on the ongoing work to address paediatric audiology recalls, workforce gaps in perinatal pelvic health and the implementation of updated NICE guidance for type 2 diabetes, with holding positions and action plans in place to manage risks and ensure patient safety. The report also highlighted achievements in maternity services, compliance with safety actions and improvements in hypertension diagnosis, as well as the development of strong links with learning improvement networks to support shared learning across the region.
- **Chief Reform and Improvement Officer Report:** The committee were informed on the significant system improvements over 2025/26, including reduced waiting times and improved standards across most Trusts, with specific mention of Wigan's performance, emphasising the importance of integrated, collaborative working.
- **Chief Strategy, People and Partnerships Report:** The committee were made aware of the work underway to bring together various neighbourhood health programmes, such as Live Well and Population Health, under a unified governance structure to ensure strategic alignment and oversight while maintaining the independence of each initiative.

**Risks discussed and new risks identified**

Risks scoring above 16 that are monitored via the Strategic Commissioning Committee:

- There were no new risks identified.

**Learning for sharing**

Summary of learning points to share from the Strategic Commissioning Committee May meeting.

- **Chief Strategy, People and Partnerships Report:** The committee discussed mechanisms for sharing best practice across localities.

| Appreciative |
| --- |
| Summary of the appreciation shared from the Strategic Commissioning Committee May meeting.<br><br>• Committee members thanked all involved for their reports shared. |

NHS
Greater Manchester

# Quality and Performance Board Paper
# May 2026

Part of Greater Manchester
Integrated Care Partnership

# NHS Greater Manchester Board – May 26

## Report information.

| Required information. | Details. |
|---|---|
| **Title of report.** | Quality and Performance Report |
| **Author.** | Miladur Rahman – Head of Performance and Improvement<br>Anita Rolfe, Deputy Chief Nursing Officer<br>Amy Jeffery, Quality Manger |
| **Presented by.** | Manisha Kumar, Chief Clinical Officer |
| **Contact for further information.** | Ed Dyson: *edward.dyson@nhs.net* |
| **Executive summary.** | This paper advises the Board on the levels of assurance regarding performance and quality. It is completed using information from localities, system boards and committees within the NHS Greater Manchester (NHS GM) integrated care system.<br><br>The Board is asked to discuss and agree the levels of assurance set out in this report |
| **The benefits that the population of Greater Manchester will experience.** | The achievement of quality and performance objectives will improve access to services and quality of care for the people of Greater Manchester. |
| **How health inequalities will be reduced in Greater Manchester's communities.** | Ensuring delivery of standards across Greater Manchester Services will lessen differences that people may experience in accessing services. |
| **The decision to be made and/or input sought.** | The Board / Committee is asked to:<br><br>1. Agree the levels of assurance for performance and quality provided in the report. |

| | |
|---|---|
| **How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.** | This supports delivery of operational planning and constitutional standards. |
| **Key milestones.** | Monthly and quarterly milestones are in place to delivery performance standards. |
| **Leadership and governance arrangements.** | Quality and Performance Committee |
| **Engagement* to date.**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | Engagement is completed within various programmes contributing to both quality and performance delivery. It is not routinely part of preparation of quality and performance reports. |
| **Financial or Legal Implications** | Not Applicable |

*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* | *No* | *No* | *No* | *No* | *No* | *Yes* |

## 1. Introduction

1.1 This paper advises the Board on the levels of assurance regarding performance and quality. It is completed using information from localities, system boards and committees within the NHS Greater Manchester (NHS GM) integrated care system. The paper highlights material issues for Board. The paper also briefs Board on provider and locality assurance arrangements.

1.2 This report uses the "Assure, Alert and Advise" approach aimed to direct members to the key issues and provide an understanding of the work that is being completed to address these issues.

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

1.3 The Board is asked to discuss and agree levels of assurance set out in this report.

## 2. Performance

2.1 This section highlights current performance against key deliverables. It references the most recent published data. Final validated positions for some 2025/26 measures are subject to national reporting timelines. Therefore, where validation is not yet complete, forecast positions or unvalidated data have been used to provide an early view of performance. Narrative commentary is provided for Alert domains only, to focus Committee attention on areas of material delivery risk requiring system oversight

**Alert**

2.2 In March, 74.1% of patients attending A&E were admitted, transferred, or discharged within **four hours.** Although behind the 78% target, it's a 2.9% improvement compared to March 2025. The latest national benchmarking (March 2026) places the ICB 28th of 42, compared to 32nd of 42 in the same period last year, indicating relative improvement despite continued delivery challenge. Unvalidated data for April 26 shows performance at 73.%.

2.3 At year end (March), 8.8% of patients attending Type 1 A&E departments spent more than **12 hours** in the Emergency Department, worse than the plan of 7.5%. However, there has been a 0.8% improvement compared to March 2025. For 2026/27, the metric will change to include all emergency care types, not just Type 1 attendances.

2.4 Whilst challenged, both the four-hour and twelve-hour wait metrics have improved from the previous year. System escalation and oversight arrangements are established through UEC governance, with a continued focus on reducing avoidable demand on emergency departments, improving discharge and patient flow, and strengthening access to timely and appropriate community-based alternatives. The ICB is working with each Trust, and Place partners, to develop robust plans to demonstrate sustained improvement toward the March 27 A&E 4-hour target of 82%.

2.5 GM Trusts are forecasting 23 patients waiting over **65 weeks** for treatment at the end of March against a target of zero. This is made up of 15 breaches at Wrightington, Wigan and Leigh NHS Foundation Trust (WWL), 9 at Northern Care Alliance NHS Foundation Trust, and 2 at Stockport NHS Foundation Trust. The forecast for the end of April is 28 breaches.

2.6 GM Trusts are forecasting 1.6% of their total waiting list to be waiting **over 52 weeks** for treatment, which is worse than the March target of no more than 1% over 52 weeks. Under-performance is due to only two of the six acute providers forecasting more than 1%. The March forecast is 2.2% better than March 2025 actual, with national benchmarking (February 2026) showing the ICB ranked 30th of 42, compared with 37th of 42 in the same period last year. More recent data shows GM providers are forecasting to reach 1.7% in April, which is better than April plan of 1.8%.

2.7 Elective recovery actions continue at system level, including escalation and targeted pathway interventions, with Independent Sector capacity supporting delivery alongside NHS activity. Also continued uptake in the use of advice and guidance by primary care, expansion of community services and the single point of access for managing referrals are areas of focus as we move into 26/7 to support in reducing demand into secondary care and waiting times.

2.8 The **average length of stay (LOS)** in a mental health acute inpatient bed for adults and older adults discharged in the three months to February 26, was 64.9 days for GM registered patients, which was worse than the February plan of 57.8 days. GM ICB is unlikely to meet the end of year March plan of 57 days. There is a continued focus on discharge planning, improved patient flow and use of step-down alternatives where available. A core focus of the system approach is reducing delayed discharges where patients are clinically ready to leave hospital but remain in beds due to non-clinical barriers.

2.9 At the end of February, there were 55 **adults with autism** (with no learning disability) in an inpatient bed. GM ICB is not expected to achieve the end of year March plan of no more than 39. Published data for LD metrics are rounded to nearest 5 prevent identification of vulnerable individuals. Work is ongoing to reduce inpatient autism admissions, with a focus on prevention, timely discharge and strengthening community alternatives. This includes improved care and treatment planning, enhanced multi-agency working, and increased emphasis on support pathways that avoid admission where possible. Progress remains dependent on system-wide collaboration and the availability of community provision.

**Advise**

2.10 At the end of February, 10.2% of patients were waiting more than **six weeks for a diagnostic test** at GM NHS providers. GM registered performance stood at 10.0%, ranking GM 7th out of 42 nationally. This metric is not an operational planning metric but is closely monitored as it's a key enabler for delivery of elective and cancer standards.

**Assure**

2.11 **RTT 18-week performance** shows significant improvement, with GM providers collectively forecast to achieve 62.2% at the end of March, better than the March plan of 61%. If

delivered, this represents an 8.4 percentage point improvement compared to March 2025. National benchmarking (February 2026) shows the ICB ranked 31st of 42, compared to 38th of 42 at the same point last year, reflecting a marked improvement in relative position. More recent data shows as of the 26th of April, GM providers are forecasting to reach 60.6% in April, which is better than April plan of 60.56%.

2.12 In March, 68.5% of elective patients in GM Acute Trusts were waiting less than **18 weeks for a first appointment**, which was better than the end of year March plan of 68.2%.

2.13 In March, average **category 2 ambulance** response times across Greater Manchester were 20 minutes and 58 seconds. Year-to-date performance for 2025/26 ended well within the 30-minute threshold, at an average of 23 minutes and 29 seconds.

2.14 GM providers were better than plan for the **cancer faster diagnosis** with 83.6% diagnosed within 28 days in February 25. GM is forecast to achieve 82.1% in March, better than 80% target by March 2026. GM ICB was ranked 10th out of 42 nationally based on the latest February benchmarking data.

2.15 In February 74.3% of **cancer** patients received treatment within **62 days**, better than February plan. Local data shows GM is forecast to achieve 77.5% in March, achieving the end of year March plan of 75%. GM ICB is ranked 7th out of 42 nationally based on latest February benchmarking data.

2.16 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 February plan of 55,000.

2.17 At the end of February, there were 45 adults with a **learning disability** (and may also be autistic) in an inpatient bed, which is currently better than the quarter four target of no more than 46. Published data for LD metrics are rounded to nearest 5 prevent identification of vulnerable individuals.

## 3. Quality Update

### 3.1 System Improvement Board Updates

**Segment 4 Oversight – Greater Manchester Mental Health NHS Foundation Trust (GMMH)**

3.2 Following the independent assurance review work continues by the trust on its improvement plan. Quality Review Meetings are in place and continue to oversee key areas of work.

**Segment 4 Oversight – The Northern Care Alliance NHS Foundation Trust (NCA)**

3.3 Northern Care Alliance's first Quality Review Meeting using the new format is scheduled for the 12th of May where updates are scheduled around the trusts progress against:

- Clinical Leadership model
- Spinal Surgery Independent Review
- CQC action plans

- Gynaecology Service Update

3.4 **Key Updates**

**Alert**

The Spinal Surgery Independent review is due to be published soon and we are working with the NCA, MFT and Spire to begin making preparations for their improvement plans and confirm oversight. Communications colleagues are already linked in ahead of the report's publication expected at the end of May. The plans will be overseen by regular Quality Review Meetings and contract meetings with providers. Further information will be provided to the board once the report is published.

Paediatric Audiology remains a system and regional risk. A clinic model has been put in place to ensure children, recalled as a result of case reviews across Greater Manchester on 4 sites, have timely access to appropriate review and treatment. The commissioning redesign is ongoing and the ICB seeks to mitigate risks through a stratified approach to recall in accordance with priority levels. This remains a risk for the ICB at present – particularly in relation to workforce capacity across ICB, Provider Trusts and Subject Matter Experts. This risk is articulated on the ICB risk register and a collective risk across all 3 North West ICBs has been articulated by the Regional team.

**Assure**

3.5 **Maternity**

3.6 NHS Resolution has confirmed that all 6 maternity providers in Greater Manchester successfully achieved all 10 safety actions within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year 7

3.7 Following a period of enhanced surveillance and support, Manchester Foundation Trust (MFT) Maternity have successfully been stepped back into routine surveillance.

3.8 MFT were placed into enhanced surveillance following a tragic maternal & neonatal death at a homebirth in June 2024 and the temporary suspension of their homebirth service

3.9 MFT completed a thorough review of the incident alongside the MNSI (Maternity & Neonatal Safety Investigation programme) external review, MFT also commissioned an external review of their homebirth service by NHSE.

3.10 A 95-point action plan followed which supported the MFT team to:

- Re-structure their homebirth service
- MDT plan of care reviews
- Audit of all homebirth care
- Developed a bespoke community-based training package alongside NWAS
- Designed a full ongoing competency package for all midwives undertaking homebirths.

MFT were commended by the coroner for the significant improvement work they completed and MFT have subsequently shared their learning across GM, the North-West and are supporting the National Homebirth working group.

**Advise**

3.11 National Patient Safety Event Data - Q3

3.12 The National Patient Safety Event Data has been published for Q3 and provides some summary reporting for all organisations in relation to patient safety events recorded on LFPSE - Patient safety event data: Quarter 3 2025/26 (October to December 2025)

3.13 Summary data is provided below to show the number of patient safety events (including good care events) recorded per 1000 bed days for each of the NHS GM Trusts, including a comparison to Q2 data:

| Recording Organisation Code | Organisation Name | Median Day Lag | Number of Incidents | Activity Denominator | Recording Rate Type | Q3 Recording Rate | Q2 Recording Rate |
|---|---|---|---|---|---|---|---|
| RMC | Bolton NHS Foundation Trust | 0 | 4,229 | 50,039 | Per 1,000 Bed Days | 84.5 | 84.7 |
| RXV | Greater Manchester Mental Health NHS Foundation Trust | 0 | 10,121 | 65,833 | Per 1,000 Bed Days | 153.7 | 155.2 |
| R0A | Manchester University NHS Foundation Trust | 0 | 15,832 | 181,570 | Per 1,000 Bed Days | 87.2 | 85.7 |
| RM3 | Northern Care Alliance NHS Foundation Trust | 0 | 11,055 | 133,083 | Per 1,000 Bed Days | 83.1 | 84.8 |
| RT2 | Pennine Care NHS Foundation Trust | 0 | 2,365 | 40,610 | Per 1,000 Bed Days | 58.2 | 62.5 |
| RWJ | Stockport NHS Foundation Trust | 0 | 4,314 | 54,704 | Per 1,000 Bed Days | 78.9 | 85.4 |
| RMP | Tameside and Glossop Integrated Care NHS Foundation Trust | 0 | 5,051 | 40,018 | Per 1,000 Bed Days | 126.2 | 135.1 |
| RBV | The Christie NHS Foundation Trust | 1 | 2,155 | 15,410 | Per 1,000 Bed Days | 139.8 | 140.4 |
| RRF | Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust | 0 | 4,138 | 46,666 | Per 1,000 Bed Days | 88.7 | 87.7 |

3.14 There are areas of good reporting and other areas that need some further exploratory conversations which have begun with providers, any discussion points or gaps in assurance will be picked up as part of the new programme of Quality Review Meeting

## 4. Recommendations

4.1 The NHS GM Board is asked to discuss and agree levels of assurance set out in this report:

NHS
Greater Manchester

# Audit Committee Report

20 May 2026

NHS Greater Manchester

# Integrated Care Board

## 20 May 2026

| Required information | Details |
|---|---|
| **Title of report** | Audit Committee Report |
| **Author** | Ross Baxter, Governance Advisor |
| **Presented by** | Jackie Njoroge, Deputy Chair / Senior Independent Director |
| **Contact for further information** | Jenny Noble |
| **Executive summary** | To highlight key issues and provide assurance to the Board, and to seek approval for minor amendments to the Terms of Reference. |
| **The benefits that the population of Greater Manchester will experience.** | N/A |
| **How health inequalities will be reduced in Greater Manchester's communities.** | N/A |
| **The decision to be made and/or input sought** | The Board is asked to:<br>• Note the contents of the verbal report including items for escalation and provide feedback to the Committee Chair.<br>• Approve the Terms of Reference |
| **How this supports the delivery of the strategy and mitigates the BAF risks** | N/A |
| **Key milestones** | N/A |
| **Leadership and governance arrangements** | This is a summary report following the March and April Audit Committee meetings. |
| **Engagement* to date**<br><br>***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.** | Draft report shared with the Chair for comments. |
| **Financial or Legal Implications** | N/A |

*Table 1 - core information relating to the content and creation of paper*

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

*Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report*

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| | |
|---|---|
| **Report from:** | **Audit Committee** |
| **Date of Meeting:** | 19 March 2026 |
| **Chair:** | Richard Paver |
| **Quoracy Achieved:** | Yes |

Key escalations and discussion points from the meeting:

| **Alert** |
|---|
| **Procurement and Provider Selection Regime (PSR) breaches -** The Committee noted several confirmed procedural breaches, largely arising from retrospective approvals, late decision records, and failures to publish transparency notices in accordance with PSR requirements. While mitigations have been applied to avoid further legal challenge, members expressed concern that these issues indicate systemic weaknesses in end-to-end decision-making, feedback loops, and accountability across budget holders and commissioning teams. Repeated non-compliance presents an ongoing legal and reputational risk if not addressed structurally.<br><br>**Organisational capacity and resilience during transition -** Significant workforce change continues to create operational risk, including pressures on finance, procurement, and governance functions. While the Executive reported that statutory deadlines (including accounts and planning submissions) are currently being met, they highlighted a risk of cumulative slippage, delayed payments, reduced management grip, and exhaustion of key staff if pressures persist into the new operating model.<br><br>**Management of complex and cross-system risks (population health / wider determinants) -** The deep dive into the wider determinants of health risk highlighted difficulties in ownership, measurable impact, and assurance where risks sit largely outside the ICB's direct control. Members warned that reliance on governance structures and partnership forums alone does not provide sufficient assurance without clearer accountability, prioritisation, and outcome-based evidence. |
| **Advise** |
| **Strengthen accountability for procurement and decision-making -** The Board is advised to reinforce expectations on Chief Officers and budget holders regarding compliance with procurement, PSR, and governance requirements. Action needs |

to be taken to clearer forward plan decisions, improved tracking from decision to publication, and targeted learning from breaches to address root causes rather than relying on retrospective controls.

**Improve flow between Board committees -** The Committee highlighted the need for stronger cross-committee dialogue and feedback loops, ensuring that risks, audit findings, and emerging issues are shared consistently and acted upon across the governance system. A more coordinated approach between committee chairs was suggested.

**Assure**

**Internal audit delivery and coverage -** Delivery against the Internal Audit Plan remains broadly on track, with core reviews completed or in progress and reasonable assurance reported in several areas (including CHC and financial processes). No material deterioration in the recommendation position was noted since the previous meeting, recognising the impact of organisational reform on closure timescales.

**External audit progress and accounts preparation -** Early external audit testing has progressed appropriately, and management actions are in place to support timely production of draft accounts and working papers. Although staffing reductions pose a risk, mitigations have been identified for critical roles. Materiality levels and audit logistics were clearly set out, providing transparency to the Committee.

**Counter-fraud arrangements -** The Committee received assurance on the effectiveness of counter-fraud activity, including improved compliance with declaration of interest requirements, appropriate handling of referrals, and proactive work on high-risk areas such as Personal Health Budgets (PHBs). The escalation of a significant PHB recovery case and alignment with national fraud intelligence were noted as positive examples of system working.

**Financial performance and planning -** Despite unprecedented organisational change, the ICB remains on track to deliver the current-year plan and has set a compliant plan for the forthcoming year. Cash flow pressures and creditor issues are recognised but actively managed, with access to additional cash agreed where required.

**Governance framework maintenance -** Committee Terms of Reference remain fit for purpose, with only minor amendments required to reflect changes in roles and committee architecture. Information Governance is appropriately placed within the Audit Committee's assurance remit, supported by a dedicated operational group.

| Risks discussed and new risks identified |
| --- |
| The Committee conducted a Deep Dive on BAF Risk SR1 to support BAF development and improvement. The discussion was constructive, with key areas of learning identified (which would be presented back to the Committee at their next meeting). |
| **Learning for sharing** |
| There were no specific areas of learning for sharing from the Audit Committee. |

NHS
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| | |
|---|---|
| **Report from:** | **Audit Committee** |
| **Date of Meeting:** | 23 April 2026 |
| **Chair:** | Richard Paver |
| **Quoracy Achieved:** | Yes |

Key escalations and discussion points from the meeting:

| **Alert** |
|---|
| **Outstanding Internal Audit Recommendations -** While the Head of Internal Audit issued a draft overall Substantial Assurance opinion for 2025/26, Committee members expressed concern about the volume of outstanding audit recommendations, including some assessed as high risk. Particular concern was raised about the pace of follow-up and the need to formally review whether legacy recommendations remain relevant or should be closed in light of organisational reform. The Board is asked to remain sighted on progress to ensure sustained improvement.<br><br>**Data Quality as a Continuing Risk Area -** The Committee highlighted delays in the internal audit review of data quality, noting the importance of timely completion ahead of the external audit opinion. Data quality was repeatedly referenced as a material risk with implications for commissioning, planning and assurance. The Board should note the expectation that clear timelines and outcomes are now delivered.<br><br>**Risk Management Maturity During Transition -** Discussion on the Risk Management Update highlighted that some existing strategic and corporate risks no longer clearly align with the ICB's evolving role. There is a risk that outdated or overly broad risks reduce the effectiveness of Board assurance during the transition to the new operating model.<br><br>**Draft Annual Report and Accounts – Narrative Risks -** Members queried whether elements of the Draft Annual Report, particularly in relation to redundancies, running cost treatment, and the scale of the reform programme, could be misinterpreted without clearer narrative. The Board should be aware of the reputational and transparency risks if these areas are not clearly explained in the final document. |
| **Advise** |

**Sustaining Assurance During Reform -** The Committee advised that the Draft Head of Internal Audit Substantial Assurance opinion should be viewed as a platform, not an endpoint, and that continued Board focus is required to maintain standards during 2026/27, particularly in high-risk areas such as IT, data quality and recommendation follow-up.

**Risk Refresh and Clarity of Ownership -** The Board is advised to support the planned refresh of the Board Assurance Framework, ensuring risks are clearly prioritised, outcome-focused and aligned to the ICB's strategic commissioner role, with clearer distinction between risks and issues.

**Transparency of Delegated Financial Decisions -** The Committee advised that enhanced forward visibility and retrospective reporting of decisions taken under delegated authority will be critical to maintaining Board assurance, particularly given increased financial thresholds.

**Debtors Position – Year-End Movement -** The Committee queried a significant increase in year-end debtors, which was not clearly explained in the report. Clarification was requested.

**Assure**

**Annual Internal Audit Plan 2026/27 -** Members were content with the revised Audit Plan, including the increased emphasis on contingency capacity and flexibility to respond to emerging risks during reform. The Committee agreed that the plan was proportionate and realistic in the current context.

**MHIS Audit Findings 2024/25 -** The Committee noted confirmation that the ICB was compliant with the Mental Health Investment Standard, with no amendments required to the accounts. The audit concluded smoothly, with only minor prior-year recommendations partially outstanding.

**External Audit Progress and Sector Update -** External audit work was reported to be on track, with no emerging issues of material concern. The Committee took assurance that appropriate prioritisation and handover arrangements were in place to mitigate workforce and capacity risks.

**Financial Scheme of Delegation -** The Committee was content that the revised Financial Scheme of Delegation strengthened accountability, clarified roles and reflected the new operating model, subject to ongoing review as arrangements bed in and increased transparency regarding decisions taken under delegated authority.

| Risks discussed and new risks identified |
| --- |
| The Committee received feedback following the Deep Dive conducted at the previous meeting to support BAF development. |
| **Learning for sharing** |
| The Committee requested that the report on the BAF Deep Dive into Population Health be circulated to all Board members as a useful tool when considering future BAF and Committee risk developments. |

# NHS Greater Manchester

# Audit Committee

# Terms of Reference

## DOCUMENT CONTROL SHEET

| | |
|---|---|
| **Name of Document:** | Audit Committee Terms of Reference |
| **Version:** | ~~9~~10 |
| **File Location / Document Name:** | |
| **Date Of This Version:** | ~~24 April 2025~~19 March 2026 |
| **Produced By:** | Izhar Chaudhary / Chris Gaffey |
| **Reviewed By:** | Audit Committee |
| **Synopsis And Outcomes of Equality and Diversity Impact Assessment:** | N/A |
| **Ratified By (Committee):** | NHS GM Board |
| **Date Ratified:** | TBC |
| **Distribute To:** | Members of the Audit Committee |
| **Date Due For Review:** | April 2026 |
| **Enquiries To:** | Izhar Chaudhary / Chris Gaffey |

### Revision History

| Revision Date | Summary of changes | Author(s) | Version Number |
|---|---|---|---|
| 15/7/22 | Membership changed from 7 to 5. Responsibility for corporate and financial policies included. | IC | 5 |
| 03/8/22 | Chief Delivery Officer or nominated deputy. | IC | 6 |
| 7/6/23 | Membership updated to reflect addition of two independent members. The role of the Audit Committee in risk management following approval by the Board. Responsibility to approve corporate and financial policies included. | JN | 7 |
| 25/1/24<br>10/04/24 | Additions to ToR to reflect SoRD<br>Further comments by AC following March meeting, as well as additional changes to reflect responsibilities around governance. | LC<br>CG | 8 |
| 11/04/25 | Remove the provision of Members providing deputies (as this is not possible).<br>Update of job title for "Chief Officer Responsible for Governance"<br>Inclusion of provision to meet with Counter Fraud provider in private<br>Update to wording on section on corporate policy approval | CG | 9 |
| 19/03/26 | Minor amendments following review by Audit Committee including removal of references to "Freedom to Speak Up" and the role of regular attendee updated from the Deputy Chief Executive to the new designated Chief Officer for Strategy, People and Partnerships, who now holds the portfolio responsibility for governance. | JN | 10 |

# NHS Greater Manchester Audit Committee Terms of Reference

## 1. Constitution

The Audit Committee (the Committee) is established by the NHS Greater Manchester Integrated Care Board ("the Board") as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on NHS GM website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive Committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS GM.

## 2. Authority

The Audit Committee is authorised 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 NHS GM (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 NHS GM for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with NHS GM's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

For the avoidance of doubt, the Committee will comply with, the NHS GM Standing Orders, Standing Financial Instructions and the SoRD.

## 3. Purpose

To contribute to the overall delivery of the NHS GM objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS GM.

On behalf of the Board, in line with the SoRD, to approve the NHS GM annual report and financial statements (including accounting policies).

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

The Audit Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

## 4. Membership and Attendance

***Membership***

The Committee members shall be appointed by the Chair of NHS GM in accordance with the NHS GM Constitution.

The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

Neither the Chair of the Board, nor employees of NHS GM will be members of the Committee.

Members will possess between them knowledge, skills and experience in: accounting, governance, risk management, internal, external audit; and technical or specialist issues pertinent to NHS GM business. The Chair should have the appropriate financial qualifications. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Membership

1. Independent Non-Executive (Chair of the Committee)
2. Independent Non-Executive (Vice Chair of the Committee)
3. Partner Member
4. Independent Member
5. Independent Member (bringing NHS Provider perspective)

***Chair and Vice Chair***

In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other Committees.

A Vice Chair (who will be a Non-Executive Director) will be appointed by the NHS GM Chair who should also have the required specific knowledge skills and experience making them suitable to chair the Committee.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

***Attendees***

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Chief Finance Officer or their nominated deputy;
- Representatives of both internal and external audit, as well as Counter Fraud;
- Individuals who lead on risk management and counter fraud matters;
- ~~Deputy Chief Executive~~Chief Strategy, People and Partnerships Officer or their nominated deputy.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

The Chief Executive should be invited to attend the meeting at least annually.

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.

***Attendance***

It is highly important that members attend the Audit Committee on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances.

If a committee member or regular attendee is unable to attend the meeting or send a deputy then a formal summary report of progress made against their areas of responsibility should be given, in advance of the meeting, identifying the key issues that should be raised.

If a member fails to attend two consecutive meetings the Chair of the Committee will speak to the individual. 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.

***Access***

Regardless of attendance, External Audit, Internal Audit and Local Counter Fraud providers will have full and unrestricted rights of access to the Audit Committee (unless there is a conflict of interest (for example their own terms of engagement)).

## 5. Meetings Quoracy and Decisions

The Audit Committee will meet at least four times a year (but may meet more frequently) and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

***Quorum***

For a meeting to be quorate a minimum of two Members are required, including the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

***Decision making and voting***

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If an urgent decision is required in extraordinary circumstances outside of the Committee meeting cycle, every attempt will be made for the Committee to conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Where this is not possible, the powers which are reserved or delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the Lead Executive subject to every effort having been made to consult with as many members as possible in the given circumstances.

In these instances, the following will be circulated/outlined to the committee:

a) The details in respect of the decision required;
b) The response required and associated timescales;
c) Communicate the outcome with the committee members

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and Audit Committee for oversight.

## 6. Responsibilities of the Committee

The Committee's duties can be categorised as follows.

***Integrated governance, risk management and internal control***

To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of NHS GM's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

To review the adequacy of the arrangements for discharging the group's statutory financial duties.

To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of NHS GM's objectives, the effectiveness of the management of principal risks, and will recommend to the Board a course of action on the approval of NHS GM management arrangements as required.

To have oversight of system risks where they relate to the achievement of the NHS GM's objectives.

To ensure that NHS GM acts consistently with the principles and guidance established in HMT's Managing Public Money.

To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

To identify opportunities to improve governance, risk management and internal control processes across NHS GM.

Organisational and system risks identified are shared with the relevant NHS GM Committee(s) and vice versa.

***Risk management***

In addition, the Audit Committee will have the following remit in relation to risk management.

As part of regular reporting, information will be provided to ensure:

- That the Committee has an understanding of how well the risk management process is being embedded within the committees, in particular:
    - Whether risks are being escalated to the Committees
    - Whether risks are being escalated to the Board
- That the Committee has an understanding of how NHS GM are horizon scanning for emerging risks. Sources could include (but would not be limited to): linkage to complaints, locality board risk reporting, possible changes to relevant Government policy, economic background, pandemics etc.
- That the Committee receive the full strategic risk register on a quarterly basis to ensure they have an overview of risk, and are able to monitor the direction of travel of risk scores and progress against mitigations over time to ensure risks are being adequately addressed.
- That by exception, the Committee are able to conduct a deep dive into particular registers or specific risks at a more detailed level where required / appropriate.

***Internal audit***

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;

- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;

- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

- Monitoring the effectiveness of internal audit and carrying out an annual review.

Committee members will meet in private at least twice a year with Internal Audit without other attendees being present.***External audit***

To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work, making recommendations to the Board when necessary. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;

- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;

- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Committee members will meet in private at least twice a year with External Audit without other attendees being present.

***Other assurance functions***

To review the findings of assurance functions in NHS GM, and to consider the implications for the governance of NHS GM.

To review the work of other Committees in NHS GM, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

To review the assurance processes in place in relation to financial performance across NHS GM including the completeness and accuracy of information provided.

To review the findings of external bodies and consider the implications for governance and the control environment of NHS GM. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

***Counter fraud***

To assure itself that NHS GM has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Committee members will meet in private (or with internal audit representatives) at least twice a year with Counter Fraud without other attendees being present.

***~~Freedom to Speak Up and~~ Whistleblowing***

To review the adequacy and security of NHS GM's arrangements for ~~its employees, contractors,~~ external parties or members of the public to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

***Information Governance (IG)***

To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

***Financial reporting***

To monitor the integrity of the financial statements of NHS GM and any formal announcements relating to its financial performance.

To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

On behalf of the Board, to review and approve the NHS GM the annual report and financial statements (including accounting policies) focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Going concern;
- System processes;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

***Conflicts of Interest***

The Chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.

The Committee shall satisfy itself that NHS GM's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with NHS GM policy and procedures relating to conflicts of interest.

Furthermore, the Committee will make recommendations to the Board to approve the arrangements for managing conflicts of interest within NHS GM

***Management***

To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within NHS GM as they may be appropriate to the overall arrangements.

To receive reports of breaches of policy and normal procedure or proceedings, including suspensions of NHS GM's Standing Orders, in order to provide assurance in relation to the appropriateness of decisions and to derive future learning.

The Committee will also recommend a course of action on any disclosure of non-compliance with the group's constitution (incorporating its standing orders, prime financial policies and scheme of reservation and delegation) to the Board as necessary.

***Communication***

To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

To review and formally approve Corporate and Financial policies (which do not fall within the responsibility / remit of any other Committees or the Board) and report to the Board meeting for information.

## 7. Behaviours and Conduct

***NHS GM values***

Members will be expected to conduct business in line with NHS GM values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the NHS GM Constitution, Standing Orders, and Standards of Business Conduct Policy.

***Declarations of Interest***

Members will be aware of what constitutes a Conflict of Interest under the NHS GM Conflict of Interest Policy and must ensure that any such Conflicts of Interest are formally disclosed to the Committee and are subsequently managed in adherence with the policy.

The Committee secretariat will formally record its deliberations in relation to Conflicts of Interest within the Committee minutes. A Register of Interests for the members of the Committee will be established and maintained.

Depending upon the topic under discussion and the nature of a conflict of interest disclosed or identified, the member may be:

- Allowed to remain in the meeting and contribute to the discussion;
- Allowed to remain in the meeting and contribute to the discussion but leave the meeting at the point of decision; or
- Asked to leave the meeting for the duration of the item under consideration.

The Chair shall be responsible for the management of all conflict of interest matters. Members and attendees will be asked at each meeting to declare any new actual or perceived conflicts. In addition, each member will be expected to declare any new or existing conflicts for any items of business for that meeting.

***Equality and diversity***

Members must demonstrably consider the equality and diversity implications of decisions they make.

## 8. Accountability and Reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Audit Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework;
- The completeness and 'embeddedness' of risk management in the organisation;
- The integration of governance arrangements;
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
- The robustness of the processes behind the quality accounts.

## 9. Secretariat and Administration

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

## 10. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: ~~April 2025~~May 2026 (TBC)

Date of review: ~~April 2026~~May 2026

# Meeting of the NW Specialised Services Committee

5th March 2026

## Highlight report of the Chair of the NW Specialised Services Committee

# Highlight report of the Chair of the North West Specialised Services Committee

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| **Committee Chair** | Dr Ruth Hussey, Non Executive Director – C&MICB |
| **Terms of Reference** | Include ICB links to the NWSSC TORs |
| **Date of meeting** | 5th March 2026 |

## Key escalation and discussion points from the Committee meeting

### Alert

- **Neonatal incidents:** A further infection prevention and control outbreak occurred at Saint Mary's (MFT); although now formally closed, a quality visit will review recurring themes and inform future actions.
- **Renal dialysis safety concerns:** Three serious incidents in Renal Dialysis units run by one of the GM system providers, including one fatality. Immediate safety measures have been implemented with investigations ongoing.
- **ICB workforce pressures:** Voluntary redundancy programmes underway across all three ICBs and NHSE, creating significant operational and business continuity risks during structural transition.

### Advise

- **OPIC transition:** National guidance confirms expectations for establishing OPIC ahead of the transfer of specialised commissioning responsibilities to ICBs by April 2027. Work continues to develop OPIC structure, staffing envelope and governance alignment.
- **AAA reporting:** Inconsistencies across the three ICBs were discussed. A single, standard AAA report and a public-facing version (supported by a Part B confidential annex) will be developed.
- **Health Inequalities Strategy:** The Committee approved the new two-year strategy and supporting group Terms of Reference. Preventative and equity-focused commissioning approaches will need to evolve as OPIC design progresses.

### Assure

- **Finance and planning:** Delegated specialised commissioning remains on track to deliver the 25/26 surplus. A balanced financial plan for 26/27 has been submitted, although risks remain subject to final provider negotiations.
- **Quality oversight:** Established escalation routes between regional, national and ICB groups continue to operate effectively.
- **Mental Health:** Regional update provided assurance on secure services, CAMHS and prison transfers, with operational detail escalated through SCOGs and strategic issues reported via the NWSSC.

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| Regional Director Update | • The Committee acknowledged the upcoming handover of the Chair role from Ruth Hussey to Steve Spill.<br>• National delegation and legislative timelines were confirmed, with OPIC development progressing across governance, commissioning, finance, BI and procurement subgroups.<br>• Development of a permanent Adult critical care transfer remains constrained by capital funding issues. Interim arrangements remain in place.<br>• Paediatric critical care SDF is being used non-recurrently to support high volume providers of level 2 activity outside tertiary centres.<br>• Voluntary redundancy outcomes within specialised commissioning teams were noted, with mitigation in place. |
| ICB update | • All ICBs are undergoing structural transition with significant workforce reductions, creating operational pressures.<br>• Work continues across systems on cardiac, vascular, trauma, neonatal engagement and neurorehabilitation services.<br>• Cheshire & Merseyside will take a detailed specialised commissioning/OPIC update to their Board in May due to limited current visibility.<br>• Lancashire & South Cumbria ICB reported improvement in cardiac performance at Blackpool and progress on cystectomy and thrombectomy, supported by the Specialised Commissioning team. |
| Items for decision/endorsement<br>• MIAA Audit Report | • Internal audits across all three ICBs reported substantial assurance.<br>• Improvement areas include the reporting and management of conflicts of interest governance, regular review of the collaboration agreement, reporting and escalation of Specialised Commissioning risks via ICB Boards.<br>• The Committee agreed to develop a standardised, public-facing AAA report. |

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| | **Action:** AB and the team to agree a timeline for the first annual audit report. |
| Quality Update | • Recent neonatal IPC incident at St Mary's Hospital and serious renal dialysis incidents at sites in Wigan and Salford were highlighted.<br>• Quality visit planned for St Mary's neonatal unit to consider longer-term actions.<br>• Positive update: Lancashire Teaching Hospitals' 24/7 thrombectomy service went live in February 2026.<br>•<br>**Action:** AB to share the quality governance SOP with new members. |
| Finance & Planning Update | • OPIC Finance, Procurement and Contracting subgroup now established.<br>• Joint financial planning continues with ICB CFOs, with 26/27 growth allocation of £50.8m (2.8%).<br>• RTT improvements of 7% required for 26/27 with no additional funding until 27/28.<br>• Block deconstruction paused temporarily but will resume for 27/28 implementation.<br>• Committee requested an overview of the final contract and activity position.<br><br>**Action:** AB to present an indicative activity plan summary when finalised. |
| Risks | • Ongoing concerns regarding cardiac surgery capacity at Blackpool.<br>• Progress noted in complex gynaecology.<br>• Some 65-week RTT risks remain but mitigations are in place |
| Mental Health Update | • Pressures remain in (ICB Commissioned) PICU capacity and (Specialised) secure placements.<br>• CAMHS inpatient demand is reducing, enabling potential service redesign.<br>• Temporary closures at Alder Hey's Sunflower House were noted. |

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| | • Committee agreed that NWSSC will retain strategic oversight, with operational detail via SCOGs. |
| NW Specialised Commissioning Health Inequalities and Prevention Strategy 2026-28 | • Terms of Reference and Strategy approved.<br>• Focus on prevention, equity, improved data use, and alignment with integrated needs assessments.<br>• Committee acknowledged excellent quality of work and the need to adapt once OPIC governance is finalised. |
| OPIC Development | • National expectations confirmed; North West allocation equates to £1.24 per head for staffing (£10.8m) which increases to £1.67 when including BI, procurement and COVID funding.<br>• Draft OPIC structure developed, with functions grouped into commissioning and shared enabling rings.<br>• OPIC may also host clinical networks and ambulance commissioning.<br><br>**Action:** AB to provide OPIC Development update in July. |
| Roadmap for evolution of NWSSC | • Committee to evolve into the OPIC Governing Board from October 2026.<br>• Work needed on; membership, subcommittees, updated ToR, Schemes of Delegation, NED roles, and ICB governance alignment.<br><br>**Action:** Establish a task and finish group with AB and ICB governance leads (April–September).<br>**Action:** AB to bring full proposal on future role and structure to the September meeting. |
| Neonatal Critical Care Review update | • Engagement progress: nine staff focus groups completed; parent/carer engagement underway.<br>• Draft long lists for LSC and GM being tested using displacement modelling. |

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| | • Work ongoing to understand Level 2 requirements at Countess of Chester and cot-use trends at Leighton.<br><br>• Alignment with maternity redesign remains essential. |
| AOB | • No additional items were raised under AOB. |

# Minutes

## Greater Manchester Transition Committee

Date: 4 March 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

## (Public)

| Present | Apologies |
|---|---|
| **In attendance:**<br>Rachel Egan (RE) – Non-Executive Director (Chair)<br>Dame Sue Bailey (SB) – Non-Executive Director (Co-Chair)<br>Colin Scales (CS) – Acting Chief Executive and Chief System Reform Officer<br>Sir Richard Leese (RL) – Chair, NHS GM<br>Leigh Vallance (LV) – VCSE Partner Member<br>Prof. Manisha Kumar (MK) – Chief Clinical Officer<br>Richard Paver (RP) – Non-Executive Director and Chair of Audit<br>Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director<br>Chris Gaffey (CG) – Associate Director of Corporate Services<br>Claire Connor (CC) – Director Communications and Engagement<br>Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer<br>Vish Mehra (VM) - GP/Partner Member<br>Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer<br>Kathy Roe (KR) - Chief Finance Officer<br>Gareth Robinson (GR) - Interim Chief Reform and Improvement Officer<br>Nicola Hepburn (NH) - ICB Recovery and Improvement Programme Director<br>Faye Vaughan (FV) – Governance Advisor (Minutes) | Owen Williams (OW) – Chief Executive, NCA<br>Kal Kay (KK) – Non-Executive Director<br>Anthony Hassall (AH) - Chief Executive, Pennine Care NHS Foundation Trust<br>Sean Fielding (SF) – Partner Member<br>Alison Mckenzie-Folan (AMF) – Wigan Place Lead |

| Item No. | Topic | Action |
|---|---|---|
| 1. | **Welcome, Introductions and Apologies**<br><br>RE welcomed everyone to the meeting and the above apologies were noted. | |
| 2. | **Declarations of Interest**<br><br>RE reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared. | |

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| 3. | **Minutes, matters arising and actions from previous meeting held on 4 February 2026**<br><br>The minutes were accepted as a true record of the previous meeting held on 4 February 2026.<br><br>There were no live actions on the action log. | |
| 4. | **Strategic Commissioning Plan: Next Steps and confirming priorities for 26/27**<br><br>The paper was presented to the committee with an update on the Strategic Commissioning Plan, outlining the process for developing outcomes-based programme plans, identifying board priorities, with a particular focus on children and young people.<br><br>It was reported that the strategic commissioning plan had been submitted to NHS England and that commissioning leads were tasked with developing outcomes-based programme plans. It was explained that the plan aimed to ensure that individual programme outcomes would collectively achieve the high-level five-year objectives, with strengthened references to learning disabilities based on feedback.<br><br>The committee were made aware of the use of quadrant analysis to identify priority areas, with a particular emphasis on children and young people due to concerning data on infant mortality, vaccination rates and dental decay.<br><br>The committee were further made aware of the Board Development Session that was due to take place to review data and discuss priority areas, including how to ensure board oversight and leadership for the priorities. It was reported that the session would also consider shifting investment towards children and young people and finalise outcomes-based plans for each programme.<br><br>JN emphasised the need for robust data quality and clear metrics to benchmark improvement. A suggestion was raised to provide the data in advance of the development session for more effective discussions.<br><br>Concerns were raised around maintaining focus on strategic priorities within operational pressures and ensuring that providers and partners were resourced and engaged in delivering the priorities.<br><br>The importance of addressing culture, co-production and system-wide readiness was further raised.<br><br>The committee requested for the feedback to be incorporated on culture, data, market readiness and financial alignment into the agenda for the development session. It was agreed that KS and JN would link in with Data Insight & Intelligence colleagues on data that would be useful for the session.<br><br>**The Committee:**<br>• **Noted the work to strengthen the draft Strategic Plan to create a fully worked through operationally credible plan.**<br>• **Noted the work to confirm Commissioning Intentions for 2026/7.**<br>• **Reviewed and discuss the work to develop priorities for 2026/7.** | |



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| 5. | **Preparations for New Governance – Progress Report**<br><br>The paper provided the committee with an update on the development of NHS GM Committee structure ahead of implementation from April 2026.<br><br>It was reported that further engagement was planned to take place ahead of consideration at the NHS GM Integrated Board on Wednesday 18 March 2026.<br><br>The proposed sub-committee structures for the People & Resources and Strategic Commissioning Committee were outlined, including the scope of each sub-group and the principles for governance. It was reported that the structure had been designed to be leaner, with ongoing work taking place to finalise the Terms of Reference and Workplans.<br><br>A discussion took place regarding the placement of Primary Care Commissioning within the new structure. The need to consider alternative structure options to ensure sufficient board oversight was raised.<br><br>Concerns were raised regarding the committee memberships, the interplay between the sub-committees and the potential risk of the committees working in silos.<br><br>The importance of ongoing review and iteration of the governance structure with checkpoints to assess effectiveness and address duplication or delays was raised.<br><br>**The Committee:**<br>• **Considered the progress to date and next steps set out in the appended slides.** | |
| 6. | **Board Assurance Framework and Risk Report**<br><br>The report provided an update to the committee on the updated strategic risks for the organisation. The report also considered the future Board Assurance Framework (BAF) and corporate risk reporting and proposals on where the risks would be considered from April 2026.<br><br>CG reported an increased risk for workforce and reduced risks for Population Health, Good Employment, Finance and Emergency Incident. The committee questioned the rationale for downgrading risks in Population Health and Good Employment and suggested that risk reductions were premature given the present uncertainties of ongoing reform and transition.<br><br>The proposals for allocating BAF and Corporate Risks to the new People & Resources and Strategic Commissioning Committee were shared. A suggestion was raised to carry out practical exercises to clarify risk ownership and reporting.<br><br>The potential duplication of safeguarding risks was highlighted. It was agreed that both risks would be reviewed and consolidated.<br><br>The committee highlighted the importance to align terminology and ensure that risk management processes remained responsive during the transition.<br><br>It was suggested that the committee would need to review the risk descriptions and reporting structures again once the feedback had been incorporated.<br><br>**The Committee:** | |



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| | • **Considered the updated strategic risk descriptions ahead of the March Board meeting.**<br>• **Considered the reporting split for BAF and Corporate Risks between the two proposed new committees.**<br>• **Noted the work ongoing on BAF risk review and progressing towards dynamic risk reporting.** | |
| 7. | **M10 Finance Report**<br><br>The report provided an update to the committee on the overall Month 10 ICS financial position for Greater Manchester as of 31 January 2026.<br><br>It was confirmed that the system was on track to meet financial targets despite a year-to-date deficit. It was reported that there were improvements in run rate, risk reduction and CIP over-delivery. The ongoing pressures in recovery areas and the need for continued vigilance in the final weeks of the financial year was raised.<br><br>The committee thanked and acknowledged all the work that had taken place from everyone for the significant financial improvement through addressing challenges and issues over the year to get to the current position.<br><br>**For the System Financial position, the Committee:**<br>• **Noted the Month 10 year to date reported financial position for GM ICS of £75.7m deficit, against a planned deficit of £50.9m, resulting in a variance against plan of a £24.8m deficit.**<br>• **Noted the in-month improvement in the deficit position, a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs), a reduction in reported gross risk of £18.4m, a further reduction in net risk of £8.4m for NHS GM as a result of the on-going delivery of recovery plans.**<br>• **Noted that whilst there has been adverse performance against the in-month recovery plan for providers, all trusts have confirmed with NHSE that they will deliver plan and manage any remaining financial risk.**<br>• **Noted the breakeven forecast outturn position in line with NHSE reporting requirements.**<br>• **Noted the year-to-date delivery of CIP as at Month 10 of £500.8m against a plan of £496.6m, an over delivery of £4.1m.**<br>• **Note the forecast capital position is expected to deliver in line with allocation.**<br>• **Noted the risk to the system wide cash position which continues to be closely monitored.**<br>• **Noted that full DSF has been received, and whilst there remains a risk that this is subject to clawback if a balanced position for the system is not delivered, this is low as the system has confirmed that it will deliver the recovery plans and an overall balanced system position.**<br>• **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.** | |
| 8. | **Alert & Assurance Reports from each function area**<br><br><u>Chief Strategy, People and Partnerships Officer:</u> | |



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| | The paper alerted the committee to the impact of recent NHS Reform developments on the workforce and mitigating actions in place.<br><br>The ongoing challenges with staff morale due to reform, low annual leave uptake and the need to encourage staff to take leave was highlighted. It was confirmed that there were measures in place to include communications through managers and leadership as well as allowing some annual leave rollover.<br><br>The committee were made aware of the changes in electronic staff records due to voluntary redundancies that had affected data accuracy for mandatory training. It was reported that soft messaging had taken place to maintain compliance on core modules.<br><br>The committee discussed the role of leadership in modelling healthy work boundaries, supporting staff to take breaks and restoring a sense of control and empowerment.<br><br>**The Committee:**<br>• **Noted the report.**<br><br><u>Chief Commissioning Officer:</u><br><br>KS summarised the key shifts in the Every Child Achieving and Thriving White paper, including broader approaches to children's well-being, changes to the legislative framework for SEND and the requirement for area-based plans to access new funding.<br><br>The delays in appointing a single major trauma clinical lead was raised. The committee discussed the importance of system-wide ownership and ongoing communication with national stakeholders. The need for timely updates to NHS England regarding any reprofiling of implementation timelines was emphasised.<br><br>The implications of the new GP contract were discussed, including the potential collective action and the importance of maintaining strong local relationships. It was agreed that VM and MK would collaborate to clarify local interpretations to ensure clinical pathways were appropriately governed.<br><br>**The Committee:**<br>• **Noted the report.**<br><br><u>Chief Reform and Improvement Officer:</u><br><br>The paper provided the committee with an overview of the issues related to the portfolio of the Chief Officer for System Reform and Improvement.<br><br>**The Committee:**<br>• **Noted the report.**<br><br><u>Chief Clinical Officer Report:</u><br><br>The paper provided the committee with an overview of NHS Greater Manchester statutory duties during a period of organisational and governance transition.<br><br>The committee were informed of the recent cases of children with complex trauma or safeguarding histories, but no acute health needs that had been placed in | |

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| | hospital beds due to lack of suitable placements. The committee discussed the need for intensive wraparound care and improvement approaches similar to those used for Mental Health crises, with commitment to further collaborative work involving local authorities and place-based teams.<br><br>**The Committee:**<br>• **Received and noted the updates on key statutory linked quality and safety matters.**<br>• **Supported the system wide actions underway, including urgent workstreams, Trust improvement plans, and programme redesign activity described in the report.**<br>• **Agreed that continued monitoring of these areas is undertaken through established governance mechanisms, with escalation to the Transition Committee where risks increase or additional decision making is required.**<br>• **Endorsed the approach to embedding learning from recent incidents and regulatory findings across NHS GM and partner organisations.**<br><br><u>Medicines Optimisation & Strategic Commissioning 2026/27:</u><br><br>The paper provided an overview of the Medicines Optimisation Horizon Scanning process and its growing strategic importance during a period of significant financial and operational pressure.<br><br>The paper also described how medicines optimisation was becoming a strategic commissioner of medicines across the system and how that would improve the lives of the population and contribute to a left shift investment.<br><br>The committee were informed of the centralisation of the medicine's optimisation team, the use of horizon scanning to align budget setting with anticipated prescribing needs and the achievement of significant cost improvements.<br><br>The need for strategic commissioning to support long-term health outcomes was also highlighted.<br><br>The committee agreed on the importance of viewing medicines as therapeutic interventions rather than solely cost pressures.<br><br>VM declared an interest in the item as the Chief Medical Officer at Health Innovation Manchester.<br><br>The committee questioned the management of medicines budgets within a constrained financial envelope, the impact of external factors on drug pricing and the risks of overspending. It was explained that a collaborative approach to budget setting, the use of horizon scanning and ongoing national discussions regarding the adequacy of budget uplifts for prescribing were taking place.<br><br>The importance of patient engagement in medicines optimising to address concerns and ongoing communication efforts was raised.<br><br>**The Committee:**<br>• **Noted the contribution of the 2025/26 Horizon Scanning analysis and its contribution to financial sustainability and significant CIP contrition to the GM health economy.**<br>• **Endorsed the Horizon scanning analysis undertaken for 2026/27 by the NHS GM Medicines Optimisation team including the financial** | |



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| | **pressures, cost improvement opportunities and associated budget setting methodology, with a minimum funding requirement of £605.9m (circa 4.3% uplift) reflecting the absolute baseline budget, but not including several risk scenarios (requirements ranging from £650.2m–£754.7m), including NG28 uptake.**<br>• **Recognised the impact of Horizon scanning on system wide priorities including the GM Clinical Strategy, Long Term Conditions programmes of work, the prevention and the "Left Shift" agenda. This will inform the development of the medicines and pharmacy strategy as a key enabler to ensure affordability, sustainability, and left shift investment.**<br>• **Supported the development of a Medicines and Pharmacy strategy aligned to the clinical strategy to be submitted to a future meeting.** | |
| 9. | **Any other business**<br><br>None were raised. | |



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NHS Greater Manchester

# Minutes

## Greater Manchester Strategic Commissioning Committee

Date: 1 April 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

## (Public)

| Present | Apologies |
|---|---|
| **In attendance:**<br>Dame Sue Bailey (SB) – Non-Executive Director (Chair)<br>Prof. Manisha Kumar (MK) – Chief Clinical Officer<br>Ben Squires (BS) - Director of Primary Care (deputising for Katherine Sheerin)<br>Leigh Vallance (LV) – VCSE Partner Member<br>Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director<br>Chris Gaffey (CG) – Associate Director of Corporate Services<br>Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer<br>Kathy Roe (KR) - Chief Finance Officer<br>Nicola Hepburn (NH) – Acting Chief Reform and Improvement Officer<br>Paul Lynch (PL) – Director of Strategy<br>Faye Vaughan (FV) – Governance Advisor (Minutes) | Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer<br>Rachel Egan (RE) – Non-Executive Director |

| Item No. | Topic | Action |
|---|---|---|
| 1. | **Welcome, Introductions and purpose of first meeting**<br><br>SB welcomed everyone to the first Strategic Commissioning Committee meeting. The above apologies were noted.<br><br>It was explained that the purpose of the committee would be to obtain assurance on behalf of the ICB Board, that the ICB had the right commissioning strategy and approach, supported by intelligence, delivering its quality performance, population health and oversight functions, whilst ensuring that the ICB operated as a strategic commissioner.<br><br>The importance of alignment, collaboration and co-design was emphasised. | |
| 2. | **Declarations of Interest**<br><br>SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared. | |



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| 3. | **Minutes from Transition Committee meeting held on Wednesday 4 March 2026**<br><br>The minutes were accepted as a true record of the previous Transition Committee meeting held on 4 March 2026. | |
| 4. | **Terms of Reference – Update & Next Steps**<br><br>The report provided the committee with the Terms of Reference for the Strategic Commissioning Committee that were approved by the ICB Board in March 2026.<br><br>It was explained that a three-month post-implementation review of the two newly established committees would be conducted to further identify areas of potential improvement and amendment to the arrangements, which may include further changes to the Terms of Reference. It was confirmed that any changes would be considered by the committee, before consideration by the ICB Board for approval.<br><br>**The Committee:**<br>• **Noted the Committee Terms of Reference (Appendix One).** | |
| 5. | **Sub Groups & Draft Workplan – Introductory Discussion**<br><br>CG informed the committee of the discussions that had taken place with committee Chairs and Chief Officers regarding the establishment of supported governance, noting that existing subgroups would continue to meet statutory requirements and that reporting would be assurance focused and thematic. It was confirmed that the work plan would be developed in alignment with the five-year commissioning strategy and committee priorities.<br><br>CB emphasised that place partnerships governance remained part of the constitution and should continue reporting to the committee until any changes were made, highlighting the importance of maintaining alignment and collaboration.<br><br>MK suggested the need to review the committees effectiveness in the summer, including a reflection on whether the business had aligned with the committees strategic positioning and how sub-governance was used in the most effective way with the right partners. | |
| 6. | **Board Assurance Framework and Risk Report**<br><br>The report confirmed the Board Assurance Framework (BAF) and Corporate Risks that would be considered by the newly established Strategic Commissioning Committee (SCC).<br><br>As a new committee of the ICB Board, it was explained in the paper that the committee would be responsible for consideration and monitoring of these risks and to provide the ICB Board with the appropriate assurance that they are being appropriately managed.<br><br>Two key areas highlighted to the committee:<br>**SR4 (Good Employment) & SR9 (Emergency Incidents):** Reduced risk scores due to improved staffing and resilience.<br>**SR5 (Health Inequalities):** Showed variation that would be analysed and reported back to the committee at the next meeting in May 2026. | |



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| | The outlined plans for the improvements in the risk reporting were shared with an aim to ensure risk narratives would be more meaningful and dynamic, with regular updates and alignment to committee objectives.<br><br>The committee were asked whether a deep dive should be conducted by the Audit Committee, noting the workload implications. The committee supported maintaining deep dives at the Audit Committee, however, emphasised open communication around resource impacts would need to continue.<br><br>JN suggested integrating performance data with risk assurance to move beyond meetings as sources of assurance and leveraging the committees rich data to strengthen the BAF and statutory compliance.<br><br>LV highlighted the need to ensure that the voluntary sector were not overlooked in risk and assurance planning, noting their ongoing challenges and contributions to system targets.<br><br>**The Committee:**<br>• **Considered the risks presented in the report.** | |
| 7. | **Chief Officers Update Reports**<br><br><u>Chief Clinical Officer Report:</u><br><br>The report provided assurance on how the ICB Board was discharging its statutory duties for quality, safety and clinical governance across the organisation and the system as a whole. It brought together intelligence from established governance routes and demonstrated how statutory clinical governance and quality functions were being exercised to identify and manage risk, reduce unwarranted variation, and support safe, effective and equitable care across Greater Manchester.<br><br>MK outlined the plans for future thematic reporting covering population needs, quality and service transformation and the identified paediatric audiology as a top risk area, with ongoing cross Northwest efforts to mitigate risks.<br><br>The committee were made aware of the new guidance on corridor care, with the systems ambition to eliminate corridor care, especially for vulnerable groups and plans for nursing-led walk round to ensure compliance.<br><br>The committee were further informed of the recent work from the Clinical Effectiveness and Governance Group (CEG) on policies for drugs of low clinical value and a system-wide plan to reduce non-best practice prescribing.<br><br>It was reported that there was a Prevention of Further Deaths review which highlighted gaps in shared care protocols, prompting a commitment to review and update all out-of-date protocols and improve patient information at the point of care, with feedback provided to NHS England and the coroner.<br><br>MK also informed the committee of updates on the Clinical Transformation and Dementia Strategy, including direct access MRI to reduce neurology wait times, a new cancer model and the regions strongest performance in dementia diagnosis with ongoing co-production and prevention initiatives.<br><br>**The Committee:**<br>• **Noted the identified patient safety risks highlighted within the report,** | |



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| | **including paediatric audiology, specialised renal services and corridor care, and to support continued system-level oversight and escalation through established provider assurance, regional review and executive governance routes, in line with national expectations and GIRFT Clinical Operational Standards.**<br>• **Noted the findings and advice arising from independent reviews and external assurance, particularly in relation to mental health services and provider-led improvement, and to support the continued development of ICB capability and capacity to provide robust clinical quality oversight during ongoing system change.**<br>• **Endorsed the recommendations previously approved by the Clinical Effectiveness and Governance Committee, including Greater Manchester Medicines Management Group decisions and Clinical Policy Audit and Standards recommendations, and to note the assurance gained from national clinical audits and the agreed approach to ongoing monitoring and improvement.**<br><br><u>Chief Commissioning Officer:</u><br><br>NH informed the committee of the participation in the NHSE led strategic programme, including the commissioning academy, leadership development and the commissioning intelligence centre, with collaborative development and external funding.<br><br>The committee were also made aware that the ICB would be an early adopter for SEND Reform, emphasising the development of 10 local SEND reform plans with active partnership with local authorities. The importance of leveraging local expertise was raised.<br><br>NH further reported the positive review by the Northeast Clinical Senate of arterial, vascular and cardiac surgery reconfiguration which was shared with written feedback pending and recognition of national alignment and collaborative approaches.<br><br>NH noted the finalisation of commissioning intentions with a focus on prevention, primary and community care and reported improvements in cancer and early diagnosis performance, ranking highly among cancer alliances.<br><br>**The Committee:**<br>• **Noted the report.** | |
| 8. | **Strategic Commissioning Plan – Assurance Approach & Reporting Cycle**<br><br>The report set out a simple framework for how the Strategic Commissioning Committee received assurance regarding progress being made towards delivery of the Strategic Commissioning Plan.<br><br>PL presented the next steps for the strategic commissioning plan, including programme milestones, reporting cycles and alignment with place outcomes.<br><br>The process for detailing programme milestones and outcomes was outlined, proposing a flexible reporting cycle to bring major themes to the committee and seeking committee feedback on the approach.<br><br>MK recommended sub-segmenting large programmes such as mental health for detailed work plans, adding womens health and diagnostics as priorities and | |



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| | ensuring reporting reflected the full commissioning cycle.<br><br>The committee advocated incorporating lived experience and alternative reporting formats such as videos and community stories to provide assurance on outcomes with support from the voluntary sector to facilitate.<br><br>**The Committee:**<br>• **Considered and confirmed the proposal for how the Strategic Commissioning Committee receives assurance regarding progress being made towards delivery of the Strategic Commissioning Plan.** | |
| 9. | **Place Outcomes Framework / Outcomes Driven Commissioning**<br><br>It was explained that the outcomes framework was nearing final draft, with alignment to neighbourhood plans and health and well-being boards. It was confirmed that the governance recommendations would clarify accountability and the relationship between place partnerships and NHS GM.<br><br>LV suggested developing co-production guidance and integrating the newly agreed accord into place partnerships. It was confirmed that there were ongoing engagement and plans to bring all elements together for locality review.<br><br>The need for a shared narrative, quantifying contributions from all sectors, including the voluntary sector and managing the systems collective resources to drive outcomes and reduce inequalities, with ongoing work to engage all collaboratives was emphasised. | |
| 10. | **Performance Report**<br><br>The report provided an update on Greater Manchesters progress in achieving NHS operational planning goals, including outlined significant risks faced by providers along with key improvement actions and a summary of quarter 3 Locality Assurance Meetings (LAMs).<br><br>The committee were provided with the year-end updates showing improved Urgent and Emergency Care performance approaching 75% and progress on elective standards with ongoing efforts to address challenges in specific Trusts and service areas, including mutual aid and industrial action planning.<br><br>The committee thanked all involved.<br><br>**The Committee:**<br>• **Agreed the recommended status of partial assurance.**<br>• **Agreed the levels of assurance and delivery risks.** | |
| 11. | **Winter Vaccination Update**<br><br>The report provided an updated overview of the Greater Manchester position on winter vaccinations for the 2025/26 programme, covering seasonal influenza (flu), COVID-19 and respiratory syncytial virus (RSV). It built on the previous paper presented to the Quality & Performance Committee in November 2025 and reflected the end of season delivery position, emerging risks and additional assurance relating to communications and engagement activity.<br><br>MK detailed the high uptake in flu and maternal vaccinations, successful COVID delivery and targeted approaches for underperforming groups, including | |



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| | commissioning additional services and tailored community engagement.<br><br>It was explained that the programme used tailored communications strategies, recognising that trusted influencers vary by community and committed to addressing health inequalities by analysing uptake data and adapting approaches for different groups.<br><br>MK flagged the upcoming transition to the Office of Pan ICB Commissioning (OPIC) and the need to maintain neighbourhood health focus and population health management, with plans to continue reporting on statutory health protection functions.<br><br>JN suggested leveraging social housing providers and large employers for outreach. It was agreed that they would pursue these opportunities and reference existing agreements to support prevention and screening initiatives.<br><br>**The Committee:**<br>• **Noted the end of season current position against winter vaccination uptake trajectories across flu, COVID-19 and RSV, and the ongoing actions in place to support delivery and the continued improvements in uptake across all population groups and localities in 2026/27.**<br>• **Noted the emerging and ongoing risks to achieving the current and future uptake ambitions in specific cohorts, and the governance and escalation arrangements in place to manage these.**<br>• **Noted the scale and reach of the 2025/26 winter vaccinations communications and engagement campaign, and the early evidence of impact from this activity for utilisation.** | |
| 12. | **Any other business**<br><br>None were raised. | |



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# Minutes

## Greater Manchester Audit Committee (Part A)

Date: Thursday 19 March 2026

Time: 11.00am to 13.00pm

Venue: 5th Floor, Tootal Buildings, Manchester

| Present | | |
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| **Members:** | | |
| Richard Paver | RP | Non-Executive Director and Audit Committee Chair, NHS GM |
| Sue Greenhill | SG | Independent Member |
| Jackie Njoroge | JN | Deputy Chair/Senior Independent Director |
| **Attendees / Participants:** | | |
| Kathy Roe | KR | Chief Finance Officer, NHS GM |
| Charlotte Bailey | CB | Chief Strategy, People and Partnerships Officer, NHS GM |
| Chris Gaffey | CG | Associate Director of Corporate Services, NHS GM |
| Izhar Chaudhary | IC | Associate Director of Finance – Financial Assurance, NHS GM |
| Sam Evans | SE | Corporate Director of Finance – Commissioning & Financial Assurance, NHS GM |
| Kaye Abbott | KA | Associate Director of Finance – Financial Control, NHS GM |
| Patrick Clark | PC | Senior Audit Manager, MIAA |
| Darrell Davies | DD | Regional Assurance Director, MIAA |
| Paul Bell | PB | Head of Anti-Crime Services, MIAA |
| Michael Green | MG | Engagement Partner, Grant Thornton |
| Perminder Sethi | PS | Senior Manager, Grant Thornton |
| David Boulger | DB | Associate Director – Population Health, NHS GM, Item 16 |
| David Dobson | DD | Head of Business Management, NHS GM Counter Fraud Champion |
| Ross Baxter | RB | Governance Advisor, NHS GM (minutes) |
| **Apologies:** | | |
| Anthony Hassall | AH | Partner Member bringing the perspective of Mental Health Providers, Chief Executive of Pennine Care NHS Foundation Trust |
| Stephen Downs | SD | Deputy Chief Finance Officer, NHS GM |

| | Topic | Action |
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| 1. | Welcome, Introductions and Apologies<br><br>The Chair welcomed members and attendees to the meeting. | |
| 2. | Declarations of Interest (DOI)<br><br>RP reminded Committee members of their obligation to declare any interest relating to items on the agenda. No interests were declared. | |
| 3. | Minutes from the last meeting<br><br>The minutes of the last Audit Committee meeting on 11 December 2025 were approved as an accurate record. | |
| 4. | Action Log<br><br>The action log was reviewed noting that updates had been provided against the open actions, with any closed actions recorded on the log. | |
| 5. | Internal Audit Progress Report<br><br>The committee received an update on internal audit activity since the previous meeting in December. Community Pharmacy, Training & Development, Continuing Healthcare (CHC) and ESR Payroll reviews had been finalised.<br><br>Four further reviews were at draft stage awaiting management responses, including work on procurement, key financial controls and financial reporting. Fieldwork was progressing well, and draft reports were expected within the next month. The only review yet to begin was the Data Quality which had suffered delays but was now being chased to get underway promptly. The committee noted that overall delivery stood at around 82% of planned audit days to the end of February. Appendix B continued to show a high number of recommendations in progress, with no significant movement since December.<br><br>Committee members also raised concerns about longstanding actions, including data-quality issues that had been highlighted multiple times by external auditors. These were acknowledged as urgent, with senior leads expected to pick them up and provide updates to ensure progress does not continue to drift.<br><br>**NHS GM Audit Committee noted the contents of the report.** | |
| 6. | Internal Audit Follow Up Report<br><br>The committee reviewed the Internal Audit Follow-Up Report, noting that a significant number of recommendations remain outstanding, with 63 still in progress, including 8 high-risk and 34 medium-risk items. Although 21 recommendations are not yet due, either because their original or revised deadlines have not passed, the remaining 36 recommendations are overdue, with | |

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| | revised timelines recently issued for 11 of them. The committee recognised that organisational reform and capacity pressures have hindered progress, but concerns were raised about the age and volume of some actions, particularly those repeatedly flagged across previous cycles.<br><br>Members emphasised the need for an honest assessment of what is realistically deliverable, suggesting that management bring forward proposals to close off outdated or impracticable actions, provided the associated risks are fully considered. Specific worries were highlighted regarding stalled health and safety actions, especially given examples of lone-working risks and the temporary standing down of the Health and Safety Oversight Group during reform, and the committee asked for assurance from senior leadership on the adequacy of current arrangements.<br><br>The discussion concluded that directorate functions should reassess their recommendations as part of the wider organisational transition, with updates escalated through the Chief Officers meeting. While April may be too soon to complete this work, the committee requested progress updates between meetings if necessary, stressing the importance of avoiding another year-long cycle of limited movement.<br><br>**NHS GM Audit Committee noted the contents of the report.** | |
| 7. | <u>Annual Internal Audit Plan</u><br><br>The committee held a thorough discussion on the development of the Annual Internal Audit Plan for 2026/27, centred around a long-form planning document outlining all potential audit reviews identified through risk assessment and consultation with chief officers. The plan was built on a 250-day audit allocation, plus anticipated carry-forward days from deferred work, and included both mandatory core audits and optional risk-based reviews.<br><br>Members emphasised the need to ensure the plan reflects the organisation's current transition, noting that some proposed reviews were based on the "old operating model" and may no longer be appropriate. Several chief officers have already provided feedback recommending changes to priorities, and more input is expected to refine which areas genuinely need assurance versus those where capacity constraints make audits impractical or duplicative of known issues.<br><br>The committee stressed the importance of avoiding a plan that is either unrealistic or heavily back-loaded, as this would place undue pressure on directorates, especially during the early phases of restructuring. They agreed that chief officers must take a "helicopter view" across all directorate submissions to ensure the final plan focuses on the highest-risk areas, aligns with organisational readiness, and maintains room for contingency audits. Members also discussed the importance of internal audit using data analytics and potentially AI-supported methods where suitable to reduce the burden on teams.<br><br>There was consensus that the plan requires further refinement before formal approval, either at the April meeting or via circulation between meetings, once Chief Officer reviews are complete and audit days have been rebalanced toward | |

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| | realistic and meaningful priorities, as well as engagement with Committee Chairs.<br><br>**NHS GM Audit Committee noted the contents of the report.** | |
| 8. | <u>Draft Head of Internal Audit Opinion and Annual Report</u><br><br>The Draft Head of Internal Audit Opinion was presented for information. The Regional Assurance Director (MIAA) advised that at this stage no formal opinion could be provided, and the current position was presented due to NHSE requirements for a submission in March. A formal Draft Head of Internal Audit Opinion would be presented to the Committee at the April meeting, followed by the final opinion in June in line with the annual reporting requirements. | |
| 9. | <u>Internal Audit Charter</u><br><br>This was noted for information. | |
| 10. | <u>Counter-Fraud Progress Report</u><br><br>This report provided a summary of anti-fraud activities undertaken from 1 September 2025 – 30 November 2025.<br><br>The committee received an update on counter-fraud activity covering programme delivery, national intelligence alerts, investigations and priority risk areas. The counter-fraud lead highlighted progress against the 12 components of the mandatory NHS Counter Fraud Standards, noting that last year's declaration of interest compliance component, previously rated Amber, had improved, with current training completion levels at around 88%, putting the organisation on track for a Green position by May.<br><br>A significant portion of the discussion focused on recent national developments: NHS Counter Fraud Authority has issued seven fraud prevention notices in just four months, a substantially higher volume than usual, reflecting a rise in national threats. Notable alerts included corporate impersonation fraud, where organised crime groups create Companies House registrations mimicking care homes to facilitate mandate-fraud attempts, and risks associated with MARS schemes. These alerts have been cascaded internally, with further communication planned to ensure frontline awareness.<br><br>The report also covered ongoing workstreams, including a corporate progress assessment aligned to new national templates and joint work with Greater Manchester Mental Health relating to Section 12 Mental Health Assessment claims, which had been delayed while awaiting additional information. Nine referrals were received during the period, covering patient, provider and personnel-related concerns from various reporting sources.<br><br>One long-running investigation was being closed after no evidence of fraud was found despite extensive enquiries, while a new case was being opened concerning a Personal Health Budget (PHB) direct payment in Trafford involving a six-figure unspent balance; this may require civil recovery with support from NHS CFS financial investigators. | |

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| | Committee members expressed concern about broader assurance on PHB controls, given the high materiality of some packages and known inconsistencies across localities. Management acknowledged the risks and explained ongoing work to standardise PHB oversight under the new operating model, including consistent audit frequencies, strengthened agreements, and improved collaboration with local authorities. Counter-fraud colleagues noted that PHBs remain an area of national focus and that additional training and awareness activities are already planned to reinforce controls across the system.<br><br>An action was taken to confirm the exact number of PHB direct-payment cases across localities, but this was confirmed later in the meeting as 700.<br><br>**NHS GM Audit Committee noted the update.** | |
| 11. | <u>Annual Work Plan for Counter-Fraud Activity</u><br><br>The committee reviewed the draft Annual Work Plan for Counter-Fraud Activity, which sets out the key priorities and mandated areas of work for the coming year. The counter-fraud lead explained that the plan must balance compliance with national Counter Fraud Standards, locally emerging risks, and the organisation's shifting operating model. Core elements include updating the fraud risk assessment, completing the scheduled Local Proactive Exercise (LPE) focused on Personal Health Budget (PHB) direct payments, and finishing the joint review with Greater Manchester Mental Health on Section 12 mental health assessment claims early in quarter one.<br><br>A strong emphasis was placed on fraud awareness and prevention, with targeted training planned for CHC and PHB teams, areas repeatedly identified as vulnerable to fraud and error, as well as refreshed support for primary care providers, who remain at heightened risk from organised crime groups. The plan also includes enhanced fraud-proofing work, such as strengthening PHB user agreements and supporting new "no purchase order, no pay" controls.<br><br>Given the surge in national fraud prevention notices and intelligence reports, the committee recognised the need for more systematic follow-up of alerts, ensuring management compares current controls against national guidance and undertakes additional testing where required. Discussion also covered the need to align the work plan with operational capacity and the forthcoming organisational restructure, ensuring counter-fraud activity remains visible, proportionate and responsive to emerging threats. The overall intent of the plan is to provide a balanced programme that both meets mandatory standards and targets areas of highest local exposure.<br><br>**NHS GM Audit Committee noted the update.** | |
| 12. | <u>Counter-Fraud Champion Update Report</u><br><br>The committee received an update from the Counter-Fraud Champion (CFC), who outlined several key points regarding potential organisational vulnerability, | |

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| | governance expectations and forthcoming work. The CFC highlighted concerns about organisational vulnerability during ongoing restructuring, reinforcing the earlier discussion that change creates heightened exposure to fraud risks emphasised the importance of retaining an external expert to provide independent scrutiny and balance to the champion role, ensuring proper oversight and guidance throughout the transition.<br><br>Reference was made to earlier discussions at Extended Leadership Team (ELT) regarding the need to share and embed the counter-fraud agenda more consistently across directorates, including the cascade of relevant updates through the ELT. The CFC also drew attention to specific sections of the report, most notably those relating to awareness, training and reporting structures, underscoring that these require active engagement from leadership to remain effective during periods of flux. Committee members were invited to provide comments and feedback on the annual work plan ahead of the next formal report in September, signalling the intention to incorporate insights early rather than wait for the next reporting cycle.<br><br>A clarification was also given around date references, confirming that material labelled September 2024 referred to the CFC's first formal update under the current standards framework. Finally, questions were raised about whether existing counter-fraud training sufficiently covers cyber-related threats, including phishing and identity fraud, particularly relevant given staff turnover and shifting responsibilities, and it was confirmed that cyber-fraud awareness is integrated into training and reinforced by supplementary alerts issued across the organisation.<br><br>**NHS GM Audit Committee supported the continued programme of work of the counter fraud agenda and the Counter Fraud Champion's work as detailed within the report** | |
| 13. | <u>External Audit Plans and Fees</u><br><br>The committee received an overview of the External Audit Plan and associated fees, with external audit outlining the key areas of focus for the 2025/26 financial statements. Two significant audit risks were highlighted: the mandatory assessment of management override of controls, which all auditors must examine each year, and the implementation of the ISFE2 ledger transition, which took place on 1 October 2025 and requires assurance over data transfer integrity and the accuracy of information feeding into the year-end accounts.<br><br>It was explained that materiality is £186.8m equating to 2% of forecast gross operating costs. There is a separate materiality for the remuneration report. Early planning and interim testing conducted in February and early March had gone reasonably well, but the auditor noted potential pressures arising from the organisation's transition and workforce reductions.<br><br>The committee discussed the implications of structural change on audit readiness, with auditors flagging that the timely preparation of working papers could be at risk once staff departures take effect. Management responded that they had identified key staff as "critical" and extended their employment dates | |

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| | accordingly, though they acknowledged there would still be significant pressure, given that around one-third of finance staff are leaving through voluntary redundancy.<br><br>The discussion also touched on the stability of financial control functions, which were considered more resilient, and on the need for strong handover processes in localities whose finance teams are being restructured. Members raised concerns about the calibre and capacity of remaining staff; management confirmed that performance management and close oversight would be essential during the transition. The auditors will continue to monitor progress and escalate issues promptly if delays or gaps emerge.<br><br>**NHS GM Audit Committee reviewed and approved the audit plan and fees.** | |
| 14. | <u>Informing the risk assessment 2025/26</u><br><br>The committee considered the draft Informing the Risk Assessment for 2025/26, which outlines the key areas of potential financial reporting risk ahead of the external audit. It was explained that the overall risk profile remains broadly consistent with the previous year, with no anticipated changes to accounting policies.<br><br>The most significant area continues to be prescribing, which, as in prior years, remains a substantial source of financial estimation uncertainty. The risk assessment has been updated to reflect two major organisational developments: the transition from the ICB to a single ledger system and the extensive workforce reform process currently underway, including the deployment of exit packages. These changes required input from multiple functions, namely fraud, governance, and senior finance leads to ensure the assessment aligns with operational realities and emerging risks.<br><br>The committee noted that the methodology used to assess prescribing risk remains unchanged and is considered robust. Management confirmed that the document would be shared with external auditors to support their planning and enable early identification of areas requiring additional scrutiny. No major concerns were raised by the committee, but the importance of maintaining strong controls and oversight during the structural transition was emphasised to ensure the accuracy and integrity of the year-end financial statements.<br><br>**NHS GM Audit Committee reviewed and approved the management responses provided.** | |
| 15. | <u>Annual Auditors' Letter Recommendations Update</u><br><br>The committee reviewed progress against the recommendations in the Annual Auditors' Letter, noting that the position had advanced since the previous update in December. Management reported that recommendations 1 and 3 had now been fully implemented, reflecting tangible movement since the last cycle. The remaining recommendation, relating to data quality, was still in progress, and progress updates had been gathered from all relevant senior leads. | |

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| | It was confirmed that Grant Thornton had begun the substantive work required for this year's annual audit, meaning that evidence of implementation would be independently tested as part of the forthcoming audit fieldwork. The committee noted that the outstanding data-quality recommendation linked closely with wider concerns raised elsewhere in the meeting, including the backlog of long-standing internal audit actions and the organisation's need for more robust, consistent data standards.<br><br>Members reiterated the importance of resolving this issue promptly, particularly given its cross-cutting impact on risk reporting, performance assurance and financial governance. Management confirmed that updates would continue to be monitored and escalated where necessary as part of audit preparation, and that progress on the remaining recommendation would be revisited once the external auditors had completed their next round of validation.<br><br>**NHS GM Audit Committee discussed and noted the updates on the implementation of recommendations.** | |
| 16. | <u>BAF Risk – Deep Dive</u><br><br>The deep dive focused on a major Board Assurance Framework risk relating to the wider determinants of health and the economic conditions affecting population outcomes. The paper was introduced by explaining that the purpose of the session was twofold: firstly, to reflect on how the risk had been managed to date, and secondly, to explore how the organisation could adopt a more dynamic and forward-looking approach to managing complex, multi-agency risks under the new operating model.<br><br>It was reinforced that this was a "global" risk where many drivers sit outside the direct control of the ICB, making strong partnerships essential, previously facilitated through the Population Health Committee, which had a notably wide membership. The discussion highlighted important learning: while strategies and multi-agency plans had been established, the mitigations often focused on process rather than evidence of actual impact.<br><br>Committee members stressed that assurance must be rooted in measurable outcomes rather than governance structures alone, questioning how the organisation could demonstrate that mitigations were working and who held true ownership of such a broad risk. Concerns were raised about the potential for shared accountability to lead to diffusion of responsibility, and members emphasised the need for clearer alignment between mitigations, partner roles and measurable change. Several pointed out that improvements in reporting agility, especially on population health outcomes, depend on better data flow from partners and thoughtful prioritisation of what to measure.<br><br>There was also debate around the challenge of evaluating population-level interventions, which often require long timeframes and can involve identifying the absence of harm rather than the presence of change. Examples such as smoking cessation initiatives were used to illustrate how targeted evaluation can reveal unexpected inequalities and reshape future interventions. | |

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| | Members further highlighted recurring themes across the organisation: many risks show limited movement, yet assurance ratings remain overly positive; actions frequently lack evidence of impact; and an overly committee-driven approach can obscure whether real progress is being made. The group agreed that a revised approach to risk management is needed, one that prioritises measurable outcomes, clarifies ownership, uses dynamic data dashboards, and ensures deep dives occur primarily within the relevant committees before coming to Audit Committee for overarching assurance.<br><br>Lastly, issues were raised regarding the inconsistent risk scoring history, with members noting the need for clearer tracking of how and why scores change over time. Overall, the session was viewed as a constructive first step toward a more rigorous, evidence-based and partnership-driven approach to managing complex system-wide risks.<br><br>**NHS GM Audit Committee noted the contents of the report and provided feedback on the reflections contained within it.** | |
| 17. | <u>Terms of Reference</u><br><br>The committee undertook a review of its Terms of Reference in preparation for the new financial year, noting that the recent organisational governance review, while comprehensive for other committees, had not included Audit Committee within its scope. As a result, only targeted updates were required. Two specific amendments were identified: first, references to “Freedom to Speak Up” needed removal, as those responsibilities would sit under the newly formed People & Resources Committee; and second, the role of regular attendee should be updated from the Deputy Chief Executive to the newly designated Chief Officer for Strategy, People and Partnerships, who now holds portfolio responsibility for governance.<br><br>Members expressed interest in ensuring consistency across the ToR for the three corporate committees and sought reassurance that no key duties or assurance areas had been missed in the redistribution of responsibilities. It was explained that the two new committees had very broad scopes, and a three-month period of operational bedding-in was planned to test whether all areas of assurance were properly captured before finalising any further ToR changes.<br><br>Members highlighted the long-standing issue that areas such as IT and digital often fall between committees, emphasising the need for clear accountability and visibility. A further point was raised about attendance transparency, with the suggestion that the ToR should strengthen expectations around attendance at the Audit Committee by invitees, particularly the Chief Executive, Chair, and People & Resources Committee Chair, rather than simply listing them as optional attendees. Management agreed this could be tightened and confirmed that these individuals had already been asked to attend the June meeting.<br><br>It was agreed that the minor amendments would be incorporated, consideration would be given to strengthening attendance requirements, and the updated ToR would be presented to the Board for approval. | |

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| | **NHS GM Audit Committee reviewed the proposed changes and recommended them to Board for approval, subject to the above amendments.** | |
| 18. | <u>M9 Accounts Update</u><br><br>The committee reviewed the Month 9 (M9) Accounts Update, noting that the submission to NHS England had been completed on time and that reconciliation work, particularly agreement of balances with NHS provider organisations, had gone through multiple iterations to ensure accuracy. The accompanying M9 accounts pack, which mirrors the structure used for the annual report, was shared for information even though it was not required for submission at this stage.<br><br>Several technical issues identified during the M9 preparation were highlighted, including mapping inconsistencies within the ledger and pension-related entries that made year-on-year comparisons appear distorted, noting that these would be corrected for the Month 12 (year-end) position.<br><br>The committee also discussed the ICB's persistent negative balance sheet, a typical feature for commissioning bodies because cash is received after liabilities fall due, but one that has been made more prominent by recent cashflow pressures. Management reported that additional cash had been successfully drawn down, £80m initially, with a subsequent request for £22m approved, to ensure timely provider payments and stabilise liquidity.<br><br>Members queried the implications of redundancy and exit-payment accruals, and it was confirmed that these are accounted for even before cash is paid, as they meet the definition of obligations once decisions are made. Further questions were raised about potential deficit support funding (DSF) clawback, which would depend on both ICB and provider organisations' final audited positions. Grant Thornton explained that they would only reflect such adjustments if formally notified following completion of audits, and management noted that all providers currently anticipate meeting their control totals.<br><br>The committee acknowledged that year-end movements might still occur but that material deviations were considered unlikely based on historic patterns. Overall, the update reflected steady progress toward final accounts preparation, while also signalling areas requiring close management as the organisation moves into the final quarter.<br><br>**NHS GM Audit Committee noted the Month 9 Draft Accounts submission for NHS GM.** | |
| 19. | <u>Review changes to standing financial instructions/prime financial policies and changes to accounting policies</u><br><br>There were no changes to note. | |
| 20. | <u>Organisational Capacity/Resilience Briefing</u><br><br>The committee discussed the organisation's current capacity and resilience | |

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| | position, recognising that the system is operating under intense pressure due to the scale and pace of the ongoing restructuring programme. Management acknowledged that significant organisational change is consuming a large proportion of leadership and operational time, around 80–90% for some roles, and that this inevitably creates vulnerabilities. However, they emphasised that despite these pressures, the organisation is still delivering against key priorities. Notably, it is on track to deliver the 2025/26 financial plan, without requiring a forecast control total adjustment, and has successfully submitted a compliant plan for 2026/27, which was highlighted as a major achievement given the backdrop of workforce turbulence and financial challenge.<br><br>The group recognised that this progress reflects deliberate prioritisation of the most critical activities, though it has meant slower progress on some other important pieces of work. Members stressed that transition-related risks, especially those linked to staffing reductions, knowledge loss, delayed processes and operational backlogs, must continue to be explicitly managed and monitored.<br><br>It was confirmed that recruitment panels for the new structure were underway, and that early signs were positive, with strong retention of skilled staff in key roles. It was also highlighted that while resilience issues are being managed daily and often shift rapidly, the overarching trend shows that the organisation is stabilising.<br><br>Committee members emphasised the importance of protecting staff wellbeing, ensuring individuals feel empowered to challenge unnecessary workload, and reducing the administrative burden so that capacity can be redirected to priority risks. The discussion concluded with recognition that although resilience remains fragile, the organisation has demonstrated remarkable capability in maintaining performance and financial discipline through a highly disruptive year.<br><br>**NHS GM Audit Committee noted the update.** | |
| 21. | <u>Standing Items:</u><br><br><u>Debtors Update</u><br><br>The committee received an update on the organisation's debtor position, noting that total outstanding debt stood at £27.6 million, of which £1.7 million was overdue beyond expected payment terms. It was explained that the aging profile of the debt remained broadly consistent with previous reporting periods, with several familiar categories continuing to drive the position. These included longstanding issues within dental services, disputes or delays associated with specialist placement costs, and a material item relating to autism services, which is being examined with support from MIAA due to potential fraud indicators.<br><br>Local authority (LA) debt totalled approximately £4 million, with the largest share attributable to Bury, although assurance was given that payment was expected following resolution of underlying issues by locality teams. The organisation's bad debt provision remained at £0.9 million, which had been reviewed as part of Month 12 processes to ensure appropriate coverage. The update also summarised recent credit notes, noting that none had adversely affected the | |

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| | overall financial position because appropriate controls, including re-issuance of corrected invoices where necessary, had been applied. One anomaly was highlighted: a recharge between the ICB and an NHS provider that appeared within the debt listing despite earlier confirmation that it should not have been outstanding; management committed to picking this up directly as a follow-up action.<br><br>Overall, the committee noted that while the profile of debt remained challenging, the themes were familiar, ongoing recovery activity was in motion, and no new material risks had emerged within the reporting period.<br><br><u>Losses/Special Payments</u><br><br>There were no updates to note.<br><br><u>Tender Waivers and Procurement Report</u><br><br>The committee reviewed the tender waivers and procurement activity for the period, noting a significant reduction in waivers compared with the previous year. Between December and February, 25 waivers were approved, bringing the year-to-date total to 65, compared with 128 in the previous year, a drop attributed to strengthened processes and earlier procurement engagement.<br><br>The update also covered the organisation's application of the Provider Selection Regime (PSR), with a summary of decisions taken across the permitted routes, Direct award A, B, C MSP and competitive process. Only one PSR representation had been received, and management explained the circumstances behind it.<br><br>Committee members raised strong concerns about the number of retrospective waivers, emphasising that many were still being brought forward months after the related activity had begun or even concluded. They challenged management on how such non-compliance was being addressed, including what, if any, consequences exist for repeat offenders. It was explained that every retrospective waiver is escalated to the responsible budget holder, finance lead, contracting lead and Chief Officer, and that repeated non-compliance is followed up with targeted support, training and formal conversations.<br><br>There was discussion about specific areas of persistent issue, notably IT, where procurement had previously highlighted patterns of late engagement. Looking forward, the committee welcomed plans to strengthen contract oversight under the new operating model, including a comprehensive programme to consolidate contracts, assign clear commissioning and finance leads, identify expiry points earlier, and reduce unnecessary local variation. The ambition is to prevent "end-of-year scrambles" and multiple small local contracts by shifting to single GM-wide contracts where appropriate, enabling better negotiating power and reduced administrative burden.<br><br>Members also stressed the opportunity to embed AI or digital tools to support contract review and consistency checking, which management agreed to explore. Overall, the committee recognised the improvements made but reiterated that retrospective waivers present a significant governance and assurance risk and | |

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| | must continue to be driven down through cultural, managerial and structural changes.<br><br>Conflicts of Interest Guardian<br><br>There were no updates to note.<br><br>Use of Corporate Seal<br><br>The report was noted.<br><br>Board Summary Report<br><br>This would be completed noting items during the meeting.<br><br>**Audit Committee noted the updates provided.** | |
| 22. | Audit Committee Workplan<br><br>The Audit Committee Workplan for 2026/27 was noted. | |
| 23. | Any Other Business, reflections on the meeting and items for escalation to the Board<br><br>There were no other items of business for consideration.<br><br>Reflections on the meeting:<br><br>Members felt the discussion had been healthy and productive. | |
| 24. | Date and time of next meeting:<br><br>23 April 2026, 11am – 2pm | |