

Agenda

Greater Manchester Audit Committee Part A

Date: 17 September 2026

Time: 10.00am to 12.00pm

Venue: MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	10.00	5 mins	Welcome, Introductions, Apologies including Attendance Matrix & Terms of Reference on a Page	Paper	Information	Chair
2.			Declarations of Interest	Verbal	Information	All
3.			Minutes from the last meeting and matters arising	Paper	Approval	Chair
4.			Action Log	Paper	Discussion	Chair
Internal Audit						
5.	10:05	10 mins	Internal audit progress reports	Paper	Discussion	Andrew Rothwell
6.	10.15	10 mins	Internal audit follow up reports	Paper	Discussion	Andrew Rothwell
7.	10.25	10 mins	Internal Audit Service External Quality Assessment	Paper	Discussion	Louise Cobain
External Audit						
8.	10:35	10 mins	Lessons learnt from year end	Paper	Discussion	Jackie Gardiner
9.	10.45	10 mins	VFM recommendations	Paper	Discussion	Jackie Gardiner
Counter Fraud						
10.	10.55	5 mins	Review counter fraud progress reports	Paper	Discussion	Paul Bell
Governance						
11.	11.00	10 mins	Risk Management Update	Paper	Discussion	Chris Gaffey
12.	11.10	5 mins	Annual Report of the Audit Committee	Paper	Discussion	Chair
13.	11.15	10 mins	Whistleblowing Annual Report	Paper	Discussion	Chris Gaffey

14.	11.25	10 mins	Conflicts of Interest Annual Report	Paper	Discussion	Chris Gaffey
15.	11.35	5 mins	Committee Development	Verbal	Discussion	Chris Gaffey
Standing Items						
16.	11.40	5 mins	Debtors Update	Paper	Information	Jackie Gardiner
17.	11.45	5 mins	Losses/ special payments including bad debt write off	Paper	Information	Jackie Gardiner
18.	11.50	10 mins	Use of Corporate Seal	Verbal	Information	Chris Gaffey
19.			Conflicts of Interest Guardian	Verbal	Information	Chair
20.			Board summary report	Verbal	Information	Chair
21.			Reflections on the meeting	Verbal	Discussion	All

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

No longer a member

Name	Title	Apr-26
Richard Paver (Chair)	Non-Executive Director, Audit Committee Chair	
Jackie Njoroge	Senior Non-Executive Director	
Anthony Hassall	Chief Executive, Pennine Care NHS Foundation Trust	
Sue Greenhill	Independent Member	
Kathy Roe	Chief Finance Officer	
Colin Scales	Chief Executive Officer	
Charlotte Bailey	Chief Strategy, 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)

Minutes

Greater Manchester Audit Committee (Part A)

Date: Wednesday 17 June 2026

Time: 9:00am to 10:35am

Venue: Boardroom, The 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
Attendees / Participants:		
Stephen Downs	SD	Deputy 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
Kal Kay	KK	Non-Executive Director and Chair of the Finance Committee, NHS GM
Colin Scales	CS	Acting Chief Executive
Richard Leese		Chair, NHS Greater Manchester
Jackie Gardiner	JG	Director of Operational Finance
Kaye Abbott	KA	Associate Director of Finance – Financial Control, NHS GM
Darrell Davies	DD	Regional Assurance Director, MIAA
Perminder Sethi	PS	Senior Manager, Grant Thornton
Paul Bell	PB	Head of Anti-Crime Services, MIAA
Faye Vaughan	FV	Governance Advisor, NHS GM (minutes)
Apologies:		
Kathy Roe	KR	Chief Finance Officer, NHS GM
Anthony Hassall	AH	Partner Member bringing the perspective of Mental Health Providers, Chief Executive of Pennine Care NHS Foundation Trust

	Topic	Action
1.	<u>Welcome, Introductions and Apologies</u> The Chair welcomed members and attendees to the meeting.	
2.	<u>Declarations of Interest (DOI)</u> RP reminded Committee members of their obligation to declare any interest relating to items on the agenda. No interests were declared.	
3.	<u>Minutes from the last meeting</u> The minutes of the last Audit Committee meeting on 23 April 2026 were approved as an accurate record.	
4.	<u>Action Log</u> The action log was reviewed noting that updates had been provided against the open actions, with any closed actions recorded on the log.	
5.	<u>Head of Internal Audit Opinion</u> The committee were informed that the Head of Internal Audit (HoIA) Opinion contributed 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. It was reported that the final opinion for 2025/26 was one of Substantial Assurance. The Internal Audit Plan aimed to address all of the key risks of the ICB on a cyclical basis. The committee were made aware of the one draft report that needed to be finalised at present. It was explained that they were awaiting management responses however, the draft outcome from the report had been included in the opinion as it was not anticipated to have any material changes. NHS GM Audit Committee noted the contents of the report.	
6.	<u>Anti-Fraud Annual Report 2025/26</u> The Anti-Fraud Annual Report offered 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. In completing the annual report on counter fraud, bribery and corruption work, the AFS had referred to and assessed the organisation against the Government Functional Standard 013 for Counter Fraud (which also applied to any relevant subsidiary company). The report highlighted relevant anti-fraud activities carried	

	out and their outcomes. It was explained that the anti-fraud work plan was designed to be dynamic to enable to respond to changing requirements, ensuring the most effective use of anti-fraud resource and meeting the requirements as set out in the relevant components of the fraud standard. The committee were made aware that the 2025/26 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. NHS GM Audit Committee noted the contents of the report.	
7.	<u>Annual Report and Accounts (including Annual Governance Statement) and Letter of Representation</u> The report detailed to the Audit Committee the changes made to the draft Annual Report and Accounts submitted in April 2026. The report also included the Letter of Representation. The committee were made aware of the minor amendments that required updating in the combined papers. JN thanked all involved and acknowledged the amount of work that had taken place to complete this work. A suggestion was raised to create an easier to read Annual Report in future for the public. CG confirmed that this is something that could be considered for future years, and would check with other ICBs whether this was something they produced. ACTION: CG to investigate whether any other ICBs had created an easy-to-read version of their Annual Report. The Audit Committee: • Approved the NHS GM Annual Report and Accounts for submission (subject to any minor, immaterial presentational amendments). • Confirmed the delegation to the Deputy CFO to undertake the national submissions required. • Approved the Letter of Representation for signature by the organisation.	CG
8.	<u>External Audit Findings Report 2025/26</u> A summary of the key findings and other matters arising from the statutory audit of NHS Greater Manchester ICB and the preparation of the ICB's financial statements for the year ended 31 March 2026 for those charged with governance were shared in the paper.	

	The number of recommendations in the report were highlighted to the committee. The committee were also made aware that the ICBs draft financial statements showed that the ICB had overspent against its revenue resource limit. As this was a breach of the statutory duty, the committee were made aware that it had been reported under the section 30(b) of the Local Audit and Accountability Act 2014 to flag the issue. It was acknowledged that this overspend had been agreed with NHS England as part of the planning process. The committee were made aware that the overall opinion on the Financial Statements was an unqualified audit opinion. Thanks were shared to the Finance Team for their support and collaborative working throughout the process. The committee were informed of the number of contract variation agreements or baseline contracts relating to specialised commissioning that had not been signed the previous year. Whilst signed agreements had been obtained or alternative confirmations received, it was explained that it would be essential to ensure all contracts and contract variations should be agreed and signed prior to payments being made. A recommendation to enforce it for the following year for best practice was raised. It was explained that compulsory redundancy and other departures reported in 2025/26 had been paid in accordance with the provisions of the redundancy scheme as agreed with NHS England. The committee were made aware that an Audit certificate could not be formally issued at present, in accordance with the requirements of the Local Audit and Accountability Act 2014 until the National Audit Office had concluded their work in respect of consolidation returns for the year ending 31 March 2026. The committee questioned whether any further progress had been made on the investment in third party company. It was confirmed that an update would be brought to the September 2026 private meeting. A discussion took place concerning the letter to the Secretary of State regarding NHS England allocated additional resource in advance of the expenditure. The committee further discussed the capacity issue in the organisation and assurance was sought on knowledge and skills retained in the organisation. It was confirmed that work would be undertaken to review the skills and capacity required across the organisation and to ensure that sufficient capability was retained to support effective delivery. The Mental Health Investment Standard was highlighted and a question was raised as to whether there was reference to meeting the Mental Health Investment Standard and the work that had taken place around it the report. It was confirmed that the disclosure was in the report which showed the target had been achieved.	
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	The Committee: • Approved the report, the recommendations and the management responses. • Agreed the additional fees proposed in the report.	
9.	<u>External Auditors Annual Report 2025/26</u> The report summarised the work undertaken by the external auditors for the 2025/26 financial year and in particular the commentary on Value for Money. It was explained that it set out the auditor's commentary on whether NHS GM had 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 reviewed the progress on implementation of recommendations made in 2024/25 and identified improvements required going forward. <u>Financial sustainability</u> It was explained that in 2025/26 the ICB delivered its agreed financial plan of a £7.5m deficit, including £175m of efficiency savings. This represented an improvement in financial delivery compared with prior years. However, a £7.5m deficit resulted in a technical breach of the ICB's statutory duty. It was explained that the key recommendation set out in the report was designed to support the ICB in strengthening arrangements to protect and deliver the medium-term strategy. It was reported that the ICB had submitted a compliant and balanced forward plan for 2026/27 to 2028/29, though this relied on significant savings. It was further explained that the ICB would need to demonstrate that prevention and transformation investment could be consistently translated into sustainable savings. <u>Governance</u> It was reported that the governance arrangements operated effectively during the year, with clear Board and Committee oversight of key risks. The committee were made aware that the ICB was now largely free from its Statutory Undertakings, with those remaining at year-end both relating to finance. As with many ICBs, it was explained that the ICB had worked to establish arrangements for consistent application of the Provider Selection Regime (PSR). However, the nature of the regime presented an ongoing risk and experience during the year which suggested that there was scope to further develop controls and governance in this area. It was reported that improvement recommendations had been raised to support assurance resilience during a time of significant transition and specifically to strengthen procurement and PSR compliance. <u>Improving economy, efficiency and effectiveness</u> The committee were informed that the ICB had maintained arrangements to oversee provider quality and performance and to support system improvement, including reporting of key performance metrics and escalation where concerns	

	appeared. The committee discussed the interplay between prior recommendations and highlighted that management had felt that all actions had been addressed whereas the report felt there was still areas to pick up. GT recognised the significant progress made in the financial sustainability area, however, highlighted that it was still a significant weakness for the current year. It was confirmed that discussions took place with Finance colleagues who agreed it should be a key recommendation, however, the improvement was acknowledged in the ICBs performance in this area. The constraints of the reporting framework in place was also highlighted. A suggestion was raised to provide further context in the report to ensure people were aware of the detail in future. The Committee: • Approved the report, the recommendations and the management responses.	
10.	<u>SIRO Report</u> Item deferred to Part B of the meeting.	
11.	<u>Anti-Fraud, Bribery and Corruption Policy</u> The NHS GM Anti-Fraud, Bribery and Corruption Policy had been reviewed and updated. It was confirmed that the updated policy would be shared with the committee after the meeting with the minor amendments raised. ACTION: IC to share the updated Anti-Fraud, Bribery and Corruption Policy with the committee. The Committee: • Approved and ratified the NHS GM Anti-Fraud, Bribery and Corruption Policy & Response Plan policy prior to publication on the NHS GM website.	IC
12.	<u>Standing Items:</u> <u>Conflicts of Interest Guardian</u> There were no updates to note. <u>Board Summary Report</u> Report to be completed noting items during the meeting. Audit Committee noted the updates provided.	
13.	<u>Audit Committee Workplan</u>	

	Suggestions were raised for topics that would need including in the workplan for future meetings.	
14.	<u>Any Other Business, reflections on the meeting and items for escalation to the Board</u> There were no other items of business for consideration. <u>Reflections on the meeting:</u> Suggestion raised for a Board Development Session on PSR to understand the detail and implications. ACTION: Future Board Development Session to cover PSR.	JN
15.	<u>Date and time of next meeting:</u> 17 September 2026, 10:00 – 13:00pm, MS Teams	

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		Complete - relevant information shared with Audit Committee members via email 17 June 2026, and confirmed at the June AC meeting.
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 conducted over summer, with ask of Chief and Lead Officers to review outstanding recommendations in detail - progress presented as part of internal audit report on September AC agenda. Follow Up Recommendations will now be a monthly item on the Operational Leadership Group meeting agenda to provide more regular senior oversight on progress, consideration of risk, and capacity management.
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		Complete - relevant information shared with Audit Committee members via email 17 June 2026, and confirmed at the June AC meeting.
131	17/06/2026	Anti-Fraud, Bribery and Corruption Policy	Updated policy to be shared with the committee after the meeting with the minor amendments raised	IC to share the updated Anti-Fraud, Bribery and Corruption Policy with the committee.	Izhar Chaudhary	Jun-26		Complete - circulated with papers for September AC meeting.
132	17/06/2026	Reflections on the meeting	Suggestion raised for a Board Development Session on PSR to understand the detail and implications.	Future Board Development Session to cover PSR.	Jenny Noble	Sep-26		Complete - this is now included on the Board's forward plan for development (specific date for training to be confirmed)

NHS GM Audit Committee 17th September 2026

Internal Audit Progress Report 2026/27

NHS GM Audit Committee

17th September 2026

Required information	Details
Title of report	Internal Audit Progress Report 2026/27
Author	Darrell Davies / Andrew Rothwell
Presented by	Andrew Rothwell
Contact for further information	Andrew Rothwell
Executive summary	This report provides the Audit Committee with a summary of the progress made in delivery of the 2026/27 Internal Audit Plan.
The benefits that the population of Greater Manchester will experience.	Assurance, through the Audit Committee, that improvements in internal control are being progressed within the organisation that should lead to improved performance and thus assist the organisations achieve its objectives.
How health inequalities will be reduced in Greater Manchester's communities.	The Internal Audit Plan aims to address all of the key risks of the ICB on a cyclical basis, including responding to the quality agenda.
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	The Internal Audit Plan aims to address all of the key risks of the ICB on a cyclical basis. The BAF is considered as part of the annual planning process to ensure that the internal audit plan includes appropriate coverage. Recommendations made by internal audit aim to strengthen the internal control environment which should contribute towards reduction in risk.
Key milestones	N/A
Leadership and governance arrangements	N/A
Engagement* to date	N/A
*Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	
Financial or Legal Implications	N/A

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

Introduction

1.0 This report provides the Audit Committee with a summary of the progress made in the delivery of the 2026/27 Internal Audit Plan.

Executive Summary

2.0 The report provides the Audit Committee with:

- This progress report covers the period from mid-April 2026 to September 2026 and includes details of seven final reports issued in relation to the 2025/26 audit plan.
- An update is provided on delivery of the 2026/27 workplan. At the time of this paper, five reviews are in progress, as noted within the report.
- Details of client briefings and intelligence issued during the reporting period.
- Updates on forthcoming MIAA conferences and masterclass events.

System Support and Implementation

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

Learning and Innovation

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

Recommendations

5.0 The Audit Committee is asked to:

- Note the contents of the report.

Internal Audit Progress Report

Audit Committee (September 2026)

NHS Greater Manchester Integrated Care Board

Contents

1 Introduction

2 Key Messages for Audit Committee Attention

Appendix A: Contract Performance

Appendix B: Performance Indicators

Appendix C: Assurance Definitions and Risk Classifications

Global Internal Audit Standards

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

3 Executive Summary

This report provides an update to the Audit Committee in respect of the progress made against the Internal Audit Plan for 2025/26 and 2026/27 and brings to your attention matters relevant to your responsibilities as members of the Audit Committee.

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

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

This progress report covers the period mid-April 2026 to September 2026.

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

Audit Reviews

2025/26

The following reviews have been finalised:

- Key Financial Transactional Processing Controls (Moderate Assurance)
- Financial Reporting (Substantial Assurance)
- Risk Management Core Controls (Substantial Assurance)
- Assurance Framework (Assurance rating not applied)
- Additional IT System Wide Assurance: IT Suppliers (Limited Assurance)
- Contingency - NEPTS Procurement (Assurance rating not applicable) - covered in Part B of the agenda.
- 25/26 Cyber Assessment Framework - Aligned Data Security & Protection Toolkit (DSPT) Phase II - covered in Part B of the agenda.

The following reviews are in progress:

- Data Quality - (Draft Report)

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

2026/27

The following reviews are in progress:

- Primary Care Commissioning Assurance Framework (POD Delegation) - Fieldwork
- Financial Sustainability and Medium-Term Financial Planning - Fieldwork
- Key Financial Transactional Processing Controls - Fieldwork
- Finance and Contract Management - Fieldwork

Follow Ups

Since the follow up position reported previously at the March 2026 Audit Committee:

- There were 95 recommendations reviewed as part of the Q2 follow up exercise: 26 High / 48 Medium / 18 Low / 3 N/A.
- Of these 95 recommendations, 10 recommendations are not due to be implemented and 23 have been fully implemented/ superseded. The remaining 62 recommendations are in either in progress and partially implemented (48) or not yet implemented (14).
- Of the 62 recommendations partially or not yet implemented, 26 have had revised implementation dates as set out in the management responses received to date, 6 of which are High risk recommendations.
- In 26 cases since the previous Audit Committee meeting a revised implementation date has been requested by management and considered by Chief Officers.

Audit Plan Changes

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

- There have been no further requests for amendments to the 2025/26 internal audit plan since those advised previously and the following changes are proposed to the 2026/27 internal audit plan.
 - A request to cancel the review of the CHC Transition Process was received due to the transition no longer progressing as envisaged when the review was included in the audit plan. This has resulted in the allocated 15 days being added to the contingency line.
 - We have received a request to review All Age Continuing Care. This work will use 20 days from the contingency allocation and will be delivered by specialists from MIAA's Solutions team.

Added Value

[Towards Excellence](#)

MIAA's Digital Teams have been formally awarded the Digital Skills Development Network's 'Towards Excellence in Digital Standards Level 3' accreditation. This is the highest level of recognition in this national framework.

This accreditation is part of the NW Skills Development Towards Excellence programme, which celebrates NHS organisations that demonstrate outstanding commitment to digital standards and workforce development.

[Investors in People \(IIP\) Gold Accreditation](#)

We are delighted to share that MIAA has been awarded Investors in People (IIP) Gold accreditation for the third consecutive time.

This is a fantastic achievement and recognition of MIAA's culture. Gold accreditation is awarded to organisations that don't just have great people practices in place, but where those practices are consistently experienced and valued by colleagues across the organisation

[MIAA Solutions Evaluated as Part of Groundbreaking NHS Consultancy Research](#)

New research from the University of Bristol highlights a major opportunity for the NHS to improve outcomes by strengthening internal consultancy capability and reducing reliance on external providers. The study, which reviewed several internal consultancies including MIAA, concludes that a more coordinated in-house consulting model can deliver greater value, sustainability, and performance across the NHS.

[Find out more](#)

MIAA Healthcare Quality & Improvement Services

We're proud to reintroduce our Healthcare Quality & Improvement Services — bringing together the combined strengths of MIAA and 360 Assurance. Our joint team brings together deep NHS clinical expertise, governance and assurance capability, and hands-on improvement experience. We've worked across acute, community, mental health, primary care and system settings — giving us a well-rounded understanding of the challenges organisations face.

Our teams include senior clinicians, governance specialists, internal auditors and quality improvement leaders, all focused on helping organisations deliver safer, higher-quality care.

[Find out more](#)

Briefings

Our latest briefings/blogs/podcasts are:

- [Key NHS Publications - August 2026](#)
- [Andrew Bowdler Blog: Ambient Voice Technology](#)
- [Key NHS Publications - July 2026](#)
- [Key NHS Publications - June 2026](#)
- 26/27 MIAA Insight – Consultant Job Planning
- [Key NHS Publications – May 2026](#)
- [Key NHS Publications – April 2026](#)
- 25/26 MIAA Insight – Safer Staffing Benchmarking
- 25/26 MIAA Insight – Emergency Preparedness, Resilience and Response Benchmarking

- [Claire Hammill Blog: The Value Equation](#)
- [Key NHS Publications - March 2026](#)

Advisory and Support Role

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

Audit Committee Chairs Webinars

We are continuing to hold sessions with groups of Trust and ICB Audit Committee Chairs focusing upon governance challenges and other key issues. The next meetings are in the process of being arranged.

Finance Committee Chairs Webinars

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

Governance Assurance & Risk Network (GARNet)

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

NEW – Mental Health Trusts Network

Supported by Hill Dickinson, who work in partnership with MIAA, the aim of the network is to bring together governance professionals to explore topical challenges, exchange learning, and identify good practice from across the sector. The inaugural session is scheduled for 16th September

Events

[Developing Tomorrow's Leaders \(18th September 2026\)](#): This session will explore the importance of effective leadership succession in today's evolving organisational landscape, highlighting what good practice looks like in action.

[ICBs and the Law: Key Issues Shaping the Future of Integrated Care \(24th September 2026\)](#): This session will provide an overview of the legal, governance and compliance challenges shaping the future of health and care systems. Drawing on expertise in Continuing Healthcare (CHC), All Age Continuing Care (AACC) and healthcare law, our speakers will share practical insights, case studies and actionable guidance to help organisations manage risk, strengthen governance and improve outcomes for patients and populations.

Appendix A: Contract Performance

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

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

Below sets out the overview of delivery for your Head of Internal Audit Opinion for 2026/27:

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 31 August 2026	Delivery %	Comment
2025/26 Review										
Data Quality	Yes	Draft Report	10/7/26	Nicola Hepburn	Limited	Dec 26	20	19.25	96.3%	Awaiting final responses
2026/27 Reviews										
Governance & Leadership										
Assurance Framework	Q4			Charlotte Bailey			16	0	0.0%	
Conflicts of Interest	Q3			Charlotte Bailey			15	0	0%	
Primary Care Commissioning	Yes	Fieldwork		Katherine Sheerin		Dec 26	7	5	71.4%	

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 31 August 2026	Delivery %	Comment
Assurance Framework (POD Delegation)										
Efficacy of New ICB Model Blueprint / Operating Model	Q4			Colin Scales			15	0	0%	
Finance Performance and Sustainability										
Key Financial Transactional Processing Controls	Yes	Fieldwork		Kathy Roe			18	1	5.6%	
Financial Sustainability and Medium-Term Financial Planning	Yes	Fieldwork		Kathy Roe			18	6.5	36%	2025/26 Deferred
Financial Governance & Budgetary Control	Q3			Kathy Roe			15	0	0%	
Finance & Contract Management	Yes	Fieldwork		Kathy Roe			20	5	25%	
STAR Panel Process	Q3			Kathy Roe			15	0	0%	
Quality										
Quality Governance Compliance	Q4			Manisha Kumar			15	0	0%	

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 31 August 2026	Delivery %	Comment
CHC Transition Model		Cancelled		Katherine Sheerin			0	0	0%	Review cancelled as transition programme no longer taking place – days added to contingency
People										
Rebuild of the ESR, Learning & Development System	Q3			Charlotte Bailey			20	0	0%	
Information and Technology										
AI Governance	Q3			Nicola Hepburn			10	0	0.0%	
Cyber Security	Planning			Nicola Hepburn			15	0	0%	
Data Security and Protection Toolkit Phase II -25/26	Yes	Final	June 26	Nicola Hepburn	High Risk / High Confidence	Sept 26	10	10	100%	
Data Security and Protection Toolkit	Q4			Nicola Hepburn			10	0	0.0	

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 31 August 2026	Delivery %	Comment
Phase I 26/27										
Follow Up										
Qtr 1 & 2	N/A	Final Report	N/A	Kathy Roe	N/A	Sept 26	20	10	50%	Complete
Qtr 3	N/A									
Qtr 4	N/A									
Planning & Reporting & Contingency										
Planning, Management, Reporting and Meetings	N/A	N/A		Kathy Roe			28	13	46.4%	
Contingency	N/A	N/A		Kathy Roe			55	0		15 days transferred in from CHC review and 20 days out to IPOC review below.
TRA Follow Up	N/A	N/A		Nicola Hepburn			8	1	12.5%	
Additional Reviews from Contingency Days										

HOIA Opinion Area	TOR Agreed	Status	Draft Report Issue Date	Executive Lead	Assurance Level	Audit Comm Reporting	Indicative Budget Days	Delivery Days as at 31 August 2026	Delivery %	Comment
All Age Continuing Care - IPOC	In Progress	Planning		Katherine Sheerin			20	0.5	2.5%	Request for additional work using contingency days.
					*- Figures exclude data quality review	TOTAL DAYS	*350	*52	*14.9%	

Added Value / Support & Guidance										
Monthly TIAN Insight Report	N/A	Issued monthly			N/A	Every meeting				
Quarterly TIAN Newsletter	N/A	Issued quarterly			N/A	Every meeting				

Appendix B: Performance Indicators

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

Element	Reporting Regularity	Status	Summary
Delivery of the Head of Internal Audit Opinion (Progress against Plan)	Each Audit Committee	Amber	There is ongoing engagement and communications regarding delivery of key reviews to support the Head of Internal Audit Opinion. There are a number of reports which are in progress and require completion.
Issue a Client Satisfaction Questionnaire following completion of every audit.		Green	Links to client satisfaction questionnaires are included in all reports.
Percentage of recommendations raised which are agreed	Each Audit Committee	Green	Trust management have accepted all recommendations made to date within final reports issued.
Percentage of recommendations which are implemented		Amber	Follow Up is reported at each Audit Committee – see separate report. A significant number of recommendations are only partially implemented and there have been 26 revisions to deadlines, since the previous follow up exercise.
Qualified Staff	Annual	Green	MIAA have a highly qualified and diverse workforce which includes 75% qualified staff. The Senior Team delivering the Internal Audit Service to the Trust are CCAB/IIA qualified.
Quality	Annual	Green	MIAA operate systems to ISO Quality Standards. MIAA conforms with the Global Internal Audit Standards (UK public sector).

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

Report Title		Key Financial Transactional Processing Controls			
Executive Sponsor	Kathy Roe, Chief Finance Officer				
Objective	The overall objective of the review was to provide assurance that the most significant key controls in the areas detailed in the scope below are appropriately designed and operating effectively in practice.				
Recommendations	0 x Critical	1 x High	2 x Medium	2 x Low	
Overall Rating	Moderate: There is an adequate system of internal control, however, in some areas weaknesses in design and/ or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.				
Summary	The ICB have undertaken a significant piece of work to review and amend staff authorisation limits to align with the Scheme of Delegation and although it was identified that out of date limits were uploaded to ISFE2 by SBS (resulting in amendments needing to be made), sample testing of 20 authorisation limits found that all were allocated in line with the Scheme of Delegation and recent review. Review of a sample of Purchase Order (PO) invoices confirmed that all POs were approved appropriately in line with allocated limits and there was evidence of receipt prior to payment. One approver has since had limits reduced due to being on long term sick, however, the ICB undertook a review of approvals prior to the transfer to ISFE2 and were satisfied that this was approved in line with previous limits. Regular finance reports were presented to the Finance Committee before the change in governance structure in early 2026 where existing sub-committees were stood down and replaced by a Transition Committee, and to the Board, which include a summary of financial position, key metrics, forecast outturn and key risks. Budget holders receive relevant and reliable information they require to perform their duties through monthly budget statements. Automated standard packs are issued monthly and include factual budget statements with YTD, forecast, establishment, and staffing numbers for example.				

Recommendations (High and Medium Only)

Recommendation 1 (High)

The ICB should review all 65 invoices currently paid that have been approved by users with incorrect limits to obtain assurance that all these payments are correct and appropriate.

Controls should be put in place to review monthly all instances of invoice approvals outside of delegated limits with appropriate action taken where necessary.

Communication should be shared with staff reminding them of the importance of not using the 'Delegate' or 'Invoice Reassign' functions within the system.

The ICB should also continue to engage with the supplier of ISFE2 to attempt to turn off this function as well.

Response & Implementation Date

The delegate function and invoice reassign both transfer the originator's approval limits to colleagues if used. NHSE and NHS SBS were reviewing this functionality, but it has been confirmed that this is a bespoke feature of the Oracle system and cannot be amended for NHS bodies use. In order to counteract the risk of inappropriate approvals the team will

- The 65 invoices have been reviewed, with the colleague reassigning identified. The next steps are to confirm the final approvals were in line with Scheme of Delegation approvals and to train colleagues on the correct process to move invoices on the system.
- Complete a monthly retrospective review of approvals made using the report outlined above. These will be included in the month end reporting pack to be reinstated as part of the monitoring undertaken by the Financial Control team.
- Reinforce communications that budget holders and colleagues should only use the delegate / reassign function if the transfer is to colleagues of the same band.
- Training will be undertaken to use the Notification Reassign function held with the VBCS element of the system generally and as a proactive response to those individuals identified within the monthly report.

30 June 2026

Recommendation 2 (Medium)

The ICB should:

- query differences identified between the supplier details report and supplier approval requests screen and take action as necessary to ensure they are able to view complete information around new suppliers and supplier bank changes.
- query with NHS SBS how the date of a recorded security call is logged and how assurance around this can be given to the ICB as part of evidencing controls more robustly in this area.

Response & Implementation Date

Requests for information have been made to the workstream leads at NHS SBS. Their responses will be reviewed and action taken to meet the recommendations according to what the possibilities and capabilities of the system allow. NHS GM will also review the Service Auditor Reports commissioned by NHS SBS to provide the necessary assurance when these are published within April / May.

31st May 2026

Recommendation 3 (Medium)

The ICB should review its creditors that have an overall debit balance and where the credit is more than 6 months old. Where the ICB is no longer trading with the organisation, the ICB should seek a refund from the supplier.

The ICB should in particular review the credit for Boots UK LTD and take action as necessary considering the size and age of this debit balance.

Response & Implementation Date

The ICB undertakes a regular review of debit balances within aged credits. However, there are areas where attempts to recover these items have not yet been effective.

	The ICB will ensure a monthly review is undertaken and documented within the reinstated month end reporting pack, so that all outstanding debit balances within creditors are highlighted and invoices raised with organisations for monies owed. 30 June 2026
--	--

Report Title	Financial Reporting			
Executive Sponsor	Kathy Roe, Chief Finance Officer			
Objective	To provide assurance that the financial position of the organisation is being reported appropriately and that there is a sufficient level of sub-committee and Board engagement.			
Recommendations	0 x Critical	0 x High	0 x Medium	3 x Low
Overall Rating	Substantial: There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently			
Summary	Examples of good practice were identified during the review including having a consistent format for the report which is easy to understand and is supported by additional information in the form of a PowerPoint slide pack. Information contained in the report can be reconciled to the GM Integrated Finance Return (IFR) which is largely based on information obtained from the financial ledger. Reports are presented to the Finance Committee/ Board on a regular basis in line with the formal submission deadlines. Regular finance related training and updates are provided to members of the Board and Finance Committee. Several areas were identified during the audit which if implemented could further enhance the existing processes. Month on month the supporting narrative mostly remains unchanged. Officers compiling the report should ensure that any significant changes and issues arising are appropriately reflected in the supporting narrative. Most of the recommendations made in respect of the Finance Report are to note the various content rather than requesting any specific actions/ discussions. To maximise discussion and obtain the valuable			

	insight that committee/ Board members can be provide recommendations should focus on requesting review, discussion, and/or endorsement of actions as appropriate. A recommendation was also made in respect of the compilation of meeting minutes.
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Report Title	Risk Management Core Controls			
Executive Sponsor	Charlotte Bailey, Chief Strategy, People and Partnerships Officer			
Objective	The overall objective was to provide assurance that core risk management controls have been adequately designed.			
Recommendations	0 x Critical	0 x High	1 x Medium	2 x Low
Overall Rating	Substantial: There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently			
Summary	Overall, our review has identified that NHS GM has a good system of core risk management controls. NHS GM has an up-to-date Risk Management Policy in place which was updated in July 2025 and approved by the Board. However, the Policy requires updating to ensure it reflects the latest review of risk appetite and outlines the process to be followed for lessons learned in relation to risk management. The Policy clearly defines governance structures and roles and responsibilities in relation to risk management throughout the majority of 2025, although there has been a significant governance change in Q4, linked to organisational reform, which has resulted in the longstanding committees (excluding the Audit and Remuneration 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. The Chief Strategy, People and Partnerships Officer is the new Executive Lead for Governance Systems and Risk Management across NHS GM. The Risk Management Policy will require updating once new			

	arrangements are introduced but we have not raised a recommendation to this effect due to the timing of this review. The Policy outlines requirements in relation to risk registers. Risk registers capture all relevant information and cover risks from all levels of the organisation. The ICB has developed its approach to risk management training. Risk management training is mandatory for risk owners and is optional for other staff. Attendance at training sessions is recorded, however, the Policy does not outline a process for monitoring completion or reporting attendance at risk management training sessions. Processes for identification, assessment and reporting of risks are clearly defined and differ depending on risk level and score. Risk registers are maintained and cover risks from across the organisation. Processes for risk reporting have been clearly defined. The Board considers the ICB's strategic risks at each meeting, via the Assurance Framework Report, which includes detail for each principal risk such as risk tolerance and risk appetite, target risk score, current, initial and previous risk scores. This enables management to consider the effectiveness of risk management activities.
Recommendations (High and Medium Only)	Recommendation 1 (Medium) NHS GM should update the Risk Management Policy to include the defined process on lessons learned in relation to risk management and how this operates in practice. Response & Implementation Date Accepted. A lessons learned field will be added to the risk template to ensure any lessons learned can be captured. These lessons will be added to a log, so that these can be reviewed regularly and learning can be applied to future risk management practice. 31 December 2026

Report Title		Assurance Framework	
Executive Sponsor		Charlotte Bailey, Chief Strategy, People and Partnerships Officer	
Objective		The overall objective was to assess the approach to which the organisation has maintained and uses the BAF to support the overall assessment of governance, risk management and internal control.	
Recommendations		3 (No Rating)	
Overall Rating		N/A	
Summary		Structure	The organisation's BAF 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 Remuneration Committees) being stood down and replaced with a Transition Committee. This committee 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.
Recommendations (No rating applied)	Recommendation 1 • Narrative in the BAF/ Accompanying report should highlight those risks where target scores are unlikely to be achieved, the impact of this and whether a revision to the target is required. • Narrative to explain risk scores should be clearly linked to the current ratings for both likelihood and impact. • The BAF should clearly identify what impact the 'stated actions' are desired to have e.g. improve assurance, decrease gaps in control or manage the risks to achieve a reduction in likelihood and/ or impact. • Where actions are 'delayed' then an anticipated date for completion should be inserted into the BAF. • Accompanying reports should clearly reference key reasons for changes to specific BAF risks. Response & Implementation Date • Accepted. Guidance will be provided to relevant risk leads. This will include the need to highlight those risks where target scores are unlikely to be achieved, the impact of this and whether a revised target is needed. • Accepted. Guidance will be provided to relevant risk leads. This will include the need to explain risk scores linked to current ratings for likelihood and impact.	

- Accepted. Guidance will be provided to relevant risk leads. This will include identifying what impact the stated actions are desired to have.
- Accepted. Guidance will be provided to relevant risk leads. This will include where actions are 'delayed' then an anticipated date for completion should be inserted into the BAF.
- Accepted. Guidance will be provided to relevant risk leads. This will include ensuring accompanying reports clearly reference key reasons for changes to specific BAF risks.

31 December 2026

Recommendation 2

The narrative should clearly reflect how the risk owner intends to move the risk to within the specified tolerance level and if this not possible then what actions/mitigations the ICB intends to put in place.

Response & Implementation Date

Accepted. Guidance will be provided to relevant risk leads. This will include ensuring the narrative reflects how the risk owner intends to move the risk to within the specified tolerance level, whilst also considering whether this is realistically achievable.

31 December 2026

Recommendation 3

Risk should be reviewed to ensure that identified gaps in controls relate to a control rather than a factor that impacts on the management of the risk. Stated actions should be linked to the control gap and clearly describe how its completion will impact on the control gap.

Response & Implementation Date

Accepted. Guidance will be provided to relevant risk leads. This will include guidance on identified gaps in controls to ensure these are captured accurately and will clarify that stated actions should be linked to the control gap and describe how its completion will impact on this.

31 December 2026

Report Title		IT System Wide Reviews: IT Supplier Management Review			
Executive Sponsor	Nicola Hepburn - Acting Chief Reform and Improvement Officer				
Objective	The overall objective of the review was to provide an assessment of the effectiveness of the organisation's IT supplier management processes and controls over Cyber security and GDPR for a sample of 6 contracts. Furthermore, where appropriate, identify any areas for improvement of best practice				
Recommendations	0 x Critical	2 x High	1 x Medium	0 x Low	
Overall Rating	Limited: There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.				
Summary	This review of IT Supplier Management at Greater Manchester Integrated Care Board (the ICB) was conducted in accordance with the 2025/26 Internal Audit Plan as approved by the Audit Committee. Greater Manchester ICB was / is operating during a period of significant national restructuring. Supplier management had been identified as an area for improvement, with work already underway through the Data Security Protection Toolkit (DSPT), however, whilst existing processes were evidenced, this assessment identified areas that required improvement. Issues found included but were not limited to succession plans for key roles and responsibilities including those in governance positions; roles and responsibilities for managing IT suppliers across the supply-chain process to ensure that key activities are not overlooked or missed were not confirmed / published for the new structure; robust contracts / risk assessments were not evidenced as being in place for PATCHS, Accurx and Service Now; and contracts were not standardised across the ICB. Contract management activities were reactive; processes to manage relationships with partners / third parties and the extended supply chain were not developed and embedded. Although the ICB had started engaging with third-party suppliers / partners around risk assessments and assurances, there was limited evidence of regular processes being carried out such as due diligence checks for certifications / accreditations. In addition, there was no documentation around Business Continuity Plans (BCPs),				

	Disaster Recovery Plans, Incident Management Plans etc such as for Accurx and PATCHS. Also, no formalised process for assessing Artificial Intelligence (AI) within systems / solutions. Failure to address the issues identified will introduce risks / exacerbate risks in terms of IT supplier management in the ICB. Overall senior management and staff within the ICB actively engaged with this review to better understand the controls in place and identify areas where controls could be strengthened.
Recommendations (High and Medium Only)	Recommendation 1 (High) The ICB should: • Complete the restructure and assign / clearly document roles and responsibilities IT supplier management. • Review and agree the 'Detailed Improvement Action Plan' (see Appendix C) • Assign responsibilities and deadlines for delivering the plan. • Ensure a governance mechanism for providing oversight and tracking of the plan. Response & Implementation Date The ICB highlights that 2026/27 will be a year of significant change in personnel / ways of working. 1. a. Complete the restructure (Malcolm Whitehouse – End December 2026) And to complete the associated transition activity to make the organisation fully operation (End March 2027) b. Document roles and responsibilities for IT supplier management (End September 2026) 2. / 3. Review and agree the 'Detailed Improvement Action Plan' and assign responsibilities and deadlines (End September 2026) 4. Plan oversight and tracking will be the IT supplier governance group – will start tracking from October 2026. Recommendation 2 (High)

The ICB should:

- Ensure robust contract management is in place as in the Detailed Improvement Action Plan
- Evidence documented contracts, with relevant UK GDPR and data protection clauses for services such as the GP practices Online and Video Consultation (OCVC) PATCHS contract.

Response & Implementation Date

Remediate the issues highlighted as part of the contract renewal for PATCHS and Accurix - End of September 2026 (ICB online consultation contracts / independent GPs may contract separately (risk tracked separately – GP independent purchase of software via network access control software (End September 2026)

- Residual broader risk on non-healthcare contracts without appropriate GDPR / Data protection and security clauses which is a known risk but needs quantifying and being formally approved by the Board. (End March 2027)

Recommendation 3 (Medium)

The ICB should:

- Ensure robust supplier monitoring and reporting is in place as in the Detailed Improvement Action Plan
- Matured and embed the new incident management solution, DATIX, once the implementation is confirmed / implemented.

Response & Implementation Date

- Rollout, deploy, mature and embed DATIX (End December 2026) (dependency on restructure).
- Mature and embed monitoring and reporting through the IT supplier governance group (dependency on restructure – IAOs etc.) (End March 2027)

Appendix D: Assurance Definitions and Risk Classifications

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

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

Limitations

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

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

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

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NHS GM Audit Committee 17th September 2026

Internal Audit Follow Up Report – Quarter 2 2026/27

NHS GM Audit Committee

17th September 2026

Required information	Details
Title of report	Internal Audit Follow Up Report – Quarter 2 2026/27
Author	Darrell Davies / Andrew Rothwell
Presented by	Andrew Rothwell
Contact for further information	Andrew Rothwell
Executive summary	This report provides the Audit Committee with an update on the progress made by NHS GM implementing outstanding internal audit recommendations.
The benefits that the population of Greater Manchester will experience.	Assurance through the Audit Committee that improvements in internal control are being progressed within the organisation that should lead to improved performance and thus assist the organisations achieve its objectives.
How health inequalities will be reduced in Greater Manchester’s communities.	The Internal Audit Plan aims to address all of the key risks of the ICB on a cyclical basis, including responding to the quality agenda.
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	The Internal Audit Plan aims to address aspects of the key risks of the ICB on a cyclical basis. The BAF is considered as part of the annual planning process to ensure that the internal audit plan includes appropriate coverage. Recommendations made by internal audit aim to strengthen the internal control environment which should contribute towards reduction in risk.
Key milestones	N/A
Leadership and governance arrangements	N/A
Engagement* to date	N/A
*Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	

Financial or Legal Implications	N/A
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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 accessibility of report

Introduction

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

Executive Summary

- 2.0** Since the follow up position reported previously at the March 2026 Audit Committee:
- There were 95 recommendations reviewed as part of the Q2 follow up exercise: 26 High / 48 Medium / 18 Low / 3 N/A.
 - Of these 95 recommendations, 10 recommendations are not due to be implemented and 23 have been fully implemented/ superseded. The remaining 62 recommendations are in either in progress and partially implemented (48) or not yet implemented (14).
 - Of the 62 recommendations partially or not yet implemented, 26 have had revised implementation dates as set out in the management responses received to date, 6 of which are High risk recommendations.
 - In 26 cases since the previous Audit Committee meeting a revised implementation date has been requested by management and considered by Chief Officers. The details of the extended implementation dates are set out in the attached paper.

System Support and Implementation

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

Learning and Innovation

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

Recommendations

- 5.0** The Audit Committee is asked to:
- Note the contents of the report.

Internal Audit Follow Up Report

Audit Committee (September 2026)

NHS Greater Manchester Integrated Care Board

Contents

- 1 Introduction
- 2 Objective
- 3 Summary
- 4 Internal Audit Action Tracker
- 5 Outstanding Internal Audit Critical and High-Risk Audit Recommendations

Appendix A: Detailed List of Outstanding Recommendations

Appendix B: Assurance Definitions and Risk Classifications

1 Introduction and Background

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

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

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

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

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

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

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

2 Objective

The objective of this follow-up review was to provide an update on progress made towards the implementation of agreed internal audit recommendations. The reported position is at the 1st September 2026.

3 Summary

Since the follow up position reported previously at the March 2026 Audit Committee:

- There were 95 recommendations reviewed as part of the Q2 follow up exercise: 26 High/ 48 Medium/ 18 Low/ 3 N/A.
- Of these 95 recommendations, 10 recommendations are not due to be implemented and 23 have been fully implemented/ superseded. The remaining 62 recommendations are in either in progress and partially implemented (48) or not yet implemented (14).
- Of the 62 recommendations partially or not yet implemented, 26 have had revised implementation dates as set out in the management responses received to date, 6 of which are High risk recommendations.
- In 26 cases since the previous Audit Committee meeting a revised implementation date has been requested by management and considered by Chief Officers. The details of the extended implementation dates are set out in the table below:

No.	Review	Recommendation	Original Date	Revised Date	Rationale
1	EPRR	The ICB should formalise its governance and oversight arrangements over BCP and EPRR, including setting up an Oversight Group, as per the policy, to oversee strategy, risks and compliance with NHSE requirements.	28/02/2025	01/10/2026 31/03/2026 31/05/2025	EPRR post holders have now left so group not established. A new AD in post (Nov), who will establish an EPRR Co-ordinating Group to manage governance and oversight arrangements for EPRR and BC (first mtg in August 26). Paused due to outcomes of restructure and identification of senior leadership team.
2	EPRR (<i>High Risk</i>)	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.	30/11/2025	01/10/2026 31/03/2026	Core standards process 25 - 26 saw NHS GM declaring partial compliance, an improvement on 24 - 25. Progress continues, improvement plan in place, additional staff in post from January 26 to facilitate improvements / action plan. The annual core standards process commences again in Sep / Oct
3	EPRR	The ICB should develop a formal mechanism for the recording of EPRR exercises, which will allow the EPRR team to document the results and evaluate their success including identifying and implementing lessons learned. Additionally, EPRR exercises should be diarised annually as part of a workplan to ensure that the ICB complies with carrying out the range of exercises as set out in the Policy.	31/03/2025	1/10/2026 31/03/2026 31/05/2025	A work programme is being developed, which will include a formal plan for exercising and testing. This will be monitored through the EPRR Co-Ord Group in terms of progress, learning and sharing good practice across the ICB.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
4	EPRR (<i>High Risk</i>)	The ICB should review training arrangements for EPRR to ensure that the following is achieved: • Training Needs Analysis forms are completed by all relevant staff involved in EPRR. • A summary of the forms is provided which informs the training programme offer for future years. • A mechanism for recording the formal completion of training is established which is used to highlight non-completion against the minimum occupational standards. • Training completion is regularly included on the agenda of an Oversight Group.	31/03/2025	01/09/2026 31/03/2026 31/05/2025	With additional staff resources now in place, a more robust process for monitoring attendance at training and exercising, including training needs analysis and competencies, will be developed in advance to the core standards process 26 - 27
5	EPRR	As the ICB's EPRR and BCP framework and processes become more established, including setting up a BCP and EPRR Oversight Group, a specific BCP and EPRR risk register should be established to highlight and monitor the key risks around these areas.	31/03/2025	01/09/2026 31/03/2026 31/05/2025	An EPRR Risk Register is under development and will be risks will be monitored through the EPRR Co-Ord Group
6	CHC- Contracts Management	To ensure that there is segregation of duty in the process of obtaining expression of interest to the awarding of the package of care and authorisation. Consideration should be given to how segregation of duties and separate authorisation is achieved where timeframes are short and whether additional layers of authorisation should be required when awarding funding over a certain value. Additionally, a periodic audit process should be considered to review the application of segregation of duties where appropriate.	30/06/2025	30/09/2026	Experiencing delays in progressing this due to ongoing Reform and gaps in structure. Therefore, the completion date has been revised to 30/09/26.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
		To ensure there is a process in place which provides an audit trail or formal record of responses and communication. Additionally, the use of a single, central email should be used for the purposes of contract award processes.			
7	CHC- Contracts Management (<i>High Risk</i>)	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.	30/06/2025	30/09/2026 31/03/2026	Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract. The Contracts Team has published a contract list covering Nursing and Residential and Domiciliary Care providers, which is available to colleagues via CHC Futures platform. This enables localities to identify which providers hold active contracts, along with the due diligence checks that have been completed. This is updated on a bi-monthly basis to reflect existing contracts in place.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
8	CHC-Contracts Management	To reinforce to the CHC team the importance and requirement to register all concerns and issues on the Provider Concerns Spreadsheet to ensure effective recording and monitoring takes place, including ensuring actions are closed off, lessons learnt recorded and that there is formal escalation and reporting.	30/06/2025	30/09/2026 31/03/2026	Experiencing delays in progressing this due to ongoing Reform and gaps in structure. Therefore, the completion date has been revised to 30/09/26.
9	CHC-Contracts Management	To ensure that the Individual Placement Agreements are retained centrally and available for review where required.	30/06/2025	30/09/2026 31/03/2026	Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers. Placement Data Captures are shared with the Contracts Team, enabling the development of a comprehensive provider list. The Contracts team facilitates the completion of PSR documentation to ensure that all providers are included to enable a GM contract. This list is then progressed through the Provider Selection Regime (PSR) governance process and, for the 2025/26 contract year, was approved under PSR Option B. This approach will be repeated for the 2026/27 contract year. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance

No.	Review	Recommendation	Original Date	Revised Date	Rationale
					processes prior to entering into an NHS Greater Manchester contract.
10	Performance Management DQ	The ICB should continue to develop and finalise the Community Services Data Quality Strategy and Policy which sets out its framework for managing and reporting on these datasets, including roles and responsibilities, reporting requirements internally and externally, as well as data quality processes and controls.	30/06/2025	30/09/2026 31/12/2025	DQ policy has been developed but seeking an appropriate ratification date and requires input from all functional areas within the ICB. governance procedures on where updates are to be provided within the ICB. Reform has delayed this development. This is a critical action to complete. Its also worth noting that this should be owned by the IG Team and not DII, but that team has been significantly cut and still operating with vacancies
11	Performance Management DQ (<i>High Risk</i>)	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.	30/09/2025	30/09/2026 31/12/2025	DQIPs are going into the 2026/27 contracts with Bolton FT, Manchester Foundation Trust FT, and Northern Care Alliance FT. They mainly relate to Community Health Services. The ICB only enter a formal contractual DQIP where we have identified a need to do so.
12	Performance Management DQ	The ICB should produce a datamap which sets out expectations for each provider against the services they deliver and the corresponding data fields in CSDS. This should then be used to manage expectations around data completion on an ongoing basis to identify genuine gaps.	30/09/2025	31/12/2026 30/09/2026 31/12/2025	Delayed due to reform activities and staff sickness.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
13	Performance Management DQ	The ICB should revisit its contracts with providers to consider whether, in the absence of clear national guidance, separate KPIs could be included which set clear requirements and parameters on providers to comply with. As data submissions are not linked to financial flows, the ICB needs to consider how it can enforce and incentivise providers to submit more comprehensive data in line with expectations and perhaps link data submissions to performance management and reporting at provider level.	30/09/2025	31/12/2026 30/09/2026 31/12/2025	Delayed due to reform activities and staff sickness.
14	Performance Management DQ	As part of the development of a performance framework, the ICB should agree a reporting framework for CSDS and SitRep data to determine how the key data it requires to oversee the effectiveness of community services provision reporting and which groups/ committees the reports should go to.	30/09/2025	31/12/2026 30/09/2026 31/12/2025	The ICB is engaging with providers at contract monitoring meetings, there is a standard agenda item on the contract monitoring meeting on Information, which is picks up all information issues, the TOR is currently being reviewed, and we will have Data Quality added to this specifically to ensure clarity.
15	Risk Management Core Controls	Externally accredited risk management training should be agreed and undertaken for specific staff where they are leading on risk management as part of their ongoing development, particularly for the Risk Management team, as well as any other operational leads where appropriate.	31/12/2025	31/12/2026 30/06/2026	Training application forms have been prepared for the team and will be submitted during November 2025. The announcements regarding NHS Reform have inevitably slowed progress with this. Implementation of this recommendation is on hold until roles are confirmed as part of the NHS GM organisational change process. Training cannot be provided / undertaken until staff are confirmed in roles.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
16	Risk Management Core Controls	The Risk Management Policy and Risk Register should be updated to include reference to exploring opportunities as part of the risk assessment process to analyse new opportunities as well as existing risks to determine whether any associated benefits could occur. These should then be tracked alongside risks.	30/09/2025	31/12/2026 30/08/2026 31/07/20/26 01/04/2026 01/01/2026	The Datix risk module has been designed to include a field where emerging opportunities can be captured. The risk module is expected to be live in September 2026.
17	Health & Safety	Ensure a formal incident reporting and management policy/ procedure is developed and appropriately communicated to all staff.	31/10/2025	30/09/2026 31/07/2026 31/03/2026	The delivery date for the new Datix system has changed due to NHS Reforms and the date has been revised to reflect this - unable to establish the system without organisational and staff hierarchy, which won't be possible until completion of alignment to the new operating model. Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.
18	Oversight Arrangements	The commissioning / governance section of the ICB should update the SOPs for the POM so that they are aligned to the expectations of the POM's TOR in order to fulfil their oversight responsibilities. They must ensure that roles and responsibilities for matters that should be delivered by the POM are reflected within the SOPs and that the POM should have an approved annual work programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities	30/09/2025	31/12/2026 31/03/2026	This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
		annually. Issues identified in our report can be used as a starting reference point for such an exercise.			
19	Oversight Arrangements	The commissioning/ governance section of the ICB should update the SOPs for the LAM so that they are aligned to the expectations of the LAM TOR in order to fulfil the delegated responsibilities. They must ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs and that the LAM for each locality should have an approved annual work programme, which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a starting reference point for such an exercise.	30/09/2025	31/12/2026 31/03/2026	This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.
20	Oversight Arrangements	The governance section of the ICB should update their SOPs for the LAM to ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs. The LAM for each locality should have an approved annual work programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a reference point for such an exercise.	30/09/2025	31/12/2026 31/03/2026	This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements.
21	CHC	Amend procedure so that the 28-day clock starts on receipt of the original referral in the event that a positive checklist is rejected and re-submitted.	30/06/2026	30/09/2026	Bolton SOP obtained and this is tabled at the GM AACC Transformation meeting on 01/06/26 for discussion to explore a GM SOP for consistency and good practice for all 10 localities to adopt and implement.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
					Bolton SOP was discussed as above, general agreement from the group to develop a GM SOP. This will be progressed via the Heads of Service
22	Key Financial Controls (<i>High Risk</i>)	The ICB should review all 65 invoices currently paid that have been approved by users with incorrect limits to provide assurance that all these payments are correct and appropriate. Controls should be put in place to review all instances of invoice approvals outside of delegated limits on a monthly basis with appropriate action taken where necessary. Communication should be shared with staff reminding them of the importance of not using the 'Delegate' or 'Invoice Reassign' functions within the system. The ICB should also continue to engage with the supplier of ISFE2 to attempt to turn off this function as well.	30/06/2026	31/12/2026	NHS GM has contacted NHS SBS and is awaiting an update in respect of the system process, and the report that can be run to monitor the volume of invoices approved by users with incorrect limits, through the incorrect use of the Delegate function. Whilst this response is awaited, an internal process for reviewing these has been designed and will be implemented going forward. As part of this, users who incorrectly delegated/transferred an invoice with incorrect authority are contacted and advised of the correct method to re-assign invoices. Reminders have also been shared with colleagues in month end guidance documents to ensure they are aware of the correct process to re-assign invoices to other users.
23	Key Financial Controls	The ICB should review its creditors that have an overall debit balance and where the credit is more than 6 months old. Where the ICB is no longer trading with the organisation, the ICB should seek a refund from the supplier. The ICB should in particular review the credit for Boots UK LTD and take action as necessary considering the size and age of this debit balance.	30/06/2026	31/12/2026	NHS GM conducts a monthly review and aims to take action against items where net debit balances remain month to month and it is unlikely to be recovered through ongoing trade. Contact is made with the specific providers and attempts are made to recover. Specifically for Boots, NHS GM has made contact with the company and is attempting to recover the funds.

No.	Review	Recommendation	Original Date	Revised Date	Rationale
24	Risk Management (2526)	The Policy should be updated to reflect the latest review of risk appetite by the Board.	30/09/2026	31/12/2026	Implementation date has been revised to align with the other recommendations around updating of the Policy.
25	Risk Management (2526)	The Risk Management Policy should be updated to outline the process for monitoring and reporting attendance and completion of risk management training.	30/09/2026	31/12/2026	Implementation date has been revised to align with the other recommendations around updating of the Policy.
26	Health and Safety (<i>High Risk</i>)	Ensure a Lone Worker Policy is developed and implemented as soon as possible. This should be supported by a full risk assessment, including ensuring the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place.	31/12/2025	30/09/2026 30/06/2026 05/02/2026	Lone worker policy developed and considered by the Policy Review Group in August 2026. Policy schedule for People and Resources committee in September 2026

The next formal follow up of previously agreed recommendations will be reported in Q3 2026/27.

4 Internal Audit Action Tracker

The following summarises progress against the internal audit recommendations as at **1st September 2026**:

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

25/26	Training and Development	Charlotte Bailey	3	0	0	1	1	1
25/26	CHC	Katherine Sheerin	5	3	0	0	2	0
25/26	ESR Payroll	Charlotte Bailey	3	0	0	1	0	2
25/26	Specialised Commissioning	Katherine Sheerin	5	0	1	0	4	0
25/26	IT Supplier Management	Nicola Hepburn	3	3	0	0	0	0
25/26	Key Financial Controls	Kathy Roe	5	0	0	3	2	0
25/26	Financial Reporting	Kathy Roe	3	0	0	3	0	0
25/26	Risk Management Core Controls	Charlotte Bailey	3	3	0	0	0	0
25/26	NEPTS Procurement	Kathy Roe	3	0	0	0	3	0
Total			95	10	7	16	48	14

5 Internal Audit High Risk Recommendations – MIAA

The following provides the details of the high-risk recommendations that have been implemented/ superseded and those outstanding as at 1st September 2026:

REVIEW	RECOMMENDATION	CURRENT POSITION
2023/24 REVIEWS		
Cyber Organisational Controls Responsible Officer: Various – see Appendix A Action Due: Various Revised date: 31/1/26	3 x high risk recommendations relating to incident management, cyber risk regime and 3 rd party management.	<u>Partially Implemented</u> Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2024/25 REVIEWS		
EPRR Responsible Officer: Andrew Bidolak (Head of EPRR) Action due: 30/11/25 Revised date: 31/3/26, 1/10/26	Recommendation 2: Now that the ICB has completed its 2024/25 Self-Assessment, an action plan should be developed which provides a clear framework setting out how and when the ICB will achieve a rating of ‘substantial’ compliance and the specific actions and resource required to deliver this objective within clear and realistic timeframes. Management Response: Since the self-assessment for the 2023/24 EPRR Core Standards assurance process, NHS GM has increased its overall level of compliance. However, further work is required to move the organisation from ‘non-compliant’ to ‘substantial’ compliance. An EPRR Core Standards improvement plan has been developed and this sits alongside the BCMS Implementation Plan, as business continuity is the domain within the self-assessment that has the highest proportion of standards rated as either ‘partially compliant’ or ‘non-compliant’. Furthermore, a new staff member is expected to join the team in February 2025 and this appointee brings experience of NHS EPRR and business continuity, which the team anticipates will help with progressing improvement actions.	<u>Partially Implemented (Awaiting Evidence)</u> July 26 Update Core standards process 25 - 26 saw NHS GM declaring partial compliance, an improvement on 24 - 25. Progress continues, improvement plan in place, additional staff in post from January 26 to facilitate improvements / action plan. The annual core standards process commences again in Sep / Oct

REVIEW	RECOMMENDATION	CURRENT POSITION
EPRR Responsible Officer: Andrew Bidolak (Head of EPRR) Action due: 31/3/25 Revised date: 31/5/25, 31/3/26, 1/9/26	Recommendation 4: The ICB should review training arrangements for EPRR to ensure that the following is achieved: • Training Needs Analysis forms are completed by all relevant staff involved in EPRR. • A summary of the forms is provided which informs the training programme offer for future years. • A mechanism for recording the formal completion of training is established which is used to highlight non-completion against the minimum occupational standards. • Training completion is regularly included on the agenda of an Oversight Group. Management Response: The EPRR team currently tracks participation by NHS GM staff in EPRR training through a basic spreadsheet. Although relevant information is collected, the functionality of the spreadsheet is limited and tracking of training participation needs to be improved to allow for better forward planning. The EPRR team will develop an enhanced EPRR training and exercising database that includes functionality to record a wider range of information and to highlight gaps and forthcoming requirements for training participation by NHS GM staff. Furthermore, the EPRR team will undertake regular reporting on training participation and requirements.	Partially Implemented July 26 Update With additional staff resources now in place, a more robust process for monitoring attendance at training and exercising, including training needs analysis and competencies, will be developed in advance to the core standards process 26 - 27
CHC Contract Management Responsible Officer: Katherine Sheerin (Chief Commissioning Officer) Action due: 30/6/25	Recommendation 1: To ensure that a policy and guidance documents are developed and put into place to ensure that there is consistency in the approach for each of the localities across GM. Additionally, a CHC strategy should be developed and agreed for CHC commissioning, operational and contract management to set out overarching principles of the service and assurance arrangements/ requirements. Management Response: A CHC commissioning policy will be developed which outlines the process for approving and selecting providers along with the operational clarity outlining the process and segregation of duties. This will be	Partially Implemented August Update Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers. Placement Data Captures are shared with the Contracts Team, enabling the

REVIEW	RECOMMENDATION	CURRENT POSITION
	reviewed by the financial assurance team to ensure this is robust and that all decisions made have a clear audit trail.	development of a comprehensive provider list. The Contracts team facilitates the completion of PSR documentation to ensure that all providers are included to enable a GM contract. This list is then progressed through the Provider Selection Regime (PSR) governance process and, for the 2025/26 contract year, was approved under PSR Option B. This approach will be repeated for the 2026/27 contract year. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract. The contracts team provide regular contract progress updates with AACC, summarising intentions, numbers of contracts in place, current contract actions or provider issues.
CHC Contract Management Responsible Officer: Katherine Sheerin (Chief Commissioning Officer) Action due: 30/6/25 Revised date: 31/3/26	Recommendation 2: To review the process around the commissioning and awarding of domiciliary contracts and ensure that there is a transparent and equitable provider contract allocation process in place which ensures quality of service standards are being considered and provides clarity in terms of roles and responsibilities in the process. The process should be consistently applied across GM which removes the current practice of 'first come first served' and considers quality and capacity, utilising systems such as 'Datix' as far as practicable.	<u>Partially Implemented</u> August Update Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers.

REVIEW	RECOMMENDATION	CURRENT POSITION
	Management Response: The process around the commissioning and awarding of care packages will be reviewed to ensure this process is transparent, equitable and there is the appropriate segregation of duties. The awarding of care packages on a first come first basis via email will be ceased with immediate effect. A CHC commissioning policy will be developed which outlines the process for approving and selecting providers along with the operational clarity outlining the process and segregation of duties. This will be reviewed by the financial assurance team to ensure this is robust and that all decisions made have a clear audit trail. The contract management process will be reviewed to ensure all necessary details and documentation is put in place once the relevant provider has been selected. To ensure only providers that meet the minimum quality standards are commissioned to provide CHC services will be outlined in the CHC Commissioning policy. The quality team will also ensure that providers are appropriately monitored to provide assurance on the quality of care being provided in line with the contract agreed and meet the minimum standards as required by NHSE.	Placement Data Captures are shared with the Contracts Team, enabling the development of a comprehensive provider list. The Contracts team facilitates the completion of PSR documentation to ensure that all providers are included to enable a GM contract. This list is then progressed through the Provider Selection Regime (PSR) governance process and, for the 2025/26 contract year, was approved under PSR Option B. This approach will be repeated for the 2026/27 contract year. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract. The Contracts team facilitated the production of a single finance schedule for 2526 detailing all locality rates and is in the process of updating this for 2627. Standard Quality requirements have also been included within contracts. (See contract templates) The Contracts Team has published a contract list covering Nursing and Residential and Domiciliary Care providers, which is available to colleagues via CHC Futures platform.

REVIEW	RECOMMENDATION	CURRENT POSITION
		This enables localities to identify which providers hold active contracts, along with the due diligence checks that have been completed. This is updated on a bi-monthly basis to reflect existing contracts in place.
CHC Contract Management Responsible Officer: Katherine Sheerin (Chief Commissioning Officer) Action due: 30/6/25 Revised date: 31/3/26, 30/09/26	Recommendation 5: To develop and agree a framework for assessing existing and new providers which includes consistent, comprehensive due diligence checks and that evidence is maintained to support this process. To identify with the Contracting function the requirements they would expect to be in place for an SLA as part of the roll out to ensure that they are comprehensive and are rolled out to all remaining providers. To ensure that nursing and clinical staff are being consulted when allocating package of care to providers and that this is recorded as part of the process. Management Response: A CHC commissioning policy will be developed which outlines the process for approving and selecting providers along with the operational clarity outlining the process and segregation of duties. This will be reviewed by the financial assurance team to ensure this is robust and that all decisions made have a clear audit trail. The contracting team will ensure for all approved providers the relevant contracting arrangements and supporting documentation is in place. Compliance with the contracting arrangements will be in conjunction with the relevant supporting teams (quality, clinical and commissioning and finance).	<u>Partially Implemented</u> June 26 update Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract. The Contracts Team has published a contract list covering Nursing and Residential and Domiciliary Care providers, which is available to colleagues via CHC Futures platform. This enables localities to identify which providers hold active contracts, along with the due diligence checks that have been completed. This is updated on a bi-monthly basis to reflect existing contracts in place.

REVIEW	RECOMMENDATION	CURRENT POSITION
Performance Management – Data Quality Responsible Officer: Matt Hennessey (Chief Intelligence and Analytics Officer) Action due: 30/9/25 Revised Date: 31/12/25 , 30/9/26	Recommendation 2: Alongside the data quality strategy, a data quality improvement plan should also be developed which revisits any actions/ solutions not yet addressed from the Health Innovation Manchester review. As part of any data quality improvement plan, a performance framework as part of commissioning requirements should also be considered. Management Response: A 2025/26 Data Quality Improvement Plan has been developed and we're just about to commence individual meetings with each provider to agree its content including baselines and timescales for implementation during 2025/26.	<u>Partially Implemented</u> July 26 Update DQIPs are going into the 2026/27 contracts with Bolton FT, Manchester Foundation Trust FT, and Northern Care Alliance FT. They mainly relate to Community Health Services. The ICB only enter a formal contractual DQIP where we have identified a need to do so.
Commissioning Responsible Officer: Associate Director of Contract Management Action due: Ongoing Revised Date: 31/12/25	Recommendation 2: The ICB should review its commissioning activities cycle and ensure that providers are contracted to offer the services in a timely manner as close to the beginning of the contract period as possible. Management Response: NHS GM ICB does issue contracts to providers in a timely manner however the delay in obtaining signature is often a result of negotiation with providers, mainly in respect of finance schedules.	<u>Partially Implemented</u> 13/11/25 Update - Work continues to progress contracts through due process and governance as described in the June update. The schedule of contracts signed and outstanding will be presented to December Finance Committee.
Commissioning Responsible Officer: Associate Director of Contract Management and Associate Director of Strategic Commissioning Action due: 1/7/25 Revised Date: 31/12/25	Recommendation 4: The ICB should ensure that all of their committees/ subcommittees with the responsibility for provider performance oversight have clearly stated assurance information requirements in their terms of reference, as well as formally approved annual work programmes so that they have the necessary capacity and capability to collate and review all of the commissioning performance data and intelligence, enabling the ICB to discharge their commissioning responsibilities including reporting externally where necessary, in a timely manner. This applies to the following governance arrangements: •For Public Health - the Screening and Immunisation Oversight Commissioning Contracting and Finance Group (SIOCCFG) and the Public Health Advisory Group which report to the Public Health Committee of the ICB. •For GPs - the ICB's Direct Commissioning & Contracting Panel (DCCP) which reports to the GMICB PCCC.	<u>Partially Implemented</u> 13/11/25 Update - The Internal Provider Oversight Group has now been disbanded due to the imminent changes in ICB assurance and oversight responsibilities as per the guidance for the model ICB. A working group is now established to develop revised TOR for NHS provider contract governance as part of the wider assurance and governance overview which is due to take effect from 1.4.26.

REVIEW	RECOMMENDATION	CURRENT POSITION
	•For Acute, Mental Health and Independent Providers – the Provider Oversight Subcommittee which reports to the executive Provider Oversight Meeting and the Quality and Performance Committee of the GMICB. Management Response: For Acute, Community, Mental Health and Independent Sector contracts - In addition to the POS, there are monthly formal Contract Review Meetings, (CRMs) which involve Performance, Commissioning and Quality. There is a set format with an agenda agreed in advance. The CRM meetings are formally recorded with a clear action log. Any issues with commissioned services will have a remedial action plan which is reviewed at CRMs. The Responsible Officers will review the agendas and with respective commissioning leads to incorporate a work programme for the year which will signal key dates / milestones.	
Health and Safety Responsible Officer: Samantha Deakin – H&S Lead Action due: 31/12/25 Revised Date: 05/02/26, 30/6/26, 30/09/26	Recommendation 1: Ensure a Lone Worker Policy is developed and implemented as soon as possible. This should be supported by a full risk assessment, including ensuring the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place. Management Response: A working group on lone working will be stood up in July 2025 with the aim of producing the policy, a full risk assessment to ensure that the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place.	<u>Partially Implemented</u> August 26 Update Lone worker policy developed and considered by the Policy Review Group in August 2026. Policy schedule for People and Resources committee in September 2026.
Health and Safety Responsible Officer: Samantha Deakin – H&S Lead Action due: 31/10/25 Revised Date: 31/3/26, 30/6/26	Recommendation 2: The ICB should ensure appropriate staff have been first-aid trained across the organisation, in line with Health and Safety (First-Aid) Regulations 1981. Reporting on completion of training should be included in current training monitoring mechanisms and reporting routines. Management Response: A first aid risk assessment to be completed for all work locations. First aid training provided has been approved; the first aiders	<u>Partially Implemented</u> First aid risk assessments to be completed. First aid training procured. Increase in first aid trained staff to 15, however further increases required. Assessment of leavers following voluntary redundancy schemes to be completed. Work still ongoing, however further delayed due to staff absence.

REVIEW	RECOMMENDATION	CURRENT POSITION
	are in the process of being booked on training courses by the end of July 2025. Some localities have asked if nurses can act as the first aiders, await response from the localities. Reporting on completion of training will be added onto the current training monitoring mechanism and reporting routines.	
IT Asset Management Responsible Officer: Malcolm Whitehouse Action due: 31/3/26	One high risk recommendation relation to Strategy and Contracts	<u>Not Yet Implemented</u> Follow up currently being undertaken
2025/26 REVIEWS		
CAF aligned DSPT Responsible Officer: Various Action due: 31/10/25 and 31/12/25 Revised Date: 31/1/26	3 x high risk recommendations relating to supply chain, identity and access control and response planning.	<u>Partially Implemented</u> Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
Community Pharmacy Advanced Services Responsible Officer: Alison Scowcroft Action due: 31/10/25	Recommendation 1: A solution should be identified to produce reports from Trello, to allow for independent scrutiny on the progress and completion of the assigned tasks. Management Response: 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.	<u>Superseded</u> A monthly report was submitted to the CPSG meeting, chaired by LPN Chair which detailed SWG progress to the objectives in the MOU The ICB have further confirmed that the MOU which oversees this work has now ended as all funding has been exhausted.
Community Pharmacy Advanced Services Responsible Officer: Alison Scowcroft	Recommendation 2: 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.	<u>Superseded</u> A monthly report was submitted to the CPSG meeting, chaired by LPN Chair which detailed SWG progress to the objectives in the MOU

REVIEW	RECOMMENDATION	CURRENT POSITION
Action due: 31/10/25	Management Response: 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.	The ICB have further confirmed that the MOU which oversees this work has now ended as all funding has been exhausted.
CHC Responsible Officer: Katherine Sheerin Action due: 31/03/26	Recommendation 1: Complete the CHAT and the development of the AACC Transformation Plan, monitoring progression through the Board Assurance Framework/ other committee and Board assurance reporting. Management Response: Work on CHAT has continued but has been slow progress due to it not being a priority during the NHS Reform change programme and as agreed by NHSE. The current section is approx 70% completed and work will continue to achieve completion. The deadline is relevant for the 2nd section. A transformation workbook has been developed by the AACC Transformation meeting which has 43 work areas on it, however many of the work areas are on hold until post structures - 01 April 2026 onwards pending new leadership and governance. Once governance routes, Committees and boards are confirmed this will be factored into the reporting of the transformation updates and work moving forwards.	<u>Partially Implemented</u> June Update Section 2 now completed and signed off by GG. Shared with NHSE as required.
CHC Responsible Officer: Katherine Sheerin Action due: 30/09/26	Recommendation 2: Further develop CHC metrics and assurances through the AACC/ Individualised Commissioning Assurance Dashboard and implement a fuller range of reporting at locality and committee level tailored to audience and appropriate to the post-transition ICB governance structure. Management Response: A new monthly assurance report/dashboard has been developed to encompass all individualised commissioning metrics and not just CHC. The new report has been collected since December 2025 in its new format via the GM CHC page on Futures platform. There are still some gaps in the MH/LD/CYP data collection for a few localities due to difficulties obtaining data as this has not been routinely collected before. This will improve over time.	<u>Not Yet Due</u> Work has commenced on further developing the suggested metrics within the monthly assurance report. The GM QM and 2 Heads of Service are meeting on 28/05/26 to refine the questions. GM QM has also emailed the GM Complaints team to ask for quarterly breakdown of the number of complaints received and Trends and themes to supplement the assurance report which can then be tabled at the next GM AACC

REVIEW	RECOMMENDATION	CURRENT POSITION
	Consideration will be given to further developing the assurance report to encompass the suggestions made by MIAA opposite and extending the range of metrics and assurance that is gathered. Post 01 April 2026 when new leadership is in place and new governance routes are confirmed, agreement on what reporting is required will follow and this will be adapted and tailored to meet the required needs of the new ICB structure and governance arrangements. Complaints statistics and lessons learnt can be obtained from complaints colleagues as and when required to enhance any future assurance reporting. Upheld appeals and statistics and lessons learnt. An IRP tracker in place to record and monitor the IRP decisions for each locality which captures the recommendations and the decision outcome of the IRP. Feedback on the IRP and shared learning is a standard agenda item on the GM AACC Assurance meeting (held quarterly) and each locality is then asked to present the learning so it shared on a wider GM footprint. Assurance on policies & Procedures - This is a priority area on the AACC Transformation workplan. A number of Heads of service have set up a small task & Finish group to review and update the policies as and when required. The T&F group had their initial meeting in December 2025 and were due to meet again at the beginning of February but the meeting was stood down due to the Reform change programme. All reviewed and updated policies & procedures will be sent through appropriate GM policy governance as required. NHS GM do not currently have a commissioning framework. However, Contracts are working to put in place contracts with providers across residential/domiciliary/Neuro and working closely with GM Quality Managers to ensure appropriate quality monitoring & oversight is in place Audit/Peer Review is a work area on the GM AACC Transformation workplan, however this has not yet been mobilised/set up due to other demanding priorities. Once set up this will be monitored via the Transformation meeting and updates can be shared via relevant committees/meetings/reports etc on progress and findings.	Assurance meeting on 22 September. This is a quarterly meeting.
IT Supplier Management	Recommendation 1: The ICB should:	<u>Not Yet Due</u>

REVIEW	RECOMMENDATION	CURRENT POSITION
Responsible Officer: Malcolm Whitehouse Action due: 31/03/27	- Complete the restructure and assign / clearly document roles and responsibilities IT supplier management. - Review and agree the 'Detailed Improvement Action Plan' - Assign responsibilities and deadlines for delivering the plan. - Ensure a governance mechanism for providing oversight and tracking of the plan. Management Response: 1. a. Complete the restructure (Malcolm Whitehouse – End December 2026) And to complete the associated transition activity to make the organisation fully operation (Malcolm Whitehouse - End March 2027) b. Document roles and responsibilities for IT supplier management (Nehel Ahmed – End September 2026) 2. / 3. Review and agree the 'Detailed Improvement Action Plan' and assign responsibilities and deadlines – Malcolm Whitehouse – End September 2026 4. Plan oversight and tracking will be the IT supplier governance group – will start tracking from October 2026. The ICB highlights that 2026/27 will be a year of significant change in personnel / ways of working.	
IT Supplier Management Responsible Officer: Malcolm Whitehouse Action due: 31/03/27	Recommendation 1: The ICB should: - Ensure robust contract management is in place as in the Detailed Improvement Action Plan (Appendix C) - Evidence documented contracts, with relevant UK GDPR and data protection clauses for services such as the GP practices Online and Video Consultation (OCVC) PATCHS contract. Management Response: a. Remediate the issues highlighted as part of the contract renewal for PATCHS and Accurix – Chris Upton / End of September 2026 (ICB online consultation contracts / independent GPs may contract separately (risk tracked	<u>Not Yet Due</u>

REVIEW	RECOMMENDATION	CURRENT POSITION
	separately – GP independent purchase of software via network access control software)) (Malcolm Whitehouse / End September 2026) b. Residual broader risk on non-healthcare contracts without appropriate GDPR / Data protection and security clauses which is a known risk but needs quantifying and being formally approved by the Board. (Malcolm Whitehouse and Colin Scales / End March 2027)	
Key Financial Controls Responsible Officer: Jackie Gardiner Action due: 30/06/2026 Revised Date: 31/12/26	Recommendation 1: The ICB should review all 65 invoices currently paid that have been approved by users with incorrect limits to provide assurance that all these payments are correct and appropriate. Controls should be put in place to review all instances of invoice approvals outside of delegated limits on a monthly basis with appropriate action taken where necessary. Communication should be shared with staff reminding them of the importance of not using the 'Delegate' or 'Invoice Reassign' functions within the system. Management Response: The delegate function and invoice reassign both transfer the originator's approval limits to colleagues if used. NHSE and NHS SBS were reviewing this functionality, but it has been confirmed that this is a bespoke feature of the Oracle system and cannot be amended for NHS bodies use. In order to counteract the risk of inappropriate approvals the team will - The 65 invoices have been reviewed, with the colleague reassigning identified. The next steps are to confirm the final approvals were in line with Scheme of Delegation approvals and to train colleagues on the correct process to move invoices on the system. - Complete a monthly retrospective review of approvals made using the report outlined above. These will be included in the month end reporting pack to be reinstated as part of the monitoring undertaken by the Financial Control team. - Reinforce communications that budget holders and colleagues should only use the delegate / reassign function if the transfer is to colleagues of the same band.	Partially Implemented NHS GM has contacted NHS SBS and is awaiting an update in respect of the system process, and the report that can be run to monitor the volume of invoices approved by users with incorrect limits, through the incorrect use of the Delegate function. Whilst this response is awaited, an internal process for reviewing these has been designed and will be implemented going forward. As part of this, users who incorrectly delegated/transferred an invoice with incorrect authority are contacted and advised of the correct method to re-assign invoices. Reminders have also been shared with colleagues in month end guidance documents to ensure they are aware of the correct process to re-assign invoices to other users.

REVIEW	RECOMMENDATION	CURRENT POSITION
	Training will be undertaken to use the Notification Reassign function held with the VBCS element of the system generally and as a proactive response to those individuals identified within the monthly report.	
NEPTS Procurement	Recommendation 1: Commissioners should strengthen project governance arrangements for the remainder of the procurement by: - Identifying the resource and roles required to complete the project and confirming arrangements with SBS in particular. - Defining and communicating clear escalation and decision-making routes. - Undertaking a strategic risk review of the procurement in its current state. - Ensuring legal advice is appropriately embedded and documented throughout the remaining stages of the process. Management Response: The NWS Commissioning Team (NWSCT) is responsible for engaging with and agreeing the requirements for the SBS procurement support. Progress against the initial project plan has been reported regularly to the NEPTS Procurement Group. At the time of the audit, discussions were ongoing to determine the number of additional support days required as a result of project delays, alongside agreement on how any additional costs would be apportioned between the organisations involved. It is important to note that there was no risk of SBS withdrawing or abandoning support for the NEPTS procurement, notwithstanding that the originally allocated days had been fully utilised. Communication routes for escalation and decision making will be clarified. As highlighted in the audit findings, escalation currently occurs through the NEPTS Procurement Group, with issues and matters being raised by group members on behalf of their respective organisations. For future procurements, the NWSCT will ensure that this escalation and decision making process is fully documented and clearly communicated to all parties.	Partially Implemented MIAA are currently reviewing response/supporting evidence.

REVIEW	RECOMMENDATION	CURRENT POSITION
	Progress against the procurement plan, together with any identified risks, has been a standing item at the weekly NEPTS Procurement Group meetings. Corrective actions have been agreed and implemented as required. The NHS Greater Manchester team relies on the NWASCT to manage this process effectively and efficiently, particularly in light of the programme's timing and resource constraints. A post procurement stocktake will be undertaken once the process concludes to assess whether any changes to processes or procedures are required. Legal advice has been sought and engaged on a proportionate and timely basis, aligned to the agreed procurement timetable and where the NEPTS Procurement Group deemed it appropriate. Advice was also taken from legal advisers regarding the most suitable stages of the process at which to engage legal support. Given the significant cost of legal services, engagement has been targeted at key points in the procurement process and where technical or complex issues have arisen.	
NEPTS Procurement	Recommendation 1: As the procurement has progressed to the Invitation to Tender stage, it is not possible to fully remediate weaknesses in pre-procurement planning for the current procurement. Commissioners should therefore: - Formally document the limitations and risks arising from these weaknesses and ensure they are actively considered during bid evaluation and decision-making. - Ensure that future procurements are supported by timely, comprehensive pre-procurement planning and engagement activity completed prior to commencing formal tendering. - Project specific evaluation templates are developed and used in the training of the evaluators. Management Response: The importance of robust evaluator training, to ensure that evaluators clearly understand their roles, responsibilities, and duties, has been reinforced with both the NWAS Commissioning Team (NWASCT) and	Partially Implemented MIAA are currently reviewing response/supporting evidence.

REVIEW	RECOMMENDATION	CURRENT POSITION
	SBS. As the organisation providing procurement support, SBS has given assurance to NHS Greater Manchester that evaluator training and ongoing support are being delivered in line with their established standard processes and procedures, providing appropriate assurance that the evaluation process is being conducted consistently and effectively.	

Appendix A: Detailed List of Outstanding Recommendations

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
2023/24	Cyber Organisational Controls	High x 3	3 recommendations made relating to incident management, cyber risk regime and 3 rd party management.	Various	Nicola Hepburn, Acting Chief Reform and Improvement Officer	Various	31/1/26	Partially Implemented Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2023/24	Cyber Organisational Controls	Medium x 3	3 recommendations made relating to critical assets, cyber security measures and cyber experience.	Various	Nicola Hepburn, Acting Chief Reform and Improvement Officer	Various	31/1/26	Partially Implemented Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2024/25	EPRR	Medium	The ICB should formalise its governance and oversight arrangements over BCP and EPRR, including setting up an Oversight Group, as per the policy, to oversee strategy, risks and compliance with NHSE requirements.	Andrew Bidolak, Head of EPRR	Nicola Hepburn, Acting Chief Reform and Improvement Officer	28/02/2025	1/10/26 31/3/26 31/05/2025	Partially Implemented July 26 Update EPRR post holders have now left so group not established. A new AD in post (Nov), who will establish an EPRR Co-ordinating Group to manage governance and oversight arrangements for EPRR and BC (first mtg in August 26). Paused due to outcomes of restructure and identification of senior leadership team.
2024/25	EPRR	High	Now that the ICB has completed its 2024/25 Self-Assessment, an action plan should be developed which provides a clear framework setting out how and when the ICB will achieve a rating of 'substantial' compliance and the specific actions and resource required to deliver this objective within clear and realistic timeframes.	Andrew Bidolak, Head of EPRR	Nicola Hepburn, Acting Chief Reform and Improvement Officer	30/11/2025	1/10/26 31/3/26	Partially Implemented (Awaiting Evidence) July 26 Update Core standards process 25 - 26 saw NHS GM declaring partial compliance, an improvement on 24 - 25. Progress continues, improvement plan in place, additional staff in post from January 26 to facilitate improvements / action plan. The annual core standards process commences again in Sep / Oct

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
2024/25	EPRR	Medium	The ICB should develop a formal mechanism for the recording of EPRR exercises, which will allow the EPRR team to document the results and evaluate their success including identifying and implementing lessons learned. Additionally, EPRR exercises should be diarised annually as part of a workplan to ensure that the ICB complies with carrying out the range of exercises as set out in the Policy.	Andrew Bidolak, Head of EPRR	Nicola Hepburn, Acting Chief Reform and Improvement Officer	31/03/2025	1/10/26 31/3/26 31/05/2025	Partially Implemented July 2026 Update A work programme is being developed, which will include a formal plan for exercising and testing. This will be monitored through the EPRR Co-Ord Group in terms of progress, learning and sharing good practice across the ICB.
2024/25	EPRR	High	The ICB should review training arrangements for EPRR to ensure that the following is achieved: •Training Needs Analysis forms are completed by all relevant staff involved in EPRR. •A summary of the forms is provided which informs the training programme offer for future years. •A mechanism for recording the formal completion of training is established which is used to highlight non-completion against the minimum occupational standards. •Training completion is regularly included on the agenda of an Oversight Group.	Andrew Bidolak, Head of EPRR	Nicola Hepburn, Acting Chief Reform and Improvement Officer	31/03/2025	1/9/26 31/3/26 31/05/2025	Partially Implemented July 26 Update With additional staff resources now in place, a more robust process for monitoring attendance at training and exercising, including training needs analysis and competencies, will be developed in advance to the core standards process 26 - 27
2024/25	EPRR	Medium	As the ICB's EPRR and BCP framework and processes become more established, including setting up a BCP and EPRR Oversight Group, a specific BCP and EPRR risk register should be established to highlight and monitor the key risks around these areas.	Andrew Bidolak, Head of EPRR	Nicola Hepburn, Acting Chief Reform and Improvement Officer	31/03/2025	1/9/26 31/3/26 31/05/2025	Partially Implemented July 26 Update An EPRR Risk Register is under development and will be risks will be monitored through the EPRR Co-Ord Group

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
2024/25	CHC - Contract Management	High	To ensure that a policy and guidance documents are developed and put into place to ensure that there is consistency in the approach for each of the localities across GM. Additionally, a CHC strategy should be developed and agreed for CHC commissioning, operational and contract management to set out overarching principles of the service and assurance arrangements/ requirements.	Katherine Sheerin, Chief Commissioning Officer	Katherine Sheerin, Chief Commissioning Officer	30/06/2025		Partially Implemented August Update Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers. Placement Data Captures are shared with the Contracts Team, enabling the development of a comprehensive provider list. The Contracts team facilitates the completion of PSR documentation to ensure that all providers are included to enable a GM contract. This list is then progressed through the Provider Selection Regime (PSR) governance process and, for the 2025/26 contract year, was approved under PSR Option B. This approach will be repeated for the 2026/27 contract year. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract. The contracts team provide regular contract progress updates with AACC, summarising intentions, numbers of contracts in place, current contract actions or provider issues.
2024/25	CHC - Contract Management	High	To review the process around the commissioning and awarding of domiciliary contracts and ensure that there is a transparent and equitable provider contract allocation process in place which ensures quality of service standards are being considered and	Katherine Sheerin, Chief Commissioning Officer / Kathy Roe, Chief Finance Officer	Katherine Sheerin, Chief Commissioning Officer	30/06/2025	31/3/26	Partially Implemented Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			provides clarity in terms of roles and responsibilities in the process. The process should be consistently applied across GM which removes the current practice of 'first come first served' and considers quality and capacity, utilising systems such as 'Datix' as far as practicable. Consideration should also be given to any opportunities to centralise and cluster arrangements across bigger locality footprints or even pan GM.					Placement Data Captures are shared with the Contracts Team, enabling the development of a comprehensive provider list. The Contracts team facilitates the completion of PSR documentation to ensure that all providers are included to enable a GM contract. This list is then progressed through the Provider Selection Regime (PSR) governance process and, for the 2025/26 contract year, was approved under PSR Option B. This approach will be repeated for the 2026/27 contract year. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract. The Contracts team facilitated the production of a single finance schedule for 2526 detailing all locality rates and is in the process of updating this for 2627. Standard Quality requirements have also been included within contracts. (See contract templates) The Contracts Team has published a contract list covering Nursing and Residential and Domiciliary Care providers, which is available to colleagues via CHC Futures platform. This enables localities to identify which providers hold active contracts, along with the due diligence checks that have been completed. This is updated on a bi-monthly basis to reflect existing contracts in place.
2024/25	CHC - Contract Management	Medium	To ensure that there is segregation of duty in the process of obtaining expression of interest to the awarding of	Katherine Sheerin, Chief	Katherine Sheerin, Chief	30/06/2025	30/9/26	Partially Implemented June 26 update

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			the package of care and authorisation. Consideration should be given to how segregation of duties and separate authorisation is achieved where timeframes are short and whether additional layers of authorisation should be required when awarding funding over a certain value. Additionally, a periodic audit process should be considered to review the application of segregation of duties where appropriate. To ensure there is a process in place which provides an audit trail or formal record of responses and communication. Additionally, the use of a single, central email should be used for the purposes of contract award processes.	Commissioning Officer	Commissioning Officer			Experiencing delays in progressing this due to ongoing Reform and gaps in structure. Therefore the completion date has been revised to 30/09/26.
2024/25	CHC - Contract Management	High	To develop and agree a framework for assessing existing and new providers which includes consistent, comprehensive due diligence checks and that evidence is maintained to support this process. To identify with the Contracting function the requirements they would expect to be in place for an SLA as part of the roll out to ensure that they are comprehensive and are rolled out to all remaining providers. To ensure that nursing and clinical staff are being consulted when allocating package of care to providers and that this is recorded as part of the process.	Katherine Sheerin, Chief Commissioning Officer / Kathy Roe, Chief Finance Officer	Katherine Sheerin, Chief Commissioning Officer	30/06/2025	30/9/26 31/3/26	Partially Implemented June 26 update Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract. The Contracts Team has published a contract list covering Nursing and Residential and Domiciliary Care providers, which is available to colleagues via CHC Futures platform.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
								This enables localities to identify which providers hold active contracts, along with the due diligence checks that have been completed. This is updated on a bi-monthly basis to reflect existing contracts in place.
2024/25	CHC - Contract Management	Medium	To reinforce to the CHC team the importance and requirement to register all concerns and issues on the Provider Concerns Spreadsheet to ensure effective recording and monitoring takes place, including ensuring actions are closed off, lessons learnt recorded and that there is formal escalation and reporting.	Katherine Sheerin, Chief Commissioning Officer	Katherine Sheerin, Chief Commissioning Officer	30/06/2025	30/9/26 31/3/26	Partially Implemented June 26 update Experiencing delays in progressing this due to ongoing Reform and gaps in structure. Therefore the completion date has been revised to 30/09/26.
2024/25	CHC - Contract Management	Low	To ensure that the Individual Placement Agreements are retained centrally and available for review where required.	Katherine Sheerin, Chief Commissioning Officer / Kathy Roe, Chief Finance Officer	Katherine Sheerin, Chief Commissioning Officer	30/06/2025	30/9/26 31/3/26	Partially Implemented June 26 update Contracts Update: Until a Greater Manchester CHC commissioning strategy is established and/or an NHS Provider Framework is in place, the contracts team will continue to issue contracts retrospectively with providers. Placement Data Captures are shared with the Contracts Team, enabling the development of a comprehensive provider list. The Contracts team facilitates the completion of PSR documentation to ensure that all providers are included to enable a GM contract. This list is then progressed through the Provider Selection Regime (PSR) governance process and, for the 2025/26 contract year, was approved under PSR Option B. This approach will be repeated for the 2026/27 contract year. The Contracts team have developed a standard contract template for consistency across all providers and undertake all standard NHS Contract due diligence checks, with each provider

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
								required to complete the necessary assurance processes prior to entering into an NHS Greater Manchester contract.
2024/25	Performance Management Data Quality	Medium	The ICB should continue to develop and finalise the Community Services Data Quality Strategy and Policy which sets out its framework for managing and reporting on these datasets, including roles and responsibilities, reporting requirements internally and externally, as well as data quality processes and controls.	Matt Hennessey, Chief Intelligence and Analytics Officer	Nicola Hepburn, Acting Chief Reform and Improvement Officer	30/06/2025	30/9/26 31/12/25	Partially Implemented July 26 Update DQ policy has been developed but seeking an appropriate ratification date and requires input from all functional areas within the ICB. governance procedures on where updates are to be provided within the ICB. Reform has delayed this development. This is a critical action to complete. Its also worth noting that this should be owned by the IG Team and not DII, but that team has been significantly cut and still operating with vacancies
2024/25	Performance Management Data Quality	High	Alongside the data quality strategy, a data quality improvement plan should also be developed which revisits any actions/ solutions not yet addressed from the Health Innovation Manchester review. As part of any data quality improvement plan, a performance framework as part of commissioning requirements should also be considered.	Matt Hennessey, Chief Intelligence and Analytics Officer	Nicola Hepburn, Acting Chief Reform and Improvement Officer	30/09/2025	30/9/26 31/12/25	Partially Implemented July 26 Update DQIPs are going into the 2026/27 contracts with Bolton FT, Manchester Foundation Trust FT, and Northern Care Alliance FT. They mainly relate to Community Health Services. The ICB only enter a formal contractual DQIP where we have identified a need to do so.
2024/25	Performance Management Data Quality	Medium	The ICB should produce a datamap which sets out expectations for each provider against the services they deliver and the corresponding data fields in CSDS. This should then be used to manage expectations around data completion on an ongoing basis to identify genuine gaps.	Matt Hennessey, Chief Intelligence and Analytics Officer	Nicola Hepburn, Acting Chief Reform and Improvement Officer	30/09/2025	31/12/26 30/9/26 31/12/25	Not Implemented Delayed due to reform activities and staff sickness.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
2024/25	Performance Management Data Quality	Medium	The ICB should revisit its contracts with providers to consider whether, in the absence of clear national guidance, separate KPIs could be included which set clear requirements and parameters on providers to comply with. As data submissions are not linked to financial flows, the ICB needs to consider how it can enforce and incentivise providers to submit more comprehensive data in line with expectations and perhaps link data submissions to performance management and reporting at provider level.	Matt Hennessey, Chief Intelligence and Analytics Officer	Nicola Hepburn, Acting Chief Reform and Improvement Officer	30/09/2025	31/12/26 30/9/26 31/12/25	Not Implemented Delayed due to reform activities and staff sickness.
2024/25	Performance Management Data Quality	Medium	As part of the development of a performance framework, the ICB should agree a reporting framework for CSDS and SitRep data to determine how the key data it requires to oversee the effectiveness of community services provision reporting and which groups/committees the reports should go to.	Matt Hennessey, Chief Intelligence and Analytics Officer	Nicola Hepburn, Acting Chief Reform and Improvement Officer	30/09/2025	31/12/26 30/9/26 31/12/25	Partially Implemented July 26 Update The ICB is engaging with providers at contract monitoring meetings, there is a standard agenda item on the contract monitoring meeting on Information, which is picks up all information issues, the TOR is currently being reviewed and we will have Data Quality added to this specifically to ensure clarity.
2024/25	Risk Management Core Controls	Low	Externally accredited risk management training should be agreed and undertaken for specific staff where they are leading on risk management as part of their ongoing development, particularly for the Risk Management team, as well as any other operational leads where appropriate.	Chris Gaffey, Associate Director of Corporate Services	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	31/12/2025	31/12/26 30/6/26	Partially Implemented Training application forms have been prepared for the team and will be submitted during November 2025. The announcements regarding NHS Reform have inevitably slowed progress with this. Implementation of this recommendation is on hold until roles are confirmed as part of the NHS GM organisational change process. Training cannot be provided / undertaken until staff are confirmed in roles.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
2024/25	Risk Management Core Controls	Low	The Risk Management Policy and Risk Register should be updated to include reference to exploring opportunities as part of the risk assessment process to analyse new opportunities as well as existing risks to determine whether any associated benefits could occur. These should then be tracked alongside risks.	Rick Thompstone, Assistant Director of PMO and Risk	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/09/2025	31/12/26 30/8/26 31/7/26 1/4/26 1/1/26	Partially Implemented June 26 Update The Datix risk module has been designed to include a field where emerging opportunities can be captured. The risk module is expected to be live in September 2026.
2024/25	Commissioning	Medium	- The Public Health Committee (PHC) should ensure that the annual delegation agreement for S7A is in place in a timely manner. - The PHC should ensure that the role of the Screening and Immunisation Oversight, Commissioning, Contracting and Finance Group is adequately defined, and reporting arrangements are appropriate for providing the assurances they require to execute their Public Health functions as required. The terms of reference of the Group should be formally approved and reviewed regularly. - GM PCCC should ensure that all locality (PCQG /PCOGs/ PCQAIF) have standard terms of reference that are appropriately approved. - The Commissioning Directorate should input into the development of the ToR for the POS and POM and these should be presented to the Commissioning Oversight Group and have these formally ratified by the Quality and Performance Committee of the ICB.	Associate Director – Strategic Commissioning (to coordinate)	Katherine Sheerin, Chief Commissioning Officer	30/06/2025		Partially Implemented Awaiting evidence 13/11/25 Update - S7A screening and immunisation programmes remain within the S7A public health functions agreement between DHSC and NHSE. Delegation of these services to ICBs has been deferred until April 2027. The services will be commissioned via the Office for Pan ICB Commissioning. The SIOCCFG has been dis-established and all S7A governance is within the GM PCCC, with updated ToR.
2024/25	Commissioning	High	The ICB should review its commissioning activities cycle and ensure that providers are contracted to	Associate Director of	Katherine Sheerin, Chief	Ongoing	31/12/25	Partially Implemented

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

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			- For GPs - the ICB's Direct Commissioning & Contracting Panel (DCCP) which reports to the GMICB PCCC. - For Acute, Mental Health and Independent Providers – the Provider Oversight Subcommittee which reports to the executive Provider Oversight Meeting and the Quality and Performance Committee of the GMICB.					
2024/25	SEND	Medium	It should be ensured that all localities have a joint SEND Strategy and Joint Commissioning Strategies in place.	Locality Deputy Place Based Leads	Katherine Sheerin, Chief Commissioning Officer	31/3/26		Partially Implemented SEND Strategies and Joint Commissioning Strategies are a Statutory duty for SEND Partnership boards. The ICB duty is to co-operate. Currently PBL hold the delegated duty for SEND. It is the responsibility of the SEND Local Area Partnership to have these in place. This will be ongoing as Strategies and Plans need updated.
2024/25	SEND	Medium	Regular audits of locality level processes that underpin the performance reports and delivery of action plans including those relating to lesson learned should be undertaken. Findings should be reported through the relevant groups/committees.	Associate Directors of Quality/Stephanie Whitelaw	Katherine Sheerin, Chief Commissioning Officer	30/9/25	31/3/26	Partially Implemented SEND Quality Framework in place. Mapping of work taking place across GM. Audit Programmes ongoing.
2024/25	Health and Safety	High	Ensure a Lone Worker Policy is developed and implemented as soon as possible. This should be supported by a full risk assessment, including ensuring the job can be done safely by one person, and the provision of training, supervision and monitoring of lone workers are all in place.	Samantha Deakin, Health Safety and Security Lead	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	31/12/25	30/09/26 30/06/26 5/2/26	Partially Implemented Lone worker policy developed and considered by the Policy Review Group in August 2026. Policy schedule for People and Resources committee in September 2026.
2024/25	Health and Safety	High	The ICB should ensure appropriate staff have been first-aid trained across the	Samantha Deakin, Health	Charlotte Bailey,	31/10/25	31/3/26	Partially Implemented

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			organisation, in line with Health and Safety (First-Aid) Regulations 1981. Reporting on completion of training should be included in current training monitoring mechanisms and reporting routines.	Safety and Security Lead	Chief Strategy, People and Partnerships Officer		31/7/26	Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.
2024/25	Health and Safety	Medium	Ensure a formal incident reporting and management policy/ procedure is developed and appropriately communicated to all staff.	Samantha Deakin, Health Safety and Security Lead	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	31/10/25	30/9/26 31/7/26 31/3/26	Partially Implemented The delivery date for the new Datix system has changed due to NHS Reforms and the date has been revised to reflect this - unable to establish the system without organisational and staff hierarchy, which won't be possible until completion of alignment to the new operating model. Implementation of this recommendation is on hold, as the implementation of the Datix system cannot be complete until completion of NHS organisational change process is complete.
2024/25	Health and Safety	Low	Ensure all required fields are completed for all risk assessments in future through additional checks of completed forms. Where forms are not completed in full, a process should be in place which returns the form to the person completing them for the incomplete information to be added.	Samantha Deakin, Health Safety and Security Lead	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	31/3/26	30/9/26	Not Yet Due
2024/25	Oversight Arrangements	Medium	The commissioning / governance section of the ICB should update the SOPs for the POM so that they are aligned to the expectations of the POM's TOR in order to fulfil their oversight responsibilities. They must ensure that roles and responsibilities for matters that should be delivered by the POM are reflected within the SOPs and that the POM should have an approved annual work	Zoe Mellon, Performance Lead	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/9/25	31/12/26 31/3/26	Not Implemented This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements. These actions remain linked to the ongoing operating model work, therefore there is not any further update or evidence of completion at this

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a starting reference point for such an exercise.					stage. The revised deadline of 31 December 2026 therefore remains applicable.
2024/25	Oversight Arrangements	Medium	The commissioning/ governance section of the ICB should update the SOPs for the LAM so that they are aligned to the expectations of the LAM TOR in order to fulfil the delegated responsibilities. They must ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs and that the LAM for each locality should have an approved annual work programme, which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a starting reference point for such an exercise.	Zoe Mellon, Performance Lead	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/9/25	31/12/26 31/3/26	Not Implemented This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements. These actions remain linked to the ongoing operating model work, therefore there is not any further update or evidence of completion at this stage. The revised deadline of 31 December 2026 therefore remains applicable.
2024/25	Oversight Arrangements	Medium	The governance section of the ICB should update their SOPs for the LAM to ensure that roles and responsibilities for matters that should be delivered by the LAM are reflected within the SOPs. The LAM for each locality should have an approved annual work programme which informs their reporting agenda and provides assurance that they have oversight on all aspects of their responsibilities annually. Issues identified in our report can be used as a reference point for such an exercise.	Zoe Mellon, Performance Lead	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/9/25	31/12/26 31/3/26	Not Implemented This action is affected by the agreement and implementation of the new operating model and cannot be implemented (e.g. redesign of LAMs) until we have clarity on the Place Partnership Agreements. These actions remain linked to the ongoing operating model work, therefore there is not any further update or evidence of completion at this stage. The revised deadline of 31 December 2026 therefore remains applicable.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
2024/25	CAF aligned DSPT	3 x High	3 x high risk recommendations relating to supply chain, identity and access control and response planning.	Various	Nicola Hepburn, Acting Chief Reform and Improvement Officer	31/10/25 and 31/12/25	31/1/26	Partially Implemented Based on the updates received in November 2025, each of the recommendations are partially implemented with further follow up work scheduled for early 2026.
2024/25	IT Asset Management	1 x High, 3 x Medium	4 recommendations made relating to Strategy and Contracts, Asset Inventory and Registers, Acquisition and Disposals, and Reporting and Documentation	Various	Nicola Hepburn, Acting Chief Reform and Improvement Officer	Various dates up to 31/3/26		Not Implemented Currently being followed up
2025/26	Financial Recovery Programme	Medium	NHS GM should ensure that financial reporting across all layers includes clearer reference to original plan targets, stretch and ambition targets and revised plan targets for clarity to the reader to avoid confusion and clearly track performance and demonstrate accountability to agreed plans.	Nicola Hepburn	Kathy Roe, Chief Finance Officer	30/6/26		Not Implemented No response received.
2025/26	Financial Recovery Programme	Medium	NHS GM should ensure that financial information is consistent across reports and throughout the various meetings/ groups in the governance structure.	Nicola Hepburn	Kathy Roe, Chief Finance Officer	30/6/26		Not Implemented No response received.
2025/26	POD Delegation	Medium	As best practice, the ICB should ensure that the 2025/26 self-declaration provides sufficient detail in response to the questions, Reference should be made, as appropriate, to specific processes and how they provide assurance. Also reference should be made to specific examples and supporting evidence available to support the rating given.	Ben Squires	Katherine Sheerin, Chief Commissioning Officer	31/3/26		Not Implemented Review of the 25/26 self-declaration indicates that this remains an area for improvement.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
2025/26	Mental Health	Medium	The GMICB should ensure that in addition to having up-to-date terms of reference of the GM Mental Health Partnership Board, they also have an annual work programme for the Board to ensure that they fulfil all their operational, strategic and assurance mandates in a timely manner.	Melissa McGuinness	Manisha Kumar, Chief Clinical Officer	31/1/26	30/7/26 31/5/26	Partially Implemented June 26 update Due to ongoing Reform and gaps in our structure, the revised date for the new ToR for the MHPG and sub groups is end July. We have made good progress and streamlined and reduced our meetings in the interim
2025/26	Community Pharmacy – Advanced Services	Medium	The conditions 8.3 and 8.3 (b) set out in the MOU should be reviewed and a plan developed to ensure these are completed as soon as possible with the evaluation and reports issued to the appropriate oversight group/ meeting. Furthermore, the extension to MOU agreements should be documented and evidenced.	Alison Scowcroft	Katherine Sheerin, Chief Commissioning Officer	31/10/2025	30/6/26	Partially Implemented June 26 update An evaluation document draft has been received in May and is currently under review. There was an agreed extension to the timeline for this evaluation due to staff members annual leave and handover arrangements. This will be presented at PCCC when finalised.
2025/26	Training and Development	Medium	The Learning and Development team should consider the current reporting systems and recording of role specific training and ensure that the current gaps in this area are addressed, with the aim of including these details as part of future assurance and reporting arrangements.	Head of L&D	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	31/03/2026	31/7/26	Partially Implemented Work to update TNAs and make associated revisions in ESR to re-map role specific modules to the new ESR positions is now scheduled for completion by July.
2025/26	Training and Development	Low	The Learning and Development team should undertake formal spot checks on the recording of completion of learning and development activity on ESR to ensure that activity approved is completed and that records are maintained comprehensively and accurately.	Head of L&D	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	31/03/2026	30/9/26	Not Implemented Defer to end of Q2 as processes including the skills panel need to be reviewed in line with the new operating model.
2025/26	CHC	High	Complete the CHAT and the development of the AACC Transformation Plan, monitoring	Katherine Sheerin, Chief	Katherine Sheerin, Chief	31/03/2026		Partially Implemented

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			progression through the Board Assurance Framework/ other committee and Board assurance reporting.	Commissioning Officer	Commissioning Officer			Section 2 now completed and signed off by GG. Shared with NHSE as required.
2025/26	CHC	High	Further develop CHC metrics and assurances through the AACC/ Individualised Commissioning Assurance Dashboard and implement a fuller range of reporting at locality and committee level tailored to audience and appropriate to the post-transition ICB governance structure.	Katherine Sheerin, Chief Commissioning Officer	Katherine Sheerin, Chief Commissioning Officer	30/09/2026		Not Yet Due Work has commenced on further developing the suggested metrics within the monthly assurance report. The GM QM and 2 Heads of Service are meeting on 28/05/26 to refine the questions. GM QM has also emailed the GM Complaints team to ask for quarterly breakdown of the number of complaints received and Trends and themes to supplement the assurance report which can then be tabled at the next GM AACC Assurance meeting on 22 September. This is a quarterly meeting.
2025/26	CHC	Medium	Update policies and publish as appropriate, including CHC Choice and Equity Policy and CHC Operational Policy.	Katherine Sheerin, Chief Commissioning Officer	Katherine Sheerin, Chief Commissioning Officer	30/09/2026		Not Yet Due Policies and procedures will be tabled for the GM AACC Transformation meeting on 01/06/26 to pick up any policies which require a review. Once they have been reviewed by Heads of Service they will be taken through policy governance for sign off and then updated versions will be circulated to all 10 Heads of service and added to the GM CHC Futures page
2025/26	CHC	Medium	Amend procedure so that the 28-day clock starts on receipt of the original referral in the event that a positive checklist is rejected and re-submitted.	Katherine Sheerin, Chief Commissioning Officer	Katherine Sheerin, Chief Commissioning Officer	30/06/2026	30/9/26	Partially Implemented Bolton SOP obtained and this is tabled at the GM AACC Transformation meeting on 01/06/26 for discussion to explore a GM SOP for consistency and good practice for all 10 localities to adopt and implement. Bolton SOP was discussed as above, general agreement from the group to develop a GM SOP. This will be progressed via the Heads of Service
2025/26	CHC	Low	Consider a shared service agreement for a CHC (and wider) clinical audit programme with regional ICBs.	Katherine Sheerin, Chief	Katherine Sheerin, Chief	01/04/2027		Not Yet Due We are looking at developing our own GM audit, once developed we would be happy to share with NHSE.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
				Commissioning Officer	Commissioning Officer			Ad-hoc audits are taking place across the 10 localities, as GM system we will look at bringing consistency across 10 teams.
2025/26	ESR Payroll	Medium	The ICB should remind managers of the need for timely completion of all forms, with all sections completed in full and correctly, including obtaining employee signatures and dates. The ICB should investigate the two issues with leavers (the deduction of holiday pay for the leaver concerned and the inconsistent termination date for the leaver concerned) with ELFS to assess whether any overpayments have arisen. The ICB should implement regular ad-hoc checks of completed forms to ensure full completion.	Krystina Curley, Head of Employment Services	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/04/2026		Not Implemented No response received.
2025/26	ESR Payroll	Medium	The updated SLA with ELFS for 2026/27 and beyond should include clear and specific details of KPIs which are reported against target. KPIs should be a formal agenda item and noted as part of contract performance meetings.	Krystina Curley, Head of Employment Services	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/04/2026		Not Implemented No response received.
2025/26	Specialised Commissioning	Medium	Recommendation – We recommend that the ICB undertakes the following actions: • A conflicts of interest register should be maintained for the NWSSC Group and made available for the Chair's reference before each meeting. Where interests have been declared, these should be documented and nil declarations noted. If members are excluded from particular agenda items, the minutes should reflect this for transparency. • Minutes should document that quoracy requirements have been met, and if not,	NW ICB SROs/Katherine Sheerin - Chief Officer for Commissioning	Katherine Sheerin, Chief Commissioning Officer	30/06/2026		Not Implemented No response received.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			the action taken. • Ongoing compliance with the requirements of the Delegation Agreement for specialised services should be assessed periodically and assurance provided to the NHS GM Board/ relevant committee. • The NWSCC should consider the development of an annual report that sets out how the committee has discharged its duties as set out in the Terms of Reference, together with a review of meeting attendance by core members, as well as highlights and progress against the Workplan for the year					
2025/26	Specialised Commissioning	Medium	We recommend that the ICB undertakes the following actions: • The members attending and any conflicts of interest declared should be checked at the start of each meeting and documented. Confirmation of quoracy should also be documented. • The SCOG agenda should be updated to include items for endorsement/ approval for the COG and Executive Team. • The SCOG Performance Report should be further refined to ensure that the data presented allows the Group to review the data in the context of the Group's responsibilities. • The finance update for ICB specific specialised services is provided quarterly. The implications of this on the Group's ability to undertake its duties,	Louise Sinnott - Head of Acute Strategy & Transformation / Place Based Lead for Greater Manchester, Specialised Commissioning North West	Katherine Sheerin, Chief Commissioning Officer	Complete		Not Implemented (awaiting evidence) No response received.

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			particularly when discussing transformation should be reviewed.					
2025/26	Specialised Commissioning	Medium	Criteria for the inclusion of specialised services commissioning risks on the ICB Strategic Risk Register/ BAF should be defined and the consideration of risks for inclusion be documented (within the SCOG minutes for example).	Katherine Sheerin- Chief Commissioning Officer /Chris Gaffey Associate Director Corporate Services	Katherine Sheerin, Chief Commissioning Officer	30/09/2026		Not Yet Due
2025/26	Specialised Commissioning	Low	The NHS GM Finance Committee and Quality and Performance Committee Terms of Reference should be updated to include reference to responsibilities relating to delegated specialised services commissioning.	Katherine Sheerin	Katherine Sheerin, Chief Commissioning Officer	30/06/2026		Not Implemented No response received.
2025/26	IT Supplier Management	2 x High, 1 x Medium	3 recommendations made relating to detailed improvement action plan, contract management and robust supplier monitoring and reporting.	Various	Nicola Hepburn, Acting Chief Reform and Improvement Officer	Various dates up to 31/3/27		Not Yet Due
2025/26	Key Financial Controls	High	The ICB should review all 65 invoices currently paid that have been approved by users with incorrect limits to provide assurance that all these payments are correct and appropriate. Controls should be put in place to review all instances of invoice approvals outside of delegated limits on a monthly basis with appropriate action taken where necessary. Communication should be shared with staff reminding them of the importance of not using the 'Delegate' or 'Invoice Reassign' functions within the system.	Kaye Abbott – Associate Director of Finance – Financial Control	Kathy Roe, Chief Finance Officer	30/06/2026	31/12/2026	Partially Implemented Currently being followed up as part of 26/27 audit. NHS GM has contacted NHS SBS and is awaiting an update in respect of the system process, and the report that can be run to monitor the volume of invoices approved by users with incorrect limits, through the incorrect use of the Delegate function. Whilst this response is awaited, an internal process for reviewing these has been designed and will be implemented going forward. As part of this, users who incorrectly delegated/transferred an invoice with incorrect authority are contacted and advised of the correct method to re-assign invoices. Reminders have

Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			The ICB should also continue to engage with the supplier of ISFE2 to attempt to turn off this function as well.					also been shared with colleagues in month end guidance documents to ensure they are aware of the correct process to re-assign invoices to other users.
2025/26	Key Financial Controls	Medium	The ICB should review its creditors that have an overall debit balance and where the credit is more than 6 months old. Where the ICB is no longer trading with the organisation, the ICB should seek a refund from the supplier. The ICB should in particular review the credit for Boots UK LTD and take action as necessary considering the size and age of this debit balance.	Andy Rippon – Finance Manager – Financial Control	Kathy Roe, Chief Finance Officer	30/06/2026	31/12/2026	Partially Implemented Currently being followed up as part of 26/27 audit. NHS GM conducts a monthly review and aims to take action against items where net debit balances remain month to month and it is unlikely to be recovered through ongoing trade. Contact is made with the specific providers and attempts are made to recover. Specifically for Boots, NHS GM has made contact with the company and is attempting to recover the funds.
2025/26	Risk Management Core Controls	Medium	NHS GM should update the Risk Management Policy to include the defined process on lessons learned in relation to risk management and how this operates in practice.	Chris Gaffey, Associate Director of Corporate Governance	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	31/12/2026		Not Yet Due
2025/26	Risk Management Core Controls	Low	The Policy should be updated to reflect the latest review of risk appetite by the Board.	Chris Gaffey, Associate Director of Corporate Governance	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/09/2026	31/12/2026	Not Yet Due Implementation date has been revised to align with the other recommendations around updating of the Policy.
2025/26	Risk Management Core Controls	Low	The Risk Management Policy should be updated to outline the process for monitoring and reporting attendance and completion of risk management training.	Chris Gaffey, Associate Director of Corporate Governance	Charlotte Bailey, Chief Strategy, People and Partnerships Officer	30/09/2026	31/12/2026	Not Yet Due Implementation date has been revised to align with the other recommendations around updating of the Policy.
2025/26	NEPTS Procurement	High	Commissioners should strengthen project governance arrangements for the remainder of the procurement by: • Identifying the resource and roles required to complete the project and confirming arrangements with SBS in	Gill Baker	Kathy Roe, Chief Finance Officer	30/06/2026		Partially Implemented MIAA are currently reviewing response/supporting evidence.

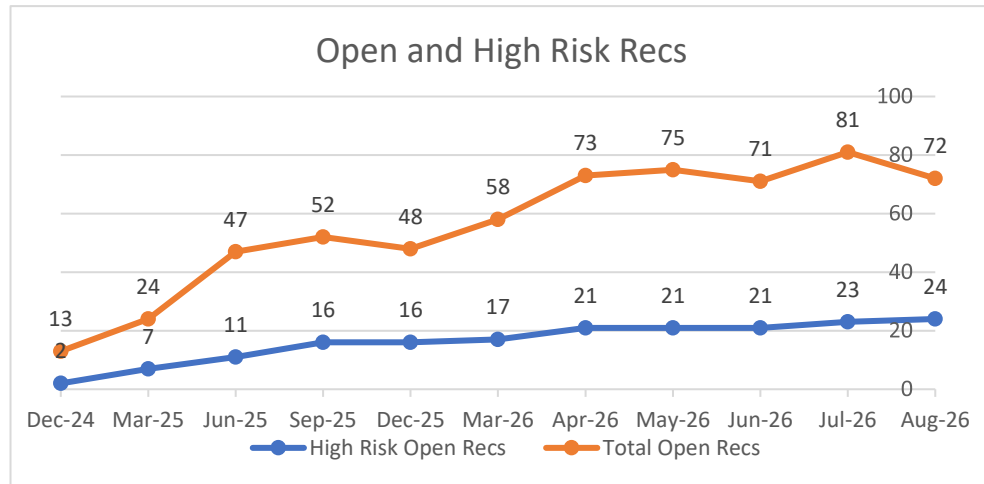
Year	Ref	Risk Rating	Recommendation	Responsible Officer	Exec Lead	Due Date	Revised Date	June 26 Update
			particular. • Defining and communicating clear escalation and decision-making routes. • Undertaking a strategic risk review of the procurement in its current state. • Ensuring legal advice is appropriately embedded and documented throughout the remaining stages of the process.					
2025/26	NEPTS Procurement	High	As the procurement has progressed to the Invitation to Tender stage, it is not possible to fully remediate weaknesses in pre-procurement planning for the current procurement. Commissioners should therefore: • Formally document the limitations and risks arising from these weaknesses and ensure they are actively considered during bid evaluation and decision-making. • Ensure that future procurements are supported by timely, comprehensive pre-procurement planning and engagement activity completed prior to commencing formal tendering. • Project specific evaluation templates are developed and used in the training of the evaluators.	Gill Baker	Kathy Roe, Chief Finance Officer	30/06/2026		<u>Partially Implemented</u> MIAA are currently reviewing response/supporting evidence.
2025/26	NEPTS Procurement	Medium	Commissioners should ensure that evaluator training includes procurement specific worked examples and clearly sets out how evaluators should apply the scoring definitions, with examples of bidder responses and examples of how scoring should be applied accordingly. Training materials should also be explicit around expectations for record keeping for transparency.	Izhar Chaudhary	Kathy Roe, Chief Finance Officer	22/04/2026		<u>Partially Implemented</u> MIAA are currently reviewing response/supporting evidence.

Appendix B: Risk Classifications

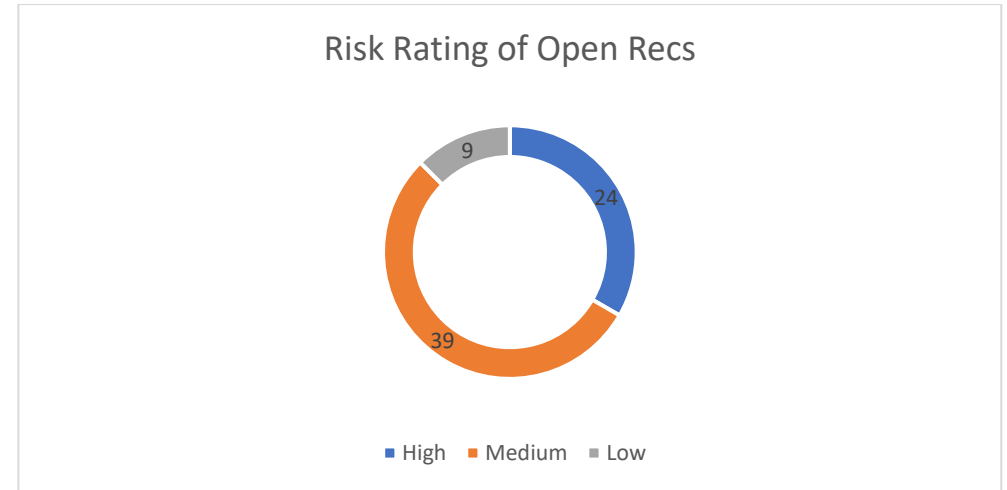
Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: - the efficient and effective use of resources. - the safeguarding of assets.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

Appendix C: Analysis of Recommendations

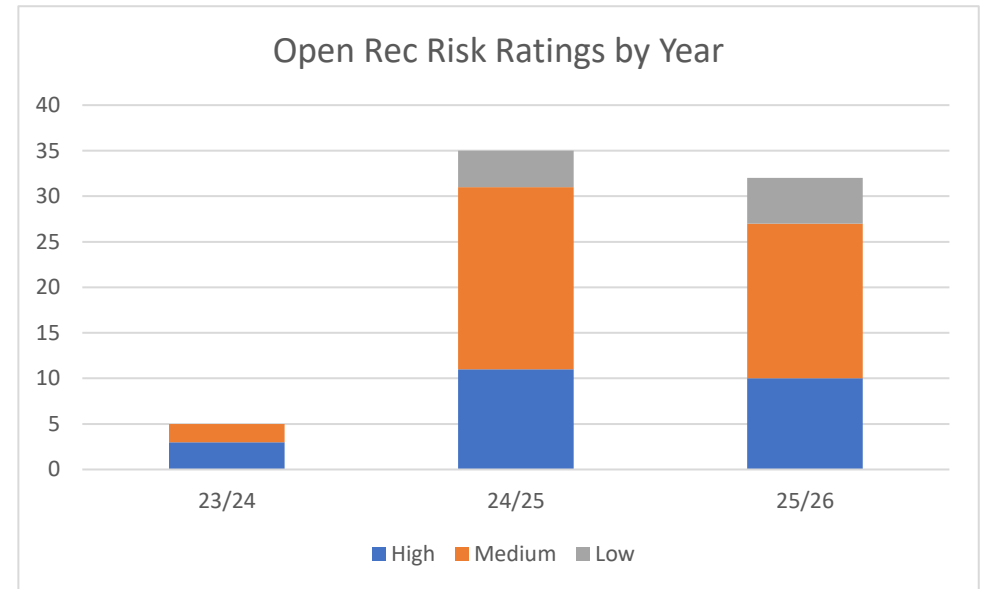
Breakdown of open and high-risk recommendations



Breakdown of risk rating of open recommendations



Breakdown of risk rating by year



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NHS GM Audit Committee 17th September 2026

MIAA - Internal Audit Service External Quality Assessment – Action Plan

NHS GM Audit Committee

17th September 2026

Required information	Details
Title of report	MIAA - Internal Audit Service External Quality Assessment – Action Plan
Author	Sarah Dowbekin Associate Director - Continuous Improvement - MIAA
Presented by	Louise Cobain, Executive Director – Assurance / Deputy Managing Director - MIAA
Contact for further information	Darrell Davies
Executive summary	As previously reported to you CIPFA undertook MIAA's External Quality Assessment (EQA) in 25/26. The assessment confirmed that MIAA is Generally Conforming with the Global Internal Audit Standards (UK Public Sector). This is the highest classification CIPFA award. CIPFA raised a small number of recommendations for management action and consideration as part of their EQA. MIAA's action plan in response to these recommendations is attached. This action plan has been reviewed and approved by MIAA's Management Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The paper is for information.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
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 accessibility of report

Introduction & Executive Summary

- 1.0** From April 2025 MIAA are required to comply with the Global Internal Audit Standards (UK Public Sector) (collectively referred to as GIAS throughout this document). These documents replace the Public Sector Internal Audit Standards (PSIAS).
- 2.0** As required by the GIAS external assessments to confirm our compliance with standards must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation. MIAA appointed the Chartered Institute of Public Finance and Accountancy (CIPFA) to undertake our EQA.
- 3.0** The assessment confirmed that MIAA is Generally Conforming with the Global Internal Audit Standards (UK Public Sector). This is the highest classification CIPFA award. This has been reported to you separately

Recommendations

- 4.0** The Audit Committee is asked to
 - Note the contents of the paper.

MIAA - Internal Audit Service External Quality Assessment – Action Plan

1 Introduction and Background

From April 2025 MIAA are required to comply with the Global Internal Audit Standards (UK Public Sector) (collectively referred to as GIAS throughout this document). These documents replace the Public Sector Internal Audit Standards (PSIAS).

As required by the GIAS external assessments to confirm our compliance with standards must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation.

There are two approaches to EQAs allowed under GIAS:

- An external reviewer undertakes a full assessment; or
- An external reviewer validates the internal audit service's own self-assessment.

MIAA undertake annual self-assessments against GIAS (and previous standards). Therefore the option that was both the most efficient and presented best value was to commission an external reviewer to validate our own self-assessment.

Our last EQA was completed in 20/21 financial year and therefore we were required to commission an EQA in 25/26 to meet the 5 year requirement outlined in GIAS.

This approach was communicated to you in November 2025 and approved.

MIAA appointed the Chartered Institute of Public Finance and Accountancy (CIPFA) to undertake our EQA.

2 EQA Results

The assessment confirmed that MIAA is **Generally Conforming** with the Global Internal Audit Standards (UK Public Sector). This is the highest classification CIPFA award. This has been reported to you separately

3 EQA Action Plan

As previously reported CIPFA raised a small number of recommendations for management action and consideration as part of their EQA.

MIAA's action plan in response to these recommendations is provided below. This action plan has been reviewed and approved by MIAA's Management Board:

Issues for Management Action	Priority	MIAA Agreed Action	Deadline
(Std 14.3) We found that for MIAA to continue to the next level with root cause analysis and theme identification and to fully match the requirements of Standard 14.3 that root cause analysis should be explicitly documented for each finding in MIAA reports and that themes identified should be more specific reflecting the more detailed nature of the root cause analysis.	Medium	CIPFA confirmed that MIAA engagement teams discuss with management root causes for each issue identified and that is how the audit team establish whether the audit findings are a control design or operating effectiveness issue, which is explicitly referenced in reports at both at finding level and collated at Executive Summary level. This approach also supports the identification of themes. To support progression of our methodology all internal audit staff will receive further training on root cause analysis and how this should be reflected in our reports.	30 th September 2026
(Std 13.4) Evaluation criteria, audit methodology and practice needs to more clearly result in sub objectives that reflect GIAS requirements. We recommend this is driven through internal quality assurance, review and training. This may also be assisted by embedding the language of GIAS; "evaluation criteria" and "condition" into the internal audit manual and documentation.	Low	To support progression of our methodology all internal audit staff will receive further training on evaluation criteria. Following training ongoing compliance with requirements will be confirmed through existing internal quality assurance and review mechanisms.	30 th September 2026
(Std 9.1) We recommend providing further training for internal auditors to allow greater incorporation of value for money (VFM) within such areas as evaluation criteria	Low	To support progression of our methodology all internal audit staff will receive further training on evaluation criteria	30 th September 2026

Issues for Management Action	Priority	MIAA Agreed Action	Deadline
and to enhance MIAA's position as a key strategic partner. This could include bite sized training sessions and other training methods but ideally expanded to include comprehensive VFM audit methodology training.		which will include coverage of value for money where applicable.	
(Std 9.2) We recommend that MIAA strengthen their Board by adding representation from their wider portfolio of clients to improve diversity of input, specifically to strategic thinking.	Advisory.	MIAA regularly assesses the composition of our Management Board. We will continue to review composition and widen representation as and when appropriate.	31 st March 2027 (date of next review completion)
(Std 1.1) We consider further including the language of GIAS, in this case the values of "honesty and courage" across all appropriate MIAA documentation will assist with embedding GIAS.	Advisory	The requirement for honesty and courage is included in the IA manual which has been updated for GIAS. As other MIAA documentation becomes due for review we will assess the relevance of these references for specific documents and update them as appropriate.	N/A – dependent on when documents are due for review.

We will monitor progress against this action plan through MIAA's governance structure and update you on the position of these actions in our Annual Report.

CIPFA Action Priority Ratings Definitions

Action Priorities	Criteria
High priority	The internal audit function needs to rectify a significant issue of non-conformance with the standards. Remedial action to resolve the issue should be taken urgently.
Medium priority	The internal audit function needs to rectify a moderate issue of conformance with the standards. Remedial action to resolve the issue should be taken, ideally within a reasonable time scale, for example six months.
Low priority	The internal audit function should consider rectifying a minor issue of conformance with the standards. Remedial action to resolve the issue should be considered but the issue is not urgent.
Advisory	These are issues identified during the course of the EQA that do not adversely impact the service's conformance with the standards. Typically, they include areas of enhancement to existing operations and the adoption of best practice.

Review of the 2025/26 Year End Audit

September 2026

NHS GM Audit Committee**17 September 2026**

Required information.	Details.
Title of report.	Review of the 2025/26 External Audit
Author.	Perminder Sethi, Grant Thornton Kaye Abbott, Associate Director of Finance - Financial Control Chris Gaffey, Associate Director of Corporate Services Alistair Ross, Head of Statutory Reporting
Presented by.	Michael Green / Perminder Sethi, Grant Thornton Jackie Gardiner, Director of Operational Finance
Contact for further information.	Michael Green / Perminder Sethi, Grant Thornton Jackie Gardiner, Director of Operational Finance
Executive summary.	This paper is presented to Audit Committee to feedback on lessons learnt from the 2025/26 year-end accounts process. This is a joint paper drafted with external audit colleagues.
The benefits that the population of Greater Manchester will experience.	Embedding the learning from the 2025/26 process is anticipated to result in a smoother audit process for 2026/27 and future years.
How health inequalities will be reduced in Greater Manchester's communities.	n/a

The decision to be made and/or input sought.	This paper is presented for information. The Audit Committee is asked to: 1. Note the contents of the paper and the proposed actions.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	n/a
Key milestones.	n/a
Leadership and governance arrangements.	This paper has been reviewed and signed off by Grant Thornton and the Director of Operational Finance (NHS GM).
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	This paper has been reviewed and signed off by Grant Thornton and the Director of Operational Finance (NHS GM).
Financial or Legal Implications	There are no specific financial or legal implications of this report.

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

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility	EHIA
N/a	N/a	N/a	N/a	N/a	N/a	Yes	N/a

Table 2: Assurance needed about the document.

1.0 Introduction

- 1.1. The Audit Committee considered the updated 2025/26 accounts on 17 June 2026 along with the Audit Findings Report and the Auditor's Annual Report for 2025/26. The accounts for NHS GM were given an unqualified audit opinion by Grant Thornton on 17 June 2026 and submitted by NHS GM on 17 June in advance of the 19 June national deadline.
- 1.2. This paper is presented to Audit Committee to share lessons learnt from this process which built on the work and experience from previous financial years.
- 1.3. The paper has been written jointly with external audit, with NHS GM feedback gathered via an anonymous survey, continuing a process implemented in 2023/24. The survey replicated questions from the previous year, and whilst fewer responses were received this is considered to be an indication of general satisfaction and improvement with the audit process, alongside reduced number of finance colleagues post year end due to the reform process.

2.0 Update on 2024/25 Lessons Learned

- 2.1. The output of the 2024/25 lessons learnt exercise is included in Appendix A, with the implementation status updated. There are a number which were not fully implemented, or where there remains room for improvement, and these have been updated to reflect progress and further improvements for 2025/26.

3.0 2025/26 Feedback

- 3.1. The overall view from both the internal survey and Grant Thornton (GT) feedback was that the 2025/26 accounts and audit process went well and ran smoothly, with continuing improvements from previous years.
- 3.2. Where difficulties were noted, these were principally related to the additional testing associated with the transition to ISFE2, as well as colleagues getting used to minor process differences on the new system (such as managing journal approvals).
- 3.3. The key positive outcomes to note were:
 - The accounts for NHS GM were completed and submitted ahead of the national deadline, which was an earlier national deadline than in previous financial years.
 - No escalation of matters to either the Chief Finance Officer or Audit Partner were required, indicating the effectiveness of working relationships.
 - Routine and regular meetings between the teams and throughout the year, which were weekly during the audit, ensured issues were resolved and cleared promptly and ensured no surprises. Further, there were benefits from having consistent team members within both teams.

- Good working relationships remain between key members of the finance team and the audit team with a high level of co-operation and timely responses to issues raised.
- Central co-ordination of the audit process through two key NHS GM managers (KA and AR) ensured working papers were of a good quality and queries were directed to the right managers across the organisation.

3.4. In terms of the finance team involvement in the year end process, the majority felt that this was “about right”.

3.5. The above is consistent with the findings of the 2024/25 Lessons Learned report, indicating that the consistent approach continues to deliver an effective auditor/client relationship.

4.0 Key development areas for 2025/26

4.1. The key development areas identified from the 2025/26 audit are:

Development 1: Working Paper Improvements

4.2. Although minor, two specific examples raised were:

- the creditors listing was a working paper of a vast number of tabs rather than a complete listing. Having all creditors in one listing would speed up the audit process.
- Development of a combined 12-month report for Better Payment Practice Code rather than monthly reports would also be useful to improve efficiency.

Agreed Action – NHS GM is engaged with NHSE working groups seeking to develop / utilise the new ISFE2 control account reconciliations, which does not offer any improved functionality compared to the existing system. The current approach will be reviewed ahead of Month 9 draft accounts, to consider a more streamlined report, however the reports are generated from multiple sources with inconsistent formats.

In respect of the BPPC report, this can be generated for a full 12-month period by NHS GM which will be incorporated into the year-end working paper. For internal reporting NHS GM will continue to need monthly reports.

Development 2: Contract Variations / Agreements with Bodies

4.3. Whilst the significant element of this issue relates to the agreement of Mental Health Specialised Commissioning values with Trusts (which remains the responsibility of NHS England), there are other matters which have an impact on the NHS GM managed contracts.

In respect of NHS GM led contracts, there were issues relating to the agreement of variable activity and the transacting of late allocations, as well as delays in the formal signature of contracts and variations.

Agreed Action – In respect of MH Specialised Commissioning contracts, NHS GM will continue to work with colleagues at NHS England to encourage the signed agreement of contracts, but it is noted that this is outside of NHS GM's control.

In respect of NHS GM managed contracts, the ICB will continue with the process to gain specific agreement from counterparty Trusts if contract variations cannot be formally agreed and signed prior to the commencement of the audit.

Development 3: Annual Report Amends

- 4.4. The process for completing and updating the Annual Report in 2025/26 was hampered by the processes of organisational change the ICB was undertaking at the same time, with staff leaving the organisation who had significant knowledge and this meant there were delays in the completion of some sections.

Agreed Action – The process for communicating updates between the Corporate Governance, Finance and other teams will be reviewed by the Corporate Governance team as part of planning for 2026/27 closedown with the aim of streamlining updates whilst maintaining version control.

- 4.5. The above development was highlighted in addition to a key area of improvement carried forward from 2023/24 and 2024/25 relating to gaps in the draft Annual Report.
- 4.6. This too had been impacted due to the departure of a significant number of key contributors to the Annual Report in the run up to the year-end, which caused delays and difficulties in completing all sections in advance of the draft submission deadline. The Corporate Governance team will ensure that named individuals are allocated relevant sections of the Annual Report and clear deadlines will be communicated as part of year end planning. It is noted that had fewer colleagues been leaving the organisation around the year end, more colleagues would have had more capacity to contribute to the report ahead of the deadline.

5.0 Recommendations

- 5.1. The Audit Committee is asked to:
- Note the contents of this report and the proposed actions.

Appendix A Key areas of development from 2024/25

The following were noted in the equivalent report from 2024/25.

The key development areas identified from the 2024/25 audit were:

- a) **Third Party Assurance** – In respect of Information Provided by the Entity (IPE) testing, earlier communication of the requirements of these specific tests would be beneficial. This would enable NHS GM to communicate with colleagues and staff at counterparty organisations where additional information or third-party confirmations may be required, including the requirement to email the auditor directly. The areas most affected by this were in respect of testing of contract variations and section 75 transactions.

Agreed Action – GT to provide a list of areas of the accounts where IPE testing is expected to be provided at an early stage and in advance of testing, as well as the form the IPE testing will take. NHS GM will then use this information to liaise with relevant contacts, to ensure that information is available to be provided to auditors when required.

Status – Complete. The approach adopted was consistent with the previous year and worked due to increased understanding across both teams around the IPE testing approach. This reduced the volume of items required to be tested, which were known in advance and were prioritised, which limited the impact on teams. However, confirmation of the items where significant IPE testing is expected to be required would be appreciated in advance as part of the audit planning process.

- b) **Section 75 Testing** – As highlighted above, the testing of contract variations and section 75 information required specific review and monitoring of progress. This monitoring will be continued for the 2025/26 audit.

Agreed Action – GT to continue to specifically monitor progress against block contract and section 75 testing to ensure the timely resolution of outstanding testing.

Status – Complete.

- c) **National General Ledger Implementation** – In respect of interim testing (see Appendix A), the prospect of reporting from the new ISFE2 ledger from October 2025 creates additional challenges for reporting for the 2025/26 accounts. Therefore, it is proposed that NHS GM and GT meet early in the audit cycle and post implementation of ISFE2 to agree the transition process and agree the approach to testing of M1-M6 balances to maximise the assurance gained in advance of the year end.

Agreed Action – NHS GM and GT to meet prior to M9 to discuss and agree a testing approach in respect of the transfer of balances to ISFE2. This will be in addition to the regular liaison meetings with GT throughout the year.

Status – Complete – The agreed process worked well, although colleagues noted that the challenges posed by a mid-year transfer of ledger created additional work for both teams, this is not expected to continue given that the accounts will all be within ISFE2 for 2026/27.

Annual Auditors' Letter Recommendations from 2025/26 (Value for Money)

Audit Committee

17 September 2026

Required information.	Details.
Title of report.	Annual Auditors' Letter Recommendations Update (Value for Money).
Author.	Kaye Abbott – Associate Director of Finance – Financial Control.
Presented by.	Jackie Gardiner – Director of Operational Finance.
Contact for further information.	Jackie Gardiner – Director of Operational Finance (Jackie.gardiner3@nhs.net).
Executive summary.	This paper is produced to update the Audit Committee on the implementation of the 2025/26 Auditor's Annual Report. In total there were one key recommendation and three improvement recommendations.
The benefits that the population of Greater Manchester will experience.	Ensure that NHS GM is a fit for purpose organisation and delivers Value for Money in its operations.
How health inequalities will be reduced in Greater Manchester's communities.	Not applicable.
The decision to be made and/or input sought.	The Audit Committee is asked to: 1. Discuss and note the updates on the implementation of recommendations.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Not applicable.

Key milestones.	The implementation of the recommendations is a key milestone for the 2026/27 assessment.
Leadership and governance arrangements.	The individual leads have provided updates for the recommendations. The paper has been agreed by the Deputy Chief Finance Officer.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	The individual leads have provided updates for the recommendations. The paper has been agreed by the Deputy Chief Finance Officer.
Financial or Legal Implications	There are no financial or legal implications of this paper.

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

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

Grant Thornton Auditor's Annual Report 2025/26

Update on Implementation of Key Recommendation

No.	Recommendation	Initial Management Comments	implementation Progress Update
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.	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.	September Update: The ICB has commenced planning for 2027/28 and 2028/29, with the intention of agreeing commissioning intentions to the September Board meeting. From the perspective of finance, the exit run rate is being refreshed to establish a baseline against which the commissioning intentions and predicted demand growth can be modelled. Status: Ongoing

Update on Implementation of Improvement Recommendations

No.	Recommendation	Initial Management Comments	Implementation Progress Update
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.	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 March 2027	September Update: The 2026/27 CIP plan currently aligns to an 80/20 recurrent/non-recurrent split, which demonstrates focus on recurrent savings. In June 2026 the ICB established a dedicated CIP Sprint Team to undertake a risk review of all existing schemes and identify any schemes that posed a risk to year end achievement. Any identified risks are being addressed through focused deep dive sessions, with the aim being to unblock issues and recover delivery in year. Where schemes are unlikely to deliver in year, mitigation plans are in place to ensure year end achievement. The ICB recognises that improvements are still required to strengthen further the CIP delivery and reporting. The recent appointment to Acting Director of Recovery and Improvement will support these developments, and as part of this work the development of the 2027/28 plan has begun which will see a shift to sustained transformational schemes supporting

No.	Recommendation	Initial Management Comments	Implementation Progress Update
			recurrency. Status: Ongoing
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.	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 Office Due Date: 30 September 2026	September Update: Process in development, with aim of implementation by the end of September as per proposed due date. Proposal is that regular report is considered by the NHS GM Operational Leadership Group (OLG) to regularly assess progress and consider the effect of capacity and priorities on delivery of improvements to assurance mechanisms. Updates to be feedback directly to internal and external audit for onward reporting to the Audit Committee. Status: Ongoing
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	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,	September Update: Procurement training modules covering both the Provider Selection Regime and the Procurement Act 2023 are currently being developed. It is recommended that these modules form part of the organisation's core training package to support consistent

No.	Recommendation	Initial Management Comments	Implementation Progress Update
	contract expiry and renewal, clearer accountability for PSR compliance at service level, and tighter controls to ensure PSR decision documentation and transparency requirements	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 Officer: Joanne Li, Associate Director of Contract Management and Procurement and Sara Roscoe, Associate Director for Commissioning Operations Executive Lead: Kathy Roe, Chief Finance Officer and Katherine Sheerin, Chief Commissioning Officer Due Date: 31 March 2027	understanding and compliance across NHS GM. The Decision-Making Record (DMR) process and associated documentation will be reviewed over the coming weeks, with the aim of creating a simplified and more user-friendly format while maintaining appropriate governance and regulatory rigour. Weekly procurement clinics continue to be available for all ICB staff, providing an opportunity to discuss emerging plans or intentions at an early stage and ensure that compliant approaches and appropriate procurement planning are undertaken. Recruitment is currently underway for an Assistant Director of Procurement. A key initial priority for this role will be to undertake a full review of procurement processes and work with the commissioning directorate to establish a robust procurement plan and future pipeline. This will support improved capacity planning across all relevant functions and teams, ensuring procurements are led successfully with timely input from the required disciplines

No.	Recommendation	Initial Management Comments	Implementation Progress Update
			and that appropriate processes are followed consistently. Under the ICB reforms the Healthcare Commissioning Team has been established which will be responsible for systematically undertaking service reviews of commissioned services. This will involve a prioritisation process in respect of value, risk and opportunity and will inform the commissioning programme. Programme leads from other commissioned programmes, i.e., cancer, mental health, urgent and emergency care will also align to this process. The newly formed Commissioning Delivery Group will oversee the commissioning programme. Whilst the CDG is not a decision-making group, it will formally report into the Strategic Commissioning Committee and People and Resources Committee. Status: Ongoing

Anti-Fraud Annual Report 2025/26

(17 June 2026)

NHS GM Audit Committee

17 September 2026

Required information	Details
Title of report	Anti-Fraud Progress Report – Sept 2026
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 anti-fraud activities undertaken in year to-date
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 accessibility of report

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

Anti-Fraud Progress Report

Presented at 17th September 2026

Audit Committee

NHS Greater Manchester ICB

Contents

1 Delivery Dashboard & Counter Fraud Standard Compliance

2 Executive Summary (in line with NHSCFA Strategic Pillars)

3 Referrals & Investigations Summary

4 Sanctions, Redress & Fraud Vulnerability Reports

5 Losses, Preventions & Recoveries

6 Management Action Tracker – MIAA AFS

7 Management Action Tracker – NHSCFA

Appendix A: Referrals Received

Appendix B: Investigations Log (CLUE Case Management System)

Appendix C: Glossary

Appendix D: Risk Classifications

1 Delivery Dashboard & Counter Fraud Standard Compliance

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

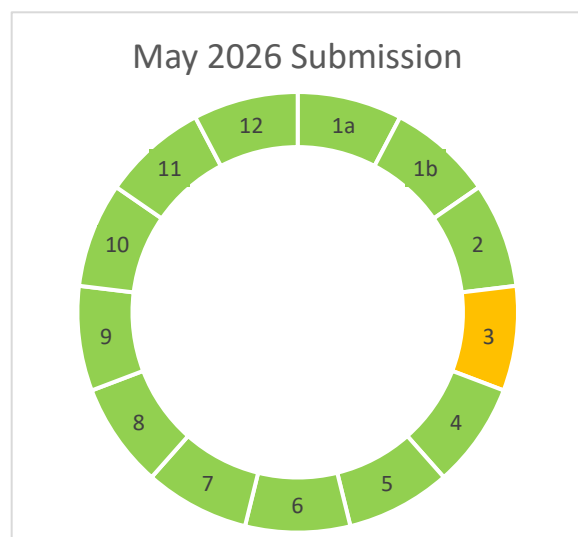
Plan Area	Status	Comment
Your Anti-Fraud Specialist	Green	Progressing as planned
MIAA Proactive Anti-Crime Team	Green	Progressing as planned
MIAA Reactive Investigations Team	Green	Progressing as planned

Open Referrals & Investigations Summary

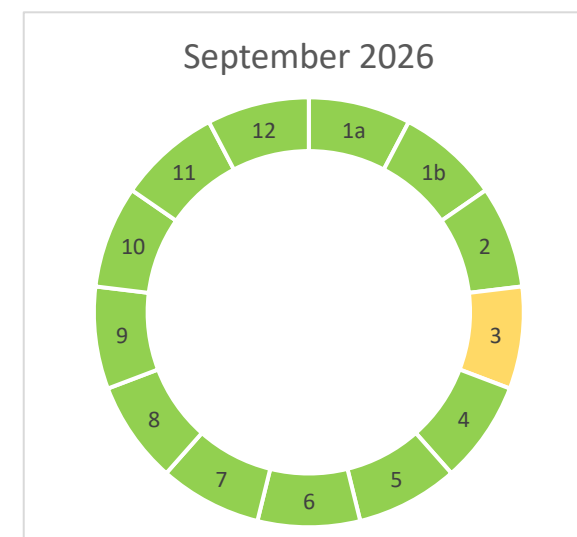
Current Open Referrals	4
Current Open Investigations (CLUE)	2

with the MIAA Investigations Team

Compliance against GovS 013 Functional Counter Fraud Standard: NHS Requirements



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



2 Executive Summary

From 01 April 2026 to 31 August 2026, the following activities have been undertaken and outcomes achieved.

Activities undertaken by: YOUR NOMINATED ANTI-FRAUD SPECIALIST

Green

Progressing as Planned

Assure

- Component 3 of the annual Counter Fraud Return submission in May was rated Amber due to the requirement to review and update the ICB's Fraud Risk Assessment to take account of the introduction of the new 'Failure to Prevent Fraud' offence, and changes in the Government Counter Fraud Profession (GCFP) risk assessment methodology. The Anti-Fraud Workplan 2026/27 includes the undertaking of this updated fraud risk assessment activity, completion of which should facilitate a Green rating for Component 3 in the next annual CFFSR. This work has now commenced with the first of these assessments covering NHS staff fraud risks issued, with the NHS supplier fraud risk assessment to also commence shortly. The AFS has issued introductory emails with NHSCFA Guidance to relevant ICB personnel to inform them of the planned work and required participation.
- At the end of June, the NHSCFA launched a new 'Ngage' site (NHSCFA extranet). It has been restructured around the role of the LCFS (AFS), making it easier to navigate and find information. As part of this transition, NHSCFA also conducted a full content audit to ensure that all information and documents on the site are up to date, relevant, and reliable. In July, the AFS attended an NHSCFA drop-in session on how to use the new site, which also included an overview of the latest version of the NHS Counter Fraud Manual.
- Regular catch-up sessions have been held between the AFS and the Counter Fraud Champion (CFC), as well as other key stakeholders including the Chief Pharmacist and senior Finance, Risk and HR personnel.
- The CFC is also authoring an article on their role at the ICB, for sharing in an NHSCFA online newsletter with the wider NHS counter fraud community.
- Internal MIAA Anti-Fraud Service catch-up meetings are held between AFSs who are nominated to ICBs, as well as bi-monthly meetings with the NHSE Counter Fraud NW liaison lead.
- The NHSCFA have advised (August 2026) that it is currently undergoing an internal "transformation review", focused on ensuring NHSCFA has the capability, capacity and flexibility to respond to an increasingly complex fraud landscape and a changing health system. The aim is to strengthen the preventative side of counter fraud work, including fraud risk management, system vulnerability, organisational learning and the use of insight from

operational activities to reduce future loss. In short, they want to build on what works well today while developing the capability they believe they will need for the fraud risks of the future. They also want to strengthen the links between national and local counter fraud activity so that intelligence, operational learning and professional expertise flow more effectively across the system. The outcomes from this review will be reported to the Audit Committee, once known.

Understand

- The AFS shared details of a new awareness campaign launched by NHSCFA. The campaign, “Careless Claims”, focused on helping NHS staff to understand how even small inaccurate or dishonest claims can impact the NHS. It also raised awareness of some of the most common types of fraud affecting NHS organisations, including mileage and travel claims, as well as timekeeping and hours worked.
- At the request of GM police, the AFS also shared details of the national Government and Police ‘Stop! Think Fraud’ campaign on how to stay safe from scams campaign and to raise awareness of cyber fraud.
- The AFS is liaising with the NHSCFA and NHSE Counter Fraud NW in relation to potentially undertaking some fraud awareness training / materials aimed at GP practice patients.
- Fraud awareness activities:
 - Awareness Activity 1 – Maintain cross GM PHB Working Group involvement: Not sure this group is still operating.
 - Awareness Activity 2 – CHC/PHB team: An initial PHB Direct Payments fraud awareness training session was delivered to the Bury team in July, at their request. Other such training to other local teams will be promoted.
 - Awareness Activity 3 – Primary Care Teams (ICB level): To be arranged.
 - Awareness Activity 4 – Primary Care (GP level): To be finalised, as noted above, possibly via a webinar delivery session for PC providers.
 - Awareness Activity 5 – International Fraud Awareness Week, 15 – 21 November: Awaiting promotional materials / campaign from NHSCFA.

Prevent

- Policy reviews / fraud proofing activities:
 - Planned Policy Review 1 – Social Media Policy: Pending
 - Planned Policy Review 2 – Artificial Intelligence (Acceptable Usage) Policy: Pending

- Planned Policy Review 3 – Asset Management Policy: AFS has requested a copy from the ICB.
- Planned Policy Review 4 – Personal Health Budget (PHB) Direct Payments User Agreement: This review will be included in the planned PHB Internal Audit Review/Local Proactive Exercise 26/27, to be commenced shortly.
- In May 2026, the AFS issued the final report to the ICB in relation to the 'Failure to Prevent Fraud' Local Proactive Exercise LPE/25/00869. The report contained several recommendations, for which management responses have been received and residual follow up work is being conducted through the 26/27 workplan to ensure implementation.
- There remains an ongoing joint LPE review into Section 12 mental health assessments with Greater Manchester Mental Health Trust. The fraud risks primarily relate to medics undertaking this work in the NHS time contracted to their substantive employer, as well as whether claims made to the ICB are submitted with adequate evidence that legitimate assessments have taken place to justify payment. The fieldwork for this review has now been completed and is in the draft report writing stage. A number of apparent control and evidentiary queries have been identified and the Audit Committee will be updated on this work once the detailed findings have been shared and discussed with relevant managers / stakeholders.
- The ICB participated in the National Fraud Initiative 2024/25 exercise. The ICB was responsible for processing the creditor matches; there are only 4 matches which remain outstanding. MIAA are responsible for processing the payroll matches, with only 1 match remaining outstanding.
- Preparations are underway in relation to the National Fraud Initiative 2026/27 exercise. Privacy Notices levels 1-3 were provided to the ICB for communicating to all staff of the forthcoming exercise and how their personal details may be used. Privacy Notice 1 consists of a payslip message to all staff, which was/is included in both August 2026 & September 2026 payslips. Privacy Notices 2 & 3 provide more comprehensive information and have been communicated in the staff brief in August and added to the intranet. The AFS has made the required declaration to the Cabinet Office to confirm that the Privacy Notices have been circulated to staff and confirmed other required information on the NFI system on behalf of the ICB as required. A MIAA Briefing Note was issued in August to key contacts providing information and requirements in relation to the 2026/27 exercise, including a timetable for actions / deadlines.
- The draft Terms of Reference for the planned PHB Direct Payments LPE has very recently been issued to key stakeholders for comment and agreement.

Respond

- A number of anti-fraud referrals have been received and passed on to the MIAA Investigations Team. See below and Sections 3 – 5, as well as Appendices A and B.

Activities undertaken by: MIAA PROACTIVE ANTI- CRIME TEAM / NHSCFA

Green

Progressing as planned

- The MIAA Proactive Anti-Crime Team have been working on the Fraud Risk Assessments (FRAs) and, in particular, initially concentrating on NHS Staff Fraud risks. FRAs relating to Suppliers, Patients, Systems and Third Party / Cyber Fraud are to follow.
- The MIAA Proactive Anti-Crime Team have also been trialling a new way in how we share some of our fraud related communications such as news, alerts and updates to the Trust. It should allow MIAA to share timely, consistent information more effectively. The pilot is currently under review.
- MIAA are producing a number of webinars covering Artificial Intelligence and Fraud, Working While Sick and Parallel Investigations (where enquiries are undertaken by both HR/Personnel and Anti-Fraud, which will cover fraud staff-related investigations).
- The team recently delivered a webinar to the NHS counter fraud community, jointly with the NHSCFA – ‘LCFS case walkthrough: from referral to prosecution’, about a successful MIAA prosecution.
- The team also contributed an article to the NHSCFA platform entitled ‘A Day in the Life of an LCFS’, in part to ensure NHSCFA staff are more knowledgeable about the role of the LCFS (AFS) and the competing demands on our time.
- The AFS liaised with the ICB’s Payroll provider and a series of four fraud awareness payslip messages have been agreed to be issued to all staff during 2026/27, covering: the National Fraud Initiative 26/27 Privacy Notice 1 (August 2026 & September 2026); Failure to Prevent Fraud Offence (October 2026); Workplace Imposters (November 2026); Artificial Intelligence and Fraud (January 2027).
- In May 2026, the AFS shared an Intelligence Alert 13-2025/26 Financial Transaction Scam from Counter Fraud Scotland in relation to a company who had over 500 1p transactions on their platform, with the majority of the transactions originating from overseas. The fraudulent transactions were likely being made in an attempt to identify which transactions were accepted and which cards being used were legitimate. No concerns were raised by this ICB.
- The NHSCFA produced ‘Learning Report Case Study 26/01: Fraudulent Refund Requests April 2026 V1.0’ which was issued by the AFS in May 2026. It provides a case study relating to the offences of fraud by abuse of position and money laundering within an NHS organisation. The Learning Report highlights a lack of controls and vulnerabilities in existing systems and provided some recommendations. This was shared with the ICB for information purposes and the AFS will follow up on any local responses / insights in due course.

- The AFS also issued a Fraud Newsflash to all staff in June 2026 relating to a phishing incident involving Microsoft Teams 'spoofing'. Spoofing is where fraudsters disguise themselves as a trusted source and contact an employee via the 'chat' function. The Newsflash highlighted the dangers and how to be aware of this type of fraud. This linked to an NHS Scotland Counter Fraud Services Intelligence Alert 03-2026/27 (June 2026) on CEO Spoof Emails/Invoices.
- The National Anti-Fraud Network (NAFN) Intelligence Alert: Mandate Fraud Alert (01062026) was also issued to the ICB on in June 2026. No concerns were notified by the ICB.
- The NHSCFA produced a reminder regarding the misuse of prescription forms and weight loss medications which was issued by the AFS in June 2026 to be shared with staff who deal with Medicines / Prescription Management, and this also cascaded to all primary care providers, via the primary care network.
- The NHSCFA produced a flurry of Learning Reports: 'Learning Report Case Study 26/02: Agency Timesheets June 2026'; 'Learning Report Case Study 26/03: Imposters/Impersonating a Medical Professional June 2026'; 'Learning Report Case Study 26/03: Single Tender Waivers June 2026'; 'Learning Report Case Study 26/04: False Qualifications June 2026'. These were issued to the ICB during June 2026 and the AFS has had some feedback already but will follow up responses in more detail in due course.
- The NHSCFA have been busy and also produced nine NHS Fraud Prevention 'Quick Guide' documents, which highlight specific fraud risk areas and provide prevention advice. The AFS issued all of these to relevant ICB personnel. These included: 'Travel expenses fraud NHS fraud prevention quick guide'; 'Imposters/Impersonating a Medical Professional'; 'Timesheet Fraud'; 'Employment Agency Fraud'; 'Conflict of Interest Supplementary Guidance'; 'Expenses and Allowances'; 'Working Whilst Sick'; 'Recruitment Fraud'; 'Multiple Employment Fraud'. Some of these accompany the Learning Reports noted above. The AFS will follow up ICB responses in due course.
- The AFS issued Fraud Prevention Checks (FPCs) numbers 1-14, which in the main related to mandate fraud / phishing emails / compromised NHS email accounts. No local concerns have been reported back by the ICB.
- In July, the AFS issued MIAA's latest Recent Fraud Cases Article, which provided details of various recent NHS fraud prosecutions in the media to be shared with all staff via the Stay Connected bulletin, and uploaded onto the anti-fraud intranet page.
- Also in July, the AFS shared with the ICB the NHSCFA warning to organisations to protect themselves from ransomware attacks, as new figures from Report Fraud reveal that 323 companies were targeted last year, equating to 26 attacks each month. Financial losses totalling around £270,000 were reported, a 50 per cent increase compared to previous year. However, these figures are likely to be much higher, as businesses often underreport financial losses, as admission of ransom payments could be seen as supporting criminal activity or breaching compliance regulations. As part of a

campaign launched in late June 2026, Report Fraud is urging everyone to protect themselves and their businesses from the active threat of ransomware attacks.

- MIAA issued a Primary Care Network (PCN) Fraud Warning 40 at the end of July, relating to a recent spate of fraudulent phishing emails for circulation to Primary Care Providers. Linked to this, the AFS issued MIAA Information Alert 1 - CEO Phishing, in August, for all staff attention and awareness.
- In August, the AFS issued to the ICB a summary of a nationwide police alert (originating from the Leeds area) in relation to the theft of controlled drugs and prescription medications destined for destruction. PCN Fraud Warning Alert 41 was also issued in relation to this police alert for the attention of Primary Care Providers. The police provided a number of recommended actions for organisations to consider reviewing current policy, security, audit, and assurance processes relating to the transportation, storage, tracking, and destruction of controlled drugs and prescription medications destined for incineration facilities. This prompted a meeting between the AFS and the Chief Pharmacist regarding potential other related risks (i.e. clinical waste destruction) and to share other reporting routes for cascading such alerts nationally – this information and key contact details were shared by the AFS with the NHSCFA's Central Intelligence Unit.
- The NHSCFA produced a new 'Fraud Prevention Notice (FPN-M-000-26) Payment Diversion Fraud' in late July to highlight a prominent risk whereby criminals impersonate suppliers or NHS staff to request changes to bank account details, exploiting weak verification processes. In addition to the FPN, the NHSCFA also published updated 'Payment Diversion Fraud Guidance July 2026' (which replaces the previous invoice and mandate fraud: guidance for prevention and detection). The AFS issued these to the ICB in early August and will follow up ICB responses in due course.
- In July 2026, the NHSCFA's Director of Finance re-issued an open letter to NHS suppliers (issued originally in December 2025) which highlights the growing threat of payment diversion fraud and the importance of strong cyber-security and verification processes: 'NHSCFA Open Letter to NHS Suppliers July 2026'. NHSCFA have two supplier guides available, 'Mandate Fraud Supplier Guide October 2025', and 'A Guide to Cyber Attacks November 2025', designed to help suppliers protect themselves and the NHS. NHSCFA advised that these three documents be shared with NHS suppliers. The AFS shared these with the ICB in August and the AFS is also in liaison with SBS as to whether they can facilitate the issuing of these across client suppliers centrally. If the ICB has any suppliers outside of SBS, then it would facilitate the issue of the documents to those suppliers directly.

Activities undertaken by: MIAA REACTIVE INVESTIGATIONS TEAM

Green

Progressing as planned

- Activities that are being undertaken by the Investigation Team are noted at Sections 3 - 5 of the Progress Report, and at Appendices A and B. There are no slippages in investigation activity with no regulatory or legislative changes which could impact the conduct of any investigations at the ICB.
- The Investigations Team aim to produce a benchmarking report in Q3 providing a full analysis of the MIAA referrals received, converted investigations and disposals, sanctions applied and financial redress, across the client base, for 2025/26.
- HR/Recruitment staff have been invited to attend one of two webinars being hosted by the MIAA Investigations Team across September and October. The webinar will focus on fraud investigations and collaborative working with HR colleagues. The session is designed to provide HR professionals with a practical understanding of fraud investigations involving NHS staff, and the vital role HR plays throughout the investigative process. It will cover working elsewhere whilst off sick, emerging fraud risks, common warning signs, and practical steps to help prevent fraud within the workplace. Four members of the ICB's HR/Workforce team are currently booked to attend one of the webinars.

3 Referrals & Investigations Summary

Referrals Activity (see Appendix A below)	Numbers
Referral brought forward from the previous reporting period (25/26)	2
Referral received in the reporting period	21
Referral converted to Investigations in the reporting period	1
Referral closed in the reporting period	18
Referral carried forward to next period	4

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

Investigations Activity (see Appendix B below)	Numbers
Investigations brought forward from the previous reporting period	1
Investigations opened from referral queries above in the reporting period	2
Investigations opened directly (i.e. NHS CFA or Transfer) in the reporting period	0
Investigations closed in the reporting period	1
Investigations carried forward to next period	2

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

4 Sanctions, Redress & Fraud Vulnerability Reports

Financial and Non-Financial Outcomes	
Total number of sanctions (all types) recorded on CLUE in reporting period:	1
Total redress amount recorded on CLUE in reporting period £:	0
Total number of FVRs / SWRs from investigations recorded on CLUE in period:	0

FVRs / SWRs – these reports highlight enablers or vulnerabilities in a system or process which have allowed, or could allow, a fraud to occur. They are inadequate internal controls or systemic vulnerabilities which can lead to an organisation facing higher fraud risks. They were previously called System Weakness reports (SWRs).

5 Losses, Preventions & Recoveries

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

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

6 Management Action Tracker – MIAA

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

Report Reference Number – LPE / INV	Report Issue Date	Rec No.	Rec Rating (CHML)	Implementation Date – Per Individual Recommendation	Actioned	Partial	No Action	Superseded	Comments
LPE/25/00869 Failure to Prevent Fraud Offence – Gap Analysis LPE	28.05.26	#01	M	31/05/2026.	✓				The amended Anti-Fraud Policy now reflects the requirements of the new offence.
		#02	M	30/09/2026		✓			Action: Associated FTPF fraud risks will be documented and scored, ahead of incorporation into ICB's overall Fraud Risk Assessment. Update: The risks have been scored and are being cross-referenced to the update of the ICB's full FRA.
		#03	L	30/09/2026		✓			Action: Guidance correspondence on the new offence and how organisations can be compliant with the legislative requirements will be prepared and issued to all ICB 'associated persons'/suppliers. Update: Guidance has been prepared and the AFS has been in contact with their counterpart at SBS to

									see whether this can be issued centrally. Awaiting an update from SBS to confirm if this can be actioned.
		#04	L	31/09/2026		✓			Action: The AFS should provide a FTPF update to the Audit Committee during 2026/27, to capture any local or national updates relating to this offence. Update: The AFS will include an update within the December progress report.

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

7 Management Action Tracker – NHSCFA

The table below summarises the NHSCFA issued Learning Reports, Fraud Prevention Notices, National Proactive Exercises etc issued in 2025/26, which contained recommended actions, which have been / are followed up periodically by the Anti-Fraud Specialist and outlines their current status.

Note: Grey shaded items indicate no further, specific follow-up required. Any applicable, related risks are captured on the Fraud Risk Assessment.

NHSCFA Document Reference	Issue Type	NHSCFA Issue Date	Fraud Risk Subject / Topic	AFS issued date	Actions Taken / Response by NHS Body (to date)	AFS Comments (To also note whether this is an identified fraud risk on main FRA)
M-005-25	FPN	23/07/25	Payment Diversion Fraud	27/07/25	No concerns received from the ICB following the initial issue. The FPN was shared with the financial services team who are the only team that can affect any changes to bank details or supplier accounts. Supplier set-up policy deals with all these issues.	No further follow up required by AFS. Various 3rd Party / Cyber fraud risks included in Fraud Risk Assessment.
M-006-25	FPN	04/12/25	Payment Terminals Fraud	12/12/25	No concerns received from the ICB following the initial issue. The FPN is not applicable due to the absence of payment terminals, although the guidance was cascaded to the primary care providers / networks, who do use them.	No further follow up required by AFS. Various 3rd Party / Cyber fraud risks included in Fraud Risk Assessment.

M-007-25	FPN	08/12/25	Virtual Credit Cards	12/12/25	No concerns received from the ICB following the initial issue. ICB finance team advised there are no VCCs and only a small number of physical cards.	No further follow up required by AFS. Will be included in NHS Systems component of the Fraud Risk Assessment.
M-008-25	FPN	04/12/25	Payment Diversion Fraud	12/12/25	No concerns received from the ICB following the initial issue. ICB finance response to AFS that they have robust controls in place and are particularly alert to this fraud risk.	No further follow up required by AFS. Various 3rd Party / Cyber fraud risks included in Fraud Risk Assessment.
L-001-26	FPN	14/01/26	Asset Management	23/01/26	No concerns received from the ICB following the initial issue. ICB finance shared with IT in particular due to the FPN's focus on mobile, high value assets. Subsequent assurance report received from Head of IT Technical Support on 27.02.26.	No immediate further action intended by AFS, although further consideration will be given during Asset Management Policy fraud-proofing review. Subject area included in both NHS Staff Non-Payroll and NHS Systems Fraud Risk Assessments.
H-002-26	FPN	16/02/26	Business Email Compromise	06/03/26	No concerns received from the ICB following the initial issue. No related referrals received by AFS. Initially sent to Finance and IT Security Manager for awareness. ICB processes in terms of business	No further follow-up planned by AFS. Various 3rd Party / Cyber risks will be included in Fraud Risk Assessment.

					email are regularly reviewed and there is an annual process to determine whether IT controls are adequate, which is overseen by the Audit Committee.	
M-003-26	FPN	03/03/26	Corporate Impersonation Fraud	06/03/26	No concerns received from the ICB following the initial issue. The FPN has been shared widely with relevant parties to make them aware of the risks and the AFS has been copied in on this email chain. Guidance also cascaded to Care Homes across GM by Director of Primary Care Services and the Quality Manager.	No further follow up required by AFS. Various 3rd Party / Cyber fraud risks included in Fraud Risk Assessment.
M-004-26	FPN	16/03/26	MARS	19/03/26	No concerns received from the ICB following the initial issue. No relevant referrals received by AFS. Initially shared with Finance and HR, with no adverse comments received.	No further follow up planned by AFS. Included in NHS Staff Fraud Risk Assessment.
M-005-26	FPN	26/03/26	Registered Nursing Apprenticeships	30/03/26	No concerns received from the ICB following the initial issue. Initially shared with Finance and Deputy Chief Nurse, who cascaded this to colleagues across the ICB.	No further follow up required by AFS. Included in NHS Staff – Governance Fraud Risk Assessment.

					The FPN has limited applicability, as the ICB has not engaged any significant numbers of RNAs.	
25/01	Learning Report	August 2025	Gifts & Hospitality	September 2025	No concerns received from the ICB following the initial issue. The AFS shared the NHSCFA guidance with Internal Audit for incorporation, along with Finance and Governance colleagues.	No further follow up required by AFS. Included in NHS Staff – Governance Fraud Risk Assessment
N/A	NHSCFA Report	14/11/25	Report on National Procurement Exercises	18/11/25	No concerns received from the ICB following the initial issue. AFS issued primarily as an advisory document to enable the ICB to consider it's existing controls against the picture from across England and Wales.	No further follow up required by AFS. Various procurement risks included in the NHS Supplier and NHS Systems Fraud Risk Assessments.

Appendix A: Referrals received in period (not converted to CLUE investigations)

Open / Closed	Date Received	Date Closed	Allegation Summary	Current Activity / Comments
Closed	01/04/2026	06/08/2026	INT/26/00877 – contracting arrangements	No evidence of fraud found
Closed	06/05/2026	21/05/2026	INT/26/01254 – selling prescription meds	Referred to practice and recommended MUR
Closed	13/05/2026	01/06/2026	INT/26/01388 – misuse of NHS services	Referred to GP practice
Closed	18/05/2026	08/08/2026	INT/26/01319 – overseas patient / eligibility	Transferred to WWL Trust AFS
Closed	18/05/2026	02/06/2026	INT/26/01389 – patient false identity	Patient not registered at GM GP practice
Closed	19/05/2026	19/05/2026	INT/26/01281 – GP funding queries	Passed to NHSE Counter Fraud (ARRS scheme)
Closed	19/05/2026	03/06/2026	INT/26/01483 – selling prescription meds	No patient address or DOB available – cannot pursue
Closed	05/06/2026	30/06/2026	INT/26/01554 – false fit note	Relates to GP – referred to ICB
Closed	16/06/2026	16/06/2026	Internal/Staff – LES maximising income	No confirmation of fraud – advice given
Closed	22/06/2026	30/06/2026	INT/26/01675 – misuse of medicines	Referred to practice and recommended MUR
Open	06/07/2026	N/A	INT/26/01779 – patient false travel claims	Enquiries ongoing
Closed	07/07/2026	05/08/2026	INT/26/01857 – conflict of interest	No evidence of fraud; ICB reviewing other matters

Closed	07/07/2026	28/07/2026	INT/26/01846 – selling prescription meds	Referred to practice and recommended MUR
Closed	10/07/2026	16/07/2026	INT/26/01919 – patient multi-registration	Passed to Primary Care Team
Closed	20/07/2026	14/08/2026	INT/26/01955 – selling prescription meds	Referred to NHSE CD Reporting, Police CDLO & GP practice
Closed	24/07/2026	06/08/2026	INT/26/02007 – overseas patient - eligibility	Referred to practice and recommended MUR
Closed	10/08/2026	26/08/2026	INT/26/02265 – selling prescription meds	Unable to trace subject - referral sent to Police by CIU
Open	10/08/2026	N/A	INT/26/02262 – false funded care package	Enquiries ongoing
Closed	14/08/2026	19/08/2026	INT/26/02354 – selling prescription meds	Referred to practice and recommended MUR
Open	04/09/2026	N/A	INT/26/02465 – selling prescription meds	Enquires ongoing
Open	01/08/2026	N/A	Internal/Staff – conflict of interest	Enquiries ongoing

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

Appendix B: Investigations Log ('CLUE' Case Management System)

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

Open/ Closed	Case Ref. (Dates)	Allegation	Current Activity	Outcomes & Sanctions						Additional Comments
				NFA	Criminal Sanction	Disciplinary Sanction	Professional Body Sanction	Financial Redress	Fraud Vulnerability	
Open	Case Ref: INV/26/02623 Added: 30/06/2026 Closed: N/A	CHC – PA claiming for hours not worked	Ongoing							
Open	Case Ref: INV/26/00980 Added: 20/03/2026 Closed: N/A	PHB – retention of excess funds	Ongoing							

Closed	Case Ref: INV/26/01818 Added: 03/06/2026 Closed: 03/06/2023	Patient Prescription Fraud	Closed – Police Caution Issued		✓						Fraud established – Police have issued a Caution
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Investigations – these are only investigations that have been recorded on NHS CFA case management system ('CLUE').

Appendix C: Glossary

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

Appendix D: Risk Classifications

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

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Disclaimer

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Risk Management Update

17 September 2026

Audit Committee

17 September 2026

Report information.

Required information.	Details.
Title of report.	Risk Management Update
Author.	Chris Gaffey, Associate Director of Corporate Services
Presented by.	Chris Gaffey, Associate Director of Corporate Services
Contact for further information.	Chris Gaffey, Associate Director of Corporate Services chris.gaffey@nhs.net
Executive summary.	This report updates the Audit Committee on the development of NHS GM's risk management arrangements following NHS Reform and implementation of the new operating model. It outlines progress in developing the refreshed Board Assurance Framework (BAF), following the Board's agreement of eight strategic risks in July 2026; the review and rationalisation of legacy corporate risks to align with revised Chief Officer portfolios, teams and governance routes; preparations to implement Datix as the organisation's digital risk management system; and progress in implementing outstanding internal audit recommendations relating specifically to risk management. Together, these workstreams are intended to strengthen accountability, escalation, assurance and oversight during organisational transition.

The benefits that the population of Greater Manchester will experience.	Effective risk management supports better and more resilient planning, decision-making and delivery across NHS GM. By strengthening the identification, ownership, mitigation and escalation of risks, the work described in this report will help NHS GM protect the continuity, quality and effectiveness of services for the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	The revised BAF and corporate risk arrangements will support the identification and oversight of risks that could affect equitable access, outcomes and experience across Greater Manchester's communities.
The decision to be made and/or input sought.	The Audit Committee is asked to: • note the eight high-level BAF risks agreed by the Board in July 2026 and progress in developing the detailed risk entries; • note the continuing review and rationalisation of corporate risks to align them with the new operating model and support management of the BAF; • note the planned implementation of Datix from October 2026 and the associated work on configuration, data migration, training and assurance; • note progress in implementing the outstanding internal audit recommendations relating to risk management; and • consider whether any further assurance or oversight is required as the revised arrangements are embedded.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The work provides a clear link between NHS GM's four strategic objectives, Year 1 deliverables, the eight high-level BAF risks and the supporting corporate risk profile. The BAF risks cover prevention-led population health improvement and inequalities, financial sustainability, strategic commissioning and service transformation, system partnership and place-based delivery, workforce and organisational capability, EPRR, cyber and digital resilience, and quality, clinical governance and safeguarding.
Key milestones.	July 2026: Board agreement of the four strategic objectives, Year 1 deliverables and eight high-level BAF risks. September 2026: Audit Committee update on detailed BAF development, the corporate risk review and Datix readiness. October 2026: Target implementation of Datix, subject to completion of configuration, data validation, testing, training and readiness assurance. Thereafter: Completion, quality assurance and formal approval of the detailed BAF entries; continuing review of the supporting corporate risks; and routine assurance reporting to the Board and its Committees.
Leadership and governance arrangements.	The Board has agreed the draft principal risks for the refreshed BAF. Chief Officers are responsible for drafting and maintaining the detailed BAF entries and for ownership of relevant corporate risks within their portfolios. The Corporate Governance function is coordinating the review, supporting consistent application of the NHS GM Risk Policy and overseeing preparations for Datix. The Audit Committee provides oversight and assurance on the effectiveness of the organisation's risk management arrangements, with individual Board Committees expected to scrutinise risks relevant to their remits.

Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	The draft principal BAF risks were agreed by the Board in July 2026. Ongoing engagement is taking place with Chief Officers, portfolio teams and relevant risk leads to develop the detailed BAF entries, review legacy corporate risks, confirm ownership and governance routes, and prepare for Datix implementation.
Financial or Legal Implications	There are no direct financial or legal implications arising from the recommendations in this report. Implementation of Datix and delivery of the wider risk improvement programme will be managed within relevant approved resources and contractual arrangements. Effective risk management supports NHS GM in identifying and managing potential financial, statutory, regulatory and other legal exposures.

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

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

Table 2: Assurance needed about the document.

Introduction

- 1.1. This report provides the Audit Committee with an update on the continuing development of risk management arrangements across NHS Greater Manchester (NHS GM) following NHS Reform and implementation of the organisation's new operating model. It focuses on four connected areas: development of the updated Board Assurance Framework (BAF); review of the organisation's corporate risk profile; implementation of Datix as the digital system for recording, managing and reporting risk; and progress in implementing outstanding internal audit recommendations relating specifically to risk management.
- 1.2. The programme of work is intended to ensure that risk arrangements remain aligned to NHS GM's revised leadership accountabilities, Chief Officer portfolios, team structures and governance routes. This is particularly important during organisational transition, when changes in responsibilities, capacity and interdependencies may alter existing risks or create new sources of risk.
- 1.3. NHS Reform, organisational reconfiguration and transition into new teams, including the management of gaps within the revised structure, have contributed to some delays in implementing elements of the risk management work programme over recent months. Notwithstanding these pressures, this report sets out clear intentions and planned milestones for progressing the key areas of risk management, including completion of the BAF, review of corporate risks, implementation of Datix and delivery of the outstanding internal audit recommendations.

Board Assurance Framework

- 1.4. In July 2026, the Board considered and agreed eight strategic risks for development within the refreshed BAF. These risks reflect the principal uncertainties that could affect delivery of NHS GM's four strategic objectives—Preventative and Proactive Care in Neighbourhoods; Targeted Action on Population Health and Inequalities; System Transformation; and Statutory Responsibilities—and the wider 5-Year Commissioning Plan.
- 1.5. The agreed BAF risks and accountable Chief Officers are summarised below (see table on next page). The risk titles remain subject to refinement through development of the detailed BAF entries.

Risk title	Proposed draft risk wording, causes and impacts	Accountable Chief Officer
1. Failure to deliver prevention-led population health improvement and reduce inequalities	Risk: NHS GM fails to achieve the planned shift towards prevention, early intervention and improved population health outcomes, including reducing unwarranted variation in access, experience and outcomes across different populations and communities. Causes: Insufficient transformation of commissioning approaches; competing operational pressures; limited partner alignment; inability to redirect resources from acute demand to prevention; ineffective targeting of resources; inconsistent use of population health intelligence; and limited engagement with communities and partners. Impacts: Poor health outcomes persist; health inequalities widen; demand for services and costs continue to grow; statutory expectations are not met; and NHS GM is unable to deliver its strategic commissioning objectives for the population of Greater Manchester.	Chief Clinical Officer
2. Inability to deliver financial sustainability	Risk: NHS GM is unable to maintain financial sustainability whilst delivering its strategic commissioning ambitions. Causes: Increasing demand; inflationary and workforce pressures; insufficient productivity improvements; and failure to realise benefits from transformation programmes. Impacts: Financial deficits emerge; investment in strategic priorities, including digital, is constrained; and organisational and system resilience is weakened.	Chief Finance Officer
3. Failure to transform services through strategic commissioning	Risk: NHS GM fails to influence and transform health and care services through effective strategic commissioning. Causes: Insufficient commissioning capability; lack of clear outcomes frameworks; poor implementation of commissioning decisions; and resistance to service redesign. Impacts: Services do not evolve to meet population need; outcomes fail to improve; and opportunities for better value and quality are lost.	Chief Commissioning Officer
4. Failure of system	Risk: NHS GM is unable to secure the collaboration required across providers, local authorities, places and	Chief Strategy, People and

partnership and place-based delivery	neighbourhoods to deliver its strategic objectives. Causes: Differing organisational priorities; weak governance arrangements; unclear accountability; and insufficient collective ownership of outcomes. Impacts: Fragmented delivery; delayed transformation; duplication of effort; and failure to realise system-wide benefits.	Partnerships Officer
5. Insufficient workforce, leadership and organisational capability	Risk: NHS GM lacks the leadership, workforce capacity and organisational capability required to deliver the strategic commissioning plan. Causes: Recruitment and retention difficulties; skills gaps; organisational change; and competing priorities. Impacts: Reduced pace of transformation; failure to deliver strategic programmes; and diminished organisational effectiveness.	Chief Strategy, People and Partnerships Officer
6. Failure to maintain effective Emergency Preparedness, Resilience and Response arrangements	Risk: NHS GM is unable to maintain effective emergency preparedness, resilience and response arrangements across Greater Manchester. Causes: Insufficient system-wide planning, testing and assurance; gaps in business continuity arrangements; limited partner alignment; and failure to meet NHS EPRR core standards and statutory duties under relevant emergency preparedness legislation and guidance. Impacts: NHS GM and the wider system are unable to respond effectively to major, critical or business continuity incidents, resulting in service disruption, increased risk to patients and communities, weakened public confidence, and regulatory or statutory non-compliance.	Acting Chief Reform and Improvement Officer
7. Failure to maintain effective cyber security and digital resilience	Risk: NHS GM is unable to maintain effective cyber security, information governance and digital resilience across its own functions and commissioned services. Causes: Increasing cyber threat levels; legacy systems; inconsistent compliance with data security standards; insufficient cyber assurance across providers and partners; and inadequate incident response or recovery arrangements. Impacts: Cyber incidents compromise the confidentiality, integrity or availability of systems and information; disrupt services; affect patient safety; reduce public confidence; and expose NHS GM to regulatory, financial and reputational consequences.	Acting Chief Reform and Improvement Officer

8. Failure to maintain effective quality, clinical governance and safeguarding arrangements	Risk: NHS GM is unable to maintain effective quality, clinical governance and safeguarding arrangements across its own functions and commissioned services. Causes: Insufficient system-wide quality oversight and clinical governance arrangements; inconsistent escalation, learning and improvement processes; variation in safeguarding and maternity assurance across providers and partners; and limited capacity to respond to emerging quality, safety, maternity and safeguarding concerns. Impacts: Quality, safety, patient experience, maternity and safeguarding risks are not identified, escalated or addressed in a timely way, resulting in avoidable harm, poor outcomes, increased inequalities, regulatory or statutory non-compliance, and reduced public confidence in NHS GM and commissioned services.	Chief Clinical Officer
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- 1.6. The risks have been designed to create an explicit link between strategy, delivery and assurance. Risks relating to prevention, inequalities, transformation and partnership delivery are primarily aligned to NHS GM's commissioning objectives, while financial sustainability, organisational capability, EPRR, cyber resilience, quality, clinical governance and safeguarding provide essential assurance over statutory responsibilities and organisational resilience. Most risks support more than one strategic objective, reflecting the interdependencies between commissioning, delivery and statutory accountability.
- 1.7. Chief Officers are now developing the detailed BAF entries for the risks for which they are accountable. Each entry will articulate the risk, causes and consequences; identify current controls and sources of assurance; assess gaps in control or assurance; set out mitigating actions, responsible leads and delivery dates; and establish current, target and tolerance risk scores. A risk workshop is planned for Chief Officers in September 2026 to ensure alignment and consistency across the BAF risks, consider how the learning from the Audit Committee's BAF deep dive earlier in the year should be implemented, and develop a shared approach to risk appetite.
- 1.8. Following the September workshop and completion of the detailed drafting and quality assurance process, in line with agreed processes, the BAF risks will be considered by the relevant Committees before the final BAF risks and proposed risk appetite are presented to the Board for consideration and approval in November 2026.
- 1.9. BAF development is being undertaken alongside the review of corporate risks to establish a clear line of sight from the strategic objectives and Year 1 deliverables, through the principal BAF risks, to the more detailed corporate risks, controls and mitigating actions managed within Chief Officer portfolios and teams. This should support proportionate escalation, reduce duplication and enable the Board and its Committees to focus on the most significant gaps in control and assurance.

Corporate Risk Management

- 1.10. Significant work is under way to review NHS GM's corporate risk register following implementation of the new operating model. Existing risks were developed under previous structures and accountabilities; they therefore require systematic review to confirm whether each risk remains current, should be revised, combined with another risk, closed, transferred or replaced.
- 1.11. The review is being undertaken with Chief Officer portfolios and relevant risk leads to identify the risks arising from their revised functions, statutory responsibilities, delivery priorities and dependencies with other portfolios, Place Partnerships and system partners.
- 1.12. Risk ownership, review frequency, escalation routes and Committee oversight are also being reassessed so that they reflect the new Chief Officer portfolios and governance arrangements. This will provide a more reliable corporate risk baseline, strengthen accountability and support the drafting and continuing management of the BAF.
- 1.13. To support consistent oversight, the Operational Leadership Group (OLG) will undertake regular monitoring and review of the corporate risk register. This will provide a forum to scrutinise risk scores, controls, mitigating actions, emerging risks and overdue actions; challenge the adequacy of management responses; and identify matters requiring further intervention. The OLG will ensure that material risks, significant changes in exposure, gaps in control or assurance, and matters outside agreed tolerance are escalated promptly to the relevant Chief Officer and/or Board Committee, in accordance with their respective accountabilities and terms of reference.
- 1.14. The proposed escalation model is as follows:
 - operational risks will be owned at team level and managed within the relevant Chief Officer portfolio, with routine review by the responsible team and escalation where exposure exceeds agreed authority, tolerance or control;
 - corporate risks will be monitored collectively through the OLG, which will challenge risk assessments, mitigating actions and control or assurance gaps;
 - material corporate risks and significant changes in exposure will be escalated to the accountable Chief Officer and/or the Board Committee with the relevant remit;
 - principal risks to achievement of NHS GM's strategic objectives will be reported to the Board through the BAF, supported by assurance from the relevant Board Committees; and
 - organisational or system risks that span more than one Committee remit will be shared between the relevant Committees, with the Audit Committee receiving assurance that escalation and cross-Committee oversight are operating effectively. The Audit Committee's role in assuring risk management systems and processes are effective remains unchanged.

- 1.15. Within this model, the recently established Strategic Commissioning Committee and People and Resources Committee will monitor and provide assurance to the Board on the BAF risks assigned to them and on relevant corporate risks within their respective remits. Each Committee will review risk exposure, controls, assurances and mitigating actions through its routine business, escalate material concerns to the Board, and share risks and dependencies with the other Committee where an issue spans both remits.

Committee	Responsible function areas and risk oversight
Strategic Commissioning Committee	• commissioning strategy and delivery; • service redesign and transformation; • clinical strategy, quality, patient safety and clinical governance; • performance and planning; • system and provider oversight; • continuous improvement; • population health and inequalities; • use of data and intelligence for strategic commissioning; • delegated NHS England responsibilities; • relevant statutory functions, including safeguarding, complaints, mortality, medicines optimisation and citizen involvement; • EPRR oversight; and • the strategic application of digital transformation to commissioning, coordinating with the People and Resources Committee where matters concern infrastructure, cyber security, data governance, investment or operational resilience.
People and Resources Committee	• financial strategy, sustainability and performance; • workforce, organisational culture, staff experience, capacity and capability; • estates; • environmental sustainability; • digital and IT infrastructure; • cyber security and resilience; and • the governance, security, resilience and investment requirements of data assets and associated infrastructure. • coordination with the Strategic Commissioning Committee where resource, infrastructure or data-related risks affect commissioning priorities, service models, outcomes or delivery.

- 1.16. The two Committees will operate through a shared governance model across the end-to-end strategic commissioning cycle. The Strategic Commissioning Committee will lead on commissioning intent, outcomes, service models, priorities and the use of population health and analytical intelligence; the People and Resources Committee will lead on the financial, workforce, estates, digital, IT, cyber and secure data infrastructure required to enable delivery. Information, risks and escalations will be shared systematically and promptly to avoid duplication or gaps in oversight. The Audit Committee will retain its overarching role in assessing whether the organisation's risk management and assurance arrangements are adequate and effective, including whether risks are being appropriately identified, shared and escalated through these Committees to the Board.

Implementation of Digital Risk System (Datix)

- 1.17. NHS GM is nearing implementation of Datix as the organisation's digital system for risk management, with the current aim of making the system operational from October 2026. Datix will provide a single, controlled repository for risk information and is intended to improve consistency in risk recording, review, approval, escalation and reporting across the organisation.
- 1.18. Work includes configuring the system to align with the NHS GM Risk Policy and governance structure; establishing user roles and permissions; confirming workflows and reporting requirements; cleansing and validating risk data before migration; and developing guidance and training for risk owners, managers and administrators. Appropriate testing and sign-off will be required before go-live to ensure that transferred information is complete, accurate and allocated to the correct owner and oversight forum.
- 1.19. Implementation will be phased and supported by clear ownership, training and post-implementation review. During transition, proportionate controls will be maintained over existing risk records so that the move to Datix does not interrupt ongoing review, escalation or reporting. The initial period after launch will be used to address data quality issues, refine reports and support consistent use across portfolios.

Internal Audit Recommendations

- 1.20. There are five internal audit recommendations specifically relating to risk management. All are being progressed alongside the organisational restructure, implementation of Datix and planned refresh of the Risk Management Policy. The recommendations are low or medium risk and are summarised below (see table on next page).

Review and recommendation	Progress and target date
Risk Management Core Controls: accredited training Agree externally accredited risk management training for staff leading the risk management function.	Training requirements have been identified and applications prepared. Progress was paused pending confirmation of roles through organisational change. The intention is to progress appropriate accredited development for the Risk Management Team, which will then support wider cascade training. Target: 31 December 2026.
Risk Management Core Controls: opportunities arising from risk Update the Risk Management Policy and risk register to capture and monitor potential opportunities and benefits alongside risks.	The Datix risk module has been designed to include a field for emerging opportunities. Completion is linked to Datix implementation and the subsequent policy refresh. Target: 31 December 2026.
Risk Management: lessons learned Define within the Risk Management Policy how lessons from risk management will be captured, reviewed and applied.	A lessons-learned field and supporting log are planned so that learning can be reviewed regularly and applied to future practice. This will be incorporated into the next policy update. Target: 31 December 2026.
Risk Management: risk appetite Update the Risk Management Policy to reflect the Board's latest review of risk appetite.	Development of the revised risk appetite is being aligned with the refreshed BAF and the September Chief Officer workshop. The final position will be incorporated into the next policy update following Board consideration. Target: 31 December 2026.
Risk Management: training monitoring Set out arrangements for monitoring and reporting attendance at, and completion of, risk management training.	The monitoring and reporting process will be defined in the refreshed Risk Management Policy, alongside the wider changes following organisational restructure. Target: 31 December 2026.

Next Steps and Actions

- 1.21. The immediate priorities are to complete and quality assure the eight detailed BAF entries; confirm their alignment with the four strategic objectives and Year 1 deliverables; conclude the portfolio-level review and rationalisation of legacy corporate risks; confirm ownership and governance routes under the new operating model; complete Datix configuration, testing and training for planned implementation from October 2026, subject to readiness assurance; progress the five outstanding internal audit recommendations; and refresh the Risk Management Policy to incorporate lessons learned, risk appetite, training monitoring and the capture of opportunities arising from risk.
- 1.22. Further updates will be provided to the Audit Committee on completion of the corporate risk review, the quality and completeness of the BAF entries, implementation of Datix, and any material risks or control weaknesses identified through the transition.

Recommendations

- 1.23. The Audit Committee is asked to:
- note the eight high-level BAF risks agreed by the Board in July 2026 and progress in developing the detailed risk entries;
 - note the continuing review and rationalisation of corporate risks to align them with the new operating model and support management of the BAF;
 - note the planned implementation of Datix from October 2026 and the associated work on configuration, data migration, training and assurance;
 - note progress in implementing the outstanding internal audit recommendations relating to risk management; and
 - consider whether any further assurance or oversight is required as the revised arrangements are embedded.

Annual Report of the Audit Committee 2025/26

NHS GM Audit Committee

17 September 2026

Required information	Details
Title of report.	Annual Report of the Audit Committee 2025/26
Author.	Kaye Abbott, Associate Director of Finance – Financial Control Jenny Noble - Board Secretary
Presented by.	Richard Paver – Audit Committee Chair
Contact for further information.	Jenny Noble, Board Secretary (jennynoble@nhs.net)
Executive summary.	The report summarises the work of the Audit Committee in respect of 2025/26.
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.	For review and adoption as the Annual Report of the Audit Committee
How this supports the delivery of the strategy and mitigates the BAF risks.	The Audit Committee has a key role in ensuring that NHS GM has robust risk management arrangements in place. This annual report sets out how the Committee has discharged its duties throughout the year, including in relation to risk management, which supports the NHS GM BAF process.
Key milestones.	Not applicable.
Leadership and governance arrangements.	Reviewed by Senior Finance Leadership

	Team Review by Associate Director of Corporate Services and Corporate Governance Team
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	
Financial or Legal Implications	There are no financial or legal implications of this paper.

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

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

Annual Report of the Audit Committee 2025/26

1.0 Introduction

- 1.1 The purpose of this report is to inform the NHS Greater Manchester Integrated Care Board (NHS GM) of the role and activities of the Audit Committee during the financial year 2025/26, including the approval of the statutory accounts and annual report submission in June 2026.

2.0 Summary of Audit Committee Responsibilities

- 2.1 The Audit Committee has operated during the year in accordance with its agreed Terms of Reference.
- 2.2 The roles and responsibilities of the Audit Committee include the review of the establishment and maintenance of effective integrated governance, risk management and internal control systems across the whole of NHS GM activities, both clinical and non-clinical, supporting the achievement of the organisation's objectives.
- 2.3 The Audit Committee placed reliance on other Committees which oversee governance, quality, and control e.g. Finance Committee, Quality & Performance Committee and People & Culture Committee. In response to NHS Reform and the model ICB Blueprint, and to prepare for transition into a new operating model, these Committees were disestablished and a new Transition Committee established for Q4 for the financial year. This was a temporary measure whilst the new Strategic Commissioning Committee and People and Resources Committee established from April 2026.
- 2.4 It includes the review and monitoring of internal and external audit functions, counter fraud and monitoring the integrity of the financial statements of NHS GM. The Audit Committee ensures that there is effective review of the work of the Local Counter Fraud Officer as set out by NHS Counter Fraud Authority (NHS CFA).
- 2.5 The key areas and risks reviewed by the Audit Committee include:
 - Agreed the 2025/26 Annual Report and Accounts for submission to NHS England, under delegated authority from the Board.
 - Considered the Audit Committee work plan for the year.
 - Received Policies for consideration, including the:
 - Rights of Access (SAR) Policy
 - Data Security Protection Policy,
 - Data Security Breach or Incident Policy,
 - Risk Management Policy,
 - Conflict of Interest Policy
 - Robotic Process Automation and Artificial Intelligence Policy,
 - Procurement Policy
 - Software Control Policy
 - Anti-Fraud, Bribery & Corruption Policy (June 2026)

- Considered risk management arrangements for the organisation, including a review of the Board Assurance Framework.
- Reviewed the SIRO Report 2024/25.
- Agreed and oversaw the delivery of the Internal Audit and Anti-Fraud Plans for 2025/26, whilst also considering plans for 2026/27.
- Receiving summaries of Internal Audit reports and following up implementation of recommendations.
- Oversaw the Internal Audit and Counter Fraud procurement and appointment process.
- Received a number of reports relating to corporate governance including Counter Fraud, Whistleblowing, Information Governance, Health and Safety, Information Technology Security / Resilience and EPRR.
- Waivers and elements of the Standing Financial Instructions, such as levels of delegation.
- Debtors' levels, in particular debtors over 90 days and scrutiny of any potential bad debt write offs; and
- Any losses and special payments in the period.
- Mental Health Investment Standard Compliance 2024/25.

2.6 The Audit Committee provides assurance to the Board on the effectiveness of the scrutiny undertaken within the Committee. It also highlights any emerging issues which the Board needs to be aware.

3.0 Membership of the Audit Committee

3.1 Membership during the year has comprised:

Richard Paver (Chair)	Non-Executive Director
Sheena McDonnell	Non-Executive Director (until 31 May 2025)
Anthony Hassall	Partner Member
Sue Greenhill	Independent Member
David Hopewell	Independent Member (until 31 January 2026)
Jackie Njoroge	Non-Executive Director (from 19 March 2026)

3.2 Invitations to attend Audit Committee meetings are normally provided to:

- NHS GM Chief Finance Officer
- NHS GM Executive Lead for Governance
- Internal Audit Representatives
- Counter Fraud Representatives
- External Audit Representatives.

3.3 In addition, other officers from within the organisation have been invited to attend Audit Committees, as delegated deputies for those listed in section 3.2, and where it was felt that to do so, would assist the Audit Committee to effectively fulfil its responsibilities. The Chair

and Acting Chief Executive attended the June 2026 meeting, along with the chair of the People and Resources Committee.

- 3.4 Administrative support has been provided by members of the Corporate Governance team.
- 3.5 Members training needs are reviewed on a regular basis, with Independent and Partner members expected to undertake their mandatory training in line with the requirements of their employing organisation, however, they are invited to attend NHS GM specific training where required.
- 3.6 The audit chair has also attended a number of meetings during 2025/26 including:
 - GM Audit Chairs
 - CIPFA Assurance and Governance forum

4.0 Meetings during the year 2025/26

- 4.1 During the year 7 meetings were held on the following dates, covering the close of the 2024/25 financial year in addition to 2025/26 financial year.
 - 24 April 2025
 - 19 June 2025
 - 11 September 2025
 - 11 December 2025
 - 19 March 2026
 - 23 April 2026
 - 17 June 2026
- 4.2 These have been held in person and in public in line with the commitment made in the NHS GM Constitution, although there have been some additional Part B (private) meetings taking place due to the nature of the discussions.
- 4.3 The public agendas and associated minutes can be accessed on the website.
- 4.4 Members attendance at the Audit Committee meetings are presented in the table below:

Date	Richard Paver (Chair)	Sheena McDonnell (until 31 May 2025)	Anthony Hassall	Sue Greenhill	David Hopewell (until 31 January 2026)	Jackie Njoroge (from 19 March 2026)
24 April 2025	✓	✓	Apols.	✓	✓	
19 June 2025	✓		Apols.	✓	✓	
11 September 2025	✓		Apols.	✓	Apols.	
11 December 2025	✓		✓	✓	Apols.	
19 March 2026	✓		Apols	✓		✓
23 April 2026	✓		✓	✓		✓
17 June 2026	✓		Apols	✓		✓

5.0 Remuneration of the Audit Committee

- 5.1 The fulfilment of the Audit Committee responsibilities by Partner Members is expected as part of each individual Partner Member's contracts with the organisations.
- 5.2 Non-Executive Members are remunerated for their role with NHS Greater Manchester as a whole rather than specifically for responsibilities with the Audit Committee. Independent Members are remunerated on a basis as agreed by the Remuneration Committee. Details of non-executives' remuneration is disclosed within the organisation's Annual Report, which can be viewed once published at [NHS Greater Manchester Reports | Greater Manchester Integrated Care Partnership \(gmintegratedcare.org.uk\)](https://gmintegratedcare.org.uk)

6.0 Financial Statements

- 6.1 On 23 April 2026, the Audit Committee reviewed the 2025/26 draft Annual Accounts, Annual Report, and the Annual Governance Statement for NHS GM, covering the 2025/26 financial year.
- 6.2 The final version of the Annual Report and Accounts were reviewed and approved on 17 June 2026.
- 6.3 The Audit Committee also reviewed the external audit report on the Annual Report and Accounts and approved the content of the 2025/26 Management Representation Letter.
- 6.4 The Annual Report and Accounts received an unmodified ("clean") audit opinion, with a qualified regulatory opinion due to the deficit position.

7.0 Internal Control and Risk Management Systems

- 7.1 At each meeting the Audit Committee has considered various reports from its Internal and External Auditors and the NHS GM Chief Finance Officer, other Chief Officers or their representative.
- 7.2 Below is a summary of the internal audit reports within the 2025/26 work plan, relating to the work completed by Mersey Internal Audit Agency (MIAA).
- 7.3 The Audit Committee agreed to the proposal from management to reduce the scale of the Internal Audit plan to reflect the pressure of the Reform Programme on the organisation. However, the Audit Committee did not agree to the removal of the review on data quality, which has concluded and will be reported in 2026/27 with limited assurance.
- 7.4 The Audit Committee also considered the approach being taken to Risk Management, and particularly the identified mitigations and their effectiveness. A number of suggestions were made on how to improve the approach, and the committee also undertook a deep dive into the BAF risk associated with Population Health, with a number of observations shared with Non-Executive Directors and Chief Officers.

	Review	Assurance Opinion	Recommendations Raised				
			Critical	High	Medium	Low	Total
1	Assurance Framework	N/A	N/A	N/A	N/A	N/A	N/A
2	Risk Management Core Controls	Substantial	0	0	1	2	3
3	Primary Care Commissioning Assurance Framework (POD Delegation)	Substantial	0	0	2	0	2
4	Key Financial Transactional Processing Controls	Moderate	0	1	2	2	5
5	Financial Recovery Programme	Substantial	0	0	2	0	2
6	Financial Reporting	Substantial	0	0	0	3	3
7	Mental Health	Substantial	0	0	3	0	3
8	Community Pharmacy – Advanced Services	Moderate	0	2	1	2	5
9	Continuing Healthcare (CHC)	Moderate	0	2	2	1	5
10	Training and Development	Substantial	0	0	2	1	3
11	ESR Payroll	Substantial	0	0	3	0	3
12	IT Supplier Management Review (Draft)	Limited	0	2	1	0	3
13	Contingency – NEPTS Procurement	No overall assurance rating	0	2	1	0	3

	Review	Assurance Opinion	Recommendations Raised				
			Critical	High	Medium	Low	Total
14	Specialised Commissioning	Substantial	0	0	4	1	5
	TOTAL		0	9	24	12	45

8.0 External Audit

8.1 Grant Thornton UK LLP are NHS GM's appointed external auditor. The Audit Committee has reviewed the work and findings of External Audit by:

- Discussing and agreeing the nature and scope of the 2025/26 Audit Plan.
- Considering the extent of its co-ordination with, and reliance on the work of Internal Audit.
- Receiving and considering reports derived from the Audit Plan including the annual Audit Findings Report for NHS GM; and
- Receiving and considering the Auditor's Annual Report for NHS GM, before its submission to the Board.

8.2 In addition, Grant Thornton LLP was appointed to undertake the Mental Health Investment Standard (MHIS) review for 2024/25 (the prior year) which they completed and reported their findings in April 2026. Following their work, Grant Thornton issued an unmodified reasonable assurance report opinion on the 2024/25 MHIS Compliance Statement. There was no equivalent review of the 2025/26 MHIS Compliance Statement for the current year, as this work has now been included as part of the main accounts audit.

8.3 The Audit Committee has also met in private with External Audit, to allow discussion of matters without the presence of executive officers.

8.4 An extract from the 2025/26 Audit Findings Report covers the year end statutory audit process and what the external auditors are required to report, which is, whether, in their opinion:

- The ICBs financial statements give a true and fair view of the financial position of the ICB and its expenditure for the year.
- The ICB's financial statements, including the audited parts of the Remuneration Report and the Staff Report have been properly prepared in accordance with International Financial Reporting Standards, the Department of Health & Social Care Group Accounting manual and the requirements of the Health and Social Care Act 2012.

8.5 The auditors are also required to report whether other information published together with the audited financial statements is materially inconsistent with the financial statements or the auditor's knowledge obtained within the audit or otherwise appears to be materially misstated and whether the income and expenditure included within the financial statements

has been applied for the purposes intended by Parliament (the regularity opinion). In addition:

- The Local Audit and Accountability Act 2014 also requires the auditors to report if they have applied any of the additional powers and duties described within the Act and to certify the closure of the audit.
- As auditors, it is required that they should “obtain sufficient appropriate audit evidence about the appropriateness of the management’s use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is material uncertainty about the entity’s ability to continue as a going concern (ISA (UK) 570).

8.6 The auditors need to report on Value for Money, to report whether in their opinion, they have been unable to satisfy themselves that the ICB has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. When reporting on these arrangements, the Code requires auditors to structure their commentary on arrangements under the three specified reporting criteria (financial sustainability, governance and improvements in economy, efficiency, and effectiveness). This report is called the Auditor’s Annual Report.

8.7 The Auditor’s Annual Report was issued in June 2026. It identified one instance where the auditor was unable to satisfy themselves with regards to the ICB’s arrangements, identifying a significant weakness in respect of the ICB’s arrangements for financial stability, reflecting ongoing financial challenges.

8.8 The report will be circulated to all members of ICB Board, with a presentation of the findings taking place as part of a future Board development session. The Audit Committee will be following up the recommendations made by External Auditor at subsequent meetings.

9.0 Summary of External Audit Conclusions

9.1 External Audit issued the following conclusions:

- An unqualified audit opinion on the accounts was issued for 2025/26.
- A qualified regulatory audit opinion was issued due to the £7.5m 2025/26 deficit, which breached the requirement of the application of income and expenditure for the purposes intended by Parliament and breached the regularity opinion. As a result, a Section 30 letter was issued to the Secretary of State under the Local Audit and Accountability Act 2014 to confirm this position. This is a statutory requirement for an organisation which delivered a deficit financial position.
- Other information published within the financial statements, which includes the Annual Report are consistent with their knowledge of the ICB and the financial statements audited, and an unmodified opinion was issued.
- A significant weakness exists in the ICB’s arrangements to deliver financial sustainability due to on-going financial challenges
- The auditors did not exercise any of their additional statutory powers or duties other than as noted above.

10.0 Internal Audit & Counter Fraud

- 10.1 During 2025/26 Mersey Internal Audit Agency (MIAA) has provided both internal audit and counter fraud services.
- 10.2 The Audit Committee has reviewed and considered the work and findings of Internal Audit and Counter Fraud by:
- Discussing and agreeing the nature and scope of the Annual Plan.
 - Receiving and considering regular progress reports from the Chief Internal Auditor / Anti-Fraud Specialist at Audit Committee meetings.
 - Receiving and considering reports derived from the Annual Plan.
 - Receiving the 2025/26 Head of Internal Audit's annual opinion on the systems of internal control.
 - Receiving the 2025/26 Internal Audit Report; and
 - Receiving the 2025/26 Counter Fraud Annual Report.
- 10.3 The anti-fraud specialist completed NHS GM's assessment against the Government Functional Standard 013 for counter fraud. This NHS GM 2025/26 organisational rating was green with one individual component relating to fraud risk assessments being rated as amber. This amber rating was due to a mid-year national change in the fraud risk assessment methodology. This area will be addressed in the 2026/27 fraud workplan. The Audit Committee were informed that over 91% of NHS GM staff have successfully completed the ESR Fraud e-learning module.
- 10.4 The Audit Committee has also met in private with Internal Auditors to allow discussion of matters in the absence of executive officers.
- 10.5 For both Internal and External Audit, the Audit Committee has ensured that management actions agreed in response to reported weaknesses, have either been implemented or that there has been adequate explanation for delays or non-implementation.

11.0 Head of Internal Audit Opinion (HOIA) 2025/26

- 11.1 The following information has been summarised from the Head of Internal Audit Opinion confirms the basis for the opinion as outlined of the following assessments:
- of the design and operation of the underpinning Assurance Framework and supporting processes including risk management
 - of the range of individual assurances arising from the risk-based internal audit assignments that have been reported through the period. This assessment has taken account of the relative materiality of systems reviewed and the management's progress in respect of addressing control weaknesses identified. Overall, there were 8 substantial opinions, 3 moderate opinions and 1 limited assurance opinion.
 - of the organisation's response to Internal Audit Recommendations, and the extent to which they have been implemented, with reasonable progress made.
- 11.2 The overall Head of Internal Audit Opinion for 2025/26 was **Substantial Assurance**.

- 11.3 The full HOIA opinion can be found within the Annual Report when it is published on the website [NHS Greater Manchester Reports | Greater Manchester Integrated Care Partnership \(gmintegratedcare.org.uk\)](https://nhs.uk/greater-manchester-reports)

12.0 Looking Ahead

- 12.1 Internal and External Audit work plans have been agreed, and an Audit Committee work plan for 2026/27 has been prepared.
- 12.2 A new independent member has been appointed to the Audit Committee, subject to completion of employment checks.

13.0 Recommendations

- 13.1 The Audit Committee is asked to:
- Note the contents of the report.

Whistleblowing Annual Report

17 September 2026

Audit Committee

17 September 2026

Required information	Details
Title of report	Whistleblowing Annual Report
Author	Jenny Noble, Board and Committee Secretary
Presented by	Chris Gaffey, Associate Director of Corporate Services
Contact for further information	Chris Gaffey, Associate Director of Corporate Services chris.gaffey@nhs.net
Executive summary	This report provides an annual update to the committee on whistleblowing for NHS GM. The report also sets out plans for reviewing the Whistleblowing Policy.
The benefits that the population of Greater Manchester will experience.	The Whistleblowing Policy and arrangements are designed to allow people to come forward with information relating to any serious allegations of wrongdoing involving the actions of NHS GM's employees, contractors, or any aspect of NHS GM's activities.
How health inequalities will be reduced in Greater Manchester's communities.	Adequate whistleblowing arrangements ensure serious allegations of wrongdoing can be raised, which could lead to the identification of issues and lead to learning and improvements in services.
The decision to be made and/or input sought	The Committee are asked to: 1. Note the report.
How this supports the delivery of the strategy and mitigates the BAF risks	Ensuring NHS GM has robust whistleblowing arrangements will support delivery of mitigations in relation to the BAF risk which relates to workforce by keeping our staff safe to do their job in the workplace and community.
Key milestones	Policy approved in September 2025
Leadership and governance arrangements	Audit Committee provides oversight of Whistleblowing Arrangements. Whistleblowing arrangements and concerns are managed via the Corporate Governance Team, through the Associate Director of Corporate Services, under the Chief Strategy, People and Partnerships Officer.
Engagement* to date *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/	Previous report went to Audit Committee in June 2025.

approval by groups/ committees.	
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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 accessibility of report

1.0 Introduction

- 1.1. This report provides the Audit Committee with information relating to NHS GM's whistleblowing arrangements, including information on whistleblowing cases received into the organisation.
- 1.2. NHS GM is committed to the highest possible standards of honesty, openness and accountability and will not tolerate malpractice or wrongdoing. The Whistleblowing Policy is designed to allow people to come forward with information relating to any serious allegations of wrongdoing involving the actions of NHS GM's employees, contractors, or any aspect of NHS GM's activities.
- 1.3. The NHS GM Whistleblowing Policy is aimed at non-NHS GM staff (NHS GM staff should refer to the Freedom to Speak Up and Raising Concerns Policy) and has been designed to protect individuals who make disclosures regarding any instance of malpractice or wrongdoing and to investigate them in the public interest.

2.0 Policy

- 2.1. The NHS GM Whistleblowing Policy was approved in September 2025, and is available on the NHS GM website: <https://gmintegratedcare.org.uk/announcement/nhs-greater-manchester-whistleblowing-policy/>
- 2.2. The Policy is due for renewal in September 2027 but was recently updated to reflect changes to the NED Whistleblowing Lead who is now Sue Bailey.

3.0 Whistleblowing Concern

- 3.1. Anybody who has a whistleblowing concern can use our whistleblowing reporting procedures. A person who wishes to report a concern or suspected serious wrongdoing (a disclosure) can contact NHS GM (or other external bodies) via one of the several avenues set out in the Policy.
- 3.2. Since the last report to the Committee in June 2025, there have been eight concerns were considered under the Whistleblowing Policy. Contacts are not always made directly via the contacts listed within the Policy, and come via other routes (for example, into the Complaints Team or directly into service areas), however there is good awareness across

the organisation that Whistleblowing is a Corporate Governance function, meaning these are shared with the team for addressing via the Policy.

- 3.3. Some communications received, on investigation, do not always fall within the remit of the policy and are dealt with via the appropriate process or policy. Of the eight contacts considered under the Whistleblowing Policy, one related to an ongoing MP enquiry, and one was a Freedom of Information (FOI) request, which were addressed via the appropriate process or policy. One case related to a fire and medical equipment provider, which NHS GM did not commission – the concerns had also been raised directly with the Care Quality Commission (CQC), therefore no investigation was undertaken by NHS GM.
- 3.4. Of the other five:
 - One related to a GP contract, which supported an already ongoing investigation.
 - One related to an NHS GM contract concern.
 - One related to performance and workforce related concerns with a GM provider.
 - One related to potential data fraud and illegal detention.
 - One related to clinical negligence.
- 3.5. Of the five cases, four were fully investigated and relevant actions taken. The fifth case (relating to clinical negligence) remains open with an investigation ongoing.

4.0 Next Steps

- 4.1. The Corporate Governance Team will continue to work with the Digital Team to publicise the NHS GM Whistleblowing Policy via its social media channels, and whistleblowing will continue to be an item on the Committee's forward plan (reported at least annually), with any serious concerns reported separately by exception.

- 5.0 In addition, work is ongoing to develop an organisation-wide report that will bring together and triangulate data from different service areas (e.g. whistleblowing, complaints, freedom to speak up) to support the identification of themes and trends across multiple data points.

6.0 Recommendations

- 6.1. The Audit Committee is asked to:
 - Note the update provided including next steps.

Conflicts of Interest Report

17 September 2026

Audit Committee

17 September 2026

Report information.

Required information.	Details.
Title of report.	Conflicts of Interest Report
Author.	Jenny Noble, Board and Committee Secretary
Presented by.	Chris Gaffey, Associate Director of Corporate Services
Contact for further information.	Chris Gaffey, Associate Director of Corporate Services chris.gaffey@nhs.net
Executive summary.	This report provides the Committee with information relation to Conflicts of Interest arrangements for NHS GM, including current compliance and plans to improve this.
The benefits that the population of Greater Manchester will experience.	Ensuring robust conflicts of interest management arrangements are in place will ensure decisions are made with integrity, with the aim of benefiting the GM population.
How health inequalities will be reduced in Greater Manchester's communities.	Ensuring robust conflicts of interest management arrangements are in place will ensure decisions are made with integrity, with the aim of benefiting the GM population.

The decision to be made and/or input sought.	The Committee is asked to: 1. Note the current position on Conflicts of Interest arrangements for NHS GM. 2. Note the plans in place to improve compliances for declarations of interest and to raise awareness of gifts and hospitality declaration requirements.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring robust conflicts of interest management arrangements are in place will ensure decisions are made with integrity, which will support the delivery of the ICP strategy.
Key milestones.	Conflicts of Interest Policy approved in September 2025.
Leadership and governance arrangements.	Conflicts of Interest Management is part of the Corporate Governance function under the Deputy Chief Executive, however Conflicts of Interest is one of the key Policies owned by the NHS GM Board. Regular oversight of Conflicts of Interest is via the People and Culture Sub-Committee.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	All staff communications on conflicts of interest arrangements via Keep Connected.
Financial or Legal Implications	No formal financial or legal implications as a result of the content of this report, however there is a legal requirement for ICBs to ensure they have Conflicts of Interest arrangements in place.

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. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of our residents.
- 1.2. As per the Health and Care Act 2022, each ICB is required to set out its own Conflicts of Interest (Col) Policy and register of interests which all staff and all board and sub-committee members are required to comply with.
- 1.3. NHS GM has a Col Policy in place which can be found on the [NHS GM website](#), which sets out Col requirements and arrangements for NHS GM, including training. The Policy was last approved in September 2025 and was due for review in July 2026. The Policy will be reviewed in due course, however there has been no recent changes to national guidance therefore no material changes would be proposed to the Policy. It is proposed that the review schedule be every three years for this policy going forward (unless changes are required earlier due to changes in national guidance or local processes).

Declarations of Interest

- 1.4. The Corporate Governance Team is responsible for maintaining NHS GM's Col registers (as well as and gifts and hospitality (G&H)), with Col registers in place for the Board and its Committees, a register for "decision makers", as well as an all staff register.
- 1.5. The most recent audit of conflicts of interest management (conducted during the 2023/24 financial year) received substantial assurance. The next internal audit review is scheduled for Q3 of 2026/27.
- 1.6. As ICBs are required to manage conflicts of interest at Board and Committee meetings, declarations of those who are members of these forums but who are not on NHS GM's ESR system (for example, partner members) are captured manually and maintained as part of the Board and Committee registers.
- 1.7. NHS GM's compliance rate for declarations of interest as of 1st September 2026 was approximately 88.53%. As part of the counter fraud return self-assessment, NHS GM is currently RAG rated as "green" in relation to conflicts of interest.
- 1.8. The following actions are being taken to ensure compliance rates are improved:
 - All staff communications sent to remind staff of the requirements around declarations of interest (most recent reminder sent to colleagues in June 2026 through the use of Keep Connected with a deadline to complete by the end of July 2026).

- Reminder raised at a Live Leadership Briefing by Colin Scales on 30th June 2026, to remind colleagues of the importance of completing their declarations of interest on ESR.
- Further reminder to colleagues included on ESR homepage using the announcement banner to remind staff of declaration of interest requirements.
- All staff communications sent out to colleagues through Keep Connected also reminded colleagues to complete Module 1 COI Mandatory Training.

1.9. To ensure these actions are having a positive impact, the Corporate Governance Team will be monitoring the compliance rate via reports directly from the ESR system.

Gifts and Hospitality

- 1.10. As part of our Col arrangements, there are also requirements for staff to declare any offers of gifts and hospitality (G&H). Information on G&H and the declaration requirements associated with these are set out in the Col Policy which is available to all staff (and has been communicated).
- 1.11. A G&H register is maintained by the Corporate Governance Team. Since the previous report to the Audit Committee (June 2025), there has been four declarations made to the team. The NHS GM G&H register for the latest period can be found on the NHS GM website [Publication scheme | Greater Manchester Integrated Care Partnership](#) (under Lists and Registers) (note that the latest version was in the process of being published at the time this report was written).
- 1.12. Compared to the NHS GM staff numbers (circa 1322 members of staff), this could be considered a low reporting rate for G&H. As a non-patient facing, commissioning organisation, the volume of G&H offers made to staff is expected to be relatively low in comparison to overall staff numbers. However, further communication to staff on these requirements, as well as enhancing Col training (further information below) will support an increase in awareness in this area.

Training

- 1.13. In May 2025, it was agreed that NHS GM could now move forward with making Module One mandatory for all staff following the updated module from NHSE.
- 1.14. Communications have been shared with staff in Keep Connected requesting the completion of Module One of the training, and performance is regularly monitored via the People Services mandatory training compliance report. The module is specially designed for completion by ICB staff, Board members and sub-committee members, including temporary appointments, deputies and committee attendees. The training module sets out the importance of keeping declarations of interests up-to-date and having an understanding of the rules on managing conflicts of interest. This includes those employed by other organisations participating in ICB decision making.

- 1.15. As at 31 August 2026, the compliance rate for completion of Module 1 of the Col training was 76.45%, which falls below the organisational target of 95% compliance.
- 1.16. Modules two (for decision makers to complete - Band 8d and above) and three (for Chairs of NHS GM ICB Committees to complete) of the Col training are also available for staff on the ESR system, however further targeted communications are required to ensure completion of these modules by relevant cohorts.

Further Improvements and Actions

- 1.17. Working with the Learning and OD Team, the Corporate Governance Team will implement a focused improvement plan to increase compliance with Module One towards the organisational target of 95%. This will include issuing a further all-staff communication setting out the mandatory requirement and completion deadline; using ESR compliance reports to identify functions and localities with lower completion rates; and asking managers to remind and support outstanding colleagues to complete the module. Where compliance remains below target, the established mandatory training compliance escalation process will be followed through the relevant governance forum, with targeted follow-up action agreed for underperforming areas. Compliance will be reviewed regularly through the People Services mandatory training report, and the effectiveness of these measures will be assessed so that further action can be taken if the required improvement is not achieved.
- 1.18. Further work is planned to take place over the following months to ensure Module Two (designed for decision makers (AfC Band 8d and above)) and Module Three (for Chairs of NHS GM ICB Committees) are completed by the required staff cohorts. The Corporate Governance Team will be working on this in due course, with compliance to be monitored.
- 1.19. Further work is also planned to raise awareness in relation to declarations of gifts and hospitality, due to the perceived or potential underreporting in this area. Further communications will be sent to staff to ensure they are aware of the requirements.
- 1.20. Finally, due to a technical issue, there remains some issues in producing Board and Committee Col registers via the ESR system. The Audit Committee should be assured that the relevant information is captured within the system, however the technical issue relates to producing the Col registers for Board and Committees. Manual changes are made to these where required / possible, and the issue has been escalated to People Services for addressing. It is hoped that this will be resolved shortly.

Recommendations

- 1.21. The Audit Committee is asked to:
 - Note the current position on Conflicts of Interest arrangements for NHS GM.
 - Note the plans in place to improve compliances for declarations of interest and to raise awareness of gifts and hospitality declaration requirements.

Debtors Position Update Month 4 (July 2026) 2026-2027

NHS GM Audit Committee

17 September 2026

Required information.	Details.
Title of report.	Debtors Position Update Month 04 (July 2026).
Author.	Chris Buckley – Finance Manager
Presented by.	Jackie Gardiner – Director of Operational Finance
Contact for further information.	Jackie Gardiner – Director of Operational Finance (Jackie.gardiner3@nhs.net)
Executive summary.	This paper updates the Audit Committee on the total level of debt due to the organisation (£4.4m) and specifically the debt values over 90 days (£1.6m). The paper also covers the value of the bad debt provision (£1.0m) and includes credit notes raised in the period, as well as £78k debt write off which is covered within the losses and special payments paper on the agenda.
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. Note NHS GM's debtor position at the end of July 2026. 2. Note the ongoing actions by the finance team to collect outstanding debt. 3. Note the information presented relating to credit notes.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Not applicable.
Key milestones.	Not applicable.
Leadership and governance arrangements.	The paper has been agreed by the Director of Operational Finance.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	The paper has been agreed by the Director of Operational Finance.
Financial or Legal Implications	The report presents the current level of debt and the provision value to cover the risk of non-NHS debtors not being recovered. There are no specific legal implications of the report.

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

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

Table 2: Assurance needed about the document.

Version Number v1.1

Introduction

- 1.1. The paper is presented to update the Audit Committee on the level of debtors for NHS Greater Manchester (NHS GM) as at the end of July 2026, the level of the existing bad debt provision and the value of credit notes raised in the period

Debt Detail

- 1.2. The total value of debtors outstanding is £4.3m, of which £1.6m (36.59%) has been outstanding over 90 days. Since the last Audit Committee report (April 2026), the overall debt has reduced by £14.3m and the 90 days overdue debt has increased by £0.07m.
- 1.3. The reduction in overall debt at July 2026 is due to a change in process relating to the Salford City Council risk share agreement. The final invoices raised to Salford City Council totalled £10.2m, which have now been settled.
- 1.4. The current total debtor is summarised in Table 1 and consists of:
- £3.6m relating to non-NHS organisations
 - £0.7m relating to NHS bodies

Table 1: Total Debt Summary

	Debtors Not Yet Due £'000	Debtors 1-30 Days £'000	Debtors 31-60 Days £'000	Debtors 61-90 Days £'000	Debtors 91-120 Days £'000	Debtors 121-180 Days £'000	Debtors 181-360 Days £'000	Debtors 361+ Days £'000	Debtors Total £'000
NHS bodies	410	294	0	0	0	0	0	2	706
Non-NHS bodies	1,295	608	-216	368	10	39	202	1,340	3,646
Total	1,705	902	(216)	368	10	39	202	1,342	4,352

Non-NHS Debt

- 1.5. The total non-NHS debt is £3.6m, of which £1.6m is over 90 days overdue and is analysed in Table 2.

Table 2: Summary of non-NHS debt by debtor category.

	Debtors Not Yet Due £'000	Debtors 1-30 Days £'000	Debtors 31-60 Days £'000	Debtors 61-90 Days £'000	Debtors 91-120 Days £'000	Debtors 121-180 Days £'000	Debtors 181-360 Days £'000	Debtors 361+ Days £'000	Debtors Total £'000
Local Authorities	594	537	(288)	366	0	21	0	292	1,522
Non NHS Health Bodies	21	14	25	2	0	0	11	61	134
Non-NHS Companies	680	56	47	0	10	18	14	972	1,797
Individuals	0	1	0	0	0	0	177	15	193
Total	1,295	608	(216)	368	10	39	202	1,340	3,646

- 1.6. The main elements of the non-NHS £1.6m over 90-day debt are as follows:
- Non-NHS Companies debt accounts for £1.0m of the £1.6m outstanding debt, of which:

- £0.4m relates to dental contractual payments previously reported to Audit Committee, where the dentist has been declared insolvent, with liquidation procedures on-going.
- £0.2m relates to a home care provider previously reported to the Audit Committee, which is being offset by care costs. To date £60k has been recovered.
- £0.3m relates to an optician who is under investigation by NHS Counter Fraud.
- A small balance remains and is accounted for over 11 organisations. Please note that this includes a balance related to the previously reported dental repayment plan which the contractor has defaulted on (£27k is over 90 days, with a total value outstanding of £120k).
- Please note that £22k of the reported balance has been agreed for write off in line with the Scheme of Delegation.
- Local Authority debt accounts for £0.3m of the £1.6m overdue debt. As reported at the previous Audit Committees, Bury Council are disputing invoices from NHS GM, the value of which is £0.31m. The senior finance team continue to liaise with the Council to resolve issues and secure payment. Please note that £2k of the reported debt has been approved for write off in line with the scheme of delegation as part of the £78k in total.
- Non-NHS Health Bodies overdue debt accounts for £72k of the total debt, which largely relates to GPs. The largest element relates to one practice (£38k), with the remaining balance accounted for across three organisations. NHS GM continues to engage with these GP practices to secure recovery. Please note that £39k of this balance has been approved for write off in line with the Scheme of delegation as part of the £78k approved in total.
- Individuals account for £0.2m, of which the majority relates to a PHB clawback, which is being disputed by the debtor. Please note that £15k of the balance has been agreed for write off.

Allowance for Bad Debt

- 1.7. The current bad debt provision for 2026/27 is £1.0m, which is in line with the year-end position reported.
- 1.8. The provision is calculated based on the following assumptions:
 - Debts that are over 12 months old and not subject to a payment plan are provided in full.
 - The proportion of debts from the previous year end which have not been recovered is calculated for each category of debtors and then applied to the outstanding balance.

- Specific adjustments are then made to increase the provision for specific cases utilising the Financial Control team's knowledge of debtors' situations

1.9. The bad debt provision will reduce by £78k due to 14 write off's agreed with the CFO in line with the Scheme of Delegation and actioned during August 2026 on the system. The detail of these is covered in the losses and special payments paper.

NHS Debt

1.10. A breakdown of the over 90-day NHS debt totalling £2k is detailed in Table 3.

Table 3: Summary of NHS Debt over 90 Days

NHS Body	Total Debtors over 90 Days £'000
NHS England	0
Others	2
Total	2

1.11. This is a reduction from the £38k reported as at the end of March 2026 principally due to the settlement of aged staff recharge debts from NHS England.

Activity

1.12. During the period April to July 2026, 282 invoices and credit notes were raised, totalling £6.6m of net debt. It should be noted that much of this relates to recharge elements and therefore does not feature as income in NHS GM's accounts, but instead as credits to offset expenditure.

Credit Notes

1.13. Table 4 summarises the credit notes raised during the period April to July. These did not impact on the reported position of the organisation as they were adjusted within month end closedown procedures.

Table 4: Summary of Credit Notes

Reason for Credit Note	Number of Credit Notes	Amount £	Replacement Invoice raised if applicable
Incorrect Value	3	(635,976)	Yes
Incorrect Supplier	1	(707)	Yes
Service/Goods not provided	14	(220,770)	No
Invoice image issues	3	(28,887)	Yes
Other	2	(4,763)	No
	23	(891,102)	

Recommendations

1.14. The NHS GM Audit Committee is asked to:

- Note NHS GM's debtor position at the end of July 2026.
- Note on-going actions by the finance team to collect outstanding debt.
- Note the information presented relating to credit notes.

Losses and Special Payments including Bad Debt Write off 2026-2027

September 2026

NHS GM Audit Committee

17 September 2026

Required information.	Details.
Title of report.	Losses and Special Payments including bad debt write off.
Author.	Kaye Abbott, Associate Director of Finance – Financial Control. Alistair Ross, Head of Statutory Reporting.
Presented by.	Jackie Gardiner, Director of Operational Finance.
Contact for further information.	Alistair Ross, Head of Statutory Reporting
Executive summary.	The report presents the Losses and Special Payments incurred by NHS GM between April and August 2026. Further information in respect of the specific costs is included separately.
The benefits that the population of Greater Manchester will experience.	Losses and Special Payment reporting is an important part of NHS GM's governance, as it represents reporting on costs incurred which are non-standard and would not have been part of Parliament's expectation when allocating funding to the organisation.
How health inequalities will be reduced in Greater Manchester's communities.	N/a
The decision to be made and/or input sought.	This report is provided for information only. The Committee is asked to: 1. Note the contents of the report
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Not applicable.

Key milestones.	Not applicable.
Leadership and governance arrangements.	The expenditure contained within this report has been authorised in line with the Scheme of Delegation. The Loss/Special Payment is subject to separate assurance processes and has been separately authorised by the CFO. The paper has been agreed with the Director of Operational Finance.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	Legal advice is sought where relevant depending on the individual cases. The Financial Control team is consulted prior to the approval of any payments made. The paper has been agreed with the Director of Operational Finance
Financial or Legal Implications	There are no general financial or legal implications of this report. The individual losses and special payments have been authorised and accounted for in the reported financial position. There may be legal implications from the individual losses and special payments, which are considered specifically as the costs are recorded.

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
N/a	N/a	N/a	Yes	N/a	Yes	Yes

Table 2: Assurance needed about the document.

Introduction

- 1.1. Losses and Special Payments are transactions which public bodies are not expected to incur, and therefore, under the principles of Managing Public Money, are subject to increased scrutiny. In general, Losses and Special Payments represent transactions which would not have been intended by Parliament when voting funds to public bodies.
- 1.2. This paper considers the register of Losses and Special Payments for such transactions incurred within the current financial year to date (2026/27 Month 5).
- 1.3. Details of the individual cases are considered to be exempt from disclosure in public meetings as they relate to specific circumstances of individuals or individual cases. Therefore, this paper considers the summary register of Losses and Special Payments which can be found in Appendix A of this report.

Losses and Special Payments incurred

- 1.4. This is the first report presented in 2026/27. If there are any further losses and special payments an updated register will be provided, including commentary relating to the additional cases only.

Case ref LSP 2627 - 001

- 1.5. A special payment of £196.77 has been made due to NHS GM paying statutory interest and additional costs to a creditor following a court claim under the Late Payment of Commercial Debts Act.
- 1.6. This is a special payment, as payment of penalties and interest is expenditure incurred otherwise than Parliament would have intended.
- 1.7. The incident relates to the late payment of an invoice due to system issues relating to invoice scanning and supplier set up, which resulted in a delay to payment. The counterparty issued proceedings against NHS GM to recover the debt due, and to claim statutory interest and court filing costs. NHS GM agreed to make the payment to avoid incurring additional costs in defending the case at court, and the late payment was accepted.
- 1.8. Invoices for voluntary redundancy legal fees have been subject to scanning errors, partly due to the scanning software identifying the colleague's postal address (which is printed on the invoice as the solicitor's contract of engagement is with the individual, rather than the ICB) rather than the NHS GM invoicing address.
- 1.9. The payment and option to settle the case was agreed with the Chief Finance Officer (CFO). This is in line with the Scheme of Delegation, which permits the CFO to agree to Special Payments up to a value of £50,000.

- 1.10. As the case was neither novel, contentious or repercussive, and the settlement payment was of low value, the case did not require referral to or approval from NHS England or HM Treasury.

Case ref LSP 2627 - 002 (14 instances)

- 1.11. Losses are reported as NHS GM has written off 14 separate invoices due from debtors on the grounds that these are not considered possible to recover. The 14 invoices total £78,846.50.
- 1.12. These are considered to be losses, as whilst it was correct for NHS GM to raise invoices at the time, the funds are no longer thought to be recoverable, and therefore NHS GM has lost access to the associated economic resources.
- 1.13. Whilst the 14 invoices relate to individual situations, there are broad trends presented, which are included in the table below:

Category	Number	Value (£)
Former staff debtors – uneconomic to pursue	5	1,563.01
Debtors with no prospect of recovery due to economic position of the debtor	6	55,926.63
Debtors transferred to NHS GM from predecessor organisations with insufficient documentation to enforce	3	21,406.86
Total	14	78,896.50

- 1.14. Action has been taken by the NHS GM Financial Control team to recover these debts, but after multiple attempts, none of these debts have been recovered. Please note that many of these debts have transferred from predecessor organisations to NHS GM.
- 1.15. The financial impact of writing off these debts is nil in terms of the financial position of the organisation, as they have been provided for within the current £1.0m allowance for irrecoverable debts.
- 1.16. The allowance for irrecoverable debts will need to be reviewed through the year and may require increasing at the year end.

- 1.17. The debt write off was agreed with the Chief Finance Officer, which is in line with the Scheme of Delegation, which permits the CFO to agree to incur such losses up to £50,000 per individual case.
- 1.18. As the cases were neither novel, contentious or repercussive, and the settlement payment was of low value, the case did not require referral to or approval from NHS England or HM Treasury.

Case ref LSP 2627 - 003

- 1.19. This case is equivalent to case ref LSP 2627 – 001 reported above. The payment relates to interest and court fees under the Late Payment of Commercial Debts Act, with this case being of value £150.40 (in addition to the value of the invoice itself).
- 1.20. The underlying causes are similar to case LSP 2627 – 001, with part of the delay being related to the incorrect invoicing address being provided, and then subsequent invoice processing delays through the Finance system.
- 1.21. The payment was approved by the Chief Finance Officer (being less than the £50,000 limit in the Scheme of Delegation) and this case is not considered novel, contentious or repercussive.
- 1.22. The Operating Costs Finance Team has reviewed the remaining outstanding legal fee cases where there are outstanding invoices to proactively prevent these penalties occurring again. There were system issues impacting on one invoice, which have now been resolved. For the remaining invoices which are known to be outstanding, NHS GM does not have contact details for the legal advisors, as they were engaged by individual colleagues, so is unable to proactively approach providers. However, the team will seek to respond to inbound queries and make prompt payment to settle such liabilities where contact is made.

Recommendations

- 1.23. The NHS GM Committee is asked to:
 - Note the contents of this report

Appendix A

QOP NHS Greater Manchester ICB

Losses & Special Payments Register 2026/27



Greater Manchester

	Date of Loss/SP	Ref	Date Approved	ICB contact	£	Accounting Treatment
Losses						
Debt write offs (14 items)	01/08/2026	LSP26-27 - 002	08/08/2026	Alistair Ross	78,846.50	Loss
					78,846.50	
Special Payments						
Small Claims Court - legal fees	23/07/2026	LSP26-27 - 001	23/07/2026	Carol Shannon-Jarvis	196.77	SP is the interest under the late payment of commercial debts Act, and the court and legal fees
Small Claims Court - legal fees	21/08/2026	LSP26-27 - 003	21/08/2026	Carol Shannon-Jarvis	150.40	SP is the interest under the late payment of commercial debts Act, and the court and legal fees
					347.17	
Total L&SP 2026/27					79,193.67	