Agenda

Greater Manchester Audit Committee Part A

Date: 19th March 2026

Time: 11.00am to 1.00pm

Venue: MV19, 5th floor, The Tootal Buildings, 56 Oxford Street, Manchester M1 6EU

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	11:00	5 mins	Welcome, Introductions and Apologies including Attendance Matrix	Paper	Information	Chair
2.	11:00		Declarations of Interest	Paper	Information	All
3.	11:00		Minutes from the last meeting and matters arising	Paper	Approval	Chair
4.	11:00		Action Log	Paper	Information	Chair
Internal Audit						
5.	11:05	10 mins	Internal Audit Progress Report	Paper	Discussion	Patrick Clark
6.	11:15	10 mins	Internal Audit Follow Up Report	Paper	Discussion	Patrick Clark
7.	11:25	10 mins	Annual Internal Audit Plan 2026/27	Paper	Discussion	Darrell Davies
8.	11:35	5 mins	Draft Head of Internal Audit Opinion and Annual Report	Paper	Discussion	Darrell Davies
9.	11:40	5 mins	Internal Audit Charter	Paper	Discussion	Patrick Clark
Counter Fraud						
10.	11:45	10 mins	Counter-Fraud Progress Report	Paper	Information	Paul Bell
11.	11:55	10 mins	Annual Work Plan for Conter-Fraud Activity	Paper	Approval	Paul Bell
12.	12:05	5 mins	Counter-Fraud Champion Update Report	Paper	Information	David Dobson
External Audit						
13.	12:10	5 mins	External Audit Plans and Fees	Paper	Discussion	Grant Thornton

14.	12:15	5 mins	Informing the risk assessment 2025/26	Paper	Discussion	Kaye Abbott/Grant Thornton
15.	12:20	5 mins	Annual Auditors' Letter Recommendations Update	Paper	Discussion	Kaye Abbott
Governance						
16.	12:25	15 mins	BAF Risk – Deep Dive	Paper	Discussion	Chris Gaffey
17.	12:40	5 mins	Terms of Reference	Paper	Discussion	Chris Gaffey
Financial Focus						
18.	12:45	5 mins	M9 Accounts Update	Paper	Discussion	Chris Gaffey/ Kaye Abbott
19.	12:50	5 mins	Review changes to standing financial instructions/prime financial policies and changes to accounting policies	Verbal	Discussion	Izhar Chaudhary
Standing Items						
20.	12:55	5 mins	Organisational Capacity/ Resilience Briefing	Verbal	Discussion	Kathy Roe/ Charlotte Bailey
21.	13:00	5 mins	Standing Items: • Debtors Update • Losses/Special Payments • Tender Waivers and Procurement Report • Conflicts of Interest Guardian • Use of Corporate Seal • Board Summary Report	 Paper Verbal Paper Verbal Paper	 Information Information Discussion Information Information Information	 Kaye Abbott Kaye Abbott Izhar Chaudhary Chris Gaffey Chris Gaffey All
22.	13:05	5 mins	Audit Committee Workplan	Verbal	Information	Izhar Chaudhary
23.	13:10	5 mins	Any Other Business, reflections on the meeting and items for escalation to the Board	Verbal	Discussion	Chair
24.			Date and Time of Next Meetings: 23 April 2026, 11:00-13:00 17 June 2026, 11:00-13:00 17 September 2026, 10:00-12:00 17 December 2026, 11:00-13:00	Verbal	Information	Chair

ToR: A 'Terms of Reference on a page' has been created for the committee's consideration

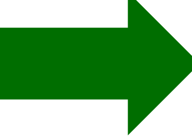
Purpose

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.



Key duties

- Integrated governance, risk management and internal control
- Risk Management
- Internal Audit
- External Audit
- Other Assurance Functions
- Counter Fraud
- Freedom to Speak Up and Whistleblowing
- Information Governance
- Financial Reporting
- Conflicts of Interest
- To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

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)

Item 1 - Audit Committee Attendance Matrix 2024

Key:

Present

Apologies

Attendance Not Required

No explanation

Member as per Terms of Reference

Attendee of meeting as per TORs

Apologies provided but Substitute attended on behalf

Name	Title	Apr-25	Jun-25	Sep-25	Dec-25	Mar-26
Richard Paver (Chair)	Non-Executive Director, Audit Committee Chair					
Anthony Hassall	Chief Executive, Pennine Care NHS Foundation Trust					
Sue Greenhill	Independent Member					
David Hopewell	Independent Partner Member					
Sheena McDonnell (until 31 May 25)	Non-Executive Director, Chair of the People & Culture Committee					
Kathy Roe	Chief Finance Officer					
Colin Scales	Deputy Chief Executive Officer					
Paul Bell	Senior Anti-Fraud Manager, MIAA					
Patrick Clark	Senior Audit Manager, MIAA					
Darrell Davies	Regional Assurance Director, MIAA					
Louise Cobain	Executive Director - Assurance, MIAA					
Perminder Sethi	Grant Thornton External Auditors					
Sarah Ironmonger	Grant Thornton External Auditors					

NHS GM: Audit Committee - Register of Interests March 2026

First Name	Last Name	Job Title	Decision Maker N/Y	Date Declaration Made / Refresh	Declared Interest (Name of organisation and nature of business)	Declared Interest	Type of Interest	Direct or Indirect	Date of Interest	End Date of Interest	Consent to Publish Y/N	Action Taken to Mitigate Risk
Richard	Paver	Independent Non-Executive Director (Audit Committee Chair)	Y	08-04-25	No interests to declare	No interests to declare	No interests to declare	No interests to declare	No interests to declare	No interests to declare	Y	No interests to declare
Sue	Greenhill	Independent Member	Y	11-12-26	No interests to declare	No interests to declare	No interests to declare	No interests to declare	No interests to declare	No interests to declare	Y	No interests to declare
Anthony	Hassall	Chief Executive, Pennine Care NHS Foundation Trust	Y	01-03-26	Pennine Care NHS Foundation Trust	Chief Executive	Financial	Direct	14-07-05	Ongoing	Y	To be declared in line with Conflict of Interest Policy and managed as required.

Minutes

Greater Manchester Audit Committee (Part A)

Date: Thursday 11 December 2025

Time: 11.00am to 13.00pm

Venue: 5th Floor, Tootal Buildings, Manchester

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Present		
Members:		
Richard Paver	RP	Non-Executive Director and Audit Committee Chair, NHS GM
Sue Greenhill	SG	Independent Member
Anthony Hassall	AH	Partner Member bringing the perspective of Mental Health Providers, Chief Executive of Pennine Care NHS Foundation Trust
Attendees / Participants:		
Kathy Roe	KR	Chief Finance Officer, NHS GM
Stephen Downs	SD	Deputy Chief Finance 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
Patrick Clark	PC	Senior Audit Manager, MIAA
Darrell Davies	DD	Regional Assurance Director, MIAA
Sarah Ironmonger	SI	Engagement Partner, Grant Thornton
Perminder Sethi	PS	Senior Manager, Grant Thornton
Gareth Robinson	GR	(item 9 only)
Phil Scott	PS	(item 11 only)
Ross Baxter	RB	Governance Advisor, NHS GM (minutes)
Apologies:		
David Hopewell	DH	Independent Member bringing Provider Partner perspective
Colin Scales	CS	Deputy Chief Executive, NHS GM
Jackie Gardiner	JG	Corporate Director of Operational Finance – Financial Management
Paul Bell	PB	Head of Anti-Crime Services, MIAA
Kaye Abbott	KA	Associate Director of Finance – Financial Control, NHS GM

	Topic	Action
1.	Welcome, Introductions and Apologies The Chair welcomed members and attendees to the meeting.	
2.	Declarations of Interest (DOI) 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 The minutes of the last Audit Committee meeting on 11 September 2025 were approved as an accurate record.	
4.	Action Log 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 This report provided the committee with a summary of the progress made in the completion of the 2024/25 Internal Audit Plan and delivery of the 2025/26 Internal Audit Plan. The discussion focused on the status and assurance levels of various audit reviews, highlighting both completed and ongoing work. It was explained that for the previous year, two reviews (IT Asset Management and Contract Management Quality of Care) were finalised, both receiving moderate assurance. For the current year, three reports (Financial Recovery Programme, Pod Delegation Review, and Mental Health Review) achieved substantial assurance, indicating medium and low risk recommendations. Concerns were raised about the number of revised deadlines and the achievability of the Q4 plan given organisational changes and capacity constraints. It was agreed that a review of outstanding and planned work was needed to prioritise high-risk and mandated audits, with some lower-priority items potentially deferred until after the reorganisation. The importance of focusing on high-risk areas, such as cyber controls, EPRR and data quality, was emphasised, and the need for a line-by-line review of recommendations to assess residual risk and ensure management is compensating for delayed actions was discussed. The process for revising implementation dates was clarified, involving lead officers and chief officers, with a commitment to provide more narrative on the risks associated with deadline extensions. **Action: Q4 work plan to be reviewed to check whether it is still deliverable.** **NHS GM Audit Committee noted the contents of the report.**	

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6.	<u>Internal Audit Follow Up Report</u> This report provided the committee with an update on progress made in implementing outstanding internal audit recommendations. The discussion centred on the status of 58 recommendations reviewed since the previous audit committee, with 26 having revised implementation dates and concerns about the frequency of deadline extensions. It was outlined that 17 recommendations were not yet due, 10 were fully implemented, and 31 were in progress or partially implemented, with 27 of these having revised dates. Members expressed the need to focus on high-priority recommendations, particularly those related to cyber controls and EPRR, which have been outstanding for several years and pose significant risks. The importance of understanding residual risk from delayed actions and ensuring that mitigation is in place was highlighted, especially for critical areas like cyber resilience. The process for revising deadlines was explained, whereby lead officers propose extensions, which are then agreed by Chief Officers, and the committee requested more narrative on the risks associated with these extensions. It was acknowledged that due to ongoing organisational change some lower-priority recommendations may need to be deferred, with a comprehensive review planned for March or April to reassess priorities and relevance in the new structure. The committee agreed to focus on managing the most critical risks and to seek assurance that partially implemented recommendations do not leave the organisation exposed. **NHS GM Audit Committee noted the contents of the report.**	
7.	<u>Counter-Fraud Progress Report</u> This report provided a summary of anti-fraud activities undertaken from 1 September 2025 – 30 November 2025. The discussion covered key elements of the fraud plan, compliance with government functional standards, and recent changes in risk assessment processes. The report indicated that the plan was progressing as scheduled, with most compliance areas rated green, though one component was temporarily amber due to the adoption of a new risk assessment methodology requiring significant re-evaluation of fraud risks. The team was optimistic that this would return to green once the assessment was complete. The ongoing gap analysis work related to the "failure to prevent fraud" offence and a joint preventive exercise with Greater Manchester Mental Health on section 12 assessments were highlighted, with both progressing well. Referral statistics were shared, noting 20 referrals in the period, most closed or transferred to NHS England or practice managers, with six still open and one	

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	historical investigation ongoing. The report provided assurance that no outstanding recommendations were due for update, and overall the committee was satisfied with the clarity and presentation of the report, especially the glossary and acronyms. The discussion also acknowledged the resource-intensive nature of the new risk assessment process but anticipated future updates would be less burdensome. **NHS GM Audit Committee noted the contents of the report and its implications for NHS GM, and highlighted any other additional information, training or awareness that may be required to ensure full compliance with the pending legislation.**	
8.	EXTERNAL Audit Progress and Sector Update This report provided an update on the progress in delivering Grant Thornton responsibilities as the external auditor at NHS GM for 2025-26. It also summarised emerging national issues and developments that may be relevant to the work of the ICB. The discussion focused on the current stage of the external audit, with it explained that initial planning discussions were underway for the 2025/26 audit, aiming to present the audit plan at the March Audit Committee. A key point raised was the need for approval of the financial control process before starting certain audit work, with delays in this process potentially impacting the audit timeline. The team discussed the importance of being agile to avoid delays, referencing past issues where audits were completed after year-end due to late approvals. There was discussion about the national challenge of transferring balances between financial systems, with concerns about how assurance would be provided for these transfers and whether internal processes or internal audit testing would be relied upon. The group agreed on the need to clarify assurance sources, particularly regarding the SBS system, and to ensure that the audit committee is confident in the integrity of transferred balances. Additionally, the discussion touched on the accounting for redundancies, noting the need for consistent national guidance and the impact of redundancy provisions on financial planning. The team planned to coordinate with national teams to ensure alignment and to bring relevant accounting policy decisions to the committee for approval. **NHS GM Audit Committee discussed and noted the report.**	
9.	Update on VFM Recommendations This report provided an update on the implementation of the 2024/25 External Auditor's Annual Report. In total there were one key recommendation and three improvement recommendations, with the key recommendation confirmed as fully implemented in the September report to the Committee.	

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	The discussion centred on the status of recommendations from the previous year and the three improvement recommendations. Progress was reported on two of these, including improved oversight of savings schemes and regular updates to committees on indicator performance. However, concerns were raised about the ongoing issues with data quality, which had been flagged by Grant Thornton for at least two years. Members acknowledged the critical importance of robust data for commissioning and financial management, especially as national policy moves toward activity-based payment mechanisms. Members discussed the challenges in validating community service costs due to inconsistent data and the need for better policies and procedures. The conversation concluded with agreement to revisit data quality assurance, recognising its increasing significance for both finance and service delivery, and to ensure that outstanding recommendations are addressed in the upcoming audit cycle. It was noted that following a recent system delivery meeting, the organisation was set to receive formal notification from NHS England confirming compliance with 34 out of 36 undertakings, with only the finance undertakings remaining. This progress was expected to lead to either a partial or full exit from the undertakings by year-end. As a result, the supporting infrastructure around the single improvement plan and related system improvement boards will be stepped down, marking a significant positive development for the organisation. **NHS GM Audit Committee discussed and noted the updates on the implementation of recommendations.**	
10.	Risk Register/Management Update (including deep dives) This report provided an update to the committee on the corporate risks across the ICB, the progress with BAF risks, the progress with implementing issue management processes, and progress on the implementation of the Datix system. It included the full committee risk registers and the full BAF risks for assurance. The discussion focused on recent efforts to improve risk moderation and the presentation of risks at both the corporate and committee levels. It was explained that feedback from previous meetings had led to more robust moderation processes, including taking the corporate risk register through the operational leadership group for wider scrutiny. There was specific mention of the need to clarify the rationale behind certain risk scores, such as the high score for primary care and the handling of EPRR and finance risks. Concerns were raised about the fragmentation of capacity and organisational change risks across multiple entries, and it was suggested these should be consolidated for greater prominence. It was confirmed that the BAF already	

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	included a risk on NHS Reform, which covered the issue of capacity and organisational change. The removal or downgrading of the mental health and neurodiversity risk was also queried, highlighting that the current situation did not justify such a change. These points were acknowledged and agreement was made to review, noting that some changes in risk scores were due to timing issues in report preparation. **Action: CG to review the removal or downgrading of the mental health and neurodiversity risk.** The group also discussed the interpretation of assurance ratings within the risk register, highlighting confusion over whether green ratings indicated effective controls or simply agreement on risk scoring. There was consensus on the need for clearer definitions and more consistent application of assurance ratings, as well as better narrative explanations for changes in risk scores. The discussion concluded with agreement to focus on managing the most critical risks over the next few months, given capacity constraints, and to ensure that risk presentation and assurance processes are uniformly understood and applied across the organisation. **NHS GM Audit Committee considered the corporate risks included within the report, noted the ongoing work on the BAF Risks, identification and management of issues, and the implementation of the Datix system.**	
11.	<u>Corporate Policies</u> <u>Software Control Policy</u> This policy was presented, emphasising its aim to ensure all software installed on the organisation's digital estate was fully controlled and compliant. It was explained that the policy had been reviewed and approved by several governance groups, including the Digital Security Programme Board and the Primary Care Digital Board. Pre-submitted questions were addressed, clarifying that GPIT devices are owned and managed by the organisation, with full visibility and control over installed software, except for minimal exceptions like supplier-provided check-in screens. It was confirmed that third-party providers using organisation-supplied devices must comply with the policy, and that council IT systems, while separate, must also adhere to policy requirements when connecting to the network. It was also noted that all devices are now upgraded to Windows 11, with any remaining Windows 10 devices still supported. It was queried whether the policy covered all mobile and third-party devices, and it was confirmed that this is the case and applies to every device managed by the organisation and connected to its network. **NHS GM Audit Committee approved the Software Control Policy**	

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12.	Committee Restructure The Chair advised that an update in this area was not required at the meeting.	
13.	Agree Final Annual Report and Accounts Timetable and Plans This report provided an update to the committee on the approach for the Month 9 and Month 12 annual report and accounts submissions to NHS England for 2025/26. The Month 9 draft accounts would be circulated to members in order to allow comments to be made. **NHS GM Audit Committee noted the approach to ensure delivery of the statutory year end returns required for 2025/26.**	
14.	Greenbury Disclosures This report was provided to agree and recommend to the Accountable Officer the posts covered by NHS GM's Remuneration Report disclosure. There was a specific query about how to account for redundancy payments for staff who will be serving notice at year-end but have not yet received their payments, highlighting the need to determine how these should be disclosed in the remuneration segment. There were also potential complexities noted regarding pension disclosures, particularly where redundancy pay is used to buy additional pension benefits, and the importance of clarifying these points before the March reporting deadline was emphasised. The group agreed that these nuances would need to be considered based on individual arrangements and that further clarity would be provided as part of the year-end process. **NHS GM Audit Committee agreed the posts included within the disclosure and recommended the posts for inclusion in the disclosure to the Accountable Officer.**	
15.	Review changes to standing financial instructions/prime financial policies and changes to accounting policies There were no changes to note.	
16.	Standing Items: Debtors Update This report provided an update on the total level of debt due to the organisation (£26.8m) and specifically the debt values over 90 days (£1.8m). It also covered the value of the bad debt provision (£0.9m) and had been updated to include credit notes raised in the period. Losses/Special Payments	

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	There were no updates to note. Tender Waivers and Procurement Report This report highlighted to Audit Committee the volume of waivers that had been completed and submitted for approval in accordance with the Standing Financial Instructions, Financial Scheme of Delegation and Procurement Policy for the period September to November 2025. Conflicts of Interest Guardian There were no updates to note. Use of Corporate Seal This was presented for information. It was noted that there was an error to the title of the document currently labelled “Tootal Building Lease agreement”, which should read as “Tootal Building Licence Agreement”. This would be updated on the register. Board Summary Report This would be completed noting items during the meeting. **Audit Committee noted the updates provided.**	
17.	Audit Committee Workplan The Audit Committee Workplan for 2025/26 was noted.	
18.	Any Other Business, reflections on the meeting and items for escalation to the Board There were no other items of business for consideration. Reflections on the meeting: Members felt the discussion had been healthy and productive.	
19.	Date and time of next meeting: 19 March 2025, 11am – 2pm	

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Actions Log: Audit Committee

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Date to be completed	Status	Further Detail
123	19/06/2025	Internal Audit Progress Report	On the SEND Review there was a recommendation for oversight of localities, and existing groups had been superseded by the LAMs process	To clarify the response to the SEND Review with the Chief Nursing Officer.	Anita Rolfe	23/04/2026		As meetings currently being stood down to enable the organisation to focus on key priorities, agreed with the Chair that a further update on this be provided post April once new Committee structures are in place, with responsibility o possibly sit with a new Comissioning Committee.
124	11/09/2025	Internal Audit Progress Report	Further information on reprioritisation required.	To bring forward a more detailed narrative explaining the reasons for reprioritisation of audit recommendations, including the balance of risk and rationale for delays	Colin Scales	11/12/2025		
127	11/09/2025	Counter-Fraud Progress Report, including a briefing on Failure to Prevent Fraud	Lessons learned report to be brought to a future meeting	To provide a lessons learned report in six months on the implementation and effectiveness of the new legislation and related training	Izhar Chaudhary	Apr-26		To be deferred until April 26

NHS GM Audit Committee 19th March 2026

Internal Audit Progress Report 2025/26

Part of Greater Manchester Integrated Care Partnership

NHS GM Audit Committee

19th March 2026

Required information	Details
Title of report	Internal Audit Progress Report 2025/26
Author	Darrell Davies/ Patrick Clark
Presented by	Patrick Clark
Contact for further information	Patrick Clark
Executive summary	This report provides the Audit Committee with a summary of the progress made in delivery of the 2025/26 Internal Audit Plan.
The benefits that the population of Greater Manchester will experience.	Assurance, through the Audit Committee, that improvements in internal control are being progressed within the organisation that should lead to improved performance and thus assist the organisations achieve its objectives.
How health inequalities will be reduced in Greater Manchester's communities.	The Internal Audit Plan aims to address all of the key risks of the ICB on a cyclical basis, including responding to the quality agenda.
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	The Internal Audit Plan aims to address all of the key risks of the ICB on a cyclical basis. The BAF is considered as part of the annual planning process to ensure that the internal audit plan includes appropriate coverage. Recommendations made by internal audit aim to strengthen the internal control environment which should contribute towards reduction in risk.
Key milestones	N/A
Leadership and governance arrangements	N/A
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A
Financial or Legal Implications	N/A

Part of Greater Manchester Integrated Care Partnership

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

Introduction

1.0 This report provides the Audit Committee with a summary of the progress made in the delivery of the 2025/26 Internal Audit Plan.

Executive Summary

2.0 The report provides the Audit Committee with:

- An update on the progress being made in delivery of the 2025/26 workplan.
- Details of client briefings and intelligence issued during the reporting period.
- Updates on forthcoming MIAA conferences and master class events.

System Support and Implementation

3.0 Where applicable and appropriate, the scope of our audits and our audit recommendations include reference to the 'system' and 'system partners'.

Learning and Innovation

4.0 Our audit recommendations seek to provide appropriate improvements to controls and processes, as well as considering best practice observed at other providers/ ICBs, to support shared learning and improvements.

Recommendations

5.0 The Audit Committee is asked to:

- Note the contents of the report.

Internal Audit Progress Report
Audit Committee (March 2026)

NHS Greater Manchester Integrated Care Board

Contents

1 Introduction

2 Key Messages for Audit Committee Attention

Appendix A: Contract Performance

Appendix B: Performance Indicators

Appendix C: Assurance Definitions and Risk Classifications

Global Internal Audit Standards

Our work was completed in accordance with Global Internal Audit Standards (UK public sector).

3 Executive Summary

This report provides an update to the Audit Committee in respect of the progress made against the Internal Audit Plan for 2025/26 and brings to your attention matters relevant to your responsibilities as members of the Audit Committee.

This progress report provides a summary of Internal Audit activity and complies with the requirements of the Global Internal Audit Standards.

Comprehensive reports detailing findings, recommendations and agreed actions are provided to the organisation, and are available to Committee Members on request. In addition, a consolidated follow up position is reported on a periodic basis to the Audit Committee.

This progress report covers the period December 2025 to February 2026.

Since the last meeting of the Audit Committee, there has been the focus on the following areas:

Audit Reviews
The following reviews have been finalised: • Community Pharmacy – Advanced Services (Moderate Assurance) • Training and Development (Substantial Assurance) • Continuing Healthcare (CHC) (Moderate Assurance) • ESR Payroll (Substantial Assurance) The following reviews are in progress: • Specialised Commissioning (Draft Report issued 27/11/25 – Substantial Assurance) • Key Financial Transactional Processing Controls (Draft Report issued 9/3/26 – Moderate Assurance) • Financial Reporting (Draft Report issued 25/2/26 – Substantial Assurance) • Contingency – NEPTS Procurement (Draft Report issued 23/2/26 – Assurance rating TBC) • Additional IT System Wide Assurance: IT Suppliers (Fieldwork) • Assurance Framework (Fieldwork)

- Risk Management Core Controls (Fieldwork)
- DSPT Phase 1 25/26 (Fieldwork)
- Data Quality (Planning)

Refer to Appendix C for details of Key Areas and Actions to be Delivered.

Follow Ups

Since the follow up position reported previously at the December 2025 Audit Committee:

- There were 63 recommendations reviewed as part of the Q4 follow up exercise: 18 High/ 34 Medium/ 8 Low/ 3 N/A.
- Of these 63 recommendations, 21 recommendations are not due to be implemented and 6 have been fully implemented/ superseded. The remaining 36 recommendations are in either in progress and partially implemented (29) or not yet implemented (7).
- Of the 36 recommendations partially or not yet implemented, 34 have had revised implementation dates as set out in the management responses received to date.
- In 11 cases since the previous Audit Committee meeting a revised implementation date has been requested by management and considered by Chief Officers.

Audit Plan Changes

Audit Committee approval will be requested for any amendments to the original plan and highlighted separately below to facilitate the monitoring process.

- The following audits have been agreed to be deferred to 2026/27 for consideration as part of agreement of the 2026/27 internal audit plan due to ongoing reforms and restructure at NHS GM:
    - Conflicts of Interest

- Supplier Due Diligence
- Financial Sustainability and Medium Term Financial Planning
- Financial System Risk

Added Value

Briefings

Our latest briefings/blogs/podcasts are:

- Key NHS Publications – February 2026
- 25/26 MIAA Insight – Freedom to Speak Up Benchmarking
- 25/26 MIAA Insight – Fit and Proper Persons Test Benchmarking
- 25/26 MIAA Insight – Audit Committee Briefing - Cyber Security
- 25/26 MIAA Insight – Risk Management Core Controls Benchmarking
- Claire Hammill Blog: Quality Improvement: The missing link in NHS productivity, clinical effectiveness & reform
- Key NHS Publications - January 2026
- Key NHS Publications - December 2025
- TIAN News - Winter 2025
- 25/26 MIAA Insight – Assurance Framework Benchmarking
- Salary Overpayments Benchmarking
- 25/26 MIAA Insight – Data Quality Benchmarking
- Jane Pine Blog: Taking Time to Reflect: Why looking back helps us move forward

Advisory and Support Role

We have continued to keep you updated on the latest key guidance through the regular issue of The Internal Audit Network (TIAN) Insight Report and News and our Fraud Threats and Advice Briefings.

Audit Committee Chairs Webinars

We are continuing to hold sessions with groups of Trust and ICB Audit Committee Chairs focusing upon governance challenges and other key issues. The next meetings will be held on Microsoft Teams on the following dates:

- Cheshire & Merseyside – 22nd April
- Greater Manchester – 13th April
- Lancashire and South Cumbria – 21st April

Finance Committee Chairs Webinars

Following client feedback we have established a Finance Committee Chairs Forum. The Forum is open to all NHS Finance Committee Chairs.

Governance Assurance & Risk Network (GARNet)

We regularly host GARNet sessions for all professionals working in audit, risk and assurance. We have established a separate monthly ICB GARNet Group specifically for ICB governance leads.

Events

- Unlocking Sustainable Productivity (19th March 2026): This masterclass will help health and social care leaders reframe productivity as a driver of sustainable improvements in care quality, not just a mechanism for meeting financial targets. Building on the NHS Productivity Commission's call for a new narrative, the session will explore how productivity gains can enhance patient outcomes, staff experience, and system resilience.

Appendix A: Contract Performance

The Global Internal Audit Standards (UK public sector) state that 'In the UK public sector, a chief audit executive must prepare such an overall conclusion at least annually in support of wider governance reporting, mindful of any specific sector obligations or processes. This overall conclusion must encompass governance, risk management and control.'

The days allocated to each review are based on initial discussions during the planning process and are considered to be indicative, based on professional judgement, of the days required. Actual days delivered may be impacted by detailed scoping discussions and experiences during the delivery of the review. Focus and priority is placed on ensuring the delivery of outputs in order to provide a robust Head of Internal Audit Opinion.

Below sets outs the overview of delivery for your Head of Internal Audit Opinion for 2025/26:

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 28 February 2026	Delivery %	Comment
Governance and Leadership										
Assurance Framework	Yes	Fieldwork	-	Charlotte Bailey	-	June 26	12	2.1	17.5%	Fieldwork
Risk Management (Core Controls)	Yes	Fieldwork	-	Charlotte Bailey	-	Apr 26	12	5.34	44.5%	Fieldwork
Primary Care Commissioning Assurance Framework (POD Delegation)	Yes	Final Report	21/7/25	Katherine Sheerin	Substantial	Dec 25	12	9.51	79.3%	Complete
Conflicts of Interest	N/A	Deferred	-	Colin Scales	-	N/A	15	0.5	3.3%	Review stood down. To be undertaken in 2026/27

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 28 February 2026	Delivery %	Comment
Specialised Commissioning (deferred 24/25 audit)	Yes	Draft Report	27/11/25	Katherine Sheerin	Substantial	Mar 26	11	14	127.3%	Draft Report
Finance Performance and Sustainability										
Key Financial Transactional Processing Controls	Yes	Draft Report	9/3/26	Kathy Roe	Moderate	Apr 26	15	12.5	83.3%	Draft Report
Financial Recovery Programme	Yes	Final Report	21/8/25	Kathy Roe	Substantial	Dec 25	20	13.09	65.5%	Complete
Supplier Due Diligence	N/A	Deferred	-	Kathy Roe	-	N/A	18	0.5	2.8%	Review stood down. To be considered in 2026/27
Financial Reporting	Yes	Draft Report	25/2/26	Kathy Roe	-	Apr 26	12	9.21	76.8%	Draft Report
Mental Health	Yes	Final Report	24/9/25	Kathy Roe	Substantial	Dec 25	12	16.65	138.8%	Complete
Quality										
Community Pharmacy – Advanced Services	Yes	Final Report	18/9/25	Katherine Sheerin	Moderate	Mar 26	13	15.52	119.4%	Complete

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 28 February 2026	Delivery %	Comment
Continuing Healthcare (CHC)	Yes	Final Report	2/2/26	Katherine Sheerin	Moderate	Mar 26	30	28.63	95.4%	Complete
People										
Training and Development	Yes	Final Report	2/12/25	Charlotte Bailey	Substantial	Mar 26	15	11.58	77.2%	Complete
ESR Payroll	Yes	Final Report	30/1/26	Charlotte Bailey	Substantial	Mar 26	12	15.84	132.0%	Complete
Information and Technology										
Additional System Wide IT Assurance – IT Suppliers	No	Fieldwork	-	Colin Scales	-	Dec 25	15	10.83	72.2%	Fieldwork
Data Security and Protection Toolkit Phase II -24/25	Yes	Final Report	30/6/25	Colin Scales	High Risk/ High Confidence	Sept 25	8	9.82	122.8%	Complete
Data Security and Protection Toolkit Phase I 25/26	Yes	Fieldwork	N/A	Colin Scales	-	Apr 26	9	3.32	36.9%	Fieldwork
Follow Up										

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 28 February 2026	Delivery %	Comment
Qtr 1	N/A	Final Report	N/A	Kathy Roe	N/A	June 25	22	20.88	94.9%	Complete
Qtr 2	N/A	Final Report	N/A	Kathy Roe	N/A	Sept 25				Complete
Qtr 3	N/A	Final Report	N/A	Kathy Roe	N/A	Dec 25				Complete
Qtr 4	N/A	Final Report	N/A	Kathy Roe	N/A	Mar 26				Complete
Planning & Reporting & Contingency										
Planning, Management, Reporting and Meetings	N/A	N/A			N/A	N/A	25	26.59	106.4%	
Contingency	N/A	N/A	-	Kathy Roe	-	-	6	7	116.7%	
Contingency – TRA Follow Up	N/A	Fieldwork	-	Colin Scales	-	-	2	2	100%	Fieldwork
Contingency – NEPTS Procurement	Yes	Draft Report		Kathy Roe	-	Apr 26	7	7	116.7%	Draft Report
Additional Reviews from Additional Contingency Days										

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 28 February 2026	Delivery %	Comment
Financial Sustainability and Medium-Term Financial Planning	N/A	Deferred	-	Kathy Roe	-	N/A	18	1	5.6%	Review stood down. To be considered in 2026/27
Data Quality	In Draft	Planning	-	Colin Scales	-	N/A	20	2.66	13.3%	Planning
Financial System Risk	N/A	Deferred	-	Kathy Roe	-	N/A	20	0.25	1.3%	Review stood down. To be considered in 2026/27
						TOTAL DAYS	**361**	**239.82**	**66.4%**	
					Excluding Stood Down Reviews		**292.25**	**239.82**	**82.1%**	
Added Value / Support & Guidance										
Monthly TIAN Insight Report	N/A	Issued monthly			N/A	Every meeting				
Quarterly TIAN Newsletter	N/A	Issued Qtr 1 -4			N/A	Every meeting				

If, due to circumstances beyond our control we are unable to achieve sufficient depth or coverage, we may need to caveat opinions and explain the impact of this and what will be done to retrieve the position in future.

Appendix B: Performance Indicators

The primary measure of your internal auditor's performance is the outputs deriving from work undertaken. The following provides performance indicator information to support the Committee in assessing the performance of Internal Audit.

Element	Reporting Regularity	Status	Summary
Delivery of the Head of Internal Audit Opinion (Progress against Plan)	Each Audit Committee	Green/ Amber	There is ongoing engagement and communications regarding delivery of key reviews to support the Head of Internal Audit Opinion. There are a number of reports which have reached draft report stage and require finalising. The Data Quality has been reinstated into the plan with the review at the planning stage and will not be complete before the end of March 26.
Issue a Client Satisfaction Questionnaire following completion of every audit.		Green	Links to client satisfaction questionnaires are included in all reports.
Percentage of recommendations raised which are agreed	Each Audit Committee	Green	Trust management have accepted all recommendations made to date within final reports issued.
Percentage of recommendations which are implemented		Amber	Follow Up is reported at each Audit Committee – see separate report. A significant number of recommendations are only partially implemented and there have been 6 revisions to deadlines since the previous follow up exercise.

Element	Reporting Regularity	Status	Summary
Qualified Staff	Annual	Green	MIAA have a highly qualified and diverse workforce which includes 75% qualified staff. The Senior Team delivering the Internal Audit Service to the Trust are CCAB/IIA qualified.
Quality	Annual	Green	MIAA operate systems to ISO Quality Standards. MIAA conforms with the Global Internal Audit Standards (UK public sector).

Appendix C: Key Areas from our Work and Actions to be Delivered

<table>
<tr><td>Report Title</td><td colspan="4">Community Pharmacy – Advanced Services</td></tr>
<tr><td>Executive Sponsor</td><td colspan="4">Katherine Sheerin, Chief Commissioning Officer</td></tr>
<tr><td>Objective</td><td colspan="4">The overall objective was to ensure GMICB has a robust management system in place for the provision of advanced services by Community Pharmacies.</td></tr>
<tr><td>Recommendations</td><td>0 x Critical</td><td>2 x High</td><td>1 x Medium</td><td>2 x Low</td></tr>
<tr><td>Overall Rating</td><td colspan="4">Moderate</td></tr>
<tr><td>Summary</td><td colspan="4">The Community Pharmacy Services Group (CPSG) oversees the delivery of the Workplan for the implementation of Community Pharmacy Services, although it was noted that two actions that should have been completed in February and May 2025 respectively, remained outstanding in the excel version of the workplan at the time of our audit (August 2025).

In the ICB governance structure at the time of the review, the CPSG reported into the Primary Care Commissioning Committee (PCCC) who in turn reported to the ICB Board. It was noted that the CPSG minutes are not always cascaded to the Primary Care Commissioning Board.

The ‘Community Pharmacy Advanced Services Implementation and Oversight Programme’ was a tripartite solution between Greater Manchester Health and Social Care Partnership - NHS England (now NHS Greater Manchester Integrated Care Board) as the supplier, the Community Pharmacy Provider Board as the recipient and ‘CPGM Healthcare Limited’ as the host. The arrangements are documented in a Memorandum of Understanding (MOU) and our review of this document noted that some of the specifications contained within the MOU had not been fulfilled, including mid and post project evaluations and spend, outcomes and progress reports.

The ‘Services Working Group’ was formed to deliver the Community Pharmacy project in 2022 after the MOU had been agreed. The most recent Workplan made available to us was dated March 2025 and this identified a significant number actions not having due dates for review and were not RAG rated.</td></tr>
</table>

	The Workplan was previously held on a spreadsheet but has now been migrated to a digital 'board' on the 'Trello' system. Despite requests for a copy of the latest Workplan from this platform, we have been unable to gain access to this due to licensing issues. No other method is available to review the tasks and progress within the Services Working Group Workplan, so we are unable to comment on the current status of the tasks in the digital workplan.
Recommendations (High and Medium Only)	**Recommendation 1 (High)** A solution should be identified to produce reports from Trello, to allow for independent scrutiny on the progress and completion of the assigned tasks. **Response & Implementation Date** An update on the progress of delivery of the actions in the excel spreadsheet workplan has been requested from the SWG as reports from Trello have been confirmed as not extractable. 31/10/25 **Recommendation 2 (High)** Review all outstanding tasks on the Workplan and ensure they are RAG rated and have dates for completion. Where dates have passed without tasks being completed, minutes of the SWG should clearly record actions being taken to address any issues and delays. **Response & Implementation Date** An update on the progress of delivery of the actions in the excel spreadsheet workplan has been requested from the SWG as reports from Trello have been confirmed as not extractable. 31/10/25 **Recommendation 3 (Medium)** The conditions 8.3 and 8.3 (b) set out in the MOU should be reviewed and a plan developed to ensure these are completed as soon as possible with the evaluation and reports issued to the appropriate oversight group/ meeting.

	Furthermore, the extension to MOU agreements should be documented and evidenced. **Response & Implementation Date** A post project evaluation has been requested and the SWG have a meeting in mid-October to discuss the format and contents. The evaluation is expected to be finalised and delivered to CPSG in February or March 2026 and the SWG will oversee its production. An update on the current spend to date has been requested from CHL who are managing the funds, and this will be requested quarterly going forwards. Previous updates were received in November 23, May 24, August 24, October 24, July 25. Written requests were submitted to the head of primary care regarding the 2 extensions to the programme team arrangements which were fully costed and rationale for the extension outlined and an email response was sent to confirm the extension on both occasions. NHS GM will endeavour to locate these emails as evidence of the process followed. 31/10/25

Report Title	**Training and Development**			
Executive Sponsor	Charlotte Bailey, Chief Strategy, People and Partnerships Officer			
Objective	The overall objective of this audit was to review and assess the effectiveness of completion of mandatory training and the approach taken to staff development.			
Recommendations	0 x Critical	0 x High	2 x Medium	1 x Low
Overall Rating	Substantial			
Summary	Overall, there is a good system of internal control in place covering training and development activity at NHS GM, which is designed to meet the system objectives and controls are generally being applied consistently.			

	The NHS GM 'Mandatory Learning Policy Framework' sets out a general overview and detailed framework that covers both mandatory training for all staff and role specific training, as well as setting out clear responsibilities for managers and employees. The core framework for mandatory training is clearly established and the current NHS GM training completion compliance rates are above the organisation's target of 95% with compliance currently at 96%. Escalation processes are in place for those areas not reaching the required levels and the ESR compliance dashboard provides a visual overview which feeds into reporting templates. The NHS GM People and Culture Sub-Committee receive regular reporting, by department, on training completion rates. Learning and Development activity is summarised in the 'Learning and Development Funding, Study Leave and Apprenticeship Policy.' The application process for funding is thorough and comprehensive with applications and funding being both reviewed and approved by the Skills Group. We nonetheless identified some areas for improvement in relation to reporting of completion of role specific mandatory training, some minor inconsistencies in the framework for mandatory training when comparing the Policy to the reporting templates due to timing differences of approvals, and a lack of checks on the recording of completion of learning and development activity on ESR.
Recommendations (High and Medium Only)	**Recommendation 1 (Medium)** The Learning and Development team should consider the current reporting systems and recording of role specific training and ensure that the current gaps in this area are addressed, with the aim of including these details as part of future assurance and reporting arrangements. **Response & Implementation Date** Role specific mandatory training reporting has not been a requested feature in the workforce pack. Additionally, national guidance (in the form of intercollegiate documents) has been updated which has required a review of the TNA of multiple role specific modules. The third TNA in two years in now being reviewed and outcomes will be implemented in ESR. Once that has been undertaken and 3 months allowed for staff to complete (in line with policy), reporting and monitoring can be progressed.

	In the meantime, partial reporting of role specific modules (i.e. Oliver McGowan) is taking place regularly as these allocations and data are up to date and other (ad-hoc) reports for role specific modules can be produced as and when necessary, noting the caveats about the accuracy of allocation pending the completion of the amends from the TNA review. 31/3/26 **Recommendation 2 (Medium)** The Learning and Development team should ensure that the Policy reflects the latest list of modules for mandatory training and that reporting of completion rates to the People and Culture Committee reconciles accordingly with all modules cross referencing back to the Policy. Where there are any variations due to timing differences of approval, these should be explained with the report. **Response & Implementation Date** Conflicts of Interest training was a recent addition to the core requirements and a period of 3 months allowed before reporting/monitoring comes into effect. The timing of the audit and data reported to that point do not reflect this module as its reporting window was not live at the time. Subsequent reports now include this module. The modules identified as not included specifically in the Policy (Preventing Radicalisation – Basic Prevent Awareness (no specified renewal); Safeguarding Adults – Level 1 (no specified renewal); Safeguarding Adults – Level 2 (no specified renewal); Safeguarding Children – Level 1 (no specified renewal); and, Safeguarding Children – Level 2 (no specified renewal)) are not listed in the policy because the staff who require them are monitored at a higher level of compliance – an incremental process. Staff need to maintain this higher level which is conditional on having once completed these earlier ones. Linked to the national review of mandatory training, the future modules and their renewal periods can be clarified/simplified. Appendix A of the policy is being updated to reflect the updated core requirements. 31/3/26

Report Title	**Continuing Healthcare (CHC)**			
Executive Sponsor	Katherine Sheerin, Chief Commissioning Officer			
Objective	The overall objective of this audit was to provide assurance on the arrangements in place at a high level over Continuing Healthcare (CHC), including governance and performance reporting arrangements, compliance with legislative requirements, expenditure and delivering savings, and performance management over service providers.			
Recommendations	0 x Critical	2 x High	2 x Medium	1 x Low
Overall Rating	Moderate			
Summary	The ICB has identified a need for improvement in commissioning continuing healthcare as part of broader transformation plans for All Age Continuing Care (AACC). At M8, as reported to the ICB Board on 26th January 2026, the AACC forecast outturn was £295.2m, a 2% overspend on plan. We gained assurance on the ICB's effectiveness of commissioning arrangements through review of ICB processes; through audit testing of CHC assessment, decision-making and review processes at four localities – Stockport, Oldham, Trafford and Bolton; and through comparative analysis against the national picture of financial data and the CHC activity dataset. On this basis we concluded overall that, despite the need for 'transformation' and forecast overspend, there were fundamentally robust processes in place for the locations reviewed, and the ICB was amongst the most efficient providers of CHC nationally, especially considering the prevalence of areas of high deprivation in its footprint. Our opinion is reflective of control gaps identified as part of transformation and improvements identified in audit, with recommendations made to support transformation plans through a time of significant change and uncertainty. Nonetheless, we emphasise the positive finance and performance data, which also indicates an improving trend in internal controls in recent years, and also note that further improvements are being made.			
Recommendations (High and Medium Only)	**Recommendation 1 (High)**			

	Complete the CHAT and the development of the AACC Transformation Plan, monitoring progression through the Board Assurance Framework/ other committee and Board assurance reporting. **Response & Implementation Date** Work on CHAT has continued but has been slow progress due to it not being a priority during the NHS Reform change programme and as agreed by NHSE. The current section is approx 70% completed and work will continue to achieve completion. The deadline is relevant for the 2nd section. A transformation workbook has been developed by the AACC Transformation meeting which has 43 work areas on it, however many of the work areas are on hold until post structures - 01 April 2026 onwards pending new leadership and governance. Once governance routes, Committees and boards are confirmed this will be factored into the reporting of the transformation updates and work moving forwards. 31/3/26 **Recommendation 2 (High)** Further develop CHC metrics and assurances through the AACC/ Individualised Commissioning Assurance Dashboard and implement a fuller range of reporting at locality and committee level tailored to audience and appropriate to the post-transition ICB governance structure. **Response & Implementation Date** A new monthly assurance report/dashboard has been developed to encompass all individualised commissioning metrics and not just CHC. The new report has been collected since December 2025 in its new format via the GM CHC page on Futures platform. There are still some gaps in the MH/LD/CYP data collection for a few localities due to difficulties obtaining data as this has not been routinely collected before. This will improve over time. Consideration will be given to further developing the assurance report to encompass the suggestions made by MIAA opposite and extending the range of metrics and assurance that is gathered. Post 01 April 2026 when new leadership is in place and new governance routes are confirmed, agreement on what reporting is required will follow and this will be adapted and tailored to meet the required needs of the new ICB structure and governance arrangements.

	Complaints statistics and lessons learnt can be obtained from complaints colleagues as and when required to enhance any future assurance reporting. Upheld appeals and statistics and lessons learnt. An IRP tracker in place to record and monitor the IRP decisions for each locality which captures the recommendations and the decision outcome of the IRP. Feedback on the IRP and shared learning is a standard agenda item on the GM AACC Assurance meeting (held quarterly) and each locality is then asked to present the learning so it shared on a wider GM footprint. Assurance on policies & Procedures - This is a priority area on the AACC Transformation workplan. A number of Heads of service have set up a small task & Finish group to review and update the policies as and when required. The T&F group had their initial meeting in December 2025 and were due to meet again at the beginning of February but the meeting was stood down due to the Reform change programme. All reviewed and updated policies & procedures will be sent through appropriate GM policy governance as required. NHS GM do not currently have a commissioning framework. However, Contracts are working to put in place contracts with providers across residential/domiciliary/Neuro and working closely with GM Quality Managers to ensure appropriate quality monitoring & oversight is in place Audit/Peer Review is a work area on the GM AACC Transformation workplan, however this has not yet been mobilised/set up due to other demanding priorities. Once set up this will be monitored via the Transformation meeting and updates can be shared via relevant committees/meetings/reports etc on progress and findings. 30/9/26 **Recommendation 3 (Medium)** Update policies and publish as appropriate, including CHC Choice and Equity Policy and CHC Operational Policy. **Response & Implementation Date** There are suite of 6 NHS GM ICB CHC policies and procedures that have been developed and embedded across the 10 localities. Updating & reviewing of the policies is a priority area on the AACC Transformation

	workplan for which a number of Heads of service have set up a small task & Finish group to review and update the policies as and when required. The T&F group had their initial meeting in December 2025 and were due to meet again at the beginning of February but the meeting was stood down due to the Reform change programme. The group are currently reviewing the Operational policy and the Enhanced Observation policy which are overdue the review date. Discussions have previously taken place with the GM comms team regarding publishing the suite of GM CHC policies, however it was recommended that not all the policies should be published due to the size of them and accessibility issues and just the operational policy should be published. All 6 GM CHC policies and procedures have been added to the NHS GM CHC Page on Futures which is a closed page for NHS GM ICB CHC staff only. 30/9/26 **Recommendation 4 (Medium)** Amend procedure so that the 28-day clock starts on receipt of the original referral in the event that a positive checklist is rejected and re-submitted. **Response & Implementation Date** Clarification around when localities stop the 28-day clock on referrals as described by MIAA can be added as an agenda item on the GM AACC Transformation meeting (currently meets bimonthly and next meeting is April), this will enable a consistent approach/assurance to ensuring all localities are adhering to the national framework. As Bolton locality is highlighted as following a good process and adhering to the framework, Bolton locality have been approached and asked to share their SOP with GM with a view of replicating it across GM to ensure consistency of practice. This can also be tabled at the next GM AACC transformation meeting in March 2026. The GM CHC operational policy is currently under review by locality Heads of service, so they will be asked to use this opportunity to ensure it is set out in the policy on when the 28-day clock should/shouldn't

	be stopped to ensure consistent application of the national framework across GM. This action will be assigned to the Heads of service reviewing the policies. 30/6/26

<table>
<tr><th>Report Title</th><th colspan="4">ESR Payroll</th></tr>
<tr><td>Executive Sponsor</td><td colspan="4">Charlotte Bailey, Chief Strategy, People and Partnerships Officer</td></tr>
<tr><td>Objective</td><td colspan="4">The overall objective of the audit was to provide an assessment of the effectiveness of the systems of control operating at NHS Greater Manchester Integrated Health Board (NHS GM) to ensure that only employees of NHS GM are paid, and only for work that they perform on behalf of the organisation.</td></tr>
<tr><td>Recommendations</td><td>0 x Critical</td><td>0 x High</td><td>3 x Medium</td><td>0 x Low</td></tr>
<tr><td>Overall Rating</td><td colspan="4">Substantial</td></tr>
<tr><td>Summary</td><td colspan="4">The review provides substantial assurance in that controls were adequately designed and operating effectively within the Electronic Staff Record (ESR) system and the management of payroll provided under contract to GM by ELFS.
The Employment Services Team at NHS GM are responsible for processing all recruitment and pay changes within ESR and work with ELFS to oversee the accuracy of the payroll.
Sample testing found that starters/ leavers and contractual changes were generally processed in a timely manner, although we identified some areas for enhancement including some queries in user responsibility profiles for ESR access rights. Testing identified some active users who have not accessed the system since October 2024.
User guides and procedural notes for staff and the Employment Services team are available on the NHS GM's intranet and changes to staff pay are controlled by the Business Critical Panel for consistency.</td></tr>
</table>

	The Service Level Agreement (SLA) with ELFS has been extended to cover the current financial year. This SLA is due to be renegotiated with the aim that it will be at a lower rate for future years based on NHS GM's future reduced payroll numbers arising from significant organisational change in 25-26. We identified some improvements to the clarity and reporting of contract KPIs which should be considered and embedded into contract monitoring processes in future.
Recommendations (High and Medium Only)	**Recommendation 1 (Medium)** The ICB should review and amend access rights accordingly for all employees with cascading and combined URPs, as well as taking action to review and remove access from those users who have not accessed the system since October 2024 or earlier. Access levels should be reviewed on a regular basis to identify any changes required. Where access profiles differ from the recommended guidance, such decisions should be documented and approved by a senior manager. This is particularly important from 1 April 2026 onwards due to the organisation undergoing significant change. **Response & Implementation Date** a) ESR access rights have not been properly updated with some users having not accessed the system since October 2024 Employees (those with an employee number) who have not accessed in some time, are no problem and are still live employees they are just choosing not to access their ESR account. Those with 'ELFS' in their description, are reviewed quarterly by the Workforce Information Officer, and Payroll confirm if they are still active and require access still (those audit emails can be provided as evidence via Workforce Information). There are some 'External Learner' accounts which exist to allow them to complete mandatory training and so the frequency of their requirement might mean they have not accessed for some time (Workforce Information checks this with the OD&L Team and requests the account removal if no longer required). Will check with Workforce Information for the full list of audit checks – for which she will be able to provide assurance for their existence as evidence if required. b) some staff allocated multiple lines to the same User Provisioning Request (UPR). Regarding the combination of URPs allocated to several individuals. This has been allocated as per the in-house matrix that was created prior to the 2024 URP allowance guidance. The matrix guidance for

	internal and external staff is being reviewed and rewritten to ensure that they align and comply with the URP Allowance guidance notes, and these will be adopted going forward when applying URPs to individuals to avoid inconsistent combination of URPs as well as being reviewed in our quarterly audits. Complete at 05/03/26 **Recommendation 2 (Medium)** The ICB should remind managers of the need for timely completion of all forms, with all sections completed in full and correctly, including obtaining employee signatures and dates. The ICB should investigate the two issues with leavers (the deduction of holiday pay for the leaver concerned and the inconsistent termination date for the leaver concerned) with ELFS to assess whether any overpayments have arisen. The ICB should implement regular ad-hoc checks of completed forms to ensure full completion. **Response & Implementation Date** Payroll deadlines are clearly published on the NHS GM intranet to support managers in the timely submission of starter, leaver and change documentation. To further strengthen awareness and compliance, consideration will be given to promoting payroll deadlines more widely each month, for example through regular highlights on Keep Connected or similar corporate communication channels. This will form the standard part of the quarterly PS update to leadership team meetings to ensure consistent focus remains on accurate termination forms In relation to the leaver where annual leave was not deducted, this has already been identified and the individual has been contacted by Finance to recover the outstanding amount owed. The case where conflicting termination dates were identified between the termination form and the payslip is currently under investigation to establish the root cause of the discrepancy. Once the correct processing date is confirmed, and if it is determined that an error has occurred, Payroll will be notified to ensure that any overpayment is reclaimed in line with established recovery processes. 30/04/26 **Recommendation 3 (Medium)**

	The updated SLA with ELFS for 2026/27 and beyond should include clear and specific details of KPIs which are reported against target. KPIs should be a formal agenda item and noted as part of contract performance meetings. **Response & Implementation Date** A new payroll contract with East Lancashire Financial Services (ELFS) is due to be implemented from 1st April 2026. As part of the development of the new agreement, NHS GM will seek further clarity within the contract documentation to clearly define Service Level Agreements (SLAs) and associated Key Performance Indicators (KPIs), including how these will be measured and monitored. Where it is not possible to fully specify KPIs and SLAs within the contract, NHS GM will request formal confirmation from ELFS of agreed SLA timescales to ensure there is shared understanding and effective performance management arrangements in place. A contract review meeting took place on 26 February 2026, at which KPI definitions, targets and reporting timelines were raised and discussed with ELFS to provide greater clarity ahead of the new contract commencement. ELFS confirmed how to see the KPI's on the reporting portal – further evidence can be provided. KPIs will continue to be included as a standing agenda item at contract performance meetings to support ongoing oversight and assurance. 30/04/26

Appendix D: Assurance Definitions and Risk Classifications

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources. • the safeguarding of assets. • the preparation of reliable financial and operational information. • compliance with laws and regulations.
High	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives. • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives, however, implementation of the recommendation would improve overall control.

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Reports prepared by MIAA are prepared for your sole use and no responsibility is taken by MIAA or the auditors to any director or officer in their individual capacity. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose and a person who is not a party to the agreement for the provision of Internal Audit and shall not have any rights under the Contracts (Rights of Third Parties) Act 1999.

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NHS GM Audit Committee
19th March 2026

Internal Audit Follow Up Report – Quarter 4 2025/26

Part of Greater Manchester Integrated Care Partnership

NHS GM Audit Committee

19th March 2026

Required information	Details
Title of report	Internal Audit Follow Up Report – Quarter 4 2025/26
Author	Darrell Davies/ Patrick Clark
Presented by	Patrick Clark
Contact for further information	Patrick Clark
Executive summary	This report provides the Audit Committee with an update on the progress made by NHS GM implementing outstanding internal audit recommendations.
The benefits that the population of Greater Manchester will experience.	Assurance through the Audit Committee that improvements in internal control are being progressed within the organisation that should lead to improved performance and thus assist the organisations achieve its objectives.
How health inequalities will be reduced in Greater Manchester's communities.	The Internal Audit Plan aims to address all of the key risks of the ICB on a cyclical basis, including responding to the quality agenda.
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	The Internal Audit Plan aims to address aspects of the key risks of the ICB on a cyclical basis. The BAF is considered as part of the annual planning process to ensure that the internal audit plan includes appropriate coverage. Recommendations made by internal audit aim to strengthen the internal control environment which should contribute towards reduction in risk.
Key milestones	N/A
Leadership and governance arrangements	N/A
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A

Financial or Legal Implications	N/A

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

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

Introduction

1.0 This report provides the Audit Committee with an update on the progress of implementing outstanding internal audit recommendations made in Internal Audit reports since the last follow up reported.

Executive Summary

2.0 Since the follow up position reported previously at the December 2025 Audit Committee:

- There were 63 recommendations reviewed as part of the Q4 follow up exercise: 18 High/ 34 Medium/ 8 Low/ 3 N/A.
- Of these 63 recommendations, 21 recommendations are not due to be implemented and 6 have been fully implemented/ superseded. The remaining 36 recommendations are in either in progress and partially implemented (29) or not yet implemented (7).
- Of the 36 recommendations partially or not yet implemented, 34 have had revised implementation dates as set out in the management responses received to date.
- In 11 cases since the previous Audit Committee meeting a revised implementation date has been requested by management and considered by Chief Officers.

System Support and Implementation

3.0 Where applicable and appropriate, our audit recommendations include reference to the 'system' and 'system partners'.

Learning and Innovation

4.0 Our audit recommendations seek to provide appropriate improvements to controls and processes, as well as considering best practice observed at other providers/ ICBs, to support shared learning and improvements.

Recommendations

5.0 The Audit Committee is asked to:

- Note the contents of the report.

Internal Audit Follow Up Report
Audit Committee (March 2026)

NHS Greater Manchester Integrated Care Board

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Appendix B: Assurance Definitions and Risk Classifications

1 Introduction and Background

In making recommendations and agreeing action plans it is intended that improvements may be made to both internal controls and operational effectiveness. However, in order to verify that the benefits of the process are achieved, it is necessary to subsequently follow up on the implementation of agreed actions, in order to fully assess:

- Whether implementation has occurred or been superseded by further events; and
- Whether the actions have produced the intended effect.

Follow-up is, therefore, a vital aspect of the internal audit process.

This report provides an update on the progress of implementing previous internal audit recommendations against the last position reported to the Audit Committee and on recommendations contained in internal audit reports issued since then.

Section 3 and 4 summarises the status of previous audit recommendations and Section 5 details the high and critical risk recommendations that are in progress/outstanding or are not yet due.

When all recommendations have been completed, reviews from previous years will be removed from the tracker once presented to Audit Committee.

To assist the Audit Committee the definitions of risk levels and assurance ratings are included in Appendix A.

2 Objective

The objective of this follow-up review was to provide an update on progress made towards the implementation of agreed internal audit recommendations. The reported position is at the 9th March 2026.

3 Summary

Since the follow up position reported previously at the December 2025 Audit Committee:

- There were 63 recommendations reviewed as part of the Q4 follow up exercise: 18 High/ 34 Medium/ 8 Low/ 3 N/A.
- Of these 63 recommendations, 21 recommendations are not due to be implemented and 6 have been fully implemented/ superseded. The remaining 36 recommendations are in either in progress and partially implemented (29) or not yet implemented (7).
- Of the 36 recommendations partially or not yet implemented, 34 have had revised implementation dates as set out in the management responses received to date.
- In 11 cases since the previous Audit Committee meeting a revised implementation date has been requested by management and considered by Chief Officers. The details of the extended implementation dates are set out in the table below:

No.	Review	Recommendation	Original Date	Revised Date	Rationale
1	Risk Management Core Controls	The Risk Management Policy and Risk Register should be updated to include reference to exploring opportunities as part of the risk assessment process to analyse new opportunities as well as existing risks to determine whether any associated benefits could occur. These should then be tracked alongside risks.	30/09/25	~~01/01/26~~ ~~01/04/26~~ 31/07/26	The implementation of the new Corporate Records system is in progress. As part of this process there is capability to shape the content and so space for capturing arising opportunities can be included. Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.
2	Risk Management Core Controls	Externally accredited risk management training should be agreed and undertaken for specific staff where they are leading on risk management as part of their ongoing development, particularly for the Risk Management team, as well as any other operational leads where appropriate.	31/12/25	30/6/26	Training application forms have been prepared for the team and will be submitted during November 2025. The announcements regarding NHS Reform have inevitably slowed progress with this. Update 9/3/26 - Implementation of this recommendation is on hold until roles are confirmed as part of the NHS GM organisational change process. Training cannot be provided / undertaken until staff are confirmed in roles.
3	Health and Safety	Ensure a Lone Worker Policy is developed and implemented as soon as possible. This should be supported by a full risk assessment, including ensuring the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place.	31/12/25	05/02/26	All pre-existing documentation collated. Lone working group to meet in September 2025 to review. Policy scheduled to be considered by the Policy Review Group in January, followed by People and Culture Sub-Committee in early February.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
4	Health and Safety	The ICB should ensure appropriate staff have been first-aid trained across the organisation, in line with Health and Safety (First-Aid) Regulations 1981. Reporting on completion of training should be included in current training monitoring mechanisms and reporting routines.	31/10/25	~~31/03/26~~ 30/06/26	First aid risk assessments to be completed. First aid training procured. Increase in first aid trained staff to 15, however further increases required. Assessment of leavers following voluntary redundancy schemes to be completed. Work still ongoing, however, further delayed due to staff absence.
5	Health and Safety	Ensure a formal incident reporting and management policy/ procedure is developed and appropriately communicated to all staff.	31/10/25	~~31/03/26~~ 31/07/26	The delivery date for the new Datix system has changed due to NHS Reforms and the date has been revised to reflect this - unable to establish the system without organisational and staff hierarchy, which won't be possible until completion of alignment to the new operating model. Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.
6	Health and Safety	Ensure all required fields are completed for all risk assessments in future through additional checks of completed forms. Where forms are not completed in full, a process should be in place which returns the form to the person completing them for the incomplete information to be added.	31/3/26	30/09/26	Not yet started
6	Oversight Arrangements	The commissioning / governance section of the ICB should update the SOPs for the POM so that they are aligned to the expectations of the POM's TOR in order to fulfil their oversight responsibilities. They must ensure that roles and	30/09/25	31/03/026	This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs)

No.	Review	Recommendation	Original Date	Revised Date	Rationale
		responsibilities for matters that should be delivered by the POM are reflected within the SOPs and that the POM should have an approved annual work programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a starting reference point for such an exercise.			until we have clarity on the Place Partnership Agreements.
7	Oversight Arrangements	The commissioning/ governance section of the ICB should update the SOPs for the LAM so that they are aligned to the expectations of the LAM TOR in order to fulfil the delegated responsibilities. They must ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs and that the LAM for each locality should have an approved annual work programme, which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a starting reference point for such an exercise.	30/09/25	31/03/26	This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.
8	Oversight Arrangements	The governance section of the ICB should update their SOPs for the LAM to ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs. The LAM for each locality should have an approved annual work programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a reference point for such an exercise.	30/09/25	31/03/26	This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
9	Mental Health	The GMICB should ensure that in addition to having up-to-date terms of reference of the GM Mental Health Partnership Board, they also have an annual work programme for the Board to ensure that they fulfil all their operational, strategic and assurance mandates in a timely manner.	31/01/26	31/05/26	All current groups mapped and streamlined. ToR for MHPG still to be reviewed within the context of the new GM Operating Model.
10	Assurance Framework	The narrative should clearly reflect how the risk owner intends to move the risk to within the specified tolerance level and if this not possible then what actions/mitigations the ICB intends to put in place.	30/09/25	~~31/1/26~~ 30/06/26	New dynamic risk reporting process being developed following further feedback from NHS GM Board and Committees. This will be addressed as part of this work.
11	Assurance Framework	Risk should be reviewed to ensure that identified gaps in controls relate to a control rather than a factor that impacts on the management of the risk. Stated actions should be linked to the control gap and clearly describe how its completion will impact on the control gap.	30/9/25	~~31/1/26~~ 30/06/26	New dynamic risk reporting process being developed following further feedback from NHS GM Board and Committees. This will be addressed as part of this work.

The next formal follow up of previously agreed recommendations will be reported in Q1 2026/27.

4 Internal Audit Action Tracker

The following summarises progress against the internal audit recommendations as at **9th March 2026:**

Audit Year	Review	Executive Lead	Total	Number of Recommendations					
				Not Yet Due	Superseded	Fully Implemented	Partially Implemented	Not Implemented	No Response Received
22/23	Post Integration IG and Digital Governance Review	Colin Scales	1	0	0	0	1	0	0
23/24	Cyber Organisational Controls	Colin Scales	6	0	0	0	6	0	0
23/24	Health and Wellbeing	Charlotte Bailey	1	0	0	1	0	0	0
24/25	EPRR	Colin Scales	5	1	0	0	4	0	0
24/25	Population Health Strategy	Charlotte Bailey	1	0	1	0	0	0	0
24/25	Culture Framework	Charlotte Bailey	2	2	0	0	0	0	0
24/25	CHC – Contract Management	Mandy Philbin	7	0	0	0	7	0	0
24/25	Performance Management Data Quality	Colin Scales	5	0	0	0	0	0	5
24/25	Risk Management Core Controls	Charlotte Bailey	2	2	0	0	0	0	0
24/25	Commissioning	Katherine Sheerin	4	0	0	0	4	0	0
24/25	SEND	Katherine Sheerin	2	1	0	0	1	0	0
24/25	Health and Safety	Charlotte Bailey	4	3	0	0	1	0	0
24/25	Assurance Framework	Charlotte Bailey	2	0	0	0	2	0	0
24/25	Oversight Arrangements	Colin Scales	3	3	0	0	0	0	0
24/25	Contract Management Quality of Care	Manisha Kumar	4	0	0	3	0	1	0
24/25	IT Asset Management	Colin Scales	4	4	0	0	0	0	0
25/26	CAF aligned DSPT	Colin Scales	3	0	0	0	3	0	0
25/26	Financial Recovery Programme	Kathy Roe	2	2	0	0	0	0	0
25/26	POD Delegation	Katherine Sheerin	2	1	0	0	0	0	1
25/26	Mental Health	Manisha Kumar	3	2	0	1	0	0	0
		Total	**63**	**21**	**1**	**5**	**29**	**1**	**6**

5 Internal Audit High Risk Recommendations – MIAA

The following provides the details of the high risk recommendations that have been implemented/ superseded and those outstanding as at 9th March 2026:

REVIEW	RECOMMENDATION	CURRENT POSITION
2023/24 REVIEWS		
Cyber Organisational Controls Responsible Officer: Various – see Appendix A Action Due: Various ***Revised date: 31/1/26***	3 x high risk recommendations relating to incident management, cyber risk regime and 3rd party management.	**Partially Implemented** Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2024/25 REVIEWS		
EPRR Responsible Officer: Andrew Bidolak (Head of EPRR) Action due: 30/11/25 ***Revised date: 31/3/26***	**Recommendation 2:** Now that the ICB has completed its 2024/25 Self-Assessment, an action plan should be developed which provides a clear framework setting out how and when the ICB will achieve a rating of 'substantial' compliance and the specific actions and resource required to deliver this objective within clear and realistic timeframes. **Management Response:** Since the self-assessment for the 2023/24 EPRR Core Standards assurance process, NHS GM has increased its overall level of compliance. However, further work is required to move the organisation from 'non-compliant' to 'substantial' compliance. An EPRR Core Standards improvement plan has been developed and this sits alongside the BCMS Implementation Plan, as business continuity is the domain within the self-assessment that has the highest proportion of standards rated as either 'partially compliant' or 'non-compliant'. Furthermore, a new staff member is expected to join the team in February 2025 and this appointee brings experience of NHS EPRR and business continuity, which the team anticipates will help with progressing improvement actions.	**Not Yet Due** 14/11/25 Update - Lack of team capacity has delayed progress. Supporting arrangements across NW region now agreed, with new target date of the end of the financial year to implement these actions.

REVIEW	RECOMMENDATION	CURRENT POSITION
EPRR Responsible Officer: Andrew Bidolak (Head of EPRR) Action due: 31/3/25 ***Revised date: ~~31/5/25,~~ 31/3/26***	**Recommendation 4:** The ICB should review training arrangements for EPRR to ensure that the following is achieved: •Training Needs Analysis forms are completed by all relevant staff involved in EPRR. •A summary of the forms is provided which informs the training programme offer for future years. •A mechanism for recording the formal completion of training is established which is used to highlight non-completion against the minimum occupational standards. •Training completion is regularly included on the agenda of an Oversight Group. **Management Response:** The EPRR team currently tracks participation by NHS GM staff in EPRR training through a basic spreadsheet. Although relevant information is collected, the functionality of the spreadsheet is limited and tracking of training participation needs to be improved to allow for better forward planning. The EPRR team will develop an enhanced EPRR training and exercising database that includes functionality to record a wider range of information and to highlight gaps and forthcoming requirements for training participation by NHS GM staff. Furthermore, the EPRR team will undertake regular reporting on training participation and requirements.	**<u>Partially Implemented</u>** 14/11/25 Update - Lack of team capacity has delayed progress. Supporting arrangements across NW region now agreed, with new target date of the end of the financial year to implement these actions**.**
CHC Contract Management Responsible Officer: Mandy Philbin (Chief Nursing Officer) Action due: 30/6/25	**Recommendation 1:** To ensure that a policy and guidance documents are developed and put into place to ensure that there is consistency in the approach for each of the localities across GM. Additionally, a CHC strategy should be developed and agreed for CHC commissioning, operational and contract management to set out overarching principles of the service and assurance arrangements/ requirements. **Management Response:** A CHC commissioning policy will be developed which outlines the process for approving and selecting providers along with the operational clarity outlining the process and segregation of duties. This will be	**<u>Partially Implemented</u>** 10/11/25 Update - Policy currently being embedded via IPoC PID. Policy has been supported via Finance Committee and CPAS. **Awaiting evidence.**

REVIEW	RECOMMENDATION	CURRENT POSITION
	reviewed by the financial assurance team to ensure this is robust and that all decisions made have a clear audit trail.	
CHC Contract Management Responsible Officer: Mandy Philbin (Chief Nursing Officer) Action due: 30/6/25 ***Revised date: 31/3/26***	**Recommendation 2:** To review the process around the commissioning and awarding of domiciliary contracts and ensure that there is a transparent and equitable provider contract allocation process in place which ensures quality of service standards are being considered and provides clarity in terms of roles and responsibilities in the process. The process should be consistently applied across GM which removes the current practice of 'first come first served' and considers quality and capacity, utilising systems such as 'Datix' as far as practicable. **Management Response:** The process around the commissioning and awarding of care packages will be reviewed to ensure this process is transparent, equitable and there is the appropriate segregation of duties. The awarding of care packages on a first come first basis via email will be ceased with immediate effect. A CHC commissioning policy will be developed which outlines the process for approving and selecting providers along with the operational clarity outlining the process and segregation of duties. This will be reviewed by the financial assurance team to ensure this is robust and that all decisions made have a clear audit trail. The contract management process will be reviewed to ensure all necessary details and documentation is put in place once the relevant provider has been selected. To ensure only providers that meet the minimum quality standards are commissioned to provide CHC services will be outlined in the CHC Commissioning policy. The quality team will also ensure that providers are appropriately monitored to provide assurance on the quality of care being provided in line with the contract agreed and meet the minimum standards as required by NHSE.	**Partially Implemented** 10/11/25 Update - Embedding of policy and process underway. This is being monitored via the IPoC CIP Plan. All new PoC are being commissioned via the care home framework where able and any bespoke PoC are commissioned via the policy off framework until the NHS framework is avaliable. Advise to extend due date to Q4 as embedding process is sustained.
CHC Contract Management Responsible Officer: Mandy Philbin (Chief Nursing Officer) Action due: 30/6/25 ***Revised date: 31/3/26***	**Recommendation 5:** To develop and agree a framework for assessing existing and new providers which includes consistent, comprehensive due diligence checks and that evidence is maintained to support this process.	**Partially Implemented** 10/11/25 Update - Embedding of policy and process underway. This is being monitored via the IPoC CIP Plan. All new PoC are being commissioned via the care home

REVIEW	RECOMMENDATION	CURRENT POSITION
	To identify with the Contracting function the requirements they would expect to be in place for an SLA as part of the roll out to ensure that they are comprehensive and are rolled out to all remaining providers. To ensure that nursing and clinical staff are being consulted when allocating package of care to providers and that this is recorded as part of the process. **Management Response:** A CHC commissioning policy will be developed which outlines the process for approving and selecting providers along with the operational clarity outlining the process and segregation of duties. This will be reviewed by the financial assurance team to ensure this is robust and that all decisions made have a clear audit trail. The contracting team will ensure for all approved providers the relevant contracting arrangements and supporting documentation is in place. Compliance with the contracting arrangements will be in conjunction with the relevant supporting teams (quality, clinical and commissioning and finance).	framework where able and any bespoke PoC are commissioned via the policy off framework until the NHS framework avaliable. Advise to extend due date to Q4 as embedding process is sustained.
Performance Management – Data Quality Responsible Officer: Matt Hennessey (Chief Intelligence and Analytics Officer) Action due: 30/9/25 ***Revised Date:31/12/25***	**Recommendation 2:** Alongside the data quality strategy, a data quality improvement plan should also be developed which revisits any actions/ solutions not yet addressed from the Health Innovation Manchester review. As part of any data quality improvement plan, a performance framework as part of commissioning requirements should also be considered. **Management Response:** A 2025/26 Data Quality Improvement Plan has been developed and we're just about to commence individual meetings with each provider to agree its content including baselines and timescales for implementation during 2025/26.	**Not Yet Implemented** Delayed due to reform activities and staff sickness.
Commissioning Responsible Officer: Associate Director of Contract Management Action due: Ongoing ***Revised Date:31/12/25***	**Recommendation 2:** The ICB should review its commissioning activities cycle and ensure that providers are contracted to offer the services in a timely manner as close to the beginning of the contract period as possible.	**Partially Implemented** 13/11/25 Update - Work continues to progress contracts through due process and governance as described in the June update. The schedule of contracts signed

REVIEW	RECOMMENDATION	CURRENT POSITION
	Management Response: NHS GM ICB does issue contracts to providers in a timely manner however the delay in obtaining signature is often a result of negotiation with providers, mainly in respect of finance schedules.	and outstanding will be presented to December Finance Committee.
Commissioning Responsible Officer: Associate Director of Contract Management and Associate Director of Strategic Commissioning Action due: 1/7/25 ***Revised Date:31/12/25***	**Recommendation 4:** The ICB should ensure that all of their committees/ subcommittees with the responsibility for provider performance oversight have clearly stated assurance information requirements in their terms of reference, as well as formally approved annual work programmes so that they have the necessary capacity and capability to collate and review all of the commissioning performance data and intelligence, enabling the ICB to discharge their commissioning responsibilities including reporting externally where necessary, in a timely manner. This applies to the following governance arrangements: •For Public Health - the Screening and Immunisation Oversight Commissioning Contracting and Finance Group (SIOCCFG) and the Public Health Advisory Group which report to the Public Health Committee of the ICB. •For GPs - the ICB's Direct Commissioning & Contracting Panel (DCCP) which reports to the GMICB PCCC. •For Acute, Mental Health and Independent Providers – the Provider Oversight Subcommittee which reports to the executive Provider Oversight Meeting and the Quality and Performance Committee of the GMICB. **Management Response:** For Acute, Community, Mental Health and Independent Sector contracts - In addition to the POS, there are monthly formal Contract Review Meetings, (CRMs) which involve Performance, Commissioning and Quality. There is a set format with an agenda agreed in advance. The CRM meetings are formally recorded with a clear action log. Any issues with commissioned services will have a remedial action plan which is reviewed at CRMs. The Responsible Officers will review the agendas and with respective commissioning leads to incorporate a work programme for the year which will signal key dates / milestones.	**Partially Implemented** 13/11/25 Update - The Internal Provider Oversight Group has now been disbanded due to the imminent changes in ICB assurance and oversight responsibilities as per the guidance for the model ICB. A working group is now established to develop revised TOR for NHS provider contract governance as part of the wider assurance and governance overview which is due to take effect from 1.4.26.
Health and Safety	**Recommendation 1:** Ensure a Lone Worker Policy is developed and implemented as soon as possible. This should be supported by a full risk	**Not Yet Due**

REVIEW	RECOMMENDATION	CURRENT POSITION
Responsible Officer: Samantha Deakin – H&S Lead Action due: 31/12/25 ***Revised Date: ~~05/02/26~~, 30/6/26***	assessment, including ensuring the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place. **Management Response:** A working group on lone working will be stood up in July 2025 with the aim of producing the policy, a full risk assessment to ensure that the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place.	All pre-existing documentation collated. Lone working group to meet in September 2025 to review. Policy scheduled to be considered by the Policy Review Group in January, followed by People and Culture Sub-Committee in early February. Update 9/3/26 – Policy in draft - progress delayed due to staff absence and capacity redirected for NHS reform.
Health and Safety Responsible Officer: Samantha Deakin – H&S Lead Action due: 31/10/25 ***Revised Date:~~31/3/26~~, 30/6/26***	**Recommendation 2:** The ICB should ensure appropriate staff have been first-aid trained across the organisation, in line with Health and Safety (First-Aid) Regulations 1981. Reporting on completion of training should be included in current training monitoring mechanisms and reporting routines. **Management Response:** A first aid risk assessment to be completed for all work locations. First aid training provided has been approved; the first aiders are in the process of being booked on training courses by the end of July 2025. Some localities have asked if nurses can act as the first aiders, await response from the localities. Reporting on completion of training will be added onto the current training monitoring mechanism and reporting routines.	**Partially Implemented** First aid risk assessments to be completed. First aid training procured. Increase in first aid trained staff to 15, however further increases required. Assessment of leavers following voluntary redundancy schemes to be completed. Work still ongoing, however further delayed due to staff absence.
Contract Management Quality of Care Responsible Officer: Claire Smith Action due: 31/10/25	**Recommendation 1:** A formal Risk Stratification exercise should be completed for all Independent Sector contracts, with evidence of results maintained. (We acknowledge that this is the proposal set out by the ICB, with current focus on the arrangements for 'high' priority providers). The format of risk stratification and parameters for future quality monitoring should be agreed with input from quality teams across all localities, reported to the GM System Quality Group and ratified by the Quality Committee and the Board. As part of the current re-organisation, the ICB should ensure that robust mechanisms are established and operating, to enable clear visibility of quality	**Fully Implemented** The risk stratification tool has been completed and has been applied to all independent sector contracts.

REVIEW	RECOMMENDATION	CURRENT POSITION
	matters by the ADNQs. These should include a process of clear and regular assurance reporting of contract performance by Quality Managers. In addition, consideration should be given to any potential negative effect of re-assignment of ADNQs, and how this can be effectively managed to ensure the continuation of robust quality monitoring to Locality Boards. There should be flexibility in allocated monitoring arrangements to account for changes in contract risk status, identified through utilisation of intelligence relating to performance and a scheduled (for example annual) repeat of the risk stratification process. **Management Response:** A Risk Stratification Tool has been developed holistically between the Contract, Quality and Safeguarding, Performance & Finance functions to enable a full assessment of risk across all NHS GM contracts. This tool has been finalised and is currently in the process of being tested by the contracts team. The reform work has slowed this down somewhat, but it is recognised that this is a necessary tool within the new ICB model and so the work is continuing. Since the Audit was undertaken several changes have occurred – the centralisation of the Quality Managers with clear areas of responsibility for independent sector contracts, as well as MDT working across the Acute & MH Trust contracts, ensures that the ADNQs have resource in place to support their understanding of quality in the individual localities. This model also provides some resilience and flexibility as we can redeploy resource where needed when level of risk changes. In addition, work has been completed to ensure the process is also linked to the Provider Accreditation Process ensuring that quality and safeguarding are involved in the assessment process for new providers onboarding and quality oversight is allocated as appropriate.	
IT Asset Management Responsible Officer: Malcolm Whitehouse Action due: 31/3/26	One high risk recommendation relation to Strategy and Contracts	**Not Yet Due**

REVIEW	RECOMMENDATION	CURRENT POSITION
2025/26 REVIEWS		
CAF aligned DSPT Responsible Officer: Various Action due: 31/10/25 and 31/12/25 ***Revised Date: 31/1/26***	3 x high risk recommendations relating to supply chain, identity and access control and response planning.	**Partially Implemented** Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.

Appendix A: Detailed List of Outstanding Recommendations

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
2022/23	Post Integration Review	N/A	IT Service Provision and Technical Framework x 5 subsidiary actions.	Malcolm Whitehouse	Colin Scales, Deputy Chief Executive	N/A	N/A	**Partially Implemented** 4 have been closed and one is partially implemented.
2023/24	Cyber Organisational Controls	High x 3	3 recommendations made relating to incident management, cyber risk regime ad 3rd party management.	Various	Colin Scales, Deputy Chief Executive	Various	31/1/26	**Partially Implemented** Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2023/24	Cyber Organisational Controls	Medium x 3	3 recommendations made relating to critical assets, cyber security measures and cyber experience.	Various	Colin Scales, Deputy Chief Executive	Various	31/1/26	**Partially Implemented** Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2024/25	EPRR	Medium	The ICB should formalise its governance and oversight arrangements over BCP and EPRR, including setting up an Oversight Group, as per the policy, to oversee strategy, risks and compliance with NHSE requirements.	Andrew Bidolak, Head of EPRR	Colin Scales, Deputy Chief Executive	28/02/2025	31/3/26 ~~31/05/2025~~	**Partially Implemented** 14.11.25 Update - Lack of team capacity has delayed progress. Supporting arrangements across NW region now agreed, with new target date of the end of the financial year to implement these actions.
2024/25	EPRR	High	Now that the ICB has completed its 2024/25 Self-Assessment, an action plan should be developed which provides a clear framework setting out how and when the ICB will achieve a rating of 'substantial' compliance and the specific actions and resource required to deliver this objective within clear and realistic timeframes.	Andrew Bidolak, Head of EPRR	Colin Scales, Deputy Chief Executive	30/11/2025	31/3/26	**Not Yet Due** 14.11.25 Update - Lack of team capacity has delayed progress. Supporting arrangements across NW region now agreed, with new target date of the end of the financial year to implement these actions.
2024/25	EPRR	Medium	The ICB should develop a formal mechanism for the recording of EPRR exercises, which will allow the EPRR	Andrew Bidolak, Head of EPRR	Colin Scales, Deputy Chief Executive	31/03/2025	31/3/26 ~~31/05/2025~~	**Partially Implemented** 14.11.25 Update - Lack of team capacity has delayed progress. Supporting arrangements

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			team to document the results and evaluate their success including identifying and implementing lessons learned. Additionally, EPRR exercises should be diarised annually as part of a workplan to ensure that the ICB complies with carrying out the range of exercises as set out in the Policy.					across NW region now agreed, with new target date of the end of the financial year to implement these actions.
2024/25	EPRR	High	The ICB should review training arrangements for EPRR to ensure that the following is achieved: •Training Needs Analysis forms are completed by all relevant staff involved in EPRR. •A summary of the forms is provided which informs the training programme offer for future years. •A mechanism for recording the formal completion of training is established which is used to highlight non-completion against the minimum occupational standards. •Training completion is regularly included on the agenda of an Oversight Group.	Andrew Bidolak, Head of EPRR	Colin Scales, Deputy Chief Executive	31/03/2025	31/3/26 ~~31/05/2025~~	**Partially Implemented** 14.11.25 Update - Lack of team capacity has delayed progress. Supporting arrangements across NW region now agreed, with new target date of the end of the financial year to implement these actions.
2024/25	EPRR	Medium	As the ICB's EPRR and BCP framework and processes become more established, including setting up a BCP and EPRR Oversight Group, a specific BCP and EPRR risk register should be established to highlight and monitor the key risks around these areas.	Andrew Bidolak, Head of EPRR	Colin Scales, Deputy Chief Executive	31/03/2025	31/3/26 ~~31/05/2025~~	**Partially Implemented** 14.11.25 Update - Lack of team capacity has delayed progress. Supporting arrangements across NW region now agreed, with new target date of the end of the financial year to implement these actions.
2024/25	Culture Framework	Low	The ICB should consider introducing a system where the responses to the three cultural questions in the appraisal	Amber Redding, OD Manager	Charlotte Bailey, Chief People Officer	30/09/2025	31/5/26	**Not Yet Due** November Update - Work has now begun on the review of the appraisal process. A core group of

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			template are collated to give another strand to assessing the cultural health of the organisation and encourage staff to complete this section in their individual template.					individuals from across People & Culture have been identified as key stakeholders and a task and finish group has been established. The group are meeting for the first time on 12.11.25. At the first meeting a project timeline will be agreed. The proposed plan at the task and finish group includes all actions required to review all elements of the appraisal process, including engagement, cultural aspects, data collection, template revision, recording requirements and policy/governance assurances. The project will be co-lead across People Services and Organisational Development with ongoing discussions about the future BAU leadership of appraisals.
2024/25	Culture Framework	Low	As part of the Framework, the ICB should set out how this has been produced including the approach and methodology it is planning to use to set and review values and behaviours.	Amber Redding, OD Manager	Charlotte Bailey, Chief People Officer	30/09/2025	31/5/26	**Not Yet Due** August Update: We propose deferring this review until after the new organisation is established on April 1, 2026, including it as an action on a future focussed OD plan. It is essential that any values accurately reflect the organisation. Once the new operating model is in place, we would develop a set of values that not only mirrors the new organisation but is also co-designed by the workforce. This approach will ensure cultural alignment with strategic intent and provide a clear definition of the strategy, purpose, and function of the ICB as a strategic commissioner.
2024/25	CHC - Contract Management	High	To ensure that a policy and guidance documents are developed and put into place to ensure that there is consistency in the approach for each of the localities across GM. Additionally, a CHC strategy should be developed and agreed for CHC commissioning, operational and contract management to set out overarching	Mandy Philbin – Chief Nursing Officer	Mandy Philbin – Chief Nursing Officer	30/06/2025		**Partially Implemented** 10/11/25 Update - Policy currently being embedded via IPoC PID. Policy has been supported via Finance Committee and CPAS. Awaiting evidence.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			principles of the service and assurance arrangements/ requirements.					
2024/25	CHC - Contract Management	High	To review the process around the commissioning and awarding of domiciliary contracts and ensure that there is a transparent and equitable provider contract allocation process in place which ensures quality of service standards are being considered and provides clarity in terms of roles and responsibilities in the process. The process should be consistently applied across GM which removes the current practice of 'first come first served' and considers quality and capacity, utilising systems such as 'Datix' as far as practicable. Consideration should also be given to any opportunities to centralise and cluster arrangements across bigger locality footprints or even pan GM.	Mandy Philbin – Chief Nursing Officer / Kathy Roe, Chief Finance Officer	Mandy Philbin – Chief Nursing Officer	30/06/2025	31/3/26	**Partially Implemented** 10/11/25 Update - Embedding of policy and process underway. This is being monitored via the IPoC CIP Plan. All new PoC are being commissioned via the care home framework where able and any bespoke PoC are commissioned via the policy off.
2024/25	CHC - Contract Management	Medium	To ensure that there is segregation of duty in the process of obtaining expression of interest to the awarding of the package of care and authorisation. Consideration should be given to how segregation of duties and separate authorisation is achieved where timeframes are short and whether additional layers of authorisation should be required when awarding funding over a certain value. Additionally, a periodic audit process should be considered to review the application of segregation of duties where appropriate. To ensure there is a process in place which provides an audit trail or formal	Mandy Philbin – Chief Nursing Officer	Mandy Philbin – Chief Nursing Officer	30/06/2025		**Partially Implemented** 10/11/25 Update - Embedding of policy and process underway. This is being monitored via the IPoC CIP Plan. All new PoC are being commissioned via the care home framework where able and any bespoke PoC are commissioned via the policy off framework until the NHS framework is available. All duties are segregated and have a clear audit trail. Awaiting evidence.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			record of responses and communication. Additionally, the use of a single, central email should be used for the purposes of contract award processes.					
2024/25	CHC - Contract Management	Medium	To ensure that all localities have an agreed pricing structure in place ensuring consistency of payments within the same care home, as part of GM wide pan-commissioning arrangements.	Mandy Philbin – Chief Nursing Officer	Mandy Philbin – Chief Nursing Officer	30/06/2025		**Partially Implemented** 10/11/25 Update - Policy currently being embedded via IPoC PID. Policy has been supported via Finance Committee and CPAS. Awaiting evidence.
2024/25	CHC - Contract Management	High	To develop and agree a framework for assessing existing and new providers which includes consistent, comprehensive due diligence checks and that evidence is maintained to support this process. To identify with the Contracting function the requirements they would expect to be in place for an SLA as part of the roll out to ensure that they are comprehensive and are rolled out to all remaining providers. To ensure that nursing and clinical staff are being consulted when allocating package of care to providers and that this is recorded as part of the process.	Mandy Philbin – Chief Nursing Officer / Kathy Roe, Chief Finance Officer	Mandy Philbin – Chief Nursing Officer	30/06/2025	31/3/26	**Partially Implemented** 10/11/25 Update - Embedding of policy and process underway. This is being monitored via the IPoC CIP Plan. All new PoC are being commissioned via the care home framework where able and any bespoke PoC are commissioned via the policy off framework until the NHS framework available. Advise to extend due date to Q4 as embedding process is sustained.
2024/25	CHC - Contract Management	Medium	To reinforce to the CHC team the importance and requirement to register all concerns and issues on the Provider Concerns Spreadsheet to ensure effective recording and monitoring takes place, including ensuring actions are closed off, lessons learnt recorded and that there is formal escalation and reporting.	Mandy Philbin – Chief Nursing Officer	Mandy Philbin – Chief Nursing Officer	30/06/2025	31/3/26	**Partially Implemented** 10/11/25 Update - Embedding of policy and process underway. This is being monitored via the IPoC CIP Plan. All new PoC are being commissioned via the care home framework where able and any bespoke PoC are commissioned via the policy off framework until the NHS framework is available. All duties are segregated and have a clear audit trail. Advise due date is Q4 as policy is sustainably embedded.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
2024/25	CHC - Contract Management	Low	To ensure that the Individual Placement Agreements are retained centrally and available for review where required.	Mandy Philbin – Chief Nursing Officer / Kathy Roe, Chief Finance Officer	Mandy Philbin – Chief Nursing Officer	30/06/2025	31/3/26	**Partially Implemented** 10/11/25 Update - Embedding of policy and process underway. This is being monitored via the IPoC CIP Plan. All new PoC are being commissioned via the care home framework where able and any bespoke PoC are commissioned via the policy off framework until the NHS framework is available. Advise due date is Q4 as policy is sustainably embedded.
2024/25	Performance Management Data Quality	Medium	The ICB should continue to develop and finalise the Community Services Data Quality Strategy and Policy which sets out its framework for managing and reporting on these datasets, including roles and responsibilities, reporting requirements internally and externally, as well as data quality processes and controls.	Matt Hennessey, Chief Intelligence and Analytics Officer	Colin Scales, Deputy Chief Executive	30/06/2025	31/12/25	**Not Yet Implemented** DQ policy has been developed but seeking an appropriate ratification date. Specific Community Service DQ strategy paused because of reform activities.
2024/25	Performance Management Data Quality	High	Alongside the data quality strategy, a data quality improvement plan should also be developed which revisits any actions/ solutions not yet addressed from the Health Innovation Manchester review. As part of any data quality improvement plan, a performance framework as part of commissioning requirements should also be considered.	Matt Hennessey, Chief Intelligence and Analytics Officer	Colin Scales, Deputy Chief Executive	30/09/2025	31/12/25	**Not Yet Implemented** Delayed due to reform activities and staff sickness.
2024/25	Performance Management Data Quality	Medium	The ICB should produce a datamap which sets out expectations for each provider against the services they deliver and the corresponding data fields in CSDS. This should then be used to manage expectations around data completion on an ongoing basis to identify genuine gaps.	Matt Hennessey, Chief Intelligence and Analytics Officer	Colin Scales, Deputy Chief Executive	30/09/2025	31/12/25	**Not Yet Implemented** Delayed due to reform activities and staff sickness.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
2024/25	Performance Management Data Quality	Medium	The ICB should revisit its contracts with providers to consider whether, in the absence of clear national guidance, separate KPIs could be included which set clear requirements and parameters on providers to comply with. As data submissions are not linked to financial flows, the ICB needs to consider how it can enforce and incentivise providers to submit more comprehensive data in line with expectations and perhaps link data submissions to performance management and reporting at provider level.	Matt Hennessey, Chief Intelligence and Analytics Officer	Colin Scales, Deputy Chief Executive	30/09/2025	31/12/25	**Not Yet Implemented** Delayed due to reform activities and staff sickness.
2024/25	Performance Management Data Quality	Medium	As part of the development of a performance framework, the ICB should agree a reporting framework for CSDS and SitRep data to determine how the key data it requires to oversee the effectiveness of community services provision reporting and which groups/ committees the reports should go to.	Matt Hennessey, Chief Intelligence and Analytics Officer	Colin Scales, Deputy Chief Executive	30/09/2025	31/12/25	**Not Yet Implemented** Delayed due to reform activities - there are steps to merge provider oversight and strategic contracting meetings and so DQ will become part of these.
2024/25	Risk Management Core Controls	Low	Externally accredited risk management training should be agreed and undertaken for specific staff where they are leading on risk management as part of their ongoing development, particularly for the Risk Management team, as well as any other operational leads where appropriate.	Chris Gaffey, Associate Director of Corporate Services	Colin Scales, Deputy Chief Executive	31/12/2025	30/6/26	**Not Yet Due** Training application forms have been prepared for the team and will be submitted during November 2025. The announcements regarding NHS Reform have inevitably slowed progress with this. Implementation of this recommendation is on hold until roles are confirmed as part of the NHS GM organisational change process. Training cannot be provided / undertaken until staff are confirmed in roles.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
2024/25	Risk Management Core Controls	Low	The Risk Management Policy and Risk Register should be updated to include reference to exploring opportunities as part of the risk assessment process to analyse new opportunities as well as existing risks to determine whether any associated benefits could occur. These should then be tracked alongside risks.	Rick Thompstone, Assistant Director of PMO and Risk	Colin Scales, Deputy Chief Executive	30/09/2025	31/7/26 ~~1/4/26~~ ~~1/1/26~~	**Not Yet Due** The implementation of the new Corporate Records system is in progress. As part of this process there is capability to shape the content and so space for capturing arising opportunities can be included. The go live date on the new Datix risk system has been moved to January 2026. This is due to the ongoing NHS reforms that will result in a new organisational structure and the need for the system to align to this. The implementation of the new Corporate Records system is in progress. As part of this process there is capability to shape the content and so space for capturing arising opportunities can be included. Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.
2024/25	Commissioning	Medium	• The Public Health Committee (PHC) should ensure that the annual delegation agreement for S7A is in place in a timely manner. • The PHC should ensure that the role of the Screening and Immunisation Oversight, Commissioning, Contracting and Finance Group is adequately defined, and reporting arrangements are appropriate for providing the assurances they require to execute their Public Health functions as required. The terms of reference of the Group should be formally approved and reviewed regularly. • GM PCCC should ensure that all	Associate Director – Strategic Commissioning (to coordinate)	Katherine Sheerin, Chief Commissioning Officer	30/06/2025		**Partially Implemented** Awaiting evidence 13/11/25 Update - S7A screening and immunisation programmes remain within the S7A public health functions agreement between DHSC and NHSE. Delegation of these services to ICBs has been deferred until April 2027. The services will be commissioned via the Office for Pan ICB Commissioning. The SIOCCFG has been dis-established and all S7A governance is within the GM PCCC, with updated ToR.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			locality (PCQG /PCOGs/ PCQAIF) have standard terms of reference that are appropriately approved. • The Commissioning Directorate should input into the development of the ToR for the POS and POM and these should be presented to the Commissioning Oversight Group and have these formally ratified by the Quality and Performance Committee of the ICB.					
2024/25	Commissioning	High	The ICB should review its commissioning activities cycle and ensure that providers are contracted to offer the services in a timely manner as close to the beginning of the contract period as possible.	Associate Director of Contract Management	Katherine Sheerin, Chief Commissioning Officer	Ongoing	31/12/25	**Partially Implemented** Update 13.11.25 - Work continues to progress contracts through due process and governance as described in the June update. The schedule of contracts signed and outstanding will be presented to December Finance Committee.
2024/25	Commissioning	Medium	The GMICB Provider Oversight Subcommittee (POS) should design reporting templates containing all of the metrics which should be considered at CRMs consistently at all providers, including the voluntary sector, so that they can compare not only service delivery for escalation, but also provider performance to learn and share lessons of good practice.	Associate Director of Contract Management and Associate Director of Strategic Commissioning	Katherine Sheerin, Chief Commissioning Officer	01/06/2025	31/3/26	**Partially Implemented** Update 13.11.25 - The Internal Provider Oversight Group has now been disbanded due to the imminent changes in ICB assurance and oversight responsibilities as per the guidance for the model ICB. A working group is now established to develop revised TOR for NHS provider contract governance as part of the wider assurance and governance overview which is due to take effect from 1.4.26.
2024/25	Commissioning	High	The ICB should ensure that all of their committees/ subcommittees with the responsibility for provider performance oversight have clearly stated assurance information requirements in their terms of reference, as well as formally approved annual work programmes so that they have the necessary capacity and capability to collate and review all of the commissioning performance data	Associate Director of Contract Management and Associate Director of Strategic Commissioning	Katherine Sheerin, Chief Commissioning Officer	01/07/2025	31/3/26	**Partially Implemented** Update 13.11.25 - The Internal Provider Oversight Group has now been disbanded due to the imminent changes in ICB assurance and oversight responsibilities as per the guidance for the model ICB. A working group is now established to develop revised TOR for NHS provider contract governance as part of the wider assurance and governance overview which is due to take effect from 1.4.26.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			and intelligence, enabling the ICB to discharge their commissioning responsibilities including reporting externally where necessary, in a timely manner. This applies to the following governance arrangements: • For Public Health - the Screening and Immunisation Oversight Commissioning Contracting and Finance Group (SIOCCFG) and the Public Health Advisory Group which report to the Public Health Committee of the ICB. • For GPs - the ICB's Direct Commissioning & Contracting Panel (DCCP) which reports to the GMICB PCCC. • For Acute, Mental Health and Independent Providers – the Provider Oversight Subcommittee which reports to the executive Provider Oversight Meeting and the Quality and Performance Committee of the GMICB.					
2024/25	SEND	Medium	It should be ensured that all localities have a joint SEND Strategy and Joint Commissiong Strategies in place.	Locality Deputy Place Based Leads	Mandy Philbin, Chief Nursing Officer	31/3/26		**Not Yet Due** SEND Strategies and Joint Commissioning Strategies are a Statutory duty for SEND Partnership boards. The ICB duty is to co-operate. Currently PBL hold the delegated duty for SEND. It is the responsibility of the SEND Local Area Partnership to have these in place. This will be ongoing as Strategies and Plans need updated.
2024/25	SEND	Medium	Regular audits of locality level processes that underpin the performance reports and delivery of action plans including those relating to lesson learned should be undertaken. Findings should be	Associate Directors of Quality/Stephanie Whitelaw	Mandy Philbin, Chief Nursing Officer	30/9/25	31/3/26	**Not Yet Due** Thematic reviews and sharing of learning is well embedded. The GM audit programme is in development, each locality undertakes audit within their SEND partnership, but a GM

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			reported through the relevant groups/committees.					approach to look at themes at the same time needs to be developed. Propose new target date of March 2026 to complete audit element.
2024/25	Health and Safety	High	Ensure a Lone Worker Policy is developed and implemented as soon as possible. This should be supported by a full risk assessment, including ensuring the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place.	Samantha Deakin, Health Safety and Security Lead	Colin Scales, Deputy Chief Executive	31/12/25	~~5/2/26~~ 30/6/26	**Not Yet Due** All pre-existing documentation collated. Lone working group to meet in September 2025 to review. Policy scheduled to be considered by the Policy Review Group in January, followed by People and Culture Sub-Committee in early February. Update 9/3/26 - Policy in draft - progress delayed due to staff absence and capacity redirected for NHS reform.
2024/25	Health and Safety	High	The ICB should ensure appropriate staff have been first-aid trained across the organisation, in line with Health and Safety (First-Aid) Regulations 1981. Reporting on completion of training should be included in current training monitoring mechanisms and reporting routines.	Samantha Deakin, Health Safety and Security Lead	Colin Scales, Deputy Chief Executive	31/10/25	~~31/3/26~~ 31/7/26	**Partially Implemented** Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.
2024/25	Health and Safety	Medium	Ensure a formal incident reporting and management policy/ procedure is developed and appropriately communicated to all staff.	Samantha Deakin, Health Safety and Security Lead	Colin Scales, Deputy Chief Executive	31/10/25	~~31/3/26~~ 31/7/26	**Not Yet Due** The delivery date for the new Datix system has changed due to NHS Reforms and the date has been revised to reflect this - unable to establish the system without organisational and staff hierarchy, which won't be possible until completion of alignment to the new operating model. Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
2024/25	Health and Safety	Low	Ensure all required fields are completed for all risk assessments in future through additional checks of completed forms. Where forms are not completed in full, a process should be in place which returns the form to the person completing them for the incomplete information to be added.	Samantha Deakin, Health Safety and Security Lead	Colin Scales, Deputy Chief Executive	31/3/26	30/9/26	**Not Yet Due**
2024/25	Assurance Framework	N/A	The narrative should clearly reflect how the risk owner intends to move the risk to within the specified tolerance level and if this not possible then what actions/mitigations the ICB intends to put in place.	Rick Thompstone – Assistant Director Risk & PMO	Colin Scales, Deputy Chief Executive	30/9/25	~~31/1/26~~ 30/6/26	**Partially Implemented** November 25 - The ICB have strengthened the link between the current risk score, actions and the agreed tolerance scores. Currently 3 of the 10 risks have a current score higher than the tolerance range. The narratives to support these risks do partially reference the link but is not explicit enough, proposed extended date to allow time to implement this. These actions are progress in line with the ongoing BAF review. The BAF risks, risk appetite statements and the BAF risk template have been reviewed in recent months, with final approval expected at September's ICB board. This review has meant that the Q1 BAF scores were not reported and so it has not been possible to demonstrate these actions yet. It's expected that reporting in September will demonstrate completion. New dynamic risk reporting process being developed following further feedback from NHS GM Board and Committees. This will be addressed as part of this work.
2024/25	Assurance Framework	N/A	Risk should be reviewed to ensure that identified gaps in controls relate to a control rather than a factor that impacts on the management of the risk. Stated actions should be linked to the control	Rick Thompstone – Assistant Director Risk & PMO	Colin Scales, Deputy Chief Executive	30/9/25	~~31/1/26~~ 30/6/26	**Partially Implemented** November 2025 - BAF template has been updates and gaps in control has its own section, however some additional work to be done on the content of gaps in control section to ensure relate

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			gap and clearly describe how its completion will impact on the control gap.					specifically to controls rather than factors that impact on the management of the risk. These actions are progress in line with the ongoing BAF review. The BAF risks, risk appetite statements and the BAF risk template have been reviewed in recent months, with final approval expected at September's ICB board. This review has meant that the Q1 BAF scores were not reported and so it has not been possible to demonstrate these actions yet. It's expected that reporting in September will demonstrate completion. New dynamic risk reporting process being developed following further feedback from NHS GM Board and Committees. This will be addressed as part of this work.
2024/25	Oversight Arrangements	Medium	The commissioning / governance section of the ICB should update the SOPs for the POM so that they are aligned to the expectations of the POM's TOR in order to fulfil their oversight responsibilities. They must ensure that roles and responsibilities for matters that should be delivered by the POM are reflected within the SOPs and that the POM should have an approved annual work programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a starting reference point for such an exercise.	Zoe Mellon, Performance Lead	Colin Scales, Deputy Chief Executive	30/9/25	31/3/26	**Not Yet Due** This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.
2024/25	Oversight Arrangements	Medium	The commissioning/ governance section of the ICB should update the SOPs for the LAM so that they are aligned to the	Zoe Mellon, Performance Lead	Colin Scales, Deputy Chief Executive	30/9/25	31/3/26	**Not Yet Due** This action is affected by the agreement and implementation of the new operating model and

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			expectations of the LAM TOR in order to fulfil the delegated responsibilities. They must ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs and that the LAM for each locality should have an approved annual work programme, which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a starting reference point for such an exercise.					cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.
2024/25	Oversight Arrangements	Medium	The governance section of the ICB should update their SOPs for the LAM to ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs. The LAM for each locality should have an approved annual work programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a reference point for such an exercise.	Zoe Mellon, Performance Lead	Colin Scales, Deputy Chief Executive	30/9/25	31/3/26	**Not Yet Due** This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.
2024/25	CAF aligned DSPT	3 x High	3 x high risk recommendations relating to supply chain, identity and access control and response planning.	Various	Colin Scales, Deputy Chief Executive	31/10/25 and 31/12/25	31/1/26	**Partially Implemented** Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2024/25	Contract Management Quality of Care	Medium	The ICB should utilise the governance structures already in place to provide clear assurance on all independent sector contracts.	Claire Smith	Manisha Kumar, Chief Clinical Officer	Complete		**Not Yet Implemented** 06/03/26 Work is ongoing to establish governance structures for the 'new' NHS GM Strategic Commissioner. Prioritisation and risk

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
			Whilst recognising the large volume of these contracts and the size and complexity in comparison with larger provider contracts, reporting should be aligned to the assigned priority and Risk Stratification outcome for each provider and include both positive assurance and escalation of key issues.					stratification is set out above. This will feed into contract meetings with escalation through quality review meetings, provider oversight meetings and to NHS E led oversight where required. The governance and reporting relationship with NHS E Regional Team is still being worked through.
2024/25	IT Asset Management	1 x High, 3 x Medium	4 recommendations made relating to Strategy and Contracts, Asset Inventory and Registers, Acquisition and Disposals, and Reporting and Documentation	Various	Colin Scales, Deputy Chief Executive	Various dates up to 31/3/26		**Not Yet Due**
2025/26	Financial Recovery Programme	Medium	NHS GM should ensure that financial reporting across all layers includes clearer reference to original plan targets, stretch and ambition targets and revised plan targets for clarity to the reader to avoid confusion and clearly track performance and demonstrate accountability to agreed plans.	Nicola Hepburn	Kathy Roe, Chief Finance Officer	30/6/26		**Not Yet Due**
2025/26	Financial Recovery Programme	Medium	NHS GM should ensure that financial information is consistent across reports and throughout the various meetings/ groups in the governance structure.	Nicola Hepburn	Kathy Roe, Chief Finance Officer	30/6/26		**Not Yet Due**
2025/26	POD Delegation	Medium	As best practice, the ICB should ensure that the 2025/26 self-declaration provides sufficient detail in response to the questions, Reference should be made, as appropriate, to specific processes and how they provide assurance. Also reference should be made to specific examples and supporting evidence available to support the rating given.	Ben Squires	Katherine Sheerin, Chief Commissioning Officer	31/3/26		**Not Yet Due**

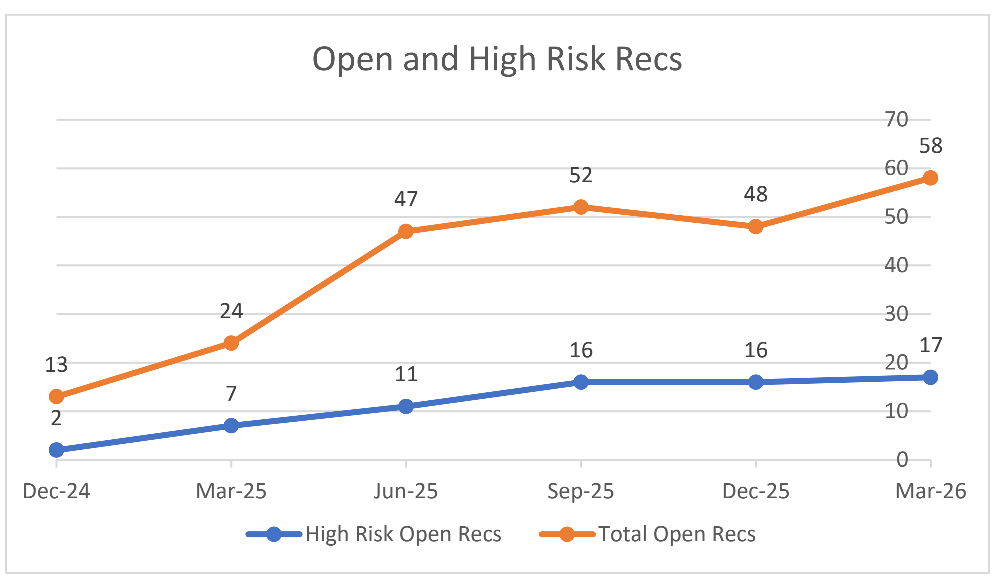
Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	December 25 Update
2025/26	POD Delegation	Medium	The ICB should introduce a formal tracking log of applications to the Pharmaceutical List. This should be referenced within the response to this question in the 2025/26 self-declaration.	Ben Squires	Katherine Sheerin, Chief Commissioning Officer	31/8/25		**Not Yet Implemented** No response received.
2025/26	Mental Health	Medium	The GMICB should ensure that there are valid contracts in place and signed with associate commissioners in a timely manner.	Helen Davies	Manisha Kumar, Chief Clinical Officer	1/4/26		**Not Yet Due**
2025/26	Mental Health	Medium	The GMICB should ensure that in addition to having up-to-date terms of reference of the GM Mental Health Partnership Board, they also have an annual work programme for the Board to ensure that they fulfil all their operational, strategic and assurance mandates in a timely manner.	Melissa Mcguiness	Manisha Kumar, Chief Clinical Officer	31/1/26	31/5/26	**Not Yet Due** All current groups mapped and streamlined. ToR for MHPG still to be reviewed within the context of the new GM Operating Model.

Appendix B: Risk Classifications

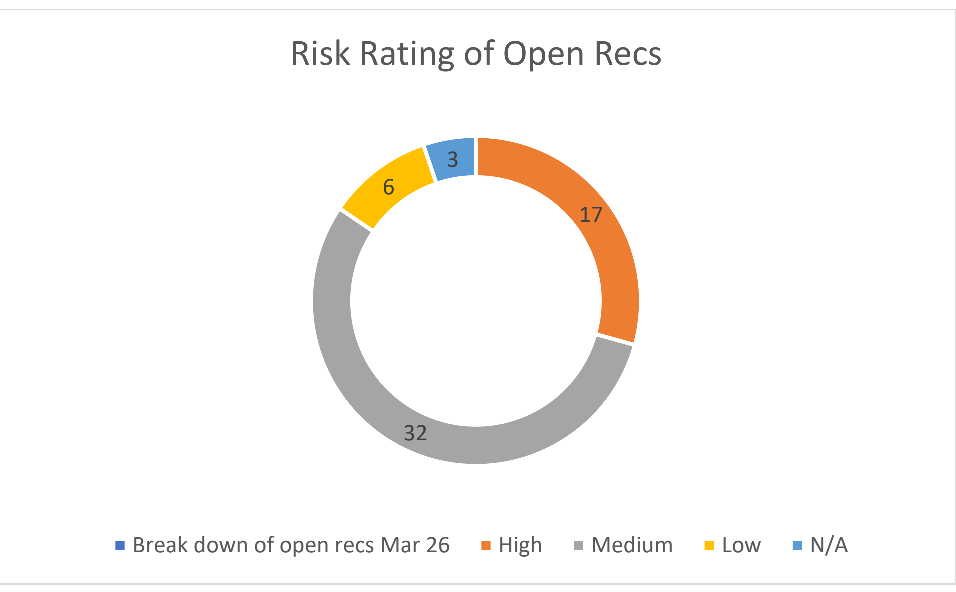
Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources. • the safeguarding of assets. • the preparation of reliable financial and operational information. • compliance with laws and regulations.
High	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significantimpact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives. • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives, however, implementation of the recommendation would improve overall control.

Appendix C: Analysis of Recommendations

Breakdown of open and high-risk recommendations



Breakdown of risk rating of open recommendations



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NHS GM Audit Committee
19th March 2026

Draft Internal Audit Plan 2026/27

Part of Greater Manchester Integrated Care Partnership

NHS GM Audit Committee

19 March 2026

Required information	Details
Title of report	Draft Internal Audit Plan (Extract) 26-27
Author	Darrell Davies/ Patrick Clark
Presented by	Darrell Davies
Contact for further information	Patrick Clark
Executive summary	This extract from the 26-27 Internal Audit Plan contains the potential audit reviews to be undertaken at NHS GM in the new financial year. These reviews have been selected following the undertaking of a detailed risk assessment and discussions with individual Executive Officers. Following this, the draft plan extract has been discussed at a meeting of the Executive Officers.
The benefits that the population of Greater Manchester will experience.	Assurance through the Audit Committee that improvements in internal control are being progressed within the organisation that should lead to improved performance and thus assist the organisations achieve its objectives.
How health inequalities will be reduced in Greater Manchester's communities.	The Internal Audit Plan aims to address the key ICB risks on a cyclical basis, including responding to the quality agenda.
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	The Internal Audit Plan aims to address aspects of the key risks of the ICB on a cyclical basis. The BAF is considered as part of the annual planning process to ensure that the internal audit plan includes appropriate coverage. Recommendations made by internal audit aim to strengthen the internal control environment which should contribute towards reduction in risk.
Key milestones	N/A

Leadership and governance arrangements	N/A
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A

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

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

Introduction & Executive Summary

1.0 As part of the internal audit planning for 26-27 it has been agreed that an outline plan would be prepared for consideration and discussion with Audit Committee members to ensure that the plan meets the needs of NHS GM and provides assurances against a range of areas.

2.0 To arrive at this first iteration of the proposed audit plan all NHS GM Executive Officers have been engaged with, to establish those areas where they believe that an internal audit review would be beneficial. Alongside this a consideration has been undertaken of current NHS GM risks as contained within the Board Assurance Framework and discussions held with other MIAA ICB Audit Managers to discuss common areas of risk.

3.0 The outline plan contained is based on a request to devise a plan with a similar level of coverage as that agreed in 25-26. On this basis a plan consisting of 306 days has been formulated (250 days plus c56 days of carried forward reviews/days). Should further additional days be required, MIAA are able to facilitate such a request.

Recommendations

4.0 The Audit Committee is asked to:

- Consider and content of the draft Internal Audit plan for 2026/27.

To: Chief Officers
Audit Committee Members

From: Darrell Davies, Regional Assurance Director
Patrick Clark, Senior Audit Manager

Date: 11/3/26

Re: **Initial Internal Audit Planning 26-27**

1 Introduction and Background

As part of the agreed internal audit planning process for 26-27 it has been agreed that an outline plan would be prepared for consideration and discussion with Chief Officers and Audit Committee members to ensure that the plan meets the needs of NHS GM and provides assurances against a range of areas.

In order to arrive at this first iteration of the proposed audit plan, all NHS GM Executive Officers have been engaged with to establish those areas where they believe that an internal audit review would be beneficial. Alongside this a consideration has been undertaken of current NHS GM risks as contained within the Board Assurance Framework and discussions held with other Mersey Internal Audit Agency (MIAA) ICB Audit Managers to discuss common areas of risk.

The outline plan contained in this document is based on a request to devise a plan with a similar level of coverage as that agreed in 25-26. On this basis a plan consisting of 306 days will be formulated (250 days plus 56 days of carried forward reviews). Should further additional days be required, MIAA are able to facilitate such a request.

2 Previous Internal Audit Coverage

In order to consider the potential reviews to be included in 26-27 it is helpful to consider and appreciate the audit coverage at NHS GM in the previous three years. The table below sets out this coverage by review area:

Review	23/24	24/25	25/26
Governance and Leadership			
Assurance Framework	✔	✔	✔
Risk Management Core Controls	✔	✔	✔
Primary Care Commissioning Assurance Framework (Pharmacy, Optometry , Dentistry) (POD)		✔	✔

Review	23/24	24/25	25/26
Risk Framework	✔		
Conflicts of Interest	✔		
Committee Effectiveness Phase 1/ II	✔		
Committee Effectiveness Phase III		✔	
NHS England (NHSE) Undertakings		✔	
Health and Safety		✔	
Finance, Performance and Sustainability			
Key Financial Transactional Processing Controls	✔	✔	✔
Finance Systems Deep Dive	✔	✔	
Population Health Strategy		✔	
Performance Management Data Quality		✔	
Emergency Preparedness, Resilience and Response (EPRR)		✔	
Continuing Healthcare	✔		✔
Provider Selection Regime		✔	
Continuing Health Care (CHC) Contracting Review		✔	
Financial Recovery Programme			✔
Financial Reporting			✔
Mental Health			✔
Data Quality			✔
Community Pharmacy Additional Services			✔
Specialised Commissioning			✔
NEPTS Procurement			✔
Quality			
Contract Management - Quality of Care		✔	
Patient Safety Incident Response Framework (PSIRF)		✔	
Oversight Arrangements Review		✔	
Commissioning		✔	
Complaints	✔		
Safeguarding	✔		

Review	23/24	24/25	25/26
Special Educational Needs and Disability (SEND)		✔	
People			
Fit and Proper Persons		✔	
Culture Framework Review		✔	
Post Virtual Private Database (VPD) Merge and Personnel Files	✔		
Workforce Planning	✔		
Electronic Staff Record (ESR) Payroll	✔		✔
Wellbeing	✔		
Training and Development			✔
Information and Technology			
IT Asset Management		✔	
Data Security Protection Toolkit (DSPT) (Annual Exercise as per NHSE Requirement)	✔	✔	
Cyber Organisational Controls	✔		
IT Review – CHC		✔	
Additional IT System Wide Assurance – 3rd Party Suppliers			✔

3 26-27 Potential Plan/ Review Areas

Following a round of planning meetings conducted with each of the Executive Officers throughout December 2025 and January 2026 as follows:

- Colin Scales – Acting Chief Executive
- Kathy Roe - Chief Finance Officer
- Manisha Kumar – Chief Clinical Officer
- Katherine Sheerin - Chief Commissioning Officer
- Charlotte Bailey (Chief Strategy, People and Partnerships Officer)

We have put together a list of potential reviews to form part of the Internal Audit Plan 2026-27. These are set out below along with the mandated/ core assurance reviews which are included annually in the audit plan, in addition to suggested reviews from our own internal planning processes.

There are a number of 'core' elements that have to be included in the audit plan on an annual basis. Based on previous experience, the core elements/ reviews account for approximately

157 days of the total plan days. This leaves 149 days to allocate to non-core audit reviews. There are circa 56 days carry forward based on reviews deferred from 2025-26. If it is agreed that these deferred reviews are still required, this then leaves 93 days available for other non-core work. Currently, the non-core work (excluding 2025-26 carry forward reviews) listed in the table below equates to 245 days and therefore this work needs to be prioritised to stay within the 93 days available, with a current over commitment of 152 days based on the suggested reviews below.

Set out below are a list of potential reviews and the relevant indicative days:

Core Reviews

Full details of the allocation of days to core reviews and those areas required under the internal audit standards are set out in Appendix B.

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
Key Financial Transactional Processing Controls	Core Assurance	Kathy Roe, Chief Finance Officer	Kaye Abbott	Q2	18
Assurance Framework & Strategic Risk Management	Mandated Assurance	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	Chris Gaffey	Q4	16
DSPT	Mandated Assurance	Colin Scales, Acting Chief Executive	Malcolm Whitehouse	Q1	20
Conflicts of Interest	Mandated Assurance (every 3 years)	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	Chris Gaffey	Q1	15
Artificial Intelligence (AI) Governance	Core Assurance	Colin Scales, Acting Chief Executive	Malcolm Whitehouse	Q2	10
POD Self-Assessment Review	Mandated Assurance	Katherine Sheerin, Chief Commissioning Officer	Ben Squires	Q1	7
Follow Up					20

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
Technology Risk Assurance (TRA) Follow Up					8
Planning and Management, Reporting and Meetings					28
Contingency					15
				Total	**157**

Non-Core Reviews (2025-26 Deferred Reviews, Chief Officer Suggestions & IA Risk Assessment)

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
2025-26 Deferred Reviews					
Supplier Due Diligence	The review will provide assurance over the systems and processes in place for the due diligence of new and existing suppliers, including the use of waivers and whether these are used in line with ICB policy and Standing Financial Instructions (SFIs).	Kathy Roe, Chief Finance Officer	Izhar Chaudhary	Q4	18
Financial Sustainability and Medium Term Financial Planning	The overall objective of this audit is to provide assurance that the financial sustainability and medium-term financial planning in the position of the organisation is being reported appropriately.	Kathy Roe, Chief Finance Officer	Sam Evans/ Jackie Gardiner	Q2	18
Financial System Risk	The overall objective of this audit is to provide assurance that the organisation has considered whether, because of NHS reforms, their future finance function has sufficient resources and structures in place to ensure that financial reporting and required processes remain in place to manage the financial system risk and fulfil their oversight responsibilities. ***(This was an original request from Audit Committee members during quarter 3 of 25/26. However, officers of the ICB have produced a report as part of the internal assessment***	Kathy Roe, Chief Finance Officer	Sam Evans/ Jackie Gardiner	Q1	20

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
	and assurance process following the two rounds of voluntary redundancies on the wider impacts to all teams of the ICB and not just the finance team, this report is to be presented to the March Audit Committee. Chief Officers and Audit Committee members are asked to confirm if this negates the need for this internal audit carrying forward into 26/27).				
				Sub-Total	**56**
2026-27 Non-Core Reviews suggested by Chief Officers and Internal Audit Risk Assessment					
Financial Governance and Budgetary Control	To review the financial processes and controls under the new operating model and new budget portfolio structure. This will include aspects of financial governance and financial reporting.	Kathy Roe, Chief Finance Officer	Sam Evans/ Jackie Gardiner	Q3	15
Finance and Contract Management Review	The review will assess how the ICB is holding providers to account financially and the monitoring processes in place for contract and commissioning management. The review will include how the ICB contract manages providers to review data and commissioned activity, systems for highlighting concerns with costs, claims and contract performance as part of a multi-disciplinary approach to ensure that value for money is achieved and that providers are delivering the outcomes commissioned.	Kathy Roe, Chief Finance Officer	Gareth Jones	Q2	15
System for Thorough Assessment of Resources (STAR) Panel Process	The STAR panel process provides assurance and control over expenditure of £10k and above. Our review will assess the processes and controls in place prior to the STAR Panel to ensure	Kathy Roe, Chief Finance Officer	Sam Evans	Q2	15

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
	that a service review framework is in place which considers: • Confirmation of a strategic need for the expenditure with supporting analysis. • A review of contract renewals to provide timely service reviews and assessment of continued need and rationale, avoiding late notice/ retrospective STAR Panel reviews. • A risk based approach to review high value contracts and high risk areas.				
Primary Care Transformation and Primary Care Networks	The review will be scoped in more detail nearer the time but will provide assurance over how the ICB is working with general practices and using primary care transformation funding to provide support in implementing the modern general practice model. NHS GM is reporting a number of issues across Primary Care Networks (PCN) with disputes and funding constraints.	Manisha Kumar, Chief Clinical Officer	Ben Squires	Q3	20
Quality Governance Compliance	The review will assess the ICB's compliance with its Quality Governance Framework after realignment of portfolios post restructure, to provide assurance that arrangements continue to be effective in overseeing key aspects of quality assurance and improvement.	Manisha Kumar, Chief Clinical Officer	TBC	Q4	15
Medicines Management	The review will consider the accountability framework in place over medicines management including compliance with statutory accountability.	Manisha Kumar, Chief Clinical Officer	TBC	Q1	15
Commissioning Cycle	The review will be scoped in more detail nearer the time but will	Katherine Sheerin,	TBC	Q2	15

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
	provide assurance over the key aspects of the completion of the commissioning cycle, in particular contract reviews and evaluation processes.	Chief Commissioning Officer			
IAPs and AMPs	To review the processes in place across the ICB in ensuring that responsibilities are met in relation to Indicative Activity Plans (IAPs) and Activity Management Plans (AMPs) covering negotiation, unilateral plan-setting where needed, consideration of systemic and patient impacts, and adherence to escalation procedures to ensure accountability and transparency.	Katherine Sheerin, Chief Commissioning Officer	TBC	Q2	15
Sickness Absence Management	The overall objective of the review is to evaluate the systems and processes in place to ensure that managers are proactively managing sickness absence, ensuring compliance with ICB policy. This will include review of the processes in place for the identification, recording, reporting and monitoring of sickness absence.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	Jane Seddon	Q3	15
Equality and Diversity	The overall objective is to evaluate whether the ICB has established systems and processes to exercise its duties and demonstrate compliance with the Equality Act.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	Jane Seddon	Q4	15
Digital Team Structure and Strategy	The Digital Team is currently made up of c80 staff whilst the organisation is evolving to a commissioning organisation. The review will need to be scoped in more detail nearer the time but is aimed at providing assurance over the Digital Team is aligned to the core business of the ICB and that capacity and skills match to business needs. We will also	Colin Scales, Acting Chief Executive	Malcolm Whitehouse	Q2	15

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
	consider how other Digital functions are configured in other public sector commissioning organisations as far as possible.				
Digital Strategy	We will review the organisation's Digital Plan to consider the progress to date made against planned milestones and to provide assurances relating to the supporting process and governance arrangements.	Colin Scales, Acting Chief Executive	Malcolm Whitehouse	Q4	15
Transition to ICB Model Blueprint/ Operating Model:	To provide assurance that the ICB's governance, risk management and internal control framework is effective in supporting delivery of its statutory duties, strategic objectives and transformation to the Model ICB Blueprint and Target Operating Model.	Colin Scales, Acting Chief Executive	Chris Gaffey	Q2	15
Freedom To Speak Up	To assess how effectively the ICB's Freedom to Speak Up arrangements enable staff to raise concerns safely, and whether governance structures provide robust oversight of speaking-up activity.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	Jane Seddon	Q2	15
Provider Collaborative/ Integrated Care System (ICS) Governance	To assess how effectively the ICB's governance arrangements support provider collaboratives and wider ICS decision-making, including clarity of roles, responsibilities, and accountability across the system.	Colin Scales, Acting Chief Executive	Chris Gaffey	Q1	15
CHC Transition Model	To ensure that transition to new operating arrangements in 26/27 are overseen by a clear transitional framework to support interim arrangements and the move to the new model beyond this.	Katherine Sheerin, Chief Commissioning Officer	Gill Gibson	Q1	15
				Sub-Total	**245**
				TOTAL	**(56+245) = 301**

Review	Description	Chief Officer Lead	Operational Lead	Planned Quarter	Indicative Days
				Less 2025-26 Carry Forward Review Days	**- 56**
				Less Days Available for Non-Core Reviews	**- 93**
				Over Commitment	**152**

4 Next Steps

Chief Officers and Audit Committee members are asked to:

- Consider the items proposed for audit reviews contained in the previous section and highlight those areas which would be considered to be a priority for inclusion in the Internal Audit plan for 2026/27.
- Ensure the audits prioritised remain within the budgeted days allocated for 2026/27.
- Suggest any other areas for potential inclusion as considered appropriate.

NHS GM Audit Committee
19th March 2026

Head of Internal Audit Opinion 2025/26 (Interim Opinion)

Part of Greater Manchester Integrated Care Partnership

NHS GM Audit Committee

19 March 2026

Required information	Details
Title of report	Head of Internal Audit Opinion 2025/26 (Interim Opinion)
Author	Darrell Davies/ Patrick Clark
Presented by	Patrick Clark
Contact for further information	Patrick Clark
Executive summary	This interim Head of Internal Audit Opinion (HoIAO) has been provided to support NHS Greater Manchester ICB in meeting NHS England (NHSE) submission deadline of the 6th March 2026. This paper summarises the Internal Audit service delivery, the basis for the production of the 2025-26 Head of Internal Audit Opinion, the assurance rating outcomes from finalised reviews and reviews currently in progress.
The benefits that the population of Greater Manchester will experience.	Assurance through the Audit Committee that improvements in internal control are being progressed within the organisation that should lead to improved performance and thus assist the organisations achieve its objectives.
How health inequalities will be reduced in Greater Manchester's communities.	The Internal Audit Plan aims to address all of the key risks of the ICB on a cyclical basis, including responding to the quality agenda.
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	The Internal Audit Plan aims to address aspects of the key risks of the ICB on a cyclical basis. The BAF is considered as part of the annual planning process to ensure that the internal audit plan includes appropriate coverage. Recommendations made by internal audit aim to strengthen the internal control environment which should contribute towards reduction in

	risk.
Key milestones	N/A
Leadership and governance arrangements	N/A
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A

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

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

Introduction & Executive Summary

1.0 This interim Head of Internal Audit Opinion (HoIAO) has been provided to support NHS Greater Manchester ICB to meet NHS England (NHSE) submission requirements set for the 6th March 2026.

2.0 This paper summarises current Internal Audit service delivery, the basis for the production of the 2025-26 Head of Internal Audit Opinion, the assurance rating outcomes from finalised reviews and also details those reviews currently in progress.

Recommendations

3.0 The Audit Committee is asked to:

- Note the contents of the paper.

Head of Internal Audit Opinion 2025/26 (Interim Opinion)

NHS Greater Manchester Integrated Care Board

Contents

1 Introduction

2 Basis of Forming the Opinion

3 Outcomes and status of reviews / support informing the Opinion

1 Introduction

In accordance with *Global Internal Audit Standards (UK public sector)*[1], the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance subject to the inherent limitations described below.

This interim Head of Internal Audit Opinion (HoIAO) has been provided to support NHS Greater Manchester ICB in providing information to NHS England (NHSE) by the 6th March 2026. This paper summarises the internal audit service delivery, the basis for the overall opinion, outcomes of reviews finalised and reviews currently in progress.

Due to the timing for the submission of the interim HoIAO, an indicative overall assurance opinion is not provided. At this stage, the delivery of the internal audit plan is continuing and outcomes, together with the overall opinion level will be included within the full HoIAO following the end of the financial year. The final HoIAO is required to be submitted to NHSE in accordance with year-end reporting timeframes.

This paper summarises the internal audit service delivery, the basis for the overall opinion, outcomes of reviews finalised and reviews currently in progress.

2 Basis of Forming the Opinion

The basis for forming our opinion is as follows:

	Basis for the opinion
1	An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.
2	An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.
3	An assessment of the organisation's response to internal audit recommendations, and the extent to which they have been implemented.

The overall opinion will be determined at the completion of the internal audit planned work for the full year (1st April 2025 - 31st March 2026).

[1] This consists of the Global Internal Audit Standards (GIAS) of the IIA and the Application Note: Global Internal Audit Standards in the UK public sector

3 Outcomes and status of reviews / support informing the Opinion

3.1 Assurance Framework

The Assurance Framework review is taking place during Q4 to support the full HoIAO.

3.2 Core & Risk Based Reviews Issued

The audit assignment element of the Opinion is limited to the scope and objective of each of the individual reviews. Detailed information on the limitations to the reviews has been provided within the individual audit reports and through the Audit Committee Progress reports throughout the year.

COMPLETED REVIEWS	ASSURANCE RATING
Primary Care Commissioning Assurance Framework (POD Delegation) Objective: To review the ICB's annual self-declaration against the primary care commissioning assurance framework. Scope Limitations: As required, our review focused solely on the ICB's completion of the self-declaration in accordance with NHSE's guidance. The findings from our review should not be taken as confirmation, or otherwise, of an ICB's compliance with the Delegation Agreement (with NHSE).	Substantial Assurance
Financial Recovery Programme Objective: The overall objective of this audit was to review and assess the effectiveness of management of the financial recovery programme through the governance structure. Scope Limitations: Our review focused only on the governance and reporting processes associated with overseeing the delivery of the financial recovery programme. Our review did not assess the underlying accuracy of any financial information presented through the governance and reporting structures.	Substantial Assurance
Mental Health Objective: The overall objective of the review was to provide assurance over Mental Health expenditure and controls for commissioning and delivering savings. Scope Limitations: The review focused on the governance arrangements around the commissioning, monitoring of performance and reporting. It does not provide assurance on the achievement of or accuracy of the key performance indicators within the contracts.	Substantial Assurance

COMPLETED REVIEWS	ASSURANCE RATING
Community Pharmacy – Advanced Services **Objective:** The overall objective was to ensure GMICB has a robust management system in place for the provision of advanced services by Community Pharmacies. **Scope Limitations:** The review focuses on the systems and processes in place within NHS GM in respect of the above objective. The review did not provide an assessment of the advanced services provided by Community Pharmacies.	Moderate Assurance
Training and Development Objective: The overall objective of this audit was to review and assess the effectiveness of completion of mandatory training and the approach taken to staff development. Scope Limitations: The review focuses on the systems and processes in place within NHS GM in respect of the above objective. The scope was limited to the controls in operation at the organisation.	Substantial Assurance

At the time of this interim opinion the following reviews are still to be completed:

- Financial Reporting – Draft Report
- Continuing Healthcare (CHC) – Draft Report
- ESR Payroll – Draft Report
- Procurement (NEPTS) – Draft Report
- Specialised Commissioning - Draft Report
- Assurance Framework – Fieldwork
- Risk Management Core Controls – Fieldwork
- Key Financial Transactional Processing Controls – Fieldwork
- IT Systems Wide Assurance – Fieldwork
- Data Quality – Planning
- DSPT Phase 1 25/26 - Fieldwork

3.3 Follow Up

An important aspect of the internal audit process is the follow up to ensure that opportunities for enhancement are delivered.

During the course of the year we have undertaken follow up reviews and can conclude that the organisation has made reasonable progress with regards to the implementation of recommendations.

We will continue to track and follow up outstanding actions.

3.4 Other contributions to governance, risks management and internal control enhancements

- Detailed insight into the overall governance and assurance processes gained from liaison throughout the year.
- Involvement and relationship with the organisation, including advice and guidance, and regular review of Board papers.
- Ongoing discussion with lead officers, managers and lay members throughout the year.
- Effective utilisation of internal audit including in year communication, and changes to the audit plan as required.
- Provided a progress update on the implementation of actions from the prior year review of internal audit effectiveness.
- Engagement with MIAA Insights benchmarking, best practice and outcome reporting including:
    - TIAN Insight Report
    - TIAN Newsletter
    - Audit Chairs Forum
    - Finance Chairs Forum
    - MIAA Insights: Briefings & Benchmarking

In providing this opinion I can confirm MIAA's continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. I also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

The interim opinion reflects a part year position derived from the conduct of risk based plans. The opinion does not imply that internal audit have reviewed all risks and assurances relating to the organisation.

Chris Harrop	Louise Cobain
Managing Director, MIAA	Assurance Director, MIAA
March 2026	March 2026

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NHS GM Audit Committee 19th March 2026

Internal Audit Charter

NHS GM Audit Committee

19 March 2026

Required information	Details
Title of report	MIAA Internal Audit Charter
Author	Darrell Davies/ Patrick Clark
Presented by	Darrell Davies
Contact for further information	Darrell Davies
Executive summary	The Internal Audit Charter is mandated through Global Internal Audit Standards (UK public sector) and is a formal document that defines the internal audit activity's purpose, mandate and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. This Charter complies with the Global Internal Audit Standards (UK public sector) and MIAA confirms ongoing compliance with these standards.
The benefits that the population of Greater Manchester will experience.	Assurance through the Audit Committee that improvements in internal control are being progressed within the organisation that should lead to improved performance and thus assist the organisations achieve its objectives.
How health inequalities will be reduced in Greater Manchester's communities.	The Internal Audit Charter includes reference to the Audit Strategy which aims to address all of the key risks of the ICB on a cyclical basis, including responding to the quality agenda.
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	The Internal Audit Charter includes reference to the approach of developing the Audit Strategy and reference to the BAF. Our approach aims to address all of the key risks of the ICB on a cyclical basis.

	The BAF is considered as part of the annual planning process to ensure that the internal audit plan includes appropriate coverage. Recommendations made by internal audit aim to strengthen the internal control environment which should contribute towards reduction in risk.
Key milestones	N/A
Leadership and governance arrangements	N/A
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A

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

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

Introduction & Executive Summary

1.0 The Internal Audit Charter is mandated through Global Internal Audit Standards (UK public sector) and is a formal document that defines the internal audit activity's purpose, mandate and responsibility.

2.0 The internal audit charter establishes the internal audit activity's position within the organisation; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities.

3.0 This Charter complies with the Global Internal Audit Standards (UK public sector) and MIAA confirms ongoing compliance with these standards.

Recommendations

4.0 The Audit Committee is asked to

- Note the contents of the Charter.

Internal Audit Charter

NHS Greater Manchester Integrated Care Board

Contents

1 Introduction & Background

2 Purpose, Mandate and Responsibility

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13 Definitions

1 Introduction

The Internal Audit Charter is mandated through Global Internal Audit Standards (UK public sector)[1] and is a formal document that defines the internal audit activity's purpose, mandate and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities.

This Charter complies with the Global Internal Audit Standards (UK public sector) and MIAA confirms ongoing compliance with these standards.

2 Purpose, Mandate and Responsibility

Internal auditing is "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes[2] ".

The internal audit mandate is outlined in the Board's standing documents and Audit Committee Terms of Reference:

"The Audit Committee is responsible for arranging appropriate internal and external audit." (NHS GM Constitution)

"To ensure there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board." (Audit Committee Terms of Reference)

The provision of assurance services is the primary role for internal audit in the NHS. This role requires the internal auditor to provide an independent opinion based on an objective assessment of the framework of governance, risk management and control. The main purpose of internal audit activity within the NHS is therefore to provide the Accountable or Accounting Officer with an objective evaluation of, and opinion on, the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The Director of Internal Audit's opinions is a key element of the framework of assurance that the Accountable or Accounting Officer needs to inform the completion of the Annual Governance Statement (AGS).

Internal audit also provides an independent and objective consultancy service which is advisory in nature, and generally performed at the specific request of the organisation. Such consultancy work is separate from but contributes to the opinion which internal audit provides on risk management, control and governance. When performing consulting services, the internal auditor will maintain objectivity and not take on management responsibility.

The above functions drive MIAA's Mission 'To drive value and improve outcomes through excellence and professionalism'.

Assurance Reviews will provide individual audit opinions to support the annual Director of Internal Audit Opinion. Formal agreement will be sought for the provision of third party assurances to other bodies in respect of the services provided by the NHS organisation.

[1] This consists of the Global Internal Audit Standards (GIAS) of the IIA and the Application Note: Global Internal Audit Standards in the UK public sector

[2] The Definition of Internal Auditing, The Institute of Internal Auditors, January 2024

In accordance with the organisation's Standing Financial Instructions, Internal Auditors will (without necessarily giving prior notice) have access to all records (including those of a confidential nature) and employees of the organisation.

3 Independence and Objectivity

The internal audit activity must be independent, and internal auditors must be objective in performing their work. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Director of Internal Audit will have direct and unrestricted access to senior management and the Audit Committee.

The Director of Internal Audit will confirm to the Audit Committee, at least annually, the organisational independence of the internal audit activity.

The Director of Internal Audit will report functionally to the Audit Committee and establish effective communication with, and have free and unfettered access to, the Accountable Officer and the Chair of the Audit Committee. This will include communicating and interacting directly with the Audit Committee.

Internal audit activity will be free from interference in determining the scope of internal auditing, performing work and communicating results. Internal auditors will have an impartial, unbiased attitude and avoid any conflict of interest. Conflicts of interest may arise where an auditor provides services other than internal audit to the organisation. Your MIAA Internal Audit Team does not currently provide other services to the organisation. If this changes steps will be taken to avoid or manage transparently and openly such conflicts of interest, so that there is no real or perceived threat or impairment to independence in performing the audit role. These steps will be documented in the charter where required.

All internal auditors will complete an annual declaration of interest identifying possible conflicts of interest and the actions taken to mitigate them. This process, and its outcomes, will be communicated to the Audit Committee annually through the Director of Internal Audit Opinion and Annual Report.

MIAA will also periodically review the specific audit manager assigned to the organisation to ensure that both parties are satisfied that relationships remain independent and objective.

If independence or objectivity is impaired in fact or appearance, the details of the impairment will be disclosed to appropriate parties. The nature of the disclosure will depend upon the impairment.

4 Proficiency and Due Professional Care

Engagements will be performed with proficiency and due professional care. Internal auditors will possess the knowledge, skills, and other competencies needed to perform their individual responsibilities. The internal audit activity collectively will possess or obtain the knowledge, skills and other competencies needed to perform its responsibilities. The Director of Internal Audit is a CCAB qualified Accountant and is responsible for ensuring access to the full range of knowledge, skills, qualifications and experience to meet the requirements of the internal audit standards. MIAA internal auditors will ensure Continuing Professional Development and compliance with professional standards.

Internal auditors will apply the care and skill expected of a reasonably prudent and competent internal auditor. Due professional care does not imply infallibility.

5 Quality Assurance and Improvement Programme

The Director of Audit will develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity. The quality assurance and improvement programme will include both internal and external assessments.

- Internal assessment will include;
- Ongoing monitoring of the performance of the internal audit activity; and
- Periodic self-assessments or assessment by other persons within the organisation with sufficient knowledge of internal audit practices.

External assessments will also be conducted at least once every five years by a qualified, independent reviewer or review team from outside the organisation. The results of external quality reviews and any consequent improvement plans will to be reported to the Accountable/Accounting Officer and Audit Committee.

6 Managing the Internal Audit Activity

The Director of Internal Audit will develop and maintain an Internal Audit strategy designed to meet the main purpose of the internal audit activity and its service provision needs. This strategy will advocate a systematic and prioritised review, outlining the resources and skills required to meet the assurance needs of the Accountable/Accounting Officer, ICS Board and Audit Committee. The strategy will take into account the relative risk maturity of the organisation, taking due regard of the Board Assurance Framework.

The Director of Internal Audit will establish risk based plans to determine the priorities of the internal audit activity consistent with the organisation's goals.

The Director of Internal Audit will include in the internal audit strategy the approach to using other sources of internal and external assurance. Periodic plans will include any work associated with placing reliance upon such work.

The Director of Internal Audit will agree the strategy and periodic plans with the Accountable/Accounting Officer and Audit Committee.

The Director of Internal Audit will work with senior management and client staff who will support MIAA in the delivery of the audit plan.

Where the Director of Internal Audit believes that the level of agreed resources will prevent the Accountable/Accounting Officer being provided with an opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control, the consequences will be brought to the attention of the Audit Committee.

The Director of Internal Audit will agree arrangements for interim reporting to the Accountable/Accounting Officer and Audit Committee in the course of the year and produce an annual report that incorporates his opinion.

The Director of Internal Audit will provide to the Accountable/Accounting Officer an opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control, timed to support the Annual Governance Statement.

7 Nature of Work

The internal audit activity will evaluate and contribute to the improvement of governance, risk management and control processes (including value for money), using a systematic and disciplined approach.

The Director of Internal Audit will liaise on a regular basis with the nominated Local Counter Fraud Specialist (LCFS) for the organisation to identify any potential risk of fraud and ensure that any potential or actual frauds identified through internal audit activity are referred to the LCFS for investigation.

The Director of Internal Audit will also liaise with the organisation's external auditors and other review bodies to facilitate the effective co-ordination of audit resources and assurances.

8 Engagement Planning

The Director of Internal Audit will establish a risk based Internal Audit Plan in conjunction with the client and with the agreement of the Audit Committee. The plan will set out the priorities for internal audit activity, consistent with the organisation's goals and objectives.

Internal auditors will develop and document a terms of reference for each engagement, including the engagement's objectives, scope, timing and resource allocations, based on an evaluation of the nature and complexity of each engagement, time constraints and available resources. A work plan will be developed and documented that achieves the engagement objectives.

Internal audit will meet regularly with the external auditor to consult on audit plans and discuss matters of mutual interest.

9 Performing the Engagement

Internal audit will identify, analyse, evaluate and document sufficient information to achieve the engagement's objectives. Internal auditors will base conclusions and engagement results on appropriate analyses and evaluations. Internal auditors will document relevant information to support the conclusions and engagement results.

Engagements will be properly supervised to ensure objectives are achieved, quality is assured and staff are developed.

10 Communicating Results

Internal auditors will communicate the engagement results with appropriate parties, including the engagement's objectives and scope, as well as applicable conclusions, recommendations and action plans.

Working with the organisation, the Director of Internal Audit will ensure that communications are accurate, objective, clear, concise, constructive, complete and timely.

The Director of internal Audit will deliver an annual internal audit opinion and report that can be used by the organisation to inform its Annual Governance Statement.

The annual internal audit opinion will conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The annual report will incorporate;

- The opinion;
- A summary of the work that supports the opinion; and
- A statement on conformance with the Global Internal Audit Standards (UK Public Sector) and the results of the quality assurance and improvement programme.

11 Monitoring Progress

The Director of Internal Audit will establish and maintain a follow-up process to monitor that management actions have been effectively implemented or that senior management has accepted the risk of not taking action. This will be operated to support the organisation in ensuring the implementation of actions, and reporting progress to the Audit Committee.

12 Communicating the Acceptance of Risks

When the Director of Internal Audit believes that senior management has accepted a level of residual risk that may be unacceptable to the organisation, the Director of Internal Audit will discuss the matter with

senior management. If the decision regarding residual risk is not resolved, the Director of Internal Audit will report the matter to the Audit Committee for resolution.

Code of Ethics

MIAA will operate within the definition of internal auditing and the requirements of the Global Internal Audit Standards (UK Public Sector). This includes compliance with the Seven Principles of Public Life.

13 Definitions

ICS Board	The main Board of the organisation with overall responsibility for governance.
Accountable Officer	Officer responsible and accountable for funds entrusted to the organisation.
Audit Committee	A committee of the ICS Board with overall responsibility for overseeing the establishment of an effective system of integrated governance, risk management and control across the organisation's activities. **Within the NHS this committee functions as the Board as defined by the Global Internal Audit Standards (UK Public Sector)**
Director of Internal Audit	Acts as the Chief Audit Executive as the independent corporate executive with overall responsibility for internal audit.
Senior Management	The overall lead director agreed by the organisation for each audit engagement.

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Anti-Fraud Progress Report & Draft Anti-Fraud Plan 26/27 (19 March 2026)

Part of Greater Manchester Integrated Care Partnership

NHS GM Audit Committee

19 March 2026

Required information	Details
Title of report	Anti-Fraud Progress Report Draft 26/27 Annual Plan
Author	Paul Bell, Head of Anti-Crime Services
Presented by	Paul Bell, Head of Anti-Crime Services
Contact for further information	paul.bell@miaa.nhs.uk
Executive summary	Summary of anti-fraud activities undertaken from December 2025 – March 2026
The benefits that the population of Greater Manchester will experience.	Assurance that NHS GM funds are not defrauded
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	For noting / approval
How this supports the delivery of the strategy and mitigates the BAF risks	Part of corporate assurance arrangements
Key milestones	N/A
Leadership and governance arrangements	N/A
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	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

Part of Greater Manchester Integrated Care Partnership

Anti-Fraud Progress Report
Presented at 19 March 2026
Audit Committee

NHS Greater Manchester ICB

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2 Executive Summary (Assure, Understand, Prevent, Respond)

3 Investigations Log ('CLUE' Case Management System)

4 Losses, Preventions & Recoveries

5 Management Action Tracker

Appendix A: Glossary

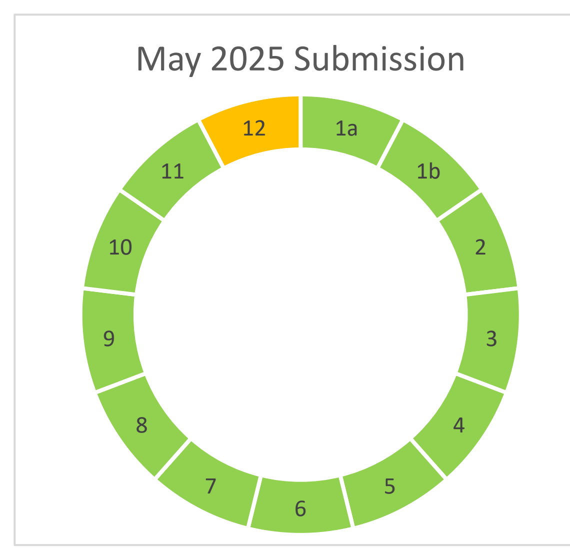
Appendix B: Risk Classifications

1 Delivery Dashboard & Counter Fraud Standard Compliance

At a glance, the delivery dashboard identifies whether, in the AFS's assessment, the agreed anti-fraud work plan is on track; or, whether there have been delays or corrective actions required. These will have been discussed and agreed with the Executive Lead for Counter Fraud and the AFS will bring to the attention of the Audit Committee the reasons for any Amber or Red ratings and the agreed remedial actions.

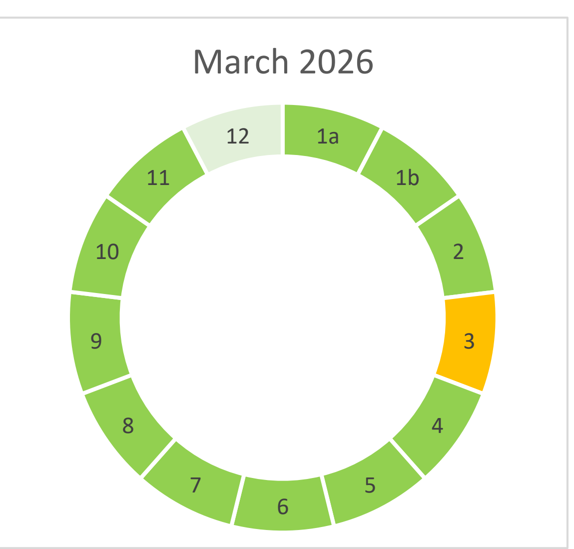
Plan Area	Status	Comment
Assure	Green	Progressing as planned
Understand & Prevent	Green	Progressing mostly as planned. One LPE will need to be completed in 2026/27
Respond	Green	Progressing as planned

Compliance against GovS 013 Functional Counter Fraud Standard: NHS Requirements



Component

1a Accountable Board Member
1b Accountable individuals
2 Fraud bribery and corruption strategy
3 Fraud bribery and corruption risk assessment
4 Policy and response plan
5 Annual action plan
6 Outcome-based metrics
7 Reporting routes for staff, contractors and members of the public
8 Report identified loss
9 Access to trained investigators
10 Undertake detection activity
11 Access to and completion of training
12 Policies and registers for gifts and hospitality and COI



2 Executive Summary (Assure, Understand & Prevent, Respond)

Since the last meeting of the Audit Committee in December 2025, the following activities have been undertaken and outcomes achieved.

ASSURE	
Green	**Progressing as planned**

- A meeting was held with the Associate Director of Finance (Financial Assurance) on 10 March 2026 to discuss current year plan progress and priorities for the 2026/27 Anti-Fraud Workplan, which is a separate agenda item for this Audit Committee. Other key stakeholder meetings have taken place in the reporting period, particularly with the Counter Fraud Champion.
- The AFS attended an Immigration Crime and Modern Slavery presentation conducted by National Crime Agency (NCA) on the 17 December 2025 at MIAA's offices, due to increasing concerns within the NHS around potential modern slavery cases and the identification of individuals working with fraudulent or false identifications.
- The AFS attended the NHS Counter Fraud Authority 'LCFS Conference 2026' in Leeds on 28th January 2026 with sessions on 'Turning insight into action: Data driven collaboration', 'Managing imposter fraud', 'Public sector fraud: current landscape and future direction' and 'Centre of Specialist Learning: building professional skills to protect the NHS'. These activities all support the AFS's CPD requirements, in-line with Component 9 of the Counter Fraud Standard.
- The AFS has, on behalf of MIAA clients, participated in NHSCFA's Stakeholder Engagement Group and System Weakness Group, covering their Ngage communications portal, the recording of identified weakness reports, the latest Fraud Hub Quarterly Intelligence Bulletin and their annual stakeholder engagement survey.
- The Fraud Risk Assessment component of the Counter Fraud Standard remains coded as Amber, as a re-assessment is required during 2026/27 due to both the introduction of the new fraud offence (and finalisation of its own risk assessment) and due to changes in the GCFP risk assessment methodology which have recently been introduced nationally.

UNDERSTAND & PREVENT	
Green	**Progressing mostly as planned. One LPE will need to be completed in Q1 2026/27**

- The AFS has issued a further 15 Fraud Prevention Checks (number 28 – 42) alerting the ICB to new phishing emails and mandate frauds. No concerns have been reported by the ICB in respect of the FPCs issued.
- The AFS has distributed 6 Fraud Prevention Notices from the NHS Counter Fraud Authority (Payment Terminals Fraud, Virtual Credit Cards, Payment Diversion Fraud, Asset Management Fraud, Business Email Compromise and Corporate Impersonation Fraud targeting NHS Care Homes). FPNs are issued by NHSCFA where there is an identified fraud concern arising from a significant investigation, or intelligence assessment, which may potentially impact multiple NHS organisations across England and Wales. Some of these FPNs have been cascaded to primary care providers, some are less relevant for ICBs than Trusts, and some have prompted management review / self-assessment, and some remain work in progress. All FPNs issued in 25/26 will be followed up by the AFS in the 26/27 plan.
- MIAA have issued to all staff 2 Fraud Information Alerts regarding Workplace Imposters and Timesheet Fraud, 5 Fraud Newsflashes [regarding the Little Book of Big Scams, the Little Book of Cyber Scams, Fake £20 Notes, the new Report Fraud site (replacing Action Fraud) and a spate of Phishing Emails targeting NHS workers], and a Recent Fraud Cases document promoting successful fraud prosecutions and sanctions from MIAA and beyond. All information, as well as being disseminated to colleagues, has been added the fraud intranet page.
- We have issued 8 more Primary Care Provider alerts to the ICB's networks regarding phishing email scams, fake payment requests and false invoices, as well as a guidance briefing updating the providers with the latest information on current threats as well as where to report fraud concerns.
- Fieldwork on the gap analysis assessment of the organisation's preparedness for the new 'Failure to Prevent Fraud' offence Local Proactive Exercise (LPE) has now been completed, and the report is in the process of being drafted. This will be issued prior to year-end.
- Another LPE which is a joint exercise with GMMH looking at s.12 Mental Health Assessments is progressing but has been delayed slightly by the need to obtain further information from GMMH. It is anticipated that this work will be completed early in Q1 of 26/27 and has been included in the new workplan.
- The AFS has worked with the Wigan Locality in this period to assist in fraud-proofing a planned Care Home Payments Agreement, ensuring that adequate declarations and transparency around the consequences of any fraudulent payment submissions are made clear.

- The AFS continues to hold bi-monthly meetings with NHSE NW Counter Fraud to discuss potential crossover referrals or intelligence which may benefit the work of the respective organisations. In the reporting period, once such referral has been transferred to NHSE for further enquires.
- Work is continuing on the clearing of the current round of NFI matches. Only 10% of the payroll matches (MIAA responsibility) remain to be cleared. Approximately 50% of creditor matches have been cleared by the ICB and we have been given assurance that the remaining matches will be resolved by the 31 March deadline.

RESPOND		
Green	**Progressing as planned**	
• Referrals brought forward (from prior period / year)	6	Mainly alleged patient medication / eligibility allegations
• Referrals received in current period	9	7 x FCRL; 3 x Internal Referrals (4 relate to patients; 3 relate to GP practices; 2 relate to NHS employees)
• Referrals closed in current period	9	1 x NFA no evidence; 2 x NHSE; 2 x CDLO; 4 x GP practices
• **Referrals carried forward to next period**	**6**	1 x NHS employee; 2 x GP Practice; 3 x Patients
• CLUE investigations brought forward (from prior period / year)	1	INV.24.01404
• CLUE investigations added in current period (inc. opened from new referrals)	0	
• CLUE investigations closed in current period	1	INV.24.01404 (insufficient evidence to pursue further) PENDING
• **CLUE investigations carried forward to next period**	**0**	
• All sanctions applied in period	0	
• All redress recovered in period	0	
• All SWRs identified from referrals / investigations	0	

Referral Queries – these are queries received which, on analysis, fall outside of the remit of investigation by the AFS (i.e. not fraud), have yet to be assessed by the AFS and/or do not meet the requirements to be recorded on the NHS CFA case management system.

Investigations – these are only investigations that have been recorded on NHS CFA case management system (‘CLUE’).

3 Investigations Log ('CLUE' Case Management System)

The table below summarises all activity recorded on NHSCFA 'CLUE' database, including those that have been closed in the current year

Open/ Closed	Case Ref. (Dates)	Allegation	Current Activity	Outcomes & Sanctions						Additional Comments
				No Further Action	Criminal Sanction	Disciplinary Sanction	Professional Body Sanction	Financial Redress	System Weaknesses	
Pending Closure	**Case Ref:** INV/24/01404 Added: 31/05/24 Closed: TBC	Alleged undisclosed interests by employee in supplier	Insufficient evidence to pursue further. All reasonable lines of enquiry followed.	✓					✓	System weaknesses identified / recorded
Closed	Case Ref: INV-25-03098 Added: 21/10/25 Closed: 18/11/25	Phishing email asking for payment to bank account	Recorded on CLUE for NHSCFA intelligence purposes	✓						No amount indicated

4 Losses, Preventions & Recoveries

The table below summarises the current status with reported fraud losses, fraud prevented amounts and, where applicable, the recovery of losses / other financial redress.

Reference Number	Loss, Prevention, Recovery	Amount	Invoice Raised / Salary Deduction	Actioned Date (i.e. invoice date)	Amount recovered in prior years	Amount recovered in current year	Current Status	Confirmed Debt Write Off
N/A								

5 Management Action Tracker

The table below summarises the Anti-Fraud Recommendations made to the organisation which have been followed up periodically and outlines the current status in relation to their implementation.

Reference Number	Report Type (LPE or INV)	Total No. of Rec's	Date Report Issued	Overall Date for Implementation	Actioned				Partial				No Action				Superseded				Comments
					C	H	M	L	C	H	M	L	C	H	M	L	C	H	M	L	
No outstanding actions currently																					

See Appendix A for Risk Classifications: Critical; High; Medium; Low

Appendix A: Glossary

CLUE	NHSCFA's case management system, used for recording investigations and LPEs, SWRs, amongst other things.
CFFSR	Counter Fraud Functional Standard Return (annual self-assessment submission in accordance with the Government Counter Fraud Standard require, GovS013).
FPCs	Fraud Prevention Checks (local alerts identified by MIAA and circulated to all its client to check for possible fraud risks relating to specific suppliers, organisations and individuals).
FPNs	Fraud Prevention Notices (issued by NHSCFA periodically, identifying a specific fraud risk noticed across multiple health bodies, with recommended local actions to be taken to test for local concerns and/or introduce additional anti-fraud controls).
FRA	Fraud Risk Assessment. A periodic corporate fraud risk assessment, undertaken as part of the requirements for the annual CFFSR submission, completed by both the AFS and the health body, identify potential areas of fraud risk across the organisation and scoring/rating those risks, often resulting in certain risks being added to risk registers, in line with the local RM strategy, and helping inform anti-fraud work priorities.
IBURN	Intelligence Bulletins usually issued by NHSCFA and relating to a very specific issue or concern where there is a request for local health body checks to be undertaken (often linked to an ongoing, national investigation).
IFAW	International Fraud Awareness Week (global, annual event, in November, which the NHS participates in to help keep fraud awareness on everyone's agenda).
LCFS	Local Counter Fraud Specialist (alternatively known as 'AFS', Anti-Fraud Specialists).
Learning Reports	A 'deep dive' report, via NHSCFA, often following a significant or high-profile investigation where system or control weaknesses were identified which allowed a fraud to occur, resulting in lessons learnt be shared for local consideration and action.
LPE	Local Proactive Exercise (a forensic review of a particular function, system, procedure etc to identify fraud or fraud risks).
NHSCFA	NHS Counter Fraud Authority for England and Wales (sometimes abbreviated to NHSCFA or just CFA).
NFI	National Fraud Initiative (bi-annual data-matching exercise run by the Cabinet Office).
RDA	Reactive Days Authority (an MIAA form used to agree the purchase of additional off-plan days for a specific task, i.e. a significant investigation).
SIA	NHSCFA's annual Strategic Intelligence Assessment which collates national statistics and trends, numbers of fraud types and values etc.
SWR	System Weakness Report. An NHSCFA terminology referring to an identified fraud risk or weakness at a system level (i.e. for example, in an organisation there are no checks on whether expense claims are accurate). SWRs need reporting on CLUE and may rise from an LPE or from an Investigation.
ToR	Terms of Reference (for an LPE, for example)

Appendix B: Risk Classifications

Risk Rating	Assessment Rationale
Critical	If this identified concern and corresponding recommendation is not addressed / implemented, it is anticipated that the likelihood of fraud / bribery occurrences in this area would increase significantly, and future instances may go undetected. Any instance of such fraud / bribery occurring would likely have an adverse impact on the ICB, of a financial (potentially material), operational, criminal, regulatory and / or reputational nature. In addition, there are control weaknesses that could have a significant adverse impact on the achievement of the organisation's objectives in relation to: • the safeguarding of ICB assets and resources. • compliance with laws and regulations.
High	If this identified concern and corresponding recommendation is not addressed / implemented, it is anticipated that the likelihood of fraud / bribery occurrences in this area would increase markedly, and future instances may go undetected. Any instance of such fraud / bribery occurring may have an adverse impact on the ICB, of a financial, operational, criminal, regulatory and/or reputational nature. In addition, there are control weaknesses that could have a marked adverse impact on the achievement of the organisation's objectives in relation to: • the safeguarding of ICB assets and resources. • compliance with laws and regulations.
Medium	If this identified concern and corresponding recommendation is not addressed / implemented, it is anticipated that this will: • fail to reduce the likelihood of fraud occurrences in this area. • fail to prevent a potentially adverse fraud impact on the achievement of the key system, function or process objectives. • continue to expose the system, function or process to a potential fraud risk. However, the likelihood of this risk materialising is assessed as low to moderate. • potentially undermine the safeguarding of ICB assets and resources.
Low	An identified control weakness that does not impact upon the achievement of key system, function or process objectives; however, implementation of the recommendation would improve overall control and reduce the potential for fraud occurrences in this area.

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Disclaimer

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NHS Greater Manchester ICB

Draft Anti-Fraud Plan 2026/27

Contents

1. Anti-Fraud Plan On A Page
2. Executive Summary
3. Supporting you through Adding Value
4. Anti-Fraud Risk Assessment
5. Anti-Fraud Plan 2026/27

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1 Anti-Fraud Plan on a Page

For NHS Greater Manchester ICB, this is the planning approach we will adopt:

PLANNING APPROACH

- **Risk Assessment** of identified and scored corporate fraud risks.
- **Fraud Intelligence** - location specific, MIAA client-wide and system/national fraud intelligence and threat assessments.
- **Mandated Requirements** – consideration of the current NHSCFA national strategy and the Govt. Functional Standard.
- **Previous Anti-Fraud Coverage** – to build upon previous work undertaken.
- **Follow-up** – Following through on outstanding recommendations and actions.

Critical Thematic Fraud Risks

- NHS Workforce
- NHS Suppliers
- Patients
- Strategic Risks & Systems Risks
- Third Party (inc. Cyber)

Anti-Fraud Plan Assurance Prioritites

- Regular reporting to Audit Committee / DoF/CFO
- Submission of GovS 013: Counter Fraud Functional Standard Return by deadline
- Fraud awareness activities – inc. IFAW
- Engagement with CFC/Key Stakeholders
- Comprehensive review of GCFP-compliant Fraud Risk Assessment
- Fraud-proofing activities (policies & procedures)
- Identification and delivery of LPE(s)
- Participation in NHSCFA initiatives
- Management Tracker Follow Up
- Residual NFI management
- Referrals / Investigations management

Outcomes

Maintain GovS 013 National Standard

Added Value

Mitigate Fraud Risks
Share Up-to-date Intelligence
Provide Expert Advice/ Guidance
Contribute a Return on Investment
Pursue Sanctions / Redress

NHS Greater Manchester

2 Executive Summary

2.1 MIAA's Strategy - Working in partnership with you

MIAA Assurance, providing cost effective assurance, insight and foresight. These services are delivered in partnership with you to ensure they are personal and responsive, ensuring the best possible customer experience. Our current MIAA wide strategy is summarised below:

2.2 Your Fraud Risk Assessment

A strong fraud risk and intelligence-led threat assessment underpins the Anti-Fraud Plan. This risk assessment is conducted in line with Government Counter Fraud Profession's (GCFP) methodology. This assessment is also considered to be an ongoing process, throughout the year, rather than a standalone exercise.

Your current assessment has considered, where appropriate, any known fraud related risks based upon a combination of factors, including referrals received and known and active threats facing the NHS. These will be updated further when the assessment is refreshed as part of the forthcoming plan. We have set out the current risks/threats which have been prioritised within the draft anti-fraud plan elsewhere in this plan.

2.3 Your Anti-Fraud Plan

Your Anti-Fraud service considers the requirements set out in the NHS Counter Fraud Authority's (NHSCFA) national strategy along with the duties placed on the ICB to comply with the Government Functional Standard 013 for Counter Fraud.

The proposed plan is based on the current assessment and provides indicative coverage for the organisation. The plan will remain dynamic and flexible to allow for responses to emerging challenges, risks and threats that may materialise in year. We will engage with you fully around plan development and any subsequent revisions.

Delivery of your plan will be co-ordinated by Paul Bell, your nominated Anti-Fraud Lead (AFS), who will be supported by members of MIAA's wider Anti-Fraud Service.

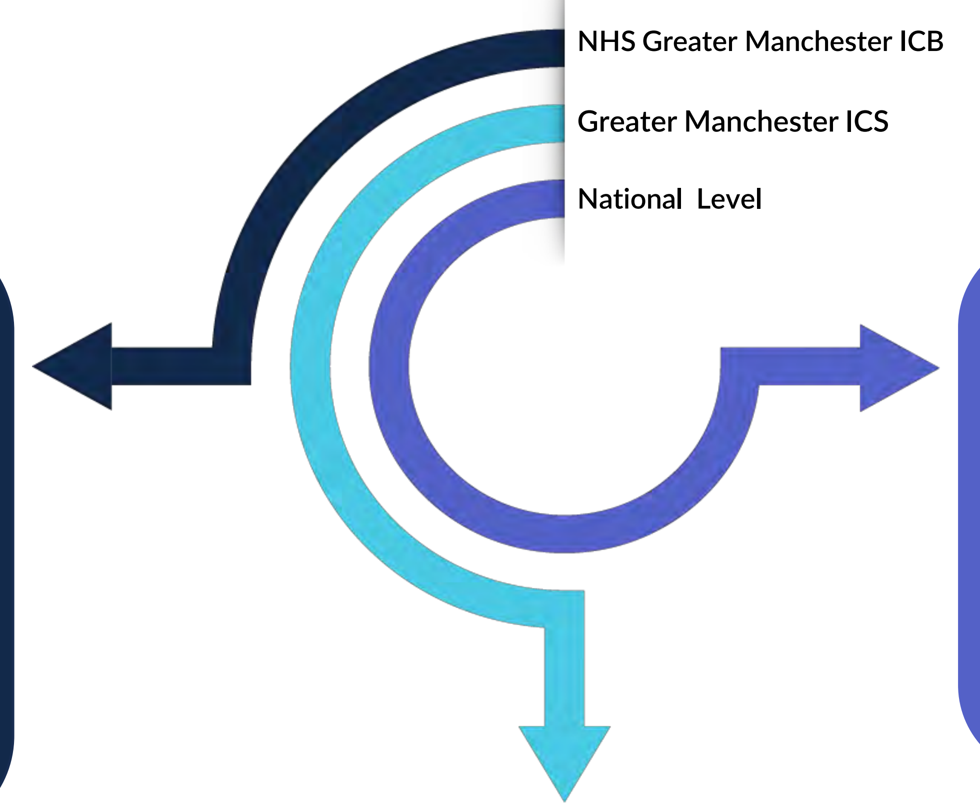
Services are delivered either by your nominated Anti-Fraud Specialist, by the MIAA Investigation Team, or by MIAA's Anti-Crime Services Team (non-investigations).

Occasionally, it may be necessary to request additional time, beyond the agreed plan, to perhaps undertake a large investigation or an additional off-plan assignment. In such circumstances we will normally utilise a Reactive Days Authority (or, RDA) to set out our request and the reasons behind it. In all circumstances, any such request will be fully discussed with you, to enable an informed decision or approval.

Fees for 26/27 will be based on 25/26 fees, uplifted in line with the NHS pay award.

NHS Greater Manchester

3 Supporting you through Adding Value



Individual Organisation Level

- **Building close professional relationships**
- **Specialist knowledge and services**
- **Local presence**
- **Flexibility and ability to respond**
- **Topical briefings on current fraud issues**
- **Intelligence alerts (FPCs) on active threats**
- **Audit Committee updates on New Legislation / Regulations**
- **Benchmarking, shared learning & best practice**
- **Insight reports on fraud trends and activities**
- **Communicating initiatives from across the NHS anti-fraud community**

National Level

- **Involvement and representation on national bodies, inc. Counter Fraud Managers Group (national network)**
- **NHSCFA Collaborative Round Table Group**
- **NHSCFA System Weakness & Stakeholder Focus Groups**
- **NHSCFA LCFS Conference Fraud Contributors**
- **National Publications, Insights and Research Contributions**

System Level

- **Regionally based teams**
- **Significant experience and knowledge: extensive client base**
- **Regional & System Groups, inc: Controlled Drugs Intelligence Network and Regional Fraud Forums**
- **Established relationships with all key Police Economic Crime Units**

4 Fraud Risk Assessment

The NHS Greater Manchester anti-fraud plan is built from a risk assessment which has considered national, regional/system and local active fraud threats, alongside strategic NHS anti-fraud priorities, as determined by the NHSCFA and the PSFA/GCFP, combined with our breadth of experience and understanding of the challenges you face.

In 2025, NHSCFA introduced a new, comprehensive fraud risk assessment methodology which will shortly become mandatory, and which is fully compliant with updated Government Counter Fraud Profession requirements.

The enhanced fraud risk assessment toolkit will consider:

- **Organisation Intelligence** – incorporating your experience of actual fraud and fraud risks in recent years.
- **Fraud Intelligence** – utilising our knowledge and expertise of active fraud threats and trends at both MIAA-client level and at a national level via both the Counter Fraud Managers Group and NHSCFA's Strategic Intelligence Assessment.
- **Previous Anti-Fraud Coverage** – taking into account work that has been completed previously, as well as any ongoing activities where an identified fraud risk can be neither terminated, transferred nor tolerated.
- **Mandated assurance** – consideration of the current NHSCFA national strategy, the Govt. Functional Standard, and the Government Counter Fraud Profession's public sector priorities.
- **Follow Up** – Anti-Fraud coverage will also include follow up of outstanding management actions arising from investigations, LPEs (Local Proactive Exercises) and SWRs (System Weakness Reports).

Strategic Risks & NHS System Risks

- Financial & Governance Controls
- Data Manipulation
- Payment Manipulation
- Patient Manipulation

NHS Workforce Risks

- Employee Governance
- Employee Payroll
- Employee Non-Payroll

NHS Supplier Risks

- Bribery
- Procurement
- Payments / Invoicing
- Performance Reporting

Patient Risks

- Travel
- Prescriptions
- Eligibility
- Compensation Claims

Third Party Risks inc. Cyber

- Payment Diversion
- NHS Data
- Impersonation
- Bursaries / Charitable Funds

5 Anti-Fraud Plan 26/27 - Assure

Priority Tasks & Activities	Fraud Risk / GovS:013 Rationale	Planned Delivery	Delivered By
ASSURE			
Fraud Risk Assessment: Development and update of GCFP compliant fraud risk assessment methodology.	**Thematic Fraud Risk Area:** All GovS:013 - Component: 3	Q1	MIAA Anti-Crime Services Team
Fraud Risk Assessment: Completion and maintenance of dynamic assessment of the Trust's / ICB's fraud risk scoring and management. **Full review in 2026/27.**	**Thematic Fraud Risk Area:** All GovS:013 - Component: 3	Q1	Your Anti-Fraud Specialist
Anti-Fraud Documentation & Templates: Development and design of GCFP/ NHSCFA compliant workplans, report templates, checklists and KPIs	**Thematic Fraud Risk Area:** All GovS:013 - Component: 2, 4, 5, 6 and 10	Q1 – Q2	MIAA Anti-Crime Services Team
Counter Fraud Functional Standard Return: Management and oversight of ongoing compliance with GovS:013 component requirements. Monitoring GovS:013 compliance throughout the year, and completion of return by end of May deadline.	**Thematic Fraud Risk Area:** Strategic GovS:013 - Component: All	Q1	MIAA Anti-Crime Services Team/ Your Anti-Fraud Specialist
Audit Committee Reporting / Stakeholder Engagement: Completion of Anti-Fraud workplans / Progress Reports / Annual Reports in line with ICB deadlines. AC attendance. Engagement with CFO and key stakeholders.	**Thematic Fraud Risk Area:** Strategic GovS:013 - Component: 1, 2	Q1 – Q4	Your Anti-Fraud Specialist
Quality Assurance & Oversight: Management review of Annual Reports/ Workplans/ Progress Reports/ Local Proactive Reports.	**Thematic Fraud Risk Area:** Strategic GovS:013 - Component: 1, 2	Q1 – Q4	MIAA Anti-Crime Services Team
AFS Training & Development: Identification of training requirements, and either delivery or sourcing of relevant training. Undertaking and successful completion of identified training requirements.	**Thematic Fraud Risk Area:** Strategic GovS:013 - Component: 9	Q1 – Q4	MIAA Anti-Crime Services Team/ Your Anti-Fraud Specialist
Anti-Fraud National Profile / Influence: Input into national counter fraud agenda, by liaison with NHSCFA, and attendance at CFMG / LIN meetings etc.	**Thematic Fraud Risk Area:** Strategic GovS:013 - Component: All	Q1 – Q4	MIAA Anti-Crime Services Team & Your Anti-Fraud Specialist

5 Anti-Fraud Plan 26/27 – Understand & Prevent

Priority Tasks & Activities	Fraud Risk / GovS:013 Rationale	Planned Delivery	Delivered By
UNDERSTAND & PREVENT			
Local Proactive Exercises - Planning: Identification and design of Terms of Reference / Testing Schedules to reflect changing fraud risks in the NHS.	**Thematic Fraud Risk Area:** Various GovS:013 - Component: 5, 10	Q1 – Q2	MIAA Anti-Crime Services Team
Local Proactive Exercises - Delivery: Completion of risk-based and targeted exercises to test controls and compliance or identify instances of actual fraud in the ICB's systems and processes. Recording of SWRs/ Fraud Vulnerabilities. • Personal Health Budgets (Direct Payments) • Completion of s.12 Mental Assessment Claims (with GMMH)	**Thematic Fraud Risk Area:** Various GovS:013 - Component: 5, 10	Q2 – Q3	Your Anti-Fraud Specialist
Awareness & Communications: Design and development of all MIAA fraud alert products (Webinars/ Alerts/ Fraud Prevention Checks/ Fraud Information Alerts etc.)	**Thematic Fraud Risk Area:** All GovS:013 - Component: 7, 11	Q1 – Q4	MIAA Anti-Crime Services Team
Awareness & Communications: Interpretation of all NHSCFA products (Fraud Prevention Notices/ IBurns/ Learning Reports/ Guidance) as well as strategy and prioritisation of any and all follow up work.	**Thematic Fraud Risk Area:** All GovS:013 - Component: 2, 7	Q1 – Q4	MIAA Anti-Crime Services Team
Awareness & Communications: Issuance and follow up of actions in relation to all MIAA / NHSCFA fraud alert communications.	**Thematic Fraud Risk Area:** All GovS:013 - Component: 5	Q1 – Q4	Your Anti-Fraud Specialist
Awareness & Communications: Delivery of risk-based targeted fraud awareness presentations / training across the ICB. • CHC / PHB team (Bury) + others • Maintain Cross GM PHB Working Group involvement • Primary Care Teams • Possibly re-run GP / Primary Care Webinar	**Thematic Fraud Risk Area:** All GovS:013 - Component: 7 and 11	Q1 – Q4	Your Anti-Fraud Specialist

5 Anti-Fraud Plan 26/27 – Understand & Prevent

Priority Tasks & Activities	Fraud Risk / GovS:013 Rationale	Planned Delivery	Delivered By
UNDERSTAND & PREVENT			
Fraud-Proofing: Identification of policies/ procedures requiring fraud input, so that all policies/ procedures with a fraud risk element to them are reviewed cyclically. Alternatively, assisting the organisation to 'design-in' anti-fraud controls from the outset when adopting new systems, processes and procedures. • Social Media Policy • AI (Acceptable Usage) Policy • Asset Management Policy • PHB Direct Payments User Agreement (cross GM) • No PO No Pay arrangements	**Thematic Fraud Risk Area: Various** GovS:013 - Component: 4, 5	Q1 – Q4	Your Anti-Fraud Specialist
Management Actions Follow-Up: Testing of evidence to clear all agreed anti-fraud recommendations from both MIAA work and from NHSCFA FPNs and Learning Reports etc. • 'Failure to Prevent Fraud' – Organisation Preparedness Gap Analysis LPE • S.12 MH Assessment LPE • CFA NPE Procurement Summary exercise actions • FPNs: M-005-25; M-006-25; M-007-25; M-008-25; L-001-26 , H-002-26; M-003-26 • Learning Reports – 25/01 (G&H); 25/02 (PHBs)	**Thematic Fraud Risk Area:** Various GovS:013 - Component: 5	Q1 – Q4	Your Anti-Fraud Specialist
National Fraud Initiative: Management of preparation for clearance of NFI matches / issues by ICB and MIAA. Liaison with Cabinet Office' s PSFA.	**Thematic Fraud Risk Area:** Various GovS:013 - Component: N/A	Q1 – Q2	MIAA Anti-Crime Services Team
National Fraud Initiative: Operational clearance of NFI matches, including liaison with relevant third parties.	**Thematic Fraud Risk Area:** Various GovS:013 - Component: N/A	Q1 – Q2	Your Anti-Fraud Specialist

5 Anti-Fraud Plan 26/27 – Respond

Priority Tasks & Activities	Fraud Risk / GovS:013 Rationale	Planned Delivery	Delivered By
RESPOND			
Initial Referrals: Receipt and initial communications with referrer of potential fraud concern, identifying early on those matters which are not fraud-related.	**Thematic Fraud Risk Area:** All **GovS:013 - Component:** 4, 7. 8. 9	Q1 – Q4	Your Anti-Fraud Specialist
Initial Enquires: Triage of initial referrals to establish if suitable for investigation, including liaison with referrer.	**Thematic Fraud Risk Area:** All **GovS:013 - Component:** 4, 7. 8. 9	Q1 – Q4	MIAA Investigations Team
Criminal Investigations: Conducting PACE compliant investigations of fraud referrals, with the aim of criminal prosecution / caution (liaison with NHSCFA/ CPS.)	**Thematic Fraud Risk Area:** All **GovS:013 - Component:** 4, 7. 8. 9	Q1 – Q4	MIAA Investigations Team
Application of Sanctions & Redress: Pursuing criminal and non-criminal sanctions against fraudsters, not limited to HR, Regulatory Body and Financial Recovery.	**Thematic Fraud Risk Area:** All **GovS:013 - Component:** 4, 7. 8. 9	Q1 – Q4	MIAA Investigations Team
Quality Assurance & Oversight: Management review of Investigation files and reports.	**Thematic Fraud Risk Area:** All **GovS:013 - Component:** 4, 7. 8. 9	Q1 – Q4	MIAA Investigations Team
Investigations-related Webinars/ Client Investigations Training (i.e. HR Teams & Internal Investigators)/ Benchmarking Reports: Provision of bespoke activities as / when identified and agreed.	**Thematic Fraud Risk Area:** All **GovS:013 - Component:** 9, 11	Bespoke training TBC by client and Investigations Team, (if required)	MIAA Investigations Team

GovS:013 – Government Functional Counter Fraud Standard

Our work is completed in accordance with the Government Functional Counter Fraud Standard (NHS Requirements) and conforms with relevant NHSCFA guidance and policy, as well as applicable legislation.

Limitations

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by MIAA's Assurance Services should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Reports prepared by MIAA are prepared for your sole use and no responsibility is taken by MIAA or the auditors to any director or officer in their individual capacity. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose and a person who is not a party to the agreement for the provision of Internal Audit and shall not have any rights under the Contracts (Rights of Third Parties) Act 1999.

Counter Fraud Champion (CFC) Update Report

2025-2026

Part of Greater Manchester Integrated Care Partnership

Audit Committee

19 March 2026

Required information	Details
Title of report	Counter Fraud Champion (CFC) Update Report
Author	David Dobson – Head of Business Management
Presented by	David Dobson – Head of Business Management
Contact for further information	daviddobson@nhs.net
Executive summary	This report provides the Audit Committee with assurance on the current CFC arrangements within NHS Greater Manchester (GM) Integrated Care Board (ICB).
The benefits that the population of Greater Manchester will experience.	To ensure that NHS GM continue to be compliant with the Counter Fraud Functional Standard.
How health inequalities will be reduced in Greater Manchester's communities.	Addressing fraud and fraud prevention will save the NHS in excess £1B, which in turn can be directed to patient care and addressing health inequalities. 'Despicable' fraud costs NHS in England £1bn a year - BBC News
The decision to be made and/or input sought	The Audit Committee is asked to support the continued programme of work of the counter fraud agenda and the Counter Fraud Champion's (CFC) as detailed within this Audit Committee Report.
How this supports the delivery of the strategy and mitigates the BAF risks	Actions are underway to develop the BAF to reflect elements of the Organisational Change Programme, as detailed within this report.
Key milestones	• NHS GM's CFC widening professional network and scope as detailed in Section 1.5 and Section 2.7. • The CFC's programme of work across NHS GM as detailed in Section 2.9 • The CFC's key messages to the Audit Committee as of March 2026.
Leadership and governance arrangements	Key duties have been fulfilled: • NHS GM's CFC continuing the wider professional engagement. • The CFC providing cyclical updates, narrative and guidance to the Audit

	Committee against the guiding principles of counter fraud, as detailed within this paper. • Head of Anti-Crime Services at MIAA recommends necessary communications for circulation across NHS GM, which is underway.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	NHS GM's CFC is now working and engaging with the Head of Anti-Crime Services at MIAA, the Senior Finance Team of NHS GM, as well as external subject matter experts (SMEs). The CFC co-facilitated a workshop in with MIAA.

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

Introduction

This report provides the Audit Committee with assurance on the current CFC arrangements within NHS Greater Manchester (GM) Integrated Care Board (ICB), as well as wider system and national learning.

Current Position

1.1. As reported to September 2024's Audit Committee, NHS GM's CFC completed the necessary training and is 100% compliant, which ensures that the ICB meets the statutory requirements of a CFC. The CFC has continued to provide the necessary assurance and challenge, as detailed within this assurance report to the Audit Committee.

1.2. The CFC has made professional connections with colleagues outside of NHS GM and beyond the GM integrated care system (ICS) footprint, to gain subject matter expert (SME) input, professional advice and guidance. NHS GM's CFC has now connected with SMEs to provide a check and balance against NHS GM's current position, as detailed within the paper.

1.3. As reported to the Audit Committee in September 2025, part of the CFC role is to enable, facilitate and support the fraud prevention work at a senior strategic level. Several of the Audit Committee members attended the Board Development Session in August 2025 and were already aware of the 'Failure to Prevent Fraud' Offence – Economic Crime & Corporate Transparency Act 2023. The Board Development Session received a presentation by the Head of Anti-Crime Services at MIAA, as well as a high-level response within the CFC's Audit Committee Report in September 2025.

1.4. In collaboration with the Head of Anti-Crime Services at MIAA, the CFC co-facilitated an internal workshop with five senior leaders from across NHS GM on 25th November 2025. This included representation from the Finance Team, Contracting Team, alongside an Associate Director of Nursing, Quality and Safeguarding (ADQ), who provided a clinical voice in the room. The discussions from the workshop allowed the Head of Anti-Crime Services at MIAA to specifically talk in more detail about the possible challenges and potential risks which may arise within the GM ICS, as a result of the new Failure to Prevent Fraud Offence. During the Audit Committee Meeting, the Head of Anti-Crime Services at MIAA may wish to elaborate in more detail.

1.5. As part of the ongoing dialogue and interface, looking beyond the GM system, the CFC has continued to seek subject matter expert (SME) input from another Integrated Care Board (ICB). The CFC has confirmed that the SME referred to two key elements which should be considered as part of the 'Failure to Prevent Fraud' Offence – Economic Crime & Corporate Transparency Act 2023. The SME referred to the first element being the need for a set of principles being developed and worked towards by the Audit Committee. The CFC can confirm these have been progressed, as detailed above. The second element was the need to work through any test case and obtain any learning for NHS GM. This was in fact discussed at length during the Board Development Session on 20th August 2025 and as part of the NHS GM internal workshop held on 25th November 2025.

1.6. Within the CFC Report to the Audit Committee in September 2025, reference was made to the Government announcement on architectural and fundamental changes to the NHS as part of NHS Reform. The role of the CFC is to provide a senior strategic voice within NHS GM to champion the counter fraud agenda and to enable and support the counter fraud programme of work. As such the CFC has added a new element for the programme of work in 25/26, specifically in response to NHS Reform. The CFC believes that greater due diligence should be taken by line managers, peers who are Heads of Services, along with colleagues at a Director and a Very Senior Manager (VSM) level, due to the potential level of changes amongst staffing internally to NHS GM. The CFC believes this level of change could leave not only NHS GM, but wider NHS colleagues vulnerable at a time of huge upheaval.

1.7. This is in keeping with the messages shared by NHS GM's CEO during the Board Development Session in August 2025, which is shown on the Risk Register to the Audit Committee Meeting. Therefore, it is essential that as part of the counter fraud programme of work, the CFC continues to promote and embed an awareness of fraud, bribery and corruption across the organisation during what will likely be a sustained period of organisational change and drive forward a counter fraud culture across the organisation, as NHS GM continues to embed a revised Operating Model and new Chief Officer portfolios from 1st January 2026. The importance of this was also followed up by the

Deputy Chief Finance Officer (DCFO) and CFC, to the Extended Leadership Team (ELT), for further cascaded learning in January 2026.

1.8. It is within the Board Assurance Framework (BAF) below, that the CFC believes NHS GM has become more vulnerable to elements of fraud. In addition to this, the change and transitional fraud risks are included in the 'strategic' thematic areas of the MIAA Updated Fraud Risk Assessment Toolkit, such as, the ICB restructuring and NHS England dissolution.

Risk: There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions. This will result in core ICB business being disrupted during the transition.

1.9. Since the last Audit Committee Meeting there has been an additional action added to the CFC's workplan, being the publication of the National Report, in response to the 2024 Procurement Local Proactive Exercise (LPE): Due Diligence and Contract Management. This has been raised by the Head of Anti-Crime Services at MIAA and referenced with the necessary Audit Committee papers for March's Audit Committee Meeting. An update on progress thus far is provided in Section 2.7.

Progress Update Report

2.0

2.1. Following the CFC's Audit Committee Report in September 2025, there were three specific areas following the current programme of work. One of which, was to have a team-based approach to the counter fraud agenda. The CFC would like to emphasise the positive engagement by members of staff, demonstrated by the NHS GM internal workshop held on 25th November 2025 with the Head of Anti-Crime Services at MIAA.

2.2. Another aspect of the current counter fraud programme of work was to have joint working with staff. Noting the comments made in previous CFC Reports to the Audit Committee, NHS GM continues to promote the counter fraud agenda through our Keep Connected bulletin to NHS GM. Members of the Audit Committee may have received these e-mail communications and will therefore be familiar with what is shared internally, across the organisation. If members of the Audit Committee have not received what has been shared internally, this can be shared upon request.

2.3. It was agreed in December 2024 to rollout the Counter Fraud Ambassadors responsibilities to all the Associate Directors of Finance across NHS GM. This is timely for the Counter Fraud Ambassadors, in the context of the current Organisational Change Programme, as well as the Failure to Prevent Fraud Offence for wider cascading and

learning. This has ensured there is continued knowledge of systems and processes in place, which is a key duty for the CFC role. Due to the sequencing of the Audit Committee Meetings, the CFC will next meet with the Counter Fraud Ambassadors in Quarter 1 (Q1) of 2026/27. Moreover, the CFC will report back to the Audit Committee later in the calendar year on the impact of the Organisational Change Programme on the Counter Fraud Ambassadors.

2.4. Part of the CFC role is to remove any blocks to the progress of counter fraud work and driving forward a counter fraud culture across the organisation. The CFC is of the view that NHS GM could be more vulnerable, as detailed in Section 1. Therefore, it would be timely to review the role of Counter Fraud Ambassadors for the new ways of working for the NHS GM revised Operating Model, which is now being rolled out as part of the Organisational Change Programme.

2.5. Noting the comments made in Section 1 and Section 2.4 above, about organisational change across the NHS, it will be essential for the CFC to continue to understand any regulatory and legislate changes between the role of the CFC and the role of NHS England, following the announcements made by both the Prime Minister and his Secretary of State for Health and Social Care in March 2025 to abolish NHS England. The CFC will duly pay close attention to any further updates from the Secretary of State and Sir Jim Mackey – CEO of NHS England, as to the future operating models across NHS, as referenced in the future NHS Operating Model blueprint document in May 2025: NHS England » Update on the draft Model ICB Blueprint and progress on the future NHS Operating Model

2.6. The intention will be for the CFC to simply align any new ways of working to the new operating model for NHS GM, which will resemble a composition in line with a slimmed down ICB and the abolition of NHS England. As reported in Section 1, cascaded learning to ELT took place in Q4, by the Deputy Chief Finance Officer (CDFO), on 6th January 2026. The DCFO provided the following update on behalf of himself and the Chief Finance Officer (CFO), and CFC which was followed up as an e-mail cascade to maintain the golden thread of the counter fraud agenda from the Board, into the Audit Committee and onto the ELT. The DCFO's email referenced the following three areas:

- The 'Failure to Prevent Fraud' Offence – Economic Crime & Corporate Transparency Act 2023 update and the connections from the Informal Board in August 2025 and the Audit Committee in September 2025. Also, through cascaded learning to our Counter Fraud Ambassadors in October 2025.

- The publication of the National Report, in response to the 2024 Procurement Local Proactive Exercise (LPE): Due Diligence and Contract Management. As this is now being worked through by the Senior Finance Team, colleagues at MIAA, the CFC and NHS GM's Head of Market Management, who is the subject matter expert (SME) in this field. The

DCFO recognised that the ELT may already be aware of this work, which is being led by the NHS GM Senior Finance Team.

- The DCFO, on behalf of the CFO, acknowledged and shared the vulnerability for NHS GM to fraud at this time, due to the sheer size and scale of NHS Reform both locally and nationally, as detailed in Section 2 above. The DCFO reminded all NHS GM staff, including Line Managers, Heads of Department, Directors and Chief Officers to continue to read and review our internal communications, as they regularly feature updates on the counter fraud agenda shared by MIAA.

2.7. Following on from Section 1.5, the CFC formally met with the Counter Fraud SME earlier in Quarter 4 (Q4). It should be noted that the Counter Fraud SME is actually stepping down from their respective NHS Non-Executive Director (NED) roles, but will maintain a professional leadership role in the audit and counter fraud setting within the public sector. Therefore, this professional connection, dialogue, check and challenge will continue beyond 1st April 2026. During the meeting, the SME shared the same concerns and observations regarding the risks associated with organisational change, as listed in Sections 1.7 and 2.3 of this report. The SME also wished to express their own observations regarding alignment of commissioning and procurement processes, in the context of organisational change. As such, the CFC has formally provided this feedback to the CFO and DCFO.

2.8. The actions undertaken thus far by the CFC in response to the National Report on the 2024 Procurement Local Proactive Exercise (LPE): Due Diligence and Contract Management, are listed below:

- The CFC discussed with the Senior Finance Team in respect of the need for NHS GM to understand the current position. The CFC has reviewed the specific and pertinent elements of Annex A.

- From a prevention perspective, following on from the above, NHS GM was measured against the outputs from the RAG rating, referred to an Annex A, with triangulation from MIAA's Head of Anti-Crime.

- To provide the necessary assurance into the Audit Committee Meeting in March 2026, this CFC Report provides a snapshot in time, following recent discussions. As such, it is clear that NHS GM has reduced the number of waivers approved. NHS GM has always had a robust process around initiating and authorising waivers, with appropriate segregation of duties for each step of the approval process. With the implementation of the provider Selection Regime (PSR), waivers are no longer applicable to healthcare services and only apply to non-healthcare related goods and services. The Contracting Team ensure appropriate contracting arrangements are put in place for all goods and services procured,

again with the appropriate segregation of duties in place to prevent fraud. NHS GM has robust processes and procedures in place to prevent fraud in this area.

2.9. In response to Section 1.9, the CFC has discussed the response with the necessary colleagues, as detailed in Section 2.8 above. Therefore, it would be appropriate for the Audit Committee to receive a position statement and progress report on the following key areas in the coming months:

- An update on the CFC's programme of work, as detailed within this report.
- A position statement specifically on the rollout of work, which has either taken place, or planned with both the ELT and Counter Fraud Ambassadors following the new Failure to Prevent Fraud Offence. This will likely also include the role of Counter Fraud Ambassadors more long-term within NHS GM.
- Any pertinent updates connected to the counter fraud agenda, following the announcement of NHS Reform, as detailed in Section 2.5.
- An update, if necessary, against the National Report on the 2024 Procurement Local Proactive Exercise (LPE): Due Diligence and Contract Management, as detailed in Section 2.8.

Recommendations

3.0 The Audit Committee is asked to:

- Note the update report provided by the CFC.
- Confirm and agree for a detailed position statement to be provided to September's Audit Committee Meeting.
- Provide any specific feedback on areas for consideration, or any additional items for inclusion within the CFC's September Audit Committee meeting, as detailed in Section 2.9.

External Audit Plan and Fees 2025-26

Part of Greater Manchester Integrated Care Partnership

Audit Committee

19 March 2026

Required information.	Details.
Title of report.	External Audit Plan and Fees 2025-26.
Author.	Perminder Sethi, Senior Manager Audit, Grant Thornton.
Presented by.	
Contact for further information.	Perminder Sethi, Senior Manager Audit, Grant Thornton.
Executive summary.	This report provides an update to Audit Committee on the 2025/26 audit plan covering: • Audit Approach • Risks • Implementation of prior year recommendations • Materiality • IT Audit • Value for Money Audit • Fees • Independence
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 Committee is asked to: 1. Review and approve the audit plan and fees.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	N/a.
Key milestones.	This is a key document within the audit planning and year end audit for 2025/26.
Leadership and governance arrangements.	The paper has been agreed by: • Grant Thornton • NHS Greater Manchester
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The paper has been agreed by: • Grant Thornton • NHS Greater Manchester
Financial or Legal Implications	The paper confirms the audit fees.

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

Table 2: Assurance needed about the document.

Grant Thornton
NHS Greater Manchester Integrated Care Board - Audit Plan
Year ending 31 March 2026
11 March 2026

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1. Introduction and headlines

Purpose

This document provides an overview of the planned scope and timing of the statutory audit of NHS Greater Manchester Integrated Care Board (the 'ICB') for those charged with governance.

Respective responsibilities

The National Audit Office (the 'NAO') has issued a document entitled the Code of Audit Practice (the 'Code'). This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. Our expected respective responsibilities are also set out in the agreed engagement letter and the agreed addendum to the contract. We draw your attention to these documents.

Scope of our audit

The scope of our audit is set in accordance with the Code and International Standards on Auditing (ISAs) (UK). We are responsible for forming and expressing an opinion on the ICB's financial statements that have been prepared by management with the oversight of those charged with governance (the Audit Committee); and we consider whether there are sufficient arrangements in place at the ICB for securing economy, efficiency and effectiveness in your use of resources. Value for money relates to ensuring that resources are used efficiently in order to maximise the outcomes that can be achieved.

The audit of the financial statements does not relieve management or the Audit Committee of your responsibilities. It is the responsibility of the ICB to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We have considered how the ICB is fulfilling these responsibilities.

Our audit approach is based on a thorough understanding of the ICB's business and is risk based.

Significant risks

Those risks requiring special audit consideration and procedures to address the likelihood of a material financial statement error have been identified as:

- Management override of controls
- Implementation of Integrated Single Financial Environment 2 (ISFE2)

We will communicate significant findings on these areas, as well as any other significant matters arising from the audit to you in our Audit Findings (ISA 260) Report.

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1. Introduction and headlines (continued)

Materiality

We have determined planning materiality to be £186.8m (PY £114.7m) for the ICB, which equates to 2% (PY 1.35%) of your forecast gross operating costs for the year. We increased the materiality percentage from 1.35% in 2024/25 to 2% in 2025/26 to recognise updated Firm guidance and because no significant matters arose from the audit in 2024/25, or earlier years.

We are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. As part of our risk assessment, we have considered the impact of unadjusted prior period errors. Clearly trivial has been set at £1m (PY £1m).

Value for money arrangements

Our risk assessment regarding your arrangements to secure value for money has identified the following risk of significant weakness:

- The ICB's arrangements in relation to managing its in-year financial performance, financial planning for 2026/27 and its medium-term financial planning.

Audit logistics

Our interim visit has taken place in February, early testing will be completed in February and March, and our final visit will take place in May and June. Our key deliverables are this Audit Plan, our Audit Findings Report and Auditor's Annual Report.

Our fee for the audit will be £241,535 (PY £230,105) for the ICB, subject to the ICB delivering a good set of financial statements and working papers, no significant changes in scope to the Audit, and management being responsive to audit requests.

We have complied with the Financial Reporting Council's Ethical Standard (revised 2024) and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements.

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2. Significant risks identified

Significant risks are defined by ISAs (UK) as risks that, in the judgement of the auditor, require special audit consideration. In identifying risks, audit teams consider the nature of the risk, the potential magnitude of misstatement, and its likelihood. Significant risks are those risks that have a higher risk of material misstatement.

Significant risk	Description	Planned audit procedures
Management override of controls Under ISA (UK) 240 there is a non-rebuttable presumed risk that management override of controls is present in all entities.	We have identified management override of controls, in particular journals, management estimates and transactions outside the course of business as a significant risk of material misstatement.	We will: • evaluate the design effectiveness of management controls over journals; • analyse the journals listing and determine the criteria for selecting high risk unusual journals; • test unusual journals made during the period and after the draft accounts stage for appropriateness and corroboration; • gain an understanding of the accounting estimates and critical judgements applied made by management and consider their reasonableness; and • evaluate the rationale for any changes in accounting policies, estimates or significant unusual transactions.

"In determining significant risks, the auditor may first identify those assessed risks of material misstatement that have been assessed higher on the spectrum of inherent risk to form the basis for considering which risks may be close to the upper end. Being close to the upper end of the spectrum of inherent risk will differ from entity to entity and will not necessarily be the same for an entity period on period. It may depend on the nature and circumstances of the entity for which the risk is being assessed. The determination of which of the assessed risks of material misstatement are close to the upper end of the spectrum of inherent risk, and are therefore significant risks, is a matter of professional judgement, unless the risk is of a type specified to be treated as a significant risk in accordance with the requirements of another ISA (UK)." (ISA (UK) 315).

In making the review of unusual significant transactions "the auditor shall treat identified significant related party transactions outside the entity's normal course of business as giving rise to significant risks." (ISA (UK) 550).

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2. Significant risks identified (continued)

Significant risk	Description	Planned audit procedures
Fraud in revenue recognition Under ISA (UK) 240, there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue.	We have considered the rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. Income from sale of goods and services and other operating income is immaterial. As a result, we have rebutted the presumed risk that revenue may be misstated due to the improper recognition of revenue for all revenue streams.	As we do not consider this to be a significant risk for the ICB, standard audit procedures will be carried out in this area. We will keep this rebuttal under review throughout the audit to ensure this judgement remains appropriate.

Management should expect engagement teams to challenge management in areas that are complex, significant or highly judgmental which may be the case for accounting estimates, going concern, related parties and similar areas. Management should also expect to provide engagement teams with sufficient evidence to support their judgements and the approach they have adopted for key accounting policies referenced to accounting standards or changes thereto.

Where estimates are used in the preparation of the financial statements management should expect teams to challenge management's assumptions and request evidence to support those assumptions.

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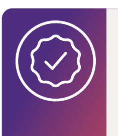
2. Significant risks identified (continued)

Risk	Description	Planned audit procedures
Fraud in expenditure recognition As most public bodies are net spending bodies, the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition.	We have assessed the risk and have rebutted the risk of fraud in expenditure recognition due to the majority of the ICB's expenditure being driven by block payment contracts agreed with providers. Other areas of expenditure are also substantially contractual in nature or managed through national frameworks such as prescribing, dental and pharmaceutical services. The opportunity to manipulate these areas of expenditure is low and as a result, we have rebutted the presumed risk that expenditure may be misstated due to the improper recognition of expenditure. Other non-contracted and pay expenditure streams are generally not material individually and our assessment is that there is limited opportunity to manipulate expenditure materially. As a result, we have rebutted the presumed risk that expenditure may be misstated due to the improper recognition of expenditure for non-contracted expenditure.	As we do not consider this to be a significant risk for the ICB standard audit procedures will be carried out in this area including a focus on consideration of unrecorded liabilities and expenditure completeness. We will keep this rebuttal under review throughout the audit to ensure this judgement remains appropriate. We will: • evaluate your accounting policy for recognition of expenditure for appropriateness and compliance with the DHSC Group Accounting Manual 2025/26; • understand and assess the ICB's process for recording expenditure accruals and deferrals, and any relevant controls; • use the DHSC mismatch report to investigate unmatched expenditure and payable balances with NHS bodies over the NAO £1m threshold; • inspect a sample of payable and expenditure accrual balances; • obtain a listing from the cash book or equivalent of payments in March, April and May to ensure they have been charged to the appropriate year; • agree significant secondary healthcare contracts to reported expenditure, reconciling agreed contracts to outturn values, investigating significant variances to supporting evidence; • agree prescribing expenditure and other areas of expenditure based on contractual or other agreements to supporting evidence, using sampling where appropriate; and • inspect a sample of expenditure for non-contracted expenditure.

2. Significant risks identified (continued)

Significant risk	Description	Planned audit procedures
New System Implementation - ISFE 2 (Integrated Single Financial Environment 2)	We have identified the new system implementation of ISFE 2 as a significant risk of material misstatement due to error.	For the risk identified in the new system implementation – ISFE 2 we will: • understand the process used for the implementation of ISFE 2; • identify potential risks created or heightened by the new ledger system; • develop appropriate audit procedures to gain the required assurance related to the risks identified; • test the data migration; • complete a review of user access restrictions; and • document and gain an appropriate understanding of corresponding IT General Controls (ITGCs).



"The auditor determines whether there are any risks of material misstatement at the assertion level for which it is not possible to obtain sufficient appropriate audit evidence through substantive procedures alone. The auditor is required, in accordance with ISA (UK) 330 (Revised July 2017), to design and perform tests of controls that address such risks of material misstatement when substantive procedures alone do not provide sufficient appropriate audit evidence at the assertion level. As a result, when such controls exist that address these risks, they are required to be identified and evaluated." (ISA (UK) 315)

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2. Other matters

Other work

In addition to our expected responsibilities under the Code of Practice, we have a number of other audit responsibilities, as follows:

- We audit parts of your Remuneration and Staff Report in your Annual Report and check whether these sections of your Annual Report have been properly prepared. These procedures are performed to a lower materiality (outlined in section 4).
- We read the sections of your Annual Report which are not subject to audit and check that they are consistent with the financial statements on which we give an opinion.
- We carry out work to satisfy ourselves that disclosures made in your Annual Governance Statement are in line with requirements set by NHS England.
- We issue a separate "consistency with" opinion on your summarisation schedules which confirm whether the schedules are consistent with the audited financial statements.
- We carry out work on your summarisation schedules for the Whole of Government Accounts process in accordance with group audit instructions.
- We give a regularity opinion on whether expenditure has been incurred 'as intended by Parliament'.
- We consider our other duties under legislation and the Code, as and when required, including:
  - referral of matters to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014;
  - issue of a report in the public interest;
  - written recommendations to the ICB under section 24 of the Local Audit and Accountability Act 2014.
- We certify completion of our audit.

Other material balances and transactions

Under International Standards on Auditing, "irrespective of the assessed risks of material misstatement, the auditor shall design and perform substantive procedures for each material class of transactions, account balance and disclosure". All other material balances and transaction streams will therefore be audited. However, the procedures will not be as extensive as the procedures adopted for the risks identified in this report.

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3. Progress against prior year audit recommendations

We identified the following issues in our 2024/25 audit of the ICB's financial statements, which resulted in 5 recommendations being reported in our 2024/25 Audit Findings Report. We have set out below management action taken on each recommendation.

Assessment	Issue and risk previously communicated	Management response
In progress. We will confirm our assessment in our Audit Findings Report in June.	**Journals** - As last year, our review of the journals system identified that users are able to self approve journals without an independent reviewer. We understand management review each self approved journal on a monthly basis to ensure these journals are appropriate and have been correctly posted. This compensating control reviews all self approved journals. An effective control system requires the segregation of duties and in the case of journals, an independent review function to review and approve the proposed journal. Without this process there remains a risk that journals may be erroneously posted.	**Management response – June 2025** NHS GM has reviewed the ability to use the Oracle system to enforce the segregation of duties relating to journals and concluded that this would cause significant disruption to the production of monthly financial information. The mitigating control of a post month end review of journals and investigation of self-approved journals has been reviewed and is still appropriate. This process remains consistent with 2023-24. The new national ledger system (ISFE2) enforces the segregation of duties. The anticipated go live date for the new system is October 2025. **Management response – March 2026** During 2025/26 the ICB has operated two ledger systems (ISFE1 and ISFE2). The implication of this is that for the first six months of the financial year, the post month end review continued in line with 2024/25 controls. For the second six months, the new ledger system enforces that journals cannot be self approved and automatically progress through the ledger hierarchy to the relevant supervisor to approve.
In progress. We will confirm our assessment in our Audit Findings Report in June.	**Journals** - Last year we reported that there were a large number of individuals within GM ICB that are able to post journals. We recommended that management should review the current list of authorised staff able to post journals and ensure journal access rights are only provided to those users considered essential. Our review as part of the 2024-25 audit noted 155 individuals who are able to post journals, of which 34 did not post any journals during 2024-25. This is considered a large number and whilst we recognise the size of GM ICB, management should review the current list of authorised staff to ensure journal access is only provided to those users considered essential. Providing access rights to post journals to users no longer considered essential can result in a potential risk of inappropriate journals being posted.	**Management response – June 2025** NHS GM has considered its processes and the controls around journal posting and approval are adequate given the size of NHS GM and the finance function. Access and responsibilities are reviewed on a regular basis and are being reviewed as part of the ISFE2 implementation programme. **Management response – March 2026** NHS GM reviews users and responsibilities on a regular basis and the number of users is still deemed appropriate given the size of the organisation.

3. Progress against prior year audit recommendations

Assessment	Issue and risk previously communicated	Management response
In progress. We will confirm our assessment in our Audit Findings Report in June.	**Contract Variations** - As last year, our audit work reviewing block contract variations noted a number of contract variations where contract variation agreements had not been signed. We also noted one acute baseline contract relating to specialised commissioning which had also not been signed. Whilst signed agreements have now been obtained or alternative confirmations received, it is essential to ensure all contracts and contract variations are agreed and signed prior to payments being made. Without a signed contract or contract variation agreement, the ICB's is at risk of potential disputes.	**Management response – June 2025** Work has continued within NHS GM to ensure that all contract variations are in place and signed in a timely manner. Due to late allocations received, not all variations will be signed at the end of the financial year. Whilst there may be unavoidable delays to the physical signing of contracts, NHS GM introduced a process of agreement and documentation of values between respective organisations. This process will be reviewed and changes implemented to ensure that the agreement documentation is available at the commencement of the audit in order to prevent delays in the audit testing process. The transfer of specialist commissioning contracts from NHS England is a key area which NHS GM will focus on alongside the continual improvement in processes for the agreement of contract variations. **Management response – March 2026** NHS GM has a process to ensure that all contract variations are in place where practical. Where there are instances of late allocation or delays in signature of the contract variations, the process remains in place from last year where explicit agreement of values outstanding between respective organisations will be provided within the year end audit process.
In progress. We will confirm our assessment in our Audit Findings Report in June.	**Related Party Disclosures** - We noted that two of the ICB's Non-Executive Directors (NEDs) have not been disclosed in accordance with International Accounting Standard IAS 24 (Related Party Disclosures) whilst transactions have taken place during the year. IAS 24 requires key management personnel having authority and responsibility for planning, directing and controlling the activities of the entity directly or indirectly including any director (whether executive or otherwise) to disclose transactions that have taken place with an entity which is controlled by or is significantly influenced by them. Without transparent related party disclosures, there remains a risk that conflicts of interest and potential irregularity may not be identified.	**Management response – June 2025** We do not consider these additional disclosures are required as the Non-Executive Directors are not able to direct or exercise control at the ICB, which is consistent with 2023-24. Following discussions at the Audit Committee meeting, these disclosures have now been made by management. **Management response – March 2026** The disclosure will follow the amendments made in 2024/25 and include all parties.

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3. Progress against prior year audit recommendations

Assessment	Issue and risk previously communicated	Management response
In progress. We will confirm our assessment in our Audit Findings Report in June.	**BPPC Performance** – Our testing of data used to calculate the BPPC performance for Non-NHS payments noted various errors in the calculation spreadsheet resulting from manual entries as opposed to the use of pre-populated formulae, in addition, we noted for faster payment runs (using bank transfer), the invoice received date automatically defaults to the payment date resulting in a pass for all payments when they may have breached the 30 day payment requirement. In total, there were 60 additional fails noted out of 161,237 payments, or £1,583k out of total payments of £8,076,660k. This error results in the BPPC performance for Non-NHS payments reducing marginally from 96.88% to 96.85% in number, and 95.45% to 95.37% in value. Management should formally review the BPPC calculation each year to ensure it is accurate, in addition, where faster payments are used, the invoice date should be recorded to ensure the BPPC calculation can be accurately determined.	**Management response – June 2025** NHS GM will ensure that the supporting working papers use pre-populated formulae rather than manual entries. In addition, NHS GM will implement a process to review items recorded in the BPPC calculation, where a payment has been made by the faster payment mechanism, to ensure that the date does not default to the date of payment as opposed to the invoice date. **Management response – March 2026** The updates to the working papers and the review process noted in the management response above have been fully implemented for 2025/26, with regular review during the financial year, and with particular focus on faster payments.

4. Our approach to materiality

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and not only applies to the monetary misstatements but also to disclosure requirements and adherence to acceptable accounting practice and applicable law.

Matter & Description	Planned audit procedures
Determination We have determined planning materiality (financial statement materiality) at the planning stage of the audit based on professional judgement in the context of our knowledge of the ICB, including consideration of factors such as public expectations, industry developments, financial stability and reporting requirements for the financial statements. We have determined financial statement materiality based on a proportion of the gross operating costs of the ICB for the financial year. At the planning stage of our audit, materiality is set at £186.8m (PY £114.7m) for the ICB, which equates to 2% of your forecast gross operating costs for the year. We increased the materiality percentage from 1.35% in 2024/25 to 2% in 2025/26 to recognise updated Firm guidance and because no significant matters arose from the audit in 2024/25, or earlier years.	We determine planning materiality in order to: – establish what level of misstatement could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements – assist in establishing the scope of our audit engagement and audit tests – determine sample sizes and – assist in evaluating the effect of known and likely misstatements in the financial statements.
Other factors An item does not necessarily have to be large to be considered to have a material effect on the financial statements.	An item may be considered to be material by nature when it relates to instances where greater precision is required (e.g. senior officer remuneration and audit fees).
Reassessment of materiality Our assessment of materiality is kept under review throughout the audit process.	We reconsider planning materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality.

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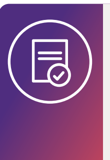
4. Our approach to materiality (continued)

	Amount (£)	Qualitative factors considered
Materiality for the ICB financial statements	£186,844,000	2% of the estimated gross operating costs for the current year.
Materiality for Senior officer remuneration	£47,000	We have identified senior officer remuneration disclosures as an area where we will apply a lower level of materiality as these are considered sensitive disclosures. Whilst we have set a materiality of £47k, we will request any changes be made where any error would alter the banding reported for any manager.



Misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; Judgements about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both; and Judgements about matters that are material to users of the financial statements are based on a consideration of the common financial information needs of users as a group. The possible effect of misstatements on specific individual users, whose needs may vary widely, is not considered. (ISA (UK) 320)

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5. IT audit strategy

In accordance with ISA (UK) 315, we are required to obtain an understanding of the IT environment related to all key business processes, identify all risks from the use of IT related to those business process controls judged relevant to our audit and assess the relevant IT general controls (ITGCs) in place to mitigate them. Our audit will include completing an assessment of the design and implementation of ITGCs related to security management; technology acquisition, development and maintenance; and technology infrastructure.

The following IT applications are in scope for IT controls assessment based on the planned financial statement audit approach, we will perform the indicated level of assessment:

IT application	Audit area	Planned level IT audit assessment
Oracle	Financial reporting	• **Detailed ITGC assessment –** we will test the design effectiveness of the controls in place. • **Complementary user entity control testing** – we will review any relevant IT controls that remain the responsibility of the ICB • **Review of Service Auditor Reports (design and operating effectiveness)** – we will review the service auditor reports for the year
ESR	Payroll	• **Detailed ITGC assessment –** we will test the design effectiveness of the controls in place. • **Complementary user entity control testing** – we will review any relevant IT controls that remain the responsibility of the ICB • **Review of Service Auditor Reports (design and operating effectiveness)** – we will review the service auditor reports for the year

In addition, due to the significant change during the period, specifically the new system implementation, additional audit procedures will be completed to address the additional risks of material misstatement identified.

IT application	Event	Relevant risks	Planned IT audit procedures
ISFE 2	New system implementation	Post migration data completeness and accuracy; system functionality operating to design.	• Obtain an understanding of the process used for new system implementation • Audit of data migration activity and results

6. Value for Money Arrangements

Approach to Value for Money work for the period ended 31 March 2026

The National Audit Office issued its latest Value for Money guidance to auditors in November 2024. The Code expects auditors to consider whether a body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Auditors are expected to report a commentary each year under the specific reporting criteria and where significant weaknesses in arrangements are identified, raise them promptly with those charged with governance. The three specified reporting criteria are set out below:

Financial sustainability

How the ICB plans and manages its resources to ensure it can continue to deliver its services.

Governance

How the ICB ensures that it makes informed decisions and properly manages its risks.

Improving economy, efficiency and effectiveness

How the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We will continue our review of your arrangements until we sign the opinion on your financial statements before we issue our auditor's annual report. Should any further risks of significant weakness be identified, we will report this to those charged with governance as soon as practically possible. We report our value for money work in our Auditor's Annual Report. Any significant weaknesses identified once we have completed our work will be reflected in your Auditor's Report and included within our audit opinion.

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6. Risks of significant weakness in VFM arrangements

Initial Risk assessment of the ICB's VFM arrangements

The Code of Audit Practice 2024 (the Code) sets out that the auditor's work is likely to fall into three broad areas: planning; additional risk-based procedures and evaluation; and reporting. We undertake initial planning work to inform this Audit Plan and the assumptions used to derive our fee. Consideration of prior year significant weaknesses and known areas of risk is a key part of the risk assessment for 2025/26. We will continue to evaluate risks of significant weakness and if further risks are identified, we will report these to those charged with governance. We set out our reported assessment below:

Criteria	2024/25 Assessment of arrangements		2025/26 Risk assessment		2025/26 risk-based procedures planned
Financial sustainability	R	Significant weakness in arrangements relating to financial sustainability continues to be identified, due to the ICB's ongoing deficit position. We also raised an improvement recommendation relating to the ICB's CIP reporting which needs to focus on recurrent savings to begin turning the tide on its deficit. Any forecast under-delivery needs to be recognised as quickly as possible to support development of mitigating actions.	R	We identified a risk of significant weakness in this area last year, 2024-25 and raised a Key recommendation based on the ICB's ongoing financial challenges and reliance on deficit support funding. As such, we consider that there is a risk of significant weakness in arrangements in this area in 2025/26.	We will follow up our Key recommendation in this area to understand the progress the ICB has made in improving its performance in this area. This will include consideration of the ICB's arrangements in relation to managing its in-year financial performance, financial planning for 2026/27 and its medium-term financial planning.

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendation(s) made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

6. Risks of significant weakness in VFM arrangements (continued)

Criteria	2024/25 Assessment of arrangements		2025/26 Risk assessment		2025/26 risk-based procedures planned
Governance	A	No significant weakness identified. On review of the ICB's arrangements, we concluded sufficient progress has been made on our prior year key recommendation which has been replaced with an improvement recommendation.	A	No risk of significant weakness identified.	We will undertake sufficient work to update our understanding of the arrangements in place and any key developments in-year and to follow up the improvement recommendations made in the prior year.
Improving economy, efficiency and effectiveness	A	No significant weaknesses in arrangements identified, improvement recommendation made in relation to ongoing issues with data quality and compliance.	A	No risk of significant weakness identified.	We will undertake sufficient work to update our understanding of the arrangements in place and any key developments in-year and to follow up the improvement recommendation made in the prior year.

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendation(s) made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

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6. Risks of significant VFM weaknesses

As part of our initial planning work, we considered whether there were any risks of significant weakness in the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources where we needed to perform additional procedures. The risks we have identified are detailed on the table overleaf along with the further work we will perform. We will continue to review the ICB's arrangements and report any further risks of significant weaknesses we identify to those charged with governance. We may need to make recommendations following the completion of our work. The potential different types of recommendations we could make are set out below.

Potential types of recommendations

Statutory recommendation

Written recommendations to the ICB under Section 24 (Schedule 7) of the Local Audit and Accountability Act 2014. A recommendation under schedule 7 requires the ICB to discuss and respond publicly to the report.

Key recommendation

The Code of Audit Practice requires that where auditors identify significant weaknesses in arrangements to secure value for money they should make recommendations setting out the actions that should be taken by the ICB. We have defined these recommendations as 'key recommendations'.

Improvement recommendation

Auditors may also include areas for improvement or to keep in view even if they do not identify any underlying significant weaknesses in arrangements. These recommendations set out actions for consideration which are not a result of identifying significant weaknesses in arrangements, but which if not addressed could increase the risk of a significant weakness in future periods.

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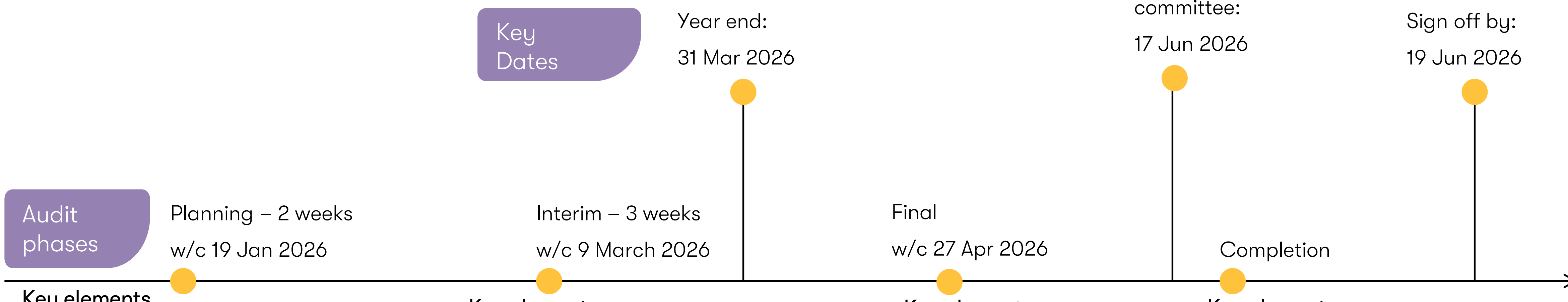
7. Logistics

The audit timeline



Key elements (Planning)

- Planning meeting with management to set audit scope
- Planning requirements checklist to management
- Agree timetable and deliverables with management and Audit Committee
- Issue the Audit Plan to management and Audit Committee

Key elements (Interim)

- Document design effectiveness of systems and processes
- Review of key judgements and estimates
- Issue Audit progress report to management and Audit Committee
- Advanced testing

Key elements (Final)

- Audit teams to complete fieldwork and detailed testing
- Weekly update meetings with management

Key elements (Completion)

- Draft Audit Findings Report issued to management
- Audit Findings Report meeting with management
- Audit Findings Report issued to Audit Committee
- Audit Findings Report presentation to Audit Committee
- Finalise Auditor's Annual Report
- Finalise and sign financial statements and audit report

7. Our team and communications

Grant Thornton core team

Michael Green
Engagement Lead/ Key Audit Partner

- Key contact for senior management and Audit Committee
- Overall quality assurance

Perminder Sethi
Senior Audit Manager

- Audit planning
- Resource management and delivery
- Contact for the finance team, senior management and Audit Committee

Muhammad Afzal
In-charge

- Audit team management
- Day-to-day point of contact
- Audit fieldwork

Andy Nichols
VFM Lead

- Value for Money (VFM) planning
- Main contact for the review of VFM arrangements
- Development of the VFM commentary in the Auditor's Annual Report

Pool of specialists and other technical specialists (eg IT audit)

	Service delivery	Audit reporting	Audit progress	Technical support
Formal communications	• Annual client service review	• The Audit Plan • Audit Progress and Sector Update Reports • The Audit Findings • The Auditor's Annual Report	• Audit planning meetings • Audit clearance meetings • Audit progress reports • Communication of issues log	• Technical updates • NHS Accountants' Webinar (Feb 26)
Informal communications	• Open channel for discussion		• Communication of audit issues as they arise	• Notification of up-coming issues

As part of our overall service delivery, we may utilise colleagues who are based overseas, primarily in India and the Philippines. Those colleagues work on a fully integrated basis with our team members based in the UK and receive the same training and professional development programmes as our UK based team. They work as part of the engagement team, reporting directly to the Audit Senior and Senior Manager and will interact with you in the same was as our UK based team albeit on a remote basis. Our overseas team members use a remote working platform which is based in the UK. The remote working platform (or Virtual Desktop Interface) does not allow the user to move files from the remote platform to their local desktop meaning all audit related data is retained within the UK.

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8. Our fee estimate

Our estimate of the audit fees we will charge is set out in the table across, along with the fees billed in the prior year

Relevant professional standards

In preparing our fee estimate, we have had regard to all relevant professional standards, including paragraphs 4.1 and 4.2 of the FRC's Ethical Standard (revised 2024) which stipulate that the Engagement Lead (Key Audit Partner) must set a fee sufficient to enable the resourcing of the audit with partners and staff with appropriate time and skill to deliver an audit to the required professional and Ethical standards.

Across all sectors and firms, the FRC has set out its expectation of improved financial reporting from organisations and the need for auditors to demonstrate increased scepticism and challenge and to undertake additional and more robust testing, as detailed in ISA (UK) 540 (revised): Auditing Accounting Estimates and Related Disclosures.

As a firm, we are absolutely committed to meeting the expectations of the FRC with regard to audit quality and public sector financial reporting. Our proposed work and fee has been agreed with the Director of Finance.

	Audit Fee for 2024/25 (£)	Proposed fee for 2025/26 (£)
ICB audit	£230,105	£241,535
Total (Exc. VAT)	**£230,105**	**£241,535**

Our fee estimate:

We have set out below our specific assumptions made in arriving at our estimated audit fees, we have assumed that the ICB will:

- prepare a good quality set of accounts, supported by comprehensive and well presented working papers which are ready at the start of the audit
- provide appropriate analysis, support and evidence to support all critical judgements and significant estimates made during the course of preparing the financial statements
- provide early notice of proposed complex or unusual transactions which could have a material impact on the financial statements.

9. Independence considerations

Ethical Standards and ISA (UK) 260 require us to give you timely disclosure of all significant matters that may bear upon the integrity, objectivity and independence of the firm or covered persons (including its partners, senior managers and managers).

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Financial Reporting Council's Ethical Standard and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements. Further, we have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in May 2020 which sets out supplementary guidance on ethical requirements for auditors of local public bodies.

We confirm that we have implemented policies and procedures to meet the requirements of the Ethical Standard. For the purposes of our audit, we have made enquiries of all Grant Thornton UK LLP teams providing services to the ICB.

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9. Independence considerations (continued)

As part of our assessment of our independence at planning we note the following matters:

Matter	Conclusions
Relationships with Grant Thornton	We are not aware of any relationships between Grant Thornton and the ICB that may reasonably be thought to bear on our integrity, independence and objectivity.
Relationships and investments held by individuals	We have not identified any potential issues in respect of personal relationships with the ICB held by individuals.
Employment of Grant Thornton staff	We are not aware of any former Grant Thornton partners or staff being employed, or holding discussions in respect of employment, by the ICB as a director or in a senior management role covering financial, accounting or control related areas.
Business relationships	We have not identified any business relationships between Grant Thornton and the ICB.
Contingent fees in relation to non-audit services	No contingent fee arrangements are in place for non-audit services provided.
Gifts and hospitality	We have not identified any gifts or hospitality provided to, or received from, a member of the ICB's board, senior management or staff (that would exceed the threshold set in the Ethical Standard).

We confirm that there are no significant facts or matters that impact on our independence at planning as auditors that we are required or wish to draw to your attention and consider that an objective reasonable and informed third party would take the same view. The firm and each covered person have complied with the Financial Reporting Council's Ethical Standard and confirm that we are independent and are able to express an objective opinion on the financial statements. Further, we have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in February 2025 which sets out supplementary guidance on ethical requirements for auditors of local public bodies.

Following this consideration we can confirm that we are independent at planning and are able to express an objective opinion on the financial statements. In making the above judgement, we have also been mindful of the quantum of non-audit fees compared to audit fees disclosed in the financial statements and estimated for the current year.

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9. Fees and non-audit services

The following tables below sets out the non-audit services charged from the beginning of the financial year, as well as the threats to our independence and safeguards have been applied to mitigate these threats.

The below non-audit services are consistent with the ICB's policy on the allotment of non-audit work to your auditor.

None of the below services were provided on a contingent fee basis

For the purposes of our audit we have made enquiries of all Grant Thornton teams within the Grant Thornton International Limited network member firms providing services to the ICB. The table summarises all non-audit services which were identified. We have adequate safeguards in place to mitigate the perceived self-interest threat from these fees in that we list below.

Assurance Service Fees

Service	£	Threats Identified	Safeguards applied
Audit Related Assurance – review of the ICB's compliance with the mental health investment standard (relates to MHIS 2024-25).	67,500 plus VAT	Self-Interest (because this is a recurring fee) Self review (because the financial information in the compliance statement is included within the ICB's financial statements) Management (because we may make recommend-actions to improve the operation of systems for producing the MHIS compliance statement).	The level of this recurring fee taken on its own is not considered a significant threat to independence as the fee for this work is £67,500 in comparison to the total fee for the audit of £241,535 and in particular relative to Grant Thornton UK LLP's turnover overall. Further, it is a fixed fee and there is no contingent element to it. These factors all mitigate the perceived self-interest threat to an acceptable level. Self review is not considered a significant threat as we are not reviewing any information that we have prepared. Additionally, the work required to review the MHIS compliance statement is different in nature to our audit of the financial statements. The scope of the work does not include making decisions on behalf of management. Any recommendations made would be for management to decide whether to implement. These factors all mitigate the perceived self-interest, self review and management threats to an acceptable level.

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10. Communication of audit matters with those charged with governance

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	●	
Overview of the planned scope and timing of the audit, form, timing and expected general content of communications including significant risks and Key Audit Matters	●	
Planned use of internal audit	●	
Confirmation of independence and objectivity	●	●
A statement that we have complied with relevant ethical requirements regarding independence. Relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	●	●
Significant matters in relation to going concern	●	●
Views about the qualitative aspects of the ICB's accounting and financial reporting practices including accounting policies, accounting estimates and financial statement disclosures		●

ISA (UK) 260, as well as other ISAs (UK), prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table here.

This document, the Audit Plan, outlines our audit strategy and plan to deliver the audit, while the Audit Findings will be issued prior to approval of the financial statements and will present key issues, findings and other matters arising from the audit, together with an explanation as to how these have been resolved.

We will communicate any adverse or unexpected findings affecting the audit on a timely basis, either informally or via an audit progress memorandum.

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10. Communication of audit matters with those charged with governance (continued)

Our communication plan	Audit Plan	Audit Findings
Significant findings from the audit		●
Significant matters and issue arising during the audit and written representations that have been sought		●
Significant difficulties encountered during the audit		●
Significant deficiencies in internal control identified during the audit		●
Significant matters arising in connection with related parties		●
Identification or suspicion of fraud involving management and/or which results in material misstatement of the financial statements		●
Non-compliance with laws and regulations		●
Unadjusted misstatements and material disclosure omissions		●

Respective responsibilities

As auditor we are responsible for performing the audit in accordance with ISAs (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance.

The audit of the financial statements does not relieve management or those charged with governance of their responsibilities.

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11. New and future standards and reporting requirements

FReM and GAM adaptations that are in effect for reporting periods beginning on or after 1 April 2025

The following adaptations to the FReM and GAM have recently been issued.

Stage 3 guidance relating to Taskforce for Climate related Financial Disclosures: Strategy Pillar

2025-26 is the final year of a three-year phased implementation of the TCFD recommended disclosures into the performance reporting requirements detailed in the FReM.

The new pillar for 2025/26 is Strategy. Which contains the following disclosures:

- Describe the climate-related risks and opportunities the organisation has identified over the short, medium and long term; and
- Describe the impact of climate-related risks and opportunities on the organisation's operations, strategy and financial planning and how these may materialise over the short, medium and long term, when considered against a global warming pathway of 2°C or lower.

Disclosures are to be made within the performance analysis section of the performance report.

Guidance for adoption of IFRS 17 Insurance Contracts from 1 April 2025

IFRS 17 is the new standard for the recognition, measurement, presentation and disclosure of in scope insurance contracts by the insurer. It replaces IFRS 4 and was developed to bring consistency to the way that insurance companies account for insurance contracts although it does not apply to just insurance companies.

It is applicable to NHS bodies from 1 April 2025 - however because it is to have full retrospective application, the transition also needs to be applied as if it had also been present in 2024/25.

The new standard will require entities to:

- Identify any insurance contracts within the scope of IFRS 17;
- Evidence the identification process to show how they have considered the existence of insurance contracts;
- To account for such contracts, where they arise, in the balance sheet and SOCNE.

Guidance relating to accounting for social benefits

The 2025 to 2026 FReM incorporates specific guidance regarding the accounting for social benefits with accompanying application guidance.

While the accounting for social benefits is anticipated to have limited relevance or material impact for DHSC group entities, a section in chapter 4 has been added to provide the definition of social benefits and the expected accounting treatment following the principles outlined in the IFRS conceptual framework and application guidance.

The impact of this is:

- Social benefits are defined as current transfers received by households (including individuals) intended to provide for the needs that arise from certain events or circumstances;
- Expenditure in respect of social benefit payments is recognised at the point the claimant meets the eligibility requirements; and
- Expenditure incurred by entities not directly related to relieving households from the financial burden of specific social risks or needs, falls outside the scope of what constitutes expenditure in respect of social benefits.

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11. New and Future standards and reporting requirements

Revision to how mental health expenditure is disclosed in ICBs' annual reports and accounts

The MHIS (Mental Health Investment Standard) requires all ICBs to spend a proportion of their allocation on mental health services. Separately the GAM has up to now incorporated a requirement for ICBs to disclose in their annual report the proportion of overall spend that relates to mental health.

The revised treatment under chapter 5 of the GAM is to incorporate both of these sets of requirements into a single disclosure that must be included as a note to the ICB’s financial statements.

The GAM requires this information be combined in a note to financial statements which presents as a minimum for the current and prior year:

- the ICB’s required minimum expenditure to meet MHIS as notified by NHS England;
- eligible mental health expenditure for the year;
- an arithmetic sum to show whether the ICB’s mental health expenditure is above or below the minimum;
- the proportion of mental health expenditure as a percentage of total ICB expenditure; and
- an explanation of the proportion of mental health expenditure of total ICB expenditure.

Updates to accounting for intangible assets and classification of IAS 16 assets stemming from the HM Treasury non-investment asset review, applicable from 1 April 2025

Valuation of intangible assets:

For valuation of intangible assets the option to employ the revaluation model has been withdrawn from 1 April 2025 and the cost model should be employed for intangible assets instead.

Transition will require the carrying values of existing intangible assets, measured under the previous revaluation approach, as at 1 April 2025, to be taken forward as a deemed historic cost.

International accounting standard (IAS) 8 has been adapted so that these changes will be completed prospectively rather than retrospectively.

Classification of non-current assets:

References to service potential for non-current assets have been replaced with operational capacity. The new guidance:

- Removes all references to assets held for their service potential;
- Defines assets held for their operational capacity – for which the primary objective is to deliver front line services or back-office functions; and
- Provides guidance on determining the primary objective of an asset.

This change does not change the valuation basis of IAS 16 assets:

- The valuation basis remains current value in existing use; and
- Valuer judgement is still required to determine appropriate valuation methodology between specialised and non-specialised asset .

The impact of this is that impairments are now based on consumption of economic benefit or reduction in operational capacity.

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11. New and future standards and reporting requirements

New or revised accounting standards that are in effect for reporting periods beginning on or after 1 April 2025

The following IFRS Standards and amendments have recently been issued but have not yet been adopted by the FReM. Early adoption by NHS bodies is not permitted by the DHSC Group Accounting Manual.

Amendment to IFRS 9 and IFRS 7 - Contracts Referencing Nature-dependent Electricity

The International Accounting Standards Board (IASB) issued amendments to IFRS 9 and IFRS 7 to improve the reporting of nature-dependent electricity contracts, such as power purchase agreements (PPAs). These contracts, which secure electricity from sources like wind and solar power, can vary due to uncontrollable factors like weather. The amendments clarify the 'own-use' requirements, permit hedge accounting for these contracts, and introduce new disclosure requirements to help investors understand their impact on a company's financial performance and cash flows. The amendments are effective from 1 January 2026.

IFRS 18 Presentation and Disclosure in the Financial Statements

IFRS 18 will replace IAS 1 Presentation of Financial Statements. All entities reporting under IFRS Accounting Standards will be impacted.

The new standard will impact the structure and presentation of the statement of profit or loss as well as introduce specific disclosure requirements. Some of the key changes are:

- Introducing new defined categories for the presentation of income and expenses in the income statement
- Introducing specified totals and subtotals, for example the mandatory inclusion of ‘Operating profit or loss’ subtotal.
- Disclosure of management defined performance measures
- Enhanced principles on aggregation and disaggregation which apply to the primary financial statements and notes.

IFRS 18 will be effective in the UK from 1 January 2027.

Amendments to IFRS 9 and IFRS 7 – Classification and measurement of financial instruments

These amendments clarify the requirements for the timing of recognition and derecognition of some financial assets and liabilities, adds guidance on the solely payment of principal and interest (SPPI) criteria, and includes updated disclosures for certain instruments (e.g. instruments with features linked to environmental social and governance (ESG) targets). The amendments are effective from 1 January 2026.

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Informing the Audit Risk Assessment for NHS Greater Manchester ICB 2025-26

Part of Greater Manchester
Integrated Care Partnership

Audit Committee

19 March 2026

Required information.	Details.
Title of report.	Informing the audit risk assessment for NHS Greater Manchester ICB 2025-26.
Author.	Kaye Abbott – Associate Director of Finance – Financial Control
Presented by.	Kaye Abbott – Associate Director of Finance – Financial Control
Contact for further information.	Kaye Abbott – Associate Director of Finance – Financial Control
Executive summary.	This report provides the Audit Committee with management responses to questions posed by Grant Thornton in order to assess the audit risk for NHS GM in 2025/26. These include: • General Enquiries • Fraud • Laws and Regulations • Related Parties • Going Concern • Accounting Estimates The Committee are asked to review and approve the management responses.
The benefits that the population of Greater Manchester will experience.	Ensure that NHS GM is a fit for purpose organisation and delivers Value for Money in its operations.
How health inequalities will be reduced in Greater Manchester's communities.	N/a,

The decision to be made and/or input sought.	The Committee is asked to: 1. Review and approve the management responses provided.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	N/a.
Key milestones.	This is a key document within the audit planning and year end audit for 2025/26.
Leadership and governance arrangements.	The responses have been reviewed and agreed by the Senior Finance Team.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	A number of colleagues within the organisation and MIAA have provided input into the management responses. The management responses have been reviewed and agreed by the Senior Finance Team.
Financial or Legal Implications	There are no financial or legal implications of this paper.

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	Yes	Yes	No	No	Yes

Table 2: Assurance needed about the document.

Informing the audit risk assessment for NHS Greater Manchester ICB 2025/26

Agenda	Management response
General inquiries	
1. What do you regard as the key events or issues that will have a significant impact on the financial statements for 2025/26.	The most significant event for NHS GM in 2025/26 is the implementation of a new ledger system ("ISFE2" / "Oracle Fusion") effective 1st October 2025. Transactions for the first 6 months of the year were incurred and recorded within the ISFE1 ledger, and then transferred to ISFE2, meaning all reporting can be done from the ISFE2 ledger. However, transactions were transferred in aggregate, being transaction per code combination per month, meaning detailed sample testing will be best performed from the ISFE1 data instead. Controls were put in place to ensure the accuracy and completeness of data transferred between the two systems, and these reconciliations provide assurance that balances and transactions transferred effectively. In addition, a set of dummy accounts for M1-M6 from ISFE1 have been prepared and compared to equivalent accounts for M1-M6 from ISFE2, with no differences at the primary statement level, providing further comfort. Whilst elements of the system remain under development and challenges exist, these do not principally affect the reporting of YTD information, which is what the annual accounts are based on. There are no known changes in 2025/26 in relation to accounting policies and procedures with no new material transaction streams. A voluntary redundancy scheme was authorised in December 2025; however, the value of exit packages is expected to be immaterial by value. The position at the reporting date will inform the accounting treatment adopted. Whilst NHS GM is reporting a planned deficit, this has been approved by NHSE and so should not make the audit any higher risk.
2. Have you considered the appropriateness of the accounting policies adopted by the GM ICB? Have there been any events or transactions that may cause you to change or adopt new accounting policies? If so, what are they?	NHS GM adopts the template accounting policies as required by NHS England, and tailors their presentation (for example, to remove immaterial policies). The policies have yet to be published by NHSE but are anticipated to mirror those adopted in 2024/25. A draft of the policies has been presented to Audit Committee for consideration in December 2025, and these will be finalised when the formal policies are distributed by NHSE, although these are not expected to be materially different. These have been used in the production of the draft M9 Accounts. No events or transactions in 2025/26 have been identified that require the consideration of alternative accounting policies or treatments, however this shall be kept under review until year end.

	The final policies will be presented to the Audit Committee in April 2026 within the draft accounts.
3. Is there any use of financial instruments, including derivatives? If so, please explain	NHS GM has limited use of financial instruments, limited to cash, invoiced debtors and creditors. In addition to this, there is a £1.1m balance relating to an equity shareholding which is accounted for at cost less impairment.
4. Are you aware of any significant transaction outside the normal course of business? If so, what are they?	Exit packages arising from the redundancy scheme are considered to be significant transactions which do not frequently occur in the normal course of NHS GM's business. These will be accounted for in line with the relevant accounting standards, reflecting the position at the reporting date.
5. Are you aware of any changes in circumstances that would lead to impairment of non-current assets? If so, what are they?	No, there are no changes in circumstances that would lead to the impairment of non-current assets. NHS GM has immaterial non-current assets, consisting principally of IFRS16 lease assets, where leases are unchanged and therefore there is no need to impair the Right of Use Asset. In addition, NHS GM holds a £1.1m investment in North-West E-Health. An impairment review will be undertaken for year end, on the basis of the 2025 out-turn position of the company and the future prospects for the company.
6. Are you aware of any guarantee contracts? If so, please provide further details	Having reviewed the criteria of IAS39/IFRS4 regarding guarantee contracts, NHS GM is not aware of any such contracts where the organisation is required to reimburse an entity where a debtor fails to make payment.
7. Are you aware of the existence of loss contingencies and/or un-asserted claims that may affect the financial statements? If so, please provide further details	No, there are no loss contingencies or un-asserted claims that may affect the financial statements.
8. Other than in-house solicitors, can you provide details of those solicitors utilised by GM ICB during the year. Please indicate where they are working on open litigation or contingencies from prior years?	As at month 10, NHS GM has spent £0.9m year to date with external legal companies, with a forecast of £1.0m. These costs are generated within CHC, mental health placements, safeguarding and the reform process. These are covered within the legal fees working papers. The main legal firms used are Hempsons and Hill Dickinson.

	No legal contingencies have been identified at March 2026, and the legal work to date is principally on minor CHC and safeguarding cases, with no material consequences for NHS GM. NHS GM has incurred legal fees on procurement advice for legal challenges.
9. Have any of the GM ICB's service providers reported any items of fraud, non-compliance with laws and regulations or uncorrected misstatements which would affect the financial statements? If so, please provide further details	No.
10. Can you provide details of other advisors consulted during the year and the issue on which they were consulted?	No advisors were consulted upon to provide a view around any accounting entries (e.g. valuers, pensions specialists etc).
11. Have you considered and identified assets for which expected credit loss provisions may be required under IFRS 9, such as debtors (including loans) and investments? If so, please provide further details	Yes, these have been considered. As identified above an impairment review of the North-West E-Health investment will be undertaken in Q4 following the results for their financial year, which ends 31st December. NHS GM has no loans, and the only credit loss provision would relate to non-NHS debt, which is reviewed and adjusted at the year-end to ensure it remains adequate.
Fraud inquiries	
12. Has GM ICB assessed the risk of material misstatement in the financial statements due to fraud? How has the process of identifying and responding to the risk of fraud been undertaken and what are the results of this process? How do the GM ICB's risk management processes link to financial reporting?	There are no fraud issues know to NHS GM, and the risk of material misstatement is low. Approximately 68.3% of the 2025/26 (at month 10) expenditure relates to NHS contracts (across Acute c, Specialised Commissioning, Mental Health care and Community) including system funding and allocations. The majority of payments have been undertaken on a payment request as mandated by NHSE, so there are less invoices in the system. In terms of non-block expenditure, all invoices are validated back to care records, activity plans, GP lists etc., to ensure that the expenditure relates to NHS GM commissioned services. The expenditure and the balance sheet are reported, discussed and endorsed monthly through the Finance Committee/ Finance Sub-Committee (governance changes for Committees which came into effect in January 2026) with the balance sheet reported every four months. NHS GM takes a risk-based approach to tackling fraud, bribery and corruption, and the Local Counter-Fraud Specialist (MIAA), on behalf of the organisation, conducts annual risks assessments to identify, fraud, bribery and corruption risks which are then recorded (if necessary) and managed in line with NHS GM Risk Management Strategy and included on appropriate risk registers. Measures to mitigate identified fraud and bribery risks are included in an anti-fraud and bribery work plan that is monitored by the Chief Finance Officer and the Audit Committee. Whilst all ICBs have delegated responsibility for NHS

	England pharmaceutical, ophthalmic and dental (POD) functions, in accordance with the NHSE Counter Fraud Statutory Guidance (document ref: PAR1586), responsibility for preventing and investigating any fraud in these functions sits across NHSE Counter Fraud and NHS GM's Local Counter Fraud Specialist. To this end, both parties maintain a regular dialogue, with the NHS GM's LCFS liaising with NHSCFA, at an Executive level, early in Q1, to establish how primary care fraud risks could best be identified and mitigated going forwards, with a particular focus on clarifying roles and responsibilities of the three main anti-fraud actors in this space: the LCFS, acting on behalf of the individual ICB; NHSE Counter Fraud, who currently have primacy regarding most primary care fraud matters; and, NHSCFA, who haven't yet provided specific input as the national NHS anti-fraud body. Resolving roles and responsibilities around primary care fraud in the short/medium term is especially important given impending changes to ICBs and NHSE . As part of proactive plan work for 2025/26, various anti-fraud guidance has been issued along with alerts to all primary care providers. During Q3 2025/26, NHS Counter Fraud Authority rolled out an updated fraud risk assessment toolkit aligned to the Public Sector Fraud Authority Standards. This has superseded the planned risk review and will commence in Q4 of 2025/26 and will be completed in Q1 of 2026/27. That said, material misstatement in the financial statements due to fraud is a risk that the AFS considers as part of the overall fraud risk assessment process, but there are a low number of instances of this type of fraud reported nationally and certainly no intelligence that this is a particular or heightened risk for the ICB.
13. What have you determined to be the classes of accounts, transactions and disclosures most at risk to fraud?	The accounts and transactions most at risk to fraud are: • Staff and payroll frauds • Recruitment frauds • Bank mandate / invoicing fraud / procurement fraud • Conflict of interest / gifts and hospitality fraud • Asset misappropriation • Patient fraud (travel claims, prescription frauds, false identity etc). • Other third-party frauds • Contractor fraud NHS GM is satisfied that it has sufficient controls in place to mitigate the risks of fraud in these areas.

14. Are you aware of any instances of actual, suspected or alleged fraud, errors or other irregularities either within GM ICB as a whole, or within specific departments since 1 April 2025? If so, please provide details	NHS GM contracts MIAA to provide an anti-fraud service, with the ICBs Anti-Fraud Specialist who reports to the Audit Committee on a quarterly basis. There have been a small number of fraud referrals received during 2025/26 predominantly due to patient related fraud regarding the onward sale of medications / and also patient eligibility. Ther have been a few primary care referrals, but none have been ophthalmic. Two previous allegations relating to ophthalmic fraud were closed locally as they were passed on to NHSE Counter Fraud, in line with their responsibilities under statutory guidance. Although one is on-going there have not been any further ophthalmic referrals received in 2025/26. There is on-going dialogue with NHS NW Counter Fraud and there are no known referrals relating directly to NHS GM. The CFO meets with the anti-fraud provider, with regular updates within the organisation and to Audit Committee.
4. As a management team, how do you communicate risk issues (including fraud) to those charged with governance?	NHS GM reports its strategic risks to the ICB Board at each meeting. The relevant sub-committees of the ICB have their own corporate risk registers in place, in line with the organisation's Risk Management Framework MIAA (who provide NHS GM with Anti-Fraud Services) provide the Audit Committee with regular reports on fraud, including any potential fraud risks / issues. MIAA also ran a Board presentation in August 2025 primarily covering the new fraud offence, Failure to Prevent Fraud, along with wider fraud risks. Additionally, the overall outcome from the annual fraud assessment process will be reported to the Audit Committee, along with any follow-up actions required. This will be reported in 2026/27 due to NHSCFA changes to the fraud risk assessment methodology and the additional work required.
5. Have you identified any specific fraud risks? If so, please provide details Do you have any concerns there are areas that are at risk of fraud? Are there particular locations within GM ICB where fraud is more likely to occur?	A fraud risk assessment is undertaken each year to inform the annual Anti-Fraud workplan. There are known fraud risks impacting all of the NHS currently (i.e. cyber mandate fraud) as well specific fraud risk types that are more relevant to commissioning organisations such as the ICB (i.e. around primary care providers, potential non-declaration of interest and personal health budgets). These were factored into the 2025/26 anti-fraud work planning arrangements for consideration. A draft 2026/27 work plan will be presented to the March Audit Committee (19.03.26). This will be based on a combination of the ICB's dynamic fraud risk assessment combined with known local and national fraud intelligence threats (i.e. ongoing cyber-enabled frauds), as well as reflecting current NHSCFA national priorities (i.e. Procurement fraud).

	Concerns remain around Personal Health budgets in particular, but these are concerns about PHB-related fraud risks nationally and are not specific to anything related to NHS GM's local PHB activities. Additionally, as NHS GM continues to develop and its systems, functions and procedures are centralised, there remains work to be done to share intelligence effectively across the 10 localities about common fraud risks and threats, but there are no current concerns about any specific localities when compared to others.
6. What processes do GM ICB have in place to identify and respond to risks of fraud?	The organisation has an Anti-Fraud, Bribery and Corruption policy in place, as well as a Conflicts of Interest Policy, a Freedom to Speak Up Policy (aimed at internal staff) and a Whistleblowing policy (with an external view). Included in the Freedom To Speak Up (FTSU) policy, is information on how colleagues can raise fraud related matters and part of the GM FTSU champion training does include a session on how to signpost anyone raising concerns about fraud. The link below is the link that is on the FTSU policy NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**. The organisation also promotes fraud awareness and items are circulated from the LCFS to relevant managers and the wider staff through communications i.e. email, newsletters and intranet and periodic fraud messages included within payslips within the 'Messages from Employer' sections. The organisation has a nominated Counter Fraud Champion and Counter Fraud Ambassadors in place across the organisation. All Fraud prevention notices are circulated to staff as applicable through the organisational communications. Any specific fraud intelligence of particular active threats are targeted at key individuals across NHS GM to enable the appropriate local checks and actions to be undertaken, rather than to all staff, as would be the case with more general fraud awareness communications.
7. How do you assess the overall control environment for GM ICB, including: • the existence of internal controls, including segregation of duties; and • the process for reviewing the effectiveness of the system of internal control?	NHS GM has segregation of duties in place in relation to all areas, but especially relating to the transactions around payments There is a fraud awareness course included within the organisational mandatory training and the Counter Fraud Champion and Counter Fraud Specialist have done updates within the wider organisation. Within the AP system, invoice approval is governed by role and band of staff as per the scheme of delegation. The monthly financial reporting of the position to NHSE is generated from a trial balance

If internal controls are not in place or not effective where are the risk areas and what mitigating actions have been taken? What other controls are in place to help prevent, deter or detect fraud? Are there any areas where there is potential for override of controls or inappropriate influence over the financial reporting process (for example because of undue pressure to achieve financial targets)? If so, please provide details	directly generated from the organisation ledger and this cannot be overwritten. If a manual adjustment is required on the monthly NHSE submission, a password is issued by NHSE. The year end accounts are generated from the Trial Balance, and no off-ledger adjustments are made to this. In terms of allocation management there are processes in place with dual approval of budget adjustments and confirmation that the spend has been agreed within the governance routes of the organisation in line with the Scheme of Delegation. The organisation has maintained the strengthened governance processes, ensuring that spend is reviewed and agreed within the STAR process, which is part of the enhanced measures implemented by the organisation in previous financial years. NHS GM has a counter fraud plan for 2025/26, and the Audit Committee receives quarterly updates.
8. Are there any areas where there is potential for misreporting? If so, please provide details	No.
9. How does GM ICB communicate and encourage ethical behaviours and business processes of its staff and contractors? How do you encourage staff to report their concerns about fraud? What concerns are staff expected to report about fraud? Have any significant issues been reported? If so, please provide details	This is done via verbal exchanges, meetings, policies and procedure training. The fraud e-learning module on ESR also incorporates material on openness, transparency and good conduct, as well as reporting any concerns. This is also covered in Freedom to Speak Up Policy and forms a key part of the Executive Team openness with the Chief Executive regularly highlighting to staff (through all staff MS teams briefings) the Freedom to Speak Up arrangements. Staff are expected to report any concerns to their line manager or the Local Counter Fraud Specialist. Although c. 40 referrals have been raised in 2025/26, most related to patient frauds. No significant / unusual issues have been reported that would adversely impact on the organisation's operations or viability.
10. From a fraud and corruption perspective, what are considered to be high-risk posts? How are the risks relating to these posts identified, assessed and managed?	All posts involved with decision making are classed as high risk, which are managed by the current Conflicts of Interest Policy (CoI). These are managed by ensuring declarations of interest are a standing item on each Board, Committee and other meetings, and ensuring that the Schemes of Delegation is followed for all decision making. Module one of NHSE Conflicts of Interest Training is mandatory for all NHS GM staff. Plans are in place to formally roll out further, more enhanced CoI training (modules 2 and 3 from NHSE) to relevant staff

	during 2026. As part of this process, the Corporate Governance Team have assessed the mandatory requirements of this training and identified key decision makers in line with the agreed CoI Policy. The two modules are already available for staff to access on ESR and have been communicated in Keep Connected. Following the internal audit review of CoI arrangements undertaken in 2023/24, recommendations were made to strengthen internal processes, and all outstanding actions have been implemented. As in previous years, based on anti-fraud learning responses at the end of 2024/25, there was a good level of reported compliance across all 12 components of the Counter Fraud Standard including Component 12 which focusses on anti-bribery measures and compliance with the declarations of interest policy, although compliance levels for Components 11 and 12 are still to be assessed ahead of the May 2026 Counter Fraud Standard Return submission. The ICB has clear processes in place to check on any non-compliances and follow-these up and further work has taken place in 2025/26 in this area, partly as preparation for the new Failure to Prevent Fraud offence that was implemented in September 2025. MIAA, in conjunction with NHS Merseyside, have previously developed an animated video designed to raise staff awareness in relation to conflicts of interest. The video was shared with the Associate Director of Corporate Services for dissemination. This is the fourth in a suite of MIAA animated videos aimed at raising general fraud awareness, or focusing on specified topics, in an easily digestible format. A hyperlink is included here to the latest video https://youtu.be/utryBb8XLs8?si=jOFFOcGbugzIecRl.
11. Are you aware of any related party relationships or transactions that could give rise to instances of fraud? If so, please provide details How do you mitigate the risks associated with fraud related to related party relationships and transactions?	No. NHS GM has a Conflict of Interest (CoI) policy, and declarations of interest are asked at the start of every meeting. All staff, including decision makers are required to complete annual conflicts of interest training (when available, as mentioned in previous responses, CoI training was withdrawn for a period, however one module now available). All staff are required to refresh their declaration of interest on an annual basis, as well as within 28 days of becoming aware of a new interest or following a change in their role / responsibilities. This also applies to all non-executives and partner organisation representatives.
12. What arrangements are in place to report fraud issues and risks to the Audit Committee? How does the Audit Committee exercise oversight over management's processes for identifying and responding to risks of fraud and breaches of internal control?	The Audit Committee has an agreed counter fraud plan for financial risk, which is managed on their behalf by the Anti-Fraud Specialist (AFS). This plan is monitored at each Audit Committee and includes both awareness raising, an agreed proactive work plan in areas which are considered to present the highest risks. A progress report detailing any current cases and recent referrals is also shared at each Audit Committee meeting and an Annual Report is also produced.

What has been the outcome of these arrangements so far this year?	To support this plan the CFO meets the AFS on a regular basis. Based upon these reports and the work programme, the risk of material misstatement is considered to be limited. Any particular fraud concerns or investigations would be discussed initially with the CFO and, if appropriate, specifically brought to the attention of the Audit Committee at the next meeting by the Anti-Fraud Specialist. The Internal Audit plan provides assurance that robust financial systems are in place. This work is supported by a detailed review at senior finance meetings and monthly scrutiny at the Finance Committee / Finance Sub Committee of financial statements. In the final quarter of 2025/26 a Transition Committee was established to replace other committees of the Board held in public, whilst the organisation focussed on reform and ahead of introducing a new governance structure and arrangements. NHS GM has a fraud champion in place and a number of Ambassadors across the organisation.
13. Are you aware of any whistle blowing potential or complaints by potential whistle blowers? If so, what has been your response?	NHS GM currently has a Freedom to Speak Up (FTSU) and Raising Concerns policy, as well as a Whistleblowing policy. FTSU concerns have been raised but none relating to fraud. There have been several formal instances of Whistleblowing into NHS GM. One has been investigated internally (and shared with internal auditors for their view), with no subsequent action to be taken beyond the continuation of regular contract monitoring.
14. Have any reports been made under the Bribery Act? If so, please provide details	No as confirmed by the Anti-Fraud Specialist.
Laws and regulations	
1. How does management gain assurance that all relevant laws and regulations have been complied with? What arrangements does GM ICB have in place to prevent and detect non-compliance with laws and regulations? Are you aware of any changes to the GM ICB's regulatory environment that may have a significant impact on the GM ICB's financial statements?	There are a variety of sources that ensures NHS GM is aware of all relevant laws and regulations and that these are complied with: - MIAA and Grant Thornton produce sector update reports - Counter Fraud update changes in legislation - Direct national team communication through bulletins and communications. There are no changes to NHS GM's regulatory environment which would have a significant impact on the organisation's financial statements in 2025/26.

2. How is the Audit Committee provided with assurance that all relevant laws and regulations have been complied with?	As in question 1 above Finance attendance at national roadshows and updates on year-end processes and changes, both NHSE led and external audit led.
3. Have there been any instances of non-compliance or suspected non-compliance with laws and regulation since 1 April 2025 with an on-going impact on the 2025/26 financial statements? If so, please provide details	None.
4. Are there any actual or potential litigation or claims that would affect the financial statements? If so, please provide details	No. NHS GM engages with legal advisors as detailed above on a variety of issues. No significant matters are noted that would have a material or significant impact on the financial statements.
5. What arrangements does GM ICB have in place to identify, evaluate and account for litigation or claims?	A review of current arrangements remains on-going to develop a standardised approach across NHS GM for the management of legal claims or litigations, with a draft Policy to be agreed and processes to be finalised, and the implementation of a Datix system for centralised logging of these also ongoing. Some of the arrangements will need to be considered in light of new organisational structures. There is regular communication with the Governance Team to identify any claims made against NHS GM. NHS Resolution provides the ICB with support in relation to any clinical negligence claims.
6. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs, which indicate non-compliance? If so, please provide details	No.
Related parties	
1. Have there been any changes in the related parties including those disclosed in GM ICB's 2025/26 financial statements? If so, please summarise: • the nature of the relationship between these related parties and GM ICB • whether GM ICB has entered into or plans to enter into any transactions with these related parties • the type and purpose of these transactions	"Institutional" related parties (caused by the group arrangements of NHS England, the Department of Health and Social Care and the wider UK Government) have not changed compared to the prior year, and these existing relationships continue in the day-to-day business of the ICB. No new organisations are identified that come within either the NHSE, DHSC, or Whole of Government Accounts group boundaries which would require additional disclosures. The ICB's operating structure does not include subsidiaries or associates that would require additional consideration here. The year end working paper behind this disclosure details all assumptions made.

2. What controls does GM ICB have in place to identify, account for and disclose related party transactions and relationships?	NHS GM has a Conflicts of Interest Policy in place. The arrangements require all staff to complete (and refresh at least annually) a declaration of interest (DoI). DoIs must also be refreshed within 28 days of a staff member becoming aware of a new interest or if they have a change in role or responsibilities. All staff are required to complete conflicts of interest training The identified 'decision makers' are offered optional enhanced training and a published register of interest for decision makers is available on the NHS GM website for transparency. All formal meetings have declarations of interest as a standing item on the agenda. These are reviewed by the Finance team in preparing the accounts, to ensure that all disclosable related party transactions are identified and disclosed.
3. What controls are in place to authorise and approve significant transactions and arrangements with related parties?	Within NHS GM, all significant expenditure decisions going through internal governance are reported through Executive Team, STAR process, Finance Committee and Board in line with the Scheme of Delegation. Any person(s) with an identified conflict would be excluded from discussions / decisions where they were conflicted. The STAR process introduced in 2023/24 has continued in 2025/26, with all spend above £10k going through this gateway, which is the start of the governance process. Any approvals will then progress through appropriate governance in line with the approval limits outlined in the Scheme of Delegation to Chief Officers, Finance Committee or Board. It is within this governance process and decision-making committees that the relevant declarations of related parties would be made. Within each meeting agenda declarations of interest are asked for any areas of business within the meeting agenda and the appropriate action taken by the meeting chair in line with policy.
4. What controls are in place to authorise and approve significant transactions outside of the normal course of business?	The organisation would not have significant transactions outside of the normal course of business i.e. purchase of healthcare, but all decisions will go through internal governance and are reported through Executive Team, Finance Committee, STAR process and Board, as outlined in the response to Q3 above. Please note that NHSE have full access to NHS GM's general ledger. As noted above, exit packages are considered as outside the normal course of business for NHS GM, which are not considered to have related party consequences. Applications for Voluntary Redundancy are made by individuals, reviewed by line managers and approval panels before agreements are formally signed with the individual to accept voluntary severance, which are then forwarded to payroll to process.

Going concern	
What processes and controls does management have in place to identify events and / or conditions which may indicate that the statutory services being provided by GM ICB will no longer continue?	NHS GM reviews the Going Concern statement on an annual basis as part of the year end accounts process and produces a working paper to justify that the accounts should continue to be prepared on a going concern basis. These consider the continuity of services to another body (FRC Practice Note 10) and that plans are in place for the future financial year.
Are management aware of any factors which may mean GM ICB that either statutory services will no longer be provided or that funding for statutory services will be discontinued? If so, what are they?	There are no such factors to consider, as NHS GM will continue to provide its statutory functions. No announcements have been made suggesting the organisation may cease, and the planning process for 2026/27 identifies continuation of funding to the ICB. Whilst there are requirements to reduce the operating cost of all ICBs (resulting in the redundancy scheme) these do not affect the organisation's requirement to deliver services in the future.
With regard to the statutory services currently provided by GM ICB, does GM ICB expect to continue to deliver them for the foreseeable future, or will they be delivered by related public authorities if there are any plans for GM ICB to cease to exist?	Statutory services are planned to continue to be provided by the ICB as part of planning for the 2026/27 financial year. Final financial plans for 2026/27 were submitted in February 2026. There is no indication of structural reform to the NHS which would cause the ICB to cease to exist. There are no issues relating to Going Concern for the ICB
Are management satisfied that the financial reporting framework permits GM ICB to prepare its financial statements on a going concern basis? Are management satisfied that preparing financial statements on a going concern basis will provide a faithful representation of the items in the financial statements?	Yes, as the organisation can evidence the going concern requirements, in line with national guidance.
Accounting estimates	
1. What are the classes of transactions, events and conditions, that are significant to the financial statements that give rise to the need for, or changes in, accounting estimate and related disclosures?	The most significant accounting estimate relates to prescribing. The estimates are made based on the PMD forecast and validated by the locality medicines management team. Whilst the estimated liability in respect of prescribing costs is anticipated to be material, the estimation uncertainty associated with this is not expected to be. Please see Appendix A. Whilst further estimates are made in respect of liability for CHC cases, these are not considered to be material to the accounts. Where accruals are made, these are based on known cases, case start dates, and agreed packages of care, meaning the actual level of estimation used is limited, as the accrual is

	based on known factors. Given the sum of accruals themselves are immaterial, the estimation uncertainty arising from the accruals is also immaterial. There are a number of other areas where NHS GM does not have up to date activity or cost information. These are individually not material, but in each case the organisation seeks to make an appropriate estimate through its understanding of trends, local intelligence and third-party evidence wherever possible. A further area of estimation could be in relation to redundancy costs, which will be dependent on the progress of the scheme at the reporting date. This is expected to be immaterial, and any estimate (if required) will be calculated based on the known information at the time.
2. How does the ICB's risk management process identify and address risks relating to accounting estimates?	The risk area for accounting estimates has been identified by the ICB as prescribing. The prescribing accounting estimates are based on national data and are discussed with internal managers, from the direct clinical leads i.e. medicines optimisation etc., these are then reviewed by the finance leads and signed off within the month end review meetings. The financial implications are covered within the reporting to Finance Committee / Sub Committee and the NHS GM Board. In the final quarter of 2025/26 a Transition Committee was established to replace other committees of the Board held in public, whilst the organisation focussed on reform and ahead of introducing a new governance structure and arrangements. The ICB identifies through monthly budget monitoring where there are significant variances caused by estimation uncertainty. This identifies where material estimates are made, allowing the ICB to consider them for the risk of estimation uncertainty.
3. How does management identify the methods, assumptions or source data, and the need for changes in them, in relation to key accounting estimates?	The ICB reviews the results of the prescribing estimates on an ongoing basis, as data is provided to the ICB by the NHS BSA two months in arrears. The methodology has therefore evolved over a number of years based with assumptions being reviewed and adjusted to improve the accuracy of the estimate, by reviewing it against outturn on an ongoing basis. The prescribing methodology is reviewed within the month end review meetings with the Corporate Director of Operational Finance and the Corporate Director of Finance – Commissioning and Assurance, alongside other finance team members.
4. How does management review the outcomes of previous accounting estimates?	Prescribing actual costs are received by the ICB two months in arrears. As such, the actual costs can be reviewed on a rolling basis.

	Any differences between accruals and actual invoices are reported to the senior finance team within the monthly review of the position ahead of the closing of the reported position as described in the response to question 3 above.
5. Were any changes made to the estimation processes in 2025/26 and, if so, what was the reason for these?	There remains a standardised methodology in place for prescribing in line with the previous financial year based on costs per dispensing day factoring in major changes in drug tariff, and expected variation in demand across the year.
6. How does management identify the need for and apply specialised skills or knowledge related to accounting estimates?	The ICB utilises the appropriate data in making estimates including past trends and information from the provider itself, which is in line with the previous financial year. Through the regular comparison of estimate vs outturn, the ICB is satisfied that it has sufficient skill and knowledge internally to enable it to make accurate estimates. Medicines Optimisation colleagues are also contacted regarding the impact of national changes.
7. How does the ICB determine what control activities are needed for significant accounting estimates, including the controls at any service providers or management experts?	In respect of Prescribing, the ICB receives and reviews an annual Service Auditor Report on the operations of the BSA. This is considered for assurance, as well as any complimentary or compensating controls within the ICB as required. The control activities in the ICB are principally internal review, and a review of outturn vs estimate as described above. The comparison of accruals vs estimate provides assurance of the material accuracy of the estimates and the effectiveness of review controls.
8. How does management monitor the operation of control activities related to accounting estimates, including the key controls at any service providers or management experts?	As described above, the comparison of accruals vs estimate provides assurance of the accuracy of the estimates and the effectiveness of review controls.
9. What is the nature and extent of oversight and governance over management's financial reporting process relevant to accounting estimates, including: • Management's process for making significant accounting estimates • The methods and models used	All adjustments / accruals have full working papers, which are reviewed by the individual team leads. These are reported through an internal senior month end review meeting with the Corporate Director of Operational Finance – Financial Management. There have been a number of internal assurance meetings to review the position and forecast in addition to the month end reviews during 2025/26. NHS GM has continued with the ICB oversight meetings (ICBOM) introduced in the previous financial year to seek assurance meetings on the NHS GM position, with a focus on run rate expenditure, profiles of spend and reasons behind any movement as well as the introduction of a number of grip and control

The resultant accounting estimates are included in the financial statements.	measures. These are conducted at Locality level (LAMS) as well as NHS GM and provider organisations (POMs) within the system. Although LAMs and ICBOM were stood down in quarter 4 the core group of finance recovery which had Chief Officer and Senior Responsible Officer membership continued to meet on a weekly basis The resultant finance statements are reported, discussed and endorsed at monthly Finance Committee / Sub Committee and Board meetings. In the final quarter of 2025/26 a Transition Committee was established to replace other committees of the Board held in public, whilst the organisation focussed on reform and ahead of introducing a new governance structure and arrangements. The year-end adjustments are subject to external audit review and sign off.
10. Are management aware of any transactions, events, conditions (or changes in these) that may give rise to recognition or disclosure of significant accounting estimates that require significant judgement (other than those in Appendix A)? If so, what are they?	The ICB is satisfied that its processes for identifying the significant accounting assessments for consideration of disclosure in the accounting policies is robust.
11. Why are management satisfied that their arrangements for the accounting estimates, as detailed in Appendix A, are reasonable?	Yes, as outlined in Appendix A. This is limited to prescribing as other areas have been assessed and they are not material in value or risk (e.g. Dental, Pharmaceutical services and Continuing Healthcare). Assurance meetings introduced in 2023/24 have continued which involve a deep dive into local positions and an increased focus on run rate of expenditure and accruals posted within the position. This work has been undertaken by the Corporate Director of Operational Finance & the Corporate Director of Finance – Commissioning & Financial Assurance on a monthly basis. Prescribing has been outlined within Appendix A, and although this has a material estimate associated with it, the level of estimation uncertainty associated with the estimate is not material.
12. How is the Audit Committee provided with assurance that the arrangements for accounting estimates are adequate?	The Audit Committee is provided with assurance that accounting estimates are adequate through the month 9 draft accounts, the final submitted accounts and the external audit review process. This assurance would also be covered by the internal audit review into financial management processes

Appendix A – Accounting Estimates

Possible examples include land and buildings valuations, council dwelling valuations, investment property valuations, valuation of defined benefit net pension fund liability/asset, fair value estimates, level 2 and 3 investments, PFI liabilities, provisions, accruals, credit loss and impairment allowances, leases.

Estimate	Method / model used to make the estimate	Controls used to identify estimates	Whether management have used an expert	Underlying assumptions: - Assessment of degree of uncertainty - Consideration of alternative estimates	Has there been a change in accounting method in year?
Prescribing	The method of estimation is included within the prescribing working papers. IPP / PADM (EPACT) data and the average cost per dispensing day is used as the base from which adjustments are made.	The accruals are based on national data and local knowledge.	The medicines management team are involved within the assessment of the prescribing impact.	NHS GM have continued with a single methodology in 2025/26 based on cost per dispensing day for main prescribing costs and latest trend data for other areas within prescribing i.e. No Cheaper Stock Obtainable (NCSO), change in drug tariffs and expected variation in demand.	There has been no material change in year.

Annual Auditors' Letter Recommendations Update

2024/25

Part of Greater Manchester Integrated Care Partnership

Audit Committee

19 March 2026

Required information.	Details.
Title of report.	Annual Auditors' Letter Recommendations Update
Author.	Kaye Abbott – Associate Director of Finance – Financial Control
Presented by.	Kaye Abbott – Associate Director of Finance – Financial Control
Contact for further information.	Kaye Abbott – Associate Director of Finance – Financial Control
Executive summary.	This paper is produced to update the Audit Committee on the implementation of the 2024/25 Auditor's Annual Report. In total there were one key recommendation and three improvement recommendations. The key recommendation was confirmed fully implemented in the September report to the Committee. Since the December Committee IR1 and IR2 have been implemented, with IR3 in progress.
The benefits that the population of Greater Manchester will experience.	Ensure that NHS GM is a fit for purpose organisation and delivers Value for Money in its operations.
How health inequalities will be reduced in Greater Manchester's communities.	N/a.

The decision to be made and/or input sought.	The Committee is asked to: 1. Discuss and note the updates on the implementation of recommendations.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	N/a.
Key milestones.	The implementation of the recommendations is a key milestone for the 2025/26 assessment.
Leadership and governance arrangements.	The individual leads have provided updates for the recommendations. The paper has been agreed by the Corporate Director of Finance – Commissioning and Financial Assurance.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The individual leads have provided updates for the recommendations. The paper has been agreed by the Corporate Director of Finance – Commissioning and Financial Assurance.
Financial or Legal Implications	There are no financial or legal implications of this paper.

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	Yes	Yes	No	No	Yes

Table 2: Assurance needed about the document.

Grant Thornton Auditor's Annual Report 2024/25

Update on Implementation of Improvement Recommendations

No.	Recommendation	Initial Management Comments	Implementation Progress Update
IR1	The ICB's CIP reporting needs to focus on recurrent savings to begin turning the tide on its deficit. Any forecast under-delivery needs to be recognised as quickly as possible to support development of mitigating actions.	**Actions:** The ICB is committed to delivering 80% recurrent CIP in 25/26 and all plans are on track to deliver this target. We have requested an objective review from MIAA to review all CIP plans and to support up to identify further savings in year. The initial report supports our CIP governance and our expected recurrent target. **Responsible Officer:** Nicola Hepburn **Executive Lead:** Colin Scales **Due Date:** Quarter 4 2025/26	**September Update:** A full objective review of the 2025/26 CIP plans was completed by MIAA. This report was completed in June. A high-level review and analysis of the influenceable spend was also undertaken which has highlighted several areas that could be explored further to close the financial gap, and the team are focusing on these to support delivery of the 2025/26 plan. The process by which the savings plan is governed has also been assessed as 'highly assured.' **Status: On-going** **December Update:** As at M7 we are reporting 70% recurrency with our schemes. In September we developed 4 recovery plans including Risk to CIP Delivery, Reduce IS –

No.	Recommendation	Initial Management Comments	Implementation Progress Update
IR1			Electives, IPOC and ADHD & Autism pathways. Following a programme health check in November 2025 we put in place accelerated recovery actions to address under delivery for 25/26 working with all key stakeholders. Following this work a Critical path highlighting the key milestones needed to achieve the in-year target has been developed and circulated . Following guidance from the BAF in terms of risk appetite a list of 'difficult decisions' has been drawn up for review and challenge. The Recovery team are working closely with all schemes within the programme to deliver in full this year and develop plans for 2026/27. **Status: On-going** **March Update:** There is recurrent in year delivery of £117m against an in-year target of £175m (which is 67%), but to note that the full year effect as a

No.	Recommendation	Initial Management Comments	Implementation Progress Update
IR1			consequence of NHS reform staff leaving only impacts in the last quarter. This delivers a further £36m of savings over and above the in-year £4m savings in 2025/26. Taking this into account would increase full year savings to £153m which is 87%. A further review of governance has been undertaken which will be in place for the new financial year and recognises the new operating model and role of ICBs as Strategic Commissioners. Work is ongoing to fully identify the 2026/27 schemes with a target that these should at least deliver 80% recurrent savings **Status: Complete**
IR2	The ICB should ensure that it has robust arrangements for monitoring ongoing progress against Single Improvement Plan (SIP) indicators once they are handed back to Committees. This should include clear triggers and protocols for escalation should performance dip. The ICB should also introduce more frequent public reporting on	**Actions**: A six-month review has been completed and approved by the NHS Greater Manchester System Improvement Board and the NHS North West System Improvement Board. Both Boards approved confirmation of compliance of 28 of the specific undertakings with transfer across to specifically described Board sub-committees for monitoring. Those undertakings that remain are monitored through a Triple A (advise, assure, alert) reporting mechanism from sub-committees to the	**September Update:** Robust monitoring processes remain in place. Since the six-month review, four additional undertakings have been approved as compliant by both NHS GM and NHSE SIBs. Therefore, only four of the initial 36 undertakings remain as non-compliant. A joint review by NHS GM and NHSE will be completed in September 2026 to assess the

No.	Recommendation	Initial Management Comments	Implementation Progress Update
IR2	the SIP via reports to the Board	System Improvement Board. A full review of all undertakings is scheduled for September 2025 SIP updates have been provided to the Board through the CEO updates on a monthly basis. **Responsible Officer:** Previously Gareth Robinson now Nicola Hepburn **Executive Lead:** Colin Scales **Due Date**: September 2025	opportunity for ceasing/ amending the undertakings. This review will progress through ICB and NHSE governance and considered at NHSE SDM/ SIB on 3rd November 2025. **Status: On-going** **December Update:** A 12-month review of all Undertakings was completed in September/ October 2025 and reviewed by NHSE at the monthly System Delivery Meeting on 3rd November. NHSE approved the review which recommended that 36/38 undertakings were compliant with the requirements of the legal undertakings. On this basis NHSE will present the current position to the RSG (the forum which reviews national & regional oversight arrangements) with a recommendation to approve all compliant undertakings. RSG takes place on 25th November and NHS GM will be informed of any changes to the Undertakings shortly after. Part of this review included full demonstration that Finance and Quality & Performance

No.	Recommendation	Initial Management Comments	Implementation Progress Update
IR2			Committees have sufficient information through reporting mechanisms to identify and escalate to Board any areas of concern previously within the scope of the Undertakings. Both committees now specifically review these areas as part of their standing agendas. **Status: On-going** **March Update:** As per the update in December, both the finance and quality and performance committee along with the transition committee have maintained oversight with sufficient information through reporting mechanisms to identify and escalate to Board any areas of concern previously within the scope of the Undertakings. All committees now specifically review these areas as part of their standing agendas and will do so in the new governance arrangements in 2026/27. **Status: Complete**

No.	Recommendation	Initial Management Comments	implementation Progress Update
IR3	The ICB needs to ensure its data quality strategy and associated governance has the necessary positive impact on data quality. It should consider developing a related programme of assessment and assurance to test the impact of the policy and embed data quality in its everyday business and reporting.	**Action 1.** Draft Data Quality Policy to be ratified and implemented - End of Quarter 3 2025/26.	**September Update:** Policy is complete and key elements are implemented but it has not yet been ratified due to staff sickness and reform work pressures. **Status: Delayed but in progress** **December Update:** Policy is on the agenda to discuss at the 8 December 2025 Policy Review Group. However, the Data, Intelligence and Insight function has already implemented the policy for its Information Assets. **Status: Delayed but in progress** **March Update:** Need to incorporate feedback from the December 2026 Policy Review Group into policy. Delayed due to NHS Reform. **Status: In Progress**
		Action 2. Data Intelligence and Insight (DII) Function to document Data Quality Assurance Process and implement – End June 2025/26	**September Update:** DQ process is being implemented informally until formal ratification of the policy. This ratification has been delayed by staff sickness

No.	Recommendation	Initial Management Comments	implementation Progress Update
IR3			and reform activities. **Status: Delayed but in progress** **December Update:** DQ process has been implemented. **Status: Complete**
		<u>Action 3.</u> Routine update and monitoring of the Data Quality issues log and associated actions e.g. Community Health Services Data Quality Improvement Plans embedded within contracts where necessary – July 2025 onward. **Responsible Officer:** Matt Hennessey **Executive Lead:** Previously Colin Scales now Nicola Hepburm **Due Date:** Task 1 End Q3 2025/26 Task 2 End June 2025/26 Task 3 implemented from July 2025. **Due Date:** Quarter 4 2025/26	**September Update:** DQ improvement plans have been produced and are in the process of being implemented but changes to the provider oversight and contract monitoring regime are imminent and plans will have to find a place within the new reporting regime. **Status: In Progress** **December Update:** DQ Improvement Plans have been discussed and metrics agreed with all Providers. However, the plans have not progressed into contracts due to reform activities and the need to agreed improvement targets with some providers.

No.	Recommendation	Initial Management Comments	implementation Progress Update
IR3			**Status: In progress** **March Update:** Data Quality Improvement Plans for Community Health Services have been agreed, and monitoring dashboards have been developed. DQIP needs formal inclusion within Provider contracts. Delayed due to NHS Reform. **Status: In Progress**

No.	Recommendation	Initial Management Comments	implementation Progress Update

Key Recommendation Implemented by September Committee

<table>
<tr><th>No.</th><th>Recommendation</th><th>Initial Management Comments</th><th>implementation Progress Update</th></tr>
<tr><td rowspan="3">KR1</td><td rowspan="3">The ICB should ensure its sustainability plan is on track and delivers the intended results. As part of this it should establish clear routes to report how the specific interventions that underpin its plans will be funded (including risks to the availability of funding); the assurances it has over the effectiveness of proposed interventions (for example, drawing on evaluations of the same interventions elsewhere) and how it will evaluate the effectiveness of the interventions, as well as the plan overall.</td><td>Response:
<u>Action 1</u>: 2025/26 NHS GM Annual Plan structured on the five Sustainability Plan pillars with key deliverables against each.

<u>Due Date</u>: Complete – and signed off by Board in May 2025</td><td>N/a</td></tr>
<tr><td><u>Action 2</u>: Development of Sustainability Plan Integrated Scorecard to track metrics under each of the five pillars:

<u>Due Date</u>: Complete – part of reporting to Quality and Performance Committee from January 2025.</td><td>N/a</td></tr>
<tr><td><u>Action 3</u>: Each locality to complete a local version of the Sustainability Plan for 2025/26 drawing on local data packs.

<u>Due Date</u>: Complete – each of the localities has a local delivery plan to be monitored via Locality Board reporting structures. This to be reviewed as part of development of place model in GM under ICB reforms.</td><td>N/a</td></tr>
</table>

No.	Recommendation	Initial Management Comments	implementation Progress Update
		<u>Action 4</u>: Investment required to deliver Pillars 3 and 4 of Sustainability Plan (Reducing Prevalence and Proactive Care) agreed as part of 2025/26 Annual Plan. **<u>Due Date</u>: Complete – approved by Board in May 2025**	N/a
		<u>Action 5</u>: Delivery of Provider and ICB CIP Plans and FSPs under pillars 1 and 2 (Cost Improvement and System Productivity and Performance). **<u>Due Date</u>:** Complete - All providers met the 2024/25 control total. Performance showed significant improvement in all key indicators. Relative performance against England ICBs showed significant improvement. Compliant plans submitted by all providers and ICB for performance and finance. Ongoing Monitoring through risk management, reporting, and governance structures.	N/a.

No.	Recommendation	Initial Management Comments	implementation Progress Update
		<u>Action 6</u>: Monitoring of Interventions in Sustainability Plan. These are tracked through system governance including system groups (for example, on UEC, Elective, Mental Health), Locality Boards and NHS GM Committees. Specific ROIs in Sustainability Plan subject to evaluation and monitoring through 2025/26 delivery plans – for example 2025/26 Population Health Business Plan. Escalation meetings in place for areas of high risk (thematically for UEC, Elective, LD, and MH) and providers (MFT, NCA, WWL). **<u>Due Date</u>:** Ongoing monitoring through governance in 2025/26. **Responsible Officer:** Ed Dyson / Paul Lynch **Executive Lead:** Colin Scales **Due Date:** As outline above.	**Update:** Ongoing monitoring being undertaken through ICB governance. **Status: Complete**

Review of BAF Risk SR1

Part of Greater Manchester Integrated Care Partnership

Audit Committee

19/3/2026

Report information.

Required information.	Details.
Title of report.	Review of BAF Risk SR1
Author.	David Boulger - Associate Director of Population Health
Presented by.	Charlotte Bailey – Chief Officer for Strategy, People and Partnerships
Contact for further information.	David Boulger - Associate Director: Population Health, david.boulger@nhs.net
Executive summary.	This report sets out key reflections in relation to Board Assurance Framework (BAF) Risk SR1 considering the scope of the risk, the approach to mitigation, learning from the management of the risk, and future proposals.
The benefits that the population of Greater Manchester will experience.	Good management of risks enhances the effectiveness and efficiency of delivery and improves outcomes for people.
How health inequalities will be reduced in Greater Manchester's communities.	Good management of risks enhances the effectiveness and efficiency of delivery and improves outcomes for people.
The decision to be made and/or input sought.	The Board / Committee is asked to: 1. Note the content of this report and provide feedback on the reflections contained within it.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This report specifically relates to the management of BAF Risk SR1
Key milestones.	N/A
Leadership and governance arrangements.	This risk was previously managed by the GM Population Health Committee. The organisational risk owner is the Chief Officer for Strategy, People and Partnerships
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	This risk was subject to review by the wide-ranging membership of the GM Population Health Committee and the supporting Population Health Advisory Group at every meeting during 2025/26.
Financial or Legal Implications	N/A

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

1. Introduction

1.1 Strategic Risk 1 (SR1) forms part of the ICB Board Assurance Framework (BAF).

1.2 It is a wide-ranging risk that was shaped by the ICB to respond to the 'Strengthening Communities' priority within the ICP Strategy and was then allocated to the Population Health Committee for oversight, mitigation and management.

1.3 The specific description of the risk is as follows:

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.

1.4 This risk reflects a fundamental consideration for the Greater Manchester (GM) system, namely, how we shape GM to be a place conducive to good health. It's inclusion as a strategic BAF risk was a positive signal to the system that the ICB considered this to be of utmost importance and was committed to collaborating with others to achieve this.

1.5 However, the risk reaches beyond the direct responsibilities of the ICB, and into the wider, social and commercial determinants or "*building blocks*" of health and the leadership and responsibilities of others at a local, city-regional and national level.

1.6 The full BAF risk overview is included as **Appendix 1** of this report.

2. Approach to Risk Mitigation

2.1 Given the comprehensive and wide-ranging nature of the risk, the Population Health Committee took a pragmatic early decision to frame the mitigation around the mobilisation and delivery of some core system strategies and approaches that reached beyond the direct responsibilities of the ICB, namely:

- The Greater Manchester Strategy (GMS)
- GM Housing Tripartite Agreement
- ICB Left Shift Model
- Transformation of the GM Public Health Network

2.2 Of these, the development, agreement and mobilisation of the GMS provided the most significant mitigation as its scope covered the breadth of the risk. It was the view of the committee that developing and implementing a GMS that placed an emphasis on improving these core building blocks would have the greatest impact on mitigating the risk.

2.3 The inherent risk score and the score for the first 3 quarters of 2025/26 was 15 (Likelihood: 3 / Impact: 5). For Q4, the likelihood score was reduced to 2 reflecting the agreement of the GMS and the development of the delivery plan and outcomes framework. This reduced the overall risk score to 10.

2.4 However, it is proposed to increase this risk again due to the cohesion challenges currently being experienced nationally, the ongoing transformational changes taking place within the GM system which could impact upon the ability of the ICB to undertake the type of shaping and influencing work required in relation to this risk, and the potential economic impact of the war in Iran. The proposed updated score is 15 (Likelihood: 3 / Impact: 5)

2.5 A pragmatic approach to assurance was undertaken which utilised the existing touchpoints within the ICP and with near system partners. However, it is recognised that the wide-ranging nature of this risk, and the lack of direct ICB responsibility for many of the determinants, posed some challenges in terms of providing wider assurance around this risk.

3. Lessons Learned from SR1

3.1 The experience of the Population Health Committee in seeking to manage this risk has generated learning that could shape the future risk management approach of the ICB under the transformed governance arrangements and the new operating model.

3.2 A summary of the learning is as follows:

a) The risk was not produced or co-produced with the Committee that was charged with overseeing it, which resulted in a lack of understanding of the context within which it was generated and the expectations of the ICB.

b) The risk is wide ranging, lacks specificity, and is not within the direct influence of the ICB. There are considerable practical challenges to effectively and meaningfully managing system risks of this kind through single organisational governance arrangements.

c) There was inherent value in the Population Health Committee having a wider membership than many other ICB committees given the scope and nature of this particular risk.

d) The measures for mitigating the risk were primarily process-focussed and lacked demonstrable and measurable outputs and outcomes against which risk reduction or escalation could be measured.

e) There are challenges to creating robust internal assurance approaches for risks where the determinants of the risk primarily sit outside the organisation.

f) The existing BAF approach is not dynamic enough to truly reflect the risks, which affects the extent to which system conditions or organisational context impact upon the attainment of the ICB

population health ambitions.

4. Future Proposals

4.1 It is proposed that this existing risk (SR1) is revisited and replaced as an ICB risk with a new co-produced strategic risk within the BAF which is focussed on the extent to which the ICB can fully deliver its population health / left shift ambitions and the outcomes associated within them, namely:

- Improved health and reduced inequalities
- Reduction in avoidable demand and cost
- Financial and operational sustainability

4.2 The new risk should consider the impact of organisational change, the new operating model, and the form and function of the new organisational governance in enabling or adversely impacting the outcomes set out above and will need to consider:

- The way in which the new organisational form and operating model supports organisational left shift, including the evolving role of localities and place partnerships.
- The transformation of everyday support services and integrated care within neighbourhoods that are set out through GM Live Well and Neighbourhood Health.
- The extent to which other system stakeholders are active participants in future ICB governance arrangements.
- The extent to which the totality of ICB investment is geared towards population health, prevention and left shift, and an understanding of the totality of ICB dedicated investment in population health, prevention and left shift activities
- The opportunities to deploy innovative models to underpin a shift in investment, such as a Population Health Investment Standard which builds upon the learning from the Mental Health Investment Standard.

4.3 However, the proposed shift is not to suggest that SR1 should be lost entirely. The risk it describes is fundamental to improving the health of the GM population, even more so than the provision of health services, and consideration should be given to how this risk is instead embedded elsewhere within the wider system governance.

5. Recommendations

5.1 The NHS GM Audit Committee is asked to:

Note the content of this report and provide feedback on the reflections contained within it.

Appendix 1 – Full overview of BAF Risk SR1

<table>
<tr><td>Strategic Risk

SR1</td><td colspan="3">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.</td></tr>
<tr><td>Strategic Objective</td><td colspan="3">Strengthen our communities</td></tr>
<tr><td>Chief Officer / Committee</td><td colspan="3">Charlotte Bailey   Transition Committee (formerly Population Health Committee)</td></tr>
<tr><td>Risk Appetite Level</td><td>3 - Open</td><td>Risk Tolerance Range (e.g. 5 to 10)</td><td>10 - 20</td></tr>
<tr><td colspan="4">Rationale for Risk Score and Progress made in the quarter</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td colspan="4">Key Controls</td></tr>
<tr><td colspan="4">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.
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 GM Housing Tripartite Agreement ensures a collaborative approach to healthy homes across NHS GM, GMCA and Housing Providers.</td></tr>
<tr><td colspan="4">Gaps in Control or Assurance</td></tr>
<tr><td colspan="4">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.</td></tr>
</table>

	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	Acceptable
2nd Line	Population Health Committee governance processes followed. PHC Chair sits on ICB and regularly reports from PH Committee and PH function to ICB and ICP Board. Maintenance of Strategic Risk Register and collation of the strategic risks into the Board Assurance Framework.	Acceptable
3rd Line	GM Public Health Leadership Group 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.	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	
4	Development and design of an integrated GM Public Health Network which consists of 10xLocal Authority Directors of Public Health, NHS GM Pop Hlth, OHID, UKHSA and NHSE NW	June 2026	On track for the implementation of Phase 1 of the transformation during Q1 2026/27.	

Terms of Reference Review

March 2026

Part of Greater Manchester
Integrated Care Partnership

Audit Committee

19 March 2026

Report information.

Required information.	Details.
Title of report.	Terms of Reference (TOR) Review
Author.	Jenny Noble, Board Secretary
Presented by.	Chris Gaffey, Associate Director of Corporate Services
Contact for further information.	Jenny Noble, Board Secretary jennynoble@nhs.net
Executive summary.	This paper sets out the Audit Committee Terms of Reference for consideration ahead of the new financial year. There are no proposed changes, however with the implementation of the proposed new committee structure, changes to the Audit Committee ToR may be required as arrangements develop. Any changes to the TOR must be submitted to the Board for approval before being formally implemented by the Committee in line with the process prescribed in the NHS GM Constitution.
The benefits that the population of Greater Manchester will experience.	Good governance arrangements will facilitate effective decision making which will benefit the population of GM.

How health inequalities will be reduced in Greater Manchester's communities.	Effective and efficient decision making will help to reduce health inequalities.
The decision to be made and/or input sought.	The Committee is asked to review the proposed changes and make a recommendation to the Board to approve the TOR for implementation.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring the TOR are reviewed annually will ensure these areas are considered as part of any discussion in relation to NHS GM BAF risks, supporting the delivery of the ICP strategy.
Key milestones.	The proposal is for the TOR of all Committees of the Board to be submitted to the March 2026 Board.
Leadership and governance arrangements.	Richard Paver, Non-Executive Director as Chair of the Audit Committee Kathy Roe, Chief Finance Officer, and Charlotte Bailey, Chief Strategy, People and Partnerships Officer, are the Lead Execs for the Audit Committee.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	None.
Financial or Legal Implications	N/A

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

Table 2: Assurance needed about the document.

Introduction

1.1. This paper sets out the Audit Committee Terms of Reference for consideration ahead of the new financial year.

Background

1.2. Section 10 of the current TOR requires that these 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.

1.3. The TOR were last reviewed and recommended for approval by the Committee in April 2025 and approved by Board in May 2025.

1.4. The aim of this was to ensure total clarity for Committees regarding their remit whilst also ensuring that all TORs were fully aligned with the delegations prescribed within the Scheme of Delegation and Reservation (SORD) as well as the Operating Model.

Proposed Changes and Further Considerations

1.5. For the Audit Committee, there no proposed changes this time. However, with the implementation of the proposed new committee structure, changes to the Audit Committee ToR may be required as arrangements develop.

1.6. Any potential changes will be discussed with the Audit Committee Chair ahead of their presentation to the Audit Committee for consideration.

Recommendations

1.7. The NHS GM Audit Committee is asked to:

- Note there are no proposed changes at this stage, and to agree the Terms of Reference for the coming year.

NHS Greater Manchester

Audit Committee

Terms of Reference

DOCUMENT CONTROL SHEET

Name of Document:	Audit Committee Terms of Reference
Version:	9
File Location / Document Name:	
Date Of This Version:	24 April 2025
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 10/04/24	Additions to ToR to reflect SoRD Further comments by AC following March meeting, as well as additional changes to reflect responsibilities around governance.	LC CG	8
11/04/25	Remove the provision of Members providing deputies (as this is not possible). Update of job title for "Chief Officer Responsible for Governance" Inclusion of provision to meet with Counter Fraud provider in private Update to wording on section on corporate policy approval	CG	9

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 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

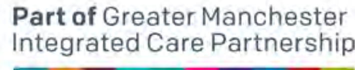
The Committee shall be supported with a secretariat function which will include ensuring that:

- 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

Date of review: April 2026

Month 9 Draft Accounts Update 2025-2026

Part of Greater Manchester Integrated Care Partnership

Audit Committee

19 March 2026

Required information.	**Details.**
Title of report.	Month 9 Draft Accounts Update.
Author.	Kaye Abbott – Associate Director of Finance – Financial Control.
Presented by.	Kaye Abbott – Associate Director of Finance – Financial Control.
Contact for further information.	Kaye Abbott – Associate Director of Finance – Financial Control. kayeabbott@nhs.net
Executive summary.	This paper updates the Audit Committee on the Month 9 Draft Accounts submission to NHS England. It covers: • Submission details. • Internal process to generate the Month 9 Accounts. • Notes on the draft accounts. • Changes from Month 9 to Month 12.
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 Audit Committee is asked to: 1. Note the Month 9 Draft Accounts submission for NHS GM

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	N/a.
Key milestones.	N/a.
Leadership and governance arrangements.	The paper has been agreed by the Corporate Director of Finance – Commissioning and Financial Assurance.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The paper has been agreed by the Corporate Director of Finance – Commissioning and Financial Assurance.
Financial or Legal Implications	There are no financial or legal implications.

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

Public engageme nt	Clinical engageme nt	Sustainabi lity impact	Financial advice	Legal advice	Conflicts of interest	Report accessibili ty
No	No	No	No	No	No	Yes

Table 2: Assurance needed about the document.

Introduction

1.1. The paper is presented to update the Audit Committee on the Month 9 draft accounts submitted to NHS England on 23 January 2026.

Submission Details

1.2. Within the national M9 draft accounts submission, NHS GM submitted the following documents:

- Month 9 Governance Return.
- Month 9 ICB Template – generated from a trial balance import from ledger which generates a number of the accounts schedules.
- Month 9 Analytical Review – which compares spend between financial years across income, expenditure (pay and non-pay) and headcount.
- Agreement of Balances – a number of submissions within the process covering debtors and creditors outstanding between NHS organisations and income and expenditure (excluding any accruals).
- There was no requirement to submit the word version of the accounts, but as this is embedded good practice, the ICB generated these to be circulated to Audit Committee members.

1.3. The Month 9 accounts give both the organisation and NHSE an opportunity to resolve any issues with templates and processes (both internal and external) before the Month 12 accounts process. This is particularly important given the transition to the ISFE2 ledger during this year. It also allows the resolution of any Agreement of Balances differences in advance of the year end.

1.4. NHS GM submitted the draft accounts on 22 January 2026, which was ahead of the national deadline, with no issues raised by the national team on the submission.

1.5. Appendix A contains the Month 9 Draft Accounts for information. Please note text highlighted in the appendix will be updated within the Month 12 final accounts.

Internal Process to Generate the Draft Accounts

1.6. The submission was completed using the method used on the previous ledger (ISFE1) and this is the process expected for the year end 2025/26, as opposed to direct submission through the group consolidation module within the ISFE2 ledger. This direct submission through the new ledger system is expected for 2026/27 (subject to national confirmation).
Outcome: There are no risks for the 2025/26 accounts from the migration to the new ledger platform which will impact on the year end accounts submission**.**

1.7. NHS GM has successfully implemented the new coding structure within the data migration to the new ledger system, which ensures that the accounts are comparable year on year. The team has also worked with NHS Shared Business Services (SBS) to replicate / create reports that teams used in the old ledger to ensure a consistent approach to month end processes.

Outcome: There are no risks within the 2025/26 accounts from the data migration, with the analytical review process and the comparison between years confirming this.

Notes of the Draft Accounts National Templates

1.8. There are a number of issues within the Month 9 accounts which are being resolved ahead of the final accounts submissions. The key elements are listed here by Note reference from the accounts contained in Appendix A.

1.9. **Notes 2 Income and Note 4 Pay** – recoveries (income) associated with the employee benefits should be netted off against salary costs as opposed to being shown as income – this is a mapping issue within the accounts templates and has been highlighted to NHSE. The impact is that pay costs and income are overstated. This has been highlighted to NHSE, and it is understood that it will be resolved ahead of the year end.

1.10. As part of the analytical review on pay, an internal review has been undertaken which includes:

- Factors impacting on pay, including headcount changes, pay award and incremental drift, the outcome is that the pay costs disclosed are comparable to those in 2024/25.
- In terms of national insurance, this is a consistent proportion of salary costs when adjusted for changes in employers NI rates (13.8% to 15%) and a reduction in the starting threshold from £9,100 to £5,000, which means that the values disclosed are comparable to 2024/25.
- At Month 9 the national amendment to pension costs had not been made which equates to £7.2m. When this is included, the pension costs are comparable to 2024/25.

1.11. **Note 6 – Better Payment Practice Code** – highlighted a failure of the target for non-NHS by value with achievement of 93.23% compared to the target of 95%. This is a direct consequence of cash constraints, which have been alleviated as year-end approaches with the availability of additional cash in the system to enable creditors to be settled.

1.12. **Note 10 – Negative Cash and Cash equivalents** – this was generated by the timing of the final BACS runs, which meant that the organisation had cash in transit at the end of the month, with cash clearing after 31 January. This is not anticipated to be an issue by year end, as NHS GM will manage payment runs to ensure that all payments will clear before 31 March 2026. Please note that the last NHS payment run is Friday 20 March and the last non-NHS payment run is Friday 27 March (clearing on Tuesday 31 March).

1.13. **Note 11 – Payables** – the Month 9 accounts show a significant reduction in the payables balance recorded, principally relating to the change in contracting for Elective Recovery Fund (ERF) activity for 2025/26.
In 2024/25, this was accrued at year end and paid on receipt of final performance data, whilst in 2025/26, the activity forms part of the core contract, and is paid through the year, reducing the closing performance accrual.
In addition, there are some classification differences at Month 9, relating to the closedown process, which are anticipated to be resolved as part of year end planning.

1.14. **Note 18 Financial Performance Targets** – this has been reported in line with the financial plan, reflecting the £7.5m planned deficit for NHS GM.

Changes between Month 9 Draft and Month 12 Final Accounts

1.15. The following notes were not required to be populated in the Month 9 draft accounts

- Pooled budget information (Note 15) – in line with internal procedures the data required to populate this note are not available until year end and locality colleagues have been contacted to collate this information.

- Related Parties (Note 16) – this is not required to be completed, but the internal finance team have been liaising with governance colleagues to ensure that this data is available at year end.

1.16. **Note 4.2 Exit Packages** - As the organisation moves to year end this note will be fully populated reflecting the impact of the Reform process. The financial impact has been funded in 2025/26, but as agreements on exit packages in respect of VR1 had not been agreed until after the closure of the Month 9 accounts, the majority of exit packages are not accounted for in these draft statements.
Due to payment timings, the cash impact of VR2 will be in 2026/27. As agreements are made in March I VR2 impacts will be accrued at the 31 March 2026.

1.17. **Note 9 Other Financial Assets** – This note covers NHS GM investment in North West e-Heath. An impairment review of the investment has been undertaken and NHS GM is satisfied that this should not be impaired. This is due to progress the company has made in securing significant contracts to deliver future revenue, which are anticipated to attract a sale price for the company that will return the ICB's original investment.

1.18. **Going Concern Assessment** – NHS GM has assessed going concern and has deemed that it is still appropriate to account for itself as a going concern. This is because public sector bodies are considered to be a going concern where the operations of the organisation are expected to continue. This is the case for NHS GM, as the function of the ICB as the commissioner of health services for the population of Greater Manchester is continuing for future years. The negative balance of net current assets is a part of the financial structure of ICBs in general (as cash is not drawn down to pay liabilities until they are due) meaning it is not considered an issue for going concern considerations.

Recommendations

1.19. The NHS GM Audit Committee is asked to:

- Note the update on the M9 Draft Accounts submission

NHS Greater Manchester Integrated Care Board

Annual Accounts

9 months to 31 December 2025

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Statement of Comprehensive Net Expenditure for the period ended 31 December 2025.

	Note	December 2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(85,283)	(108,569)
Other operating income	2	(811)	(2,670)
Total operating income		**(86,094)**	**(111,239)**
Staff costs	4	84,239	108,503
Purchase of goods and services	5	6,920,736	8,740,527
Depreciation and impairment charges	5	792	1,096
Provision expense	5	-	1,706
Other operating expenditure	5	911	1,994
Total operating expenditure		**7,006,678**	**8,853,826**
Net Operating Expenditure		**6,920,584**	**8,742,587**
Finance income		-	-
Finance expense		74	83
Other Gains & Losses		-	(7)
Net expenditure for the Year		**6,920,658**	**8,742,663**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**6,920,658**	**8,742,663**
Comprehensive Expenditure for the year		**6,920,658**	**8,742,663**

During the current and previous financial years, there were no items of Other Comprehensive Income or Expenditure.

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Statement of Financial Position as at 31 December 2025.

	Note	**31 December 2025 £'000**	31 March 2025 £'000
Non-current assets:			
Right-of-use assets	7	6,931	7,724
Other financial assets	9	1,106	1,106
Total non-current assets		**8,037**	**8,830**
Current assets:			
Trade and other receivables	8	67,369	34,006
Cash and cash equivalents	10	(11,095)	1,112
Total current assets		**56,274**	**35,118**
Total assets		**64,311**	**43,948**
Current liabilities			
Trade and other payables	11	(376,755)	(444,636)
Lease liabilities	7	(1,038)	(1,028)
Provisions	12	(2,315)	(2,315)
Total current liabilities		**(380,108)**	**(447,979)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(315,797)**	**(404,031)**
Non-current liabilities			
Lease liabilities	7	(6,005)	(6,805)
Provisions	12	(202)	(202)
Total non-current liabilities		**(6,207)**	**(7,007)**
Assets less Liabilities		**(322,004)**	**(411,038)**
Financed by Taxpayers' Equity			
General fund		(322,004)	(411,038)
Total taxpayers' equity:		**(322,004)**	**(411,038)**

The notes on pages 7 to 41 form part of this statement

The financial statements on pages 1 to 41 were approved by the Audit Committee on XX XXX 2026 and signed on behalf of the Board by:

Accountable Officer

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Statement of Changes in Taxpayers' Equity for the period ended 31 December 2025.

	General fund £'000
Changes in taxpayers' equity for 2025-26	
Balance at 01 April 2025	(411,038)
Transfer between reserves in respect of assets transferred from closed NHS bodies	-
Adjusted NHS Integrated Care Board balance at 01 April 2025	**(411,038)**
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26	
Net operating expenditure for the financial year	(6,920,658)
Net gain/(loss) on revaluation of right-of-use assets	-
Total revaluations against revaluation reserve	**-**
Transfers by absorption to (from) other bodies	-
Net Recognised NHS Integrated Care Board Expenditure for the nine-month period	**(6,920,658)**
Net funding	7,009,692
Balance at 31 December 2025	**(322,004)**

	General fund £'000
Changes in taxpayers' equity for 2024-25	
Balance at 01 April 2024	(356,817)
Transfer of assets and liabilities from closed NHS bodies	-
Adjusted NHS Integrated Care Board balance at 01 April 2024	**(356,817)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25	
Net operating costs for the financial year	(8,742,663)
Net gain/(loss) on revaluation of right-of-use assets	-
Total revaluations against revaluation reserve	**-**
Transfers by absorption to (from) other bodies	-
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(8,742,663)**
Net funding	8,688,442
Balance at 31 March 2025	**(411,038)**

The notes on pages 7 to 41 form part of this statement

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Statement of Cash Flows for the period ended 31 December 2025.

	Note	December 2025-26 £'000	2024-25 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(6,920,658)	(8,742,663)
Depreciation and amortisation	5	792	1,096
Interest paid / received		74	83
Other Gains & Losses		-	(7)
(Increase)/decrease in trade & other receivables	8	(33,363)	13,116
Increase/(decrease) in trade & other payables	11	(67,881)	40,097
Provisions utilised	12	-	-
Increase/(decrease) in provisions	12	-	1,706
Net Cash Inflow (Outflow) from Operating Activities		**(7,021,036)**	**(8,686,572)**
Cash Flows from Investing Activities			
Interest paid / received		-	-
(Payments) for property, plant, and equipment		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	**-**
Net Cash Inflow (Outflow) before Financing		**(7,021,036)**	**(8,686,572)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		7,009,693	8,688,442
Repayment of lease liabilities		(864)	(1,152)
Net Cash Inflow (Outflow) from Financing Activities		**7,008,829**	**8,687,290**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(12,207)**	**718**
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,112**	**394**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) Balance		**(11,095)**	**1,112**

The notes on pages 7 to 41 form part of this statement.

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Notes to the financial statements

The draft accounting policies for 2025-26 have not yet been issued by NHS England and have been updated below as no significant changes are anticipated. These are subject to change when the final versions are issued in March 2026.

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care.

The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected.

The policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis despite the 2025-26 deficit position.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a going concern basis as the organisation will continue to provide services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations.

Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

From 1 April 2025, NHS GM gained commissioning responsibility for certain additional Specialised Commissioning services, previously commissioned by NHS England, in addition to those which had transferred in previous years. Whilst commissioning responsibility transferred, no assets or liabilities associated with the services transferred, therefore no restatement of performance is required. The additional expenditure in 2025-26 is reflected in Note 5.

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1.4 Pooled Budgets

NHS GM has entered into pooled budget arrangements with each of the 10 local authorities in Greater Manchester, in accordance with Section 75 of the NHS Act 2006.

Under these arrangements, funds are pooled for the purpose of improving the commissioning of health and social care and Note 15 to the accounts provides details of the income and expenditure.

The operating arrangements relating to each pooled budget are specific to that arrangement and are further discussed in Note 15 to these accounts.

1.5 Revenue

The main source of funding for NHS GM is from NHS England. This is drawn down and credited to the General Fund.

Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when NHS GM accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages, and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant, and equipment.

1.8 Leases

A lease is a contract, or part of a contract, which conveys the right to control the use of an asset for a period of time in exchange for consideration.

NHS GM assesses whether a contract is or contains a lease, at inception of the contract.

1.8.1 NHS GM as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant, and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

1.9 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Cash, bank and overdraft balances are recorded at current values.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of NHS GM's cash management.

1.10 Provisions

Provisions are recognised when NHS GM has a present legal or constructive obligation as a result of a past event, it is probable that NHS GM will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

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1.11 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which NHS GM pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with NHS GM.

1.12 Contingent liabilities and contingent assets

1.12.1 A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of NHS GM, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation, or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

1.12.2 A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of NHS GM. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.13 Financial Assets

Financial assets are recognised when NHS GM becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired, or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income; and
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.13.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other similar debt instruments. After initial recognition, these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.13.2 Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, NHS GM recognises a loss allowance representing the expected credit losses on the financial asset.

NHS GM adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables, and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

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HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. NHS GM therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies, and NHS GM does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.14 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when NHS GM becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.15 Value Added Tax

Most of the activities of NHS GM are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Foreign Currencies

NHS GM’s functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB’s surplus/deficit in the period in which they arise.

1.17 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.18 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS GM not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.19 Critical accounting judgements and key sources of estimation uncertainty

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In the application of NHS GM's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.19.1 Critical accounting judgements in applying accounting policies

NHS GM has reviewed the judgements that management has made in the process of applying its accounting policies and concluded that there are no critical accounting judgements made which have a material impact on these financial statements.

1.19.2 Sources of estimation uncertainty

NHS GM has considered the areas where it makes significant estimates in preparing these accounts. On review of the estimates, NHS GM has concluded that there are no estimates made which are subject to material uncertainty.

1.20 New and revised IFRS Standards in issue but not yet effective

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which was expected to be April 2025: early adoption is not therefore permitted.
- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

NHS GM has considered the potential impact of the above new standards on its accounts and concluded that it does not expect them to have a material impact on NHS GM’s financial statements.

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2. Other Operating Revenue

	December 2025-26 Total	2024-25 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training, and research	57	67
Non-patient care services to other bodies	7,026	14,045
Prescription fees and charges	31,343	41,753
Dental fees and charges	37,742	48,852
Other Contract income	5,020	3,675
Recoveries in respect of employee benefits	4,095	177
Total Income from sale of goods and services	**85,283**	**108,569**
Other operating income		
Non-cash apprenticeship training grants revenue	-	65
Other non-contract revenue	811	2,605
Total Other operating income	**811**	**2,670**
Total Operating Income	**86,094**	**111,239**

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3. Disaggregation of Income - Income from sale of good and services (contracts)

	December 2025-26					
	Education, training, and research	**Non-patient care services to other bodies**	**Prescription fees and charges**	**Dental fees and charges**	**Other Contract income**	**Recoveries in respect of employee benefits**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Source of Revenue						
NHS	17	2,545	-	-	509	1,322
Non-NHS	40	4,481	31,343	37,742	4,511	2,773
Total	**57**	**7,026**	**31,343**	**37,742**	**5,020**	**4,095**

	2024-25					
	Education, training, and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	64	2,896	-	-	359	169
Non-NHS	3	11,149	41,753	48,852	3,316	8
Total	**67**	**14,045**	**41,753**	**48,852**	**3,675**	**177**

NHS GM has no contract revenue expected to be recognised in future periods related to contract performance obligations not yet completed at either the current or previous reporting dates.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**December 2025-26**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	64,004	2,870	**66,874**
Social security costs	8,450	192	**8,642**
Employer Contributions to NHS Pension scheme	8,185	179	**8,364**
Other pension costs	3	-	**3**
Apprenticeship Levy	305	-	**305**
Termination benefits	51	-	**51**
Gross employee benefits expenditure	**80,998**	**3,241**	**84,239**
Less recoveries in respect of employee benefits (note 4.1.2)	(4,095)	-	**(4,095)**
Total - Net employee benefits including capitalised costs	**76,903**	**3,241**	**80,144**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**76,903**	**3,241**	**80,144**

4.1.1 Employee benefits	Total		2024-25
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	77,226	4,306	81,532
Social security costs	8,833	175	9,008
Employer Contributions to NHS Pension scheme	17,230	213	17,443
Other pension costs	4	-	4
Apprenticeship Levy	391	-	391
Termination benefits	125	-	125
Gross employee benefits expenditure	**103,809**	**4,694**	**108,503**
Less recoveries in respect of employee benefits (note 4.1.2)	(177)	-	(177)
Total - Net employee benefits including capitalised costs	**103,632**	**4,694**	**108,326**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**103,632**	**4,694**	**108,326**

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4.1.2 Recoveries in respect of employee benefits

	December 2025-26			2024-25
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(3,979)	-	(3,979)	(177)
Social security costs	(116)	-	(116)	-
Employer contributions to the NHS Pension Scheme	-	-	-	-
Total recoveries in respect of employee benefits	**(4,095)**	**-**	**(4,095)**	**(177)**

4.2 Average number of people employed

	2025-26			2024-25		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	1,496.16	40.29	**1,536.45**	1,502.01	48.19	**1,550.20**
Of the above:						
Number of whole-time equivalent people engaged on capital projects	-	-	-	-	-	-

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4.3 Exit packages agreed in the financial year.

	December 2025-26 Compulsory redundancies		**December 2025-26 Other agreed departures**		**December 2025-26 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	1	11,024	-	-	1	11,024
£25,001 to £50,000	1	40,000	-	-	1	40,000
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**51,024**	**-**	**-**	**2**	**51,024**

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	4,206	-	-	1	4,206
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	121,008	-	-	1	121,008
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**125,214**	**-**	**-**	**2**	**125,214**

4.4 Analysis of Other Agreed Departures

	December 2025-26 Other agreed departures Number	**£**	2024-25 Other agreed departures Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**-**	**-**

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the period of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report. In the current and prior years, no individuals disclosed in the Remuneration Report received an exit payment.

No Special Payments have been made associated with of the departures included in the tables above.

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4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years.”

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability is based on data as at 31 March 2023, with the valuation updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5. Operating expenses

	December 2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	806	969
Services from foundation trusts	4,548,802	5,757,538
Services from other NHS trusts	158,456	204,387
Services from Other WGA bodies	537	261
Purchase of healthcare from non-NHS bodies	756,603	932,628
Purchase of social care	105,926	136,840
General Dental services and personal dental services	156,371	201,965
Prescribing costs	448,646	579,540
Pharmaceutical services	101,297	119,709
General Ophthalmic services	33,739	44,156
GPMS/APMS and PCTMS	535,286	649,685
Supplies and services – clinical	5,548	4,839
Supplies and services – general	20,418	41,474
Consultancy services	-	1,197
Establishment	19,583	24,086
Transport	202	539
Premises	25,862	32,893
Audit fees	217	276
Other non-statutory audit expenditure		
· Internal audit services	-	-
· Other services	61	140
Other professional fees	1,385	5,303
Legal fees	531	1,713
Education, training, and conferences	460	324
Non-cash apprenticeship training grants	0	65
Total Purchase of goods and services	**6,920,736**	**8,740,527**
Depreciation and impairment charges		
Depreciation	792	1,096
Total Depreciation and impairment charges	**792**	**1,096**
Provision expense		
Provisions	-	1,706
Total Provision expense	**-**	**1,706**
Other Operating Expenditure		
Chair and Non-Executive Members	145	178
Grants to Other bodies	682	1,282
Clinical negligence	34	33
Expected credit loss on receivables	-	(34)
Other expenditure	50	535
Total Other Operating Expenditure	**911**	**1,994**
Total operating expenditure	**6,922,439**	**8,745,323**

In accordance with Statutory Instrument 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, NHS GM's contract with its auditors provides for the limitation of the auditor's liability to a maximum of £5m.

The other non-statutory audit fees relate to the certification of NHS GM's Mental Health Investment Standard Compliance Statement. Audit fees include VAT as this is not recoverable by NHS GM.

Prescribing costs include £93.329m of accrued expenditure in the year to 31 December 2025 (£104.711m to 31 March 2025).

6. Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	December 2025-26 Number	December 2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	115,455	1,578,554	158,447	2,025,867
Total Non-NHS Trade Invoices paid within target	111,930	1,471,625	153,450	1,932,154
Percentage of Non-NHS Trade invoices paid within target	**96.95%**	**93.23%**	**96.85%**	**95.37%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,174	5,169,370	2,790	6,050,793
Total NHS Trade Invoices Paid within target	2,093	5,166,952	2,663	6,048,276
Percentage of NHS Trade Invoices paid within target	**96.27%**	**99.95%**	**95.45%**	**99.96%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

No claims have been made under the Late Payment of Commercial Debts (Interest) Act 1998.

7. Leases

7.1 Right-of-use assets

2025-26	Land £'000	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2025	640	10,205	10,845
Additions	-	-	-
Derecognition for early terminations	-	-	-
Impairments charged	-	-	-
Reversal of impairments	-	-	-
Cost/Valuation at 31 December 2025	**640**	**10,205**	**10,845**
Depreciation 01 April 2025	240	2,882	3,122
Charged during the year	60	732	792
Upward revaluation gains	-	-	-
Impairments charged	-	-	-
Derecognition for early terminations	-	-	-
Transfer (to) from other public sector body	-	-	-
Depreciation at 31 December 2025	**300**	**3,614**	**3,914**
Net Book Value at 31 December 2025	**340**	**6,591**	**6,931**

7.2 Lease liabilities

	December 2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 2025	(7,833)	(8,767)
Additions purchased	-	(878)
Reclassifications	-	-
Interest expense relating to lease liabilities	(74)	(83)
Repayment of lease liabilities (including interest)	864	1,152
Lease remeasurement	-	-
Derecognition for early terminations	-	742
Transfer (to) from other public sector body	-	-
Other	-	1
Lease liabilities at 31 December / 31 March 2025	**(7,043)**	**(7,833)**

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 December 2025	31 March 2025
	£'000	£'000
Within one year	(1,126)	(1,125)
Between one and five years	(3,806)	(4,213)
After five years	(2,518)	(2,976)
Balance at 31 December / March 2025	**(7,450)**	**(8,314)**

Note 7.3 illustrates the cash payments which NHS Greater Manchester is required to make in respect of leased assets. Note 7.2 illustrates the present value of the same leases.

8. Receivables

8.1 Trade and other receivables	**Current 31 December 2025 £'000**	**Non-current 31 December 2025 £'000**	Current 31 March 2025 £'000	Non-current 31 March 2025 £'000
NHS receivables: Revenue	873	-	2,169	-
NHS prepayments	34,411	-	2,458	-
NHS accrued income	107	-	177	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	4,051	-	11,926	-
Non-NHS and Other WGA prepayments	22,888	-	15,452	-
Non-NHS and Other WGA accrued income	5,160	-	1,120	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(898)	-	(898)	-
VAT	739	-	1,545	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Other receivables and accruals	38	-	57	-
Total Trade & other receivables	**67,369**	**-**	**34,006**	**-**
Total current and non-current	**67,369**		**34,006**	
Included above:				
Prepaid pensions contributions	-		-	

8.2 Receivables past their due date but not impaired

	31 December 2025 DHSC Group Bodies	**31 December 2025 Non DHSC Group Bodies**	31 March 2025 DHSC Group Bodies	31 March 2025 Non DHSC Group Bodies
	£'000	**£'000**	£'000	£'000
By up to three months	884	-	557	-
By three to six months	117	-	33	-
By more than six months	456	-	24	-
Total	**1,457**	**-**	**614**	**-**

8.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies
	£'000
Balance at 01 April 2025	**(898)**
Lifetime expected credit loss on credit impaired financial assets	-
Lifetime expected credit losses on trade and other receivables-Stage 2	-
Lifetime expected credit losses on trade and other receivables-Stage 3	-
Credit losses recognised on purchase originated credit impaired financial assets	-
Amounts written off	-
Financial assets that have been derecognised	-
Other changes	-
Balance as at 31 December 2025	**(898)**

9. Other financial assets

	December 2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	1,106	1,106
Additions	-	-
Impairments	-	-
Impairment reversals	-	-
Transfer (to)/from other public sector body	-	-
Balance at 31 December / 31 March 2025	**1,106**	**1,106**

The balance represents NHS GM's minority interest in North West E-Health.

10. Cash and cash equivalents

	2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	1,112	394
Net change in year	(12,207)	718
Balance at 31 December / 31 March 2025	**(11,095)**	**1,112**
Made up of:		
Cash with the Government Banking Service	(11,095)	1,112
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**(11,095)**	**1,112**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 December / 31 March 2025	**(11,095)**	**1,112**
Patients' money held by NHS GM, not included above	-	-

11. Trade and other payables	**Current 31 December 2025 £'000**	**Non-current 31 December 2025 £'000**	Current 31 March 2025 £'000	Non-current 31 March 2025 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	4,002	-	17,546	-
NHS payables: Capital	-	-	-	-
NHS accruals	4,299	-	82,462	-
NHS deferred income	174	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	58,861	-	90,654	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	203,251	-	189,681	-
Non-NHS and Other WGA deferred income	986	-	293	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	1,309	-	1,127	-
VAT	-	-	-	-
Tax	1,180	-	1,139	-
Payments received on account	-	-	-	-
Other payables and accruals	102,693	-	61,734	-
Total Trade & Other Payables	**376,755**	**-**	**444,636**	**-**
Total current and non-current	**376,755**		**444,636**	

Other payables and accruals include payments to General Practitioners under GP contracts.
Other payables include £5.474m outstanding pension contributions at 31 December 2025 (£5.426m at 31 March 2025).

12. Provisions

	Current 31 December 2025 £'000	**Non-current 31 December 2025 £'000**	Current 31 March 2025 £'000	Non-current 31 March 2025 £'000
Continuing care	1,760	-	1,760	-
Other	555	202	555	202
Total	**2,315**	**202**	**2,315**	**202**
Total current and non-current	**2,517**		**2,517**	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2025	**1,760**	**757**	**2,517**
Arising during the year	-	-	**-**
Utilised during the year	-	-	**-**
Reversed unused	-	-	**-**
Unwinding of discount	-	-	**-**
Change in discount rate	-	-	**-**
Transfer (to) from other public sector body	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	**-**
Balance at 31 December 2025	**1,760**	**757**	**2,517**
Expected timing of cash flows:			
Within one year	1,760	555	**2,315**
Between one and five years	-	202	**202**
After five years	-	-	**-**
Balance at 31 December 2025	**1,760**	**757**	**2,517**

Other provisions include dilapidations costs associated with NHS GM's estate.

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13. Commitments

13.1 Other financial commitments

NHS GM has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	December 2025-26 £'000	2024-25 £'000
In not more than one year	702	702
In more than one year but not more than five years	2,807	2,807
In more than five years	12,454	12,980
Total	**15,963**	**16,489**

In addition to the above, NHS GM is committed to funding the cost of the estate which NHS Property Services and Community Health Partnerships inherited from the former NHS Primary Care Trusts within Greater Manchester. NHS GM works with the property companies to maximise utilisation, but where the property companies do not recover the full cost of the estate, NHS GM is charged. The amount which NHS GM is charged varies each year dependent upon occupation and a value of the future liability cannot be reliably estimated. These assets are not considered to be leased, as NHS GM does not have control of a defined space, which rests with the relevant property company.

14. Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

As NHS GM is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

Working capital management operations are carried out by the finance department, within parameters defined formally within NHS GM's standing financial instructions and policies agreed by the Board.

14.1.1 Currency risk

NHS GM is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. NHS GM has no overseas operations and therefore has low exposure to currency rate fluctuations.

14.1.2 Interest rate risk

Where NHS GM borrows, it does so from government for capital expenditure, subject to affordability as confirmed by NHS England. Therefore, NHS GM has low exposure to interest rate fluctuations.

14.1.3 Credit risk

As the majority of NHS GM revenue is parliamentary funding, the organisation has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in Note 8 trade and other receivables.

14.1.4 Liquidity risk

NHS GM is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. NHS GM draws down cash to cover expenditure, as the need arises. The organisation is therefore not exposed to significant liquidity risks.

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14.1.5 Financial Instruments

As the cash requirements of NHS GM are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS GM's expected purchase and usage requirements, and NHS GM is therefore exposed to little credit, liquidity or market risk.

14.2 Financial assets

	Financial Assets measured at amortised cost 31 December 2025 £'000	Financial Assets measured at amortised cost 31 March 2025 £'000
Loans receivable with group bodies	-	-
Loans receivable with external bodies	-	-
Trade and other receivables with NHSE bodies	395	1,093
Trade and other receivables with other DHSC group bodies	585	1,254
Trade and other receivables with external bodies	9,249	13,103
Other financial assets	1,106	1,106
Cash and cash equivalents	(11,095)	1,112
Total	**240**	**17,668**
Items not classed as financial instruments	57,140	18,556
Total	**57,380**	**36,224**
Relevant items as per Statement of Financial Position		
Other Financial Assets	1,106	1,106
Trade and other receivables	67,369	34,006
Cash and cash equivalents	(11,095)	1,112
Total	**57,380**	**36,224**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 December 2025 £'000	Financial Liabilities measured at amortised cost 31 March 2025 £'000
Loans with group bodies	-	-
Loans with external bodies	-	-
Trade and other payables with NHSE bodies	215	1,431
Trade and other payables with other DHSC group bodies	8,086	102,448
Trade and other payables with external bodies	364,804	338,198
Other financial liabilities	-	-
Private Finance Initiative and finance lease obligations	7,043	7,833
Total	**380,148**	**449,910**

Items not classified as financial liabilities	3,649	2,559
Total	**383,797**	**452,469**
Relevant items as per Statement of Financial Position		
Trade and other payables	376,754	444,636
Current lease liabilities	1,038	1,028
Non-current lease liabilities	6,005	6,805
Total	**383,797**	**452,469**

15. Joint arrangements - interests in joint operations

NHS GM has entered in to Pooled Budget arrangements with each of the local authorities within Greater Manchester under the provisions of Section 75 of the NHS Act 2006.

A pooled budget allows NHS GM and the local authority to co-ordinate expenditure to maximise the benefit of that spend to patients and residents, allowing for joined up services to be commissioned and provided.

Each of the pooled budgets are different, and this is reflected in the pooling agreement (the "Section 75 Agreement") between NHS GM and each individual Local Authority.

The scope of each pooled budget is as agreed with each Local Authority, but all agreements include for the pooling of resources through the Better Care Fund as mandated by NHS England.

The common objectives of the pooled budgets are to promote joint and co-ordinated working between NHS GM and the relevant Local Authority.

NHS GM's share of expenditure of the pooled funds is recorded in Note 5 (operational expenditure) to these financial statements.

This includes where funding is provided to a Local Authority to deliver services within a Local Authority hosted element of a pooled budget, which is also shown as expenditure in Note 5.

Where NHS GM administers a pooled budget on behalf of the partners, net accounting is adopted, meaning Note 5 to these accounts only shows the expenditure of NHS GM, and excludes expenditure formally incurred by the Local Authority, but hosted by NHS GM.

More details on the Local Authority's share of expenditure from the pooled funds can be found in the annual accounts of each local authority.

The tables below provide a summary of the spend within each of the pooled budgets and the hosting arrangements.

Note, pooled budget information has not been prepared at December 2025, therefore the tables and text below have not been updated.

9 months to 31st December 2025	Bolton MBC	Bury MBC	Rochdale MBC	Manchester City Council	Oldham MBC	Salford City Council	Stockport MBC	Tameside MBC	Trafford MBC	Wigan MBC
Host of pool	Both	Both	Both	Both	Both	NHS GM	Both	Both	Both	Both
Gross or Net Accounting	Net	Net	Net	Net	Net	Net	Net	Net	Net	Net
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS GM contributions to pooled budget recorded in NHS GM's accounts										
NHS GM expenditure from pooled budget recorded in NHS GM's accounts										
Total contributions to pooled budget										
Total expenditure from pooled budget										
Amounts owed to/(by) NHS GM in respect of pooled budget										

12 months to 31st March 2025	Bolton MBC	Bury MBC	Rochdale MBC	Manchester City Council	Oldham MBC	Salford City Council	Stockport MBC	Tameside MBC	Trafford MBC	Wigan MBC
Host of pool	Both	Both	Both	Both	Both	NHS GM	Both	Both	Both	Both
Gross or Net Accounting	Net	Net	Net	Net	Net	Net	Net	Net	Net	Net
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS GM contributions to pooled budget recorded in NHS GM's accounts	35,650	78,380	60,355	65,295	25,537	91,180	29,892	24,076	25,860	35,062
NHS GM expenditure from pooled budget recorded in NHS GM's accounts	35,650	78,380	60,355	65,295	25,537	91,180	29,892	24,076	25,860	35,062
Total contributions to pooled budget	61,715	217.522	244,409	113,716	44,079	343,234	45,530	42,710	73,678	60,710
Total expenditure from pooled budget	61,715	217.522	244,409	113,716	44,079	343,234	45,530	42,710	73,678	60,710
Amounts owed to/(by) NHS GM in respect of pooled budget	-	-	-	-	-	(860)	-	-	-	-

15.1 Pooled Budget arrangements with Bolton Metropolitan Borough Council

A pooled budget exists between NHS GM and Bolton MBC known as the Bolton Better Care Fund (BCF). The pooled budget covers both health care spend (hosted by NHS GM), and social care spend (hosted by the Council).

The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The section 75 arrangements do not provide for risk sharing between the organisations. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £35.650m, (2024: £34.015m), of the total value of the pool of £61.715m (2024: £58.081m).

15.2 Pooled Budget arrangements with Bury Metropolitan Borough Council

A pooled budget exists between NHS GM and Bury MBC known as the Bury Integrated Commissioning Fund (ICF) pooled budget.

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The purpose of the pool is to support integrated health and social care. Commissioning decisions are made by the Bury Locality Board whose voting rights on matters pertaining to the pooled budget are made up of equal numbers of NHS and Council representatives.

The pooled budget covers services under the headings of Primary Care Services, Secondary Care Services (where expenditure is incurred by NHS GM) and Communities & Adult Social Care (where expenditure is incurred by the Council). The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis.

Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner. The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £78.380m (12-month period to 31st March 2024: £111.172m) of the total value of the pool of £217.522m (2024: £214.919m).

The value of the NHS GM contribution to the pool has reduced in 2024-25, principally due to prescribing expenditure being excluded from the pool.

15.3 Pooled Budget arrangements with Rochdale Metropolitan Borough Council

There are two pooled budgets between NHS GM and Rochdale Borough Council known as the Rochdale Health & Social Care Pooled Fund, and the Rochdale Health & Social Care Better Care Fund.

These are both governed by the Rochdale Locality Board.

Firstly, the Rochdale Health & Social Care Better Care Fund relating to the Commissioning of Integrated Health and Social Care Services. The purpose of this arrangement is to enable joint design, development, procurement, and monitoring of services for local people. This pool contains expenditure relating to services covered by the Better Care Fund. The fund is hosted by the Council and monitored through regular reports to the Locality Board

Each organisation is responsible for over or underspends in respect of services where it has commissioning responsibility. The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

There are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £22.262m (12-month period to 31st March 2024: £21.069m), of the total value of the pool of £34.917m (2024: £33.724m).

Secondly, a pooled budget exists between NHS GM and Rochdale MBC known as the pooled budget for the provision of All Age Health and Social Care Services.

The purpose of this arrangement is to enable joint design, development, procurement, and monitoring of services for local people. This pool contains expenditure relating to services in addition to those covered by the Better Care Fund. The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £38.093m (12-month period to 31st March 2024: £82.084m), of the total value of the pool of £209.5m (2024: £228.1m).

The value of the NHS GM contribution to the pool has reduced in 2024-25, principally due to prescribing expenditure being excluded from the pool.

15.4 Pooled Budget arrangements with Manchester City Council

A pooled budget exists between NHS GM and Manchester City Council covering the Better Care Fund pooled budget for Manchester. The Manchester Health and Wellbeing Board has strategic oversight of the pooled budget.

The aims and benefits of the partners in entering into this agreement are to:

- improve the quality and efficiency of the services in scope.
- meet the Local Objectives and the National Conditions which are as follows:
    - deliver a jointly agreed plan between the partners, signed off by the Health and Wellbeing Board.
    - ensure that NHS GM's financial contribution to adult social care is maintained in line with the uplift to NHS GM's minimum contribution.
    - investing in NHS-commissioned out-of-hospital services, and
    - delivering a plan for improving outcomes for people being discharged from hospital.
- make more effective use of resources through the establishment and maintenance of the BCF Pooled Fund for revenue expenditure on the Services.

The pooled budget covers both health care spend (commissioned by NHS GM), and social care spend (commissioned by the Council). The fund is jointly managed by the parties on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £65.295m (2024, £61.461m), of the total value of the £114.203m pool plan and of the £113.716m total expenditure (2024, £107.110m).

15.5 Pooled Budget arrangements with Oldham Metropolitan Borough Council

A pooled budget exists between NHS GM and Oldham MBC with the decision-making body being the Oldham Integrated Care Partnership Committee.

The purpose of the pool is to ensure the provision of services to support reduced hospital admissions and length of stay, building on the aims and objectives of the Partners in entering the Agreement to:

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- improve the quality and efficiency of service provision.
- meet the National Conditions of funding streams, such as the Better Care Fund and Local Objectives.
- make more effective use of resources through the establishment and maintenance of an aligned fund for revenue expenditure on services.
- ensure that people in Oldham will be independent, resilient, and self-caring so fewer people reach crisis point, and.
- to develop an integrated health and care system, for those that need it, that enables people to proactively manage their own care with the support of their family, community, and the right professionals at the right time in a joined-up system.

The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £25.537m (2024: £96.923m),of the total value of the pool of £44.079m (2024: £344.408m).

During the year 2024/25, NHS GM and Oldham Council reviewed the section 75 Agreement including the classification of items as pooled, pooled aligned and non-pooled, and the associated contributions made to the pooled budget. NHS GM elected to remove Prescribing expenditure from the pool, and Oldham Council to reclassify expenditure previously classified as "pool aligned" as non-pooled. Both organisations continue to incur the equivalent expenditure in 2024/25, however, this is now done outside of the pool. Information in respect of the expenditure is still mutually shared between the organisations under streamlined governance arrangements.

In 2023-24, a second pooled budget existed between NHS GM and Oldham MBC known as the Oldham Integrated Community Equipment Service pooled budget. This pool was hosted by Oldham MBC for the purposes of commissioning equipment to promote independent living. The Section 75 agreement allowed for the sharing of risk between the parties in proportion with their contributions to the pool, or as otherwise agreed.

During the year to 31st March 2024, NHS GM incurred expenditure of £0.951m, of the total value of the pool of £1.916m. No separate contributions were made in 2024-25 and the objectives of the pool are now fulfilled through a single pooled budget.

15.6 Pooled Budget arrangements with Salford City Council

NHS GM and Salford City Council have an integrated fund for health and social care services in Salford. NHS GM administers the integrated fund, which covers Adults Services, Public Health Services, Children's Services, and Primary Care Services. The Integrated Fund focuses on improving population health and inequalities along with improving outcomes and delivering safe, effective, and efficient services for the Salford population.

The Salford Integrated Care Partnership Committee governs the use of the pooled fund. A risk share exists between NHS GM and Salford City Council which covers all expenditure within the Integrated Fund. The partners have agreed that any under or overspends of the fund are apportioned between them for 2024/25 in line with planned contribution levels.

As at 31st March 2025, the net balance on the fund resulted in a creditor of £0.860m being owed to Salford City Council (2024:debtor of £6.698m recorded from Salford City Council).

During the year to 31st March 2025, NHS GM incurred expenditure of £91.180m (2024: £135.435m), of the total value of the pool of £343.234m (2024: £354.667m).

The value of the NHS GM contribution to the pool has reduced in 2024-25, principally due to prescribing expenditure being excluded from the pool.

15.7 Pooled Budget arrangements with Stockport Metropolitan Borough Council

A pooled budget exists between NHS GM and Stockport Metropolitan Borough Council, known as the Stockport Better Care Fund. This pooled funding aims to enhance partnership working between the organisations and deliver integrated and improved services for patients.

While the provisions within the Section 75 agreement establish joint control, the fund operates under lead commissioner arrangements. Under this structure, the nominated lead commissioner enters into legal contracts with providers, and the non-lead commissioner cedes control over the resulting contracts. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to or from the pool at the balance sheet date. Each organisation is responsible for any over or underspends related to the services it oversees as the lead commissioner.

For the year ending 31st March 2025, NHS GM incurred expenditure of £29.892 million (2023/24: £28.327 million). This includes £19.616 million contributed by NHS GM to support the Council in fulfilling its role as lead commissioner, from a total pool value of £45.530 million (2023/24: £39.400 million).

15.8 Pooled Budget arrangements with Tameside Metropolitan Borough Council

A pooled budget exists between NHS GM and Tameside MBC known as the Tameside Better Care Fund. The fund is jointly hosted by NHS GM and Tameside Council on a lead commissioner basis.

Each organisation is responsible for any over or under spends in respect of services where it is lead commissioner. The Section 75 agreement provides for risk sharing between the organisations, via mutual agreement, to manage pressures in either the health or care position.

During the year to 31st March 2025, NHS GM incurred expenditure of £24.076m (12-month period to 31st March 2024: £22.170m), of the total value of the pool of £42.710m (2024: £39.618m).

15.9 Pooled Budget arrangements with Trafford Metropolitan Borough Council

A pooled budget exists between NHS GM and Trafford Metropolitan Borough Council, incorporating the Better Care Fund, the Learning Difficulties (LD) Fund and the Discharge to Assess fund. The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well and independent and in control of their own care.

As per the S75 agreement, the Trafford Health & Wellbeing Board (H&WB), made up of Council and NHS GM locality representatives, is the group that governs the fund. The fund is jointly hosted by NHS GM and Trafford Council on a lead commissioner basis. Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.

The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £25.860m (2024: £24.093m), of the total value of the pool of £73.678m (2024: £70.016m).

15.10 Pooled Budget arrangements with Wigan Metropolitan Borough Council

A pooled budget exists between NHS GM and Wigan Metropolitan Borough Council known as the Wigan Better Care Fund pooled budget. The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well and independent and in control of their own care.

The Wigan Health and Wellbeing Board, made up of Wigan Council and NHS GM representatives, govern the use of the fund. The fund is jointly hosted by the Council and NHS GM on a lead commissioner basis.

Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner. The Section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the year to 31st March 2025, NHS GM incurred expenditure of £35.062m (2024: £32.256m), of the total value of the pool of £60.710m (2024: £55.680m).

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16. Related party transactions – not required at December 2025.

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Leigh Vallance (Bolton Hospice)	1,822	-	76	-
Dr Vishral Mehra (Gorton Medical Centre)	1,518	-	179	-

The Department of Health and Social Care is regarded as a related party. During the period, NHS GM has had a number of material transactions for which the Department is regarded as the parent Department, including:

Bolton NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Manchester University NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
North West Ambulance Service NHS Trust
Pennine Care NHS Foundation Trust
Stockport NHS Foundation Trust
Tameside & Glossop Integrated Care NHS Foundation Trust
The Christie NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
NHS England
NHS Pensions

Similarly, NHS GM considers the following Local Authorities to be related parties, on the grounds that they are under the common control of the UK Government. Further details of the pooled budget arrangements with these local authorities are included in Note 15 to these accounts.

Bolton Metropolitan Borough Council
Bury Metropolitan Borough Council
Manchester City Council
Oldham Metropolitan Borough Council
Rochdale Metropolitan Borough Council
Salford City Council
Stockport Metropolitan Borough Council
Tameside Metropolitan Borough Council
Trafford Metropolitan Borough Council
Wigan Metropolitan Borough Council

17. Events after the end of the reporting period

NHS Greater Manchester has no items which are considered as reportable events after the reporting period.

18. Financial performance targets

NHS GM has a number of financial duties under the NHS Act 2006 (as amended).
NHS GM's performance against those duties was as follows:

	2025-26 Forecast Target	**2025-26 Forecast Performance**	**2025-26 Target met?**	2024-25 Target	2024-25 Performance	2024-25 Target met?
Expenditure not to exceed income	9,346,667	9,354,167	No	8,797,933	8,853,909	No
Capital resource use does not exceed the amount specified in Directions	-	-	n/a	143	143	Yes
Revenue resource use does not exceed the amount specified in Directions	9,237,777	9,245,277	No	8,686,687	8,742,663	No
Revenue administration resource use does not exceed the amount specified in Directions	46,375	46,375	Yes	56,045	54,952	Yes

As can be seen from the position reported above, NHS GM has failed the two statutory duties on maintaining costs within the funding available. This will result in a Section 30 letter being issued by external audit to the Secretary of State.

19. Operating Segments

NHS GM has reviewed its operations and concluded that it has one operating segment, for the commissioning of healthcare, therefore a segmental reporting analysis is not provided.

20. Losses and special payments

20.1 Losses

In 2025-26, NHS GM did not incur any losses (2024-25: 5 losses, £13k).

20.2 Special payments

In 2025-26, NHS GM made one special payment of £2k (2024-25: no special payments, £nil).

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Debtors Position Update Month 11 (February 2026)

2025-2026

Part of Greater Manchester
Integrated Care Partnership

Audit Committee

19 March 2026

Required information.	Details.
Title of report.	Debtors Position Update Month 11 (Feb 2026).
Author.	Tony Crossland – Finance Advisor.
Presented by.	Kaye Abbott – Associate Director of Finance – Financial Control.
Contact for further information.	Kaye Abbott – Associate Director of Finance – Financial Control. kayeabbott@nhs.net
Executive summary.	This paper updates the Audit Committee on the total level of debt due to the organisation (£27.6m) and specifically the debt values over 90 days (£1.7m). The paper also covers the value of the bad debt provision (£0.9m) and includes credit notes raised in the period.
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 Audit Committee is asked to: 1. Note NHS GM's debtor position at the end of February 2026. 2. Note the ongoing actions by the finance team to collect outstanding debt. 3. Note the information presented relating to credit notes.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	N/a.
Key milestones.	N/a.
Leadership and governance arrangements.	The paper has been agreed by the Corporate Director of Operational Finance – Financial Management.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The paper has been agreed by the Corporate Director of Operational Finance – Financial Management.
Financial or Legal Implications	The report presents the current level of debt and the provision value to cover the risk of non-NHS debtors not being recovered. There are no specific legal implications of the report.

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

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

Table 2: Assurance needed about the document.

Introduction

1.1. The paper is presented to update the Audit Committee on the level of debtors for NHS Greater Manchester (NHS GM) as at the end of February 2026, the level of the existing bad debt provision and the value of credit notes raised in the period

Debt Detail

1.2. The total value of debtors outstanding is £27.6m, of which £1.7m (6.2%) has been outstanding over 90 days. Since the last audit committee report (October 2025), the overall debt has increased by £0.8m and the 90 days overdue debt has decreased by £0.1m.

1.3. The current total debtor is summarised in Table 1 and consists of:

- £27.2m relating to non-NHS organisations
- £0.4m relating to NHS bodies

Table 1: Total Debt Summary

	Debtors Not Yet Due £'000	Debtors 1-30 Days £'000	Debtors 31-60 Days £'000	Debtors 61-90 Days £'000	Debtors 121-180 Days £'000	Debtors 181-360 Days £'000	Debtors 361+ Days £'000	Debtors Total £'000
NHS bodies	162	0	60	0	19	81	77	399
Non-NHS bodies	23,446	1,504	275	486	48	547	886	27,192
Total	**23,608**	**1,504**	**335**	**486**	**67**	**628**	**963**	**27,591**

Non-NHS Debt

1.4. The total non-NHS debt is £27.2m, of which £1.5m is over 90 days overdue and is analysed in Table 2.

Table 2: Summary of non-NHS debt by debtor category.

	Debtors Not Yet Due £'000	Debtors 1-30 Days £'000	Debtors 31-60 Days £'000	Debtors 61-90 Days £'000	Debtors 121-180 Days £'000	Debtors 181-360 Days £'000	Debtors 361+ Days £'000	Debtors Total £'000
Local Authorities	23,126	310	261	303	46	185	170	24,401
Non NHS Health Bodies	0	20	0	5	2	24	49	100
Non-NHS Companies	209	1,171	14	0	0	338	652	2,384
Individuals	110	3	0	178	1	0	15	307
Total	**23,445**	**1,504**	**275**	**486**	**49**	**547**	**886**	**27,192**

1.5. The main elements of the non-NHS £1.5m over 90-day debt are as follows:

- Non-NHS Companies debt accounts for £1.0m of the £1.5m outstanding debt, of which:

  - £0.6m relates to dental contractual payments where activity is below contract, the main elements are:
    - A dental debt of £0.4m, previously reported to Audit Committee, where the dentist has been declared insolvent, with liquidation procedures on-going.
    - £0.1m relates to a dental practice previously reported to the Audit Committee, with an agreed 30-month repayment plan in place which is being adhered to. The repayments to date cover 17 months of the plan.
  - £0.1m relates to a home care provider previously reported to the Audit Committee, which is being offset by care costs. To date £52k has been recovered.
  - £0.3m relates to an optician who is under investigation by NHS Counter Fraud.
  - A small balance remains and is accounted for over 19 organisations.
- Local Authority debt accounts for £0.4m of the £1.5m overdue debt. As reported at the December Audit Committee, Bury Council are disputing invoices from NHS GM, the value of which is £0.37m. The locality is liaising with the Council to resolve.
- Non-NHS Health Bodies overdue debt accounts for £75k of the total debt, which relates to GPs. The largest element relates to one practice (£37k), with the remaining balance accounted for across four organisations. NHS GM continues to engage with these GP practices to secure recovery.

Allowance for Bad Debt

1.6. The current bad debt provision for 2025/26 is £0.9m, which is in line with the value in 2024/25.

1.7. The provision is calculated based on the following assumptions:

- Debts that are over 12 months old and not subject to a payment plan are provided in full
- The proportion of debts from the previous year end which have not been recovered is calculated for each category of debtors and then applied to the outstanding balance.
- Specific adjustments are then made to increase the provision for specific cases utilising the Financial Control team's knowledge of debtors' situations

1.8. The provision will be monitored for adequacy as year-end approaches.

NHS Debt

1.9. A breakdown of the over 90-day NHS debt totalling £0.18m is detailed in Table 3.

Table 3: Summary of NHS Debt over 90 Days

NHS Body	Total Debtors over 90 Days £'000
NHS England	146
Others	31
Total	**177**

1.10. £98k of the £146k debt relating to NHS England is due to a dispute regarding staff recharges for ICB staff who provide support to NHS England. ICB management have now resolved this with NHS England, and they have confirmed that payment will be made.

Activity

1.11. During November 2025 to February 2026, 317 invoices and credit notes were raised, totalling £103.0m of net debt. It should be noted that much of this relates to recharge elements and therefore does not feature as income in NHS GM's accounts, but instead as credits to offset expenditure.

Credit Notes

1.12. Table 4 summarises the credit notes raised during the period. These did not impact on the month end reported position as they were adjusted during the month end reporting in advance of the credit note being raised.

Table 4: Summary of Credit Notes

Reason for Credit Note	Number of Credit Notes	Amount £	Replacement Invoice raised if applicable
Incorrect Value	1	(190,242)	No
Duplicate Invoice	4	(203,135)	No
Service/Goods not provided	1	(6,500)	No
Recovered through Accounts Payable	2	(14,776)	No
Incorrect Customer	3	(12,136)	Yes
Total	11	**(426,789)**	

Recommendations

1.13. The NHS GM Audit Committee is asked to:

- Note NHS GM's debtor position at the end of February 2026.
- Note on-going actions by the finance team to collect outstanding debt.
- Note the information presented relating to credit notes.

Procurement Update Report March 2026

Part of Greater Manchester Integrated Care Partnership

Audit Committee

March 2026

Required information.	Details.
Title of report.	Procurement Update Report – March 2026
Author.	Stuart Moore – Head of Market Management
Presented by.	Sam Evans - Corporate Director of Finance – Commissioning & Financial Assurance Izhar Chaudhary - Associate Director of Finance- Financial Assurance
Contact for further information.	Stuart Moore – Head of Market Management stuart.moore2@nhs.net
Executive summary.	Highlight to the Audit Committee: 1. The volume of waivers that have been completed and submitted for approval in accordance with the Standing Financial Instructions, Financial Scheme of Delegation and Procurement Policy. For the period December 2025 to February 2026. 2. Summary update on the number of waivers approved in 2025/26. 3. Decision-Making Records (DMR) completed since the process commenced in January 2024 up to the end of February 2026.
The benefits that the population of Greater Manchester will experience.	Ensure goods and services are procured compliantly.

How health inequalities will be reduced in Greater Manchester's communities.	Compliant contracts that have been through appropriate legislative procurement processes that deliver against quality service specifications and provide VFM will provide better health outcomes to all persons across all communities.
The decision to be made and/or input sought.	The Audit Committee is asked to note: 1. The number of waivers that have been submitted for authorisation and the ongoing work of the service to advise and support alternative procurement solutions when a waiver may not be required. 2. The number of waivers completed in the financial year 2025/26. 3. The number of DMRs completed and the classification of decisions for the period 2024/25 and 2025/6.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Helps deliver Healthcare & Non-Healthcare services compliantly and the delivery of CIP targets.
Key milestones.	N/A
Leadership and governance arrangements.	Audit Committee
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Reviewed by S.Evans & I.Chaudhary

Financial or Legal Implications	Adherence to NHS GM's Standing Financial Instructions (SFIs) and Financial Scheme of Delegation (FSOD) is paramount in ensuring appropriate governance and accountability in procuring goods and services. Waivers must be authorised strictly in line with these frameworks, requiring appropriate sign-off by designated budget holders, finance officers, the Head of Procurement, and the Executive, as applicable. This structured approach safeguards financial integrity, ensures transparency, and upholds the principles of value for money and regulatory compliance across NHS GM operations.

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	Yes	No	Yes	Yes

Table 2: Assurance needed about the document.

Purpose of Report

The purpose of this report is to highlight to the Audit Committee:

1. The volume of waivers that have been completed and submitted for approval in accordance with the Standing Financial Instructions, Financial Scheme of Delegation and the Procurement policy for the period December 2025 to February 2026.
2. A summary update on the number of waivers approved in 2025/26.
3. Decision-Making Records (DMR) completed since the process commenced in January 2024 up to the end of February 2026.

Waivers Completed for the Period December 2025 to February 2026

1.0 Eighteen (18) waiver requests have been submitted for Executive approval during the period December 2025 to the end of February 2026. An extract from the register can be found below. A separate appendix has been provided to members which includes a description of the service, additional comments from the procurement team and the authoriser.

2.0 Key Points to Note

There has been an increase of four (4) waivers compared with the previous reporting period from September 2025 to the end of November 2025. The appendix has been updated in response to the Audit Committee's request and now includes a revised version of the register that highlights key areas of focus, together with additional commentary from Procurement Leads and authorised NHS GM Executive signatories.

It should be noted that, although the number of waivers processed has increased, there has been a concerted effort to ensure that procurements are undertaken through established frameworks wherever possible, including towards the end of the financial year. As a result, there has been an increase in the number of procurements particularly IT services being processed via frameworks such as Crown Commercial Solutions (CCS),

G-Cloud, NHS Shared Business Services (NHS SBS) and North of England Procurement Collaborative (NOEPC).

3.0 Total number of waivers: 18

Reference	Provider Name	Start Date	End Date	Financial Value / Impact £	Approved Yes / No
NHSGM-WR442	CLINISYS	01.04.2025	31.03.2026	22,884	Yes
NHSGM-WR443	Arden & GEM CSU	01.04.2025	31.03.2027	2,086,243	Yes
NHSGM-WR444	Bolton GP Partnership Ltd	01.04.2025	31.03.2026	680,000	Yes
NHSGM-WR445	Bolton GP Partnership Ltd	01.04.2025	31.03.2026	2,750,000	Yes
NHSGM-WR446	Airelogic	01.04.2025	31.03.2026	228,000	Yes
NHSGM-WR447	EFL in the Community Trust	01.04.2025	31.03.2026	85,000	Yes
NHSGM-WR448	Plane Sailing	01.04.2025	31.03.2026	177,800	Yes
NHSGM-WR449	23 Ltd Smoke Free App	01.04.2025	31.03.2026	410,199	Yes
NHSGM-WR450	BT	02/02/2026	31/03/2027	27,132	Yes
NHSGM-WR451	Manchester Camerata	01.04.2025	31.03.2026	108,000	Yes
NHSGM-WR452	Live Well Communities Fund	26.01.2026	25.01.2027	300,000	Yes
NHSGM-WR453	Leicestershire Partnership NHS Trust	01.03.2026	28.02.2027	18,906	Yes
NHSGM-WR454	Viaduct Care CIC	01.04.2026	31.03.2027	217,502	Yes
NHSGM-WR455	Stockport MBC	01.04.2025	31.03.2026	130,000	Yes
NHSGM-WR456	One Identity	02.02.2026	31.03.2029	81,084	Yes

NHSGM-WR457	The Regional Drug and Therapeutics Centre (RDTC),	01.04.2025	31.03.2027	400,000	Yes
NHSGM-WR458	PrescQIPP CIC	01.04.2025	31.03.2027	180,018	Yes
NHSGM-WR459	Amwell	01.04.2026	31.03.2029	3,244,288	Yes
		Total Value of Waivers Processed		**11,147,056**	

Twelve (12) retrospective waivers have been recorded with an effective start date of 1 April 2025. The majority of these were required to facilitate payment for services that had already commenced and were being delivered prior to the completion of the appropriate procurement processes.

The Procurement Team has continued to deliver targeted training sessions to Localities and operational teams to reduce the occurrence of retrospective waivers and waivers in general. These sessions reinforce the requirement to utilise approved procurement frameworks where applicable and to undertake full procurement exercises in line with the NHS Greater Manchester Standing Financial Instructions (SFIs). In addition, the team hosts four weekly procurement clinics on Thursday afternoons to encourage NHS GM staff to engage with Procurement at the earliest opportunity and ensure that appropriate and compliant procurement processes are followed wherever possible.

We have also reinforced the importance of Service Leads having a clear understanding of the relevant governance processes (STAR / FSOD) and ensuring these are incorporated into future service planning and delivery timelines.

Following the December Audit Committee meeting, this message was further reinforced with Chief Officers to ensure appropriate accountability and oversight in order to minimise unnecessary waiver requests. Procurement clinics continue to emphasise that waivers should not be considered a default option and should only be used in exceptional circumstances.

Summary Update on the Number of Waivers Approved in 2025/26

Waivers:

To date in 2025/26, a total of **65** waivers have been authorised.

Key issues identified during the initial waiver review process, include the frequent absence of required STAR and Financial Scheme of Delegation (FSOD) approvals to support submissions and non-compliance with governance protocols, specifically, the omission of budget holder and financial officer signatures.

Additionally, there has been a recurring lack of embedded supporting documentation, such as relevant committee papers, and in many cases, the rationale provided has been insufficient to justify the waiver request.

This financial year NHS GM made amendments to the Waiver threshold for low value contracts. From 1st April 2025, a waiver will not be required to directly award a contract to a supplier, where expenditure is less than £20,000.

This has had an impact on the number of waivers submitted so far, this financial year, during the same accounting period in 2024/25 there were 128 waivers submitted, therefore a reduction of 63 waivers over the same period for 2025/26. Although this reduction in volume isn't purely in relation to waivers being submitted below £20k, it is a contributing factor.

Summary Update Decision-Making Records (DMR) Approved Since the Implementation of PSR

Decision Making Records:

Since the inception of the Provider Selection Regime (PSR) on the 1st January 2024, a total of **181** Decision-Making Records (DMRs) have been authorised to support the compliant commissioning of healthcare services. **84** were recorded in the Financial Year 2024/25 and to date this Financial Year we have had a further **97**. At the time of this report, we still expect to receive a significant number of Decision-Making Records for review before the financial year end.

The PSR information outlined in the below tables is required to be published by NHS GM on an annual basis.

Section number	Requirements	Comments
1	number of contracts directly awarded under direct award processes A, B or C	Direct Award Process A - 10 Direct Award Process B - 9 Direct Award Process C - 55 Total - 84
2	number of contracts awarded under the most suitable provider process	0
3	number of contracts awarded under the competitive process	2
4	number of framework agreements concluded	0
5	number of contracts awarded based on a framework agreement	0
6	number of urgent contracts awarded and urgent modifications	Urgent Award - 5 Contract Modification - 3 Total - 8
7	details of representations received, including:	
a	the number of representations received in writing and during the standstill period in accordance with Regulation 12(3)	0
b	summary of the outcome of all representations received and of the nature and impact of those representations.	n/a

84 Decision Making Records were recorded from the implementation of the PSR regulations on the 1st January 2024 to 31st March 2025. Please be advised that the first Decision Making Record was authorised in July 2024 - these are broken down below:

No representations were received in the financial year 2024/2025.

97 Decision Making Records were recorded in the Financial Year 2025/26 – these are broken down below:

Section number	Requirements	Comments
1	number of contracts directly awarded under direct award processes A, B or C	Direct Award Process A - 12 Direct Award Process B - 8 Direct Award Process C - 69 Total - 89
2	number of contracts awarded under the most suitable provider process	0
3	number of contracts awarded under the competitive process	3
4	number of framework agreements concluded	0
5	number of contracts awarded based on a framework agreement	0
6	number of urgent contracts awarded and urgent modifications	Urgent Award - 5 Contract Modification - 0 Total - 5
7	number of new providers awarded contracts	41
8	number of providers who ceased to hold any contracts with the relevant authority	11

9	details of representations received, including:	
a	the number of representations received in writing and during the standstill period in accordance with Regulation 12(3)	2 both in relation to the Community Dermatology Procurement
b	summary of the outcome of all representations received and of the nature and impact of those representations.	**Panel Advice** The Panel advised that NHS GM should return to Step 3 of the competitive process (assessment of offers received) to address issues identified in relation to the impact of the change in ownership of About Health. The Panel further advised that NHS GM may confine its reassessment to the relevant elements of About Health's offer, after obtaining sufficient information about the effect of the ownership change and then proceed through the remaining stages of the competitive process. **Current Position** Chief Officers and relevant teams are reviewing the Panel's advice and assessing the appropriate way forward. A further update will be provided once a decision has been made.
10	In addition, relevant authorities are expected to publish:	
a	total number of providers the relevant authority is currently contracted with	635
b	details of any reviews by the Independent Patient Choice and Procurement Panel:	**PSR Representation and Independent Panel Outcome** On 7 January 2025, NHS Greater Manchester (NHS GM) commenced a competitive process under the PSR to procure a Community Dermatology

		Service across five lots, with a total contract value of £44.3 million.(5 years (3+2 year contract)). Following a comprehensive evaluation process, on 12 August 2025 NHS GM published an intention to award notice confirming About Health Limited as the successful bidder for all five lots. **Challenge and Panel Referral** Two unsuccessful providers — Community Health and Eyecare Ltd (CHEC) and Health Harmonie Limited — submitted challenges, citing concerns regarding a change in control of the recommended provider. Health Harmonie Limited did not pursue its representation further following NHS GM's response. CHEC, however, sought additional clarification on two further occasions and, on 28 October 2025, formally requested advice from the Independent Patient Choice and Procurement Panel. The Panel accepted the case on 3 November 2025 and held a detailed review meeting on 1 December 2025. Its advice was published on 29 January 2026.
bi	number of requests for consideration received by the Independent Patient Choice and Procurement Panel	1
bii	number of requests accepted and rejected by the Independent Patient Choice and Procurement Panel for consideration	1 (Accepted)

biii	number of times where the Independent Patient Choice and Procurement Panel advised the relevant authority to re-run or go back to an earlier step in a provider selection process under the PSR, and the number of times the advice was followed.	1

To facilitate implementation and improve the quality of submissions, the Procurement team has delivered targeted training sessions for service leads and embedded comprehensive guidance notes within the DMR template. Despite these efforts, several recurring issues have emerged.

These include the absence of required STAR and FSOD approvals, confusion regarding whether a service falls under healthcare or non-healthcare classification, and limited understanding of the "considerable change" threshold and its correct application.

There has also been inconsistency in identifying the appropriate Direct Award route, particularly regarding Direct Award C and in the application and documentation of the five key criteria and the necessary supporting evidence. A significant operational concern has been the concentration of submissions toward the final two quarters of the financial year, which poses risks to quality and compliance.

Recommendations

4.0 The Audit Committee is asked to note:

- The number of waivers that have been submitted for authorisation and the ongoing work of the service to advise and support alternative procurement solutions when a waiver may not be required.
- The number of waivers completed in the financial year 2025/26.
- The number of DMRs completed and the classification of decisions reached for the period 2024/25 and 2025/6.

CONTACT OFFICER

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Use of Corporate Seal

19 March 2026

Part of Greater Manchester
Integrated Care Partnership

Audit Committee

19 March 2026

Report information.

Required information.	Details.
Title of report.	Use of Corporate Seal
Author.	Jenny Noble, Board Secretary
Presented by.	Chris Gaffey, Associate Director of Corporate Services
Contact for further information.	Jenny Noble, Board Secretary jenny.noble@nhs.net
Executive summary.	This report provides the Audit Committee with information relating to the execution of documents by NHS GM using the corporate seal since the previous meeting. NHS GM has a seal for executing documents where necessary, with the requirements to seal set out in the NHS GM Constitution. The Use of the Corporate Seal is a standing item on the Audit Committee agenda, and this report provides the Committee with information on the use of the corporate seal for the execution of documents since the previous meeting.
The benefits that the population of Greater Manchester will experience.	Ensuring robust governance arrangements are in place will ensure decisions are made with integrity, with the aim of benefiting the GM population.

How health inequalities will be reduced in Greater Manchester's communities.	Ensuring robust governance arrangements are in place will ensure decisions are made with integrity, with the aim of benefiting the GM population.
The decision to be made and/or input sought.	The Committee is asked to: 1. Note the contents of the report.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring robust governance arrangements are in place will ensure decisions are made with integrity, which will support the delivery of the ICP strategy.
Key milestones.	The corporate seal was last used for the execution of documents in March 2026.
Leadership and governance arrangements.	Audit Committee
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	Not applicable.
Financial or Legal Implications	The legal requirements to seal are set out in section two of this report.

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

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

Table 2: Assurance needed about the document.

Introduction

1.1 NHS GM has a seal for executing documents where necessary.

1.2 As per the NHS GM Constitution, the following individuals or officers are authorised to authenticate its use by their signature:

a) the Chief Executive
b) the Chair
c) the Chief Finance Officer

1.3 The following individuals are authorised to execute a document on behalf of the group by their signature:

a) the Chief Executive
b) the Chair
c) the Chief Finance Officer
d) other managers as per the Delegated Financial Limits

1.4 This report provides the Audit Committee with information relating to the execution of documents by NHS GM since its last meeting.

Requirement to Seal

1.5. It is a legal requirement to place any property transactions, e.g., purchase, sale, lease, under seal. Other contracts/ documentation should be approved by an authorised signatory 'under hand' i.e., signed.

1.6. Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer and authorised and countersigned by the Chief Operating Officer, or an officer nominated by them who shall not be within the originating directorate.

1.7. As a general guide, the following should be placed under seal:

- All contracts for the purchase/lease of land and/or building
- All contracts for capital works exceeding £100,000
- All lease agreements where the annual lease charge exceeds £10,000 per annum and the period of the lease exceeds beyond five years
- Any other lease agreement where the total payable under the lease exceeds £100,000
- Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000

1.8. The Accountable Officer or nominated representative shall keep a register, an entry of every sealing shall be made and numbered consecutively in a register provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. The digital register is maintained by the Corporate Services Team.

Use of Corporate Seal

1.9. The corporate seal was used to execute two documents since the previous Audit Committee meeting. The information relating to these are set out in Appendix A (entries 17 and 18) of this report for the Committee's information.

Recommendations

1.10. The Audit Committee is asked to:

- Note the contents of the report including next steps.

NHS Greater Manchester Integrated Care

REGISTER OF SEALED DOCUMENTS

	Date	Lead Officer	Document	Number of Copies	Between Parties	ICB Signatories (to 'use of the seal')
1	15/02/2023	Lyn Brankin	Shaw Crompton Scheme	2	NHS GM and the Partners of Oak Gables Practice	Sam Simpson/Mark Fisher
2	15/02/2023	Jo Larkin	Werneth PCC - ICB Subsidy Agreement Kapur Practice	2	NHS GM and the Partners of the Kapur Family Care	Sam Simpson/Mark Fisher
3	15/02/2023	Jo Larkin	Werneth PCC - ICB Subsidy Agreement Danson Practice	2	NHS GM and the Partners of the Danson Family Practice	Sam Simpson/Mark Fisher
4	11/12/2023	Jo Larkin	Deed of Accension - Manchester, Salford and Trafford NHS Lift Strategic Partnering Agreement	1	NHS GM and Foundation for Life Limited	Sam Simpson / Mark Fisher
5	11/12/2023	Jo Larkin	Deed of Accension - Bury, Tameside and Glossop NHS Lift Strategic Partnering Agreement	1	NHS GM and Foundation for Life Limited	Sam Simpson / Mark Fisher
6	11/12/2023	Jo Larkin	Deed of Accension - Ashton, Leigh and Wigan NHS Lift Strategic Partnering Agreement	1	NHS GM and Foundation for Life Limited	Sam Simpson / Mark Fisher
7	26/06/2024	Clare Postlewaite / Izhar Chaudhary	LIFT SPA agreement	1	The SPA, NHS GM and Manchester, salford and Trafford LIFT Company Limited	Kathy Roe / Mark Fisher
8	18/07/2024	Warren Heppolette	Shaw Crompton Scheme	2	NHS GM and the Partners for the Time Being of Oak Gables Partnership	Kathy Roe / Mark Fisher
9	18/07/2024	Warren Heppolette	Shaw Crompton Scheme	2	NHS GM and Hope Citidel Healthcare Community Interest Company	Kathy Roe / Mark Fisher
10	14/08/2024	Alistair Ross	North West EHealth Third Supplemental Investment Agreement	1	The Shareholders of North West Ehealth	Kathy Roe / Mark Fisher
11	14/08/2024	Alistair Ross	North West EHealth Amended and Restated Investment Agreement	1	The Shareholders of North West Ehealth	Kathy Roe / Mark Fisher
12	14/08/2024	Alistair Ross	North West EHealth Power of Attorney	1	ICB granting power of attorney to the Chair of North West EHealth	Kathy Roe / Mark Fisher
13	30/04/2025	Julie Powell	Grant Agreement Hawthorn GM	1	GM ICB, NHS England and Hope Citadel Healthcare CIC	Kathy Roe / Mark Fisher
14	30/04/2025	Julie Powell	Whitefields Grant Agreement	1	GM ICB, NHS England and Ifat Hussain	Kathy Roe / Mark Fisher
15	22/10/2025	Clare Postlewaite	Nye Bevan House	1	Community Health Partnerhsip Ltd and NHS GM ICB	Kathy Roe / Mark Fisher
16	26/11/2025	Karen Wonnacott	GMCA and GMICB licence agreement relating to the use of space within the building known as first floor Broadhurst House and second floor Lee House, Tootal Building	1	Greater Manchester Combined Authority	Kathy Roe / Mark Fisher
17	21/01/2026	Michelle Buls	Grant Agreement Seven Brooks Medical Centre	1	GM ICB, NHS England and Kung-Kim Chan and Toni Cooper	Kathy Roe / Colin Scales
18	04/03/2026	Karen Wonnacott	Grant Agreement Lockside Medical Centre	1	NHS England, GM ICB, Dr Richard Ian Bircher, Dr Joanna Theresa Bircher, Dr Rachel Edwards, Dr Adam Cliffe, Dr Emily Victoria Harvey and Dr Thomas McNevin Jones	Kathy Roe / Colin Scales

Audit Committee Workplan 2026/27									
	Executive	Lead Officer	13-Apr-26	17-Jun-26	17-Sep-26	17-Dec-26	Mar-27	Apr-27	Jun-27
Internal Audit									
Review and approve annual internal audit plan (2026/27)	Kathy Roe	Izhar Chaudhary	X						
Annual review of the effectiveness of internal audit	Kathy Roe	Izhar Chaudhary				X			
Receipt of Internal Audit Charter	Kathy Roe	Izhar Chaudhary	X					X	
Receive internal audit progress reports	Kathy Roe	Izhar Chaudhary	X	X	X	X	X	X	X
Receive internal audit follow up reports	Kathy Roe	Izhar Chaudhary		X	X	X	X		X
Draft Head of Internal Audit Opinion and Annual Report	Kathy Roe	Izhar Chaudhary	X				X	X	
Final Head of Internal Audit Opinion and Annual Report	Kathy Roe	Izhar Chaudhary		X					X
External Audit									
Agree external audit plans and fees	Kathy Roe	Kaye Abbott	X				X		
Review the effectiveness of external audit	Kathy Roe	Kaye Abbott			X				
Review external audit progress reports	Kathy Roe	Kaye Abbott		X		X			X
Receive the external auditor's report to those charged with governance	Kathy Roe	Kaye Abbott		X					X
Receive / consider the external auditor's annual report	Kathy Roe	Kaye Abbott			X				
Counter Fraud									
Review and approve the annual work plan for counter fraud activity	Kathy Roe	Izhar Chaudhary	X						
Review counter fraud progress reports	Kathy Roe	Izhar Chaudhary		X	X	X	X		X
Review the effectiveness of those carrying out counter fraud activity	Kathy Roe	Izhar Chaudhary				X			X
Receive the counter fraud annual report, including the self assessment against the fraud standards	Kathy Roe	Izhar Chaudhary		X					X
Governance									
Review and approve the Committee's Terms of Reference	Charlotte Bailey	Chris Gaffey	X					X	
Review the Board Assurance Framework (BAF)	Charlotte Bailey	Chris Gaffey					X		
Risk Management Update	Charlotte Bailey	Chris Gaffey	X		X	X	X	X	X
Risk Deep Dive	Charlotte Bailey	Chris Gaffey	X		X	X	X	X	X
Review the draft annual report (including Annual Governance Statement)	Charlotte Bailey	Chris Gaffey	X					X	
Approve the annual report (including Annual Governance Statement)	Charlotte Bailey	Chris Gaffey		X					X
Self-assess the committee's effectiveness	Chair	Chris Gaffey / Izhar Chaudhary				X			
Annual Report of the Audit Committee	Chair	Chris Gaffey / Izhar Chaudhary			X				
Whistleblowing Annual Report	Charlotte Bailey	Chris Gaffey		X					X
SIRO Report Update	Charlotte Bailey	Malcolm Whitehouse				X			
SIRO Annual Report	Charlotte Bailey	Malcolm Whitehouse			X				X
Corporate Policies	Relevant Exec	Relevant Lead Officer			X	X	X	X	X
Conflicts of Interest Annual Report	Charlotte Bailey	Chris Gaffey			X				
Financial Focus									
Internal / External Audit Provision beyond 2027/28	Kathy Roe	Izhar Chaudhary							X
Agree final annual report and accounts timetable and plans	Kathy Roe	Chris Gaffey / Kaye Abbott				X			
Review annual accounts progress	Kathy Roe	Kaye Abbott					X		
Review the draft annual accounts and financial statements	Kathy Roe	Kaye Abbott	X					X	
Approve the audited annual accounts and financial statements (including the external audit opinion)	Kathy Roe	Kaye Abbott		X					X
Review changes to standing financial instructions / prime financial policies and changes to accounting policies	Kathy Roe	Izhar Chaudhary	X				X	X	
Standing Items									
Debtors update	Kathy Roe	Kaye Abbott	X		X	X	X	X	X
Losses/ special payments	Kathy Roe	Kaye Abbott	X		X	X	X	X	X
Tender Waivers and Procurement Report	Kathy Roe	Izhar Chaudhary	X	X	X	X	X	X	X
Use of corporate seal	Colin Scales	Chris Gaffey	X		X	X	X	X	X
Conflicts of interest Guardian	Chair	Chris Gaffey	X	X	X	X	X	X	X
Board summary report (verbal)	Chair	Chris Gaffey	X	X	X	X	X	X	X
Reflections on the meeting	Chair	N/A	X	X	X	X	X	X	X
Private Meetings for Scheduling									
Private meeting Audit Committee members only	Chair	N/A	X	X	X	X	X	X	X
Private discussions with internal and counter fraud specialists	Chair	N/A	X		X		X		X

Private discussions with external auditors	Chair	N/A		X		X		X	