NHS Greater Manchester

Agenda

Greater Manchester Audit Committee Part A

Date: 17th June 2026

Time: 9.00am to 10.45am

Venue: Boardroom, The Tootal Buildings, 56 Oxford Street, Manchester M1 6EU

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	09:00	5 mins	Welcome, Introductions, Apologies including Attendance Matrix & Terms of Reference on a Page	Paper	Information	Chair
2.	09:00		Declarations of Interest	Paper	Information	All
3.	09:00		Minutes from the last meeting and matters arising	Paper	Approval	Chair
4.	09:00		Action Log	Paper	Discussion	Chair
Internal Audit						
5.	09:05	5 mins	Head of Internal Audit Opinion	Paper	Discussion	Darrell Davies
Counter Fraud						
6.	09:10	5 mins	Anti-Fraud Annual Report 2025/26	Paper	Discussion	Paul Bell
External Audit						
7.	09:15	25 mins	Annual Report and Accounts (including Annual Governance Statement) and Letter of Representation	Paper – to follow	Approval	Chris Gaffey / Kaye Abbott
8.	09:40	20 mins	External Audit Findings Report 25/26	Paper	Discussion	Grant Thornton
9.	10:00	20 mins	External Auditor's Annual Report 25/26	Paper	Discussion	Grant Thornton
Governance						
10.	10:20	5 mins	SIRO Report	Paper – to follow	Discussion	Shavarnah Purves
11.	10:25	5 mins	Anti-Fraud, Bribery and Corruption Policy	Paper	Approval	Izhar Chaudhary

Standing Items						
12.	10:30	5 mins	Standing Items: • Conflicts of Interest Guardian • Board Summary Report	Verbal Verbal	Information Information	Richard Paver All
13.	10:35	5 mins	Audit Committee Workplan	Paper	Information	Izhar Chaudhary
14.	10:40	5 mins	Any Other Business, reflections on the meeting and items for escalation to the Board	Verbal	Discussion	Chair
15.			Date and Time of Next Meetings: 17 September 2026, 10:00-13:00 MS Team (Virtual)	Verbal	Information	Chair

Tootal Buildings, 56 Oxford Street, Manchester M1 6EU
www.gmintegratedcare.org.uk

Item 1 - Audit Committee Attendance Matrix 2026-27

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-26	Jun-26	Sep-26	Dec-26	Mar-27
Richard Paver (Chair)	Non-Executive Director, Audit Committee Chair					
Anthony Hassall	Chief Executive, Pennine Care NHS Foundation Trust					
Sue Greenhill	Independent Member					
Jackie Njoroge	Independent Member					
Kathy Roe	Chief Finance Officer					
Charlotte Bailey	Chief, Strtagey People and Partnerships 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					
Michael Green	Grant Thornton External Auditors					

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
- 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)

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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.
Jackie	Njoroge	Independent Member	Y	01-03-26	Chief Strategy & Data Officer	University of Salford	Financial	Direct	2025	Ongoing	Y	To be declared in line with Conflict of Interest Policy and managed as required.
					Independent Non Exec	First Choice Homes Oldham	Financial	Direct	2025	Ongoing	Y	
					Independent Audit Committee Member	Greater Manchester Combined Authority	Financial	Direct	2025	Ongoing	Y	
					Trustee	Transforming Access & Student Outcome	Non-financial professional	Direct	2025	Ongoing	Y	
					Deputy Chair	Higher Education Strategic Planning Association	Non-financial professional	Direct	2025	Ongoing	Y	

Minutes

Greater Manchester Audit Committee (Part A)

Date: Thursday 23 April 2026

Time: 11.00am to 12.45pm

Venue: 5th Floor, Tootal Buildings, Manchester

Present		
Members:		
Richard Paver	RP	Non-Executive Director and Audit Committee Chair, NHS GM
Sue Greenhill	SG	Independent Member
Jackie Njoroge	JN	Senior Non-Executive Director, Vice Chair
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
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer, NHS GM
Chris Gaffey	CG	Associate Director of Corporate Services, NHS GM
Izhar Chaudhary	IC	Associate Director of Finance – Financial Assurance, NHS GM
Sam Evans	SE	Corporate Director of Finance – Commissioning & Financial Assurance, NHS GM
Jackie Gardiner	JG	Corporate Director of Operational Finance – Financial Management
Kaye Abbott	KA	Associate Director of Finance – Financial Control, NHS GM
Patrick Clark	PC	Senior Audit Manager, MIAA
Darrell Davies	DD	Regional Assurance Director, MIAA
Perminder Sethi	PS	Senior Manager, Grant Thornton
Ross Baxter	RB	Governance Advisor, NHS GM (minutes)
Apologies:		
Stephen Downs	SD	Deputy Chief Finance Officer, NHS GM
Paul Bell	PB	Head of Anti-Crime Services, MIAA
Michael Green	MG	Engagement Partner, Grant Thornton

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	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 19 March 2026 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. It was agreed that the Counter Fraud update (Action 127) would be brought to the September meeting.	
5.	Internal Audit Progress Report The Committee received and considered the Internal Audit Progress Report, noting progress since the previous update and the current status of the internal audit work plan. The internal audit team highlighted that the Specialised Commissioning review had been finalised and had received a Substantial Assurance rating, with one medium-risk and one low-risk recommendation identified, primarily relating to strengthened governance processes and improved risk monitoring. It was reported that, at the time of the meeting, six audit reviews were in progress, of which one had been finalised shortly prior to the meeting, leaving five reports outstanding. These covered a range of core areas including key financial controls, procurement, IT systems, system-wide assurance, the Assurance Framework, and risk management core controls. The Committee noted that fieldwork was ongoing for two reviews, including the DSPT review, which was nearing completion and expected to be reported to the Committee at the next meeting. The Committee was advised that the Data Quality review had experienced delays but that terms of reference had now been agreed, and an initial meeting had been scheduled to formally commence the work but had had to be postponed. Members emphasised the importance of agreeing and monitoring clear timelines for this review, expressing concern that further slippage could undermine assurance ahead of the external audit opinion. It was noted that data quality represented a recurring and material risk area with implications for	

	commissioning, planning, and decision-making. Members discussed the KPIs, particularly noting that progress in following up internal audit recommendations remained rated Amber. While some improvement was anticipated, the Committee reiterated the importance of timely completion and monitoring of agreed actions, particularly in the context of organisational transition. The Committee raised specific concern regarding two audit areas where draft briefing notes had been issued without a formal assurance rating. Members expressed dissatisfaction with this approach, noting that the absence of a clear assurance assessment limited the Committee's ability to understand the level of risk and assurance, particularly in relation to IT-related audits, which had been the subject of broader and ongoing risk discussions. The Committee requested that either formal assurance ratings be provided or, as a minimum, that the draft briefing notes be shared with members to enable appropriate scrutiny. The rationale for issuing briefing notes without assurance ratings was explained as relating to changes in personnel and ownership of recommendations. However, the Committee did not consider this fully satisfactory and requested that the internal audit team revisit the approach, particularly where findings were not positive or related to areas of heightened organisational risk. Discussion also covered the Assurance Framework review, with clarification provided that the assessment followed nationally mandated NHS England methodologies. It was noted that changes to the approach were anticipated in future audit years, and the Committee requested to be kept informed once this became clearer. In concluding the item, the Committee acknowledged overall progress against the audit plan but reiterated expectations around timeliness, clarity of assurance ratings, and transparency, particularly for high-risk areas such as IT and data quality. The importance of early visibility of audit findings during the transition period was emphasised to ensure that risks and recommendations could be addressed in a timely and proportionate manner. **NHS GM Audit Committee noted the contents of the report.**	
6.	<u>Annual Internal Audit Plan 2026/27 (including feedback from Chief Officers and Committee Chairs)</u> The Committee considered the proposed Annual Internal Audit Plan for 2026/27, noting that the paper presented reflected a revised version of the plan previously discussed, following further engagement with Chief Officers and Committee Chairs. It was confirmed that this additional consultation had been undertaken to refine the proposed scope of reviews and ensure alignment with organisational priorities and capacity. The Head of Internal Audit advised that the revised plan included the removal and amalgamation of a number of proposed audit reviews, together with the inclusion of a significant contingency allocation. This was intended to ensure the plan remained sufficiently flexible to respond to emerging risks, system pressures, and	

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	organisational change during the year. The Committee was asked to indicate whether it was content with the revised proposed coverage. It was also requested that approval in principle would enable internal audit work on Quarter 1 reviews to commence, alongside early discussions on terms of reference for Quarter 2 work. Members sought assurance regarding the removal of certain audit areas from the plan, requesting clarity on the rationale and the underlying risk considerations. It was acknowledged that there was not a single reason for all removals; rather, these reflected a combination of factors including duplication with other audits, the opportunity to expand the scope of retained reviews, and the timing and maturity of key strategies and programmes (for example, digital strategy), which were not considered ready for meaningful audit review within the proposed timeframe. It was noted that, while the Committee did not require full detail within the plan, it would be helpful to include brief narrative explanations against removed items to evidence that risks had been considered and consciously accepted. The Committee also discussed the achievability and deliverability of the plan in the context of significant organisational change and workforce pressures. It was recognised that the scale and pace of reform across Greater Manchester would inevitably impact audit capacity and management attention. While it was not possible to provide absolute assurance at this stage that all reviews could be delivered as planned, it was emphasised that the plan represented a realistic and proportionate assessment of what could be undertaken, with progress to be monitored closely throughout the year and the plan adjusted as necessary. It was confirmed that audits removed from the 2026/27 plan had not been discounted entirely but would instead be considered as part of the three-year strategic internal audit plan, with the intention that they could be revisited and re-profiled into future years should risks remain relevant. Members welcomed the increased emphasis on contingency capacity, noting this as a key strength of the proposed plan in light of uncertain future risks and the need for responsive assurance, particularly in relation to the reform programme. The Committee also highlighted the importance of ensuring that any significant new risks identified later in the year were surfaced early enough, ideally by September, to allow internal audit resource to be deployed effectively. In concluding the discussion, the Committee indicated that it was content with the direction and structure of the revised Annual Internal Audit Plan, subject to the inclusion of clearer explanatory narrative on removed audit areas and ongoing oversight of deliverability. It was agreed that the plan should be progressed on this basis, and with internal audit activity for Quarter 1 commencing in line with the proposals. **Action: CG to add discussion on this area to the Chief Officers meeting agenda, with a brief rational to be provided for audit areas removed from the proposed plan.** **NHS GM Audit Committee;** • **Confirmed the items proposed for audit reviews contained in the previous section for inclusion in the Internal Audit Plan for 2026/27**	

	• **Ensured the audits prioritised remain within the budgeted days allocated for 2026/27** • **Considered the suggestions put forward for audit reviews by the Committee Chairs and Non-Executive Directors for inclusion in the Internal Audit Plan** • **Noted that the current Internal Audit Plan is under committed by 45 days, which would be set aside as a contingency** • **Noted that the Internal Audit Plan would need to be reviewed in early September 2026 to ensure it remains fit for purpose taking into account the embedding of the new operating model and structures**	
7.	<u>Draft Head of Internal Audit Opinion</u> The Committee considered the Draft Head of Internal Audit Opinion, which summarised the results of internal audit work undertaken during 2025/26 and provided the overall annual assurance opinion. It was explained that the opinion was derived from three core elements: an assessment of the organisation's assurance framework and governance arrangements, consideration of the individual assurance ratings issued across completed audit reviews, and progress in implementing internal audit recommendations. The Head of Internal Audit reported that the overall opinion for 2025/26 was Substantial Assurance, representing the first occasion on which the ICB had received a substantial assurance rating since its establishment, having previously received moderate assurance. It was further noted that, while improvements had been observed across other ICBs in the North West, Greater Manchester's position was particularly strong by comparison. Members were advised that, across the year, three audits had received Moderate Assurance ratings, with no Limited Assurance opinions issued, and that those reviews still in draft were assessed as either substantial or moderate and therefore did not adversely impact the overall opinion. The Committee was assured that the assurance framework process had matured over the year and was operating effectively, albeit with some recommendations identified to further strengthen it, none of which were assessed as high risk. The Committee discussed how the Draft Opinion would contribute to the Annual Governance Statement, alongside other sources of assurance, and the extent to which it reflected organisational progress over recent years, particularly in the context of sustained system pressures and organisational change. While welcoming the improvement reflected in the audit opinion, members expressed caution and challenge, noting the continued existence of a significant number of outstanding audit recommendations, including some assessed as high risk, and queried how this reconciled with a substantial assurance rating. Concern was expressed that, despite improvements, the organisation had recently faced challenges in progressing actions and follow-up of recommendations, which could give rise to perceived tension between the headline opinion and operational reality. In response, the Head of Internal Audit explained that the opinion was based on	

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	the robustness of core controls, governance arrangements, and the outcomes of audits completed within the year, rather than solely on the volume of open recommendations. It was acknowledged that further work was required to review whether some outstanding recommendations remained relevant or had been superseded by organisational reform, and that clear decisions were needed to formally close or update such items. The Committee was also reassured that the opinion had been subject to MIAA internal moderation and quality review, including oversight by senior assurance directors, and considered proportionate within the wider regional context. Senior officers acknowledged the Committee's challenge, recognising that while significant improvement had been made, some weaknesses remained, particularly in relation to legacy recommendations and certain high-risk areas. However, it was emphasised that the substantial assurance opinion represented a notable milestone and a positive signal to the organisation, reflecting sustained effort to maintain governance and control through a particularly demanding period. Members agreed that the key challenge now was to maintain and embed this position during 2026/27, particularly in light of ongoing reform, reduced capacity, and further system change. The Committee also discussed the forthcoming External Quality Assessment of Internal Audit, noting that this had been completed and was in the final stages of report clearance. It was confirmed that the results would be shared with the Committee once finalised, either at the June meeting if timings allowed, or otherwise at the September meeting, with an offer to circulate the findings in advance. In concluding the item, the Committee acknowledged the achievement represented by the Substantial Assurance opinion, while emphasising that it should not lead to complacency. Members stressed the importance of continued focus on resolving outstanding recommendations, strengthening IT and control weaknesses, and ensuring that improvements were sustained throughout the transition period. **NHS GM Audit Committee noted the contents of the report.**	
8.	<u>MHIS Audit Findings</u> The Committee received and considered the MHIS Audit Findings for 2024/25, noting that this was the final year in which the audit would be presented in its current format. The external auditor confirmed that the audit work had been completed and the MHIS opinion had been signed off earlier in the week, with no issues arising from the review. Members were advised that the audit concluded that the ICB was compliant with the Mental Health Investment Standard for 2024/25. It was reported that there were no amendments required to the figures or disclosures included in the accounts, and that the relevant compliance statement had been provided and finalised. The Committee noted that the MHIS disclosures would be reflected both in the Annual Report and within the 2024/25 accounts, with confirmation provided of the relevant note reference. Going forward it will reflected in the 2025/26	

	accounts. The auditor reported on three recommendations carried forward from the prior year, noting that progress had been made against these. One recommendation had been partially implemented, with the remaining action relating to the completion of supporting working papers and documentary evidence, particularly in relation to Continuing Healthcare (CHC). It was confirmed that this final element had been included as an action within the current report. Members acknowledged the positive outcome and smooth conclusion of the audit, noting that the work had been completed without complication and provided appropriate assurance. The Committee further noted that, from 2025/26 onwards, MHIS compliance would be addressed through the main accounts and financial reporting process, rather than through a standalone audit report. A member expressed disappointment that MHIS audits would no longer be undertaken and reported formally in future years, highlighting that the requirement to demonstrate and report compliance had historically provided a valuable focus and assurance mechanism. It was noted that the MHIS process had helped to maintain visibility and accountability for mental health investment, and concern was expressed that the loss of a specific reporting requirement could reduce the emphasis placed on mental health funding over time. In response, it was acknowledged that while the formal audit requirement was ending, MHIS compliance would continue to be disclosed and monitored through statutory financial reporting arrangements. The Committee recognised the strength of feeling expressed and noted the importance of maintaining continued focus and transparency in relation to mental health investment, notwithstanding the change in reporting arrangements. In concluding the discussion, the Committee noted the MHIS Audit findings for 2024/25, welcomed the confirmation of compliance, and acknowledged both the assurance provided and the concerns raised regarding future visibility of mental health investment assurance. **NHS GM Audit Committee noted the achievement of the MHIS Standard in 2024/25.**	
9.	<u>External Audit Progress Report and Sector Update</u> The Committee received the Audit Progress Report and Sector Update from the external auditor and considered progress against the 2025/26 external audit programme, together with broader sector intelligence relevant to the ICB. It was reported that audit work was progressing as planned, with no significant issues or delays identified at that stage. Members noted reassurance that the audit team remained on track to complete their work in line with the agreed timetable. It was anticipated that the remaining elements of audit work, including those relating to local authority aspects, would be finalised in the coming weeks. The Committee discussed resourcing and capacity considerations, acknowledging that the ICB was operating within a challenging context of	

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	organisational change, staff turnover, and reduced capacity. It was noted that steps were being taken to prioritise audit activity appropriately, including the retention of key staff for longer handover periods where possible, to ensure continuity and minimise risk to audit delivery. Members highlighted the importance of knowledge retention and documentation, particularly in light of staff departures. The Committee emphasised the need for robust documentation of processes, judgements, and working practices to ensure that remaining and incoming staff were able to maintain continuity for year-end accounts, audit work, and associated reporting requirements. It was recognised that this extended beyond finance teams alone and included contributions from people, HR, and other service areas involved in the annual reporting process. The discussion referenced earlier consideration of organisational resilience, transition, and handover arrangements, noting that these issues continued to present a risk not only to the completion of the 2025/26 accounts, but also to the robustness of arrangements heading into 2026/27. It was noted that Executive leaders had been asked to take responsibility for ensuring appropriate transition planning within their respective portfolios, with messaging already issued to support this work. In providing a wider sector update, the external auditor advised that there was nothing emerging at that time which caused material concern for the Committee. Members were assured that any emerging issues, audit risks, or sector-wide developments with relevance to the ICB would be highlighted promptly. In concluding the discussion, the Committee noted the Audit Progress Report and Sector Update, took assurance that external audit work was progressing as expected, and reiterated the importance of continued focus on capacity, knowledge transfer, and documentation to support both current-year audit completion and future resilience. **NHS GM Audit Committee noted the update presented.**	
10.	<u>Risk Management Update</u> The Committee received the Risk Management Update, which was presented as a follow-up to the detailed risk deep dive undertaken at the previous meeting, focused on a Board Assurance Framework (BAF) strategic risk. Members noted that the paper was intended not to revisit the individual risk discussed previously, but to capture the key learning points from that session and set out how these would be used to strengthen risk management and reporting arrangements going forward. It was explained that the paper sought to reflect the Committee's feedback on how strategic risks should be articulated, monitored and assured, and proposed a number of improvements to the approach to risk reporting. Key themes highlighted included the need to move beyond process-based assurance towards a clearer focus on outcomes and impact, to strengthen the ownership and accountability of system-level risks, and to ensure that strategic risks were sufficiently prioritised and clearly defined, rather than being overly broad in scope.	

	The Committee noted the emphasis placed on improving the use of data, metrics and evaluation within risk reporting, to better demonstrate whether mitigating actions were effective and proportionate. Members also supported the proposal to align risk management more closely with the organisation's operating environment, recognising the scale and complexity of the system in which the ICB operates. The paper outlined proposed actions to strengthen the BAF, including the intention to apply the learning from the risk deep dive as part of the forthcoming refresh of strategic risks. It was confirmed that this work was already underway, with initial discussions planned with Chief Officers, followed by engagement with the Board to agree the revised BAF risks. Members noted that improvements would be iterative rather than delivered as a single exercise, with progress developing over time as risks were reviewed and refined. The Committee discussed the need for the risk refresh to extend beyond the BAF to include corporate and committee-level risks, acknowledging that some existing risks reflected responsibilities or system roles that had evolved or no longer sat fully with the ICB. The importance of ensuring that risks accurately reflected the organisation's current and future role, particularly as a strategic commissioner, was emphasised. Members highlighted the importance of clearly distinguishing between risks and issues, noting that some risks represented immediate operational issues requiring active management, while others related to longer-term strategic uncertainty. It was suggested that reintroducing clearer differentiation between risks and issues would support more effective oversight and prioritisation. The role of horizon scanning was also discussed, with members noting the importance of identifying emerging risks arising from policy change, government priorities, the wider economy and system pressures. While recognising that not all future challenges could be mitigated in advance, the Committee agreed that structured horizon scanning would support more informed and proactive risk management. The Committee emphasised the importance of clear communication and shared understanding of risk management expectations across the organisation. It was agreed that the learning from the risk deep dive and the proposed changes to risk reporting should be shared with other committees, the Board, and senior risk leads, to ensure consistency and support cultural change. The value of articulating a clear timetable and direction of travel for these improvements was also noted, to help manage expectations during a period of ongoing transition. In concluding the discussion, the Committee agreed that the paper provided an accurate reflection of the previous discussion and a helpful framework for improving risk management arrangements. Members endorsed the proposed direction of travel and supported the continued use of the learning from deep dives to strengthen the BAF and wider risk reporting over time.It was requested that the paper be shared widely as it would impact other Committees' consideration of Risks and Issues	

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	NHS GM Audit Committee considered the learning and next steps set out and agreed that it adequately reflected the key areas of focus and discussion at the March Audit Committee meeting.	
11.	<u>Draft Annual Report and Accounts (including Annual Governance Statement)</u> The Committee considered the Draft Annual Report and Accounts, noting that the draft submission had been circulated late due to dependencies on final information and audit inputs. It was confirmed that the statutory submission deadline was 9.00am on the following Monday, with the intention to complete outstanding updates and refinements before the end of April and to share a near-final version with the external auditors to enable the commencement of their work. The Committee was advised that the majority of the content had now been completed, with only a small number of minor gaps remaining. Members were invited to provide any comments on the draft to officers as soon as possible, to allow these to be incorporated ahead of finalisation. It was emphasised that formatting issues should be disregarded at this stage, as the document would be subject to further review by communications colleagues to improve accessibility, consistency and presentation, including the addition of appropriate front sheets and signposting. Officers reported that a further review of the Annual Report would be undertaken following the meeting to ensure that all recent feedback and updates had been reflected. It was confirmed that the pensions disclosure had now been updated, having not been finalised at the point of the previous draft, and that final checks were ongoing in relation to pooled budgets, with information still awaited from a small number of localities. Final checks were also being undertaken on the staff and remuneration disclosures to ensure completeness and accuracy. Members raised a number of specific points of clarification and challenge on the draft content. It was noted that the organisational structure chart appeared to omit the former Chief Executive, despite that role being held up to the end of March, and members requested that the structure accurately reflect both substantive and acting arrangements during the year. Concerns were also raised regarding the presentation of redundancy figures, particularly compulsory redundancies. Members noted that, while provisions and costs had been recognised, the narrative risked implying that compulsory redundancies had already taken place, whereas in practice staff remained formally “at risk” and processes were ongoing. It was agreed that the narrative required clearer explanation and nuance to accurately reflect the current position. The Committee also discussed the treatment of redundancy costs within running costs and programme expenditure. Members queried the consistency of this treatment with previous years. Officers advised that this approach reflected specific guidance issued by NHS England as part of the reform programme, and that while this differed from historical treatment, it was compliant with current requirements. It was agreed that this rationale should be explicitly referenced within the Annual Report, to aid transparency and understanding.	

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	Further comments were made regarding the intended audience and accessibility of the Annual Report. Members observed that the document contained a high level of technical and regulatory detail and queried whether the report was sufficiently clear and accessible for a public audience, given its role as the organisation's formal public account. While acknowledging the constraints imposed by national templates and guidance, officers confirmed that work would be undertaken with communications colleagues to improve readability, and members suggested that options such as a glossary of terms could help support public understanding. Members also questioned whether the scale and impact of the reform programme were sufficiently visible within the draft Annual Report, noting that the programme had been a key driver of workforce change, redundancy costs and organisational focus during the year. While it was acknowledged that some reference was included, members suggested that the reform narrative could be strengthened and made more explicit, particularly to provide context for financial and workforce disclosures. Officers confirmed that this point would be reviewed and reflected further, including through the foreword and overarching narrative. In concluding the discussion, the Committee acknowledged the progress made in bringing the Draft Annual Report and Accounts to an advanced stage, despite a challenging context. Members emphasised the importance of clear narrative, transparency and accuracy, particularly in relation to workforce change, costs and governance arrangements. The Committee noted the update, requested that the points raised be reflected in the next iteration of the document, and acknowledged the intention to finalise the report for submission in line with national deadlines. **NHS GM Audit Committee reviewed the proposed changes, subject to the above amendments.**	
12.	<u>NHS GM Financial Scheme of Delegation Amendments</u> The Committee considered the proposed amendments to the NHS Greater Manchester Financial Scheme of Delegation, noting that the review had been undertaken in response to the new operating model, revised committee structures, and changes to budget delegation arrangements arising from the reform programme. It was noted that the revised Scheme was being presented following prior consideration at the People and Resources Committee and was scheduled for onward submission to the Board in May 2026. Officers outlined that the revised Scheme sought to reflect the consolidation of budgets, including the move away from previous delegation arrangements across the ten localities, and the need to ensure that the organisation could continue to operate effectively and at pace while maintaining appropriate governance and control. Members were advised that the review had involved a significant rationalisation and clarification of delegated financial authorities, including the removal of redundant tables, improved hierarchy and sequencing of delegations, and clearer articulation of "who can do what, when". The Committee noted that the revised Scheme placed greater accountability with	

	budget holders, reducing reliance on central finance authorisation and aligning with earlier Audit Committee discussions on procurement accountability. This was presented as a deliberate shift to strengthen ownership and responsibility at portfolio level, while ensuring transparency and oversight through appropriate reporting mechanisms. Particular discussion focused on the delegation of authority for consultancy expenditure. The Committee noted the confirmation that NHS England approval was still required for consultancy spend above £50k. It was explained that the proposed Scheme introduced a revised internal delegation route for consultancy spend between £50k and £100k, involving approval by two Chief Officers (one which must be the Chief Executive or Chief Finance Officer), with onward transparency to non-executive members through committee reporting. Members indicated that this approach was acceptable, provided that visibility and transparency to Board members were maintained, given the sensitive nature of consultancy expenditure. The Committee emphasised the importance of forward visibility and retrospective transparency for decisions taken under delegated authority, particularly where large financial thresholds were involved. Members reiterated longstanding concerns that significant delegations must be accompanied by clear reporting, including forward plans and summaries of decisions taken, to support effective non-executive scrutiny and assurance. Discussion also considered the relative roles of the Strategic Commissioning Committee, Finance functions, and the People and Resources Committee. Members stressed the principle that commissioning decisions and business cases for service change should be considered through the Strategic Commissioning Committee, with appropriate financial oversight, rather than being determined solely through financial delegations. Concerns were expressed by the Executive regarding the absence of finance representation on the Strategic Commissioning Committee, and the need to ensure that financial pressures and in-year flexibility could still be managed effectively. Officers acknowledged these concerns and confirmed that further refinement would be undertaken, including setting clear delegation limits for the Strategic Commissioning Committee and reviewing arrangements over the coming months as structures settled. The Committee noted that the revised Scheme included significant increases in some financial thresholds, reflecting the move from multiple locality-level contracts to larger pan-Greater Manchester arrangements. Members asked that the rationale for these increases be clearly explained in supporting documentation, to ensure transparency and understanding of scale. It was recognised that the revised Financial Scheme of Delegation represented a substantial piece of work, undertaken during a period of considerable organisational change. Members acknowledged that, while the Scheme had been strengthened and clarified, it would require ongoing review in practice, to ensure it operated effectively and did not inadvertently create bottlenecks or impede timely decision-making. A member suggested that, during the transition period, consideration be given to	

	more agile mechanisms for capturing learning on how the Scheme operated in practice, potentially through less formal means than committee papers, to allow non-executive members to maintain oversight without placing undue burden on executive teams. Officers welcomed this suggestion and agreed to consider how learning and feedback could be captured and shared. In concluding the discussion, the Committee confirmed that it was content with the revised Financial Scheme of Delegation, subject to the clarification of the consultancy approval route, continued emphasis on transparency of delegated decisions, and ongoing review as the new operating model embedded. The Committee noted that the Scheme would proceed to the Board, accompanied by appropriate explanatory narrative and assurances. **NHS GM Audit Committee endorsed the proposed amendments to the NHS GM Financial Scheme of Delegation.**	
13.	<u>Standing Items:</u> <u>Debtors Update</u> The Committee received the Debtors Update, which set out the current debtor position and movements since the previous report to the Committee. Officers advised that the position was largely consistent with that reported in March, with no material deterioration overall. It was highlighted that the bad debt provision had been recalculated as part of the year-end process, resulting in an increase from approximately £0.9m to just over £1.0m. This adjustment was noted as part of normal year-end accounting activity rather than a reflection of new or unexpected risks. The Committee was provided with a specific update in relation to Bury Council. It was reported that payments had been received; however, these related to current-year debts rather than older outstanding balances. Officers confirmed that further engagement was underway, in liaison with relevant colleagues, to address and unblock recovery of the older debts. A member queried the significant increase in year-end debtors, noting a rise from approximately £35m to £42m, and commented that this movement did not appear to be clearly reflected or explained within the report. In response, officers advised that this may relate to a coding or a presentation issue and undertook to review the position and provide clarification outside of the meeting. In concluding the discussion, the Committee noted the Debtors Update, acknowledged the year-end adjustment to the bad debt provision, and requested further clarification on the reported increase in year-end debtor balances once the underlying cause had been confirmed. <u>Losses/Special Payments</u> There were no updates to note. <u>Conflicts of Interest Guardian</u>	

	There were no updates to note. Use of Corporate Seal This was noted for information. Board Summary Report This would be completed noting items during the meeting. **Audit Committee noted the updates provided.**	
14.	Audit Committee Workplan It was noted that this needed reviewing to ensure the June agenda only has items relating to the Annual Report.	
15.	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.	
16.	Date and time of next meeting: 17 June 2026, 9am – 1pm	

DRAFT

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		SEND oversight now included within responsibilities of Strategic Commissioning Committee, with bi-annaul updates planned for the Committee, and next update scheduled in August 2026.
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	01/07/2026		Deep dive into current outstanding internal audit recommendations ongoing as part of transition into new teams. Updates being gathered, with proposals to go to Chief Officers in early July, ahead of discussion with Audit Committee Chair and Internal Auditors. Outcome to be shared with Audit Committee membership for view as soon as complete. New target date of July 2026
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	Jun-26		Complete - update shared with June Audit Committee papers.
130	23/04/2026	Annual Internal Audit Plan 2026/27 (including feedback from Chief Officers and Committee Chairs)	Discussion on Annual Internal Audit Plan at COs	To add discussion on this area to the Chief Officers meeting agenda, with a brief rational to be provided for audit areas removed from the proposed plan..	Chris Gaffey	Jun-26		

NHS
Greater Manchester

NHS GM Audit Committee
17th June 2026

Head of Internal Audit Opinion 2025/26 (Final)

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

NHS GM Audit Committee

17th June 2026

Required information	Details
Title of report	Head of Internal Audit Opinion (Final) 2025/26
Author	Darrell Davies/ Patrick Clark
Presented by	Darrell Davies/ Patrick Clark
Contact for further information	Darrell Davies/ Patrick Clark
Executive summary	In accordance with Global Internal Audit Standards, the Head of Internal Audit (HoIA) 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. The HoIA Opinion contributes to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS). Our final opinion for 24-25 is currently one of Substantial Assurance. There is currently one draft report to finalise which are awaiting management responses however, we have included the draft outcome from this report in this opinion as we do not anticipate any material changes.
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	The Internal Audit Plan aims to address all of

Greater Manchester's communities.	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

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 the 2024/25 Head of Internal Audit Opinion.

Executive Summary

- The purpose of the Head of Internal Audit (HoIA) Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS).

- The overall opinion, as reported previously in the draft opinion document, remains as Substantial Assurance in that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

- The changes to note since the draft opinion was issued in April 2026 include four previously draft reports that have now been finalised and their status has been updated in the final opinion. Also, following discussions at the April Audit Committee the format of the IT Supplier Management Review has been changed from a briefing note with no assurance rating into a draft assurance report, with a Limited Assurance rating being awarded.

Recommendations

2.0 The Audit Committee is asked to:

- Note the contents of the report.

Internal Audit Annual Report & Head of Internal Audit Opinion 2025/26

NHS Greater Manchester Integrated Care Board

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Contents

1 Executive Summary

2 Head of Internal Audit Opinion

3 Informing our Opinion

4 Internal Audit Coverage and Outputs

5 Areas for consideration – your Annual Governance Statement

6 Ensuring Quality

1 Executive Summary

This annual report provides your 2025/26 Head of Internal Audit Opinion, together with the planned internal audit coverage and outputs during 2025/26 and MIAA Quality of Service Indicators.

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. The opinion should contribute to the organisation's annual governance statement.

Head of Internal Audit Opinion	1st April 2024 – 31st March 2025	1st April 2025 – 31st March 2026		Factors considered in forming our opinion
High Assurance, can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.				• **Inherent risks** in the areas audited • **Scope limitations** of individual audit reviews • **Control weaknesses identified** and their impact • **Internal control environment** adequacy and effectiveness • **Management's responses** to recommendations • **Progression of implementation of recommendations** by management
Substantial Assurance, can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.		✓		
Moderate Assurance, can be given that 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 of the organisation's objectives at risk.	✓			
Limited Assurance, can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk.				
No Assurance, can be given that 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 organisation's objectives.				

[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

Key Area	Summary
Head of Internal Audit Opinion	As highlighted above, the overall opinion for the period 1st April 2025 to 31st March 2026 provides **Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.** **Context:** This opinion is provided in the context that the ICBs like other organisations across the NHS is continuing to face a number of challenging issues and wider organisational factors particularly with regards to the changes to national and local bodies and the corresponding uncertainty this causes, ongoing elective recovery response, workforce challenges, financial challenges and increasing collaboration across organisations and systems. During 2024/25, the NHS Greater Manchester Integrated Care Board was issued with Enforcement Undertakings from NHS England. A formal set of agreed actions was set out in a Single Improvement Plan to deliver the changes and actions required. As at 31st January 2026, NHS England has formally discontinued the Undertakings and a compliance certificate has been issued, although areas of financial oversight remain in place. The organisation is going through a significant organisational restructure which include rounds of voluntary redundancies, as well as changes in portfolio at Chief Officer level with the Chief Executive recently retiring. Although this has not provided significant challenges in terms of disruption to engagement and delivery of the audit plan, it nonetheless represents a period of change for the organisation. A decision was taken towards the end of the financial year to stand down several review from the agreed Internal Audit plan primarily due to internal capacity issues. Governance arrangements have recently been reviewed to align with the ICB Model Blueprint and the new NHS GM Operating Model and will see two new committees established, the Strategic Commissioning Committee and the People and Resources Committee, alongside the existing Remuneration Committee and Audit Committee. An interim Transition Committee was established to bridge the gap between the move from the historical governance arrangements to the new model. The latest finance report to the Board in March 2026 (month 10) reported an ICS £75.7m year to date deficit which is £24.8m worse than the £50.9m revised planned deficit. All of the negative variance relates to GM NHS Providers. The CIP position reported is ahead of target at month 10 by £4.1m and overall, the forecast outturn position is breakeven in line with the revised plan. However there remain significant financial pressures across the system and risks associated with achievement of the plan.

Key Area	Summary
	In 25-26 NHS GM has improved its overall assurance rating from the Moderate Assurance rating achieved in prior years to Substantial Assurance. This is largely based upon the findings and assurances arising from the work which MIAA has undertaken on the internal control environment within NHS GM. As set out in section 4 below, the majority of reviews resulted in either 'substantial' or moderate' assurance ratings. Reviews of Key Financial Transactional Processing Controls and CHC both resulted in 'moderate' assurance ratings but it is too early to assess implementation of the high-risk actions associated with these reviews as they are not yet due at this time. **Compliance with professional standards**: In providing this opinion we can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. We also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting. **Purpose:** The purpose of our Head of Internal Audit (HoIA) Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS). *Please include the summary text in the table above when referring to the HoIA Opinion in your AGS.*
Scope and Limitations of Our Work	Our opinion is formed through the completion of a risk-based plan of assignments, agreed with management and approved by the Audit Committee. Our opinion is subject to the following inherent limitations: • We have not reviewed all risks and assurances relating to the organisation. • The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS) • The opinion is based on the findings and conclusions of the agreed audit assignments which were limited to the objectives and scope agreed with management.

Key Area	Summary
	• Where strong controls have been identified and confirmed, their effectiveness may still be impaired in some instances. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance. • Due to the limited scope of individual audit assignments, there may be weaknesses in controls which we are not aware of, or which were not brought to our attention. • The points raised in this report relate only to the issues we encountered during delivery of the internal audit service. It is not an exhaustive list of all weaknesses or potential improvements. Management is responsible for maintaining a robust system of internal controls, and internal audit should not be the sole basis for identifying all strengths and weaknesses. • This report is prepared solely for the use of the Audit Committee and/or senior management of NHS Greater Manchester Integrated Care Board.
Planned Audit Coverage and Outputs	The 2025/26 Internal Audit Plan has been delivered with the focus on the provision of your HoIA Opinion. This position has been reported within the progress reports across the financial year. Review coverage has been focused on: • The organisation's Assurance Framework • Core and mandated reviews, including follow up; and • A range of individual risk-based assurance reviews.
Recommendations / Management Actions	We have raised 45 recommendations as part of the reviews undertaken during 2025/26, although one of these is currently in draft report stage as set out in section 4 below. Where reports are finalised, all recommendations raised by MIAA have been accepted by management. • Of these recommendations: None were critical and 9 were high risk recommendations in relation to the reviews of Key Financial Transactional Processing Controls, Community Pharmacy Advanced Services, Continuing Healthcare, IT Supplier Management Review (Draft) and Contingency – NEPTS Procurement. • There were 69 outstanding recommendations relating to prior year reviews as at the 1st April 2025.

Key Area	Summary
	• During the course of the year, we have undertaken follow up reviews and can conclude that the organisation implemented 59 actions during 2025/26. • The total number of recommendations yet to be implemented as at 9th June 2026 is 71. Of the 71 actions yet to be implemented, 18 high risk, 33 medium risk and 2 low risk recommendations were overdue at 9th June 2026. Details of these outstanding actions are available in Section 4 of this report. The remaining recommendations were not yet due. It should be noted that the number of recommendations in terms of those outstanding at the start of the year, recommendations made in year and those yet to be implemented at the end of the year, do not fully reconcile due to some of the recommendations being made in year relate to draft reports and are not formally tracked for follow up purposes until they are finalised, also there has been movement in the status of recommendation throughout the year where revised implementation dates have been requested by management.
MIAA Quality of Service Indicators	**ISO9001**: MIAA operate systems to ISO Quality Standards which is subject to annual reaccreditation. **External Quality Assessment:** The External Quality Assessment, undertaken by CIPFA (2026), provides assurance of MIAA's compliance with the Global Internal Audit Standards (UK Public Sector). We also undertake regular internal assessments to ensure our ongoing compliance with requirements. **Information Governance and Cyber Security:** MIAA are committed to delivering and demonstrating the highest standards of information governance and cyber security to protect not only our information and systems but to protect the data we collect and create through our audit and advisory activities with clients. We have consistently submitted a compliant NHS Data Security and Protection Toolkit return and we are one of only circa 20 NHS organisations certified to the Cyber Essentials Plus standard. Certification to this standard required rigorous independent testing of our cyber security controls across our devices. That we have achieved this certification is a demonstration not only of the security of our devices but also a validation of the proactive monitoring and maintenance that we have in place to protect data and systems from malicious threats. Also, in 2025/26 MIAA was officially recognised as an Assured provider under the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF). This accreditation reflects our ongoing commitment to helping organisations strengthen their cyber resilience and safeguard critical systems and services. This achievement, which is the result of a rigorous assessment process, demonstrates our credentials in auditing against the NCSC's Cyber Assessment Framework and,

Key Area	Summary
	highlights the exceptional skills and experience of our staff as well as our organisational commitment to the highest cyber security standards.

2 The Head of Internal Audit Opinion

Your internal audit service has been performed in accordance with MIAA's internal audit methodology which conforms with Global Internal Audit Standards (UK public sector). Global Internal Audit Standards (UK public sector) require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

2.1 Roles and Responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The AGS is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievements of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with Global Internal Audit Standards (UK public sector), the HoIA 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 can provide assurance, subject to the inherent limitations described below. The outcomes and delivery of the internal audit plan are provided in Section 4.

3 Informing our Opinion

3.1 Basis for the Opinion

The basis for forming our opinion is as follows:

1	An assessment of the design and operation of the underpinning Assurance Framework, risk management systems 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.

3.2 Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1st April 2025 to 31st March 2026 inclusive and is underpinned by the work conducted through the risk-based internal audit plan.

A) Assurance Framework (AF)

Opinion	
Structure	The organisation's AF is structured to meet the NHS requirements.
Governance	Governance, reporting, challenge, and scrutiny processes are in place for the BAF, which have been reviewed and updated during the year. There has been a significant governance change in Q4, linked to organisational reform, which has resulted in the longstanding committees (excluding the Audit and Renumeration Committees) being stood down and replaced with a Transition

	Committee which has taken on the responsibilities, from Q4, of the former committees until new governance arrangements are introduced in 26/27.
Update	Processes in place to update the BAF were robust, although some aspects of the content within the BAF could be strengthened.
Strategic Objectives	The organisation's strategic objectives are derived from the strategy document 'Improving Health and Care in Greater Manchester 2023-2028 and therefore were not updated during 25-26.
Risk Appetite	The NHS GM Risk appetite processes been reviewed and approved by the Board. Each risk stated on the BAF has a documented risk appetite statement along with stated risk tolerance levels. Risk Appetite has been reviewed in year.
Engagement	The BAF is visibly used by the organisation. The BAF and risk registers were periodically assessed by the former committees. Minutes record that detailed discussions have taken place in these committees in respect of the risk register/ BAF agenda items. This engagement will need to be sustained during the interim governance arrangements.
Quality & Alignment	The BAF clearly reflects the risks discussed by the Board.

B) Core & Risk-Based Reviews Issued

We issued:

Zero high assurance opinions:	N/A	One **limited** assurance opinion:	IT Supplier Management Review (Draft)
8 substantial assurance opinions:	• Risk Management Core Controls • Primary Care Commissioning Assurance Framework (POD Delegation) • Financial Recovery Programme • Financial Reporting	Zero **no** assurance opinions:	N/A

	• Mental Health • Training and Development • ESR Payroll • Specialised Commissioning		
3 moderate assurance opinions:	• Key Financial Transactional Processing Controls • Community Pharmacy – Advanced Services • Continuing Healthcare (CHC)	2 reviews without an assurance rating	• Contingency – NEPTS Procurement

C) Data Security and Protection Toolkit (DSPT)

As required by NHS England our work aimed to assess and provide assurance based upon the validity of the organisation's intended final DSPT submission, and consider compliance with the NHS CAF aligned Data Security and Protection Toolkit (DSPT) profile for 25/26 for the in-scope security and governance of information control environment outcomes and the level of risk / wider risk associated with weak or failing controls and security and governance of information objectives not being achieved.

The organisation was assessed against the NHSE profile for the mandatory and additional outcomes as agreed by the organisation.

Overall Assurance Rating	
Across the CAF DSPT our assurance is based on the number of in-scope outcomes rated as meeting / not-meeting the minimum achievement levels as profiled by NHS England. As a result of this our overall assurance level across the in-scope outcomes and indicators of good practice is rated as:	**High Risk**

Veracity of the organisation's self-assessment	
In or view, the organisation's self-assessment for the in-scope outcomes **fully aligned** with that of the Independent Assessor and as such, the confidence-level in the veracity of the organisation's CAF DSPT self-assessment is:	**High Confidence**

D) Follow Up

During the course of the year we have undertaken follow up reviews and can conclude that the organisation has made **some progress** with regards to the implementation of recommendations. Further progress is required to reduce the number of outstanding recommendations. We will continue to track and follow up outstanding actions.

E) Themes

Through delivery of your internal audit plan, we noted the following thematic areas:

- The split of control design/ operating effectiveness recommendations shows that more weaknesses were identified in relation to control design.
- Improvements could be made by NHS GM in implementing outstanding recommendations throughout 2026/27.

F) Third Party/Other Assurance

We have not placed any direct reliance on other assurance providers. At the time of writing this final opinion, the following Service Auditor Reports have been provided to the organisation:

- ISAE 3402 Type 2 ELFS Business Services
- 134310 NHS Sharded Business Services FA ISAE 3402

Chris Harrop
Managing Director, MIAA
March 2026

Louise Cobain
Assurance Director, MIAA
March 2026

4 Internal Audit Coverage and Outputs

The 2025/26 Internal Audit Plan has been delivered with the focus on the provision of your Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year.

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

A summary of the reviews performed in the year is provided below:

	Review	Assurance Opinion	Recommendations Raised					Issue Category	
			Critical	High	Medium	Low	Total	Control Design	Operating Effectiveness
1	Assurance Framework	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	Risk Management Core Controls	Substantial	0	0	1	2	3	3	0
3	Primary Care Commissioning Assurance Framework (POD Delegation)	Substantial	0	0	2	0	2	1	1
4	Key Financial Transactional Processing Controls	Moderate	0	1	2	2	5	2	3
5	Financial Recovery Programme	Substantial	0	0	2	0	2	2	0

	Review	Assurance Opinion	Recommendations Raised					Issue Category	
			Critical	High	Medium	Low	Total	Control Design	Operating Effectiveness
6	Financial Reporting	Substantial	0	0	0	3	3	0	3
7	Mental Health	Substantial	0	0	3	0	3	0	3
8	Community Pharmacy – Advanced Services	Moderate	0	2	1	2	5	0	5
9	Continuing Healthcare (CHC)	Moderate	0	2	2	1	5	3	2
10	Training and Development	Substantial	0	0	2	1	3	3	0
11	ESR Payroll	Substantial	0	0	3	0	3	1	2
12	IT Supplier Management Review (Draft)	Limited	0	2	1	0	3	3	0
13	Contingency – NEPTS Procurement	No overall assurance rating	0	2	1	0	3	2	1
14	Specialised Commissioning	Substantial	0	0	4	1	5	5	0
		TOTAL	**0**	**9**	**24**	**12**	**45**	**25**	**20**

The following critical and high risk recommendations were overdue at the time of reporting:

Review	Recommendation Details	Risk Rating	Due Date	Current Status
EPRR	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.	High	31/3/2026	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.
EPRR	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.	High	31/3/2026	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.

	• Training completion is regularly included on the agenda of an Oversight Group.			
CHC Contract Management	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.	High	30/6/2025	Policy currently being embedded via IPoC PID. Policy has been supported via Finance Committee and CPAS. Awaiting evidence.
CHC Contract Management	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	High	31/3/2026	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 to extend due date to Q4 as embedding process is sustained.

	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.			
CHC Contract Management	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.	High	31/3/2026	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.

Performance Management Data Quality	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.	High	31/12/2025	Delayed due to reform activities and staff sickness.
Commissioning	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.	High	31/12/2025	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. Awaiting evidence of volume of signed contracts timely in 25/26.
Commissioning	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	High	31/3/2026	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.

	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.			
CHC	Complete the CHAT and the development of the AACC Transformation Plan, monitoring progression through the Board Assurance Framework/ other	High	31/3/2026	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

	committee and Board assurance reporting.			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.
Community Pharmacy – Advanced Services	A solution should be identified to produce reports from Trello, to allow for independent scrutiny on the progress and completion of the assigned tasks.	High	31/10/2025	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.
Community Pharmacy – Advanced Services	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.	High	31/10/2025	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.
DSPT 2024/25 Phase II	7 actions relating to Supply Chain	High	31/10/2025	Follow Up Ongoing – partially implemented
DSPT 2024/25 Phase II	7 actions relating to Identity and Access Controls	High	31/10/2025	Follow Up Ongoing – partially implemented
DSPT 2024/25 Phase II	4 actions relating to Response Plan	High	31/12/2025	Follow Up Ongoing – partially implemented

Cyber Organisational Controls	A series of actions recommendations made relating to incident management.	High	31/12/2024	Follow Up Ongoing – partially implemented
Cyber Organisational Controls	A series of actions relating to cyber risk regime.	High	31/12/2024	Follow Up Ongoing – partially implemented
Cyber Organisational Controls	A series of actions relating to 3rd party management.	High	31/12/2024	Follow Up Ongoing – partially implemented
IT Asset Management	1. Update the contracts / SLAs in place for the IT Service Providers / GPs, to ensure they align with relevant frameworks, include security clauses, the latest legislation, licensing / hardware leasing / purchase requirements, key policies, metrics and business requirements. 2. Schedule and undertaken relevant service reviews as part of a standardised governance framework. 3. Confirm and document responsibilities for IT and the disposal companies for the secure sanitisation of all sensitive data / destruction of IT assets.	High	31/03/2026	Follow Up Ongoing – not yet implemented

	4. Confirm all signed contracts are in place for the ICB and at a locality / supplier level are in place for:- a. Disposal companies. b. Supporting solutions to track / manage IT assets.			

We will continue to follow up progress against all recommendations as part of the 2026/27 Internal Audit Plan.

ADVISORY SUPPORT AND GUIDANCE: Areas where MIAA have supported the organisation in strengthening arrangements in respect of governance, risk management and internal control.
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, as well as holding sessions with groups of Trust and ICB Audit Committee Chairs focusing upon governance challenges and other key issues

CONTRIBUTION TO GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL ENHANCEMENTS: *Additional areas where MIAA have provided added value contributions.*
Detailed insight into the overall Governance and Assurance processes gained from liaison throughout the year with the Officer/ Senior Management Team, facilitation of Board sessions, regular review of Board papers and work to develop the Assurance Framework.
Involvement with the organisation in respect of advice and guidance relating to Board reporting, corporate governance documentation and assurance mapping.
Involvement and relationship with the organisation (e.g. attendance and contribution to finance meetings, Risk Management Committee, etc.).
Ongoing discussion with lead Officers, Managers and Non-Executive Directors throughout the year.

Facilitation of committee workshops, effectiveness sessions and review of internal audit effectiveness.
Effective utilisation of internal audit including in year communication, requests for support in relation to specific procurement activity.

2025/26 DELIVERY OF ADDED VALUE

5 Areas for Consideration – your AGS

The Head of Internal Audit Opinion is one source of assurance that the organisation has in providing its AGS other third party assurances should also be considered. In addition the organisation should take account of other independent assurances that are considered relevant.

We have identified a number of other strategic challenges that should be considered by the Board when drafting the AGS. Whilst the scope of the Internal Audit Plan would have considered elements of these, it is important that the ICB reflects more widely on how these should be factored into the AGS. Areas for consideration include:

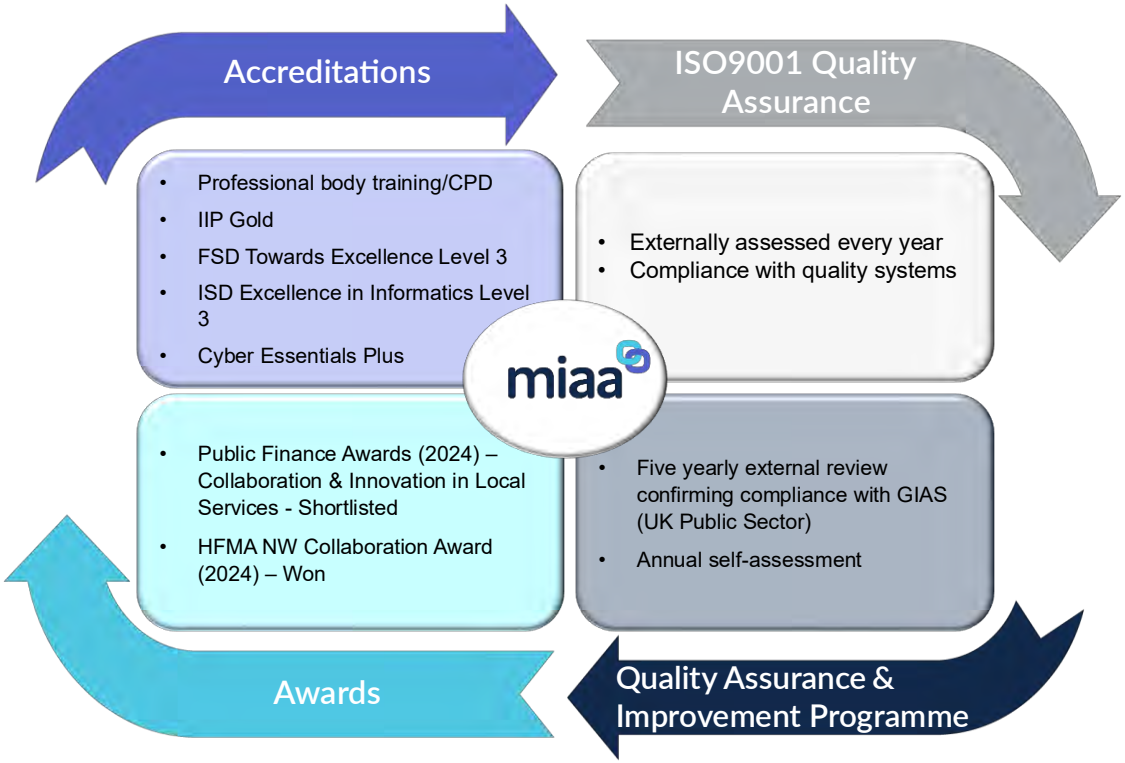
- Wider partnership working and engagement at system and place level, including the ICB's engagement with system developments and transformation programmes.
- Achievement of financial duties, ongoing financial viability, delivery of CIP, service pressures and key relationships with Commissioners.
- Changes to governance, risk management and internal control arrangements.
- Impact of elective recovery and industrial action on the delivery of services with the requirements of the Provider Licence, and compliance with the UK Corporate Governance Code. Maintenance and improvement of the quality of services alongside and overall organisation performance, including the delivery of targets.
    - Progress against any undertakings issued by NHSE.
    - Regulatory compliance.
- Board leadership, including compliance with revised Fit and Proper Persons Test and any significant changes to the Board, Executive and Senior Management Team.
- Workforce capacity, engagement, wellbeing and development.
- Ensuring there is a fit for purpose infrastructure.
- Cyber security, information governance risks and any associated reportable incidents to the Information Commissioner.
- Relationship and management of 3rd party providers upon which the ICB places reliance, and the provision of assurances from these.

6 Ensuring Quality

MIAA's strategy has quality at the heart of everything we do and our overall approach to quality assurance includes ISO9001:2015 accreditation, compliance with Global Internal Audit Standards (UK public sector), the quality of our people and how we support them, staffing levels, compliance and outcome measures.

Professional Standards and Accreditations

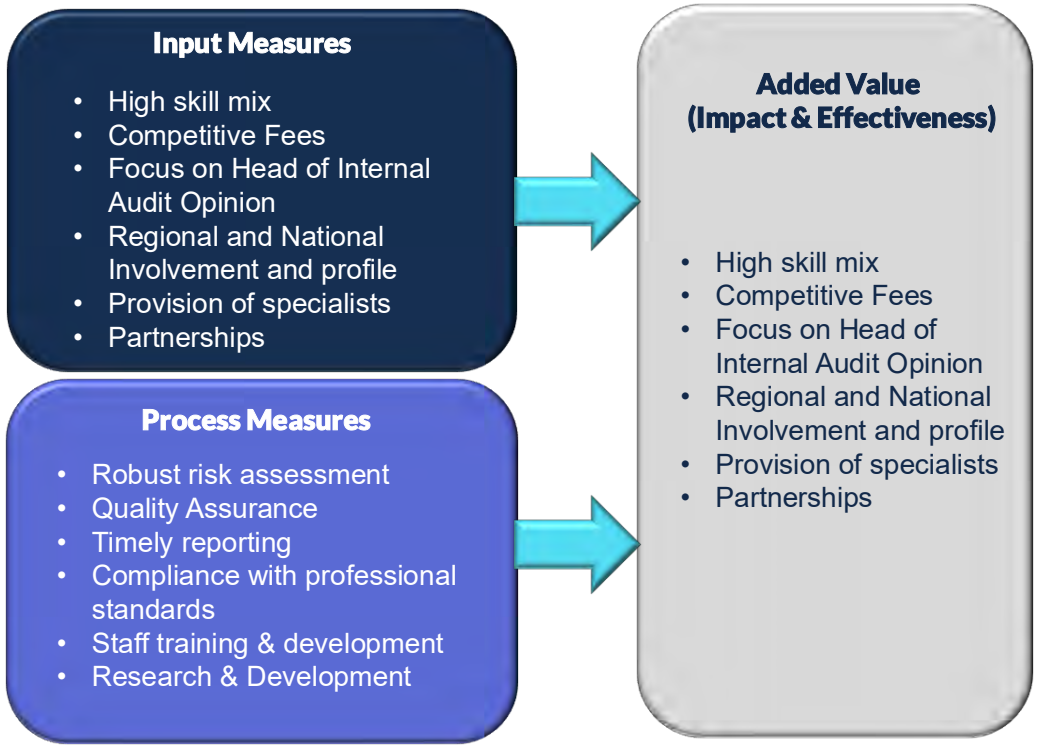
MIAA comply fully with professional best practice, internal audit standards and legal requirements.



Service delivery and outcome measures

It is important that client organisations ensure an effective Internal Audit Service, and whilst input and process measures offer some assurance, the focus should be on outcomes and impact from the service. The infographic on this page confirms the measures that we believe demonstrate an effective service to you.

MIAA regularly report on input and process KPIs as part of our Audit Committee Progress reports, and the impact and effectiveness measures can be assessed through the HOIA Opinion.



The ICB has also undertaken an assessment of the effectiveness of internal audit during 2025/26 which followed up on actions identified during 2024/25, the outcomes of which were reported to Audit Committee. The conclusions from the assessment were positive overall, with good feedback on more effective communication between MIAA and NHS GM colleagues, with clear routes for escalation to resolve bottle necks and key issues. The only outstanding area for improvement/ development from the set of actions identified in 2024/25 relates to the feasibility of conducting follow up work (client + IA) via an electronic portal. We will continue to work in partnership with the ICB to deliver a high quality service.

Darrell Davies

Engagement Lead

Tel: 07785 286381

Email: darrell.davies@miaa.nhs.uk

Lauren Ball

Delivery Manager

Tel: 07825 605561

Email: lauren.ball@miaa.nhs.uk

Patrick Clark

Engagement Manager

Tel: 07754 226518

Email: patrick.clark@miaa.nhs.uk

NHS
Greater Manchester

Anti-Fraud Annual Report 2025/26

(17 June 2026)

Part of Greater Manchester Integrated Care Partnership

NHS GM Audit Committee

17 June 2026

Required information	Details
Title of report	Anti-Fraud Annual Report 2025/26
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	Report on all anti-fraud activities undertaken in 2025/26
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

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

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

Anti-Fraud Annual Report 2025/26

NHS Greater Manchester ICB

Contents

1 Introduction

2 Executive Summary

3 Component Ratings: Self-Assessed Compliance with the Government Functional Standard 013 for Counter Fraud

4 Summary of Key Work Completed by AFS in Support of GovS 013

Appendix A: Contract Performance / Nominations Overview

Appendix B: Fraud Risk Assessments & Local Proactive Exercises (LPEs)

Appendix C: Summary of Referrals, and Investigation Activity Recorded on the National Case Management System (CLUE)

1 Introduction

The Anti-Fraud Annual Report offers the Audit Committee the opportunity to consider the work completed by the ICB's Anti-Fraud Specialist (AFS) during the period from April 2025 to March 2026.

The ultimate aim of all anti-fraud work is to support improved NHS services and to ensure through awareness raising and local proactive work that fraud within the NHS is clearly seen as being unacceptable. Stopping the loss of public money by fraudsters who are committing criminal offences allows NHS funds to be utilised for the public good, as the taxpayer intended.

In completing this annual report on counter fraud, bribery and corruption work, the AFS has referred to, and assessed the organisation against, the Government Functional Standard 013 for Counter Fraud (which also applies to any relevant subsidiary company). The report highlights relevant anti-fraud activities carried out and their outcomes.

The anti-fraud work plan was designed to be dynamic to enable us to respond to your changing requirements, ensuring the most effective use of your anti-fraud resource, and meeting the requirements as set out in the relevant components of the fraud standard.

2 Executive Summary

Strategic Governance (NHSCFA Strategic Pillar 'Assure')

We have continued to receive excellent strategic support for our counter fraud, bribery and corruption work from the ICB throughout the year from the Chief Finance Officer (CFO), the Counter Fraud Champion, the Associate Director of Finance for Financial Assurance, the Audit Committee and other key stakeholders across the organisation.

The 2024/25 annual self-assessment against the Government Functional Standard 013 for Counter Fraud, known in the NHS as the Counter Fraud Functional Standard Return (CFFSR), was submitted early in Q1 of 2025/26, ahead of the deadline, with the ICB receiving green ratings across 11 of the 12 assessed requirements resulting in an overall green rated self-assessment.

For the ICB's 2025/26 CFFSR, the rating against Requirement 3 (fraud, bribery and corruption risk assessment) has been rated as amber due to a requirement to review and update the fraud risk assessment following changes in the NHS strategic risk profile arising from the new corporate fraud offence, and due to an updated Government Counter Fraud Profession risk framework being recently introduced. This particular piece of work will be undertaken in 2026/27. The 2025/26 CFFSR was submitted ahead of the May 2026 deadline and received a green rating overall, with 11 of the 12 requirements being self-assessed as 'green'.

The AFS undertook various training and continuous professional development (CPD) opportunities organised by both MIAA and NHSCFA. The AFS attended internal training on audit principles, improving AC presentation skills and fraud risk requirements. The AFS also attended webinars and focus groups organised by NHSCFA covering topics including 'failure to prevent fraud', fraud vulnerability and system weakness reporting, and conducting fraud prevention exercises. Members of the NHSCFA Fraud Hub attended MIAA offices in October 2025 and provided bespoke follow-on training on related topics. The AFS also attended an externally delivered session in Organised Immigration Crime and Modern Slavery, conducted by a member of the Regional Organised Crime

Unit (ROCU). All of these activities and others assist in ensuring ongoing compliance with NHS Requirement 9 of the Counter Fraud Functional Standard (GovS:013).

In terms of the legislative landscape, the new corporate fraud offence of 'failure to prevent fraud' was established under the Economic Crime and Transparency Act (EECTA) 2023 and came into force in September 2025. Further work will be undertaken in 2026/27 to ensure that the ICB has adequate measures in place to address the requirements of the legislation.

The organisation continues to demonstrate a risk-based approach to the counter fraud, bribery and corruption provision in the anti-fraud work plan, and this informed decisions during the year on the resources allocated to the work. The ICB's Anti-Fraud Plan 2025/26 was finalised and approved by the Audit Committee in March 2025. The plan provided coverage across a number of key fraud risk areas, including working whilst sick, cyber-enabled frauds, mandate fraud and the new corporate fraud offence of 'failure to prevent fraud', as well as the provision of support and guidance in respect of PHB and primary care providers. For working whilst sick, the plan included continued participation in the latest National Fraud Initiative (NFI) exercise and, for cyber-enabled fraud, invoice and mandate frauds, it included the circulation of local Fraud Prevention Checks (FPCs) and other relevant local and national alerts and bulletins. For PHB, additional guidance and support was provided via the AFS's regular attendance at the NHS GM PHB Leads Group. For primary care providers, various alerts and guidance were disseminated throughout the year, as well as the sharing of intelligence with NHSE Counter Fraud (NW). A Local Proactive Exercise (LPE) was undertaken in relation to the new corporate fraud offence, to assess the organisation's preparedness.

Counter fraud, bribery and corruption work has been monitored by the CFO (and delegated deputies) through the year and via regular reporting through Anti-Fraud Progress Reports and briefings presented to the Audit Committee.

Raising Fraud Awareness / Sharing Intelligence (NHSCFA Strategic Pillar ''Understand)

Several activities were conducted during the year to raise fraud awareness and understanding, including training delivered to all staff in respect of the new 'failure to prevent fraud' offence, including a Board development session. Three webinars on this topic were also delivered across multiple MIAA clients, with several ICB personnel attending. The AFS regularly engaged with the Communications Team and other key stakeholders, supported by the CFC, to promote the anti-fraud, bribery and corruption agenda ICB-wide, including circulating Recent Cases Articles, MIAA's 'Talking Fraud' Newsletters, Newsflashes, Fraud Information Alerts on various topics, anti-fraud payslip messages, anti-fraud guidance and fraud warnings cascaded to all primary care providers, and the provision of awareness materials in support of International Fraud Awareness Week (IFAW) in November. Fraud awareness materials shared with staff are also located on the ICB's fraud section of the internet. Relevant fraud updates are added to the ICB website's dedicated fraud section periodically.

Levels of fraud awareness and understanding are measured annually via the mandatory completion by staff of the ESR '000' fraud e-learning module. These contribute to the self-assessment of Requirement 11 of annual CFFSR. For 2025/26, the compliance rate was assessed at 91.3% and compliance with the ICB's conflicts of interest policy, which is measured as part of Requirement 12 of the CFFSR, was at 87% at year-end. This is positive given the ongoing ICB reforms which have been taking place and the difficulties experienced with achieving Requirement 12 in the previous year.

Prevention, Deterrence & Detection Activities (NHSCFA Strategic Pillar 'Prevent')

A Local Proactive Exercise was completed in relation to the new corporate fraud offence of 'failure to prevent fraud' (FTPF), which came into force on 1st September 2025. The purpose of the exercise was

to, firstly, assess the controls and procedures in place at the ICB to comply with the 'reasonable procedures' requirements of the new offence and identify any gaps which needed to be addressed and, secondly, assist the ICB in ensuring that relevant 'associated persons' were made aware of their responsibilities in relation to the new legislation and the expectations on the NHS. A number of activities were undertaken as part of the LPE, including circulation of briefings for all staff, senior leaders, and the board/audit committee, a board development session presentation, development of a CEO statement, delivery of webinars, review and update of relevant policies and procedures, and a FTPF risk assessment workshop. Overall, the report for the LPE was very positive, with a small number of agreed management recommendations in place for taking forward. The review findings and agreed actions will be reported at a future Audit Committee in 2026/27, as part of progress reporting.

A joint LPE with Greater Manchester Mental Health Trust was also commenced looking at claims for Section 12 Mental Health Act activities. It is anticipated that this review will be completed in early Q2 of 2026/27.

The ICB participated in the 2024/25 NFI exercise. The ICB completed 86% (over 4,000) of the creditor matches by year-end, with no issues or duplicates noted to date. The AFS has completed and closed 90% of the payroll matches, with five outstanding queries to be addressed once information has been provided by NHS Professionals.

Over 40 local and some regional/national alerts, each around specific identified fraud threats, were circulated to key staff for relevant checks to be conducted and mitigating actions to be taken where appropriate. For each of these local Fraud Prevention Checks (FPCs) issued, the required actions generally centred around a supplier check against a potentially compromised email and/or a bank account check against identified fraudulent account details and/or an IT check against identified fraudulent email domain(s). No local issues or concerns were identified or reported to the AFS with regard to any of the local FPCs issued.

The AFS also issued national Fraud Prevention Notices (FPNs) published by the NHSCFA around identified high fraud risk areas, including Payment Diversion Fraud, Business Email Compromise, Asset Management, Virtual Credit Cards, Nursing Apprenticeships and the Mutually Agreed Resignation Scheme (MARS), amongst others. Each of the FPNs detailed fraud prevention advice to assist the ICB in mitigating against the threat identified. No immediate issues were raised with the AFS by relevant ICB personnel, and several managers have responded positively to confirm the adequacy of existing controls, although the AFS will follow up on actions taken by the ICB, in relation to the FPNs issued, as part of the Anti-Fraud Plan 2026/27.

Similarly, two Learning Reports were issued by NHSCFA, one on Gifts and Hospitality and one on Personal Health Budgets, and both of these will also be followed up in 2026/27. Findings and recommendations of 2024/25's national NHSCFA-led Procurement proactive exercise were also issued in November 2025 for consideration. An Intelligence Bulletin (IBURN) determining whether named individuals were working locally, in support of an NHSCFA investigation, was also actioned promptly. Updated prescribing and procurement guidance issued by NHSCFA were also circulated appropriately and cascaded to the primary care providers, along with other anti-crime guidance and fraud warnings, utilising the communications network managed by the Director of Primary Care services.

The AFS also provided controls advice and guidance to the ICB in respect of both 'No PO, No Pay' arrangements, as well as to the Wigan locality with regard to strengthening Care Home contractual

payments and anti-fraud declarations as part of routine arrangements. The AFS is always happy to be contacted for the provision of advisory anti-fraud input to the design of controls and systems.

Referrals & Investigations Activities (NHSCFA Strategic Pillar 'Respond')

In 2025/26, MIAA introduced a dedicated investigations team to provide a streamlined and focused investigation service to its clients; the primary purpose of this act was to ensure investigations are conducted in a timely manner and to achieve consistency when reviewing and investigating allegations of fraud.

The first year has been both a successful and busy one for the team. There were 677 fraud referrals received in total, from all of our NHS clients, covering a wide range of fraud types. The most prevalent type of referral received, echoing national trends, was working whilst sick, for which there were 163 (24% of the total). Other fraud types which saw a notable number of referrals were patient fraud, for which there were 95 (14%) and timesheet fraud, for which there were 51 (7.5%). Most referrals relating to patient fraud concerned the alleged onward sale of prescription medication. Referrals relating to timesheet fraud encompassed a several different fraudulent activities, including false overtime claims and roster manipulation.

Of the 677 referrals received, 244 referrals were converted to Investigations and logged on the NHS case management system CLUE. Many of the investigations opened were unsurprisingly in relation to working whilst sick – 101 (41%). There were 19 investigations (8%) opened in relation to alleged working elsewhere whilst on NHS time, 15 investigations (6%) opened for alleged recruitment fraud and 12 investigations (5%) opened in relation to alleged false documentation.

A separate paper will be produced by the Investigations Team during 2026/27 providing a full analysis of the referrals received, converted investigations and disposals, sanctions applied and financial redress.

Locally, 11 referral queries were brought forward from the previous year (2024/25). 51 referrals were received in 2025/26 (from various internal and external sources) and two of these were converted to CLUE investigations. The majority of referrals revolved around patient-related matters, with prescription medicines abuse being the primary allegation. At year end, two referrals remained open, with the rest either closed due to insufficient or no evidence of fraud, referred back to local GPs for MURs (in the main) and a small number referred to NHSE Counter Fraud where they related to primary care providers or NHSE funded services.

Two investigations were brought forward from the prior year (2024/25):

- INV/24/01404 – related to an allegation of a possible undeclared interest in a supplier but was eventually closed due to a lack of evidence.
- INV/25/03286 – related to optical claims fraud and was transferred to NHSE Counter Fraud.

The two converted referrals received in-year are currently as follows:

- INV/25/03098 – Unsolicited payment request – reported to NHSCFA as intelligence; fraud prevented amount recorded; case closed.
- INV/26/00980 – PHB allegation – enquiries ongoing.

Summaries of investigations opened, closed and ongoing in-year are recorded in Appendix C.

The AFS would like to acknowledge the support provided by ICB management and staff in delivering the programme of anti-fraud, bribery and corruption work and continuing to embed a strong anti-fraud, bribery and corruption culture within the organisation.

Contract performance information can be found in Appendix A.

Report from the Counter Fraud Champion

As the Counter Fraud Champion (CFC) for NHS Greater Manchester (GM) Integrated Care Board (ICB), I have undertaken significant pieces of work to fulfil the statutory role, by providing a senior voice within the organisation. I am able to champion the counter fraud agenda through enabling and delivering against my counter fraud programme of work. The CFC programme of work covers the four guiding principles of understand, prevent, assure and respond. I have detailed an example under each of these four guiding principles, to demonstrate my work programme in action across the last 12 months.

Understanding

On 20th August 2025, I delivered a short presentation to the ICB's Informal Board Meeting, to explain and discuss the new Failure to Prevent Fraud Offence, which is a corporate criminal offence under the UK's Economic Crime and Corporate Transparency Act 2023. As a result of attending the Informal Board Meeting, I was able to ensure there was a strategic awareness at the Board level with regards to the Offence, enabling a golden threat of awareness and communication from the Board into the Audit Committee.

Prevent

Within my CFC Report to the ICB's Audit Committee in September 2025, I made reference to the Government's announcement on architectural and fundamental changes to the NHS as part of NHS Reform. As such, I added a new element for the programme of work in 2025/26, specifically in response to NHS Reform. I believed 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 the ICB. I advocated how this level of change could leave not only the ICB, but wider NHS colleagues vulnerable at a time of huge upheaval.

This aspect is an essential part of the counter fraud programme of work, to promote and embed an awareness of fraud, bribery and corruption across the organisation during what has been a sustained period of organisational change. I have ensured that the ICB has still been able to drive forward a counter fraud culture across the organisation, during this time. This has coincided with the ICB implementing and embedding a revised Operating Model and new Chief Officer portfolios from 1st January 2026. The importance of maintaining key counter fraud communication messages during this time, was also followed up by the Deputy Chief Finance Officer (DCFO) and myself, to the ICB's Extended Leadership Team (ELT). This was for the ELT's awareness and for further cascaded learning within their respective teams across the ICB.

Assure

Though my cyclical reporting to the Audit Committee, I have sourced external checks and balances against my own role as the CFC, through that of a national subject matter expert (SME). As the CFC, I believe it is important to make professional connections with colleagues outside of ICB and beyond

the GM integrated care system (ICS) footprint. Part of the supportive role of the national SME has allowed myself as the CFC to gain input, professional advice and guidance, including a check and balance against my CFC programme of work.

Respond

As part of my strategic response to the new Failure to Prevent Fraud Offence, in collaboration with the ICB Anti-Fraud Lead (Head of Anti-Crime Services at MIAA), I co-facilitated a workshop on 25th November 2025. The workshop including with five senior leaders from across ICB. This included representation from the Finance, Contracting and Clinicals Teams. The workshop explored the possible challenges and potential risks which may arise within the GM ICS, as a result of the new Failure to Prevent Fraud Offence. The outcomes from the workshop, were discussed in more detail with the Audit Committee Meeting in March 2026.

3 Component Ratings: Government Functional Standard 013 for Counter Fraud

Each NHS organisation is required to undertake an annual self-assessment against the requirements set out in the 'Government Functional Standard 013 for Counter Fraud'.

The following self-assessed RAG ratings have been applied to each of the components contained within the fraud standard:

Government Functional Standard 013 for Counter Fraud: Self-Assessment 2025/26

	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

Based on the above assessment, the overall rating for NHS Greater Manchester is:	**Green**

Red or Amber Rating(s)

The following table sets out those components of the Government Functional Standard 013 for Counter Fraud rated as red or amber, the rationale for this assessment and proposed action to assist the organisation in achieving an improved rating:

Ref	Descriptor	Rational for Assessment	Proposed Future Action(s)
3.	Fraud bribery and corruption risk assessment	Requirement to review and update the full fraud risk assessment.	Review and update of the fraud risk assessment during 2026/27.

The NHSCFA require a formal signed declaration by the Accountable Board member with responsibility for fraud within the ICB in order for the organisation to be compliant with the Functional Standard Requirements.

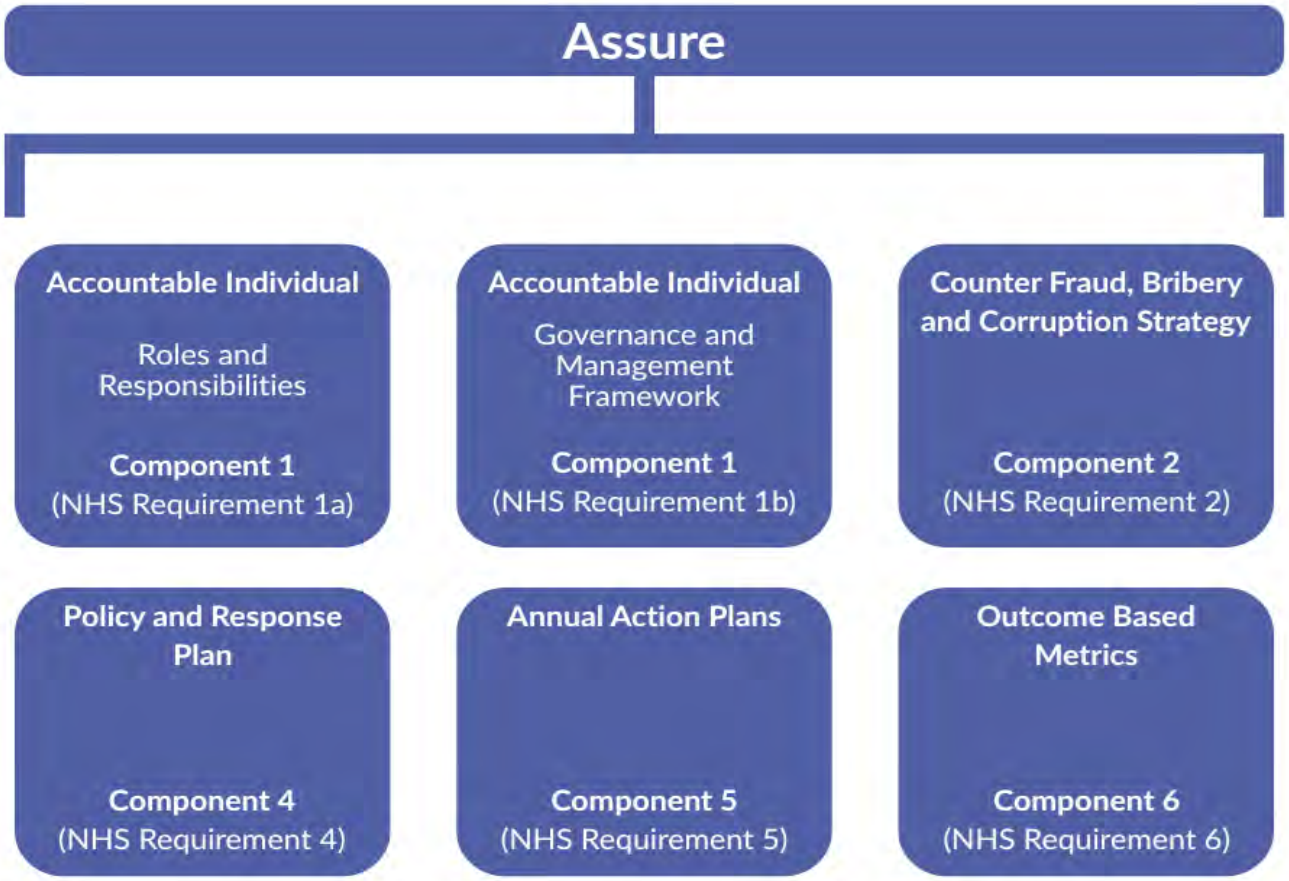
Organisation Declaration

I declare that the counter fraud, bribery and corruption work carried out during 2025/26 has been self-reviewed against the Functional Standard Requirements relating to fraud, bribery and corruption and Service Condition 24 of the NHS Standard Contract, and that the above rating has been achieved.

Organisation	NHS Greater Manchester
Accountable Board Member Signature	Kathy Roe, Chief Finance Officer
Date	

4 Summary of Key Work Completed by AFS in Support of GovS 013

The key deliverables during the past year are covered in the following summary, in line with the Counter Fraud Standard components:



COMPONENT 1A

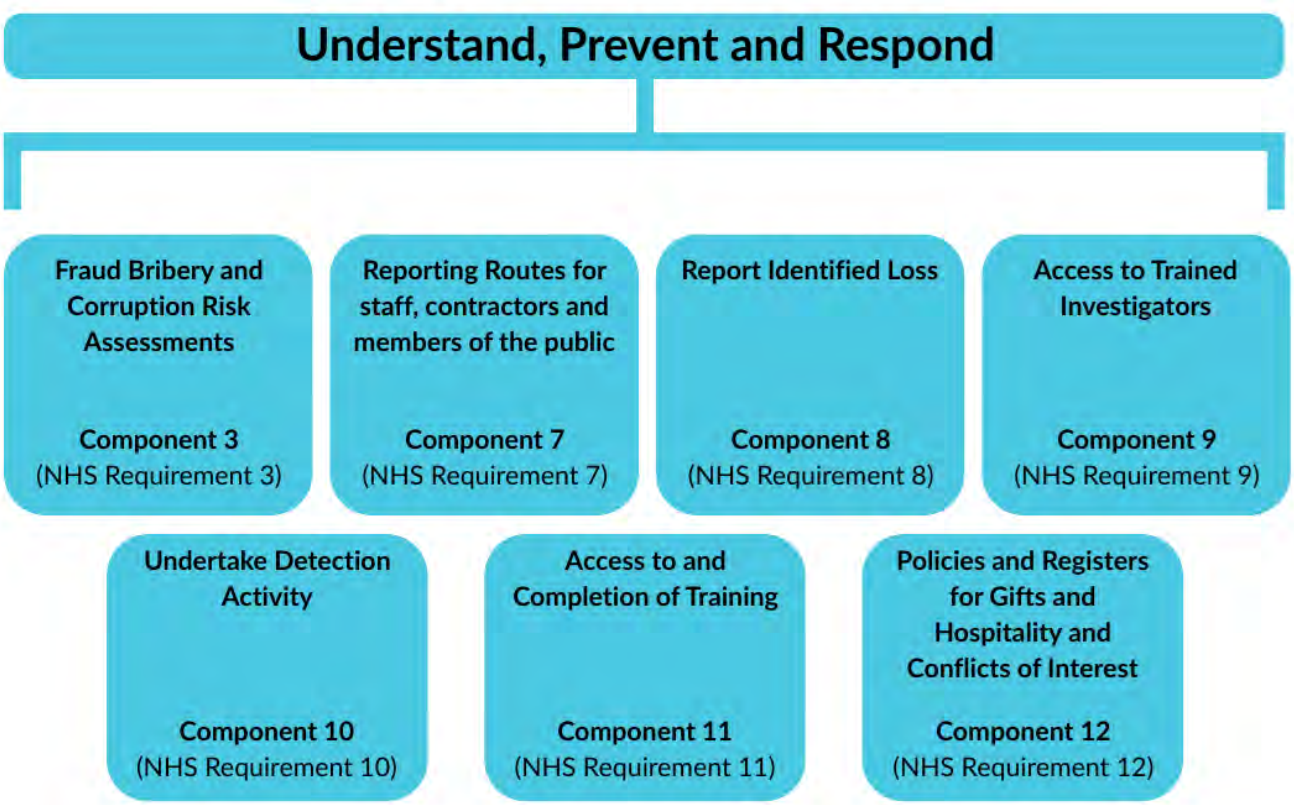
This relates to the role of the Accountable Board Member and their responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work, including timely reporting and accurate notification of nominations to the NHSCFA.

- The CFO is accountable at board level for the provision of strategic management of counter fraud, bribery and corruption (FB&C) work at the ICB. Nominations to the NHSCFA for all roles are correct. The CFO participates in the development and agreement of the annual anti-fraud (AF) work plan and also contributes at Audit Committee (AC), where fraud work is regularly reported.
- The role and responsibilities of the CFO, NEDs, Board and AC are clearly defined in
- Evidence of the effective discharge of these duties is contained in: AF Progress Reports; AF Work Plans; AF Annual Reports; AC minutes; ACC reports to Board; Board minutes;
- Records of engagement between the AFS and CFO (and deputies); Comprehensive dedicated fraud internet section; ICB Annual Reports; nominations to the NHSCFA; CLUE records; LPE records; and NHSCFA benchmarking data.

the SORD, SOs, SFIs, AC ToR & Anti-Fraud, Bribery & Corruption (ABC) Policy.	
COMPONENT 1B **This relates to the work of the organisation's board / governing body in gaining assurance and evaluating the counter fraud work undertaken during the year. This requirement also covers the role of the Counter Fraud Champion.**	
• ICB NEDs and senior management obtain assurance via AF Progress Reports to AC. Any issues arising from AC are escalated to the Board via ACC. Evidence of discussions held are contained in Board and AC meeting minutes, CFO/AFS meetings. • ICB engages constructively with AFS regarding NHSCFA recommendations received via national intelligence bulletins (IBURNs), Fraud Prevention Notices and Learning Reports issued. • AF Annual Reports comply with NHSCFA guidance on content and provide clear updates on progress against work plan objectives.	• Head of Business Management is the ICB's nominated CFC, who proactively supports AFS to promote fraud awareness across the ICB and actus as key liaison. Also, CF Ambassadors assist at local level. • CFO and ACC review and approve annual CFFSR. • ICB has a comprehensive fraud internet section which includes CEO Statement re the new corporate offence of failure to prevent fraud (FTPFO), a copy of Anti-Fraud Policy, and contact details for: CFC, FTSUG Champions, AFS, NHSCFA. MIAA delivered FTPFO webinars to Board/ Senior Leaders in Q3 2025/26.
COMPONENT 2 **This component relates to the organisation's over-arching counter fraud, bribery and corruption strategy, and how the counter fraud work plan and resource allocation is aligned to the objectives of the strategy and locally identified risks.**	
• The ICB's anti-fraud work is aligned to NHSCFA strategic priorities, policies, directions, instructions and guidance. The ICB's AF Work Plan 2025-26 and allocation of resources was risk based, taking into consideration national & local risks, threats and priorities. • Evidence to support the alignment of the ICB's anti-fraud work and work plan and allocation of resources to the NHSCFA strategy is contained in the Anti-Fraud Policy which aligns with the NHSCFA Strategy 2023-2026 and agreed at Audit Committee.	• Evidence of anti-fraud risk assessments; AF Progress Reports and AF Work Plan to AC which are aligned to the NHSCFA four strategic pillars; AC minutes; AF Work Plan; AF Annual Report; records of meetings and engagement between AFS, CFO, CFC, and ICB key personnel.
COMPONENT 4	

This component relates to the organisation's counter fraud, bribery and corruption policy and response plan and its alignment to the NHSCFA strategic guidance.	
• The ICB has an Anti-Fraud Policy in place that is in line with NHSCFA's Template Policy and references NHSCFA Strategy 2023-2026. • The policy is periodically reviewed and was reviewed / updated in 25/26 to include information in relation to the new corporate offence of 'failure to prevent fraud'. It is pending ratification by the AC.	• The policy is available to all staff and general public via the intranet and ICB website. • Awareness of the policy is also circulated via awareness training and through the various awareness materials that are produced and issued during the year.
COMPONENT 5 **This component relates to the development and management of the organisation's annual counter fraud work plan. This plan should be informed by national and local fraud, bribery and corruption risk assessments.**	
• The ICB's anti-fraud work plan 2025/26 and allocation of counter fraud resources was risk based, taking into consideration national and local risks, threats and priorities. • The work plan contained a list of specific activities broken down across each area of the NHSCFA's four strategic pillars. Each activity was aligned to a relevant component of the Functional Standard and assigned an estimated delivery time. The work plan included some agreed output measures. • The final work plan was presented to and approved by the AC in March 2025.	• Progress in relation to work plan delivery is monitored by the CFO and reported through to the AC via periodic progress reports for appropriate discussion and scrutiny. • Should it be necessary, the CFO would provide allocation of additional resources and/or reallocation of existing resources to ensure that work plan objectives are progressed. This wasn't required in 2025/26. • Policy reviews were undertaken as a result of FTPFO LPE recommendations.
COMPONENT 6 **This component relates to how the organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance.**	
• The ICB's anti-fraud work plan 2025/26 identified risk-based priorities and measurable outputs, which were monitored by the CFO and AC via progress reports. • These metrics included the number of fraud prevention checks (FPCs), alerts and awareness materials issued.	• NFI metrics such as number of payroll and creditors matches, broken down by report type, and their outcomes were also reported. • Counter fraud costs and split of proactive / reactive days delivered during the year were reported through to the AC in the anti-

• Several outcome-based investigation metrics were reported through to the AC and via the NHSCFA case management system, including all reported incidents, the value of identified fraud losses, the value of fraud recoveries, criminal sanctions and disciplinary sanctions.	fraud work plan, annual report and to the NHSCFA via the annual CFFSR.



COMPONENT 3 **This component relates to the local fraud risk assessments undertaken in line with Government Counter Fraud Profession methodology to identify fraud, bribery and corruption risks, and how the organisation's counter fraud, bribery and corruption provision is proportionate to the level of risk identified.**	
• The AFS has carried out local risk assessments to identify fraud and bribery risks in line with GCFP fraud risk assessment methodology and with consideration of NHS fraud risks identified by NHSCFA that are applicable to ICBs.	• Progress of work plan delivery is monitored by the CFO and reported through to the AC via anti-fraud progress reports. • The AFS and CFO ensure sufficient resources are available to address any emerging risks. The AC is the committee responsible for fraud risk and provides the Board with an assessment of adequacy

• Measures to mitigate against identified risks, where possible, are contained in the work plan. • Risks were re-assessed in 2024/25. The FRA is comprehensive and considers specific individual risks and broader thematic risk areas. • The FRA is subject to monitoring and review in line with the ICB's Risk Management Policy.	and effectiveness of ICB's risk management. • Requirement 3 is currently rated 'Amber' due to a requirement to take account of changes in NHS strategic risk profile, around the failure to prevent fraud offence, and as a result of the updated GCFP risk framework. This work will be addressed via the 26/27 work plan.
COMPONENT 7 **This component relates to the reporting routes in place at the organisation to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations on the approved NHS case management system CLUE.**	
• AFS contact details, the national FCRL and the online reporting tool are all publicised in the ICB's anti-fraud policy (on the intranet and internet), in presentation materials and in fraud awareness materials circulated, inc. articles, newsletters, videos, podcasts, webinars, social media platforms, payslip messages, alerts and IFAW promotional materials. • The relevant reporting routes are also referenced in other ICB policies. • Reporting routes to other appropriate bodies, e.g. Action Fraud and National Cyber Security Centre, are included in relevant awareness materials circulated.	• The ICB has a comprehensive anti-fraud section on its website which includes the policy and contact details for AFS, CFC, the MIAA Investigations Team and links to the NHSCFA website. • Levels of staff awareness and knowledge of the reporting routes are measured through occasional surveys and the ESR-based fraud e-learning module. • Reported incidents of fraud, bribery and corruption are recorded on CLUE and reported to the CFO and the AC via progress reports.
COMPONENT 8 **This component relates to the organisation's use of the approved NHS case management system CLUE to record all allegation and investigative activity. Including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.**	
• The AFS uses the NHSCFA case management system ('CLUE') to record reported incidents of suspected fraud etc, investigation activity and also Local Proactive Exercises undertaken for the ICB. • Regular anti-fraud management checks are conducted to ensure the completeness and	• Evidence of the correct use of the system is contained in: NHSCFA case management system records; investigation files; and Local Proactive Exercise records.

timeliness of information recorded on the system, with updates provided to the CFO and AC via anti-fraud progress reports and the Annual Reports.	
COMPONENT 9 **This component relates to the accredited LCFS at the organisation, and details of the continuous professional development undertaken. All LCFS undertaking counter fraud activity at the organisation must be nominated with the NHSCFA.**	
• ICB has a fully accredited nominated AFS to undertake anti-fraud work on its behalf. • MIAA ensures that AFS receives appropriate training and Personal Development opportunities and these activities are referenced in the anti-fraud progress reports presented to the AC. • AFS undertakes training and continuous professional development (CPD), as well as receiving guidance, support and updates from managers, peers and the NHSCFA.	• AFS and MIAA Anti-Fraud Team members attended the following during 25/26: internal training on Audit Principles; training with the NHSCFA Fraud Hub Team on the use of the CLUE system and the recording of Outcome records and System Weakness Reports; external NHSCFA Prevention Engagement Session – LPEs/System Weakness Reports; external training on organised immigration crime; internal training on NHS risk management, and on improving AC presentation skills; NHSCFA LCFS annual conference 2026 in Leeds; NHSCFA Webinars inc. PHB fraud.
COMPONENT 10 **This component relates to the proactive work completed to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and the work undertaken in response.**	
• Proactive work forms a part of the agreed anti-fraud work plan. Local Proactive Exercises (LPE) are included based on risk, local intelligence, and discussions with the CFO. • The ICB undertakes local proactive work to help detect instances of fraud and bribery identify potential system weaknesses. • In 2025/26, the AFS conducted an LPE in relation to the new corporate fraud offence of 'failure to prevent fraud' (FTPF), which resulted in a number of actions and recommendations, including policy updates, staff briefings, 'associated persons' awareness raising and webinars.	• The AFS also commenced an LPE in respect of s.12 MHA claims. • ICB participates in national exercises, including NFI. • ICB engages constructively with the AFS regarding national IBURNs, FPNs and Learning Reports issued to identify potential system weaknesses & implement agreed recommendations. • The AFS issued over 40 local Fraud Prevention Checks (MIAA local alerts) in 2025/26. • The outcomes of proactive work undertaken are reported through to the CFO and the AC via progress reports.

COMPONENT 11 **This component relates to the programme of work undertaken at the organisation to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff. The effectiveness of the awareness programme is measured.**	
• Numerous activities are undertaken to promote awareness including staff presentations, circulation of articles, newsletters, videos, alerts, payslip messages and privacy notices, training delivery, promotion of IFAW, policy updates and promotion, dedicated intranet/internet sections, new NHSCFA materials circulated. • All fraud materials reference AFS contact details, the FCRL and online reporting tool.	• In 25/26, awareness sessions / webinars were delivered to various staff groups, including senior managers and the board, in relation to the new 'failure to prevent fraud' offence. • Effectiveness of the programme and levels of staff awareness are measured through occasional staff surveys. An ICB-wide staff survey is due to be undertaken in 26/27. • Compliance with the ESR '000' fraud awareness e-learning module was at 91.3%
COMPONENT 12 **This component requires the organisation to have in place policies and registers for gifts and hospitality and conflicts of interest that reference the requirements of the Bribery Act 2010 that are communicated to all staff. The effectiveness of the policies and registers is regularly tested.**	
• ICB COI Policy & Procedure consistent with national guidance, references fraud and the Bribery Act; also, Standards of Business Conduct Policy. • Process for completion of all staff declarations in place. • Thorough processes to check and follow up on non-compliance, raise awareness, and reiterate importance of strong financial governance, via ICB-wide communications. • ICB maintains Registers of Interests and G&H, scrutinised by AC and available for public access on website.	• ICB decision-making staff cohort required to make at least annual declaration, inc. if nil. • ICB committed to maintaining high compliance rates, FY 25/26 was 87%. • Awareness materials and AFS training include COI & Bribery Act awareness. • ICB processes subject to periodic IA review and follow-ups.

Appendix A – Contract Performance / Nominations Overview

Area of Activity	£	Days
Proactive costs / days	£19,981.00	53
Reactive costs / days	£4,524.00	12
Total costs / days	**£24,505.00**	**65**

Role	Name of Nominated Person(s)
Accountable Board Member	Kathy Row, Chief Finance Officer
Audit Committee Chair	Richard Paver, NED
Counter Fraud Champion	David Dobson, Head of Business Management
Lead AFS	Paul Bell, Anti-Fraud Specialist / Head of Anti-Crime Services (MIAA)
Nominated supporting AFS	Phillip Leong, Anti-Fraud Specialist Sarah Bailey, Anti-Fraud Specialist Paul McGrath, Investigations Manager Claire Smallman, Head of Investigations

Appendix B – Fraud Risk Assessments & Local Proactive Exercises (LPEs)

Risk Assessments

Fraud Risk Assessments undertaken in line with GCFP methodology	Number
Number of comprehensive FRAs undertaken in line with GCFP methodology:	0
Number of thematic FRAs recorded in line with GCFP methodology:	1*
Total number of FRAs in line with GCFP methodology:	1
Number of comprehensive FRAs integrated into the organisational risk register in line with the organisational risk management policy:	0
Number of thematic FRAs integrated into the organisational risk register in line with the organisational risk management policy:	8

Comments:

* Organisation-wide FRA originated from a pre-2025/26 FRA, per the table above. An updated, CGFP compliant, comprehensive fraud risk-assessment is scheduled in the 2026/27 anti-fraud plan.

LPEs

LPE reference number	Date Opened	Date Closed	Title Type	Outcome - Financial Recovery (Y/N)	System Weakness Reports added to CLUE (Y/N)
LPE/25/00869	19/09/25	Open on CLUE, pending closure as final report issued	Failure to Prevent Fraud – Gap Analysis	No	No - Advisory recommendations
LPE/25/00863	12/09/25	N/A ongoing	S.12 MH Assessment Claims	N/A	N/A

Appendix C – Summaries of Referrals and Investigation Activity Recorded on the NHSCFA Case Management Systems (CLUE) in year

Referrals & Investigation Activities

The table below summarises:

- **Referral Queries:** These are queries received which either on analysis fall outside of the remit of investigation by the AFS (i.e. not fraud) or do not meet the requirements to be recorded on the NHSCFA case management system; and
- **CLUE Investigations:** These are formal investigations that have been recorded on the NHSCFA case management system.

N.B. A 'referral query' is an allegation or suspicion of fraud(s) which may come from a variety of sources, requiring some initial inquiry work by the AFS to determine whether or not there is sufficient basis for a full investigation.

An 'Investigation' is opened by the AFS once it has been decided in conjunction with the CFO that a referral warrants further investigation.

Referral Queries	Referral Numbers
Referral queries brought forward from 2024/25 Annual Report	**11**
Referral queries received in 2025/26	51
Referral queries upgraded to Investigations on the case management system	2
Referral queries closed in 2025/26	60
Referral queries carried forward to 2026/27	**2**

CLUE Cases Open (at year end)

URN/INV number	Date opened	Case type	Current Status / Update	System Weakness Report (SWR) on CLUE (Y/N)
INV/25/00980	20/03/26	PHB allegation	Enquiries ongoing	N/A

Comments: No additional comments.

CLUE Cases Pending Closure

For cases that are closed criminally (with NFA) but alternative disposal is still being considered or actioned.

URN/INV number	Date opened	Case type	Outcome – Disciplinary	Outcome – Regulatory	Outcome – Redress:	SWR on CLUE (Y/N)
N/A						

Comments: No additional comments.

CLUE Cases Closed

URN/INV number	Date opened	Date closed	Case type	Outcome – Criminal	Outcome – Disciplinary	Outcome – Regulatory	Outcome – Redress	SWR on CLUE (Y/N)
INV/24/01404	31/05/24	13/03/26	Undeclared interest	N	N	N	N	N
INV/24/03286	20/12/24	05/05/25	Optical claims	N	N	N	N	N
INV/25/03098	25/09/25	21/10/25	Unsolicited payment req.	N	N	N	YES	N

Comments: No additional comments.

Financial Redress

URN/INV number:	Fraud Identified	Fraud Loss Identified	Fraud Prevented	Fraud Recovered	Non-Fraud Loss	Non-Fraud Prevented	Non-Fraud Recovered
INC/24/01361 INV/25/03098 INV/25/02325			£14,928.0 £2,498.5 £635.4				

Comments: No additional comments.

Paul Bell
Head of Anti-Crime Services
Tel: 07552 253068
Email: paul.bell@miaa.nhs.uk

Darrell Davies
Regional Assurance Director
Tel: 07785 286381
Email: darrell.davies@miaa.nhs.uk

Chris Harrop
Managing Director
Tel: 07881 036900
Email: chris.harrop@miaa.nhs.uk

NHS
Greater Manchester

External Audit Findings Report 2025/2026

Part of Greater Manchester Integrated Care Partnership

Audit Committee

17 June 2026

Required information.	Details.
Title of report.	External Audit Findings Report 2025/26.
Author.	Michael Green – Grant Thornton Perminder Sethi – Grant Thornton
Presented by.	Michael Green – Grant Thornton Perminder Sethi – Grant Thornton
Contact for further information.	Kaye Abbott – Associate Director of Finance – Financial Control. kayeabbott@nhs.net
Executive summary.	The paper summarises the year-end audit of NHS GM covering: 1. The key headlines and status of the on-going audit, confirming the issue of a section 30 Letter to the Secretary of State due to the in-year deficit position reported. 2. The materiality values within the audit process. 3. An over-view and conclusion on the potential significant audit risks and updates on the key judgements and estimates within the 2025/26 accounts. 4. The audit adjustments made and those identified but remaining unadjusted within the accounts. 5. The audit firm's independence and agreement of additional fees. 6. A number of appendices which include: • the action plan and management responses to these, including the follow up of prior year recommendations. • Draft Letter of Representation to be agreed by Committee. • Draft Audit Opinion

	• Copy of the section 30 Letter to the Secretary of State.
The benefits that the population of Greater Manchester will experience.	Not applicable.
How health inequalities will be reduced in Greater Manchester's communities.	Not applicable.
The decision to be made and/or input sought.	The Audit Committee is asked to: 1. Approve the report, the recommendations and the management responses. 2. Agree the additional fees proposed in the report.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Not applicable.
Key milestones.	Final documents will be issued once the process is finalised and this will be submitted to NHS England within the statutory accounts submission process, by 9am on Friday 19 June 2026.
Leadership and governance arrangements.	This report has been discussed and agreed with the Chief Finance Officer. The report has also been circulated to Chief Officers.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	This report has been discussed and agreed with the Chief Finance Officer. The report has also been circulated to Chief Officers.
Financial or Legal Implications	There are no direct financial or 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	No

Table 2: Assurance needed about the document.

Grant Thornton

Audit Findings for NHS Greater Manchester ICB

For the year ended 31 March 2026

17 June 2026

Grant Thornton

Members of the Audit Committee
NHS Greater Manchester Integrated Care Board
The Tootal Buildings
56 Oxford Street
Manchester
M1 6EU

Grant Thornton UK LLP
Landmark
St Peter's Square
1 Oxford Street
Manchester
M1 4PB

T +44 (0)161 953 6900
www.grantthornton.co.uk

17 June 2026

Dear Members of the Audit Committee

Audit Findings for NHS Greater Manchester Integrated Care Board for the year ended 31 March 2026

This Audit Findings Report presents the observations arising from the audit that are significant to the responsibility of those charged with governance to oversee the financial reporting process and confirmation of auditor independence, as required by International Standard on Auditing (UK) 260. Its contents have been discussed with management.

As auditor we are responsible for performing the audit, in accordance with International Standards on Auditing (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 for the preparation of the financial statements.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Chartered Accountants

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We encourage you to read our transparency report which sets out how the firm complies with the requirements of the Audit Firm Governance Code and the steps we have taken to manage risk, quality and internal control particularly through our Quality Management Approach. The report includes information on the firm's processes and practices for quality control, for ensuring independence and objectivity, for partner remuneration, our governance, our international network arrangements and our core values, amongst other things. This report is available at transparency-report-2025.pdf (grantthornton.co.uk)

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Michael Green

Partner
For Grant Thornton UK LLP

Chartered Accountants

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Contents

Section	Page
Headlines	5
Our approach to materiality	8
Overview of significant risks identified	9
Other findings	14
Communication requirements and other responsibilities	20
Audit adjustments	26
Value for Money arrangements	32
Independence considerations	33
Appendices	35

Appendices	Page
A. Communication with those charged with governance	36
B. Action plan	38
C. Follow up of prior year recommendations	42
D. Management letter of representation	46
E. Draft audit opinion	50
F. S30 Letter to Secretary of State for Health and Social Care	57

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Headlines

Summary of the key findings and other matters arising from the statutory audit of NHS Greater Manchester ICB ('the ICB') and the preparation of the ICB's financial statements for the year ended 31 March 2026 for those charged with governance.

Financial statements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to report whether, in our opinion:

- The ICB's financial statements give a true and fair view of the financial position of the ICB and of its income and expenditure for the period;
- The ICB's financial statements, and the parts of the Remuneration and Staff Report to be audited, have been properly prepared in accordance with the Department of Health and Social Care (DHSC) group accounting manual 2025/26 (GAM); and
- Expenditure has been incurred 'as intended by Parliament'.

We are also required to report whether other information published together with the audited financial statements in the Annual Report, is materially consistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

Our findings are summarised on the following pages. Based on our work completed to date, we have not identified any agreed adjustments to the financial statements which impact on your reported Comprehensive Expenditure figure. We have however identified a number of disclosure amendments which are detailed on pages 27 to 30. We have also raised four recommendations for management as a result of our audit work which are set out at Appendix B. Our follow up of recommendations from the prior year's audit are detailed at Appendix C.

The ICB's draft financial statements show that the ICB has overspent against its revenue resource limit of £9,432,074k for 2025-26 by £7,493k. This overspend for the year of £7,493k indicates NHS Greater Manchester Integrated Care Board has taken a course of action that is unlawful and has caused a loss. This gives rise to a duty on us to report under section 30(b) of the Local Audit and Accountability Act 2014 to the Secretary of State for Health and Social Care (our letter is reproduced at Appendix F). In addition, given the overspend, the ICB has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion, as a result, our audit opinion will be qualified in this respect. We understand from management that the overspend of £7,493k was agreed with NHS England as part of the planning process. For context, the ICB's overspend outturn position is not dissimilar to some other ICBs' who like NHS Greater Manchester Integrated Care Board are facing on-going financial pressures and increased demand for services.

Our work is substantially complete and there are no matters of which we are aware that would require modification of our audit opinion (Appendix E) or material changes to the financial statements, subject to the following outstanding matters:

- completing audit work in a number of areas including block and non-block contracts, creditors, MHIS, journals and the remuneration and staff report
- completing work on the Whole of Government Accounts (WGA) consolidation schedules and the assurance statement
- satisfactorily resolving matters arising from the technical hot review of the accounts by our technical team

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Headlines (Continued)

Financial statements continued

- our internal quality review processes, including final reviews of the file by the Senior Manager and Partner
- reviewing the final version of the financial statements, Annual Report and Annual Governance Statement
- receipt of the signed management letter of representation
- review of the final set of financial statements, including confirming the other information published together with the financial statements remains consistent post all audit adjustments at the date of signing the opinion.

We have concluded that the other information to be published with the financial statements, is consistent with our knowledge of your organisation and the financial statements we have audited.

We anticipate our audit report opinion as set out at Appendix E will be unmodified except for the regularity opinion as noted earlier.

Value for Money (VFM) arrangements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to consider whether the ICB has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Auditors are required to provide a commentary on the ICB's overall arrangements and set out our key recommendations on any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the ICB's arrangements under the following specified criteria:

- Financial sustainability;
- Governance; and
- Improving economy, efficiency and effectiveness.

As part of our 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. We identified one potential risk of significant weakness in the ICB's arrangements in relation to managing its in-year financial performance, financial planning for 2026/27 and its medium-term financial planning which we included in our Audit Plan.

We have now completed our Value for Money arrangements work and our findings are set out in our Auditor's Annual Report which is included on the Audit Committee agenda.

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Headlines (Continued)

Value for Money (VFM) arrangements continued

Our work identified one significant weakness relating to financial sustainability. No significant weaknesses were identified relating to Governance, or Improving economy, efficiency and effectiveness.

Our detailed findings are included within our Auditor's Annual Report.

Statutory duties

The Local Audit and Accountability Act 2014 ('the Act') also requires us to:

- report to you if we have applied any of the additional powers and duties ascribed to us under the Act; and
- to certify the closure of the audit.

We have not exercised any of our additional statutory powers or duties except:

- we made a referral to the Secretary of State for Health and Social Care and NHS England under section 30 of the Local Audit and Accountability Act 2014 given the ICB had overspent against its revenue resource limit of £9,432,074k for 2025-26 by £7,493k
- we will qualify our regularity opinion as the ICB overspent against its revenue resource limit by £7,493k and has not applied income and expenditure for the purposes intended by Parliament.

We cannot formally conclude the audit and issue an audit certificate for NHS Greater Manchester Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 until the National Audit Office has concluded their work in respect of consolidation returns for the year ended 31 March 2026.

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Our approach to materiality

As communicated in our Audit Plan dated 11 March 2026, we determined materiality at the planning stage as £186,844k based on 2% of estimated gross operating costs for the current year. On receipt of draft financial statements, we have reconsidered planning materiality based on the 2025/26 figures in the draft financial statements, given the increase is less than 3%, we have retained the materiality determined at the planning stage. Our approach to determining materiality is set out below.

Area	Amount (£)	Qualitative factors considered
Materiality for the financial statements	£186,844k	This is equivalent to approximately 2% of the estimated gross operating costs for the year ended 31 March 2026. On receipt of draft financial statements, we recalculated materiality based on the ICB's draft gross operating costs, however, given the calculated increase in materiality was less than 3%, we retained the materiality determined at the planning stage.
Performance materiality for the financial statements	£140,133k	Performance materiality has been set at 75% of financial statements materiality. This reflects our risk-assessed knowledge of potential for errors occurring. Performance materiality is used for the purposes of assessing the risks of material misstatement and determining the nature, timing, and extent of further audit procedures. This is the amount we set at less than materiality for the financial statements as a whole, to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.
Reporting threshold	£1,000k	This balance is set at £1,000k as this is the reporting threshold for any errors identified as part of our work on the National Audit Office's Whole of Government Accounts (WGA) exercise.
Senior officer remuneration disclosures: Materiality Performance materiality (70%)	 £47k £32.9k	Due to the public interest in senior officer remuneration disclosures, we apply specific audit procedures to this work and set a lower materiality level for this area. We evaluate errors in this disclosure for both quantitative and qualitative factors against this lower level of materiality. We have retained the materiality from planning stage at final accounts stage. We note management's approach is to make amendments identified in this area irrespective of the amount.

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Overview of significant risks identified

The table below summarises the significant risks discussed in more detail on the subsequent pages.

Significant risks are defined by ISAs (UK) as an identified risk of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum due to the degree to which risk factors affect the combination of the likelihood of a misstatement occurring and the magnitude of the potential misstatement if that misstatement occurs.

Other risks are, in the auditor's judgment, those where the risk of material misstatement is lower than that for a significant risk, but they are nonetheless an area of focus for our audit.

Risk title	Risk level	Change in risk since Audit Plan	Fraud risk	Level of judgement or estimation uncertainty	Findings
Risk 1 Management override of controls	Significant	↔	✓	Low	●
Risk 2 New System Implementation - IFSE 2	Significant	↔	×	Low	●
Risk 3 Fraud in Revenue recognition	Significant (Rebutted)	↔	×	Low	●
Risk 4 Fraud in Expenditure recognition	Significant (Rebutted)	↔	×	Low	●

Key

↑ Assessed risk increase since Audit Plan

↔ Assessed risk consistent with Audit Plan

↓ Assessed risk decrease since Audit Plan

● No adjustment or change in disclosure required

● Non-material adjustment or change in disclosure required

● Material adjustment or change in disclosure required

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Significant risks identified

Risks identified	Audit procedures performed	Key observations
Management override of controls Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management override of controls is present in all entities. The ICB faces external pressures to meet targets, and this could potentially place management under undue pressure in terms of how they report performance. We have therefore identified management override of controls, in particular journals, management estimates and transactions outside the course of business as a significant risk of material misstatement.	As part of our work, we have: • evaluated the design and implementation of management controls over journals • analysed the journals listing and determined the criteria for selecting high risk unusual journals • challenged management's key judgements and estimates and considered whether these judgements and estimates are individually or cumulatively indicative of management bias • tested unusual journals made during the year and after the accounts production stage for appropriateness and corroboration • gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness • evaluated the rationale for any changes in accounting policies, estimates or significant unusual transactions. In performing the procedures above, we identified a population of journals to test using data analytic software to analyse journal entries and to split large batch journals into smaller sets of transactions that support targeted testing based on specific risk criteria assessed by the audit team. These criteria include: • Journals reducing expenditure • Self-approved journals • Post year-end journals • Manual material journals • Year-end journals • Journals posted by senior management These routines were completed on ISFE 1 and ISFE 2. Application of these routines and supplementary procedures identified a total sample of 36 journals to test. Of these 22 were on ISFE1 and 14 on ISFE 2. Review of accounting policies and their application and consideration of critical judgements and key accounting estimates has not identified any matters to bring to your attention.	Our audit work is substantially complete and to date has not identified any issues in respect of management override of controls.

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Significant risks identified (continued)

Risks identified	Audit procedures performed	Key observations
New System Implementation – IFSE 2 (Integrated Single Financial Environment 2) We identified the new system implementation of ISFE 2 as a significant risk of material misstatement due to error.	As part of our work, we have: • gained an understanding of the processes used for the implementation of ISFE 2 • identified potential risks created or heightened by the new ledger system • tested the data migration • completed a review of user access restrictions • documented and gained an appropriate understanding of corresponding ITGCs (information technology general controls) • reviewed the service auditor report regarding the migration of Integrated Single Financial Environment (ISFE) data from ISFE1 to ISFE2.	Our audit work to date has not identified any issues in respect of implementing the new system IFSE 2.

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Significant risks identified (continued)

Risks identified	Audit procedures performed	Key observations
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 rebutted this presumed risks for the ICB because: • the majority of the ICB's revenue is an allocation from NHS England which is not accounted for in the Statement of Comprehensive Net Expenditure and does not primarily involve cash transactions • income from sale of goods and services and other operating income is not material • there is little incentive or opportunities to manipulate revenue or expenditure • the culture and ethical frameworks of the NHS mean that all forms of fraud are seen as unacceptable. We therefore do not consider this to be a significant risk for the ICB and have rebutted it.	As part of our final accounts audit process, we have reassessed our rebuttal of the revenue recognition risk and concluded the rebuttal remains appropriate. Despite this, we have undertaken audit procedures on the ICB's revenues including: • evaluating the ICB's accounting policy for recognition of income for appropriateness and compliance with the DHSC Group Accounting Manual 2025/26 • using the DHSC mismatch report to investigate unmatched income balances with other NHS bodies over the NAO £1m threshold • agreeing relevant income disclosures and figures from the draft annual accounts, including operating income to supporting evidence • agreeing the ICB's revenue resource allocations to supporting information from NHSE.	Whilst our audit work remains on-going, no significant issues have arisen to date.

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Significant risks identified (continued)

Risks identified	Audit procedures performed	Key observations
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 part of our final accounts audit process, we have reassessed our rebuttal of the expenditure recognition risk and concluded the rebuttal remains appropriate. As we do not consider this to be a significant risk for the ICB, standard audit procedures were undertaken including a focus on consideration of unrecorded liabilities and expenditure completeness. As part of our work we have: • evaluated your accounting policy for recognition of expenditure for appropriateness and compliance with the DHSC Group Accounting Manual 2025/26; • Considered and assessed the ICB's process for recording expenditure accruals and deferrals, and any relevant controls; • used the DHSC mismatch report to investigate unmatched expenditure and payable balances with NHS bodies over the NAO £1m threshold; • inspected a sample of payable and expenditure accrual balances; • obtained a listing from the cash book of payments in March and April to ensure they have been charged to the appropriate year; • agreed significant secondary healthcare contracts to reported expenditure, reconciling agreed contracts to outturn values; • agreed prescribing expenditure and other areas of expenditure based on contractual or other agreements to supporting evidence; and • inspected a sample of expenditure for non-contracted expenditure.	Whilst our audit work remains on-going, no significant issues have arisen to date except for one matter relating to contract variations. Our audit work reviewing block contract variations noted a number of contract variation agreements or baseline contracts relating to specialised commissioning had 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 is at risk of potential disputes. This matter was reported last year 2024-25 (in relation to contract variations) and has been reported again in the Action Plan at Appendix B.

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Other findings – accounting policies

Accounting area	Summary of policy	Comments	Assessment
Accounting policies The ICB's accounting policies are contained within the notes to the financial statements at Note 1 (Note 1 to Note 1.20).	The ICB's accounting policies are based on the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. The accounting policies are the specific methods and practices the ICB uses to recognise, measure, and present assets, liabilities, income, and expenditure in its financial statements. The accounting policies include: • Going Concern • Accounting Convention • Pooled Budgets • Revenue • Employee Benefits • Other Expenses • Property, Plant & Equipment • Cash and Cash Equivalents • Provisions • Contingent Liabilities and Contingent Assets • Financial Assets and Liabilities • Value Added Tax • Losses and Special Payments	• The ICB's accounting policies meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care and follow International Financial Reporting Standards to the extent as determined by HM Treasury. • We have reviewed the ICB's accounting policies including expenditure recognition and they are considered appropriate • The ICB's accounting policies have been adequately disclosed.	🟢

Assessment:
- 🔴 Marginal accounting policy which could potentially be open to challenge by regulators
- 🟡 Accounting policy appropriate but scope for improved disclosure
- 🟢 Accounting policy appropriate and disclosures sufficient

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Other findings – key judgements and estimates

This section provides commentary on key estimates and judgements in line with the enhanced requirements for auditors.

Key judgement or estimate	Summary of management's approach	Auditor commentary	Assessment
Prescribing accrual The ICB included an accrual of £95.2m at 31 March 2026 for prescribing costs. (£93.4m at 31 March 2025)	The accrual is based on ten months prescribing data and the forecast for the remaining two months is based on the previous monthly costs adjusted for any known changes. Actual data is available two months in arrears of the current reporting period. Assumptions are derived from different cost elements using prescription pricing authority (PPA) and itemised prescribing payment (IPP) data. The ICB's approach to calculating the prescribing accrual is consistent to the prior year.	We have: • agreed the completeness and accuracy of the underlying information used to determine the prescribing accrual • considered the appropriateness of any alternative assumptions • reviewed the reasonableness of any increase/decrease in the estimate • agreed the disclosure of the estimate in the financial statements. In addition, we have compared the prescribing accrual to the actual prescribing costs which became available during May 2026. Actual prescribing costs for the last two months of the year total £96.4m compared to the prescribing accrual of £95.2m, an under accrual of £1.2m. The prescribing accrual was based on information available at the time it was calculated and followed the same approach to calculation as in the prior year. The process followed appears appropriate. We have discussed this difference with management who do not consider an amendment to the accounts is necessary given the amount is not considered material. As such, it has been recorded as an unadjusted error.	

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Other findings – information technology

This section provides an overview of results from our assessment of information technology (IT) environment and controls which included identifying risks from the use of IT related to business process controls relevant to the financial audit. This includes an overall IT general control (ITGC) rating per IT system and details of the ratings assigned to individual control areas.

			ITGC control area rating			
IT application	Level of assessment performed	Overall ITGC rating	Security management	Technology acquisition, development and maintenance	Technology infrastructure	Related significant risks/other risks
Common Controls	ITGC assessment (design, implementation only)	●	●	●	●	None
SBS Oracle	ITGC assessment (design and implementation effectiveness only)	●	●	●	●	None
SBS Electronic staff records	ITGC assessment (design and implementation effectiveness only)	●	●	●	●	None

Assessment

- ● Significant deficiencies identified in IT controls relevant to the audit of financial statements
- ● Non-significant deficiencies identified in IT controls relevant to the audit of financial statements/significant deficiencies identified but with sufficient mitigation of relevant risk
- ● IT controls relevant to the audit of financial statements judged to be effective at the level of testing in scope
- ● Not in scope for testing

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Other findings – information technology

We performed specific procedures in relation to the move from Integrated Single Financial Environment ISFE1 to ISFE2 during the year and considered the new system implementation as well as data migration. We observed the following results:

IT system	Event	Related significant risks	Result
Oracle ISFE	New system implementation ISFE 1 to ISFE 2	We identified the new system implementation of ISFE 2 as a significant risk of material misstatement due to error.	As part of our audit work, our central IT Team obtained the service auditor report and performed a review which covered ten key areas of the ISFE 2 project lifecycle, including planning, design, security, testing, data migration, reporting, interfaces, go-live approval, and post-implementation review. Our work noted no deficiencies or other issues.

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Other findings – service auditor reports

Matter	Commentary	Auditor view
Service Auditor Reports Under ISA 315R, auditors are required to understand and assess relevant internal controls of the systems relevant to the preparation of financial statements. This includes systems provided by service organisations. An independent auditor produces a service auditor report to provide management with assurance over the internal control environment of the system they use and as external auditors we review these service auditor reports when undertaking our work. The following systems used by the ICB are provided by service organisations. The data from these systems are relevant to preparation of financial statements of the ICB. • NHS Shared Business Service Limited: Finance and Accounting Services • NHS Business Services Authority: Electronic Staff Records • NHS Business Services Authority: Prescription Payments • NHS Business Services Authority: Dental Payments • Capita Primary Care Support Services. *Continued overleaf*	**NHS Shared Business Service Limited: Finance and Accounting Services** The audit team reviewed the ISAE 3402 Audit Type II service auditor report, which assesses the design and operating effectiveness of the controls of finance and accounting systems, Oracle EBS and BI, provided by NHS Shared Business Service Limited for period 1 April 2025 to 31 March 2026. This report noted no significant findings and concluded an unmodified opinion. **NHS Business Services Authority and IBM UK Limited: The Electronic Staff Record Programme** The audit team have reviewed the ISAE 3000 Audit Type II service auditor report which assesses the design and operating effectiveness of controls of the ESR system provided by NHS Business Services Authority for period 1 April 2025 to 31 March 2026. This report noted no significant findings and concluded an unmodified opinion. **NHS Business Services Authority: Prescription Payments** The ISAE 3402 Service Auditor Report for NHS Business Services Authority: Prescription Payments gives a clean opinion on the controls reviewed. No issues were identified within the report. **NHS Business Services Authority: Dental Payments** The ISAE 3402 Service Auditor Report for NHSS Business Services Authority: Dental Payments gives a clean opinion on the controls reviewed. No issues were identified within the report. Continued overleaf.	Assurance has been gained over the design and implementation over the controls at the service organisations for the below systems: • Finance and Accounting Services: Oracle E-Business Suite (EBS) and Business Intelligence (BI) • The Electronic Staff Record Programme (ESR) • The Prescription Payments System • The Dental Payments System Continued overleaf.

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Other findings – service auditor reports (continued)

Matter	Commentary	Auditor view
	Capita Primary Care Support Services A qualified opinion was given due to the following: • Control Objective 7 – Capita asserts that controls ensure changes to POL and PCSE Online data are accurate and properly authorised. However, testing identified one instance (out of 25 samples) between 1 April 2025 and 31 March 2026 where a GP's leave date was not updated in line with the request. As a result, the control did not fully support the accuracy assertion during the reporting period. • Control Objective 8 – Capita asserts that controls provide reasonable assurance that payments are only made following validated changes to bank details. However, in two of 14 sampled bank detail change requests, although Directors had signed the bank declaration forms, the changes were processed without approval from an authorised contact listed on the AEL, as required for GP practices without GP Partners. Consequently, the assertion that payments are only made after bank details are validated was not met during the reporting period. As per our assessment, the qualification is not considered to impact on the audit approach as observation noted was only relevant for application 'PCSE Online'. There is no observation noted with respect to other IT relevant applications. Additionally, the central IT audit team of Grant Thornton reviewed the compensatory controls related to PCSE Online and they considered these to be sufficiently robust to address the risk of inappropriate access being assigned in the year.	We have considered the control findings identified and do not consider them significant enough to have an impact on our audit opinion. The qualifications are relevant to controls operating at the third party and not the ICB. We are satisfied that that the ICB has appropriate compensating controls in these areas to mitigate against any increased area of risk.

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Communication requirements

Issue	Commentary
Matters in relation to fraud	We have previously discussed the risk of fraud with management and the Audit Committee. We have not been made aware of any significant incidents in the period and no other issues have been identified during the course of our audit procedures.
Matters in relation to related parties	We are not aware of any related parties or related party transactions which have not been disclosed.
Matters in relation to laws and regulations	You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations and we have not identified any incidences from our audit work except for the following matter. The ICB's draft financial statements indicate that the ICB has overspent against its revenue resource limit of £9,432,074k for 2025-26 by £7,493k. This overspend for the year of £7,493k indicates NHS Greater Manchester Integrated Care Board has taken a course of action that is unlawful and has caused a loss. As a result, we have a duty to report under Section 30(b) of the Local Audit and Accountability Act 2014 to the Secretary of State for Health and Social Care (our letter is reproduced at (Appendix F). In addition, given the overspend, the ICB has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion, as a result, our audit opinion will be qualified in this respect. We understand from management that the overspend of £7,493k was agreed with NHS England as part of the planning process.
Written representations	A letter of representation has been requested from the ICB which is included at Appendix D in this Report.
Accounting practices	We have evaluated the appropriateness of the ICB's accounting policies, accounting estimates and financial statement disclosures. We are satisfied with the accounting policies, accounting estimates and financial statement disclosures contained within the financial statements.
Confirmation requests from third parties	We requested from management permission to send confirmation requests. This permission was granted and the requests were sent and have been received as part of our final accounts work.
Disclosures	Our review found no material omissions in the financial statements except for minor disclosure issues in the notes to the accounts, which have been amended by management.
Audit evidence and explanations	All information and explanations requested from management was provided.
Significant difficulties	We did not encounter any significant difficulties in completing our work.

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Other responsibilities

Issue	Commentary
Going concern	In performing our work on going concern, we have had reference to Statement of Recommended Practice – Practice Note 10: Audit of financial statements of public sector bodies in the United Kingdom (Revised 2024). The Financial Reporting Council recognises that for particular sectors, it may be necessary to clarify how auditing standards are applied to an entity in a manner that is relevant and provides useful information to the users of financial statements in that sector. Practice Note 10 provides that clarification for audits of public sector bodies. Practice Note 10 sets out the following key principles for the consideration of going concern for public sector entities: • the use of the going concern basis of accounting is not a matter of significant focus of the auditor's time and resources because the applicable financial reporting frameworks envisage that the going concern basis for accounting will apply where the entity's services will continue to be delivered by the public sector. In such cases, a material uncertainty related to going concern is unlikely to exist, and so a straightforward and standardised approach for the consideration of going concern will often be appropriate for public sector entities • for many public sector entities, the financial sustainability of the reporting entity and the services it provides is more likely to be of significant public interest than the application of the going concern basis of accounting. Our consideration of the ICB's financial sustainability is addressed by our value for money work, which is covered elsewhere in this report. Practice Note 10 states that if the financial reporting framework provides for the adoption of the going concern basis of accounting on the basis of the anticipated continuation of the provision of a service in the future, the auditor applies the continued provision of service approach set out in Practice Note 10. The financial reporting framework adopted by the ICB meets this criteria, and so we have applied the continued provision of service approach. In doing so, we have considered and evaluated: • the nature of the ICB and the environment in which it operates • the ICB's financial reporting framework • the ICB's system of internal control for identifying events or conditions relevant to going concern • management's going concern assessment. On the basis of this work, we have obtained sufficient appropriate audit evidence to enable us to conclude that: • a material uncertainty related to going concern has not been identified; and • management's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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Other responsibilities

Issue	Commentary
Other information	We are required to give an opinion on whether the other information published together with the audited financial statements (including the Annual Report), is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. No inconsistencies have been identified and we plan to issue an unmodified opinion in this respect – refer to Appendix E.
Auditable elements of Remuneration Report and Staff Report	In line with national guidance, the ICB commenced the process to reduce its staffing levels during the year. The draft financial statements indicate 52 compulsory redundancies and 334 other agreed departures with payments made of £2,701k and £21,162k respectively. We are required to give an opinion on whether the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the requirements of the Act, directed by the Secretary of State with the consent of the Treasury. We have audited the elements of the Remuneration Report and Staff Report, including the Fair Pay Multiple Disclosures, as required by the GAM, and note the following matters: • we identified a number of minor disclosure amendments and enhancements within the remuneration report which have been actioned by management within the annual report • we noted two individuals whose salaries were incorrectly classified within the Senior Manager Remuneration Table, these have now been corrected by management • we identified four individuals whose real increase in Cash Equivalent Transfer Value was incorrect. Management has now amended for these errors within the annual report • within the exit package disclosures, the ICB accrued for 48 individuals as compulsory redundancies which are considered under IAS37 to be provisions rather than accruals totalling £2.3m. As a result, Note 4.4 Exit Packages should be corrected to remove these compulsory redundancies and included within Note 13 Provisions. Management do not consider this error to be sufficiently material to require a change in the draft accounts, as such it has been recorded as an unadjusted error • within the remuneration report, the disclosure relating to compensation on early retirement or for loss of office has omitted two senior officers with agreed exit packages in year but have not yet left the organisation. Management has agreed to correct this omission within the annual report. We propose to issue an unqualified opinion on whether the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the requirements of the Act, directed by the Secretary of State with the consent of the Treasury.

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Other responsibilities under the Code

Issue	Commentary
Matters on which we report by exception	We are required to report on a number of matters by exception in a number of areas: • the Annual Governance Statement does not comply with guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit; • the information in the annual report is materially inconsistent with the information in the audited financial statements or is apparently materially incorrect based on, or is materially inconsistent with, our knowledge of the ICB acquired in the course of performing our audit, or otherwise misleading; • if we have applied any of our statutory powers or duties; or • where we are not satisfied in respect of arrangements to secure value for money and have reported significant weaknesses. We have nothing to report on these matters except for: • the ICB has overspent against its revenue resource limit of £9,432,074k for 2025-26 by £7,493k. This overspend for the year of £7,493k indicates NHS Greater Manchester Integrated Care Board has taken a course of action that is unlawful and has caused a loss. As a result, we have reported this matter under Section 30(b) of the Local Audit and Accountability Act 2014 to the Secretary of State for Health and Social Care (our letter is reproduced at Appendix F). In addition, given the overspend, the ICB has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion, as a result, our audit opinion will be qualified in this respect. We understand from management that the overspend of £7,493k was agreed with NHS England as part of the planning process. • our value for money work which is reported in our Auditor's Annual Report identified one significant weaknesses relating to financial sustainability. No significant weaknesses were identified relating to Governance, or Improving economy, efficiency and effectiveness. Our detailed findings are included within our Auditor's Annual Report.
Review of accounts consolidation schedules and specified procedures on behalf of the group auditor	We are required to give a separate audit opinion on the ICB accounts consolidation schedules and to carry out specified procedures (on behalf of the NAO) on these schedules under group audit instructions. In the group audit instructions the ICB was not selected as a sampled component. Whilst our work in this area remains on-going, there are no matters arising to report.

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Other responsibilities under the Code

Issue	Commentary
Certification of the closure of the audit	We cannot formally conclude the audit and issue an audit certificate for NHS Greater Manchester ICB for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 until the National Audit Office has concluded their work in respect of consolidation returns for the year ended 31 March 2026. We expect to certify the closure of this audit as soon as possible thereafter.
Regularity opinion	This opinion sets out whether expenditure incurred is in line with the purposes for which it was provided. We are also required to identify whether any unadjusted misstatements impact the ICB surplus/deficit position. Where there is such an impact, we are required to consider whether that will impact the regularity opinion we should give. As noted earlier, the ICB has overspent against its revenue resource limit by £7,493k. The ICB has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion, as a result, our audit opinion will be qualified in this respect. We have also issued a S30 letter to the Secretary of State for Health and Social Care as referred to earlier given the overspend position for the year.

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Other matters

Issue	Commentary
Better Payment Practice Code	The Better Payment Practice Code (BPPC) requires 95% of all valid invoices to be paid by the due date or within 30 days of receipt of the invoice (unless in dispute). As part of our audit work on BPPC performance, we recalculated the 2025/26 disclosure and identified errors in the figures disclosed for the ICB's BPPC performance in note 6.1. These errors arose as a result of reconciliation issues following the implementation of ISFE2, driven by timing and coding variances within the new reporting environment. As a result, the figures disclosed for both Non-NHS Payables and NHS Payables needed revising as follows: • Non-NHS payables: Paid in year increases from 155,054 to 155,226 whilst total paid within target reduces from 151,126 to 150,845, with overall performance reducing from 97.47% to 97.18%. Similarly, total paid in year reduces from £2,149,532 to £2,133,081, and paid within target reduces from £1,999,581 to £1,983,849, with overall performance reducing from 93.02% to 93.00%. Management has agreed to correct for these errors. • NHS payables: Paid in year increases from 2,767 to 2,777 whilst total paid within target reduces from 2,682 to 2,678, with overall performance reducing from 96.93% to 96.44%. Similarly, total paid in year reduces from £6,895,576 to £6,672,585, and paid within target reduces from £6,892,536 to £6,669,876, with no overall change in performance which remains at 99.96%. Management has agreed to correct for these errors.

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Audit adjustments

We are required to report all non-trivial misstatements to those charged with governance, whether or not the accounts have been adjusted by management.

Impact of adjusted misstatements

No adjusted misstatements have been identified at the date of issuing our report. We will provide an update to Management and the Audit Committee should any issues be identified from the remaining testing.

	Statement of Comprehensive Net Expenditure	Statement of Financial Position	Impact on net deficit
Detail	£'000	£'000	£'000
NONE	-	-	-
Overall impact	0	0	0

Misclassification and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

Disclosure	Misclassification or change identified	Adjusted?
Statement of Cashflows	We noted three issues in the Statement of Cash Flows (SOCF): • The narrative sub heading net operating expenditure for the financial year should read net expenditure for the year • The increase/(decrease) in provisions line references to Note 10 but should reference to Note 13. Management has agreed to update the final accounts for these changes.	✓

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Audit adjustments

Disclosure	Misclassification or change identified	Adjusted?
Annual Governance Statement	Our review of the Annual Governance Statement (AGS) noted the following matter: • there was no disclosure relating to compliance with the requirements with the central government Corporate Governance Code and the Orange Book. Management has now agreed to expand this disclosure.	✓
Statement of Changes in Taxpayers' Equity	We noted one issue in the Statement of Changes in Taxpayers' Equity: • The sub heading net operating expenditure for the financial year within Changes in NHS Integrated Care Board taxpayers' equity for 2025-26 (and 2024-25) should read net expenditure for the year Management has agreed to update the final accounts for these amendments.	✓
Remuneration report	Page 144 of the Annual Report, Remuneration of Very Senior Managers (VSMs) references the disclosure threshold as £160,000, however this should be £170,000. Management has agreed to correct for this error.	✓
Various minor changes within the draft financial statements	We noted various minor typographical and disclosure amendments within the draft financial statements including: • Note 6.1 – Better Payment Practice Code - the current disclosure does not explain the target of 95% and should be added in • Note 4.4 – Exit packages agreed in the financial year – the narrative should be expanded to include how many people left by 31 March and the profile of future departures • Note 11 – Mental Health Expenditure – the disclosure should be expanded to explain the additional services provided within mental health specialised commissioning and that MHIS disclosures now form part of the financial statements from 2025-26. Management has agreed to update the final accounts for these matters.	✓

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Audit adjustments

Disclosure	Misclassification or change identified	Adjusted?
Annual report – page 142	The percentage change in remuneration of the highest paid director has not been annotated as being "subject to audit" which is not in line with the requirements of GAM sections 3.86 and 3.46. Management has agreed to update the Annual Report for this matter.	✓
Annual report – page 157 & Note 4.4 Exit Packages agreed	The disclosure of compensation for loss of office is not in line with the requirements of GAM section 3.163 which, for each individual who was a senior manager and has received a payment for loss of office during the financial year the ICB should disclose the following: a. total amount payable to the individual broken down into each component. b. an explanation of how each component was calculated. Additionally, Note 4.4 Exit Packages agreed in the financial year of the draft accounts should also provide this information. Management has agreed to update for these disclosures.	✓
Annual report – page 142	There is currently no context provided regarding the percentage figures disclosed as required by GAM section 3.117. The percentages changes for both the highest paid director and the employees as a whole have significantly reduced from the prior year and this context would help users of the accounts understand the percentages disclosed. Management has agreed to add additional disclosure to address this matter.	✓
Annual report – page 145	Within the remuneration report tables, the banded salary of the highest paid director is reported to be £300k - £305k. This is not consistent with what has been reported in the Pay ratio information on Page 142 which mentions a banded remuneration of £290k - £295k. Management has agreed to update these disclosures so they are consistent.	✓

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Audit adjustments

Misclassification and disclosure changes continued

Disclosure	Misclassification or change identified	Adjusted?
Annual report – page 174	The exit packages disclosures does not include Table 2: analysis of other departures which is not in line with GAM section 3.177. Management has agreed to update and add this disclosure.	✓

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Unadjusted misstatements

Impact of unadjusted misstatements

We have noted two unadjusted misstatement at the date of issuing our Report. We will provide an update to Management and the Audit Committee should any further adjustments be identified in completing our remaining work.

Detail	Statement of Comprehensive Net Expenditure £'000	Statement of Financial Position £'000	Impact on net deficit £'000	Reason for not adjusting / Notes
1. Prescribing Accrual				
Prescribing accrual	1,232	(1,232)	(1,232)	
Management included an accrual for prescribing costs of £95.2m in the draft 2025-26 financial statements. We have compared the prescribing accrual to the actual prescribing costs which became available during May 2026. Actual prescribing costs for the year total £96.4m compared to the prescribing accrual of £95.2m, a difference of £1.2m in the estimate. The accrual is understated by this amount.				Management do not consider an amendment to the accounts is appropriate given the amount is not considered material.
2. Compulsory redundancies				
Exit packages – accrual	(2,300)	(2,300)	-	Management do not consider an amendment to the accounts is appropriate given the amount is not considered material.
Exit packages - provisions	2,300	2,300	-	
Within Note 4.4 Exit packages agreed in the financial year, the ICB accrued for 48 individuals as compulsory redundancies which are considered under IAS37 to be provisions rather than accruals totalling £2.3m.				
Overall impact (increased expenditure)	**1,232**	**(1,232)**	**(1,232)**	

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Impact of unadjusted misstatements in the prior year

Detail	Statement of Comprehensive Net Expenditure £'000	Statement of Financial Position £'000	Impact on net deficit £'000	Reason for not adjusting
Investment in third party company Impairment to reflect valuation of company has significantly reduced.	1,070	-1,070	1,070	Management consider the amount is not material.
Overall impact (increased expenditure)	1,070	-1,070	1,070	

Note: This unadjusted misstatement remains relevant for 2025-26.

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Value for Money arrangements

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

The National Audit Office issued its latest Value for Money guidance to auditors in March 2026. The Code requires auditors to consider whether a body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In undertaking our work, we are required to have regard to three specified reporting criteria. These are as 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.

In undertaking this work we have identified one significant weakness in arrangements at the ICB. Our Auditor's Annual Report accompanying this audit findings report is included on the Audit Committee agenda and includes our detailed findings.

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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). In this context, there are no independence matters that we would like to report to you.

We confirm that we have implemented policies and procedures to meet the requirement of the Financial Reporting Council's Ethical Standard.

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.

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

Matter	Conclusion
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.
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 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 (and network firms) 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.

Other services

The following additional services were provided by Grant Thornton UK LLP. We do not consider these services impact on our independence or objectivity to undertake the audit of Greater Manchester Integrated Care Board.

- Review of the ICB's compliance with the Mental Health Investment Standard (MHIS). Note, this work relates to the prior year, 2024-25 but was completed during January to March 2026. The ICB had accrued the costs associated with this work in the prior year, 2024-25 and as such no fees relate to the separate reasonable assurance report on the ICB's compliance statement for 2025-26 which is no longer a requirement. Further details including fees charged are set out overleaf.

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Fees and non-audit services

The following tables below sets out the total fees for audit services that we have been engaged to provide or charged from the beginning of the financial year to 16 June 2026.

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 NHS Greater Manchester ICB. We have not provided any non-audit services to the ICB relating to 2025-26. We have adequate safeguards in place to mitigate the perceived self-interest threat from these fees as detailed below.

Audit fees 2025-26	£
Audit of ICB	£241,535
Additional work relating to:	
- MHIS 2025-26 (Audit of MHIS Note 11 - new disclosure requiring additional review and testing, this replaces the separate reasonable assurance work)	£5,000
- ISFE 2 (Additional audit work by the local audit team and national IT team – see page 11 & 17)	£6,000
Total	£252,535

The above fees are exclusive of VAT.

The fees included in the financial statements of £290k agree to the above fees once VAT is added (£242k plus VAT £48k = 290k), excluding the additional fees proposed.

Other services

As noted overleaf, we completed the review of the ICB's compliance with the Mental Health Investment Standard (MHIS) for the prior year, 2024-25 during January to March 2026. The ICB had accrued the costs associated with this work of £67,500 in 2024-25 and as such no fees relate to the separate reasonable assurance report on the ICB's compliance statement for 2025-26 which is no longer a requirement. This disclosure is made for transparency.

This covers all services provided by us and our network to the ICB, its directors and senior management and its affiliates, that may reasonably be thought to bear on our integrity, objectivity or independence.

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Appendices

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A. 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.	●	
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	●	●

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.

Distribution of this Audit Findings report

Whilst we seek to ensure our audit findings are distributed to those individuals charged with governance, as a minimum a requirement exists for our findings to be distributed to all the company directors and those members of senior management with significant operational and strategic responsibilities. We are grateful for your specific consideration and onward distribution of our report, to those charged with governance.

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A. Communication of audit matters with those charged with governance

Views about the qualitative aspects of the ICB's accounting and financial reporting practices including accounting policies, accounting estimates and financial statement disclosures	●
Significant findings from the audit	●
Significant matters and issues 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	●
Expected modifications to the auditor's report, or emphasis of matter	●

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 Findings, outlines those key issues, findings and other matters arising from the audit, which we consider should be communicated in writing rather than orally, together with an explanation as to how these have been resolved.

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B. Action plan

We set out here our recommendations for the ICB which we have identified as a result of issues identified during our audit. The matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

Assessment	Issue and risk	Recommendations
Medium	**1. Journals and system access** From our testing of leavers as part of our journals work, we identified a number of instances where a user had left the ICB however their access to the Oracle ledger was not revoked in a timely manner. Without the timely removal of leavers, there remains a risk that users could still inappropriately access the ICB's systems.	We recommend that management should improve its processes and controls to ensure leavers have their access rights revoked in a more timely manner. **Management response** Agreed – 2025/26 was an unprecedented year in terms of the numbers of leavers in the organisation as a result of the national Reform programme, with the impact continuing into 2026/27 until the position stabilises. NHS GM is processing leaver requests in a timely manner, but this is dependant on supervisors informing the Financial Control team. There had previously been an additional control in place, with HR sharing the leavers reports and checks were undertaken. This process was paused during the Reform process but has now been reinstated. There is a further complication within the ISFE2 system, as it is a requirement that the supervisor approves the deactivation, rather than it being approved centrally, and this is causing delays. This process flaw has been escalated to the national team to understand if this approach can be revisited and to enable central deactivation. Internally an escalation process is being implemented to ensure that these time delays are addressed.

Key

- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

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B. Action plan

Assessment	Issue and risk	Recommendations
Medium	**2. Contract Variations agreements** As last year, our audit work reviewing block contract variations noted a number of contract variations where contract variation agreements had not been signed. Whilst signed agreements have now been obtained or alternative confirmations received, it is essential to ensure all contract variations are agreed and signed prior to payments being made. Without a signed contract or contract variation agreement, the ICB is at risk of potential disputes.	Management should ensure all contracts and contract variations are formally agreed and signed prior to payment being made. **Management response** Agreed – This largely relates to the newly delegated mental health specialised commissioning contracts, where contracting is the responsibility of NHS England. There were similar challenges experienced when Acute Specialised Commissioning was delegated, which has improved during 2025/26, with a similar approach to be adopted in 2026/27. Within NHS GM, there is 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 is documented and this evidence has been provided as part of the year end audit. The activity values of any variable elements of the contract will be separately agreed with the counterparty trusts.

Key

- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

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B. Action plan

Assessment	Issue and risk	Recommendations
Medium	**3. Contract variation reconciliations** Our audit work reviewing block contracts noted 9 out of 15 samples where contract reconciliations did not include the contract variations relating to Specialised Commissioning for the year. In addition, 4 out 15 samples also did not include all core block expenditure. Without including Specialised Commissioning variations within the reconciliation process and all core block expenditure, there is a risk of a mismatch of the reconciliation, the amounts included in the general leger and the draft financial statements.	Management should ensure all contract variations and all core block expenditure is included within the annual reconciliations for each locality. **Management response** Agreed - A standardised approach will be developed to ensure teams are clear on the total provider reconciliation required, which can be across multiple expenditure lines in Note 5. This approach will be made mandatory during the year to feed into the audit process and will be co-ordinated by the Provider Finance & Insight Team and reviewed by the Financial Control team as part of internal quality checks on working papers.

Key

- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

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B. Action plan

Assessment	Issue and risk	Recommendations
● Medium	**4. BPPC Performance** As part of our audit work on BPPC performance, we recalculated the 2025/26 BPPC disclosures and identified the following errors in note 6.1: • Non-NHS payables: Paid in year increases from 155,054 to 155,226 whilst total paid within target reduces from 151,126 to 150,845, with overall performance reducing from 97.47% to 97.18%. Similarly, total paid in year reduces from £2,149,532 to £2,133,081, and paid within target reduces from £1,999,581 to £1,983,849, with overall performance reducing from 93.02% to 93.00%. Management has agreed to correct for these errors. • NHS payables: Paid in year increases from 2,767 to 2,777 whilst total paid within target reduces from 2,682 to 2,678, with overall performance reducing from 96.93% to 96.44%. Similarly, total paid in year reduces from £6,895,576 to £6,672,585, and paid within target reduces from £6,892,536 to £6,669,876, with no overall change in performance which remains at 99.96%. Management has agreed to correct for these errors. Without effective review, there remains a risk of disclosures being calculated incorrectly.	Management should strengthen the review and reconciliation process underpinning the BPPC disclosure to ensure accuracy and consistency between underlying working papers and the draft financial statements. **Management response** Agreed – The issue within this recommendation principally arose during the cutover period between ISFE1 and ISFE2, with the team familiarising themselves with the system and differences in process post go live as there was no access to a training environment in advance. The issues which generated the errors have been confirmed as resolved by NHS SBS, particularly around the timing of when reports are generated. NHS GM reviews the in month BPPC performance in detail, but a new control has been implemented to re-run the report to ensure that any additional postings to the dataset are captured and reflected in the calculations.

Key

- ● High – Significant effect on control system and financial statements
- ● Medium – Effect on control system and financial statements
- ● Low – Best practice for control systems and financial statements

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C. Follow up of prior year recommendations

We identified the following issues in the audit of the ICB's 2024/25 financial statements, which resulted in five recommendations being reported in our 2024/25 Audit Findings Report. We provide an update on each recommendation below.

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
✓	**1. 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.	We recommended management should ensure all journals are independently approved through the journals system prior to being posted. **Management response** 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. **Audit Update – June 2026** We are satisfied with the controls in place with ISFE 2. Our journals work noted no issues relating to this matter for the first half of the year under IFSE 1. As a result, we have closed this recommendation.

Assessment

✓ Action completed

X Not yet addressed

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C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
✓	**2. 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 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. **Management response** 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. **Audit Update – June 2026** Given the ICB periodically reviews its users and access rights and considers all users with access necessary, we have closed this recommendation.

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C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
X	**3. 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 this year 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 should ensure all contracts and contract variations are formally agreed and signed prior to payment being made. **Management response** 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. **Audit Update – June 2026** We have raised this matter and recommendation again as our audit work noted not all block contract variations had been signed.
✓	**4. Related Party Disclosures -** We note 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 should update its related party disclosure to include the omitted Non-Executive Directors that have transactions with Greater Manchester ICB. **Management response** Management has confirmed that the 2025/26 disclosure will follow the amendments made in 2024/25 and include all parties. **Audit Update – June 2026** We are satisfied related party disclosures are appropriate in 2025/26.

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C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
X	**5. 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** 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. **Audit Update – June 2026** Our audit work identified various errors in the calculation of the BPPC disclosures for 2025-26. As a result, we have raised this recommendation again in the action plan.

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D. Management letter of representation

[**Prepare on client letterhead**]

Grant Thornton UK LLP

11th Floor
Landmark St Peter's Square
1 Oxford Street
Manchester
M1 4PB

xx June 2026

Dear Grant Thornton UK LLP

NHS Greater Manchester Integrated Care Board
Financial Statements for the year ended 31 March 2026

This representation letter is provided in connection with the audit of the financial statements of NHS Greater Manchester Integrated Care Board (the "ICB") for the year ended 31 March 2026 for the purpose of expressing an opinion as to whether the ICB's financial statements give a true and fair view in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2025-26 and applicable law.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. We have fulfilled our responsibilities for the preparation of the ICB's financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2025-26 (the "GAM"); in particular the financial statements are fairly presented in accordance therewith.

ii. We have fulfilled our responsibilities for ensuring that expenditure and income are applied for the purposes intended by Parliament and that the financial transactions in the financial statements conform to the authorities which govern them.

iii. We have complied with the requirements of all statutory directions affecting the ICB and these matters have been appropriately reflected and disclosed in the financial statements.

iv. The ICB has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of any regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

v. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

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D. Management letter of representation

vi. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable. Such accounting estimates include prescribing accrual. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with the GAM and adequately disclosed in the financial statements. We understand our responsibilities includes identifying and considering alternative methods, assumptions or source data that would be equally valid under the financial reporting framework, and why these alternatives were rejected in favour of the estimate used. We are satisfied that the methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in accordance with the GAM and adequately disclosed in the financial statements.

vii. We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the ICB ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii. Except as disclosed in the financial statements:

a) there are no unrecorded liabilities, actual or contingent;

b) none of the assets of the ICB has been assigned, pledged or mortgaged; and

c) there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi. We have considered the unadjusted misstatements schedule included in your Audit Findings Report and attached to this letter. We have not adjusted the financial statements for these misstatements brought to our attention as they are immaterial to the results of the ICB and its financial position at the year-end for the reasons noted on the schedule. The financial statements are free of material misstatements, including omissions.

xii. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

xiii. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xiv. We have updated our going concern assessment. We continue to believe that the ICB's financial statements should be prepared on a going concern basis and have not identified any material uncertainties related to going concern on the grounds that:

a) the nature of the ICB means that, notwithstanding any intention to liquidate the ICB or cease its operations in their current form, it will continue to be appropriate to adopt the going concern basis of accounting because, in such an event, services it performs can be expected to continue to be delivered by related public authorities and preparing the financial statements on a going concern basis will still provide a faithful representation of the items in the financial statements;

b) the financial reporting framework permits the ICB to prepare its financial statements on the basis of the presumption set out under a) above; and

c) the ICB's system of internal control has not identified any events or conditions relevant to going concern.

We believe that no further disclosures relating to the ICB's ability to continue as a going concern need to be made in the financial statements.

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D. Management letter of representation

Information Provided

xvi. We have provided you with:

a) access to all information of which we are aware that is relevant to the preparation of the ICB's financial statements such as records, documentation and other matters;

b) additional information that you have requested from us for the purpose of your audit; and

c) unrestricted access to persons within the ICB from whom you determined it necessary to obtain audit evidence.

xvii. We have communicated to you all deficiencies in internal control of which management is aware.

xviii. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xix. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xx. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the ICB and involves:

a) management;

b) employees who have significant roles in internal control; or

c) others where the fraud could have a material effect on the financial statements.

xxi. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, analysts, regulators or others.

xxii. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxiii. We have disclosed to you the identity of the ICB's related parties and all the related party relationships and transactions of which we are aware.

xxiv. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Governance Statement

xxv. We are satisfied that the Governance Statement fairly reflects the ICB's risk assurance and governance framework, and we confirm that we are not aware of any significant risks that are not disclosed within the Governance Statement.

Annual Report

xxvi. The disclosures within the Annual Report fairly reflect our understanding of the ICB's financial and operating performance over the period covered by the ICB's financial statements.

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D. Management letter of representation

Approval

The approval of this letter of representation was minuted by the ICB's Audit Committee at its meeting on 17 June 2026.

Yours faithfully

Name……

Position……

Date……

Name……

Position……

Date……

Signed on behalf of the ICB

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E. Draft audit opinion

Independent auditor's report to the members of the Board of NHS Greater Manchester Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Greater Manchester Integrated Care Board (the 'ICB') for the year ended 31 March 2026, which comprise the statement of comprehensive net expenditure, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

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E. Draft audit opinion

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

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Qualified opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The ICB reported an overspend of £7,493k against its revenue resource limit of £9,432,074k in its financial statements for the year ended 31 March 2026. The ICB thereby breached its duty under section 223GC (1) of the National Health Service Act 2006, as amended, to ensure that expenditure it incurred in a financial year does not exceed the sums received by it in that year. Under sections 223GB and 272(7) and (8) of the National Health Service Act 2006, as amended, NHS England directed that revenue resource use for the ICB in 2025-26 should not exceed £9,432,074k. The ICB's revenue resource use for 2025-26 was £9,439,567k, thereby breaching the direction given to it by NHS England.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 12 May 2026 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the ICB's breach of its revenue resource limit for the year ending 31 March 2026.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

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Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - the processing of inappropriate journals, in this regard we tested journals over performance materiality, including post year end journals, journals relating to year end accruals, journals posted by senior managers, self authorised journals and a random selection of journals throughout the period; and
  - the prescribing accrual and the appropriateness of the estimate. We reviewed management's estimate of the prescribing accrual and challenged management on the assumptions used in its calculation.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals over performance materiality, post year end journals, journals relating to year end accruals, journals posted by senior managers, self authorised journals and a random selection of journals throughout the period;

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E. Draft audit opinion

  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

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We have nothing to report in respect of the above matter except on 17 June 2026 we identified one significant weakness in respect of:

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

  The ICB has made significant progress in delivering its in-year financial plan developing a coherent medium term financial plan. However, there is an ongoing significant risk to delivering the required investment in transformation and prevention and realising the benefits indicating a significant weakness in arrangements for financial sustainability. The ICB must strengthen its medium-term financial arrangements to support delivery of the 2026/27 plan. The Board and its Committees must receive appropriate oversight and assurance to enable effective and timely decision making, ensuring transformation and prevention investment is sustained and aligned to the plan.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- 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; and
- 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 have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Greater Manchester Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

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E. Draft audit opinion

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

[**Signature**]

Michael Green, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

xx June 2026

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F. S30 Letter to Secretary of State for Health and Social Care

Grant Thornton UK LLP
11th Floor
Landmark St Peter's Square
1 Oxford St
Manchester
M1 4PB
T +44 (0)161 953 6900

Rt Hon Wes Streeting
Secretary of State
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

Sir Jim Mackey
Chief Executive of NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 May 2026

Dear Secretary of State,

Referral under section 30 of the Local Audit and Accountability Act 2014

We are the auditor appointed to the audit of NHS Greater Manchester ICB (the 'ICB') for the period ended 31 March 2026.

Our responsibility

Section 30 of the Local Audit and Accountability Act 2014 states that:

A local auditor of the accounts of a health service body must as soon as reasonably practicable refer the matter to the Secretary of State and notify the National Health Service Commissioning Board if the auditor believes that the body or an officer of the body:

(a) is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or

(b) is about to take or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We are writing to you in accordance with section 30(b) of the Local Audit and Accountability Act 2014.

The duties of the ICB

The NHS Act 2006, as amended by paragraph 223GC of section 29 of the Health and Care Act 2022 sets a statutory duty for ICBs to ensure that expenditure incurred by the board in a financial year does not exceed the sums received by it in that year.

Reasons for making a referral under section 30 of the Local Audit and Accountability Act 2014

NHS Greater Manchester ICB has reported within their draft financial statements for the year ended 31 March 2026, an overspend of £7.493m against its revenue resource limit.

NHS Greater Manchester ICB has taken a course of action that is unlawful and has caused a loss. This gives rise to a duty on us to report to you under section 30(b) of the Local Audit and Accountability Act 2014.

We understand that this is a matter which is already known to the Secretary of State, hence the brevity of this referral letter. Please do not hesitate to contact us if you need any further information.

Yours sincerely

Grant Thornton UK LLP

Grant Thornton UK LLP, local auditors

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NHS
Greater Manchester

Auditors Annual Report 2025/2026

Part of Greater Manchester Integrated Care Partnership

Audit Committee

17 June 2026

Required information.	Details.
Title of report.	Auditors Annual Report 2025/26.
Author.	Michael Green – Grant Thornton Perminder Sethi – Grant Thornton Andy Nichols – Grant Thornton
Presented by.	Michael Green – Grant Thornton Perminder Sethi – Grant Thornton
Contact for further information.	Kaye Abbott – Associate Director of Finance – Financial Control. kayeabbott@nhs.net
Executive summary.	The report summarises the work undertaken by the external auditors in the 2025/26 financial year and in particular the commentary on Value for Money. This sets out the auditor's commentary on whether NHS GM has in place proper arrangements for securing Value for Money in its use of resources in respect of: • Financial Sustainability • Governance • Improving economy, efficiency and effectiveness The report reviews the progress on implementation of recommendations made in 2024/25 and identifies improvements required going forward. Overall, the ICB has been rated: • red (indicating a 'significant weakness' in arrangements) for financial sustainability, although recognises the significant improvement made since the last report, and • amber for the governance and efficiency (indicating no significant weaknesses, but with improvement recommendations made.

	The report therefore makes one key recommendation and four improvement recommendations and the ICB's responses to these including implementation dates have been provided.
The benefits that the population of Greater Manchester will experience.	This report provides an independent commentary on whether NHS GM has arrangements in place to use its resources effectively.
How health inequalities will be reduced in Greater Manchester's communities.	Not applicable as not related to direct patient care.
The decision to be made and/or input sought.	The Audit Committee is asked to: 1. Approve the report, the recommendations and the management responses.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Not applicable.
Key milestones.	This report has been circulated to Chief Officers due to timings and will be discussed at a future Chief Officer meeting (date TBC). It will then be presented to a future Board meeting.
Leadership and governance arrangements.	The report will be presented at Chief Officers and once approved by Audit Committee will be presented to Board. The implementation of the recommendations will be reported to the Audit Committee on a quarterly basis.

Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The report has been circulated to Chief Officers due to timings and will be discussed at a future meeting (date TBC) and once approved by Audit Committee will be presented to Board. The implementation of the recommendations will be reported to the Audit Committee on a quarterly basis.
Financial or Legal Implications	There are no direct financial or 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	No

Table 2: Assurance needed about the document.

Grant Thornton

NHS Greater Manchester Integrated Care Board

Auditor's Annual Report
Year ending 31 March 2026

17 June 2026

Contents

01	Introduction and context	3
02	Executive summary	7
03	Opinion on the financial statements and use of auditor's powers	12
04	Value for Money commentary on arrangements	16
	Financial sustainability	18
	Governance	23
	Improving economy, efficiency and effectiveness	28
05	Summary of Value for Money Recommendations raised in 2025/26	31
06	Follow up of previous Key recommendations	36
Appendix A - Responsibilities of the NHS Integrated Care Board		39
Appendix B - Value for Money Auditor responsibilities		40
Appendix C - Follow-up of previous improvement recommendations		41

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of completing our work under the NAO Code and related guidance. Our audit is not designed to test all arrangements in respect of value for money. However, where, as part of our testing, we identify significant weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all irregularities, or to include all possible improvements in arrangements that a more extensive special examination might identify. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting, on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

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01 Introduction and context

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Introduction

This report brings together a summary of all the work we have undertaken for NHS Greater Manchester ICB during 2025/26 as the appointed external auditor. The core element of the report is the commentary on the value for money (VfM) arrangements. The responsibilities of the NHS Integrated Care Board (ICB) are set out in Appendix A. The Value for Money Auditor responsibilities are set out in Appendix B.

Opinion on the financial statements

Auditors provide an opinion on the financial statements which confirms whether they:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025/26, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We also consider the Annual Governance Statement, the relevant disclosures within the Annual Report including the Remuneration and Staff Report.

Auditor's powers

Under Section 30 of the Local Audit and Accountability Act 2014, the auditor of an NHS body has a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be referred to the Secretary of State and notified to NHS England. They may also issue:

- Statutory recommendations to the ICB Board which they must consider publicly
- A Public Interest Report (PIR).

Value for money

Under the Local Audit and Accountability Act 2014, we are required to be satisfied whether the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources (referred to as Value for Money). The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

- financial sustainability
- governance
- improving economy, efficiency and effectiveness.

Our report is based on those matters which come to our attention during the conduct of our normal audit procedures which are designed for the purpose of completing our work under the NAO Code and related guidance. Our audit is not designed to test all arrangements in respect of value for money. However, where, as part of our testing, we identify significant weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all irregularities, or to include all possible improvements in arrangements that a more extensive special examination might identify.

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The NHS – context

ICBs are transforming as they take on new roles and responsibilities

National

Past

Structural challenges

National reviews highlighted that ICBs inherited long-term structural pressures and management capacity issues, impacting ICBs' ability to lead system improvement effectively.

Worsening inequalities

Rising demand and worsening population health increased pressure on local services in the near-term leaving less capacity for ICBs to meaningfully progress their longer-term strategic responsibilities.

Present (see page 6)

Major transformation

ICBs are fundamentally changing, significantly reducing running costs, restructuring senior leadership teams and managing major staff reductions. Many ICBs are clustering or merging with neighbours.

Ongoing responsibility

ICBs must still maintain safe performance and deliver challenging plans ensuring statutory duties and met and risk management and governance remain robust during the transitional phase.

Future

Embedding new ways of working

Embedding new operating models with reduced headcounts, ICBs will be adopting new ways of working, with a focus on agility, matrix working, as well as digital transformation and AI.

Adapting to new responsibilities

ICBs are shifting toward a strategic commissioning role requiring system collaboration, focus on outcomes, resource allocation and market and contract management, while retaining core system financial responsibilities.

Local

The Greater Manchester integrated care system covers some of England's most deprived areas, with significant challenges from ill health, health inequalities and infant mortality. Those in better health are living significantly longer than those with poorer health.

The system – and the ICB – have faced financial challenges since its inception. We have previously reported that the ICB has made progress with statutory Undertakings and developed strong governance to report progress, as well as improved arrangements to oversee and engage with system providers. As with all ICBs, 2025-26 has been a year of significant change as the ICB transforms to meet challenging targets to reduce management costs and adapt to a new strategic commissioning role.

It is within this context that we set out our commentary on the ICB's value for money arrangements in 2025/26.

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Integrated Care Boards - context

2025/26 was a challenging year for ICBs as they transitioned to new operating models and organisational structures

Organisational change

ICBs are expected to align to a new “blueprint” of revised roles and functions which has evolved over the year. They are also expected to operate with reduced core funding of around £19 per head of population served. This requires significant reductions in running and programme costs, adoption of new operating models and significant reductions in staffing. Such change and uncertainty inevitably increases pressure on leadership, organisational capacity and staff morale.

Clustering and mergers

Many ICBs outside the North East, Yorkshire and North West have adopted clustering arrangements, sharing larger footprints while remaining legally separate, partly to achieve the economies of scale required to reduce management costs. Government has approved the first formal mergers and boundary changes, taking effect 1 April 2026, with further merger decisions due in 2026.

Strategic Commissioning

ICBs are transitioning to become strategic commissioners, with less focus on direct delivery functions. Their future role will centre on: Long-term population health strategy, operating as healthcare “payers”, market-shaping and intelligent purchasing, and evaluating impact and outcomes, not just activities and outputs.

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02 Executive Summary

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Executive summary – our assessment of value for money arrangements

Our overall summary of our Value for Money assessment of the ICB's arrangements is set out below. Further detail can be found on the following pages.

Criteria	2024/25 Assessment of arrangements		2025/26 Risk assessment	2025/26 Assessment of arrangements	
Financial sustainability	R	Significant weakness in arrangements identified in relation to the ICB's deficit position and improvement recommendation also raised.	One risk of significant weakness identified in relation to the ICB's ongoing financial challenges and reliance on Deficit Support Funding.	R	We continue to identify one significant weakness in arrangements for financial sustainability - but significant progress has been made toward resolving this. One improvement recommendation made relating to savings delivery.
Governance	A	No significant weaknesses identified; improvement recommendations raised in relation embedding progress on the ICB's undertakings.	No risks of significant weakness identified.	A	No significant weaknesses identified. Two improvement recommendations raised in relation to compliance issues. We also note a heightened level of governance risk at a time of significant organisational change, which will persist into 2026/27.
Improving economy, efficiency and effectiveness	A	No significant weaknesses identified; improvement recommendations raised in relation to ongoing data quality and compliance issues.	No risks of significant weakness identified.	A	No significant weaknesses identified. An improvement recommendation continues to be raised in relation to data quality issues.

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

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Executive Summary

We set out below the key findings from our commentary on the ICB's arrangements in respect of value for money.

Financial sustainability

In 2025/26 the ICB delivered its agreed financial plan of a £7.5m deficit, including £175m of efficiency savings. The wider Greater Manchester system delivered a £24.1m surplus against a planned breakeven position. This represents an improvement in financial delivery compared with prior years. However, a £7.5m deficit results in a technical breach of the ICB's statutory duty. As such we continue to identify a significant weakness in arrangements and therefore must make a Key recommendation, but we also acknowledge the improvement in the ICB's performance in this area. Our Key Recommendation is designed to support the ICB in strengthening arrangements to protect and deliver the medium-term strategy. The ICB has submitted a compliant and balanced forward plan for 2026/27 to 2028/29, though this relies on significant savings. The ICB needs to demonstrate that prevention and transformation investment can be consistently translated into sustainable savings.

Governance

Governance arrangements operated effectively during the year, with clear Board and Committee oversight of key risks. The ICB is now largely free from its Statutory Undertakings, with those remaining at year-end both relating to finance.

As with many ICBs, the ICB has worked to establish arrangements for consistent application of the Provider Selection Regime (PSR). However, the nature of this regime presents an ongoing risk and experience during the year suggests there is scope to further develop controls and governance in this area.

We have raised Improvement Recommendations to support assurance resilience generally during a time of significant transition and specifically to strengthen procurement and PSR compliance.

Improving economy, efficiency and effectiveness

The ICB maintained arrangements to oversee provider quality and performance and to support system improvement, including reporting of key performance metrics and escalation where concerns arise.

Good partnership working was evident, including the shared Integrated Fund approach to reduce mental health out-of-area placements and reinvest savings into community alternatives.

Data quality remains a long-standing issue, with delayed implementation of agreed actions and continued reliance on assurance activity that has not yet been completed at the pace originally planned. We have therefore continued to raise an Improvement Recommendation in relation to data quality to support timely delivery of agreed actions and stronger day-to-day control

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Governance focus – organisational change and ongoing risk

Additional context around our review of the ICB's governance arrangements in 2025/26

Governance changes in 2025/26

The 2025/26 operating context materially increased inherent governance risk across Integrated Care Boards.

National reforms required ICBs to adopt revised operating models, reduce management costs, and transition away from some direct delivery functions, whilst also maintaining statutory accountability and delivering financial recovery.

Higher turnover and structural change increase risk around management capacity, continuity, and retention of institutional knowledge during transition.

Governance models are evolving to reflect ICBs' new roles and responsibilities.

What we observed in 2025/26

The ICB maintained effective Board and Committee oversight of key risks, but assurance delivery was affected by capacity pressures linked to organisational change.

The ICB established clear transitional arrangements to oversee key functions and provide assurance to the board as it moved to embed new governance structures for 2026/27.

These reforms have had a significant workforce impact. The ICB funded around 386 exit packages in 2025/26 in line with the NHS England scheme guidance.

Based on our review, delivery assurance has been stretched in areas that rely heavily on management capacity, including the pace of internal audit completion, follow-up and implementation of audit recommendations, and the timely embedding of new compliance requirements. Procurement compliance provides a clear example.

Residual risks

Heightened assurance and compliance risk remains as organisational change continues into 2026/27.

Significant staff turnover increases the risk of gaps in operational grip, assurance work, and embedding of new regulatory requirements. This can lead to greater reliance on reactive mitigation, interim arrangements, and post-event regularisation, increasing legal, governance, and reputational exposure.

At the same time, the ICB will be embedding new committee structures to support the Board.

The risk is most acute where the ICB must demonstrate procedural compliance under new frameworks, and where timely assurance is essential to the Board's ability to rely on management reporting. Managing this will require sustained executive and Board focus on capacity, skills retention, and the effective functioning of the assurance pipeline.

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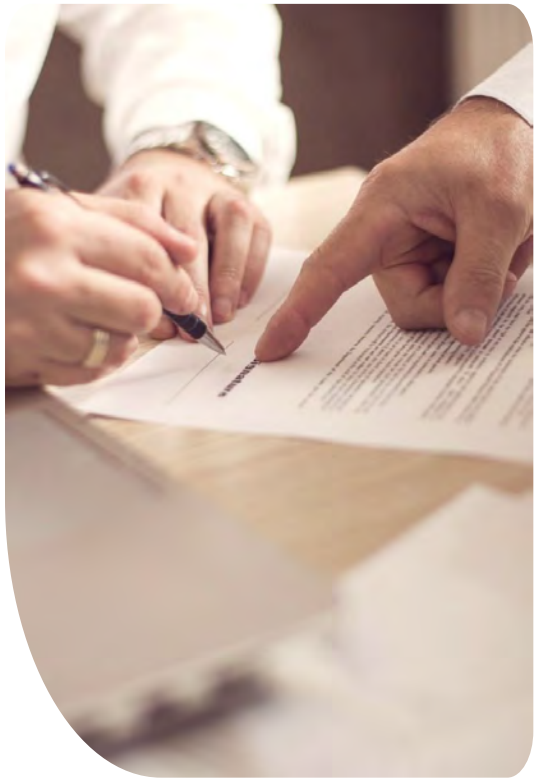
Executive summary – auditor's other responsibilities

This page summarises our opinion on the ICB's financial statements and sets out whether we have used any of the other powers available to us as the ICB's auditors.

Auditor's responsibility	2025/26 outcome
Opinion on the Financial Statements	We have substantially completed our audit of your financial statements and expect to issue an unqualified audit opinion by 19 June 2026 following the Audit Committee meeting on 17 June. The ICB delivered a planned outturn deficit of £7.493m and therefore has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion, as a result, our audit opinion will be qualified in this respect. Our findings are set out in further detail on pages 12 to 14.
Use of auditor's powers	We issued a section 30 referral to the Secretary of State for Health and Social Care regarding the ICB's break even duty on 12 May 2026. We do not consider that any unlawful expenditure has been made or planned for. No other issues have been identified during our work which require us to make statutory recommendations, or issue a Public Interest Report (PIR).



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03 Opinion on the financial statements and use of auditor's powers

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Opinion on the financial statements

These pages set out the key findings from our audit of the ICB's financial statements, and whether we have used any of the other powers available to us as the ICB's auditors.

Audit opinion on the financial statements

We have substantially completed our audit of your financial statements and expect to issue an unqualified audit opinion by 19 June 2026 following the Audit Committee meeting on 17 June. Given the ICB delivered a planned outturn deficit of £7.493m and therefore has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion, as a result, our audit opinion will be qualified in this respect.

The full opinion is included in the ICB's Annual Report for 2025/26, which can be obtained from the ICB's website.

Grant Thornton provides an independent opinion on whether the ICB's financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025/26, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We conducted our audit in accordance with: International Standards on Auditing (UK), the Code of Audit Practice (2024) published by the National Audit Office, and applicable law. We are independent of the ICB in accordance with applicable ethical requirements, including the Financial Reporting Council's Ethical Standard.

Findings from the audit of the financial statements

The ICB provided draft accounts for audit ahead of the national deadline.

As in previous years, the draft financial statements were of a good standard and supported by detailed working papers.

In line with the plan agreed with NHS England, the ICB delivered a deficit outturn of £7.493m for 2025/26, thereby overspending against its revenue resource limit by £7.493m. The deficit for the year of £7.493m indicates NHS Greater Manchester Integrated Care Board has taken a course of action that is unlawful and has caused a loss. This gives rise to a duty on us to report under section 30(b) of the Local Audit and Accountability Act 2014 to the Secretary of State for Health and Social Care. In addition, given the outturn deficit, the ICB has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion, as a result, our audit opinion will be qualified in this respect.

Audit Findings Report

We report the detailed findings from our audit in our Audit Findings Report. The Audit Findings Report will be presented to the ICB's Audit Committee on 17 June 2026. Requests for this Audit Findings Report should be directed to the ICB.

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Other reporting requirements and use of auditor's powers

Remuneration and Staff Report

Under the Code of Audit Practice (2024) published by the National Audit Office, we are required to audit specified parts of the Remuneration and Staff Report included in the ICB's Annual Report for 2025/26.

These specified parts of the Remuneration and Staff Report have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025/26.

Annual Governance Statement

Under the Code of Audit Practice (2024) published by the National Audit Office, we are required to consider whether the Annual Governance Statement included in the ICB's Annual Report for 2025/26 does not comply with the guidance issued by NHS England, or is misleading or inconsistent with the information of which we are aware from our audit.

We have nothing to report in this regard.

Regularity of income and expenditure

Under the Code of Audit Practice (2024) published by the NAO, we are required to consider whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Our regularity work has found that income and expenditure included in the financial statements has not been applied for the purposes intended by Parliament. The ICB's draft financial statements for 2025-26 show an outturn deficit of £7.493m, where expenditure has exceeded income. As a result, the ICB has not applied income and expenditure for the purposes intended by Parliament and has breached the regularity opinion. Our audit opinion will be qualified in this respect.

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Use of auditor's powers

We bring the following matters to your attention:

Referrals to the Secretary of State

We issued a section 30 referral to the Secretary of State for Health and Social Care because the ICB had delivered a deficit outturn of £7.493m for 2025/26, thereby overspending against its revenue resource limit by £7.493m which gave rise to a duty on us to report under section 30(b) of the Local Audit and Accountability Act 2014. We made this referral on 12 May 2026.

Statutory recommendations

Under Schedule 7 of the Local Audit and Accountability Act 2014, auditors can make written recommendations to the audited body.

We did not issue any statutory recommendations to the ICB in 2025/26.

Public Interest Report

Under Schedule 7 of the Local Audit and Accountability Act 2014, auditors have the power to make a report if they consider a matter is sufficiently important to be brought to the attention of the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view.

We did not issue a report in the Public Interest with regard to arrangements at Greater Manchester ICB for 2025/26.

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04 Value for Money commentary on arrangements

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Value for Money – commentary on arrangements

This page explains how we undertake the value for money assessment of arrangements and provide a commentary under three specified areas.

All NHS ICBs are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. NHS ICBs report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under the Local Audit and Accountability Act 2014, we are required to be satisfied whether the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

Financial sustainability

Arrangements for ensuring the ICB can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

Governance

Arrangements for ensuring that the ICB makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, making decisions based on appropriate information.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the ICB delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

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Financial sustainability – commentary on arrangements

We considered how the ICB:	Commentary on arrangements	Rating
identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them	The ICB met its plan to deliver a £7.5m deficit in 2025/26, contributing to a Greater Manchester system surplus of £24.1m against a planned breakeven position. This was net of a substantial deficit support allocation of £200m, of which the ICB's allocation was £50m. The delivery of a deficit plan does result in the ICB breaching its statutory duty for its expenditure not to exceed the resources it is allocated, and for this reason – alongside the level of risk remaining in the medium term – we continue to identify a significant weakness in its arrangements for 2025/26. That said, the ICB has made clear progress in financial control and planning maturity. In 2025/26, the ICB delivered its agreed financial plan, including £175m of efficiency savings. This represents a material improvement on the prior year. The ICB also expects to have addressed the financial element of its Undertakings, the last remaining, in delivering its 2025/26 plan. The ICB has also developed a coherent medium-term plan. While we are unable to conclude that arrangements were satisfactory in 2025/26, the ICB has shown it is able to deliver its financial plans in-year. Risks remain to medium-term delivery. **We set out further detail and a Key recommendation (page 20).**	R
plans to bridge its funding gaps and identify achievable savings	In 2025/26, the ICB delivered its £175m efficiency requirement in full. Of this, £108.6m (62 per cent) was delivered recurrently and £66.4m (38 per cent) through non-recurrent measures. While this fell short of the ICB's stated ambition of 80 per cent recurrency, this was a high bar to meet. At system level, delivery was even more challenging. Against a £656m efficiency requirement agreed with NHS England, total savings delivered were £635.4m, representing a £20.6m (4 per cent) shortfall. Providers delivered £460.4m savings against a target of £481.0m, of which 60 per cent were recurrent. The ICB's 2026/27 efficiency programme remains challenging, with £66.2m (44 per cent) of the £150.0m programme assessed as high-risk. **We retain an improvement recommendation (page 21).**	A

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

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Financial sustainability – commentary on arrangements (continued)

We considered how the ICB:	Commentary on arrangements	Rating
plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities	The ICB's medium term plan aligns clearly with the system's Six Missions. Prevention, neighbourhood-based care, digital transformation and system reform are clearly embedded within the Plan and the related Operating Model. The MTFP represents a clear evolution of the prior Sustainability Plan, providing greater transparency over cost pressures, committed growth and a quantified £56m investment in 'left-shift', moving from acute to more preventive, proactive activity) for 2026/27. Delivering this in practice remains challenging and the Key Recommendation raised on page 21 addresses this. However, we do not identify any weaknesses in the ICB's arrangements for developing the plan itself.	G
ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning which may include working with other local public bodies as part of a wider system	The ICB's MTFP aligns with its wider strategic, digital, workforce and neighbourhood-based plans, with a clear and consistent narrative across the MTFP and the Operating Model. The ICB's 2025 Green Plan is already aligned to this strategic direction, though delivery responsibilities primarily rest with provider trusts and other system partners rather than the ICB, which is acting as a system convenor. While overall alignment between financial strategy, plans and other plans is strong, opportunities remain to make linkages with estates and net-zero strategies more explicit within financial planning. An accompanying insight highlights how this could be strengthened further.	G
identifies and manages risk to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions in underlying plans	The ICB continues to demonstrate clear arrangements for identifying and managing financial risk. Financial reports to the Board and Finance Committee – and later the Transition Committee - remained clear and structured, covering ICB and system level risks, and quantifying risk exposure. Financial recovery reporting highlights potential for a gap between the ICB's stated financial risk appetite and the reality of operational decision making. We do not raise a recommendation as the ICB has identified this issue itself and begun a process of realignment but it is important that the ICB ensures any divergences in the organisation's culture and approach to financial risk management are minimised.	G

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

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Financial sustainability (continued)

Significant weakness identified in relation to financial sustainability

Key finding: The ICB has made significant progress in delivering its in-year financial plan, and developing a coherent medium term financial plan. However, there is an ongoing risk to delivering the required investment in transformation and prevention and realising the benefits of that investment.

Evidence: The ICB's Medium-Term Financial Plan (MTFP) is strategically coherent, financially transparent and clearly aligned to the Greater Manchester Integrated Care Partnership's Six Missions. The MTFP places prevention, neighbourhood-based care and demand reduction at the centre of the ICB's recovery strategy. The MTFP identifies £56m of 'left-shift' investment in prevention and proactive interventions in 2026/27 and sets out a clear reconciliation between the ICB's starting deficit, cost pressures, committed growth and mitigations, building on the previous Sustainability Plan.

However, the Board's Assurance Statements accompanying the plan confirm that material delivery risk remains, and the plan acknowledges in particular a continuing "tension" between meeting constitutional standards and enabling upstream investment. In previous years we have reported that the ICB has not consistently protected prevention budgets when in-year financial pressures emerged in those years, leading to reductions or delays to planned investments in prevention activity. While the ICB has an underlying financial deficit and faces financial operational pressures, there continues to be a risk that planned prevention and left-shift investments come under pressure, given the overriding requirement for the ICB to deliver the financial plan agreed with NHS England. In order to reduce this risk, the ICB needs to move into recurrent financial balance.

Impact: If the ICB is not able to protect left-shift investment, it will not deliver on the opportunities identified in its financial plan and will remain reliant on in-year recovery to balance its financial position.

Key recommendation 1

Having now set a clear trajectory to a sustainable position, the ICB must now deliver on its short and medium-term plans, including delivering a balanced financial position each year. To support this, it should further strengthen its medium-term financial arrangements to support delivery of the 2026/27 plan. The Board and its Committees must receive appropriate oversight and assurance to enable effective and timely decision making, ensuring transformation and prevention investment is sustained and aligned to the plan.

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Financial sustainability (continued)

Area for Improvement identified: identifying and delivering recurrent savings

Findings: The ICB has made progress in the identification, governance and delivery of efficiency schemes and has strengthened transparency over performance. However, continued reliance on non-recurrent measures and late-year recovery activity indicates underlying issues have not yet been fully resolved.

Evidence:

During 2025/26, the ICB's efficiency programme was fully developed and the ICB delivered its £175m savings requirement in full. Of the savings delivered, £108.6m (62 per cent) was achieved on a recurrent basis, with the remaining £66.4m (38 per cent) delivered non-recurrently.

While this represents delivery of the headline target and compares favourably with wider system performance, it fell short of the ICB's stated ambition of achieving 80 per cent recurrent savings.

Evidence from in-year reporting shows that risks to recurrency were identified part-way through the year, with recurrency reported at around 70 per cent at Month 7, and that the response relied on recovery plans, accelerated actions and enhanced oversight in the second half of the year.

Impact: A lack of adequate saving plans and/or inability to deliver recurrent savings puts the ICB's financial plan at risk.

Improvement Recommendation 1

The ICB should continue to strengthen its approach to CIP delivery and reporting, with a clear focus on earlier and sustained recurrent savings. In particular, the ICB should ensure that reporting places greater emphasis on in-year recurrent delivery trajectories, rather than year-end achievement alone; and that emerging risks to recurrency are identified earlier in the financial year.

	CIP		
	ICB	Providers	Total
	£m		
2025/26 **plan**	175.0	481.0	**656.0**
2025/26 **actual**	175.0	460.4	**635.4**
2026/27 **plan**	150.0	*From 2026/27 each provider body will be accountable to NHSE for its own financial performance.*	

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Governance – commentary on arrangements

We considered how the ICB:	Commentary on arrangements	Rating
monitors and assesses risk and how the ICB gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud	We have seen considerable development of the Board Assurance Framework (BAF) over the years. The Board considers the BAF at each meeting. The BAF itself is aligned with the ICB's strategic objectives and shapes the Board agenda. There is evidence BAF risks are delegated to Board Committees and discussed at relevant meetings. Last year, a system well-led review recommended that the Board would benefit from a "BAF on a page" to support strategic oversight and this is now in place. The BAF is supported by a clear risk management structure. A risk management policy is in place, revised and approved in July 2025, and deep dives of risks are presented to Audit Committee. The ICB's Internal Audit function and counter-fraud services continues to be provided by MIAA, with regular reports presented to the Audit Committee. The Draft Head of Internal Audit Opinion for 2025/26 reported an overall opinion of Substantial Assurance. Despite maintaining overall appropriate arrangements in this area, we did not notice some risk from management capacity to respond to assurance recommendations in some areas. We note late delivery of the 2024/25 Audit Plan, which was reported as complete to the Audit Committee in December 2025. The ICB considered that staff changes and capacity challenges contributed to this delay. The Audit Committee completed an assessment to identify work that could be deferred, with a view to ensuring high-risk areas were measured. We also noted other instances where capacity challenges have affected the ICB's ability to implement previous assurance recommendations and while we did not identify significant issues, we nonetheless raise an improvement recommendation to support the ICB in maintaining a robust, proportionate overview of its assurance activity during a time of significant organisational change.	A

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

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Governance – commentary on arrangements (continued)

We considered how the ICB:	Commentary on arrangements	Rating
approaches and carries out its annual budget setting process	As in the prior year the ICB has maintained clear budget-setting arrangements, with budgets set in line with the revised responsibilities for financial oversight that have flowed from the revisions to ICB roles more widely. The move to developing plans in parallel with system providers inevitably brings an increased risk of misalignment between ICB and provider submissions at any given point in time. However, this is a risk inherent in the process rather than an issue with the ICB's arrangements, and there is no evidence from our review that this has impacted the ICB's ability to set its own budget for 2026/27.	G
ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information; supports its statutory financial reporting; and ensures corrective action is taken where needed, including in relation to significant partnerships	The ICB's financial management arrangements in 2025/26 operated as expected, with the Board receiving regular, transparent and well-structured financial reports. Finance reports clearly set out in-month, year-to-date and forecast positions, along with detailed variance analysis and explanations of pressures across acute, mental health, community, prescribing and CHC budgets. Demand-led pressures continued, particularly in mental health services such as ADHD and Autism. As required by NHSE, the ICB continued to report a breakeven forecast despite recognising internal financial risk, but this was flagged clearly in finance reports.	G

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

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Governance – commentary on arrangements (continued)

We considered how the ICB:	Commentary on arrangements	Rating
ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency, including from audit committee	The ICB Board continues to meet on a regular basis with the Board agenda clearly set out. Until the end of the 2025 calendar year, the Board received Assurance Reports from all Committee chairs using the Assure, Alert, Advise (AAA) framework which has become established sector practice. The ICB is undergoing a period of substantial change and is evolving its governance in response. From January 2026, some Board Committees responsible for monitoring finance, performance, quality and people issues stood down and the Board and an interim Transition Committee were tasked with overseeing assurance across key areas of work. Members of the Transition Committee raised initial concerns regarding the management of any governance gap. On reflection and in later cycles, however, Committee members expressed more confidence in the model. A revised Board Committee model was due to take effect from April 2026. As reported last year, our knowledge of the Audit Committee is that the arrangements are adequate and our attendance at meetings verify that the Committee is chaired well and each agenda item is considered in sufficient detail, with appropriate challenge and questioning. We are aware that the ICB's former Chief Executive was suspended from duty in December 2025 following a whistleblowing concern. The ICB has reported that the internal investigation concluded with no case to answer, and the former Chief Executive was free to return to his role. Given the proximity of his retirement, he did not resume substantive duties, and existing interim leadership arrangements continued to be in place.	G

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

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Governance – commentary on arrangements (continued)

We considered how the ICB:	Commentary on arrangements	Rating
monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of staff and board member behaviour	The ICB has arrangements to report legislative and regulatory information. The Annual Governance Statement did not note any large-scale cyber-attack or serious data security breaches during the year. Policies are revised and presented to the Audit Committee for approval in line with the Scheme of Delegation with the Conflicts of Interest Policy and Procurement Policy revised to reflect legislation and NHSE guidance. The introduction of the Provider Selection Regime (PSR) has presented a challenge to many NHS bodies and increased the importance of robust procurement and commissioning processes to manage the risk of bidder challenge. Despite establishing arrangements and an internal audit "substantial assurance" opinion on the same during the year, the ICB experienced some challenges from bidders . While the ICB has appropriately escalated issues once identified and maintained effective Audit Committee oversight, the evidence indicates that PSR compliance arrangements need to be further strengthened during 2026/27. We have made an improvement recommendation to strengthen arrangements. All ICBs are undergoing significant change and this has had a major impact on staff. The ICB funded 386 exit package during 2025-26, with a total cost of around £24m. Compulsory redundancy and other departures reported in 2025-26 have been paid in accordance with the provisions of the redundancy scheme as agreed with NHS England. However, increased staff turnover inevitably increases risk due to reduced management capacity and loss of institutional 'memory'. Managing this risk in 2026/27 will require ongoing focus from the ICB's executive leadership and the whole Board.	A

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

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Governance (continued)

Area for Improvement: ensuring timely assurance at a time of heightened risk

Findings: While the ICB overall maintains appropriate governance arrangements for internal audit and internal control, our review indicated some risks from gaps in timely assurance and timely implementation of related recommendations, during a period of significant organisational restructuring.

Evidence:

Delivery of the Internal Audit Plan for 2024 to 2025 was backloaded, with completion confirmed only late in the year. Senior management attributed slippage to staff and management changes linked to NHS reform rather than provider performance.

Progress reports show repeated deferral and rephasing of audit work, with reliance on reassessment of high-risk areas to manage capacity constraints.

Implementation of internal audit recommendations shows persistent delays, including multiple revised target dates for medium-risk recommendations since March 2024, indicating difficulty embedding change during transition.

Some areas of long-standing concern remain, including our improvement recommendation around data quality (see Improvement recommendation 4), where implementation has also been delayed due to capacity challenges. The BAF continues to identify further gaps in assurance relating to data quality and workforce data timeliness, despite actions being reported as underway.

Impact: Delays or gaps in assurance, or limited capacity to respond to recommendations in a timely way increases the risk of non-compliance with relevant standards. This risk arises from pressures on organisational capacity to deliver, follow up and embed assurance activity consistently, rather than the design of the ICB's assurance frameworks.

Improvement Recommendation 2

The ICB should strengthen assurance resilience by introducing a short, forward-looking assurance capacity assessment, owned at executive level and reviewed by an appropriate committee such as the Audit Committee. This should identify where organisational change, workforce turnover or programme dependency may affect the timeliness of assurance work and implementation of recommendations and set out mitigating actions.

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Governance (continued)

Area for Improvement: compliance with procurement standards

Findings: Procurement and Provider Selection Regime (PSR) arrangements were not yet fully embedded across the organisation during 2025/26.

Evidence:

The introduction of the PSR has presented a risk for many NHS bodies, with the increased risk of challenge from bidders heightening the need for clear procedural controls, early planning, and consistent documentation across commissioning teams. The shift to PSR places greater emphasis on decision records, transparency requirements, and defensible process, which increases the consequences of inconsistent application.

The ICB has established governance arrangements to manage the risks inherent under the PSR regime, and received a "substantial assurance" opinion on these from internal audit in June 2025. Despite this, the NHS England Independent PSR Panel, advised in January 2026 that the ICB breached regulations in respect of the Community dermatology and advised it to a return to an earlier stage of evaluation.

The ICB has kept its Audit Committee updated on progress and recent Audit Committee reporting indicates that the ICB has acknowledged a need to further strengthen its PSR-related procedures and governance, and the ICB will manage this through appropriate governance and escalation routes.

More generally the volume and value of waivers during the year also reinforces the need for stronger forward planning and consistent procurement controls.

Impact: There is an increased risk of procedural non-compliance under the PSR with regulations and the ICB needs to continually evolve its arrangements to match this risk.

Improvement Recommendation 3

The ICB should further strengthen procurement and commissioning arrangements to ensure consistent compliance with PSR requirements, particularly for high-value and complex services. This could include earlier procurement planning for contract expiry and renewal, clearer accountability for PSR compliance at service level, and tighter controls to ensure PSR decision documentation and transparency requirements.

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Improving economy, efficiency and effectiveness – commentary on arrangements

We considered how the ICB:	Commentary on arrangements	Rating
uses financial and performance information to assess performance to identify areas for improvement	The ICB continued to have oversight of the ICB's performance and that of Providers in the GM system during the year. Performance was reported to the Quality and Performance Committee at all meetings until that Committee was stood down as the Transition Committee was established in the final quarter of the year. Reports included a useful summary of performance against national priority metrics using the 'AAA' framework. The Operational Delivery Report provides the current position, key actions taken and improvement programmes in place, as well as providing detailed data relating to each Providers performance with charts showing trends. Overall, the report is easy to navigate, and the supportive commentary provides useful context. The ICB has not yet implemented our improvement recommendations relating to data quality, first raised as part of our 2023/24 review. The ICB has reported delays to fully implementing the agreed actions during the year. In addition, concern has been raised in regard to the timeliness of the Internal Audit of data quality during the year. We have therefore re-raised this improvement recommendation to support the ICB to prioritise work to ensure appropriate mechanisms are in place to monitor and address data quality issues.	A
evaluates the services it provides to assess performance and identify areas for improvement	The ICB maintained arrangements, relevant to its role during the year, to identify and report provider quality and performance issues, including updates to the Board on planned CQC activity and NHS England quality visits. Internal Audit reviewed the ICB's processes for obtaining assurance from providers on commissioned service quality and provided 'moderate Assurance', with actions tracked through the normal follow-up process. NHS England's annual assessment noted that legal undertakings were agreed in response to earlier finance and governance concerns, with management reporting that these undertakings have now been substantively completed.	G

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

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Improving economy, efficiency and effectiveness – commentary on arrangements (continued)

We considered how the ICB:	Commentary on arrangements	Rating
ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives	The ICB has continued to engage stakeholders in shaping its 2023 to 2028 strategy and to reflect strategic objectives in day-to-day governance, including through Board reporting and the BAF. Notably, the ICB and system mental health provider Trusts collaborated in a shared Integrated Fund, which allows savings from reduced use of independent sector beds and out-of-area placements to be reinvested into community mental health services. This Fund operates on a 'gainshare' basis: the two Trusts each receive 25% of gains, with the ICB receiving 50%. Reductions in inpatient activity, driven by alignment of budgets, enhanced data sharing and improved management of placements between partners, have therefore directly supported development of community-based alternatives, directly supporting the ICB's strategy.	G
commissions or procures services, assessing whether it is realising the expected benefits	The ICB has arrangements for managing provider performance through contract review meetings, with high-risk contracts having more frequent meetings than lower-risk contracts. Contract risk is determined using an in-house tool, considering quality, value, political sensitivity and patient safety factors. As NHS reform shifts the ICB into a strategic commissioning role, the Contract Management Team has seen some reduction in resource and the team's governance and escalation routes are currently under review. The ICB has confirmed it does not intend to join the new shared procurement service for NHS providers operating in the Greater Manchester system due to the risk of a conflict of interest. The ICB currently receives procurement services from NHS Shared Business Services (SBS). Alternative opportunities include the establishment of a shared service with other ICBs in the region, which may provide further efficiencies and access to expertise. Improvement recommendation 3, which relates to procurement arrangements, is also relevant to this reporting criterion.	A

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

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Improving economy, efficiency and effectiveness

Area for Improvement: contract management

Findings: The ICB has not yet implemented our improvement recommendations relating to data quality, first raised as part of our 2023/24 review.

Evidence: The ICB has accepted our improvement recommendation in this area but reported delays to fully implement the agreed actions this year. In addition, concern has been raised to the timeliness of the Internal Audit of data quality during the year. We have re-raised the Improvement recommendation to support the ICB to prioritise work to ensure appropriate mechanisms are in place to monitor and address data quality issues.

In March 2026 an update report showed that two of the actions remained 'in progress' with delays reported as being due to NHS reform. The Audit Committee raised concerns about ongoing issues with data quality which had been flagged, including by us, over at least two years. The Audit Committee also raised concerns about the achievability of the Q4 internal audit plan and it was suggested the plan should focus on high-risk areas, including data quality. The IA progress report shared with Audit Committee in March 2026 shows that the Data Quality review is in the Planning Stage.

We have therefore re-raised and updated this improvement recommendation to support the ICB to prioritise work to ensure appropriate mechanisms are in place to monitor and address data quality issues

Impact: Ongoing issues with data quality increase the risk of misreporting underlying performance.

Improvement Recommendation 4

The ICB should prioritise actions to address previously-identified data quality issues, allocate resources to address issues, and ensure the quality of data is continuously monitored. The ICB should gain ratification of its data quality policy which incorporates those mechanisms, continue to develop its data quality improvement plans and ensure data quality is embedded into everyday business.

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05 Summary of Value for Money Recommendations raised in 2025/26

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Key recommendations raised in 2025/26

	Recommendation	Relates to	Management Actions
KR1	Having now set a clear trajectory to a sustainable position, the ICB must now deliver on its short and medium-term plans, including delivering a balanced financial position each year. To support this, it should further strengthen its medium-term financial arrangements to support delivery of the 2026/27 plan. The Board and its Committees must receive appropriate oversight and assurance to enable effective and timely decision making, ensuring transformation and prevention investment is sustained and aligned to the plan.	Financial sustainability	Actions: The new structure creates a Strategic Finance team and includes a dedicated financial planning team. Furthermore, during 2026/27 there is a programme of work to review all areas of ICB spend to ensure the spend is consistent with the ICB priorities and there is rigour on outcomes. The work programme for the People and Resources Committee includes routine updates on the Medium-Term Financial Plan. Responsible Officer: Chief Officers Executive Lead: Kathy Roe, Chief Finance Officer Due Date: Ongoing

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Improvement recommendations raised in 2025/26

	Recommendation	Relates to	Management Actions
IR1	The ICB should continue to strengthen its approach to CIP delivery and reporting, with a clear focus on earlier and sustained recurrent savings. In particular, the ICB should ensure that reporting places greater emphasis on in-year recurrent delivery trajectories, rather than year-end achievement alone; and that emerging risks to recurrency are identified earlier in the financial year.	Financial sustainability	Actions: The ICB acknowledges the need to increase the level of recurrent CIP and this is a focus for 2026/27. The 2026/27 plan has been built from run rate and the 2026/27 plan focuses on recurrent CIP and full year effect. Non-recurrent mitigations will be used to bridge the in-year shortfall. Responsible Officer: Chief Officers Executive Lead: Nicola Hepburn, Acting Chief Reform & Improvement Officer Due Date: 31/03/2027
IR2	The ICB should strengthen assurance resilience by introducing a short, forward-looking assurance capacity assessment, owned at executive level and reviewed by an appropriate committee such as the Audit Committee. This should identify where organisational change, workforce turnover or programme dependency may affect the timeliness of assurance work and implementation of recommendations, and set out mitigating actions.	Governance	Actions: • Develop capacity assessment process, linked to delivery of assurance relating to both internal and external audit plans, and follow up recommendations. • Link these to Internal and External Audit Progress Reports, already part of Audit Committee workplan. Responsible Officer: Chris Gaffey, Associate Director of Corporate Governance Executive Lead: Charlotte Bailey, Chief Strategy, People & Partnerships Officer Due Date: 30/09/2026

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Improvement recommendations raised in 2025/26

	Recommendation	Relates to	Management Actions
IR3	The ICB should further strengthen procurement and commissioning arrangements to ensure consistent compliance with PSR requirements, particularly for high-value and complex services. This could include earlier procurement planning for contract expiry and renewal, clearer accountability for PSR compliance at service level, and tighter controls to ensure PSR decision documentation and transparency requirements.	Governance	Actions: The ICB remains committed to continuous improvement and has work underway to further enhance the efficiency and oversight of its arrangements, including: • A more efficient and effective DMR process, improving consistency of completion while maintaining regulatory rigour. • Centralisation of commissioning under the wider reform agenda, strengthening oversight, supporting more proactive pipeline management, and enabling earlier procurement planning for contract expiry and renewal. Responsible Officers: Joanne Li, Associate Director of Contract Management and Procurement and Sara Roscoe. Associate Director for Commissioning Operations Executive Leads: Kathy Roe, Chief Finance Officer and Katherine Sheerin, Chief Commissioning Officer Due Date: 31/03/2027

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Improvement recommendations raised in 2025/26

	Recommendation	Relates to	Management Actions
IR4	The ICB should prioritise actions to address previously-identified data quality issues, allocate resources to address issues, and ensure the quality of data is continuously monitored. The ICB should gain ratification of its data quality policy which incorporates those mechanisms, continue to develop its data quality improvement plans and ensure data quality is embedded into everyday business.	Improvement economy, efficiency and effectiveness	Actions: The current policy document is from April 2024 and will be updated during 2026/27. There will also be a process to ensure that staff are made aware of the policy / strategy and a review to validate how the new processes are bedding in. Building on the data quality improvement plan for community services (which was audited in 2024/25 and received Limited Assurance), we will have a wider reaching Improvement Plan that covers data quality aspects relating to accuracy; completeness; validity; consistency; and relevance for all commissioned services. The ICB recognises that it should develop a programme of assessment and assurance to test the impact of the policy and embed data quality in its everyday business and reporting. This remains outstanding and is on action plan, alongside a governance process to monitor it. Responsible Officer: Matt Hennessey, Chief Data and Analytics Officer Executive Lead: Nicola Hepburn, Acting Chief Reform and Improvement Officer Due Date: 31/03/2027

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06 Follow up of previous Key recommendations

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Follow up of 2024/25 Key recommendations

This slide summarises progress against previous Key recommendations we have raised. Progress with prior year improvement recommendations is summarised in Appendix C.

	Prior Recommendation	Raised	Progress	Current status	Further action
KR1	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.	2024/25	The ICB addressed the recommendation through a series of actions, with all actions reported as complete at September 2025. However, in our view, the underlying issues were not fully resolved within the 2025/26 financial year given the reliance on non-recurrent measures and risks to short and medium-term delivery.	In Progress/ partially implemented	See revised Key recommendation 1

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07 Appendices

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Appendix A: Responsibilities of the NHS Integrated Care Board

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The ICB's directors are responsible preparing the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The directors are required to comply with the Department of Health & Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the ICB is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

The ICB is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

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Appendix B: Value for Money Auditor responsibilities

Our work is risk-based and focused on providing a commentary assessment of the ICB's Value for Money arrangements

Phase 1 – Planning and initial risk assessment

As part of our planning we assess our knowledge of the ICB's arrangements and whether we consider there are any indications of risks of significant weakness. This is done against each of the reporting criteria and continues throughout the reporting period.

Phase 2 – Additional risk-based procedures and evaluation

Where we identify risks of significant weakness in arrangements we will undertake further work to understand whether there are significant weaknesses. We use auditor's professional judgement in assessing whether there is a significant weakness in arrangements and ensure that we consider any further guidance issued by the NAO.

Phase 3 – Reporting our commentary and recommendations

The Code requires us to provide a commentary on your arrangements which is detailed within this report. Where we identify weaknesses in arrangements we raise recommendations.

A range of different recommendations can be raised by the ICB's auditors as follows:

Statutory recommendations – recommendations to the ICB under Section 24 (Schedule 7) of the Local Audit and Accountability Act 2014.

Key recommendations – the actions which should be taken by the ICB where significant weaknesses are identified within arrangements.

Improvement recommendations – actions which are not a result of us identifying significant weaknesses in the ICB's arrangements, but which if not addressed could increase the risk of a significant weakness in the future.

Information that informs our ongoing risk assessment

Cumulative knowledge of arrangements from the prior year	Key performance and risk management information reported to the Board
Interviews and discussions with key officers	NHS Oversight Framework (NOF) rating
Progress with implementing recommendations	Care Quality Commission (CQC) reporting
Findings from our opinion audit	Annual Governance Statement including the Head of Internal Audit annual opinion

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Appendix C: Follow up of 2024/25 improvement recommendations

	Prior Recommendation	Raised	Progress	Current position	Further action
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.	2024/25	The ICB has made progress in the identification, governance and delivery of efficiency schemes and has strengthened transparency over performance. However, continued reliance on non-recurrent measures and late-year recovery activity indicates underlying issues have not yet been fully resolved.	In progress - recommendation updated.	See Improvement recommendation 1.
IR2	The ICB should ensure that it has robust arrangements for monitoring ongoing progress against Single Improvement Plan (SIP) indicators once they 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 the SIP via reports to the Board.	2024/25	The ICB's Finance Committee and Quality and Performance Committee, along with the Transition Committee once established, 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.	Implemented and closed.	No additional work required.

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Appendix C: Follow up of 2024/25 improvement recommendations

	Prior Recommendation	Raised	Progress	Current position	Further action
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.	2024/25	The ICB has reported delays to fully implement the agreed actions this year due to NHS reform and transformational change.	In progress - recommendation updated.	See improvement recommendation 4.

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NHS
Greater Manchester

NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan

17 June 2026

Part of Greater Manchester Integrated Care Partnership

NHS GM Audit Committee

17 June 2026

Report information.

Required information.	Details.
Title of report.	NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan
Author.	Izhar Chaudhary
Presented by.	Izhar Chaudhary
Contact for further information.	Izhar Chaudhary Associate Director of Finance- Financial Assurance izharchaudhary@nhs.net
Executive summary.	The Financial Assurance Team presents the NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan for approval by the NHS GM Audit Committee. The policy has been reviewed and updated.
The benefits that the population of Greater Manchester will experience.	Reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care.
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought.	Approval of the NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Reduces financial risk.
Key milestones.	N/A
Leadership and governance arrangements.	The Policy Review Group has reviewed the policy.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	MIAA – Anti Fraud Specialist Policy Review Group
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. The NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan is presented for ratification by the Audit Committee.

1.2. This policy has been reviewed and updated in line with the requirements relating to Failure to Prevent Fraud and Information Governance. It has been considered by the NHS GM Policy Review Group to ensure appropriate engagement across relevant functions, with all feedback and comments incorporated into the finalised policy.

1.3. The NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan applies to all NHS employees and provides a structured guide as to what fraud is in the NHS, to emphasise that it's everyone's responsibility to prevent fraud, bribery and corruption and to provide guidance on how to report it.

Recommendations

1.4. The NHS GM Audit Committee is asked to:

1.4.1. Approve and ratify the NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan policy prior to publication on the NHS GM website.

NHS
Greater Manchester

Anti-Fraud, Bribery and Corruption Policy & Response Plan

Date:15 April 2026 V4

Review Date: 31 July 2028

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester

Document Control

Title / Reference:	Anti-Fraud, Bribery and Corruption Policy & Response Plan for Greater Manchester Integrated Commissioning Board
Status:	DRAFT
Version:	V4
Date Issued / Ratified:	Issued 15/04/26
Originator of Document and Job Role:	Paul Bell (Senior Anti-Fraud Manager) Izhar Chaudhary (Associate Director of Finance- Financial Assurance)
File Classification:	Official Data
Retention:	Life of the organisation plus 6 years (place of deposit)
Target Audience:	All NHS Greater Manchester Integrated Care Staff & 3rd Party Partners
Links to other strategies, policies, procedures etc:	Whistleblowing Policy; Conflicts of Interest Policy; Disciplinary Policy; SFIs & SOs (Constitution); and Standards of Business Conduct Policy. Also, the NHS Anti-Fraud Manual & Investigations Toolkit, Government Functional Standard GovS 013: Counter Fraud (NHS Requirements); NHS Counter Fraud Strategy; and the NHSE ICB Counter Fraud Statutory Guidance.

Change History

Summary of Changes	Name	Date	Version
First Draft	Daryl Davies	21/04/22	0
NHSE ICB Counter Fraud Statutory Guidance refs	Paul Bell	02/08/22	1
Updated NHSCFA Strategy 2023-2026	Paul Bell	31/03/24	2
Review / Amendments.	Izhar Chaudhary	09/05/24	2
Review	Sam Evans	14/05/24	2
V2.0 Final	Paul Bell	24/05/24	2
V3.0 & V3.1 Final minor amendments.	Izhar Chaudhary	16/07/24	3
V4 – Updated Failure to Prevent Fraud/ Information Governance	Paul Bell Izhar Chaudhary	21/04/26	4

Review

Name	Role	Date	Version
Izhar Chaudhary	AD Finance – Financial Assurance	16/07/24	3.1

Izhar Chaudhary	AD Finance – Financial Assurance	11/05/26	4.0

Approval

Name	Role	Date	Version
Izhar Chaudhary	AD Finance – Financial Assurance	16/07/24	3.1
Sam Evans	Corporate Director of Finance – Commissioning & Financial Assurance	11/05/26	4.0

Distribution

Name	Role	Date	Version

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Contents

1. Introduction 5
2. Purpose & Scope 6
3. Definitions 7
4. Roles and Responsibilities 11
5. The Response Plan 15
6. Review 18
7. Data Protection Legislation 18
8. Training and Awareness 19
9. Classification and Retention of Information 20
10. Legislation & Guidelines 20
11. Equality Statement 20
12. Monitoring and Review 20

1. Introduction

1.1 General

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in the NHS conduct themselves in an honest and professional manner and they believe that fraud, bribery and corruption, committed by a minority, is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

The NHS GM is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The NHS GM does not tolerate fraud, bribery or corruption and aims to eliminate all such activity as far as possible.

NHS GM, at its most senior levels, wishes to encourage anyone having reasonable suspicions of fraud, bribery or corruption to report them. For the purposes of this policy "reasonably held suspicions" shall mean any suspicions other than those which are totally groundless (and/or raised maliciously).

It is NHS GM policy that no employee will suffer in any way as a result of reporting these suspicions. This protection is given under the provisions of the Public Interest Disclosure Act, and other related legislation / regulations, which NHS GM is obliged to comply with.

NHS GM will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, with the Government Functional Standard GovS 013: Counter Fraud (NHS Requirements), NHS contractual requirements and with regard to the policies, directions, instructions and guidance as issued by the NHS Counter Fraud Authority (NHSCFA), as well as in accordance with relevant UK legislation.

NHS GM will seek the appropriate disciplinary, regulatory, civil and criminal sanctions [as well as referral to professional bodies, where appropriate] against fraudsters and where possible will attempt to recover losses.

NHS GM is required to appoint its own dedicated Anti-Fraud Specialist (AFS), also known as Local Counter Fraud Specialist (LCFS), who is accredited by the NHSCFA and accountable to them professionally for the completion of a range of preventative anti-fraud and corruption work, as well as for undertaking any necessary investigations. Locally, the AFS is accountable on a day-to-day basis to the Chief Finance Officer for NHS GM, and also reports, periodically, to the NHS GM Audit Committee.

All instances where fraud, bribery and/or corruption is suspected are thoroughly investigated by suitable accredited personnel. Any investigations will be undertaken in accordance with the NHSCFA investigatory toolkit requirements.

[NB. For staff awareness, **theft issues** are usually dealt with by Local Security Management Specialists (LSMS), not the AFS. However, the AFS will be mindful of any potential criminality identified in the course of any investigation and will, with the agreement of the Chief Finance Officer, notify the appropriate investigating authority].

2. Purpose & Scope

2.1 Purpose

NHS GM is committed to taking all necessary steps to counter fraud, bribery and corruption.

The aim of this policy is to provide a guide for employees as to what fraud is in the NHS, to emphasise that it's everyone's responsibility to prevent fraud, bribery and corruption and to provide guidance on how to report it.

Tackling fraud in the NHS is guided by the NHSCFA Strategy 2023-26, which details how the NHSCFA works collaboratively with the health sector to understand, find and prevent fraud in the NHS. They have developed four key pillars of activity to facilitate this:

1. Understand: Understand how fraud, bribery and corruption affects the NHS.
2. Prevent: Ensure the NHS is equipped to take proactive action to prevent future losses from occurring.
3. Respond: Ensure the NHS is equipped to respond when a fraud occurs.
4. Assure: Provide assurance to key partners, stakeholders and the public that the overall response to fraud across the NHS is robust.

NHS GM ensures transparency in how personal data is used by maintaining appropriate privacy notices, including information about the use of data for fraud prevention, detection and investigation purposes.

2.2 Scope

This policy has been produced by NHS GM's AFS, and is intended to provide a guide for all employees [regardless of position or employment status], contractors, consultants, vendors and other internal and external stakeholders who have a professional or business relationship with NHS GM, on what fraud and corruption are in the NHS; what everyone's responsibility are to prevent fraud, bribery and corruption; and also how to report concerns and/or suspicions with the intention of reducing fraud to a minimum within NHS GM.

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud, corruption or bribery. It provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud, bribery and corruption.

3. Definitions

3.1 NHS Counter Fraud Authority (NHSCFA) / NHS Counter Fraud Strategy

The NHS Counter Fraud Authority (NHSCFA) is a special health authority which has the responsibility for the detection, investigation and prevention of fraud and economic crime within the NHS. Its aim is to lead the fight against fraud affecting the NHS and wider health service, by using intelligence to understand the nature of fraud risks, investigate serious and complex fraud, reduce its impact and drive forward improvements.

NHSCFA also maintains a national NHS Counter Fraud Strategy which sets out the strategic approach and direction, key challenges and opportunities, and the priority areas identified for tackling fraud and corruption in the NHS. NHS GM's local approach to tackling fraud and corruption, through the work of the Anti-Fraud Specialist, organisational resources and the annual risk-assessed counter fraud work-plan, fully acknowledges and aligns itself to the priorities set out in the national strategy.

Government Functional Standard GovS 013: Counter Fraud (NHS Requirements)

A requirement in the NHS standard contract is that providers and commissioners of NHS services must take the necessary action to comply with the NHSCFA's counter fraud standards. Others should have due regard to the standards. The contract places a requirement on providers / commissioners to have policies, procedures and processes in place to combat fraud, corruption and bribery to ensure compliance with the standards. The NHSCFA carries out regular assessments of health organisations in line with the counter fraud standards.

3.2 ICB Counter Fraud Statutory Guidance

As per the ICB Counter Fraud Statutory Guidance, NHS GM will liaise with NHSE and providers as necessary in respect of any fraud allegations arising around primary care provision. Due consideration will be given to the nature of the allegations raised and where the contractual responsibility resides for any primary care funds identified as being at risk of abuse. On occasions, this may necessitate a multi-agency approach to an investigation and NHS GM's Anti-Fraud Specialist will advise NHS GM accordingly. Similarly, the AFS will advise on any other counter fraud arrangements relating to primary care provision that

may be necessary or appropriate. The AFS will ensure NHS GM compliance with the relevant requirements of the guidance.

3.4 Fraud

The Fraud Act 2006 introduced an entirely new way of investigating and prosecuting fraud, which can relate to money, property or other benefits of value. Previously, the word 'fraud' was an umbrella term used to cover a variety of criminal offences falling under various legislative acts. It is no longer necessary to prove that a person has been deceived, or for a fraud to be successful. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain either for themselves or another; to cause a loss to another; or, expose another to a risk of a loss.

There are several specific offences under the Fraud Act 2006; however, there are three primary ways in which it can be committed that are likely to be investigated by the AFS.

The offence of fraud can be committed in three ways:

- **Fraud by false representation (s.2)** – lying about something using any means, e.g. falsifying a CV or NHS job application form

- **Fraud by failing to disclose (s.3)** – not saying something when you have a legal duty to do so, e.g. failing to declare a conviction, disqualification or commercial interest when such information may have an impact on your NHS role, duties or obligation and where you are required to declare such information as part of a legal commitment to do so.

- **Fraud by abuse of a position of trust (s.4)** – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation, e.g. a carer abusing their access to patients monies, or an employee using commercially confidential NHS information to make a personal gain.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. Successful prosecutions under the Fraud Act 2006 may result in an unlimited fine and/or a potential custodial sentence of up to 10 years.

3.5 Bribery and Corruption

NHS GM adopts a 'zero tolerance' attitude towards bribery and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose.

NHS GM is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery.

The Bribery Act 2010 reformed the criminal law of bribery, making it a criminal offence to:

Give, promise or offer a bribe (s.1), and/or

Request, agree to receive or accept a bribe (s.2).

Corruption is generally considered to be an "umbrella" term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism, theft or embezzlement. Under the 2010 Act, however, bribery is now a series of specific offences.

Generally, bribery is defined as: ***an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.***

Examples of bribery in an NHS context could be a contractor attempting to influence a procurement decision-maker by giving them an extra benefit or gift as part of a tender exercise; or, a medical or pharmaceutical company providing holidays or other excessive hospitality to a clinician in order to influence them to persuade their organisation to purchase that company's particular clinical supplies.

A bribe does not have to be in cash; it may be the awarding of a contract, the provision of gifts, hospitality, sponsorship, the promise of work or some other benefit. The persons making and receiving the bribe may be acting on behalf of others – under the Bribery Act 2010, all parties involved may be prosecuted for a bribery offence.

All staff are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship and they should refer to the separate NHS GM policy, the 'Managing Conflicts of Interest Policy' covering:

Acceptance of Gifts and Hospitality

Declaration of Interests

Sponsorship

The Bribery Act 2010 applies to (and can be triggered by) everyone "associated" with NHS GM who performs services for us, or on our behalf, or who provides us with goods. This includes those who work for and with us, such as employees, agents, subsidiaries, contractors and suppliers (regardless of whether they are incorporated or

not). The term 'associated persons' has an intentionally wide interpretation under the Bribery Act 2010.

Sanctions, following a successful prosecution, are similar to those of the Fraud Act 2006.

3.6 Failure to Prevent Fraud Offence (ECCTA 2023)

The Economic Crime and Corporate Transparency Act (ECCTA) 2023 covers a range of reforms relating to organisational requirements and enhancements to deliver a suite of wider-ranging reforms to tackle economic crime and improve transparency over corporate entities.

As part of this legislation, the Government has introduced a new *'failure to prevent fraud offence'* to hold organisations to account if they profit from fraud committed by their employees or those associated with it. This offence came into force on 1st September 2025. Information regarding this offence can be found at: Failure to prevent fraud.

The new offence seeks to discourage organisations from turning a blind eye to **fraud undertaken by associated persons (e.g. employees, contractors working for it, associates, agents and/or subsidiaries), which ultimately benefits the organization, directly or indirectly. The benefit does not just have to be financial, and the benefit can be to all or just part of the organization. Also, fraud does not have to be successful. The intent is sufficient.**

The legislation will hold organisations to account through prosecution if they profit from the fraudulent actions of associated persons.

The legislation states that an organisation could avoid prosecution if it is able to prove that, at the time that the fraud offence was committed, it had 'reasonable procedures' in place to prevent this type of fraud from occurring. What constitutes 'reasonable procedures' is not defined in the legislation and would be determined by a court, if a prosecution was brought.

The offence applies to all sectors. However, to ensure burdens on organisations are proportionate, only large organisations are currently in scope – defined as organisations meeting two out of three following criteria:

- more than 250 employees.
- more than £36 million turnover; and
- more than £18 million in total assets.

The organisation may be prosecuted with the potential for an unlimited fine. If resources are held across a parent organisation and its subsidiaries cumulatively meet the size threshold, that group of institutions will be in scope of the failure to prevent fraud offence.

Regardless, this legislation / offence applies to all NHS organisations.

The ICB's Anti-Fraud Specialist works with the organisation in order to help it establish reasonable procedures to mitigate the risk of this offence occurring.

4. Roles and Responsibilities

Through our day-to-day work, we, i.e. all staff, are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure that those risks – however large or small – are identified and eliminated. Where you believe the opportunity for fraud, corruption or bribery exists, whether because of poor procedures or oversight, you should report it to the AFS or the NHS Fraud and Corruption Reporting Line and/or online Fraud Reporting Form.

This section states the roles and responsibilities of employees and other relevant parties in reporting fraud or corruption.

4.1 Chief Executive

NHS GM's Chief Executive, as the organisations accountable officer, has overall responsibility for securing funds, assets and resources entrusted to it, including instances of fraud, bribery and corruption.

The Chief Executive/ Chief Officer must ensure adequate policies and procedures are in place to protect the organisation and the public funds it receives. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all NHS GM employees. NHS GM therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and Chief Finance Officer will monitor and ensure compliance with this policy.

4.2 Board

NHS GM's Board has a duty to provide adequate governance and oversight of NHS GM to ensure that it's funds, people and assets are adequately protected against criminal activity, including fraud, bribery and corruption.

The Board provides clear and demonstrable support and strategic direction for counter fraud, bribery and corruption work. They review the proactive management, control and the evaluation of counter fraud, bribery and corruption work. The Board and non-executive directors scrutinise NHSCFA assessment reports, where applicable, and ensure that the recommendations are fully actioned.

4.3 Chief Finance Officer

The Chief Finance Officer (CFO) has the power to approve financial transactions initiated by directorates across the organisation.

They prepare, document and maintain detailed financial procedures and systems and apply the principles of separation of duties and internal checks to supplement those procedures and systems.

They will report annually to the Board on the adequacy of internal financial controls and risk management as part of the Board's overall responsibility to prepare a statement of internal control for inclusion in the annual report.

They also act as the Executive Lead for the organisation's counter fraud arrangements, liaising closely with the Anti-Fraud Specialist.

The CFO will, depending on the outcome of initial investigations, inform appropriate senior management of suspected cases of fraud, bribery and corruption, especially in cases where the loss may be above an agreed limit or where the incident may lead to adverse publicity.

4.4 Senior Information Risk Owner (SIRO) and Caldicott Guardian

The SIRO has overall responsibility for information risk within NHS GM and will ensure that risks relating to fraud investigations and data use are appropriately managed.

The Caldicott Guardian will provide oversight where patient confidential data is involved, ensuring that access and sharing is justified and compliant with the Caldicott Principles.

4.5 Audit Committees

The role of Audit Committees is in reviewing, approving and monitoring counter fraud workplans, receiving regular updates on counter fraud activity, monitoring the implementation of action plans, providing direct access and liaison with those responsible for counter fraud, reviewing annual reports on counter fraud, and discuss NHSCFA quality assessment reports. Reference: NHS Audit Committee Handbook 2024 HFMA Policy and Guidance

4.6 Internal and External Audit

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions. They have a duty to pass on any suspicions of fraud, bribery or corruption to the Anti-Fraud Specialist (AFS).

4.7 Human Resources / Personnel Management

Human resources (HR) play a role in relation to employees in suspected cases of fraud, bribery and corruption, including liaison with the AFS and the conduct of any investigation, and instigating the necessary disciplinary action against those who fail to comply with the policies, procedures and processes. HR work with the AFS to ensure that appropriate parallel sanctions are applied (in accordance with the NHSCFA Anti-Fraud Manual) where fraud, bribery or corruption is proven against employees'. Appropriate joint working protocols exist to detail this relationship.

4.8 Anti-Fraud Specialist

The AFS is responsible for taking forward all anti-fraud work locally in accordance with the national functional counter fraud standards (NHS requirements), as well as the NHS Counter Fraud Strategy and ICB Counter Fraud Statutory Guidance, and reports directly to the CFO.

Adhering to NHSCFA functional counter fraud standards (NHS requirements) is important in ensuring that the organisation has appropriate counter fraud, bribery and corruption arrangements in place and that the AFS will look to achieve the highest standards possible in their work.

The AFS will work with key colleagues and stakeholders to promote counter fraud work, apply effective preventative measures and investigate allegations of fraud and corruption.

The AFS will conduct risk assessments in relation to their work to prevent fraud, bribery and corruption.

The AFS has responsibility for investigating any allegations of fraud and corruption within the organisation. NHS GM has secured the services of the Mersey Internal Audit Agency (MIAA) to provide this service.

4.9 Counter Fraud Champion

NHS GM has appointed a Fraud Champion; their role and duties include:

- Promoting awareness of fraud, bribery and corruption within the organisation,
- Understanding the threat posed by fraud, bribery and corruption and,
- Understanding best practice on counter fraud.
- They do not have any remit to investigate allegations of fraud or corruption.

4.10 Freedom to Speak-Up Guardians

Speak-Up Guardian has a responsibility to report allegations they receive relating to fraud or corruption against the organisation to the AFS (whilst protecting the identity of the referrer, if necessary).

You can raise your concerns directly with NHS GM's Non-Executive Director, Jackie Njoroge by emailing Jackie.njoroge1@nhs.net

The Freedom to Speak Up Policy can be found on the NHS GM website.

4.11 Whistleblowing

Anybody who has a whistleblowing concern relating to NHS GM can use our whistleblowing reporting procedures. A person who wishes to report a concern or suspected serious wrongdoing (a disclosure) should contact NHS GM in one of the following ways:

- E-mail your concerns to NHS GM's Corporate Governance Team at:
  gmhscp.gmicp.corporate@nhs.net
- Call NHS GM by telephone, asking to speak to the Corporate Governance Team: 0161 742 6023.
- Concerns can also be reported in writing to:
  NHS GM Corporate Governance Team

Confidential
Tootal
56 Oxford Street
Manchester
M1 6EU

Alternatively, you can raise your concerns directly with NHS GM's Non-Executive Director and Whistleblowing Lead, Jackie Njoroge by emailing Jackie.njoroge1@nhs.net

The Whistleblowing Policy can be found on the NHS GM website.

4.12 Managers

All managers are responsible for ensuring that policies, procedures and processes within their local area are adhered to and kept under constant review.

Managers have a responsibility to ensure that staff are aware of fraud, bribery and corruption and understand the importance of protecting the organisation from it. Managers will also be responsible for the enforcement of disciplinary action for staff who do not comply with policies, procedures and processes.

Managers should report any instances of actual or suspected fraud, bribery or corruption brought to their attention to the AFS immediately. It is important that managers do not investigate any suspected financial crimes themselves.

Other responsibilities managers have includes conducting risk assessments and mitigating identified risks.

4.13 All Employees

Employees are required to comply with the organisation's policies, procedures and processes and apply best practice in order to prevent fraud, bribery and corruption (for example in the areas of procurement, personal expenses and ethical business behaviour). Staff should be aware of their own responsibilities in accordance with the organisation's standards of behaviour and in protecting the organisation from these crimes.

Employees who are involved in or manage internal control systems should be adequately trained and supported in order to carry out their responsibilities.

If an employee suspects that fraud, bribery or corruption has taken place, they should ensure it is reported to the AFS and/or to NHSCFA as explained below.

4.14 Information Management and Technology

The Head of Information Security (or equivalent) will contact the AFS immediately in all cases where there is suspicion that NHS GM ICT (Information and Communications Technology) is being used for fraudulent purposes in accordance with the Computer Misuse Act 1990. They will also ensure that any access to systems required for investigative purposes is appropriately authorised, proportionate, and auditable, and that system access controls are reviewed where risks are identified. Similarly, the Head of Information Security or equivalent will liaise closely with the AFS to ensure that a subject's access (both physical and electronic) to NHS GM ICT resources is suspended or removed where an investigation identifies that it is appropriate to do so.

5. The Response Plan

5.1 Fraud, Bribery and Corruption

The AFS undertakes an annual fraud and bribery risk assessment, in conjunction with the organisation conducting periodic assessments (in line with Ministry of Justice guidance) to assess how bribery and corruption may affect it and to ensure proportionate procedures and measures have been put in place to mitigate identified risks.

The organisation also has a policy and procedure in place in relation to the completion of declarations of interest, declarations of secondary employment and the hospitality/gifts register. The relevant policy and procedures are accessible via the intranet and staff are required to comply with these arrangements. Instances of non-compliance may be referred to the AFS for further investigation.

The AFS has primary organisational responsibility for investigating allegations of fraud and corruption against or with the organisation.

5.2. Reporting Fraud, Bribery or Corruption

This section outlines the action to be taken if fraud, corruption or bribery is discovered or suspected.

All genuine suspicions of fraud, bribery and corruption must be reported directly to the AFS:

Paul Bell – Head of Anti-Crime Services, (Mersey Internal Audit Agency)

M: 07552 253068 / T: 0151 285 4500

E: paul.bell@miaa.nhs.uk

Paul McGrath – Anti-Fraud Manager, (Mersey Internal Audit Agency)

M: 07584 774761

E: paul.mcgrath@miaa.nhs.uk

If the referrer believes that the Chief Finance Officer or AFS is implicated, they should notify whichever party is not believed to be involved who will then inform the Chief Executive and Audit Committee Chairperson.

An employee can contact any executive or non-executive director of NHS GM to discuss their concerns if they feel unable, for any reason, to report the matter to the AFS or Chief Finance Officer.

Details of a suspected fraud, bribery and corruption may also be reported through the **NHS Fraud and Corruption Reporting Line** on **Freephone 0800 028 40 60**, (powered by 'Crimestoppers 24/7') or online at **https://cfa.nhs.uk/reportfraud**, in addition to the AFS or the organisation's Chief Finance Officer.

The AFS and/or NHSCFA will undertake an investigation and seek to apply criminal and civil sanctions, where appropriate. Any investigation would follow our set investigative procedures.

Investigations may also include police involvement, where appropriate.

All NHS bodies including private providers, commissioners and Trusts refer to the Home Office's bribery and corruption assessment template in order to assess their response to bribery and corruption. Home Office Bribery and corruption assessment template.

Where a fraud investigation identifies or involves a personal data breach, this must also be reported and managed in accordance with NHS GM's Data Security Incident Reporting Procedure, including assessment for notification to the Information Commissioner's Office (ICO) where required.

5.3 Whistleblowing

Concerns regarding fraud, bribery or corruption may also be reported to NHS GM via the Freedom to Speak Up Guardian in accordance with the Freedom to Speak Up Policy, or via the NHS GM Whistleblowing Policy.

5.4 Disciplinary Action

Disciplinary procedures, in the context of fraud allegations, will be initiated where an employee is suspected of being directly involved in a fraudulent or illegal act, or where their negligent action has led to a fraud being perpetrated. NHS GM's disciplinary policy should be referred to.

5.5 Sanctions and Redress

This section outlines the sanctions that can be applied and the redress that can be sought against individuals who commit fraud, bribery and corruption against the organisation.

NHS GM's approach to pursuing sanctions in cases of fraud, bribery and corruption is that the full range of possible sanctions – including criminal, civil, disciplinary and regulatory – should be considered at the earliest opportunity and any or all of these may be pursued where and when appropriate. The consistent use of an appropriate combination of investigative processes in each case demonstrates this organisation's commitment to take fraud, bribery and corruption seriously and ultimately contributes to the deterrence and prevention of such actions.

Briefly, the types of sanction which the organisation may apply when a financial offence has occurred include:

Civil – civil sanctions can be taken against those who commit fraud, bribery and corruption to recover money and/or assets which have been fraudulently obtained, including interest and costs.

Criminal – The AFS will work in partnership with NHSCFA, the police and/or the Crown Prosecution Service to bring a case to court against an alleged offender. Outcomes can range from a criminal conviction to fines and imprisonment.

Disciplinary – Disciplinary procedures will be initiated where an employee is suspected of being involved in a fraudulent or illegal act, as per Section 4.3 of this policy.

Professional Body Disciplinary – If warranted, staff may be reported to their professional body as a result of a successful investigation/prosecution.

NHS GM will seek financial redress whenever possible to recover losses to fraud, bribery and corruption. Redress can take the form of confiscation and compensation orders, a civil order for repayment, or a local agreement between the organisation and the offender to repay monies lost.

6. Review

6.1 Monitoring and auditing policy effectiveness

Monitoring is essential to ensuring that controls are appropriate and robust enough to prevent or reduce fraud. Monitoring arrangements include reviewing system controls on an ongoing basis and identifying weaknesses in processes.

Where deficiencies are identified as a result of monitoring, appropriate recommendations and action plans are developed and implemented.

6.2 Dissemination of the policy

This policy will be brought to the attention of all employees and will form part of the induction process for new staff.

This policy will be disseminated NHS GM wide for all employees to understand and be made aware of via awareness presentations, NHS GM Bulletin's and on NHS GM's Anti-Fraud intranet page.

It is important that staff understand and are aware of this policy.

7. Data Protection Legislation

Personal data processed for the purposes of preventing, detecting and investigating fraud, bribery and corruption will be handled in accordance with UK data protection legislation. This includes processing under Article 6(1)(e) UK GDPR (public task) and/or Article 6(1)(c) (legal obligation).

Where special category data is processed, this will be undertaken in accordance with Article 9 UK GDPR and relevant conditions under Schedule 1 of the Data Protection Act

2018 including substantial public interest conditions such as the prevention and detection of unlawful acts and safeguarding of public funds.

All information used in fraud investigations will be processed in accordance with the principles of lawfulness, fairness and transparency, data minimisation, purpose limitation, accuracy, storage limitation, integrity and confidentiality, and accountability.

Access to personal and confidential information during investigations will be strictly limited to that which is necessary and proportionate, and on a need-to-know basis only.

All access to systems and records for investigative purposes will be logged, auditable and subject to appropriate oversight.
NHS GM and its staff and any other third party who works for or on behalf of NHS GM must comply with all Data Security (IG) policies and procedures to ensure data is confidential, available when needed, and is of high integrity.

All staff, whether permanent, temporary or contracted, working in a clinical or non-clinical environment, are responsible for ensuring that they are aware of the Data Security & Protection requirements incumbent upon them and for ensuring that they comply with these on a day-to-day basis.

NHS GM's Data Security (IG) policies and procedures can be found on the Information Governance Team's intranet GM Intranet (sharepoint.com)

If a staff member requires advice and guidance relating to the disclosure of personal information, then advice should be sought from NHS GM IG Team gmhscp.icpig@nhs.net

NHS GM may share information with external agencies such as the NHS Counter Fraud Authority, NHS England, the police, or other relevant bodies where it is lawful and necessary to do so for the purposes of preventing or detecting fraud.

All information sharing will:

- Be justified, proportionate and necessary
- Be limited to the minimum required information
- Be carried out in accordance with data protection legislation and Caldicott Principles
- Where appropriate, be supported by formal Data Sharing Agreements or protocols

8. Training and Awareness

This document will be made available to all staff via Keep Connected and published on NHS GM's Website and on the IG Intranet page for NHS GM.

All staff are responsible for adhering to the UK General Data Protection Regulations, Caldicott Principles, the National Data Guardian Data Security Standards, the Data Protection Act 2018 and the common law duty of confidentiality.

All staff are mandated to undertake Data Security Awareness training on an annual basis.

Staff will receive guidance regarding this document from a number of sources:

- Policies and procedures are located on the intranet;
- Line manager;
- Other communication methods (e.g., staff briefings, team meetings, IG updates).
- The IG Team.

9. Classification and Retention of Information

NHS GM implements appropriate information classification and retention controls, based upon the data security legislation and the Records Management Code of Practice for Health and Social Care.

Further details of the classifications controls can be found in the Information Classification Policy and the Records Management Policy.

10. Legislation & Guidelines

A set of procedural documents will be made available via the IG intranet page.

- UK General Data Protection Regulations
- Data Protection Act 2018
- The National Data Guardian Data Security Standards
- Confidentiality: NHS Code of Practice
- Common Law Duty of Confidence
- Human Rights Act 1998
- Computer Misuse Act 1990
- Electronic Communications Act 2000
- Guide to the Notification of Data Security and Protection Incidents.

11. Equality Statement

NHS GM aims to design and implement services, policies and measures that are fair and equitable. As part of its development, this document and its impact on staff, patients and the public have been reviewed in line with the NHS GM's legal equality duties. The purpose of the assessment is to improve service delivery by minimizing, and if possible, removing any disproportionate adverse impact on employees, patients and the public on the grounds of race, socially excluded groups, gender, disability, age, sexual orientation or religion/belief.

The Equality Assessment has been completed, and any associated documents will be analysed accordingly.

12. Monitoring and Review

This policy will be reviewed on an annual basis to ensure it is fit for purpose, triangulated with any other relevant policies. The policy will be reviewed by Izhar Chaudhary, Associate Director of Finance – Financial Assurance

This document will be monitored through staff awareness and supporting evidence to the Data Security & Protection Toolkit.

This policy will be reviewed on a two-year basis and in accordance with the following as and when required:

- Legislative changes;
- Good practice guidance;
- Case law;
- Significant incidents reported;
- New vulnerabilities; and
- Changes to organisational infrastructure.

The next review is scheduled for 31 July 2028 or sooner if there is any further change in legislation.

Audit Committee Workplan 2026/27								
	Executive	Lead Officer	Jun-26	Sep-26	Dec-26	Mar-27	Apr-27	Jun-27
Internal Audit								
Review and approve annual internal audit plan (2026/27)	Kathy Roe	Izhar Chaudhary						
Annual review of the effectiveness of internal audit	Kathy Roe	Izhar Chaudhary			X			
Receipt of Internal Audit Charter	Kathy Roe	Izhar Chaudhary					X	
Receive internal audit progress reports	Kathy Roe	Izhar Chaudhary		X	X	X	X	X
Receive internal audit follow up reports	Kathy Roe	Izhar Chaudhary		X	X	X		X
Draft Head of Internal Audit Opinion and Annual Report	Kathy Roe	Izhar Chaudhary				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		
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						
Review counter fraud progress reports	Kathy Roe	Izhar Chaudhary		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	
Review the Board Assurance Framework (BAF)	Charlotte Bailey	Chris Gaffey				X		
Risk Management Update	Charlotte Bailey	Chris Gaffey		X	X	X	X	X
Risk Deep Dive	Charlotte Bailey	Chris Gaffey		X	X	X	X	X
Review the draft annual report (including Annual Governance Statement)	Charlotte Bailey	Chris Gaffey					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	Colin Scales / Nicola Hepburn	Malcolm Whitehouse			X			
SIRO Annual Report	Colin Scales / Nicola Hepburn	Malcolm Whitehouse	X					X
Corporate Policies	Relevant Exec	Relevant Lead Officer	X	X	X	X	X	X
Conflicts of Interest Annual Report	Charlotte Bailey	Chris Gaffey		X				
Neurodevelopmental Business Case Lessons Learned	TBC	TBC		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	
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	
Standing Items								
Debtors update	Kathy Roe	Kaye Abbott		X	X	X	X	X
Losses/ special payments	Kathy Roe	Kaye Abbott		X	X	X	X	X
Tender Waivers and Procurement Report	Kathy Roe	Izhar Chaudhary		X	X	X	X	X
Use of corporate seal	Charlotte Bailey	Chris Gaffey		X	X	X	X	X
Conflicts of interest Guardian	Chair	Chris Gaffey	X	X	X	X	X	X
Board summary report (verbal)	Chair	Chris Gaffey	X	X	X	X	X	X
Reflections on the meeting	Chair	N/A	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
Private discussions with internal and counter fraud specialists	Chair	N/A		X		X		X
Private discussions with external auditors	Chair	N/A	X		X		X	