Bristol, North Somerset and South Gloucestershire ICB Annual Report 1 July – 31 March 2023

Contents

PERFORMANCE REPORT

Shane Devlin

Accountable Officer

29 June 2023

Performance Overview

This performance overview provides a summary explaining what NHS Bristol, North Somerset and South Gloucestershire ICB does, the key risks faced in 2022/23 and how the ICB performed against a range of measures. We describe performance in detail in the Performance Analysis section (p13)

Chair and Chief Executive's statement

Welcome to our Annual Report for 2022/23. It has been a unique and busy year as we moved on from the Clinical Commissioning Group model to launch the new Integrated Care Board (ICB).

As with the development of any new organisation there are going to be many challenges and opportunities. We are working with our partners, to improve health and wellbeing, reduce inequalities, and provide integrated services for the one million people living in Bristol, North Somerset and South Gloucestershire. The move to an ICB has given us the opportunity to build on the successes of our partnership to date, but also to accelerate progress on behalf of the people and communities we serve.

It has also been a pressured year for our wider health and care system, with sustained challenge across all services. The ongoing impacts of the Covid-19 pandemic combined with staff sickness, industrial action and increased demand, have meant longer waits for some services. It has also meant that our dedicated staff have had to work very differently at times – something we are hugely grateful for. People have stepped up to significant challenges this year to continue to provide safe and effective care to everyone who needs it.

This year we have focussed on getting the foundations of our ICB right so that we can achieve our purpose of improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money and supporting broader social and economic development.

We have taken this work forward through a wide range of initiatives and activities. For example, we have further strengthened the system Clinical Assessment Service (CAS) within NHS 111, so that a greater range of professionals are now available to provide advice online and over the phone. This has helped more people get to the right care for their needs first time and reduced pressure on busy Minor Injuries Units and Emergency Departments. Our new Care Traffic Co-ordination System is another exciting project that provides us with a live overview of the pressures in our health and care system. Drawing

on sophisticated analytical capabilities, it is enabling us to make more informed decisions about how we deliver urgent and emergency care, on a daily basis. General Practice has also worked differently to overcome the constraints brought about by the pandemic, including the expansion of primary care teams to include a greater range of professionals, and improving remote and online triage.

We started the year with significant numbers of long waiting patients, with over 400 people waiting 104 weeks or more and over 1,400 people waiting 78 weeks or more. We have made significant progress in tackling these backlogs and will close this year with 11 people who have been waiting for 104 weeks or more and 254 people who have been waiting for 78 weeks or more.

We are proud to say that to support our aims of improving people's health, our GP's have ensured that over 80% of people with a learning disability have had an Annual Health Check in the last year, with at least 95% receiving a Health Action Plan, the highest completion rate in the Southwest.

This focus on working differently and smarter will continue to be a hallmark of our approach as we look to the future, getting the best value from every pound we spend. We are committed to working together as an integrated health and care system to increase access to healthcare whilst also focussing collectively on ensuring that people are supported to stay well and independent in their own homes wherever possible. Alongside strengthening our community services, this also means improving flow through our hospitals, so that people can be discharged home in a timely way – where we know people can recover their independence more fully.

We have achieved a lot in our first year and would like to take this opportunity to say thank you to all of our staff, across all of our partners, who have played a role in these achievements. It is our people that will continue to be the driving force within the Integrated Care Board, and as we seek to make a difference in the health, wellbeing and lives of the population we serve.

Shane Devlin, CEO

Jeff Farrar, Chair

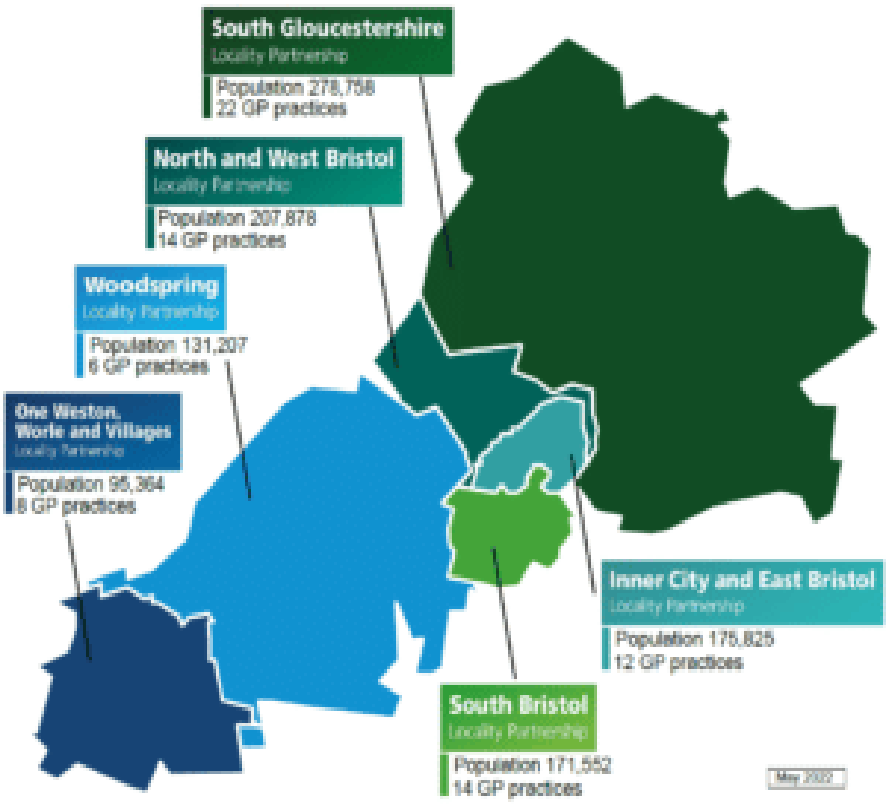
Performance Overview

About Bristol, North Somerset and South Gloucestershire Integrated Care Board

Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) is a statutory NHS organisation that was established on the 1st July 2022. We are responsible for developing the plans to meet the health needs of our population, managing the NHS budget and arranging for the provision of health services in our area. We are part of the local Integrated Care System, Healthier Together Partnership. Integrated Care Systems bring together a range of partner organisations to help people stay happy, healthy and well for longer. Designed to ensure that health and care services join up around individual needs, Integrated Care Systems break down the boundaries between physical health, mental health and social care. Our ICS is made up of 10 partner organisations including the three Local Authorities in our area, the ICB, NHS Trusts, community providers, general practice and other partners. Locality Partnerships have been established within our ICS, working at a 'place' level and responding to the specific needs of local people. ICBs' to are expected to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcome, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

Figure 1: Bristol, North Somerset and South Gloucestershire Integrated Care System



Population of 1 million served by:

- 1 Integrated Care Board planning NHS services
- 6 integrated locality partnerships
- 3 local authorities and Health and Wellbeing Boards
- 56 children's centres
- 278 care homes
- 1 GP Federation with 76 general practices and 19 primary care networks
- 1 Primary Care Out of Hours and 111 service
- 171 pharmacies
- 135 dentists
- 101 opticians
- 1 community care provider
- 1 Healthwatch
- 1 mental health trust
- 1 ambulance service trust
- 1 Academic Health Science Centre
- 2 acute hospital providers
- Hundreds of voluntary, community and social enterprise organisations

Bristol, North Somerset and South Gloucestershire is home to about 1.1 million people and our diverse population has varied health needs. The numbers of people aged between 15 and 24 years old and people over the age of 60 years are growing, and the population predicted to increase most significantly over the next 25 years is those aged 85 and over. We are an ethnically diverse population, with Bristol having the greatest proportion of Black and Minority Ethnic (BME) people (16%) compared to South Gloucestershire (5%) and North Somerset (2.7%). There are significant pockets of deprivation across Bristol, North Somerset and South Gloucestershire, with around one in ten people living in a deprived area. Average life expectancy varies between those living in the most and least deprived areas by around six years, with some places seeing a 15-year difference.

Our priorities and plans for 2023/24 are set out in our One Year Operational Plan (6.1-Our-system-operational-plan-2023-24-ICB-Board-May-2023.pdf). Our plan reflects spending commitments required by NHS England and also includes our local commitment to continue investing in our Home First and Healthy Weston transformation programmes, continued investment in Urgent Care and additional planned care beds.

Our Home First programmes focus on home-based rehabilitation and reablement and aims to reduce peoples' onward care needs and relieve the pressure on our hospital system. Healthy Weston concentrates on the development of services in Weston super Mare and Weston General Hospital:

- expanding same day emergency care,
- providing a one-stop urgent surgical assessment clinic,
- creating a centre of excellence for older people and
- establishing a centre of excellence for planned surgical care

We are also committing resources to reduce health inequalities. Our planning processes have ensured that plans include how they will reduce health inequalities and promote inclusivity. Plans also need to identify whether unintended health inequalities might emerge from them and, if this is the case how these will be tackled.

Our Joint Forward Plan sets out how we will deliver the national vison of high-quality healthcare for all, with equitable access, excellent experience and optimal outcomes. Our plan describes how we plan to achieve and delivery the priorities set out in our strategy over the next five years. The plan builds on the work of our local Health and Wellbeing Boards, our Locality Partnerships and our 2023/24 Operational Plan. Our Joint Forward Plan will be refreshed annually to provide a five-year rolling plan. As our partnerships develop and the wider system matures our plans will increase in depth and breadth. Our plan sets out how we will work together with partners to:

- Improve the lives of our children
- Improve the lives of people in our communities
- Improve the lives of people with mental health issues, learning disabilities and autism
- Improve the outcomes for people using our hospitals

We set out the key enablers to support our ambitions and the work needed to take these forwards:

- Workforce
- Digital
- Population Health Management
- Research and Innovation
- Estates
- Finance and Procurement
- Health and Care Professional Leadership
- Medicines Optimisation

Throughout both our Operational Plan and our Joint Forward Plan we have embedded the triple aim (Section 14z43 NHS Act 2006 as amended by The Health and Care Act 2022), to ensure that we consider the effects of our decisions on:

- The health and wellbeing of local people
- The quality of services provided and arranged
- The sustainable and efficient use of resources

To help us to achieve our objectives we have looked at our organisation structure and developed a new operating model. We have 8 directorates lead by the following directors:

- Strategy, Partnerships and Population – Colin Bradbury
- People – Jo Hicks
- Business and Planning – Sarah Truelove
- Performance and Delivery – Lisa Manson
- Transformation, Data, and Digital – Deborah El-Sayed
- Integrated and Primary Care – David Jarrett
- Chief Medical and Chief Nurse Office – Jo Medhurst and Rosi Shepherd
- Office of the Chair and Chief Executive – Shane Devlin

Summary of key risks to delivering objectives

Our healthcare system continued to face significant challenges during 2022/23. Key risks reported through performance reports to the Board and highlighted on the ICB internal corporate risk register included:

- Improving performance across planned and urgent care, including ambulance services and ensuring that mental health services were able to meet the demands placed on them continued to areas of focus.
- The impact of Covid-19 on services, staff and the implementation of long-term plans. There was a particular focus on the impact on waiting times for urgent care, elective care services, diagnostics, mental health services and ambulance services.
- Risks relating to health inequalities and the risk of increasing health inequalities for specific groups were highlighted
- Risks relating to Healthcare Associated Infections
- The delivery of improved population health and financial sustainability

- Organisational restructuring within the Integrated Care Board deflecting time and resources from the need to deliver change quickly

Mitigating actions were put in place to manage and reducing the likelihood of these risks materialising. More detail regarding performance and actions taken is provided in the Performance Analysis section of this report (p13)

Adoption of the going concern basis

The ICB has reported a small surplus of £3,000 against the ICB Revenue Resource Limit of £1,489,985,000 (full year of £1.943,961,000).

Table 1

Revenue resource limit	CCG	ICB	Total
	£m	£m	£m
Revenue resource limit	(453.976)	(1,489.985)	(1,943.961)
Net Expenditure	453.976	1,489.982	1,943.958
Surplus/(Deficit)	**-**	**0.003**	**0.003**

The ICB inherited an accumulated deficit from Bristol, North Somerset and South Gloucestershire CCG caused by prior year deficits, including of predecessor bodies, against its Revenue Resource Limit of £117,059,000. However, the financial framework for ICBs states that if the ICB 'system' achieves breakeven or better against the In Year Resource Limit for the next 2 financial years the requirement to repay the accumulated deficit will be withdrawn.

These accounts have been prepared on a going concern basis.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of ICBs across England and abolished CCGs. ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

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

When clinical commissioning groups ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). Should the Integrated Care Board cease to exist, it would consider whether its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

The ICB's revenue allocations are backed by cash limits. The ICB expects to maintain a positive cash flow and continue to meet the Better Payment Performance standard.

On this basis, the ICB considers it remains a Going Concern and the financial statements are prepared on this basis.

Summary of performance

Overview of how ICB performance is measured

The Regulatory and oversight framework is being revised in light of the 2022 Act.

The overarching approach is via the NHS Oversight Framework and reiterates the commitment that NHS England will work through and will support ICBs to deliver services for their population.

In relation to how ICB performance is measured this is through the NHS Oversight Framework which consists of five national themes with associated high-level metrics that reflect the ambitions of the NHS Long Term Plan and apply across trusts and ICBs:

- Quality of care
- Access and outcomes
- Preventing ill-health and reducing inequalities;
- People; finance and use of resources;
- Leadership and capability

And a sixth theme of local strategic priorities.

Each ICB will be placed into a segment based on assessment against the NHS Oversight Framework. Bristol, North Somerset and South Gloucestershire ICB is currently in segment 3. The following table displays the segmentation descriptions at ICB and Trust level and the support needs associated with each segment.

Table 2

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

The following table shows Bristol, North Somerset and South Gloucestershire performance against NHS Constitutional Standards.

Key to symbols in table 3 below:

 Better than last year but not achieving standard

 Achieving standard

 Worse than last year and not achieving standard

Table 1: 2022/23 YTD performance compared to 2021/22 Year end

		BNSSG		
Indicator	**Standard**	**2021/22**	**2022/23**	**Change**
Percentage of patients admitted, transferred or discharged from A&E within 4 hours (BNSSG Acute Trusts Total)	95%	64.98%	60.74%	
Percentage of patients on an incomplete RTT Pathway waiting less than 18 weeks	92%	65.40%	64.12%	
Number of patients on an incomplete RTT Pathway waiting more than 52 weeks	1	3,779	4,961	
Percentage of patients waiting six weeks or more for a diagnostic test (15 key tests)	1%	37.90%	32.18%	
Maximum two-week wait for first appointment for patients referred urgently for suspected cancer	93%	64.90%	48.87%	
Maximum two-week wait for first appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	28.20%	41.56%	
Percentage of patients receiving a diagnosis or ruling out of cancer, or a decision to treat within 28 Days of an urgent referral for suspected cancer (new standard for 2021/22)	75%	66.80%	57.40%	
Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	96%	92.50%	90.83%	
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	81.10%	71.71%	
Maximum 31 day wait for subsequent treatment where that treatment is anticancer drug regimen	98%	99.00%	98.06%	
Maximum 31 day wait for subsequent treatment where that treatment is radiotherapy	94%	99.70%	99.40%	
Maximum 62 day wait from urgent GP referral (two-month wait) to first definitive treatment for cancer	85%	68.80%	53.87%	
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for cancer	90%	59.60%	57.95%	
Total Number of CDIFF Cases	<same period previous year	304	230	
Total Number of MRSA Cases Reported	0	38	23	
Eliminating Mixed Sex Accommodation	0	2	13	

Performance analysis

The following pages provide a more detailed summary of performance, key activities and programmes of work including:

- Work to improve the quality of services
- How we have worked to improve Safeguarding
- How we have engaged with people and communities
- Work to reduce health inequalities and promote equality across the local community and workforce
- Work with local Health and Wellbeing Boards
- Sustainable development
- A summary of our financial position. This is given in detail in the Annual Accounts section of the Annual Report (p114)
- The actions to tackle fraud and bribery are described in the Governance Statement (pxx)

Through performance management we ensure services delivered achieve good outcomes for our population and provide value for money. Performance is monitored and reported through:

- Finance: detailed financial plans are created to plan for patient care activity and outcomes, and to monitor the in-year performance of our providers
- Performance against NHS Constitutional Standards
- Performance in quality and outcomes: to ensure services are safe, patients have a positive experience of healthcare, and improvements in clinical outcomes are delivered

Performance of NHS Services 2022/23

The ICB is assessed on its performance against constitutional targets which form the basis of the operational plan for 2022/23 agreed with NHS England. Key constitutional targets relate to urgent care, planned care, mental health, learning disabilities and autism and community services including urgent care response within two hours.

Planned Care and Cancer Care

2022/2023 has been a challenging year for our system in relation to planned care and the numbers of patients waiting for treatment. The impacts of the OMICRON Covid surge in the spring and early summer of 2022 had significant impacts on recovery and in particular caused very high levels of sickness among our planned care workforce. Recovery across many aspects of planned care and cancer care has, gained momentum throughout the autumn and winter, despite the additional pressures the NHS faced during winter and the recent impacts of Industrial Action. This has been achieved through providing more appointments in the evenings and super clinics at the weekends as well as using Independent Sector providers to support the delivery of NHS care.

Whilst the referral to treatment standard of 18 weeks remains as a constitutional standard, the national focus has been directed to the backlog of patients that have been waiting a long time for treatment as a result the Covid-19 pandemic. Our system started the year with significant numbers of long waiting patients, with over 400 people waiting 104 weeks or more and over 1400 people waiting 78 week or more. We have made significant progress in tackling these backlogs and will close this year with 11 people who have been waiting for 104 weeks or more and 254 people who have been waiting for 78 weeks or more. Of the people who have been wating 104-week waiters or more, four are waiting due to the complexity of the treatment they need, which is only available from a small number of providers, four are waiting because there is a national shortage of the graft material they need for their surgery and two patients have requested to delay their treatment at this time. Over a quarter of people waiting over 78 weeks have requested to do so, over half require complex treatment and 42 of this number are waiting as a result of the national shortage of graft material. Some of the remaining patients have requested to wait on a list for their preferred provider or consultant.

As a system, we have not met all diagnostic waiting targets or planned activity levels across all diagnostic tests. Across all systems in the South West region, a target for 2023/24 was set for all diagnostic services to achieve; the target is for no more than 25% of patients waiting more than six weeks for their test and with no people waiting over 26 weeks for their test. Our system has achieved this for most diagnostic imaging services. We still have a high number of people waiting for endoscopy services but our future strategic plans to realise greater capacity in this diagnostic will be realised with the introduction of community diagnostic centres in 2023/24. Our system is working with independent sector partners expand capacity in planned care and diagnostics to achieve the national targets and help to improve the experiences and outcomes of local people.

The numbers of people waiting more than 63 days for cancer treatment have reduced significantly and are now at lower than pre-covid levels. This has been achieved through improving transition through earlier steps in the cancer pathways, increasing capacity and making more appointments available through, for example, weekend mega clinics for breast cancer services. The numbers of people receiving their first treatment for cancer has increased. We have not achieved the 28-day faster diagnosis standard at either system or trust level but for our population we have improved from 56.43% in January 2022 to 61.31% in January 2023 and our diagnostic modality improvement in waiting time standards has contributed towards this achievement. We are routinely meeting the 94% target for maximum 31 day wait for subsequent treatment where treatment is a course of radiotherapy as well as meeting the 98% target for maximum 31 day wait for subsequent treatment where treatment is an anti-cancer drug regime.

We understand how difficult it is for people to wait for long periods of time to receive the treatment and care they need. We will continue to work together as a system to significantly reduce waiting times for our local people.

Urgent Care

We have experienced continued pressures in urgent and emergency care in relation to numbers of attendances to emergency departments for adults and children as well as pressures caused by outbreaks like Flu and Norovirus, which were significantly reduced in

previous years due to social distancing. We have worked as a system with our partners to respond to these demands and ensure safe services are in place. We are working with University Hospitals Bristol and Weston Foundation Trust (UHBW) to review the children's emergency department flow to create more space and enabling more timely triage and treatment for children. We have made good progress into our ambulance handover delays performing to our local trajectory and reducing from 6,888 hours lost in ambulance handovers in April 2022 to 2,592 hours lost in handovers in February 2023.

We are also continuing to work on creating pathways away from hospital which enables more timely access to care for our patients We have created a system clinical assessment service in our Integrated Urgent Care service (accessed via 111) to provide greater clinical validation (clinician call back to patient) of ambulance and emergency treatment outcomes, improving from 64% validation in April 2022 to 81% validation in February 2023, as well as now validating 111 Online ambulance outcomes, all reducing the number of patients that need to be managed via 999 or attend hospital.

Mental Health, Learning Disabilities & Autism

The following table shows our performance against NHS Long Term Plan and Operational Plan Targets for mental health, Learning Disabilities and Autism services.

Key to symbols in table 1 below:

 Better than last year but not achieving **national target.**

 Achieving **national target.**

 Worse than last year and not achieving **national target.**

Table 4: 2022/23 YTD performance (Feb-22) compared to 2021/22 Year end

Indicator	Org	2022/23 National Target	2022/23 Local Target	2021/22	2022/23	Change
IAPT Access	BNSSG ICB	29936	29936	21900	18136	
Estimated Diagnosis Rate for people aged 65+	BNSSG ICB	66.7%	66.7%	65.4%	66.4%	
The proportion of CYP with ED (routine cases)	BNSSG ICB	95.0%	95.0%	86.8%	88.4%	
The proportion of CYP with ED (urgent cases)	BNSSG ICB	95.0%	95.8%	84.8%	95.7%	
Inappropriate OAP bed days for adults	BNSSG ICB	0	309	506	122	
Inappropriate OAP bed days for adults	AWP	0	450	747	122	

People with severe mental illness receiving a full annual physical health check	BNSSG ICB	5344	5000	4630	4599	
Number of Women Accessing Perinatal MH services	BNSSG ICB	1164	1099	635	793	
Number of people accessing IPS services	BNSSG ICB	714	714	193	193	
Data Quality Maturity Index Score (DQMI)	AWP	90.0%	95.0%	95.0%	93.9%	
People who receive two or more contacts from NHS or NHS commissioned CMH services for adults and older adults with SMI	BNSSG ICB	4177	4200	703	6735	
Adult mental health inpatients receiving a follow up within 72hrs of discharge	BNSSG ICB	80.0%	80.0%	52.7%	86.5%	
First episode of psychosis treatment within 2 weeks of referral	BNSSG ICB	60.0%	60.0%	61.5%	76.9%	
Improving Access to CYPMH Services	BNSSG ICB	10998	8948	5591	7830	
Reliance on inpatient care for people with a LD and/or autism - Adults in ICB beds	BNSSG ICB	9	13	16	10	
Reliance on inpatient care for people with a LD and/or autism - Adults in NHSE beds	BNSSG ICB	13	13	19	19	
Reliance on inpatient care for people with a LD and/or autism - Children <18 in inpatient care	BNSSG ICB	<7	<7	<7	<7	
Annual Health Checks delivered by GPs for those on the LD register aged 14+ in the period	BNSSG ICB	3825 (75%)	3825 (75%)	3496	3614	

Access for Talking Therapies continues to be an issue for services nationally as well as locally within Bristol, North Somerset and South Gloucestershire. This is predominantly due to difficulties in recruitment for Psychological Wellbeing Practitioners (replicated in the South West and nationally) and a lack of referrals into the service. Vita has a dedicated Partnership liaison team who actively reach out across our area to promote Talking Therapies. Regular conversations are ongoing with regional NHS England colleagues as well as Health Education England around workforce requirements including using NHS England South West's new workforce calculator tool to ascertain trainee numbers for 2023/24.

Our system is doing well on the estimated dementia diagnosis rate for people aged 65+. Bristol and North Somerset exceed the target rate and estimated diagnosis rates for people aged 65+ in South Gloucestershire have been improving since June 2022. Historically the dementia diagnosis rate for Bristol has consistently met or exceeded the national targets, and since March 2022 we have seen a significant increase in performance in both South Gloucestershire and North Somerset which has improved our overall dementia diagnosis rate.

There has been a steady improvement from 2022 on the proportion of children and young people with an eating disorder being seen on time and a positive trajectory into 2023/24. Historically our system has not created enough access into mental health services for children and young people and this has resulted in prioritisation of a service expansion in 2023/24.

We have improved the number of inappropriate out of area bed days for adults. Performance is currently ahead of the trajectory set locally with 3-4 people outside of the local footprint.

We are on target to delivering a full annual physical health check for people with a severe mental illness. This target requires a system approach working with primary care and our mental health provider Avon and Wiltshire Partnership Trust (AWP).

The number of women accessing perinatal mental health services is below the long-term plan target. This target was based on the birth rate recorded in 2016 birth rate and our birth rate in 2020 was lower than this number. We are working closely with AWP to target specific referrers and help increase referrers into the team. AWP and the ICB will also continue to work with both UHBW and North Bristol Trust (NBT) to improve the data flows between trusts. Both AWP and the ICB are working with four VCSE providers to design a service model that will support women in and out of specialist team, including dedicated community outreach to underserved parts of the population. This should help to increase the number of referrals to the specialist team.

Reliance on mental health inpatient beds that we have commissioned for individuals with a learning disability and or Autism has steadily decreased during 2022/2023, and now sits below the target of 13. There is greater use of mainstream beds, which demonstrates that individuals are being admitted appropriately due to mental health conditions and not because of behaviours related to their learning disability and or Autism. There is a lack of community provision and work force difficulties, which includes a major issue with care coordination which is impacting on timely discharges from hospital beds.

Table 5

Financial Years	2021/22	2022/23 Annual MHIS Spend	2022/23 Months 4 to 12 MHIS Spend
	£000	£000	£000
Mental Health Spend	160,072	164,919	123,104
ICB Programme Allocation	1,859,377	1,930,275	1,476,305
Mental Health Spend as a proportion of ICB Programme Allocation	8.61%	8.54%	8.34%

(22/23 figures reflect the Mental Health Investment Standard recategorization workings undertaken in September 2022. 22/23 figures are consistent with 22/23 M12 ICB IFR NHSE submission.)

Learning Disability and Autism

This year our priority has been to work in partnership with people with learning disabilities, autistic people, and those with lived experience. We have made real progress in addressing

health inequalities to help people to live longer, healthier lives; and always be treated with dignity and respect.

Improving health
To support our aims of improving people's health, our GP's have ensured that over 80% of people with a learning disability have had an Annual Health Check in the last year, with at least 95% receiving a Health Action Plan, the highest completion rate in the Southwest. We have met or exceeded the national target for three consecutive years. Annual Health Checks are important as people with learning disabilities often have several co-morbidities and generally have poorer health outcomes than the general population, dying up to twenty years earlier. We have undertaken a number of co-produced health projects with learning disabled people to address the health inequalities they experience, on cancer, constipation, obesity, and aspiration pneumonia.

Voice and influence
Ensuring people with learning disabilities have voice and influence is a key ambition for the ICB. This requires a commitment and funding to build systems for people with learning disabilities to be equal partners in our different workstreams. To enable people to shape the care they receive, and the decisions taken around how care is provided across our area, we are working with People First who have established 12 new self-advocacy groups across our area.

With 'Autism Independence' we commissioned research to understand how families from minority ethnic communities with a learning disabled or autistic person in the family, access health services. They worked with 46 families from Somali, Asian, Afro-Caribbean, and Polish communities. Their final report was published in January 2023, and we will now act on their recommendations.

Improving access to health care for autistic people - Autism Audit of Emergency Departments
We worked with a group of autistic people to audit the emergency pathway experienced by autistic people first developing a co-produced audit tool. All Emergency Departments across Bristol, North Somerset and South Gloucestershire were audited. These whole day audits include looking at access to the department, rooms and environments, adaptations made. There were interviews with key staff that focused on their understanding of autism.

Recommendations based on the audit findings have been shared with each Emergency Department. This has included the recent purchase of reasonable adjustment resources for autistic people and people with learning disabilities and across all our hospitals. These will be made available in a wide range of clinical areas to support people's access needs and promote a calming environment, for example, ear defenders, soothing lights and smells, 'fidgets', weighted blankets or lap pads, dark glasses or visors for light sensitivity, augmented alternative communication boards, with guidance & training on how to use the resources.

Learning Disabilities Mortality Review (LeDeR)
The Learning Disabilities Mortality Review (LeDeR) Programme is a national programme designed to review the quality and improve the experience of services for people with learning disabilities using health services.

A review is undertaken when the death of a person with a learning disability is notified, whether they die in hospital or in the community. This involves looking at GP, hospital, and community patient notes for the last couple of years of the person's life, against an enquiry review template designed by NHS England. During a review any family member, the GP and staff who knew the person well, will be interviewed to get a portrait of the person and the care they received. The reviewer reports on their findings and makes recommendations.

Over the course of 2022/23, we received 62 new notifications and closed 65 cases. The LeDeR national average is that people with learning disabilities die 20 years earlier than the general population. Our data shows that people with a learning disability in the Bristol, North Somerset and South Gloucestershire area live approximately 8 years longer than the LeDeR national average. Reviews identified the following areas for improvement in the care of people with learning disabilities:

- Production of Health Action Plans
- Early detection and access to cancer screening programmes
- Access to cancer treatments
- Identification and treatment of constipation
- Better management of illnesses, such as pneumonia and sepsis
- making reasonable adjustments so people can better access healthcare

Community Services

Community Services

Our NHS 111 services is delivered by Severnside, a collaboration between Practice Plus Group (PPG) and BrisDoc Healthcare Services. PPG provide the 111 element of the service and BrisDoc the other elements of Out of Hours GP provision. As the data shows, performance has been mixed, with higher than anticipated activity over a sustained period of time, coupled with challenged performance due to a range of factors within these services, including recruitment and retention. A recovery action plan is in place for the 111 element, and we are working closely with Severnside to drive improvements to service delivery in the coming months.

Table 6 Integrated Urgent Care Key Performance Indicators

Ref	Title	Standard	Avg YTD
1	Proportion of calls abandoned *	≤ 3%	21.7%
2	Average speed to answer calls (s) *	≤ 20	565
3	95th centile call answer time (s) *	≤ 120	1673.58
4	Proportion of calls assessed by a clinician or Clinical Advisor	≥ 50%	49.1%
5a	Proportion of calls assessed by a clinician in agreed timeframe (within 20 minutes)	≥ 90%	53.3%

5b	Proportion of calls assessed by a clinician in agreed timeframe (over 20 minutes)	≥ 90%	70.3%
6	Proportion of callers recommended self-care at the end of clinical input	≥ 15%	62.1%
7a	Proportion of calls initially given a category 3 or 4 ambulance disposition that are validated within 30 minutes [ADC Definition]	≥ 50%	48.5%
7b	Proportion of calls initially given a category 3 or 4 ambulance disposition that are validated ***	≥ 80%**	70.7%
8a	Proportion of calls initially given an ED disposition that are validated [ADC Definition]	≥ 50%	68%
8b	Proportion of calls initially given an ED disposition that are validated ***	≥ 80%**	81.7%
9	Directory of Services: no service available other than ED (ED catch-all) *	≤ 0.30%	0.0%
10	Proportion of callers allocated the first service offered by Directory of Services *	≥ 75%	70.2%
11	Proportion of calls where the caller was booked into a GP practice or GP access hub *	≥ 75%	56.5%

As per *Integrated Urgent Care Key Performance Indicators and Quality Standards 2022-23 V1.0, with exceptions*

** Telephony, validation and appointment data - 111 only*

*** Local target*

**** Not calculated from IUCADC*

Adult and Children's community services are provided by Sirona care and health across Bristol, North Somerset and South Gloucestershire. The full extend of services provided by Sirona adult services is show in the table below. As with all our services, workforce challenges are a key issue affecting performance.

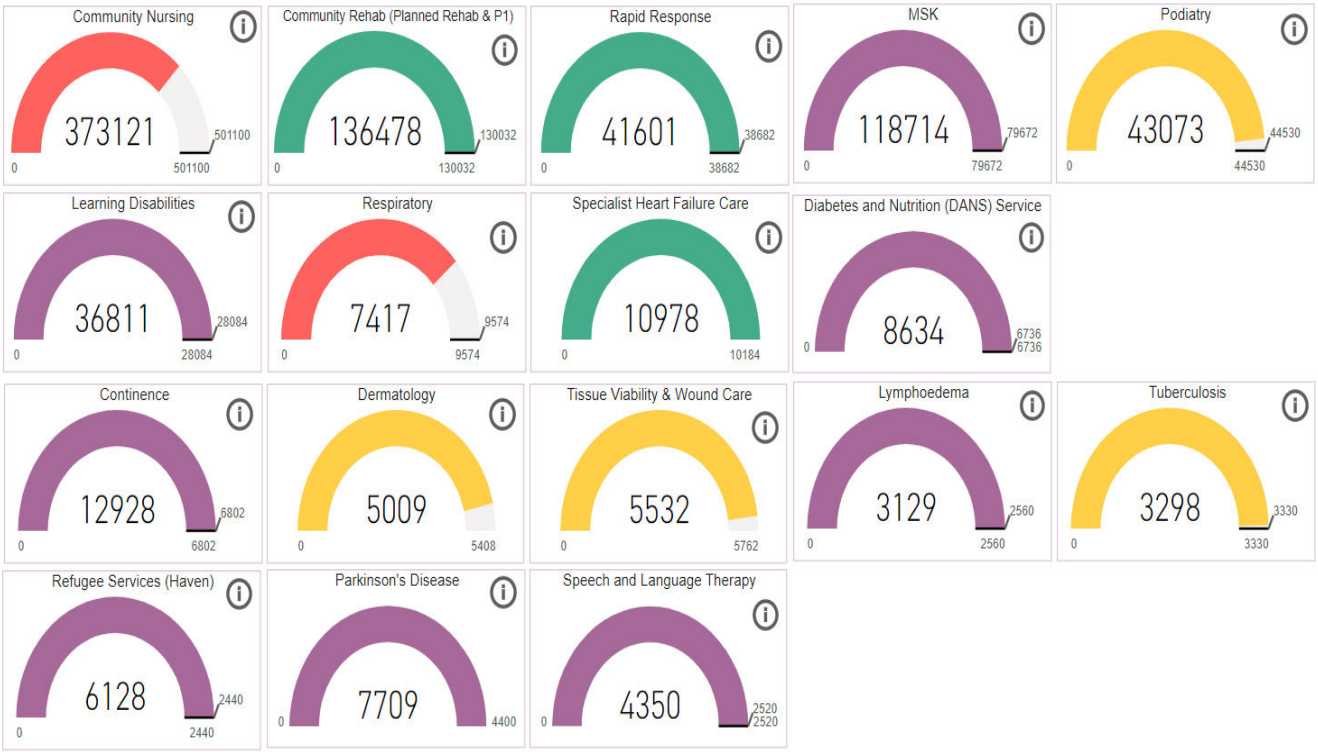
Sirona is integral partner in the development and delivery key services designed to improve patient care including are plans for stroke services, supporting people to avoid hospital admission and help their timely discharge through virtual wards and other home-based services.

Summary of Year-to-Date 2022/23
Percentage of Patients Seen Within 18 Weeks

Back to Contents

Summary of Year-to-Date 2022/23
Number of Contacts Against Target

Back to Contents



Funded Care Services (Children's Continuing Care, individually funded Mental Health, Learning disability and Autism, Adult CHC,)

Our Funded Care team is an all-age team which works alongside system partners to ensure individuals with highly complex needs continue to be met in the most appropriate environment. This includes children, young people and adults with both complex physical, psychological and mental health needs whose needs cannot be met with care and support from existing commissioned services and for whom a bespoke plan is required.

Our priority is to that ensure high quality, safe and effective care is delivered to our population. Work is underway to review and standardise the review documentation we use to reduce variation in approach and to increase capability and confidence in the whole team to be part of the Quality Assurance work. Our commitment to continuous improvement remains and has been supported by increasing audit, which has become common practice within the team resulting in change in practice/process derived from the learning. The funded care team continue to work on a cohesive model of care which is an 'all age' approach and to dedicate time and consideration to how individuals transitioning from a child/young person to an adult are supported.

A whole team, multi professional approach has been adopted to our preparedness for changes in Mental Health legislation; this will see a departure from Deprivation of Liberty orders to a Liberty Protection approach. Working alongside colleagues in Safeguarding the aim is to ensure processes are as aligned as possible across all organisations within the Bristol, North Somerset and South Gloucestershire ICB footprint.

We are committed to improving improve the use of Personal Health Budgets and to developing greater governance to reduce the likelihood of misuse and ensure public funds are used to meet the needs of as many of possible.

Professional supervision has been introduced and made available for all staff in Funded Care in 2022/23. This is aligned to policy and is a key contribution to staff wellbeing and professional development.

Children's Continuing Care

We have piloted a pooled budget approach with our three Local Authority partners. This a different approach to funding care and meeting needs for children and young people to enhance a person-centred approach and deliver better value for money. The pilot has been evaluated by Bristol University and will be used to inform how our organisations can work differently to deliver better outcomes in line with the strategy and priorities of the ICS for our children and young people.

Individually funded Mental Health, Learning disability and Autism

Our newly created Key Worker Team for Children and young people with LD and Autism has been well received and has seen greater demand than predicted. The team is supporting more young people to stay well in their own environment.

Adult CHC funded care.

The ICB retains statutory responsibility for assessing and delivering care in line with the national Continuing Health Care framework which is designed to ensure those with a primary

health need and for whom their needs cannot be met from the suite of available services are met and funded by the NHS.

Our CHC team remain committed to a culture of continuous improvement and delivered on many achievements in 2022/2023 delivering efficiencies and improving outcomes for the population. As part of the national specification outlining the expectation of the service, our has moved from one of the poorest performing services to one which has been referred to as the most improved in the Southwest. An illustration of this is the performance against the national standard; our performance is 90% of all new assessments determined within 28 days against the national standard which is 80%. Alongside this, the team compare well with national teams in other domains such as cost of care, independent reviews of NHS England reviewed cases and continues to continue the journey of improvement against the national maturity matrix.

Primary Care

Across Bristol North Somerset and South Gloucestershire there are approximately 80 GP practices, 20 Primary Care Networks (PCNs) and a 24/7 GP Out of Hours service. This year has required significant preparatory work for 1st April 2023, which sees us expand to delegated responsibility for pharmacy, optical and dental (POD) services.

General practice Bristol North Somerset and South Gloucestershire in has come together to form the General Practice Collaborative Board (GPCB), a representative decision-making body for general practice to enable general practice to work and deliver as an equal partner in the ICS. The GPCB brings together representatives from all the PCNs, localities, Avon Local Medical Committee, One Care and BrisDoc. GPCB facilitates system wide engagement along with the newly established Primary Care Collaborative Board (PCCB), which includes representation from pharmacy, optical and dental services.

The backlog from the Covid-19 pandemic has resulted in performance issues across our health and care system, which has had a huge impact. While demand and complexity grow, exceeding pre-pandemic levels, our traditional clinical workforce is shrinking. Multiple programmes of work are underway to move care into the community requiring general practice support. Face to face appointments continue to account for 56% of activity which reflects embedding of the new hybrid model of telephone, video, online or face to face options where clinically appropriate.

We are on track to deliver the national trajectory of 50 million more appointments in general practice by the end of March 2024 and we have already achieved the increase in additional roles national target of 26,000 for our area.

Our GP Patient Survey 2022 results are above the national average for people’s overall experience (75% good compared to 72% national), the helpfulness of receptionists (85% compared to 82%), the satisfaction of appointment offered (74% compared to 72%) and for confidence and trust in the healthcare professional (95% yes compared to 93% nationally).

We recognise there are some areas for improvement and are continuing to work on improving access for our patients to healthcare advice and treatment. Supporting resilience and additional capacity, reviewing and addressing variation, increasing on the day appointment and urgent care needs to improve patient experience.

The largest proportion of activity remains same day appointments at 42%, with practices also providing direct booking for 111 during core hours. 86% of appointments are seen within two weeks, consistently above the national average. Pre-planned long term condition management and patient choice account for some longer duration times.

The new model for Enhanced Access started in October 2022, building on the existing Extended Access and Improved Access offer which supported practices to offer appointments in the early morning, evening and at weekends. Enhanced Access appointments are available between 6.30-8.00 PM Monday to Friday and 9.00-5.00 PM on Saturdays, offering a different blend of clinic types. The new service means a more standardised offer to patients. Primary Care Networks have worked together to develop plans at locality level.

We are successfully rolling out our Community Pharmacist Consultation Service (CPCS) for patients requiring simple advice, treatment and urgent repeat prescriptions to go to their community pharmacy. We achieved our goal of 3000 referrals per month for this year, averaging 3461. Our aim is for 5000 per month next year with 90% of surgeries actively engaging with the service.

The Covid vaccination programme continues to be a priority alongside day-to-day business. We continue to work as a system to deliver Covid vaccinations through PCNs, Community Pharmacies, hospitals, and the school age immunisation service. Building on the valuable work with communities started with the vaccination programme this has been expanded to other health offers eg, BP checks, Cancer early diagnosis, health literacy work for both individuals and a family approach to continue close working with the community. As a result of the vaccination programme, we are looking to bring together work on all age immunisations and improve the offer and uptake.

Health inequalities work in general practice has continued through the Primary Care Strategy Board (PCSB) in collaboration with Public Health, Healthwatch, Building Healthier Communities Group and Population Health Management/Prevention and Health Inequalities Groups in the following areas:

- Prevention: Mental Health & Wellbeing, Healthy Weight, Alcohol, Tobacco and Cardiovascular Disease
- Long Term Conditions management
- Ethnicity coding
- Cancer earlier diagnosis
- Continuing to support clinically vulnerable patients
- Learning Disabilities
- Severe Mental Illness

Safeguarding Children and Young People and Vulnerable Adults

The ICB Safeguarding team has continued to contribute to the partnership arrangements across our system and deliver our statutory duties for safeguarding in this reporting period. During 2022/23, discussions have been had across Bristol, North Somerset and South Gloucestershire about how we can work as a system more effectively at a ‘place’ level through our six locality partnerships, with our three local authorities and with other system partners.

This work has included scoping a review paper. The Local Government Association has been commissioned to support us as a system by reviewing our current arrangements and exploring any potential improvements. This review will take place in 2023/24. Our Safeguarding Reports can be found on the websites given below:

Keeping Bristol Safe Partnership	Welcome to the Keeping Bristol Safe Partnership website. (bristolsafeguarding.org)
South Gloucestershire Safeguarding Adults Board	Annual report and business plan | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)
South Gloucestershire Children's Partnership	Annual report and business plan | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)
North Somerset Safeguarding Adults Board	Annual reports | North Somerset Council (n-somerset.gov.uk)
North Somerset Safeguarding Children's Partnership	Annual reports | North Somerset Council (n-somerset.gov.uk)

Self-neglect continues to be the main theme emerging from Safeguarding Adult Reviews during this year, and we are working as a system through the findings from a thematic review undertaken in North Somerset by Professor Michael Preston-Shoot; a leading academic researcher in this area.

Our three Children's Partnerships have collaborated to review their position against the recommendations made in the report of the national review into the murders of Arthur Labinjo-Hughes and Star Hobson (National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk)) addressing information sharing barriers and the multi-agency responses to child protection when there are triggers to indicate a statutory process.

A Tier-two Information Sharing Agreement, to sit underneath the overarching Bristol, North Somerset and South Gloucestershire Integrated Care System Information Sharing Agreement, has been drafted and consulted on to support the frameworks for sharing information and data in relation to safeguarding.

We have invested in Learning and Development, following funding from the Regional NHS England Safeguarding team, for those in a Safeguarding role across the health system during this year. Two cohorts of Safeguarding Supervision training have been commissioned and delivered. 32 delegates from across health providers and the ICB are now trained to deliver safeguarding supervision effectively. Bespoke Level 4 Safeguarding Children training has also been delivered to a cohort of 16 colleagues from across the health system which was extremely well received and is likely to be recommissioned in 2023/24. Two further courses including 'Leading Culture Change in Safeguarding', delivered by University of Worcester to Designated and Named Professionals working in the health system have been commissioned.

As part of the ICB's statutory duties, our Safeguarding Team has participated in a variety of multi-agency audits during 2022/23 including adults and mental health, and early help support for children, as well as Section 11 Audits; these are self-assessments undertaken by Local Children Safeguarding Partnerships that look at how organisations and services and meeting standards to safeguard children and young people. Learning briefs have been shared across

the system as a result of these exercises and through the One Care bulletin with colleagues in primary care. These key messages have been reiterated and discussed at Safeguarding LINK GP meetings to ensure changes to practice are embedded. Our Safeguarding Team's offer to Primary Care in terms of training, supervision and support has also been refined with signposting to Multi Agency Level 3 Safeguarding Children training, monthly Q&A drop ins, and quarterly Safeguarding LINK GP meetings. The review of the training offer has incorporated a revision of the GP information pages, and will have a standalone Children in Care section. This is underpinned by the introduction of a new post within our ICB Safeguarding Team, a Named Nurse for Primary Care (All Age) who will be supported by two Named GPs for All-Age Safeguarding.

We are a statutory partner in three Local Authority Safeguarding Children Partnership/Adult Boards. In line with the statutory guidance, and adherence to the NHS England Safeguarding Accountability and Assurance Framework (SAAF) the ICB has Designated Doctors for Safeguarding Children, Named GP's all age safeguarding, Designated Nurses for Safeguarding Children in Care (CIC), Children and Adults at risk.

The ICB has representation on the subgroups of the partnerships and Boards and is involved in all the statutory reviews for children and adults, Rapid Reviews, Child Safeguarding Practice Reviews, Domestic Homicide Reviews and Safeguarding Adults Review and other work streams. National and Local learning is disseminated through the system and assurance sought that learning is embedded through both multi and single agency audits.

The ICB has its own governance structure, with reporting through our Chief Nursing Officer and Executive via various governance and committee reports and meetings. Designated Nurses/Professionals within the ICB hold a monthly safeguarding "clinic" with our Chief Nurse to share good news stories, and discuss risks and concerns we have identified.

The ICB hosts a Strategic Health Safeguarding System Group meeting for senior leaders in provider organisations and an all age safeguarding provider network. Safeguarding assurances are sought from provider organisations via the Section 11 audits described above and through contract monitoring by our quality team. The Designated Nurses sit on various safeguarding committee meetings of provider organisations and receives safeguarding data via this route.

In line with the SAFF guidance ICB workstreams have included:

- Child Protection Information Sharing (CP-IS) which assists information sharing between local authorities and health
- Female Genital mutilation (FGM)
- Prevent; the duty on specified authorities to have due regard to the need to prevent people from being drawn into terrorism
- Working Together; supporting interagency working to safeguard and promote the welfare of children
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Liberty Protection Safeguards.

In addition to the above, extensive multidisciplinary/partnership work has been completed to support adults, families and child residents in the asylum seeker hotels. This includes working with the system partners and National Government Offices like the Home Office to complete

preventative work in safeguarding, in addition to modern slavery/trafficking for adults and unaccompanied children.

As set out in Working Together to Safeguard Children 2018 (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) , ICBs are responsible for the provision of effective clinical, professional and strategic leadership in child safeguarding, including the quality assurance of safeguarding through their contractual arrangements with all provider organisations and agencies, including from independent providers. We confirm that NHS Bristol, North Somerset and South Gloucestershire ICB has followed the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework.

All previous functions and duties of Bristol, North Somerset and South Gloucestershire CCG have now passed to the BNNSG Integrated Care Board (ICB) including commissioning responsibilities and contracts. Bristol, North Somerset and South Gloucestershire ICB's core principles of Safeguarding children, young people and adults at risk in the NHS, including protecting the paramountcy of children, are sustained by adherence to the Safeguarding accountability and assurance framework (SAAF) NHS England 2022.

Children in Care

To reflect statutory guidance, Children in Care should receive an initial health assessment to evaluate the child's physical health and any requirement for access to specialist behavioural, mental, and emotional health assessment within 20 working days of becoming a child in care. Performance against this metric has been challenging for some time owing to timeliness of local authority notifications, capacity, availability of community paediatricians within Sirona Care and Health to undertake the assessment and a proportion of appointments where children were not brought.

A systemwide Children in Care workshop took place on 9th November 2022 to discuss how as an Integrated Care System all system partners have a statutory responsibility for this cohort of Children. It was the first meeting of its kind. There was representation from the ICB, Sirona Care and Health, and our three Local Authorities. All system partners represented agreed that an exploration of different options to undertake Initial Health Assessments and Review Health Assessments was needed, for example, working with GPs to complete Initial Health Assessments instead of Community Paediatricians.

In addition to this, a pilot is underway to quality assure additional packages of care commissioned by the ICB for Children who are in care and placed out of area. This will ensure that as Corporate Parents, the ICB is providing the best possible care and protection for the child in the same way as a good parent would, and to quality assure the services being provided. In the same way, the ICB is exploring what could be included in a Care Leavers Health Offer, for example pre-paid prescription exemptions for those eligible.

Improve quality

The ICB has a duty to ensure that safe, high quality, and effective health services for the people of Bristol, North Somerset and South Gloucestershire are in place as per section 14z34 of the National Health Service Act 2006 (as amended by the Health Care Act 2022). Our Outcomes, Performance and Quality Committee (p62) ensures comprehensive oversight and monitoring of

the quality of services; providing assurance to the ICB Board. Highlighted below are some of the key indicators of quality, performance against these across our system.

Infection Control Management

Between 1st July 2022 and 31st March 2023 there were 216 cases of Clostridioides difficile Infection (CDI) assigned to the ICB. The NHS England set threshold for cases for the year was 231 and the number of cases reported showed an improvement against the quarterly threshold guidance. New infection/s and a female cohort may be the focus for end-to-end reviews being undertaken.

During the same period there were 378 cases of E. coli bacteraemia assigned to the ICB. Our threshold for E.coli bacteraemia cases set by NHS England was 401. If we compare data to previous years, we can see a year-on-year reduction in cases (58).

We also reported, during the same period:

- 21 cases of Methicillin Resistant Staphylococcus Aureus (MRSA) assigned to the ICB meaning that we did not meet the standard.
- A 17% increase in Methicillin-Sensitive Staphylococcus. aureus (MSSA) bacteraemia cases compared to 2020/21 with 149 cases reported cases.
- 123 assigned cases of Klebsiella bacteraemia against an ICB threshold of 120
- 49 assigned cases of Pseudomonas Aeruginosa bacteraemia against an ICB threshold of 47. We saw a peak in cases in the Autumn of 2022

Clostridioides difficile: In discussion with our secondary care partners, we have re-established a process for undertaking the 2021/22 secondary care case reviews and a rapid review process to review and close all 2020/21 cases. We have reviewed our information governance arrangements and processes to support the launch of the new CDI data collection process for community onset cases, enabling the identification of themes, trends and associated learning. We are also looking at themes and trends related to the prescribing of certain antibiotics for example Vancomycin. The ICB actively contributes to the NHS England CDI collaborative process. This is an opportunity to ensure that our approach is supported by the latest evidence and that our processes with both secondary care, and primary care/community are aligned. The local system CDI working group continues to meet and progress local quality improvements such as the CDI patient information leaflet, implementation of an alert between community and acute patient records when a patient tests CDI positive.

E.coli bacteraemia: Work with system partners will continue to seek assurance that previous quality initiatives have been embedded and work in partnership will continue to develop and agree an E. coli (gram-negative) improvement action plan. Using the findings of Reliance on a Carer (ROC) pilot we are developing a future programme of work focused on promoting patient hydration.

The three key areas of work agreed by our Antimicrobial Stewardship Group include Clostridioides Difficile Infections, antibiotic consumption and prescribing. These continue to be monitored with a focus on urinary tract infections and also on appropriate documentation of penicillin allergies and antibiotic prescribing in children. During the period both community and secondary prescribing met antibiotic prescribing targets

Seasonal influenza (flu) is an unpredictable but recurring pressure that our population and services face every winter. Each year we prepare for the season flu' period, offering vaccinations to people identified as vulnerable and at risk in national guidance. We also provide vaccination programmes for frontline staff.

During 2022/23 our System Flu Group met with system partners to share plans and the learning from successful strategies to support staff vaccinations. Staff vaccination rates for our NHS system partners and Health and Social Care staff are given below:

Table 7

Organisation	Front Line Healthcare workers vaccination uptake rate.
Avon & Wiltshire Mental Health Partnerships	54%
North Bristol Trust	69%
Sirona Healthcare	80%
South West Ambulance Service Foundation Trust	54%
University Hospital Bristol and Weston Foundation Trust	61%
Health and Social Care Staff	22.5%

A cross system film featuring staff from organisations across Bristol, North Somerset and South Gloucestershire was shared with partners to encourage staff to come forward for vaccination and comms messages were sent out to home care staff and GP Practices. We also held drop-in vaccination clinics for Social Care Staff. As a system we:

- Roving Clinics designed by Sirona to target staff who could not be released from clinical activities. This meant staff and patients could be vaccinated at the same time.
- The Acute Trusts held clinics throughout the 24-hour period to attract staff working different shift patterns to drop into the clinics.
- Sirona's Vaccination Tracking system with staff being able to access Flu vaccinations when they were having their Covid Booster vaccinations.
- Staff in different locations could be identified where staff had not been vaccinated, these locations were then targeted by the Vaccination Team
- Successful communication campaign with weekly messaging to staff took place.

During 2022/23 a pilot, aimed to reduce inequalities and improve access, delivered Flu vaccinations to 2- and 3-year-olds via clinics in children centres in Hartcliffe and Bedminster in collaboration with the Swift Primary Care Network. Clinics were held in the Malcolm X Community Centre in collaboration with our Programme Vaccination Team alongside the Sirona School Immunisation Team. These clinics had support from Caafi Health and translated resources to best support the local communities. By February 2023 34.4% of 2- and 3-year-olds in our area had been vaccinated.

Opportunistic Flu vaccinations continued to be offered at the UWE Vaccination Centre to those people who are eligible when attending the clinic for Covid-19 vaccinations. This centred closed at the end of March 2023. Community Pharmacy uptake was also positive during this season.

In our area 84.3% of the 64 years and above age group were vaccinated in 2022/23. Although this is just below the percentage vaccinated during 2021/22 it is above the national average.

A comprehensive evaluation of the learning from the vaccination pilots and the successful staff vaccination strategies will be used when planning for 2023/24 and will include:

- preparing and starting vaccination clinics earlier than previous years.
- Providing additional vaccination training to midwives who can offer people vaccinations during anti-natal and post-natal clinics.
- Offering vaccinations to people on maternity and sick leave.
- Continuing bespoke and walk in clinics.
- Reviewing contracts to enable to provide social care staff vaccinations in conjunction with residents.
- Completing insight work to understand barriers in relation to Health and Social Care staff access to vaccinations and targeted communications issued.
- Improving GP Practice reporting of social care staff vaccinations.

The NHS Patient Safety Strategy (NPSS) NHS England » The NHS Patient Safety Strategy sets out how the NHS in England will achieve its safety vision to continuously improve patient safety. The strategy involves moving for the Serious Incident Framework which has been in place since 2015 to the NPSS. We have embraced this opportunity to improve patient safety through a patient safety culture and a patient safety system that is based on insights, involvement and improvement. As an early adopter we have established initiatives to support our partners across our system, including:

- Incident reporting systems sharing group with our partners
- Implementing the new Patient Safety Incident Response Framework
- The development of a Patient Safety app
- Development of a Patient Safety Incident Response Plan

ICB quality surveillance

We have established a Bristol, North Somerset and South Gloucestershire Serious Incident Learning monthly panel with stakeholder and partner organisation representation. This is a robust environment where our system can understand and share learning from themes/trends following Patient Safety Incident Investigations and quality improvement deep dives. Our System Quality Group (SQG) provides a strategic forum at which partners from across health, social care, public health and wider within the ICS can join up to consider:

- common priorities
- routinely and systematically share insights and intelligence
- identify opportunities for improvement and concerns and risks to quality, and
- develop system responses to enable ongoing improvement in the quality of care and services across the ICB

We have contributed to quality visits within the mental health and care hotel environments.

Patient Experience

We believe that the voice of local people and communities is imperative and continue to engage with our communities to co-design and co-create new services. One of the main challenges we face is how to use data intelligently to lead to real improvements in patient experience. By continuous analysis of patient experience information and learning encountered along the way, themes and trends can be ascertained to help improve the patient experience.

Our Customer Services Team continues to gather feedback from patients through:

- compliments and complaints
- advice and liaison enquiries
- MP enquiries
- feedback from healthcare professionals
- patient surveys and Healthwatch reports

Our Customer Services Team will be developing and improving how we gather patient feedback in 2023.

We use social media, including Twitter and Facebook, and monitor responses posted on the NHS Choices and Care Opinions websites. The Citizens panel has an important role, providing feedback on their experiences of healthcare. A customer satisfaction survey is sent to all patients raising a complaint, and this data is regularly reviewed with colleagues across the ICB.

Between 1st July 2022 and 31st March 2023, the ICB received 1513 contacts, 1152 General Enquiries, 213 formal complaints, 39 compliments and 108 MP enquiries. Two complaints were reported to the Parliamentary and Health Service Ombudsman.

We have used patient experience to improve how the ICB operates across the health system. Feedback and analyse trends or themes are shared with the Outcomes, Performance and Quality Committee and the ICB Board, to ensure that learning is shared and patient experience improves.

Our Customer Services Team continues to provide training for ICB staff regarding patient feedback, how this it was used and why it was important to the ICB. This is also explored at the corporate induction for all ICB new starters.

Customer Services implemented regular meetings with key service providers within the ICB, to discuss feedback from patients and to facilitate a swifter and smoother process for people contacting the Customer Services Team.

Customer services implemented a Clinical Review Team who met weekly to discuss complex cases, process and strategy with a view of giving the best possible patient experience.

There were regular meetings with external providers to improve services and to facilitate a swifter and smoother process for patients and improve collaborative working. Learning and intelligence collected was used to inform and update policies and related documentation, to provide a fair and transparent service for patients.

We have a monthly learning panel attended by the ICB Quality Team, and Customer Services and other trusts and providers to go through monthly learning which incorporates thematic reviews.

Working with our people and communities

ICBs have a duty to engage with and involve members of the public as outlined in section 14z45 of the NHS Act 2006 (as amended by the Health Care Act 2022). Across our integrated care system, and as an ICB and a partnership. we are agreed that the communities we serve, the people who we provide health and care for, are at the heart of all that we do.

We know the vital impact and value that working with the diverse communities who live across Bristol, North Somerset and South Gloucestershire has. We will continue to work hard to ensure our communities' needs, aspirations, and priorities are reflected in our strategy and programmes of work. We are developing a Working with People and Communities strategy which outlines that we will:

- Turn understanding of our population into action
- Ensure our decision-making is informed by insight and lived experience
- Make co-production everyone's business, and embed best practice

These commitments have guided our activity and decision-making over our first year as an ICB.

Turning an understanding of our population into action

Have Your Say

Understanding our population is essential to help us focus on, and prioritise, the issues of greatest importance to our people: their health and care needs, and what helps to keep them happy, health and well (haveyoursay - BNSSG Healthier Together)

As we have developed our strategy over the past year, we have kept the voice of patients, services users, and our population are at the heart of all that we do. In the summer of 2022, we carried out our Have Your Say engagement exercise where we asked people across our area what helps them to be happy, healthy, and well. We had over 3,000 responses to the exercise, with over 21,000 different comments from those who completed an online survey or attended one of more than 50 community events.

We worked with:

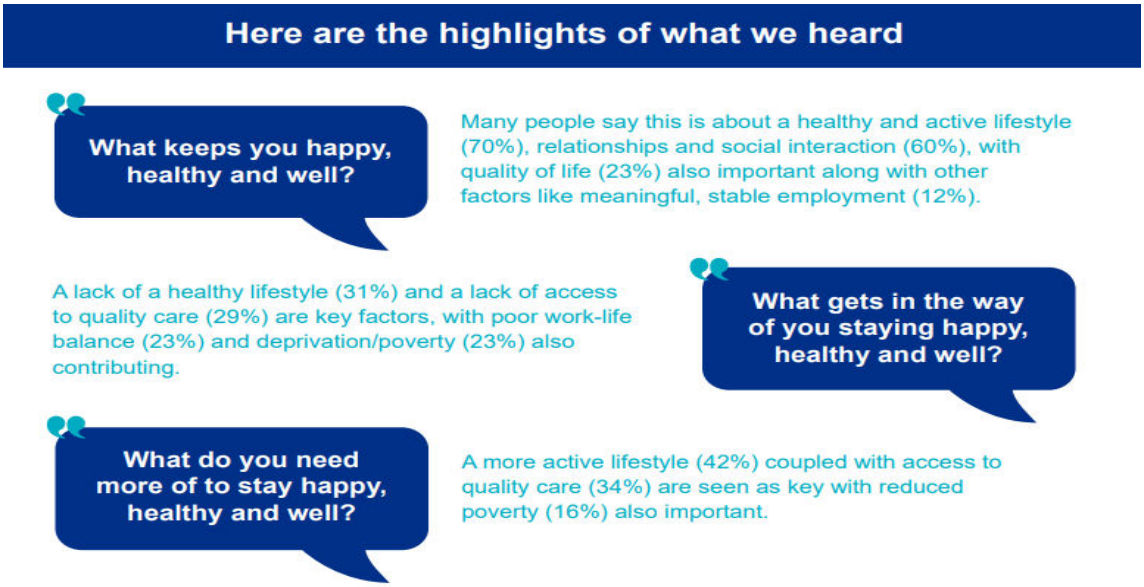
- local hospitals
- community health
- primary care
- mental health
- local councils
- charities
- community groups
- the voluntary sector, and
- businesses

As a result, many different people from our communities are represented in the findings, and this includes different age groups, health needs, abilities, and people from a variety of backgrounds.

To hear from as many different people as possible we attended community health clinics, job fairs, groups supporting disabled people and their carers, family playdays, deaf community events, vaccination clinics, and an Alzheimer's memory café among others.

We reviewed the responses to the first phase of the survey to identify under-represented groups. This analysis helped us to identify further community events to include in the second phase of engagement.

Following the analysis of responses to the Have Your Save engagement, we produced a report (PowerPoint Presentation (bnssghealthiertogether.org.uk) of the findings to share with our population in a variety of languages and formats, including an easy read version; these can be found on the Have Your Say webpage (haveyoursay - BNSSG Healthier Together).



The findings from Have Your Say – along with our population health needs assessment OurFutureHealth-Sept-2022.pdf (bnssghealthiertogether.org.uk) will be the foundation for our ICS strategy; and engagement with people and communities will continue throughout the development process. For example, in Spring 2023, we presented potential ICB priorities to our Citizens' Panel. This gave people an opportunity to feedback on the areas we are considering as priorities, telling us what they think is most important for us to focus on in the next few years.

Following Have Your Say, and survey to the Citizens' Panel, we plan to conduct more research in the summer of 2023 with our population on the final stages of the strategy development.

About the Bristol, North Somerset and South Gloucestershire Citizens Panel

The Bristol, North Somerset and South Gloucestershire Citizen Panel was established in 2018 to provide a robust, representative group of our population to provide insight on key issues. The Panel currently has around 1,400 members, and has contributed to our insight on a wide range of important issues, including attitudes towards digital apps, urgent care behaviours, and seasonal vaccinations.

Vaccination Programme

Our Covid-19 Vaccination Programme engagement activities have continued since July 2022, with a recent focus on Covid-19 Seasonal Booster vaccinations. We have also maintained the offer of primary doses to people who are still coming forward for their first and second Covid vaccinations, delivered flu vaccinations alongside Covid-19 and led our local MPox (Monkey Pox) vaccination response.

The Programme's operations and communications have been guided throughout by past and new insights from residents and staff.

Over 3,600 people responded to post Covid-19, Flu and MPox vaccination surveys from clinics held in primary care settings, the Vaccination Centre at UWE Bristol and outreach clinics. These insights have influenced our communications and underpinned changes to operations, services, and clinic locations.

To help inform our 2022 winter Flu vaccination and Covid-19 booster campaign, we surveyed over 500 Bristol, North Somerset and South Gloucestershire staff to help us understand the likely uptake of vaccination, as well as staff motivations and concerns. This understanding of our staff led us to focus on maximising vaccination access, offering a spread of locations and appointment times, alongside providing reassurance for some about the effectiveness and safety of the vaccine.

The survey results also informed the development of a collaborative video featuring interviews with health and care staff from all the health and care organisations in our area, encouraging all staff to have their seasonal flu and Covid-19 vaccinations. This film was also adopted by NHS England who shared a version on their social media channels.

Insights from people in key areas of health inequalities also continue to be a vital element of the Bristol, North Somerset and South Gloucestershire vaccination programme. Understanding the factors that have an impact on the lives of people in these communities, as well as their questions and concerns about vaccines, has proved instrumental in shaping the services we offer and the way in which we communicate.

Home First

We have continued to keep our population and workforce at the heart of our Home First, Discharge to Assess, and NHS@Home activity:

- NHS@Home – to support the continued expansion of NHS@Home through virtual wards, we undertook 16 interviews with service users and staff in to understand their experience of being part of the programme. We also attended a University Hospitals Bristol and Weston 'Health Matters' public event, as well as five meetings of service users and their carers. This insight captured the views of over 80 people, and was used to inform expansion of the NHS@Home programme in Bristol, North Somerset and South Gloucestershire.
- Working to understand people's views around being discharged home from hospital, working with two specialist agencies (Ethical Healthcare and the Local Government Association / Newton Europe via the Better Care Support Fund), we completed a discovery phase to understand the challenges and opportunities for more people to recover at home or the right place for them following a hospital stay. This included focus groups with people, carers and staff to understand the barriers and challenges to a Home First approach. Case reviews were also carried out with 76 staff across health and social care to develop a detailed understanding of how the stages in the Discharge to Assess process are operating currently and the impact on people's short and long term outcomes. This insight and understanding is being used in the short term to inform the development of a people-centred campaign, focused on both staff and service users, and to drive transformation work to improve the hospital discharge process.

Ensuring our decision-making is informed by citizen insight and lived experience

Healthy Weston

Between June and August 2022, we asked members of the public, staff, people who might be particularly affected, and those who had not been involved before to help plan practical next steps for the Healthy Weston programme – especially our plans for Weston General Hospital.

890 people took part in the engagement. We advertised the survey and opportunities via the local media, stand-ups in hospitals, social media, and staff communication channels. Community groups, partner organisations hospital staff were also invited directly to take part, and we worked with others, including placing leaflets in health and care organisations, and attending existing meetings of community groups and staff.

This work helped us understand how the local community in Weston and staff at Weston General Hospital felt about the next phase of the proposed plans. While there was positive feedback about the plans, people also shared their views on the extra travel that could affect up-to eight patients per day. They commented on the physical, emotional, and financial challenges that further journeys could bring, not just on the patients but for loved ones and carers too. People said that technology, such as video call equipment, could help to overcome this, but also shared thoughts on improving transport links.

People also said that more could be done around communicating the plans. One in four people were not clear on what was being proposed and many saying that more needs to be done to enhance the reputation and trust in Weston General Hospital. The outcomes of the engagement period are being used to inform plans for implementation of Healthy Weston 2 Phase 1, alongside informing how we communicate the changes to staff and public.

Other work

Citizen insight and lived experience is central to much of our recent work, for example:

As part of our Healthier with Nature programme, the Green Social Prescribing programme for Bristol, North Somerset and South Gloucestershire, we worked with Lived Experience representatives from the Independent Mental Health Network to "mystery shop" our Green Social Prescribing projects across Bristol, North Somerset and South Gloucestershire. Eight people with lived experience of mental health conditions attended six sessions on a project of their choice and completed a brief feedback form about the experience. This feedback was invaluable and highlighted areas of success, as well as areas for further development across the projects that have been taken on board including around communications and promotion of the projects.

We also worked with Bristol Green Capital, West of England Healthier with Nature, and local community groups to co-produce an event encouraging local residents to connect with local outdoor spaces for their wellbeing. 20 organisations fed into the co-production and event planning, and 140 people and eight local grassroots organisations attended the event. The event allowing people to try out taster sessions for six green social prescribing projects.

A key priority for Health Education England (HEE) is to encourage student nurses and registered professionals to gain experience working in social care settings. However, the take up of placements in social care by student nurses in Bristol, North Somerset and South Gloucestershire is currently low. During Autumn of 2022, we commissioned an insight project to explore the opportunities and barriers to increasing placements for student nurses in nursing homes. This included perceptions of nursing homes and placements in these settings, and the process of matching students to placements, from both a student and Higher Education staff perspective.

The outcome of this insight work is informing the focus of work between social care providers, health education providers, and the ICB to further develop and increase the number of high-quality placement opportunities within nursing homes. This includes developing a plan to address the barriers to nursing homes offering placements, and optimising take-up of those placements.

Making co-production everyone's business and embedding best practice

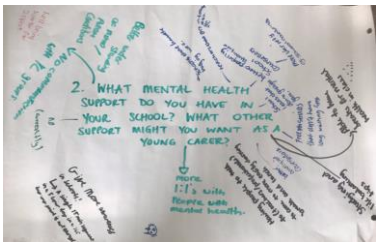
We are committed to going beyond consultation and discussion, to embedding true collaboration and co-production with our people.

Children and Young People

Co-production formed a key part of the development of the Children and Young People's (CYP) Outcomes Framework. The views of children and young people were a key criterion used to

prioritise outcomes along with identifying the size and impact of the health inequality, availability of data, and the extent of the population health need.

Through 2022/23, the ICB's children and families transformation team held nine co-production sessions with established children and young people's groups linked to partner organisations. This involved more than 65 children and young people aged between 10 and 18-years old.



The team also visited 10 family friendly events, youth groups and a university fair to talk to families and young people about what keeps them happy, healthy, and well as part of Have Your Say.

Following the sessions, we identified four priority areas for activity - better mental health support, community safety, poverty and cost-of-living support, and the importance of strong friendships and positive relationships**.** We are building on this approach by working with young people employed by Barnardo's Helping Young People Engage (HYPE) service who will consult with their peers to inform and meaningfully influence the design and delivery of services and programmes that directly impact them.

Bristol, North Somerset and South Gloucestershire Locality Partnerships

Each of the six Locality Partnerships in our ICS works as one team to understand what matters most to their local community. They then share their expertise, experiences, and knowledge to improve services for their population and ensure people are at the heart of every decision.

For example, Inner City and East Locality has one of the most diverse populations in the South West, it is also a place where structural and entrenched discrimination drive persistent health inequalities in minoritized communities. Reducing these health inequalities is the aim of the Inner City and East Locality, and to help achieve this the Locality Partnership adopted a set of guiding principles. One of the first principles was a commitment to transformative coproduction, where those most impacted by the issue are closest to the design, decision-making and delivery. This was used to develop the governance of the Locality Partnership Board, where there is now a majority from the Voluntary, Community, and Social Enterprise sector and people with Lived Experience, compared to the number of representatives from statutory organisations.

The Inner City and East Locality has also adopted the approach of designing at the margins, where services are designed for marginalised communities, rather than for the dominant group with small modifications at the edges. We initially used this approach in the Locality's response to the national Community Mental Health Programme by setting up Reference Groups with those with lived experience of mental health issues, those from local community and faith organisations, as well as the mental health workforce. We continue to use this approach in our

work with Children and Young People, and in our response to the national Ageing Well programme.

In Weston, Worle, and Villages the ICB, the West of England Academic Health Science Network, Pier Health Group, and VSCE partners are collaborating on a family health improvement programme to optimise cholesterol management for Core20PLUS communities. Based on the Brazilian Family Health Strategy, the project aims to reduce cardiovascular risk of patients from two GP surgeries in the One Weston Locality's most deprived communities through the use of a Community Health & Wellbeing Worker approach.

Community Health & Wellbeing Workers act as the eyes and ears of primary care in the community. They are lay members of the community who are trained, paid, and integrated into the GP practice and proactively and regularly visit local households to build trust and relationships, promote prevention opportunities, provide chronic disease support, connect to local services and act as a point of contact.

Reducing Health Inequality and Inequalities

ICBs have a duty to reduce inequalities between persons with respect to their ability to access health services, and the outcomes achieved for them by the provision of health services as outlined in section 14z35 of the NHS Act 2006 (as amended by Health Care Act 2022). Under the Public Sector Equality Duty 2011 ICBs are required, in carrying out their functions, to have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010; advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Health Inequalities

We have continued the work started by our predecessor organisation, BNNSG CCG, to reduce health inequalities and we are committed to advancing equality and reducing health inequalities for our diverse population.

In the summer of 2022, we led a system-wide population health needs assessment, called 'Our Future Health'. Population health management approaches were used to set out the key issues and inequalities faced by our communities. The report, which can be found at OurFutureHealth-Sept-2022-1.pdf (icb.nhs.uk), highlights the 'health gaps' between different groups of people, notably linked to deprivation and ethnicity. These gaps begin in early life and widen through to older age. For example, people in the most deprived areas have the same level of ill-health in their early 50's as people in the least deprived areas in their late 60's. People with a Bangladeshi ethnicity experience the same level of health in their 50's as people with a Chinese ethnicity do in their 70's. These insights and others have been central to developing our strategic approach to health and wellbeing, and will be described in the ICS Strategic Plan and the Joint Forward Plan. This will be taken forward in the priority setting for our system-wide strategy.

We have continued to embed the Core20Plus5 approach for adults to focus on certain conditions/health risk factors for groups of people who experience health inequalities. This national NHS England approach focuses on:

- people living in the 20% most deprived areas nationally;
- plus, other groups of the population that may be experiencing health inequalities (acknowledging the frequent cross over between those two groups);
- for five different areas of care or health conditions (maternity; severe mental illness; chronic respiratory disease; early cancer diagnosis; hypertension and lipids (cholesterol).

A children and young people-specific version of Core20Plus5 has been launched and we are planning how to implement in Bristol, North Somerset and South Gloucestershire. We have worked to ensure that a focus on tackling health inequality is embedded in our planning processes so that we ensure a consistent focus on reducing health inequalities across our system and increase ownership with specific programmes.

ICB Workforce Inequality

We have developed a People Strategy based on extensive insights work undertaken with staff. The resulting People Plan, overseen by the ICB People Committee, includes specific key actions focused on reducing inequality within our workforce. The ICB Inclusion Council oversees the delivery of these actions.

We have continued work to ensure that recruitment is inclusive and equitable and to attract a diverse talent pool. This includes the addition of new Inclusion requirements within person specifications and template Job descriptions for the ICB; managers continued to have access to line manager and recruitment training and resources.

We have continued to focus on building an inclusive culture with the redesign and roll out of a centralised reasonable adjustment process, co-designed with the Disability Staff Network and reviewed by the Business Disability Forum. A robust wellbeing offer continues to help staff stay physically and mentally well including access to Mental Health First Aiders, culturally appropriate mental health support, an onsite gym in our office at 360, Bristol and guidance to support financial literacy.

Work to review Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES) data to identify opportunities to improve the working life experience of our ethnic minority and disabled staff continues. We are committed to monitoring and acting on evidence. The most recent mandatory and statutory reporting can be found in the Bristol, North Somerset and South Gloucestershire ICB Equality Annual Report for 2022. Regular temperature checks have been taken to ensure that Equality, Diversity and Inclusion initiatives have an impact. We have also continued to support our four staff networks (race, disability, parents and carers and LGBTQ+) who represent the voice of staff at key strategic forums

Across this period, we held a range of training and engagement events across both the ICB and wider ICS to raise awareness of Equality, Diversity and Inclusion issues affecting the diverse workforce and population. These have included Green Social Prescribing Workshops, continuation of the Inclusion Roadshows and ‘Imagine If’ sessions to support community engagement.

ICS Workforce Inequality

The ICS partners adopted a system approach to improving Equality, Diversity and Inclusion across a number of shared objectives including inclusive recruitment, supporting staff networks,

BAME talent management, and improving the robustness and quality of Equality Impact Assessment.

In addition to the events mentioned above, two specific programmes were delivered to support the advancement of staff from BAME backgrounds across our system, the 'Make it Right' programme and 'Believe' programme. Guidance documentation has been delivered to support positive action across all system partners and an inclusive recruitment review has started across the system.

During 2022/23, we started work to deliver the Equality Delivery System (EDS) 2022 at a system level. EDS 2022 is a system that helps NHS organisations to have conversations with staff, local partners and population in order to review and improve performance for people with characteristics protected under the Equality Act 2010 and Public Sector Equality Duty. This has included system review of equalities data including WRES, DES and gender pay gap to support system wide improvements in supporting staff with protected characteristics.

The ICB is also working with system partners in relation to the Accessible Information Standard to collectively improve accessible communications and engagement for patients.

Working with Health and Wellbeing Boards and the Health and Wellbeing Strategies

The ICB is a key partner in each of the three Health and Wellbeing Boards (HWBs) of Bristol, North Somerset and South Gloucestershire, where the ICB Director of Strategy, Partnerships and Population serves as Deputy Chair. We have worked with our three Directors of Public Health to produce this section that describes the engagement and consultation undertaken with our three HWBs.

In 2022/23, the ICB worked closely with the three HWBs to develop a Strategic Framework for Bristol, North Somerset and South Gloucestershire, which was published December 2022. The Strategic Framework sets out the overarching aims, vision and mission of our Integrated Care System, and identifies the most important things we need to address to improve population health in Bristol, North Somerset and South Gloucestershire:

- Prevention
- Inequalities
- Clustering of needs
- Workforce sustainability

The process to develop the Strategic Framework also involved joint working with Health and Wellbeing Boards to:

- Facilitate public engagement through the *Have Your Say* listening exercise, which involved approximately 54 public events and over 3,000 responses to an online survey.
- Develop a strategic population health needs assessment for the whole of Bristol, North Somerset and South Gloucestershire: *Our Future Health*. This work builds on the Joint Strategic Needs Assessments of the three HWBs and highlights key opportunities for improving population health, along the life course (i.e. 'from cradle to grave').

The Strategic Framework and *Our Future Health* align closely with the Health and Wellbeing Strategies of the three HWBs in Bristol, North Somerset and South Gloucestershire. This reflects the shared goals of Local Authorities, the NHS and our partners in all three Health and Wellbeing Boards.

In 20223/23, the ICB has also worked closely with partners in the three HWBs, to deliver integrated care through Locality Partnerships. Each of the six Locality Partnerships in Bristol, North Somerset and South Gloucestershire is aligned to one Local Authority area, and the ICB Locality Delivery Directors are members of the Health and Wellbeing Board for that area.

South Gloucestershire Health and Wellbeing Board

The South Gloucestershire Health & Wellbeing Board (HWB) has held four formal meetings during 2022/23. Colleagues from the ICB have supported or participated in HWB discussions which included highlights such as the Learning Disabilities Partnership report, combatting drug and alcohol misuse, clean air, and discharge to success. We have also aided in Joint Health and Wellbeing Strategy (JHWS) deep dives into three of the four aims in the JHWS.

The meeting papers can be viewed on the South Gloucestershire Council Health and Wellbeing Board site.

The JHWS for 2021/25 has an overarching theme of reducing inequalities and taking a place and community-based approach, and four strategic objectives, which are illustrated below:

Each of the priorities has an associated action plan and nominated lead(s) from across the HWB membership.

The ICS Strategic Framework is closely aligned to these objectives and themes. The Strategic Framework, highlights mental health as the most impactful condition affecting people living in Bristol, North Somerset and South Gloucestershire of all ages. The Strategic Framework also identifies priorities for improving health and wellbeing for children and young people and identifies healthy weight as a priority along the life course.

Bristol Health and Wellbeing Board

The Bristol Health & Wellbeing Board (HWB) has held six formal meetings during 2022/23. Colleagues from the ICB have supported or participated in HWB discussions, the highlights of which included papers on suicide prevention, fuel poverty, cost of living, immunisations, stroke services and domestic abuse and sexual violence.

The meeting papers can be seen on the Bristol City Council Health and Wellbeing Board site.

The Bristol Joint Health and Wellbeing Strategy is set within the context of the Bristol City Council "One City Plan" and is updated annually to reflect changing priorities. The 2022 update highlights the following priorities:

Many of these priorities have also been identified as part of the ICS Strategy development process, including: mental health, especially in adolescence, smoking and substance abuse, healthy weight, and trauma.

Additionally, in Bristol South, to directly support the aims of the HWB, we have been working with Feeding Bristol to extend the work of their Children's kitchen, which works in the most deprived 20% of areas of Bristol to encourage healthy eating, improve access to quality food and share how to cook it. They were successful in obtaining funding from the ICB to further extend their food leaders programme which offers digital food leader's courses to those who work in early education.

The North Somerset Health and Wellbeing Board

The North Somerset Health & Wellbeing Board (HWB) has held three formal meetings during 2022/23. Colleagues from the ICB have supported or participated in HWB discussions on a range of topics; of particular importance was the continued support on the Healthy Weston

Programme, which is now in Phase 2. This Programme aims to ensure that Weston Hospital becomes a thriving hospital at the heart of the community, supporting the wider ambitions of the HWB.

You can find meeting minutes and agendas on the North Somerset Health and Wellbeing Board site.

The Joint Health and Wellbeing Strategy for 2021/24 has a focus on shared aims to reduce health inequalities, improve the health and wellbeing of people living and working in North Somerset, and to enable organisations, communities, and residents to come together around a single vision for North Somerset. The priorities in the JHWS are illustrated below:

The strategy and its action plan were developed in partnership with organisations across North Somerset. The ICS Strategic Framework is aligned to many of these priorities including a focus on mental health, tobacco use and substance misuse

Environmental Matters

We are committed to delivering the Green Plan agreed by our predecessor organisation, Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group, and we will formally adopt the plan in early 2023/24. The Bristol, North Somerset and South Gloucestershire Green Plan can be found at Healthier Together Integrated Care System Green Plan 2022-2025 - NHS BNSSG ICB

The Green Plan focuses our system work over the forthcoming years as high standards of quality health and care are delivered whilst addressing the environmental impact this creates. Our sustainability vision is set out as one of our seven Integrated Care System (ICS) strategic aims:

“We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 20230; improving the quality of the natural environment; driving efficiency of resource use”

Our Deputy Chief Executive, Sarah Truelove, is the nominated ICB executive lead for sustainability and is a member of the Bristol, North Somerset and South Gloucestershire ICS Green Plan Steering Group which is expanding to cover the breadth of partner organisations in the system which is so crucial to driving change. Greener NHS have made available £5,000 to support ICB Board training.

As part of the ICS, we want to do more than just minimise any negative impact of our activities and our Green Plan shows how, through developing sustainably, we can make a significant positive contribution to the local economy, society and environment. We have set out the commitments we have made to deliver three key outcomes for our population which we will do by holding a shared ambition, establishing the enabling conditions for change including the allocation of resources, coordinating highest impact projects, and creating assurance of delivery of actions.

Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution. This will create a cleaner, safer, more ecologically sound environment locally and globally, including restoring biodiversity as much as possible

Net zero carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030

Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

Working in partnership, we have agreed how we will commit resources to co-ordinate and lead delivery across the system. An ICS Head of Sustainability post has been jointly funded to assist with the delivery of our shared ambitions.

The Green Plan Steering Group is identifying opportunities for collaboration including Climate Adaptation -Heat Vulnerability, travel initiatives, Communications and engagement, and funding streams. It is also focused on identifying Key Performance Indicators so that data can be used track delivery. The ICB has commenced reporting through the Green Plan Support Tool provided by NHS England.

To promote the importance of sustainability, and in fulfilment of our stated pledge governing capital investments, the directors of finance across our system use a capital prioritisation matrix

which makes positive contributions to sustainability a pass/fail requirement, unless there are exceptional circumstances. Through the Estates Group work has begun to prioritise our pooled capital resources. Sustainability is a core component of this initiative and for 2024/25 £3m has been committed to support sustainable developments.

In the ICB we have further developed Our Hybrid Way of Working with more remote working and less time spent in an office base. To do this we have exploited digital opportunities to keep colleagues and connected and engaged. This way of working has reduced the impact of commuting on the environment, and also on staff. For staff who have a need to travel, colleagues continue to be able to access benefits associated with the Cycle to Work Scheme. Recently we have confirmed our commitment to the use of public transport through our association with First Bus which will provide benefits to staff when using their services as part of the Commuter Travel Club. As part of the hybrid working initiative the ICB is working to reduce our office footprint from three sites to one and this work will continue in 2023/24. Although the ICB does not have a fleet of vehicles, electric vehicle charging points are specified as part of the requirements which will support the use of these vehicles by South Central and West Commissioning Support Unit who provide the ICB and general practice with IT services. The provision of our digital infrastructure for general practice continues to cater for remote working which also reduces the need for travel while enabling connections between patients and clinicians. We continue to use the standard NHS contract which requires providers of health care to meet NHS Green Plan responsibilities.

We are continuing with the Weston Villages Primary Care building development. This will result in a new building which, through the BREEAM (Building Research Establishment Environmental Assessment Method) Excellent Standard, will have a positive environmental impact. It is anticipated that this development with open in Summer 2023.

Meanwhile, we have worked with partners and other stakeholders to replace the Graham Road surgery in Weston super Mare with a new development on the Weston Rugby Club site. This development will also meet the BREEAM Excellent Standard. The developer for this new site had included an Energy and Sustainability Statement in support of the planning application which demonstrates a strong focus on minimizing energy consumption and making the scheme as sustainable as possible.

NHS Property Services (NHSPS) has set out its own green plan, and the ICB and system partners are dependent on this landlord for contributions which support the green plan. Commitment has been made by NHSPS to replace lighting in premises to reduce energy consumption. Additionally, consultants have been engaged to identify how pilot premises could reduce carbon footprint and the level of investment that would be required. For non-NHSPS owned primary care properties funding has been allocated to undertake 25 energy surveys of GP owned surgeries to identify opportunities to make energy savings and reduce environmental impact. This will enable assessment of the scale of investment needed and saving opportunities across these properties.

Financial review 2022/23

The financial year 2022/23 was another unique one for the NHS, our patients and population, and partners in social care, public health commissioners and providers as we started our recovery from the unprecedented impact of Covid-19 pandemic. Some notable issues were as follows:

- the first where the NHS 'system by default' financial framework delivery and performance regime was in place.
- the demise of Bristol, North Somerset and South Gloucestershire CCG and the establishment of the ICB from 1 July 2022.
- recovery of core services, while continuing to live with Covid, and a return to 'routine' population-based NHS funding allocations.
- continued progress towards NHS Long Term Plan ambitions.
- significant inflationary cost pressures and multiple in year changes to NHS pay awards, tax and National Insurance thresholds.

It is very pleasing to report that in this challenging context the ICB met all its core financial duties for the year; as well as meeting the financial duties across the Integrated Care System.

Whilst the ICB is audited as a statutory public body and has prepared its accounts for the period 1st July 22 to 31 March 23, NHS England's performance management regime works on an annualised basis, taking into account the financial position of the ICB, the predecessor CCG and constituent NHS partner bodies. The ICB novated what were generally annual commissioning contracts with providers and prepared monthly managements accounts with the aggregate of CCG and ICB budget and expenditure positions and used this to hold budget holders to account and to identify, address and mitigate emerging pressures. It should also be noted that whilst the ICB plans focus its population, the providers in the ICS have significant inflows of patients along with teaching and research income, notably for specialised services on a regional and occasionally national footprint. Avon and Wiltshire Mental Health Partnership also has income and assets related to the Bath, Swindon and Wiltshire ICB population footprint.

The annual financial plan for 2022/23 was prepared as a system financial plan, and useful lessons were learned about governance processes, joint decision-making across multiple stakeholders and shared ownership of planning and delivery. The final allocations and a balanced financial plan for 2022/23 was approved by the predecessor CCG Governing Body later than desired in June 2023, when funding for excess cost inflation and for Elective Recovery was confirmed with NHS England. The opportunity to engage partner Boards and incoming ICB Non-Executive and Executive Directors was taken.

Within this context the ICB has reported a small surplus of £2.7k (0.00%) against the In-Year Revenue Resource Limit of £1,489,985k. The draft financial statements report the total system revenue financial position as a surplus of £349k, as analysed below:

Table 8

Organisation	Surplus / (Deficit)
	£000's
Bristol, North Somerset and South Gloucestershire ICB (Q2-Q4)	**3**
Bristol, North Somerset and South Gloucestershire ICB (Q1)	-
Net Commissioning sector	***3***
University Hospitals Bristol and Weston NHS Foundation Trust	21
North Bristol NHS Trust	315
Avon and Wiltshire Mental Health Partnership NHS Trust	9
Net Provider sector	***346***
Total System	***349***

The goal of the system was to ensure breakeven for each organisation and a commitment to shared system working and management of financial and operational risk.

This is the third successive year that the ICB and predecessor CCG has delivered a balanced financial position. As well as demonstrating financial control and value for the taxpayer, this is important because the predecessor CCGs accumulated deficits against allocations of £116 million; and NHS England has confirmed that delivering breakeven or better in both financial years 2022/23 and 2023/24 will result in the cancellation of this debt and remove the need to pay back in future years.

In delivering the outturn position savings of £8.892 million were achieved:

Table 9

Control Centre	2022/23 Month 12		
	YTD planned net saving £ms	YTD actual net saving £ms	YTD Variance £ms
Running Costs/Support costs	0.375	0.375	-
Funded Care	3.000	2.113	0.887
Medicine Optimisation	4.404	4.433	(0.029)
Mental Health	1.579	1.971	(0.392)
Total	**9.358**	**8.892**	**0.466**

Providers also delivered a further £29.394m of savings in 22/23

The total system capital envelope was £84.9155m and the outturn position was £85.171m, as shown below:

Table 10:

	Capital Allocation £m	2022/23 Expenditure £m	2022/23 Variance £m
AWP	5.348	5.346	0.002
NBT	20.750	21.287	(0.537)
UHBW	56.513	56.244	0.269
CCG/ICB	2.304	2.294	0.010
TOTAL	**84.915**	**85.171**	**(0.256)**

Financial performance and outlook

The ICB spent £1.944 billion on behalf of the patient population during 2022/23. This is in line with the total notified allocation, achieving a small nominal surplus of £0.003 million.

Table 11

March 2023 - Month 12	2022/23 Budget	2022/23 YTD Budget	Expenditure	Variance		Report Ref
Programme Area	£m	£m	£m	£m		
Acute	1,007.207	1,007.207	1,008.616	(1.408)		2.3
Mental Health	213.467	213.467	212.829	0.638		2.5
Community	209.075	209.075	209.149	(0.075)		2.6
Delegated Primary Care	166.890	166.890	167.673	(0.783)		2.7
Medicines Management	149.442	149.442	150.162	(0.721)		2.7
Primary Care	43.398	43.398	40.296	3.102		2.7
Funded Care	101.629	101.629	106.521	(4.892)		2.8
Childrens	20.993	20.993	20.721	0.272		2.9
Support Costs	21.243	21.243	22.205	(0.962)		2.10
Reserves	-8.003	-8.003	-13.506	5.503		2.10
Running Costs	18.621	18.621	19.291	(0.670)		2.10
BNSSG ICB Surplus/(Deficit)	**1,943.961**	**1,943.961**	**1,943.958**	**0.003**		
Provider Surplus/Defict	-	0.000	0.346	0.346		
ICS Position	**1,943.961**	**1,943.961**	**1,944.304**	**0.349**		
				-0.02%		

There was a small overspend against Delegated Primary Medical Services allocations, offset by small underspends against Core Programme Allocation and Running Costs (Administration) Allocations:

The financial year was affected by the following factors:

- The opening budget was not balanced due to excess inflationary pressures, caused by pay inflation (notably in the care market) and prescribing. Additional funding was successfully negotiated.
- Late notification of NHS pay-awards, as well as numerous personal tax changes caused by instability in Government fiscal policy led to funding allocation changes and renegotiation of contract prices with key NHS and non-NHS providers. The full cost of the final Agenda for Change pay award was higher than the funding allocated by NHS England.
- Continued investment in the NHS Long Term Plan ambitions, notably in Primary Care; Mental Health & Learning Disabilities, as well as dedicated Service Development Funding for Cancer, Learning Disabilities Community Capacity and Community Mental Health services invested through plans developed by the six Locality Partnerships.
- Investment in the local 'Home First' strategy, including c£20m in Discharge to Assess, jointly with local authorities; and £3.5million for Stroke services.
- A new Elective Services Recovery Fund of £38million was allocated to ensure progress on reducing planned care backlogs, including eliminating long waits. Whilst it was initially envisaged that funding would be clawed back for under-delivery, the funding policy was subsequently changed due to higher-than-expected COVID activity and funding was retained despite challenges in recovering activity to pre-pandemic levels.
- As the financial year began, it quickly emerged that Covid prevalence levels had not reduced as quickly as assumed in NHS planning guidance, and together with returning levels of other infectious diseases such as Flu and Strep A, this would lead to a difficult winter for NHS services. To address these challenges three subsequent funding packages were released, first £14.2million for Urgent & Emergency Care 'Demand and Capacity', then a further £11.5million joint NHS and LA allocation for discharge support, and for Quarter 4, access to a further Hospital Discharge Fund of £2.7million. Adapting to this required fast paced and agile decision-making, which helped support immediate operational responses to the pressures to be mobilised and a notable turnaround in Urgent & Emergency Care performance was achieved in Quarter 4 from a very challenging Quarter 3. This enabled the bringing forward of planned Home First investments but lead in times and recruitment meant that short term solutions were also sought which it was recognised did not always align with the medium-term strategy which aims for reduced reliance on bed-based care and wasn't best value for money.
- As the year developed Funded Care expenditure levels began to overspend against budget, as nursing care activity began recovering from the Covid pandemic, Funded Care Fast Track pathways were used to support Hospital Discharge, a growing cohort of complex, high acuity patients have been discharged from hospital institutions into community settings, and staff shortages delayed delivery of savings plans.
  This in-year overspend was mitigated by underspends caused by slippage on planned investments, notably in mental health services which was caused primarily by workforce availability.
- Delays in recruitment to urgent community care services was largely offset by additional expenditure on Ambulance services to create capacity to offset the impact of longer handover delays.

- The impact of pay negotiations between Government and the NHS Staff Council remains unresolved at the time of preparing the accounts. The ICB has therefore made provision for community staff as the proposed one off non-consolidated pay award for 2022/23 currently excludes non-NHS providers even where they match Agenda for Change terms and conditions.

The additional Government and NHS funding for Urgent & Emergency Care, together with the retention of Elective Services Recovery Funding supported achievement of financial plans and mitigated delays in delivery of transformation savings and the new cost pressures arising in year. However, as demand begins to recover to pre-pandemic levels, further investment is made in elective recovery, and the full year impact of Home First and Urgent & Emergency Care investment takes place the underlying deficit of the ICS is exposed.

Looking forward to 2023/24, the ICB and provider partners in the ICS have worked together to develop a medium-term financial plan that demonstrated return to recurrent financial balance by 2025/26, alongside a transition plan to manage the in-year pressures. However, cost inflation in 2023/24 is forecast to be significantly higher than funded levels and challenging to control giving a cost pressure of £38million. This includes the impact of energy prices, inflation pressures where contracts are linked to RPI, drug prices and care market costs which are driven by mandatory increases in minimum wages together with competition from other low pay sectors. At the time of writing, industrial action is ongoing, and it is assumed that any additional pay inflation pressures will be fully funded by Government.

In this context, the ICB has developed a balanced budget and has plans to achieve most NHS England operational priorities for 2023/24. The 2023/24 plan requires delivery of approximately 3% cash releasing savings across all NHS provider partners; and also, approximately £98 million of non-recurrent, non-repeatable actions, including non-recurrent NHS England funding of £12million, planned slippage on investments, as well as the release of all identified contingencies and provisions. The ICB and partners will therefore need to focus on delivery of all the benefits identified in the medium-term financial plan and the business cases that support new investment plans.

As set out above, achievement of financial balance in 23/24 will ensure £116million of accumulated historic deficits are written off, together with access to additional capital funding, more autonomy and influence with NHS England.

The delay in delivery of recurrent savings in 2022/23 and the impact of a further £38million pressure from excess inflation in 2023/24 means the ICB and partners do not yet have a fully costed plan to return to financial balance beyond 2024/25.This will need to be addressed in the next iteration of the medium-term financial plan by September 2023.

ACCOUNTABILITY REPORT

Shane Devlin

Accountable Officer

29 June 2023

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April to 30 June 2022, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

The Corporate Governance Report includes:

- The Members Report
- The Statement of Accounting/Accountable Officers Responsibilities and
- The ICB Governance Statement

We provide information about the ICB Board and Committees, explain there were no Personal Data Incidents between 1st July 2022 and 31st March 2023. We also include the ICB Modern Slavery Statement.

ICB Board Members Report

The ICB Board membership is set out in our Constitution (Governance Handbook - NHS BNSSG ICB). The ICB Board is responsible for discharging the functions set out in legislation and our Constitution. Our Board is made up of:

- The Chair
- Chief Executive
- Chief Finance Officer/Deputy CEO
- Chief Medical Officer
- Chief Nursing Officer
- Five Non-executive Directors

- Nine Partner members

The nine partner members bring the perspectives from:

- Acute and community mental health services,
- Acute secondary care and tertiary services
- Ambulance services
- Primary care and community services
- Costal, rural and urban communities

For more details about our ICB Board members visit Our Integrated Care Board - NHS BNSSG ICB . Our Board holds meetings in public and we publish our Board papers on our website Events - NHS BNSSG ICB

Details about the declared interests of ICB Board members and participants can be found at ICB register of interests - NHS BNSSG ICB

From 1st July to 31st March voting Board members were:

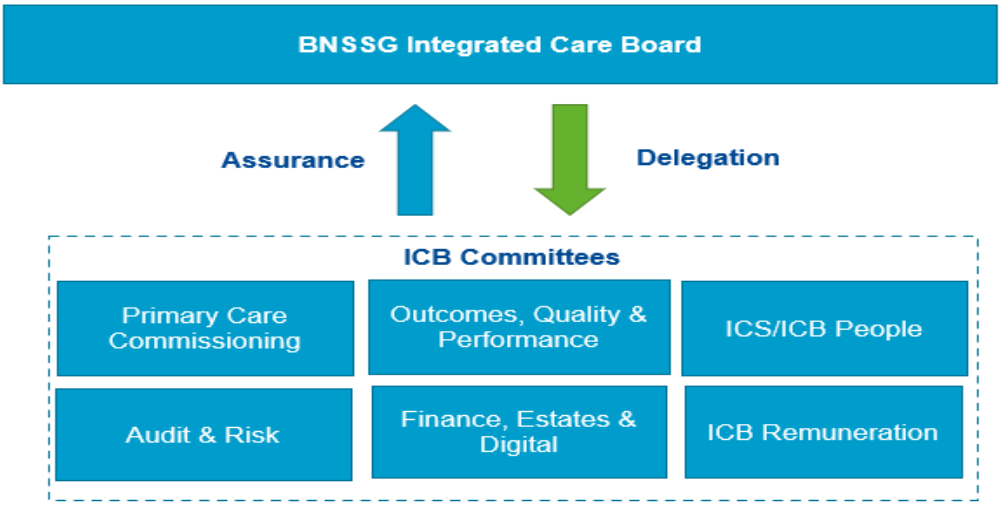
Name	Title	Tenure 2022/23	Attendance
Jeff Farrar	Chair of BNSSG Integrated Care Board	1st July – present	Six of six
John Cappock	Non-Executive Director, Chair of Audit and Risk Committee	1st July – present	Five of six
Jaya Chakrabarti	Non-Executive Director, Chair of People Committee	1st July – present	Six of six
Shane Devlin	Chief Executive Officer, BNSSG ICB	1st July – present	Five of six
Ellen Donovan	Non-Executive Director Chair Quality and Performance Committee and Chair of Remuneration Committee	1st July – present	Six of six
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	1st July – present	Six of six
Jon Hayes	Chair of the GP Collaborative Board	1st July – present	Four of six
Mike Jackson	Chief Executive, Bristol City Council	1st July – 30th Sept 2022	Three of three
Maria Kane	Chief Executive Officer, North Bristol Trust	1st July – present	Five of six
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	1st July – present	Four of six
Alison Moon	Non-Executive Director, Chair Primary Care Committee	1st July – present	Six of six

Stephen Peacock**	Chief Executive, Bristol City Council	1st January 2023 – present	Two of two (Closed sessions)
Dave Perry	Chief Executive, South Gloucestershire Council	1st July – present	Four of six
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	1st July – present	Five of six
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	1st July – present	Six of six
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	1st July – present	Six of six
Jo Walker	Chief Executive Officer, North Somerset Council	1st July – present	Four of six (check this)
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	1st July – present	Three of six
Steve West	Non-Executive Director – Finance, Estates and Digital	1st July – present	Five of six
Eugine Yafele	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	1st July – present	Four of six (check this)

Participants regularly attending the ICB Board in 2022/23 included:

Name	Title
Julie Bacon	Interim Chief People Officer, BNSSG ICB
Colin Bradbury	Director of Strategy, Partnerships and population BNSSG ICB
Deborah El-Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB
Jo Hicks	Chief People Officer, BNSSG ICB
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB
Lisa Manson	Director of Performance and Delivery, BNSSG ICB
Ruth Taylor	Chief Executive Officer, One Care
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire
Sue Doheny	NHS England SW Chief Nurse

Our ICB Board has six committees that report to it. Their terms of reference can be found here Governance Handbook - NHS BNSSG ICB. We provide more information about our committees, their membership and attendance details, including the Audit and Risk Committee, in the Governance Statement (p59).



Personal data related incidents

A personal data breach is a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.

If we experience a personal data breach at the ICB, we need to consider the impact on the individual or group of individuals. We need to consider the likelihood and severity of the risk to people's rights and freedoms, following the breach. Once this assessment has been made by our Data Protection Officer, if it's likely there will be a risk then we will notify the Information Commissioner's Office (ICO). If it's unlikely then we will deal with the breach according to our policies, without reporting to the ICO.

In the period covered by this report, 1st July 2022 to the 31st of March 2023, there was one reported incident to the ICO. In February 2023 personal data was disclosed in error. The ICO has stated no further direct action will be taken but recommended the ICB highlight the importance of double-checking attachments and recipients when communicating both internally and externally.

Modern Slavery Act

NHS Bristol, North Somerset and South Gloucestershire ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. Our Modern Slavery and Human Trafficking Statement can be read at Modern Slavery & Human Trafficking Statement - BNSSG ICB

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Bristol, North Somerset and South Gloucestershire ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Bristol, North Somerset and South Gloucestershire ICB. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Bristol, North

Somerset and South Gloucestershire ICB assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Bristol, North Somerset and South Gloucestershire ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

NHS Bristol, North Somerset and South Gloucestershire ICB is a body corporate established by NHS England on 1st July 2023 under the National Health Service Act 2006 (as amended).

The NHS Bristol, North Somerset and South Gloucestershire ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Bristol, North Somerset and South Gloucestershire ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Bristol, North Somerset and South Gloucestershire ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the NHS Bristol, North Somerset and South Gloucestershire ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and

economically, and complies with such generally accepted principles of good governance as are relevant to it.

The ICB Board composition and attendance is described at (p54). The ICB Constitution sets out how appointments are made to the Board and the process for the joint nomination, assessment, selection and appointment of ICB partner members and role descriptions are on our website. Governance Handbook - NHS BNSSG ICB

NHS England approved the ICB Constitution prior to its established and at its inaugural meeting the ICB Board approved a range of governance documents that set out the arrangements we have in place to ensure we maintain a robust system of internal control Governance Handbook - NHS BNSSG ICB:

- The ICB Constitution
- Standing Orders
- Standing Financial Instructions
- Functions and decision map
- Scheme of Reservation and Delegation
- Committee Terms of Reference

Six committees are accountable to the ICB Board. Our committees are each chaired by a non-executive director of the ICB Board. The committees kept their terms of reference and membership under review throughout the period:

Audit and Risk Committee

The Audit and Risk Committee provides the ICB Board with an independent objective view of and assurance on controls and governance arrangements. The Committee is responsible for the oversight of financial reporting and disclosure and is chaired by a non-executive director who is a qualified accountant and has experience at Director of Finance level. Membership of the Committee and attendance at meetings are detailed in the table below. The Audit and Risk Committee provides assurance to the Board that an appropriate system of internal control is in place, so that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for

- Financial statements are prepared in a timely fashion and give a true and fair view of the financial position for the period in question
- Economic, efficient and effective use of resources is secured
- Adequate arrangements are in place and reasonable steps are taken to prevent and detect fraud and other irregularities
- An effective system of integrated governance, risk management and internal control across the whole of the ICB's activities is established and maintained.

Name	Title	Attendance
John Cappock	Non-Executive Director, ICB Chair of Audit and Risk Committee	Four of four
Jaya Chakrabarti	Non-Executive Director, ICB Board	None
Ellen Donovan	Non-Executive Director ICB Board	Four of four
Lorna Harrison	Non-Executive Director, Sirona	One of one
Alison Moon	Non-Executive Director, ICB Board	Four of four
Jane Norman	Non-Executive Director, UHBW	Two of two
Jo Walker	Chief Executive Officer, North Somerset Council	Two of two
Steve West	Non-Executive Director ICB Board	One of four

Remuneration Committee

The Remuneration Committee makes decisions on all aspects of remuneration and other allowances (including pension schemes) for employees not covered by Agenda for Change terms and conditions and other individuals providing services to the ICB. More detailed about the committee's role is contained in its Terms of Reference Governance Handbook - NHS BNSSG ICB

The Remuneration Committee membership is drawn from the ICB Board non-executive directors and from ICB Board partner members. Membership and attendance are detailed in the table below:

Name	Title	Attendance
Ellen Donovan	Non-Executive Director ICB Chair of Remuneration Committee	Five of six
Jaya Chakrabarti	Non-Executive Director, ICB Board	Four of six
Jeff Farrar	Chair ICB Board	Five of six
Alison Moon	Non-Executive Director, ICB Board	Six of six
Steve West	Non-Executive Director ICB Board	Five of six
Dominic Hardisty	Mental Health Provider Members ICB Board	One of one
Jon Hayes	Primary Care Member ICB Board	One of one
Mike Jackson	Local Authority Member ICB Board	One of one
Maria Kane	Provider Member ICB Board	One of one

Outcomes, Performance and Quality Committee

Our Outcomes, Performance and Quality Committee and oversees and seeks assurance on the effective delivery of the ICB Operational Plan and that cohesive and comprehensive structures are in place for effective planning, management and improvement of outcomes, quality and performance. The committee's Terms of Reference provide more detail about its responsibilities Governance Handbook - NHS BNSSG ICB . The membership and attendance at meetings are detailed in the table below. Details of performance matters can be found in the Performance Report from page 4.

Name	Title	
Ellen Donovan	Non-Executive Director ICB Chair of Outcomes, Performance and Quality Committee	Nine of nine
Sue Balcombe	Non-Executive Director ICB UHBW	Two of six
Hugh Evans	Executive Director Adult Social Care Bristol City Council	Five of six
Sue Geary	Healthwatch	Three of four
Jon Hayes	Primary Care Director ICB Board	Two of three
Lisa Manson	Director of Performance and Delivery, ICB	Eight of nine
Paul May	Non-Executive Director Sirona	Four of six
Jo Medhurst	Chief Medical Officer, ICB	Two of six
Rosi Shepherd	Chief Nurse, ICB	Eight of nine
Sarah Weld	Director of Public Health, South Gloucestershire Council	Four of four

Finance, Estates and Digital Committee

The Finance, Estates and Digital Committee considers all draft strategic and financial plans prior to their submission to the Board for approval, including the financial plans associated with the Operational Plan, Joint Forward Plan and savings plans. The Committee monitors the longer term financial strategic direction of the ICB, the delivery of savings plans and the ICB's in year financial performance, identifying key issues and risks requiring discussion and decision by the ICB Board. The committee oversees the development of the ICB Estates Strategy and Digital Strategy and gains assurances that these strategies are embedded into the ICS financial framework. The membership and attendance at meetings are detailed in the table below.

Name	Title	Attendance
Steve West	Non-Executive Director ICB Chair of Finance, Estates and Digital Committee	Eight of nine
John Cappock	Non-Executive Director, ICB Board	Nine of nine
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, ICB	Nine of nine
Richard Gaunt	Non-Executive Director NBT	Two of seven
Christina Gray	Director of Public Health, Bristol City Council	Three of four
Jo Medhurst	Chief Medical Officer, ICB	Four of eight
Nina Philippidis	Section 151 Officer South Gloucestershire Council	Two of six
Brian Stables	Non-Executive Director, AWP	Four of seven
Martin Sykes	Non-Executive Director, UHBW	Three of seven
Sarah Truelove	Chief Financial Officer, ICB	Nine of nine

Primary Care Committee

The ICB has delegated authority for the commissioning of primary medical care, and has established a committee to oversee the contracting of general practice services. The committee provides assurance on the revie, planning and procurement of primary care services delegated by NHS England to the ICB. In 2022/23 these services covered primary care medical services provided by GPs. As of April 2023, this will expand to:

- Primary Care Medical Services
- Primary Dental Services and Prescribed Dental Services
- Primary Ophthalmic Services
- Pharmaceutical Services and Local Pharmaceutical Services

Membership and attendance at meetings are detailed in the table below.

Name	Title	Attendance
Alison Moon	Non-Executive Director ICB Chair of Primary Care Committee	Six of six
Amanda Cheesley	Chair, Sirona	Two of five
David Jarrett	Director of Primary and Integrated Care, ICB	Six of six
Jo Medhurst	Chief Medical Officer, ICB	Two of five
Sarah Purdy	Non-Executive Director, NBT	Three of four
Rosi Shepherd	Chief Nursing Officer, ICB	Two of six
Sarah Truelove	Chief Financial Officer, ICB	Two of six

People Committee

The People Committee is made up of the ICS People Committee and the ICB People Committee. The ICB People Committee oversees the development of the ICS People Strategy and Plan, monitoring its implementation across the system. The committee challenges and scrutinises workforce risks, ensuring mitigating actions are identified

and implemented. The committee seeks assurance on the ICB's Equalities and Diversity Strategy and Equality Delivery Strategies. The ICB People Committee element ensures that the ICB has in place a robust People Strategy and monitors its implementation. The membership and attendance at meetings are detailed in the table below.

ICS People Committee

Name	Title	Attendance
Jaya Chakrabarti	Non-Executive Director, ICB Board Chair of ICS People Committee	Four of four
Julie Bacon	Interim Chief People Officer, ICB	Four of four
Kevin Blake	Non-Executive Director NBT	Three of three
Bernard Galton	Non-Executive Director UHBW	Four of four
Jo Hick	Chief People Officer, ICB	One of one
Helen Holland	Chair Bristol Health and Wellbeing Board	Three of four
Jo Medhurst	Chief Medical Officer, ICB	One of four
Ernie Messer	Non-Executive Director AWP (Retired April 2023)	Three of three
Rosi Shepherd	Chief Nursing Officer, ICB	Three of four
Sarah Truelove	Chief Financial Officer, ICB	One of three

ICB People Committee

Name	Title	Attendance
Jaya Chakrabarti	Non-Executive Director, ICB Board Chair of IBS People Committee	Four of four
Julie Bacon	Interim Chief People Officer, ICB	Four of four
Colin Bradbury	Director of Strategy, Partnerships and population ICB	Two of four
Ellen Donovan	Non-Executive Directors, ICB Board	Four of four
Alison Moon	(Shared membership)	
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, ICB	One of four
Shane Devlin	Chief Executive ICB	One of four
David Jarrett	Director of Primary and Integrated Care, ICB	Three of four
Lisa Manson	Director of Performance and Delivery, ICB	One of four
Jo Medhurst	Chief Medical Officer, ICB	Two of four
Rosi Shepherd	Chief Nursing Officer, ICB	Four of four
Sarah Truelove	Chief Financial Officer, ICB	Three of four

ICB Decision Making Framework

The ICB Board agreed the adoption of a decision-making framework which sits within the governance arrangements. The aim for decisions of the ICB to be timely, responsive and proportionate. The Decision-Making Framework aligns to the Scheme of Reservation and Delegation and Standing Financial Instructions), distributing

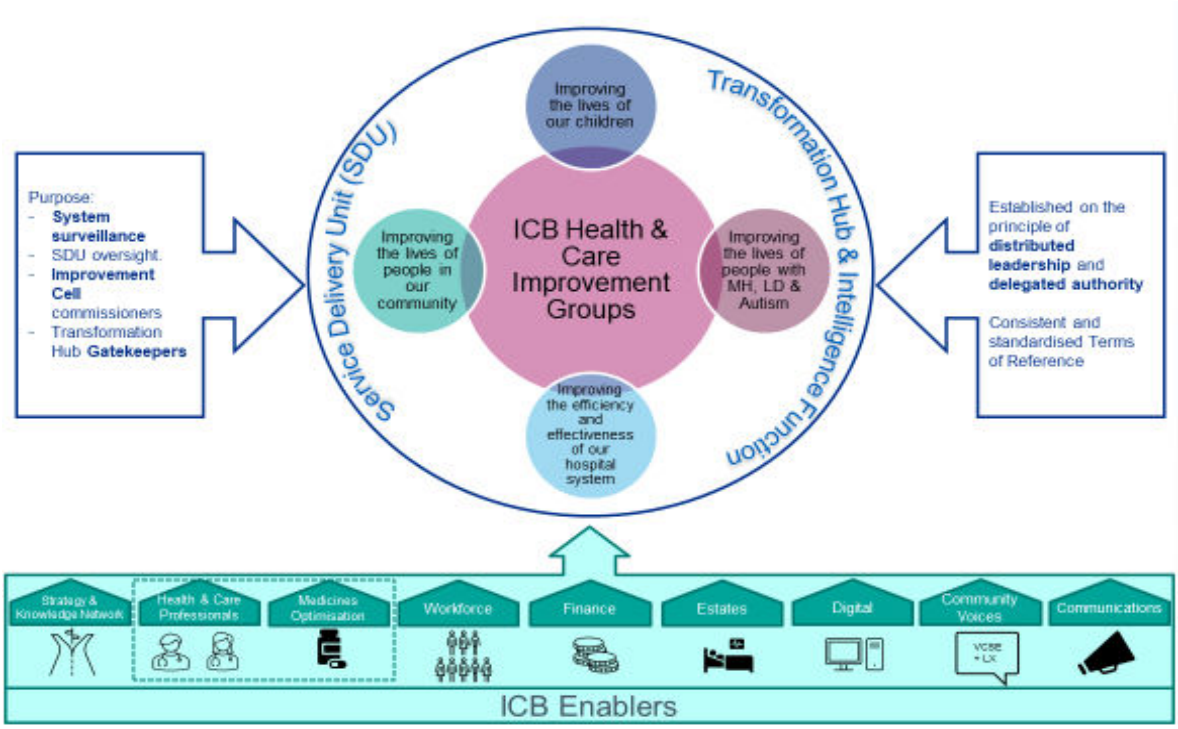
decision making in accordance with the delegated authorities set out in these documents. The decision-making framework is at p66

The decision-making framework introduces new system groups with specified delegated authority:

The System Executive Group (level 2) is made up of the ICS's delivery partners (NHS (including One Care), and Local Authority) Chief Executives, and is chaired by the ICB Chief Executive. This group drives activity requested by the ICB Board, takes system decisions when required within delegated limits and is a forum for deeper discussions on system challenges or opportunities.

The Health and Care Improvement Groups (level 2a) are responsible for achieving the ICS's System Deliverables: the ICS Integrated Care Strategy (including the ICS Green Plan) and subsequent System Outcomes and Joint Forward Plan, national priorities as directed by NHS England and the ICB in-year and medium term financial operating plan

The Health & Care Improvement Groups provide the surveillance structure for the system; ensuring our ICS partners and ICB enabler functions are working together effectively and collaboratively. They operate under standardised terms of reference, with system delivery as their primary purpose. The ICB Health & Care Improvement Groups are the gatekeepers of the ICB Transformation Hub; driving innovation and continuous improvement. The ICB Health & Care Improvement Groups once established will report directly to the ICB Board.



BNSSG Integrated Care System Decision-Making Framework	System Function / Types of Decision	Example of Decision	System Delegation (£)
Level 0 — Integrated Care Partnership; Health & Wellbeing Boards (x 3)	Setting health and care strategy	Agree 5, 10, 20 year strategy	£0 - no delegated authority
Level 1 — ICB Board	Oversight of NHS system financial resources Sign off of NHS LTP response / JFP Approval of operational delivery plans Sign off the outcomes framework	Approve ICS LTP response / **5-Year JFP** Approve operational plans Sign off system finance plans and ICB Budget Approve system capital priorities Approve Long Term Financial Model A decision to move outside of nationally agreed Terms and Conditions	>£1million
Level 1a — ICB Committees	Oversight and assurance for relevant functions e.g accountability for effective performance management framework	Recommend Risk Management Framework is adopted by the ICB Board	£0 - no delegated authority
Level 2 — System Executive Group (If Required)	Actions from ICB Board Issues from ICB Committee's Oversight of major programmes Risk by exception Operational Decision making **if required**	Agree to establish a Winter Control Centre. Review recommendations from Winter Control Centre and make system operational decisions. **All decisions taken by the System Executive Group will be recorded in a register and reported to the ICB Board via the ICB Chief Executive report.**	£500K - £1million*
Level 2a — See '2a: The Detail' slide — ICB Health & Care Improvement Groups; ICB Transformation Hub; ICB Service Delivery Unit; ICB Enablers	Support strategic delivery across Transformation Programmes and System Financial Position	Recommend allocation of SDF funding based on understanding of population need an current services in this area	<£500K*
Level 3 — NHS Statutory Organisational Boards; **Provider Collaboratives; **Locality Partnerships; **GPCB	Set organisational strategy within the context of the health and care strategy and the Long Term Financial Model Provide oversight of organisational quality, performance and financial delivery	Approve organisational budgets within the framework of the system LTFM	£ Organisational annual budget
Level 3a — NHS Trust Executives / Divisional Boards			£ In accordance with organisations SORD

System Aim: Functions and decisions of ICB to be timely, responsive and proportionate

**As system matures, Provider Collaboratives, Locality Partnerships and the GPCB will be delegated budgets as system delivery partners

*ICB Executive delegated authority as set out in SORD

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. The ICB is required to undertake a Governance and Partnership Review in 2023/24 that will help to inform the development of the ICB, its partnership arrangements, the ICB Board and the governance arrangements.

Discharge of Statutory Functions

NHS Bristol, North Somerset and South Gloucestershire ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties supported where appropriate by resources commissioned from South Central and West Commissioning Support Unit (SCWCSU).

Risk management arrangements and effectiveness

The ICB has adopted risk management arrangements focused on the management of risk within the ICB and developed an ICS Risk management framework. Our internal ICB risk management arrangements can be found in the ICB Governance Handbook Governance Handbook - NHS BNSSG ICB . This defines the structures for the management and ownership of risk within the ICB. The Audit and Risk Committee seeks assurances on the ICB governance arrangements including financial governance and risk management. The ICB committees are responsible for the oversight and scrutiny of risks within their remit. The Board receives monthly updates from each committee which include the escalation of concerns where committees are not sufficiently assured. The risk management framework includes a risk appetite statement. Further information on the development of an ICS risk appetite statement which will be adopted by the ICB is given below. During 2022/23 the ICB Corporate Risk Register was reviewed by the ICB committees. During quarter four the ICB executive carried out an in-depth review of the Corporate Risk Register to ensure that it correctly captured the key internal risks. The ICB Corporate Risk Register identifies

risks to the achievement of the ICB objectives, highlights gaps in controls and assurances and details the mitigations to be implemented. Risks are identified through data analysis, external and internal audit reports and other regulatory reporting mechanisms, incident reporting, complaints and litigation, and staff concerns/whistle blowing. Risks are evaluated and assessed using a risk scoring matrix set out in the Risk Management Framework and are reported through Directorate and Corporate Risk Registers. Risk is embedded in the reporting arrangements to the Board as part of the standard paper template. Equality Impact Assessments are used to assist with the identification and mitigation of risks. Equality Impact Assessments also form part of the standard template for papers to the ICB Board and committees.

As part of the framework of control the ICB has in place processes for the reporting, investigation, management and learning from incidents. All serious incidents and risks are reported through incident reporting procedures. Incident reports and trends are used to identify risks, and this is referenced in the Risk Management Framework.

Our work with patients and members of the public ensures that our local people are involved throughout our planning and commissioning processes and these present the opportunity for public stakeholders to highlight relevant risks and engage in discussions around how to mitigate them.

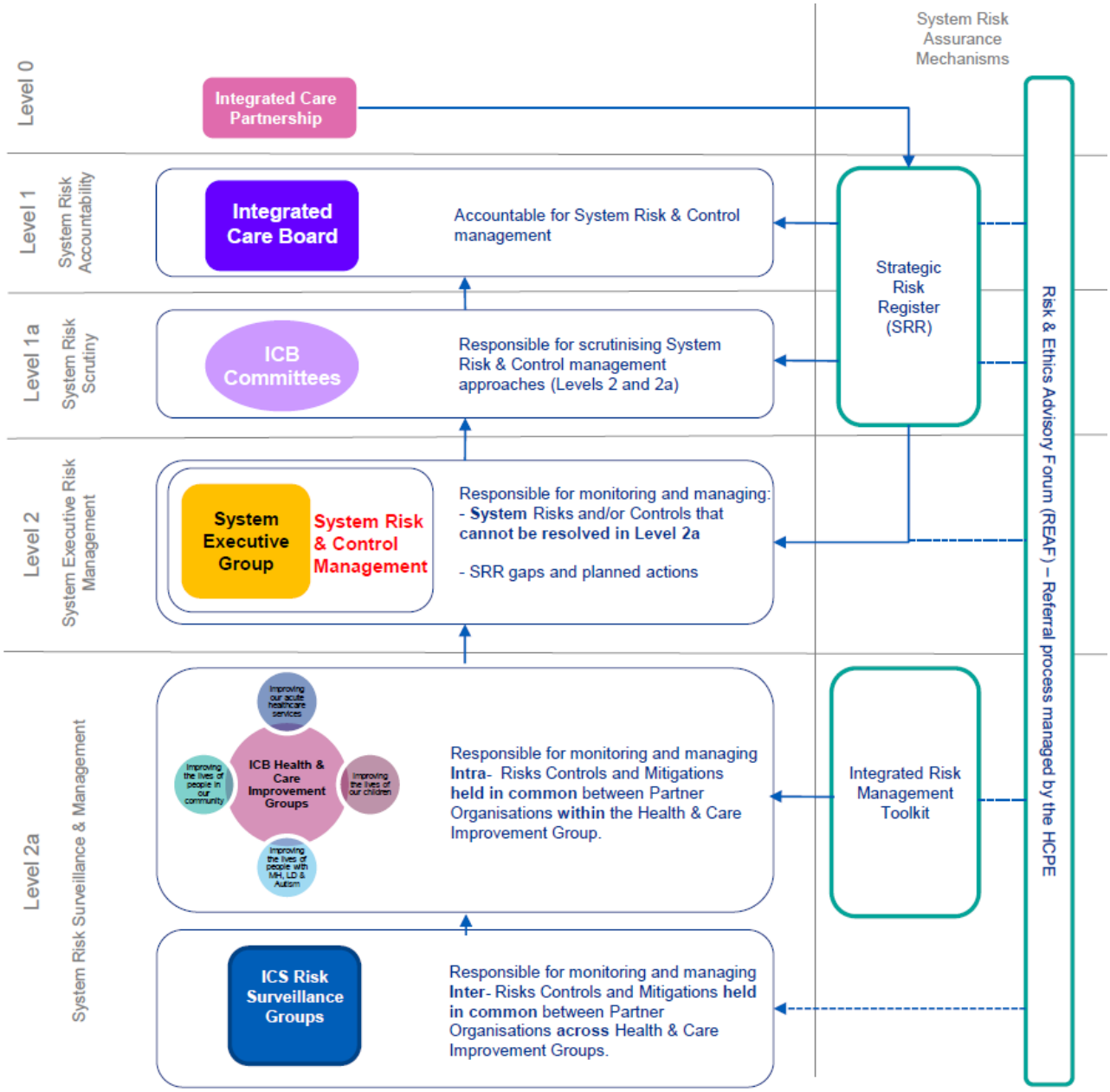
In support of the Risk Management Framework and Policy, the ICB has adopted policies for managing conflicts of interest and gifts and hospitality, and tackling fraud and bribery. The ICB has established Standing Financial Instructions.

ICS System risk management

As our ICS establishes how it will deliver health and care services in partnership it is important that there is a structure in place to enable the identification of system risks to delivering these services. To support this the ICB led work in 2022/23 to develop a framework and a set of principles for managing system risks. A system risk is defined as a risk that is held in common between health and care partner organisations which cannot be controlled or mitigated by individual partners in isolation. The responsibility for ownership and management of system risks is shared across ICS partners.

The ICS Risk Management Framework developed describes the principles for identifying system risks, escalation protocols for system risks and supporting arrangements for health and care partners to use to better understand and manage actions to control and mitigate system risks. The levels of system risk surveillance,

management, scrutiny and accountability (below diagram) mirror the ICB Decision Making Framework (p66).



To provide assurance to the ICB Board on principal strategic risks to the achievement of the core aims of the ICB a Strategic Risk Register is being developed for 2023/24. This will support the ICB Board and committees to review and scrutinise system risks, the mitigations and controls in place to manage them and map assurances. The ICB Board began to identity core objectives and risks in January 2023 and this will inform the assurance process for 2023/24. The ICB is leading work to develop a shared system risk appetite which will ensure there is common understanding and shared risk appetite.

Capacity to Handle Risk

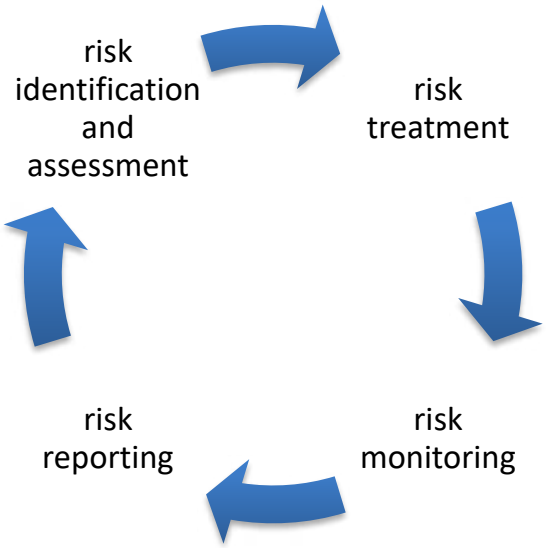
The ICB's policy is to identify, minimise, control and, where possible, eliminate risks that could have an adverse impact on patients, staff and the organisation. As Accountable Officer I carry ultimate responsibility for all risks within the ICB. Our Risk Management Framework and the ICS Risk Management Framework describe the governance structures and responsibilities for risk management within the ICB and across partners including the roles of the Board and its committees.

The ICB Board receives monthly reports on performance and quality, and finance providing timely, accurate data that supports the ICB Board in the assessment of risks, including risks to compliance with statutory obligations. The Board's regular review and interrogation of these reports and other ad hoc reports enables it to have robust and rigorous oversight of performance. The Health and Care Improvement Groups provide system wide fora for monitoring system risks and mitigations, and with the System Executive Group support the reporting of risks to the ICB Board.

Staff are required to undertake training for the management of risk where relevant. In addition to core risk management training, training sessions and e-learning was available for key topics such as health and safety, manual handling, basic life support, infection control, fire safety, conflict resolution and information governance. It is mandatory for employees to undertake training on an annual, bi-annual, or three-yearly basis, as appropriate to their role. Learning is drawn from good practice, performance management, continuing professional development where relevant, audit and the application of evidence-based practice.

Risk Assessment

Risk assessment and management follows the steps described in the diagram below



Risks are identified and assessed using a risk-scoring matrix, risks are analysed, the actions required to mitigate them are identified and implemented and the impact of these mitigations is monitored. Risks are reported through Board reports and via the committees through the Corporate Risk Register. Major risks to governance, risk management and internal control in 2022/23 are detailed below and at page 76 'Control Issues':

- Increased waiting times across key services including A&E, 52 week waiting times, access to planned care and diagnostic services and cancer waiting times, waiting times ADHD services
- Risks related to the delivery of core mental health services
- Patients were at risk of harm due to ambulances being unable to attend calls within required timeframes, and ambulance handover delays
- Patients were at risk of potential harm through contracting Healthcare Associated Infections

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is described through the Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions for the ICB. These ensure compliance with statutory requirements for the management of governance. Internal audit and the counter-fraud service provide an independent review of internal controls.

The risk assessment component of the internal system of control is contained in the Risk Management Framework as described previously.

The Board has a clear understanding of the key pressures facing the organisation. A key element of control is the provision of assurance through regular reporting including but not limited to:

• Audit and assurance reports

• Minutes of committees of the ICB and other key groups

• Strategic planning

• Reports on patient safety and quality of clinical care

• Performance management

• Financial management

Procurement activities are carried out within the framework of control set out in legislation and regulation. The ICB has a range of policies relating to information governance, human resources, health and safety, equalities and diversity, and emergency preparedness and resilience, all of which contribute to the internal control environment.

As Accountable Officer, I am responsible for reviewing the effectiveness of the system of control and for providing leadership and direction to staff. Other members of the Executive Team have lead responsibility for the specific systems of control that fall within their remit:

Deputy Chief Executive/Chief Finance Officer:

- Governance framework and risk management framework,
- Financial controls and financial risk

Chief Nursing Officer:

- Quality of services
- Patient safety and safeguarding
- Customer experience and complaints

Chief Medical Officer:

- Innovation and research
- Caldicott Guardian

The Director of Transformation/Chief Digital Officer:

- Management of information governance and related risks as the Senior Information Risk Officer (SIRO)

The role of all of our Executive Directors is to ensure that appropriate arrangements and systems are in place so that risks are:

- identified and assessed
- eliminated or reduced to an acceptable level
- effectively managed

Executive Directors ensure that staff comply with policies and procedures, and statutory as well as regulatory requirements.

Conflicts of interest management

The ICB arrangements to manage actual and potential conflicts of interest include:

- Managing Conflicts of Interest and Gifts and Hospitality Policies
- the appointment of a Conflicts of Interest Guardian – the chair of the Audit and Risk Committee
- an internal process requiring regular declarations to be made supported by a regular reminder system
- regular updates and reminders through the internal newsletter
- monthly updating of the register of interests on the ICB website
- regular audits undertaken by the Corporate Governance Team
- statutory and mandatory training

Data Quality

The information used by the ICB Board and its Committees enables the ICB to carry out its responsibilities and discharge its statutory functions. Information is strategic operational, financial, or relates to outcomes, performance, quality and patient experience. The Board and its Committees are engaged in a continuous cycle of improvement with regard to the quality of the information received. The reports received underwent regular review and improvement. The Board found the quality of data to be acceptable. No risks relating to the quality of data were highlighted between 1st July 2022 and 31st of March 2023.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The ICB completed the Data Security and Protection Toolkit submission for 2021/22 and reported that they had met the standards expected. The ICB is on target to submit 2022/23 submission by the deadline date of 30th June 2023.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

Information risk management is considered to be the responsibility of all staff. The ICB Director of Transformation and Chief Digital Officer is the Senior Information Risk Owner (SIRO) and responsible for providing assurance to the Board and to me regarding information governance. The SIRO is familiar with, and takes ownership of, information risk management, acting as advocate for information risk management on the ICB Board. The ICB Chief Medical Officer is our Caldicott Guardian, actively supporting the ICB and enabling information to be shared where appropriate.

There are processes in place for incident reporting and the investigation of serious incidents and this encompasses information governance. The NHS Digital Guide to the Notification of Data Security and Protection Incidents is used in the investigation of all information governance related incidents.

Business Critical Models

An appropriate framework and environment were in place to provide quality assurance of business-critical models, in line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models.

Third party assurances

The ICB purchases services from the South Central and West Commissioning Support Unit which include HR, procurement, IT, and information governance support. Independent assurances on these services are provided through service auditor reports. Day to day assurance of the above services is achieved through regular performance meetings attended by senior members of staff from both organisations. ISAE3402 Assurance Letters of Comfort are received and shared with the Chief Financial Officer, and the Internal Auditors. The internal auditor reviewed:

- The Service Auditor Report from the internal auditors of NHS Shared Business Services who provide services to the ICB. This was an unqualified report.
- The Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering financial, payroll and non-clinical procurement services. The service auditors did not feel this impacted on the effectiveness of the control framework, and has not affected the Head of Internal Audit Opinion for the ICB
- The Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering CQRS (calculating quality reporting systems) services. The findings were not of sufficient significance to affect the Head of Internal Audit Opinion for the ICB.
- The Service Auditor Report from the internal auditors for NHS England in regard to GP Payments. The findings were not sufficiently significant to impact the Head of Internal Audit Opinion for the ICB.
- We reviewed the Service Auditor Report from the internal auditors for the NHS Business Services Authority for Prescriptions Payments Process. The findings

were not sufficiently significant to impact the Head of Internal Audit Opinion for the ICB..

- The Service Auditor Report in relation to Capita for Primary Care Support Services. The findings have not impacted on our overall Head of Internal Audit Opinion.
- The Service Auditor Report from the internal auditors of ESR (Electronic Staff Record Programme) who provide a single payroll and Human Resources management system to the ICB. The findings have not impacted on our overall Head of Internal Audit Opinion.

Control Issues

The following control issues were reported to NHS England in the January 2023 Governance Statement return. More detail about performance is provided in the Performance section of the Annual Report (p13).

Access to services/capacity - diagnostics

Delivery has been challenging and mitigations have included optimised recovery plans and waiting list initiatives coupled with the use of independent sector capacity. Workforce issues have been addressed through recruitment drives and the piloting of a new model to accelerate the training of clinical endoscopists. Other workforce approaches have involved a shared bank model. Further collaboration with the Independent Sector in 2023/24 will aim to increase capacity.

Accident and Emergency

A&E performance remains significantly challenged with pressures driven by delays in discharges, the continued impact of outbreaks of Covid-19, ‘flu and norovirus. Mitigations have included investment in the Bristol, North Somerset and South Gloucestershire Discharge to Assess service and adult social care and the seasonal use of a Care Hotel. We are developing an Urgent Care Workforce strategy to address the significant workforce issues.

Mental Health and Dementia

The impact of Covid-19 and other outbreaks such as ‘flu impacted on our mental health services. We met regularly with providers and NHS England to monitor the position and in period of extreme pressure the focus was placed on whole system support to keep people safe.

Planned Care

Performance against the targets for the length of time people waited for planned treatment and care has shown improvements although national targets were not met. Mitigations have included targeting specific waiting lists and those waiting over 104 weeks and over 78 weeks. Additional capacity has been identified and waiting list validation continues with clinical prioritisation. We continue to work with Independent Sector providers to source additional capacity.

Ambulance services

Whilst maintaining strong resourcing levels, the ambulance service has experienced high levels of hospital handover delays, which increased the number of cases waiting in the clinical call stack and affected performance levels, especially Category 2 and Category 3 performance. Mitigating actions have included increasing ambulance validation in 111, developing access to 24/7 mental health crisis services, developing direct referral protocols and alternative destinations to ED, developing the directory of services, and the implementation of safely reducing avoidable conveyance schemes such as improved access to care plans. A process has been agreed at regional level to establish learning from incidents in cases where the SWAST incidents may have been associated with wider system pressures rather than just the organisation.

Cancer

Performance has been challenged however we have seen some improvements against targets. Mitigating actions have included a Bristol, North Somerset and South Gloucestershire wide non-site-specific rapid diagnostic service pilot for patients with "vague symptoms" and who do not meet the criteria for established 2 week wait referrals. The Targeted Lung Health Check will go live in three Bristol Primary Care Networks in 2023. Health Inequalities work remains a core workstream and maintains focus on the screening programmes (breast, bowel, cervical and lung) working with public health and community organisations to reduce inequality for Black, Asian and minority ethnic people and people with Severe Mental Illness or a Learning Disability.

Finance, Governance and Control - Procurement

There was one legal challenge to a procurement in 2021/22 which continued into the 2022/23; legal advice was taken. The challenge concerned a joint procurement with other CCGs and the CCG was not responsible for the management of the procurement. The ICB reached a settlement agreement with the claimant and a review of

procurement process was completed. Action was taken to strengthen our procurements processes and the review and learning were shared with the Audit and Risk Committee.

Review of economy, efficiency & effectiveness of the use of resources

The ICB undertakes a comprehensive range of contract monitoring, benchmarking and budget monitoring to ensure the robust management of resources.

The ICB Board has overarching responsibility for ensuring that the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance.

Detailed performance, quality and finance reports, which included the use of comparative analysis to assess performance, are presented at each ICB Board meeting. These reports provide an overview of progress against key indicators and financial objectives.

The Audit and Risk Committee has oversight of internal and external audit, reviews financial and information systems and monitors the integrity of the financial statements. The Audit and Risk Committee receives regular reports from Internal and External Audit as well as Counter Fraud. External Audit, as part of its audit plan, reviewed the ICB's governance arrangements to identify whether it had in place appropriate arrangements for securing economy, efficiency and effectiveness in its use of resources.

The ICB's Scheme of Reservation and Delegation and Standing Financial Instructions underpin the use of economic, efficient and effective resources. These are supported by budgetary controls and other policies and procedures. The Internal Audit Reports relating to the main accounting process have provided assurance regarding these arrangements. Regular contract management processes are established with providers to link service quality, performance and financial management.

Financial planning and in-year performance monitoring

The financial year 2022/23 was another unique one for the NHS, our patients and population, and partners in social care, public health commissioners and providers as we started our recovery from the unprecedented impact of Covid-19 pandemic. Some notable issues were as follows:

- the first where NHS 'system by default' financial framework delivery and performance was in place

- the demise of the predecessor CCG and establishment of Bristol, North Somerset and South Gloucestershire ICB from 1 June 2023
- recovery of core services, Living with Covid, return to 'routine' NHS commissioning funding allocations
- continued progress towards NHS Long Term Plan ambitions
- significant cost inflationary pressures and multi-year changes to NHS pay awards and tax and National Insurance thresholds

It is very pleasing to report in that context that the ICB met all of its core financial duties for the year; as well as meeting the new Integrated Care System duties.

Whilst the ICB is audited as a statutory public body, and has prepared its accounts for the period 1st July 22 to 31 March 23, the NHS performance management regime is based on an annualised basis and taking account financial position of the ICB, predecessor CCG and constituent NHS partner bodies. The ICB novated what were generally annual commissioning contracts with providers and prepared monthly managements accounts with the aggregate of CCG and ICB budget and expenditure position and used this to hold budget holders to account and address and mitigate emerging pressures. It should also be noted that whilst the ICB has a duty to serve its population, the ICS has significant inflows of patient care and teaching and research income, notably for specialised services on a region and national footprint, and Avon and Wiltshire Mental Health partnership income and assets related to Bath, Swindon and Wiltshire population footprint.

The annual financial plan for 2022/23 was prepared as a system financial plan, and useful lessons were learned about governance processes, joint decision-making across multiple stakeholders and shared ownership of planning and delivery. The final allocations and balanced plan were approved by the predecessor CCG Governing Body later than desired in June 2023, whilst funding for excess cost inflation and for Elective Recovery was confirmed with Government. The opportunity to engagement partner boards and incoming ICB Non-Executive Directors and Executive Directors was taken.

Regular financial monitoring and reporting arrangements exist and these are accompanied by actions to address emerging financial risks, and development and delivery of recovery plans, where necessary. Assurance of the financial position is provided to the Board via the Finance, Estates and Digital Committee, which receives

monthly reports on system financial position, ICB financial position and ICB savings position. The Committee has also received deep dives into high-risk areas, and areas of concern. The Bristol, North Somerset and South Gloucestershire ICS Directors of Finance Group, supported by a Deputy Directors of Finance group, continued to meet weekly, usually with NHS England assurance colleagues present, to oversee the system-wide financial planning and in year performance. The workings of this group are shared with Finance, Estates and Digital Committee.

Bristol, North Somerset and South Gloucestershire System Directors of Finance collaborate to maintain a rolling 5-year Medium Term Financial Plan. The plan aims to maximise use of resources for our population and NHS providers; and deliver ICS duty to achieve breakeven in each financial year, with a minimum contingency of 0.5% of system revenue allocation. The plan is reviewed each financial year, refreshed to take account of the latest underlying system cost base, and notified NHS funding allocations. The inputs to the model take account of Government and Office for Budget Responsibility economic indicators and forecasts; notified NHS funding allocations;, local strategy; approved business cases at Strategic Outline Case, Outline Business Case or Final Business Case level; system sponsored transformation programmes; local and national guidelines such as NHS England Operational Planning Guidance and Long Term Plan; national contracts and frameworks, such as Agenda for Change pay policy and GP contracts; plans from other major commissioners such as NHS England Specialised Commissioning, Health Education England; and best practise and benchmarking data, such as NICE guidelines, CQC and other regulator recommendations, NHS GIRFT programmes and benchmarking from a variety of sources. The NHS Medium Term Financial Plan is assured by ICB Finance, Estates and Digital Committee and recommended for approval by ICB Board. Local Authority Medium Term Financial Plan is assured through local authority governance, and ultimately relevant Mayor, Cabinet and Full Council approval. The plan is also reported to the Integrated Care Partnership. System Directors of Finance have agreed to a distributed leadership model to align themselves to key system enablers such as Health and Care Improvement Groups, and Enablers such as Digital Delivery Board, Estates Steering Group and Workforce Steering Group; to ensure professional financial advice and feedback between financial strategy and other strategies. System Directors of Finance meet weekly and are supported by a weekly Deputy Directors of Finance Group. ICB and local authority Directors of Finance meet fortnightly.

At present there are separate models for System revenue (Resource Departmental Expenditure Limit basis) [incorporating costs analysed between NHS programme spend categories, inter-system and intra-system funding flows to NHS providers, primary care providers and Sirona, funding flows between NHS and LAs, and provider costs analysed between pay, non-pay, and financing costs]; System capital (Capital Developmental Expenditure Level basis) [incorporating major medical equipment, digital, operational estates and strategy investments including those funding by NHS Programmes]; and 3 local authorities Medium Term Financial Plans. System Directors of Finance have an ambition to create a fully integrated financial strategy, plan and model incorporating Income and Expenditure, balance sheet, and cash flow; as well as integrating this with associated workforce, activity, capacity, performance, estate and digital plans; all aligned with ICS Strategy and the Joint Forward Plan.

The purpose of the plan is to provide parameters and judge affordability of key investments and decisions required over multiple years and beyond the period of certain funding sources eg multi-year commissioning contracts, capital investment and borrowing decisions and multi-year contracts for supply of goods and services, and recruitment of staff. The Medium Term Financial Plan forms the baseline for the annual operating plan and budget. Whilst maintain delivery of statutory financial duties and further financial parameters defined by Government or NHS England regulation (eg. Mental Health Investment Standard, Running Cost allowance).

The plan will identify evidence-based opportunities for savings and efficiencies, including the cashable benefits of transformation and against a reasonable do-nothing growth scenario taking account cost inflation, business as usual efficiency plans, demographic demand growth and long term non-demographic demand growth.

The plan can allow for recurrent deficits as long as non-recurrent funding sources are identified and the plan is balanced within 5 years. A key assumptions, risks and mitigations log is also maintained and incorporated into both ICB and system partners risk registers.

Once the overall plan is balanced but there remains surplus/deficits within individual organisational plans the System Directors of Finance will propose solutions to Healthier Together Executives to enable all organisations to achieve a balanced financial plan.

Central management costs

Our central management costs are contained within our Running Cost Allowance. The CCG and ICB identified and delivered savings to achieve the annual Running Cost Allowance of £20.798million in 2022/23.

Delegation of functions

Where the ICB has delegated functions internally feedback is received through bottom-up information such as performance reports, the evaluation and assessment of processes, the review of the corporate risk register, evidence from internal audit reports highlighting failures in internal controls and or the poor management of risk and also from feedback from whistle-blowers through its Freedom to Speak Up arrangements (p104).

Where the ICB has chosen to commission business functions from other organisations, services are managed against a service level agreement and subject to regular performance review and independent audit where applicable. The ICB commissions the South Central and West Commissioning Support Unit to provide a number of services. Feedback is gained on business, use of resources and responses to risk through independent assurance, principally Service Auditor Reports as described previously. The ICB receives general ledger services from Shared Business Services Limited, and payroll services from North Bristol Trust.

Counter fraud arrangements

The ICB's counter fraud arrangements are aligned with the NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption.

The ICB's annual Counter Fraud Plan, focussing on risk-based prevention and deterrence, is overseen by the Audit and Risk Committee. A Counter Fraud Bribery and Corruption Policy, helping staff to understand in simple terms what fraud, bribery and corruption are and containing useful guides on how to identify fraud, together with details on how to report and how cases will be dealt with, is in place. The policy emphasises that it is the responsibility of all staff to work to prevent fraud and protect the assets of the NHS. The policy is supported by the Management of Conflicts of Interest and Gifts and Hospitality Policies. A Local Counter Fraud Specialist (LCFS) is contracted by the ICB to provide counter fraud training to all staff as part of the staff induction programme. Counter Fraud training is a mandatory element of the ICB's e-learning programme.

The Chief Finance Officer is responsible for overseeing and providing strategic management and support for all counter fraud, bribery and corruption work within the

organisation, and is assisted by the Chair of the Audit and Risk Committee who is the Counter Fraud Champion. The LCFS works in consultation with the Chief Finance Officer to identify and report cases of actual or suspected fraud and ensure that learning identified from any subsequent investigation is implemented.

The Audit and Risk Committee receives regular reports and an annual report outlining compliance against each of the Government Functional Standard GovS 013: Counter Fraud, and identifies risks to be addressed in the annual work plan overseen by the committee. Appropriate action is taken regarding any NHS Counter Fraud Authority (NHSCFA) quality assurance recommendations, in line with NHSCFA Standards.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1st July 2022 to 31st of March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

During the period, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
Key Financial Controls Review	Reasonable Assurance
Agency Arrangements	Partial Assurance
System Performance Management	Reasonable Assurance
System Risk Management	Management Letter Issued
Financial Sustainability	Advisory

The audit work focused on agency arrangements identified the lack of a centralised process and definition of responsibility for managing agency usage and spend across the ICB. This was due to the historic lack of internal HR resource within the predecessor CCG. The audit found the ICB had established a People Directorate

enabling central oversight and ownership of processes. Two high and five medium priority actions were agreed with management and to address the weaknesses and risks identified in the audit. These will be followed up to confirm implementation and reported to the Audit and Risk Committee.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our risk management framework has provided me with evidence that the effectiveness of controls that manage risks to the ICB achieving its objectives are reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the ICB Board, and Audit and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place:

- The Audit and Risk Committee agreed an annual plan for Internal Audit focusing on areas of particular concern or risk. Reports were made to the Committee on audit findings, with assurance and recommendations. Discussions were held with the External Auditors regarding audit plans, and regular reports from Auditors and Counter Fraud colleagues were made to the committee.
- Internal Audit and Counter Fraud provide assurances through their reports on various aspects of internal control to the Audit, Governance and Risk Committee. These reports also provide assurances and support for the work undertaken by the external auditors.

Conclusion

With the exception of the control issues identified and reported in the 2022/23 Month 9 return to NHS England, no significant control issues have been identified during the year.

Shane Devlin

Accountable Officer

29 June 202

Remuneration and Staff Report

This Remuneration and Staff Report provides information about the remuneration of ICB directors and senior managers, and other matters such as compensation on early retirement or for loss of office, any payments to past directors, the fair pay disclosure and staff numbers and costs. The section also contains a report on staff sickness absence, key staff policies, staff engagement, and Freedom to Speak Up arrangements. This is in line with corporate governance best practice.

Remuneration Report

Remuneration Committee

The ICB has established a Remuneration Committee which makes decisions about the remuneration and allowances for Very Senior Managers (VSM) and persons in senior positions within the ICB. More information about our Remuneration Committee, including the membership can be found at the Governance Statement in this report (p58).

Entities are required to disclose:

a - The percentage change from the previous financial year in respect of the highest paid director, and;

b- The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole.

Two percentage figures will therefore be provided for each single total figure component, giving a total of four percentages to be disclosed for each financial year under this requirement. The calculation for salaries and allowances shall be based on the mid-point of the band for each salary and performance pay and bonuses payable.

The calculation for salaries and allowances is the total for all employees on an annualised basis, excluding the highest paid director, divided by the FTE number of employees (also excluding the highest paid director). The calculation in respect of performance pay and bonuses payable is the total for all employees, excluding the highest paid director, divided by the FTE number of employees (also excluding the highest paid director).

The highest paid director in the 9 months to March 2023 and in the financial year 2021/22 was Shane Devlin, ICB Chief Executive.

Shane Devlin did not receive performance pay in the 9 months to March 2023.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS Bristol, North Somerset and South Gloucestershire ICB in the reporting period of July 2022 to March 2023 was £175,000.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table 12.

2022/23	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£29,180	£41,659	£54,619
Salary component of total remuneration (£)	£29,180	£41,659	£54,619
Ratio to highest paid director – Total remuneration	6.00	4.20	3.20
Ratio to highest paid director – Salary component of total remuneration	6.00	4.20	3.20

During the reporting period 2022/23, one employee received remuneration in excess of the highest-paid director/member.

A contractor was engaged as System Chief Operating Officer for the ICB on an annualised salary of £374,000 during the financial year 2021-22 and until September 22. This is higher than the annualised salary of highest-paid director (£175,000).

Remuneration ranged from £12,230 to £374,000 during the period. As at March 2023, remuneration ranged from £12,230 to £175,000.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

The policy on the remuneration of VSM, including members of the ICB Board is set using NHS England guidance. National remuneration guidance for VSM pay was applied for 2022/23.

Remuneration of Very Senior Managers

Advance approval of the Chief Secretary to the Treasury (CST) is required for remuneration packages at £150,000 or above. Where the ICB has VSM roles that fall into this category, business cases for the posts are completed, taking into consideration:

- Influence and impact of role
- The specialist nature of the role including the skills and experience required
- Labour market considerations
- Relevant supporting benchmarking data
- The package of the previous incumbent or any obvious comparators and
- Only when appropriate, biographical information

Table 13 Senior manager remuneration (including salary and pension entitlements)

This statement is audited by the external auditors and is covered by the Audit Opinion issued on the ICB's financial statements.

Name and Title	Note	1 July 2022 to 31 March 2023					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Shane Devlin, Chief Executive Officer	1	130-135	-	-	-	30-32.5	160-165
Jeffrey Farrar, Clinical Chair	2	45-50	-	-	-	-	45-50
Sarah Truelove, Chief Financial Officer and Deputy Chief Executive	3	115-120	-	-	-	-	115-120
Julie Bacon, Interim Chief People Officer	4	95-100	-	-	-	-	95-100
Colin Bradbury, Director of Strategy, Partnerships and Population	5	85-90	-	-	-	32.5-35	120-125
Deborah El-Sayed, Director of Transformation and Chief Digital Information Officer	6	100-105	-	-	-	45-47.5	145-150
Joanne Hicks, Chief People Officer (start date 27/02/2023)	7	10-15	-	-	-	2.5-5	10-15
David Jarrett, Director of Primary and Integrated Care	8	90-95	-	-	-	40-42.5	130-135
Lisa Manson, Director of Performance and Delivery	9	100-105	-	-	-	25-27.5	130-135
Joanne Medhurst, Chief Medical Officer (start date 01/08/2023)	10	95-100	-	-	-	45-47.5	145-150

Name and Title	Note	1 July 2022 to 31 March 2023					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Rosalind Shepherd, Chief Nursing Officer	11	95-100	-	-	-	130-132.5	230-235
Non-Executives							
John Cappock, Non-Executive Member, Chair of Audit and Risk Committee	12	10-15	-	-	-	-	10-15
Jaya Chakrabarti, Non-Executive Member, Chair of People Committee	12, 13	10-15	-	-	-	-	10-15
Ellen Donovan, Non-Executive Member Chair Quality and Performance Committee	12, 13	10-15	-	-	-	-	10-15
Alison Moon, Non-Executive Member, Chair Primary Care Committee	12	10-15	-	-	-	-	10-15
Steve West, Non-Executive Member – Finance, Estates and Digital	12, 13	10-15	-	-	-	-	10-15
Non-remunerated Senior Managers							
Dominic Hardisty, Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	14	-	-	-	-	-	-
Jonathan Hayes, Chair of the GP Collaborative Board	14	-	-	-	-	-	-
Maria Kane, Chief Executive Officer, North Bristol Trust	14	-	-	-	-	-	-
Stephen Peacock, Chief Executive, Bristol City Council	14	-	-	-	-	-	-

Name and Title	Note	1 July 2022 to 31 March 2023					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
(Feb 23 onwards)							
Mike Jackson, Chief Executive, Bristol City Council (Jul- Oct 22)	14	-	-	-	-	-	-
Dave Perry, Chief Executive, South Gloucestershire Council	14	-	-	-	-	-	-
Julie Sharma, Interim Chief Executive Officer, Sirona Care & Health	14	-	-	-	-	-	-
Jo Walker, Chief Executive Officer, North Somerset Council	14	-	-	-	-	-	-
Will Warrender, Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	14	-	-	-	-	-	-
Eugine Yafele, Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	14	-	-	-	-	-	-

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Notes:

No senior manager waived his/her remuneration.

1 The full year equivalent salary for Shane Devlin is £175,000 - £180,000. Shane Devlin received non-taxable relocation expenses during the period July 22 to March 23 as part of his remuneration package.

2 The full year equivalent salary for Jeffrey Farrar is £65,000 - £70,000.

3 The full year equivalent salary for Sarah Truelove is £155,000 - £160,000.

4 The full year equivalent salary for Julie Bacon is £125,000 - £130,000. Julie Bacon was the Interim Chief People Officer. She left the ICB on 31st March 2023.

5 The full year equivalent salary for Colin Bradbury is £115,000 - £120,000.

6 The full year equivalent salary for Deborah El-Sayed is £135,000 - £140,000.

7 The full year equivalent salary for Joanne Hicks is £125,000 - £130,000. Jo Hicks joined the ICB as Chief People Officer on 27th February 2023.

8 The full year equivalent salary for David Jarrett is £120,000 - £125,000.

9 The full year equivalent salary for Lisa Manson is £135,000 - £140,000.

10 The full year equivalent salary for Joanne Medhurst is £130,000 - £135,000. Joanne Medhurst joined the ICB as Chief Medical Officer on 1st August 2022.

11 The full year equivalent salary for Rosalind Shepherd is £130,000 - £135,000.

12 The full year equivalent salary for John Cappock, Jaya Chakrabarti, Ellen Donovan, Alison Moon and Steve West is £15,000 - £20,000.

13 Pension deductions were made in error for Jaya Chakrabarti, Ellen Donovan and Steve West in the period April to Jun 2022. These pension deductions were re-paid to them in full during the period July 2022 to March 2023. Neither Jaya Chakrabarti, Ellen Donovan or Steve West are members of the NHS Pension Scheme.

14 These are non-remunerated posts.

15 Peter Brindle was made redundant on the closedown of the CCG. The package was agreed on 1 July 2022 in line within HM Treasury rules at an original value of £128,000 based on service of 24 years' service with a termination date in January 2023.

Following that agreement, Peter agreed a shorter notice period with a termination date of 31 August 2022, which meant he was only entitled to 23 years redundancy totalling £122,667. The ICB has agreed to pay this as a top up to his pension, to which Peter will contribute £1,632. These transactions have been accrued for in the accounts.

Peter continued to receive his salary in July and August, which totalled £20,711 including pay uplift arrears. During the period 1 July 22 to 31 March 23, his total pension related benefits increased by £7,006.

16 A performance award was paid to the directors in the financial year 2021/22 in line with letter from the Chief People Officer for the NHS dated 8 September 2021. The payments were approved at the Remuneration Committee on 2 November 2021. No performance payments were made in the period April 2022 to June 2022 or in the period July 2022 to March 2023.

17 All Pensions Related Benefits: The real increase in the value of pension benefits accrued during the period excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value of pension benefits accrued during the year is calculated as:

- The real increase in pension multiplied by 20 (for the 12 months from 1 April 2022 to 31 March 2023);
- Less the contributions made by the individual over the same 12-month period;

- Apportioned pro-rata between the periods 1 April 2022 to 30 June 2022 and 1 July 2022 to 31 March 2023 on the basis of calendar days.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual.

Table 14 Pension benefits

This statement is audited by the external auditors and is covered by the Audit Opinion issued on ICB's financial statements.

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2022	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Shane Devlin (note 1)	Chief Executive Officer	0-2.5	-	0-5	-	15	12	45	-
Colin Bradbury	Director of Strategy, Partnerships and Population	0-2.5	0-2.5	35-40	50-55	537	30	591	-
Deborah El-Sayed	Director of Transformation and Chief Digital Information Officer	2.5-5	2.5-5	40-45	70-75	710	43	783	-
Jo Hicks	Chief People Officer	0-2.5	-	0-5	-	-	1	3	-
David Jarrett	Director of Primary and Integrated Care	2.5-5	0-2.5	40-45	75-80	635	34	696	-
Lisa Manson	Director of Performance and Delivery	0-2.5	-	55-60	100-105	912	27	975	-
Joanne Medhurst	Chief Medical Officer	2.5-5	0-2.5	40-45	65-70	742	42	816	-
Rosalind Shepherd	Chief Nursing Officer	5-7.5	12.5-15	60-65	170-175	1229	148	1422	-

Notes:

1 The pension figures are only for this employment. The individual was previously a member of the Northern Ireland NHS Pension scheme. He is currently in the process of transferring across his membership of the North Ireland NHS Pension scheme across to the NHS Pension Scheme, as the membership does not automatically transfer.

2 The ICB has no pension liabilities for Sarah Truelove, Deputy Chief Executive and Chief Finance Officer, Julie Bacon, Interim Chief People Officer and Jeffrey Farrar, ICB Chair. None of these employees are contributing to the NHS Pension Scheme.

3 Non-remunerated senior managers do not receive pensionable pay.

4 Real increase in pension at pension age is calculated based on the increase between 1 April 2022 and 31 March 2023, as adjusted for inflation, pro-rata for 9 months.

5 Real increase in pension lump sum at pension age is calculated based on the increase between 1 April 2022 and 31 March 2023, as adjusted for inflation, pro-rata for 9 months.

6 Real increase in cash equivalent transfer value is calculated based on the increase between 1 April 2022 and 31 March 2023, as adjusted for inflation, pro-rata for 9 months, less the contributions made by the employee in the period 1 July 2022 to 31 March 2023.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements.

Peter Brindle was made redundant on the closedown of the CCG. The package was agreed on 1 July 2022 in line within HM Treasury rules at an original value of £128,000 based on service of 24 years' service with a termination date in January 2023.

Following that agreement, Peter agreed a shorter notice period with a termination date of 31st August 2023, which meant he was only entitled to 23 years redundancy totalling £122,667. The ICB has agreed to pay this as a top up to his pension, to which Peter will contribute £1,632. These transactions have been accrued for in the accounts.

Peter continued to receive his salary in July and August, which totalled £20,711 including pay uplift arrears. During the period 1 July 22 to 31 March 23, his total pension related benefits increased by £7,006.

No payments for compensation on early retirement were received by any senior managers in 2022/23.

Payments to past directors

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements.

Peter Brindle was made redundant on the closedown of the CCG. The package was agreed on 1 July 2022 in line within HM Treasury rules at an original value of £128,000 based on service of 24 years' service with a termination date in January 2023. In addition, Peter Brindle received £20,711 in salary and arrears during the period 1st July 2022 to 31st March 2023 and pension related benefits of £7,006.

Staff Report

Number of senior managers, Staff numbers and costs

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements.

There was an average of number 116 Senior Managers between 1 July 2022 and 31 March 2023.

Table 15 Senior Manager Numbers 1 July 2022 to 31 March 2023

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	6	3	9	0	0	0	6	3	9
Band 9	5	3	8	0	0	0	5	3	8
Band 8D	3	5	8	4	0	4	7	5	12
Band 8C	22	11	33	6	4	10	28	15	43
Band 8B	19	14	33	7	4	11	26	18	44
Total	**55**	**36**	**91**	**17**	**8**	**25**	**72**	**44**	**116**

Staff numbers and costs

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the ICB's Financial Statements, with the exception of any sex analysis.

The total staff costs for the period 1 July 2022 to 31 March 2023 were £25,641,750. The breakdown by cost, contract type and category is set out in the table below.

Table 16 Staff costs 1 July 2022 to 31 March 2023

	Admin			Programme			Total		
	Permanent Employees	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**
Employee Benefits	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	6,750	1,269	8,019	9,943	2,603	12,546	16,693	3,872	20,565
Social security costs	834	0	834	1,116	0	1,116	1,950	0	1,950
Employer contributions to the NHS Pension Scheme	1,804	0	1,804	1,244	0	1,244	3,048	0	3,048
Apprenticeship Levy	76	0.	76	3	0	3	79	0	79
Gross employee benefits expenditure	**9,464**	**1,269**	**10,733**	**12,306**	**2,603**	**14,909**	**21,770**	**3,872**	**25,642**

Included in the above is £1.165m relating to the agenda for change non-consolidated pay offer. The total average number of staff was 519 between 1 July 2022 and 31 March 2023. The breakdown by staff category, contract type and sex is set out in the table below.

Table 17 Staff Numbers 1 July 2022 to 31 March 2023

	Permanent			Other			Total		
Staff Category (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Administrative and Clerical	210	74	284	22	6	28	232	80	312
Medical and Dental	4	4	8	1	0	1	5	4	9
Add Professional. Scientific and Technical	17	7	24	0	0	0	17	7	24
Nursing and Midwifery	53	5	58	0	0	0	53	5	58
Allied Health Professionals	0	0	0	0	0	0	0	0	0
Estates and ancillary	0	0	0	0	0	0	0	0	0
Senior Managers	55	36	91	17	8	25	72	44	116
Total	**339**	**126**	**465**	**40**	**14**	**54**	**379**	**140**	**519**

Staff composition

There were 607 staff (headcount) between 1 July 2022 and 31 March 2023 The breakdown by sex, seniority and contract type is set out in the table below.

Table 18 Staff composition

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Members of the governing body	3	3	6	0	0	0	3	3	6
Directors	6	3	9	0	0	0	6	3	9
Band 9	5	3	8	0	0	0	5	3	8
Band 8D	4	5	9	4	0	4	8	5	13
Band 8C	24	11	35	7	5	12	31	16	47
Band 8B	21	15	36	9	4	13	30	19	49
Other employees	**333**	**103**	**436**	**31**	**8**	**39**	**364**	**111**	**475**
Total	**396**	**143**	**539**	**51**	**17**	**68**	**447**	**160**	**607**

Sickness absence data

The ICB has a detailed and robust Sickness Absence Policy. A range of services are available to support staff at work or returning to work. These services include access to Occupational Health and an Employee Assistance Programme, which includes access to counselling sessions. The People Resources team have worked with managers on best practice for managing sickness absence. All managers are required to undertake return to work interviews with employees which are designed to support them in returning to work. Managers are also supported to undertake stress risk assessments to help identify and manage stress, are provided with support and guidance on making reasonable adjustments in the workplace and how to increase wellbeing amongst staff. All sickness absence is managed in line with the Managing Sickness Absence Policy.

The ICB has created and collated a portfolio of resources for staff to support health and well-being. These resources have been collated in one place to ensure that everyone can easily access all of the wide-ranging support available. This resource bank has been promoted to staff and managers to help them in signposting to the most appropriate resources if needed.

We are required to report annual sickness absence data for the calendar year 2022.

The ICB had an average number of full time equivalent members of staff (FTE) of 461 over the period 1st July 2022 to 31st December 2022. The full time equivalent possible working days available was 87,053.18. The table below has been provided using data from the NHS Digital, using the Electronic Staff Record Data Warehouse.

Table 19 Full Time Equivalent (FTE) Members of Staff

	Number of FTE staff (average)	Sum of FTE Days Sick	Sum of FTE Days Available	FTE sickness absence %	Average Annual Sick Days per FTE
NHS Bristol, North Somerset and South Gloucestershire ICB	**460**	**2544.04**	**87053.18**	**2.9**	**5.5**

Staff turnover percentages

Bristol, North Somerset and South Gloucestershire ICB staff turnover is reported via the Electronic Staff Record (ESR). During the period 1st July 2022 to 31st March 2023, 78 members of staff joined the ICB and 99 staff members left. Staff turnover measures the number of staff who leave an organisation during a period of time. The ICB staff turnover for the period 1st July 2022 to 31st March 2023 of 18.32% is based on a headcount of 99 leavers.

Whilst the turnover rate measures the outflow of people from an organisation and is expressed in terms of the number of people who leave over a period of time, the stability rate calculates the proportion of the workforce who remain employed for a specified period and measures how effectively the organisation is retaining staff. The ICB's stability index reports that 86.2% of employees were retained during the period 1st July 2022 and 31st March 2023.

Staff engagement percentages

Staff engagement is an important source of information about our staff and in the Autumn of 2022 the ICB participated in the Annual NHS Staff Survey. There were 395 responses, which equated to a response rate of 75% and demonstrated good staff engagement. The ICB response rate was consistent with the national average of 76% for similar organisations. The full Staff Survey can be found at NHS Staff Survey Results 2022. The results have been shared across the ICB and key themes incorporated within our ICB People Plan.

The ICB maintains staff engagement through a variety of routes including the following staff networks: disability, LGBTQ+, and parents and carers.

We have an Inclusion Council and a Staff Partnership Forum that meet monthly. We use a variety of communication methods to maintain staff engagement including the weekly Have We Got News for You sessions with the Chief Executive and the Voice, a weekly email bulletin, monthly line manager briefing and regular staff temperature checks.

Staff policies

Work to reduce inequalities in line with the Public Sector Equality Duty 2011 is reported in the Performance section of the Annual Report (p40). The ICB has an integrated approach to delivering workforce equality. Equalities issues are incorporated in policies

covering all aspects of employee management ranging from recruitment to performance to discipline.

The ICB's duty is to operate in ways that do not discriminate against potential or current employees with any of the protected characteristics specified in the Equality Act 2010, and to support employees to maximise their performance including making any reasonable adjustments that may be required on a case-by-case basis.

The ICB has a Reasonable Adjustments Guide which supports employees and managers in making reasonable adjustments so that our staff are able to work comfortably and efficiently. We worked closely with our Disabled Staff Network. Our guidance aims to help line managers and staff to have open conversations on what barrier staff maybe facing and how they can support in making reasonable adjustments within the ICB. This includes external support services from Access to Work, Occupational Health and the Business Disability Forum.

The ICB is disability confident which means it is committed to carrying out inclusive and accessible recruitment, offering an interview to disabled people, providing reasonable adjustments and supporting existing employees.

We continue to review and develop staff policies. All staff policies are subject to consultation with staff and Trade Union representatives through the Staff Partnership Forum. All policies are developed to ensure the ICB is able to recruit and retain a diverse workforce whilst ensuring equal treatment of staff and meeting the organisation's duty of care around staff health and safety at work. All policies have an Equality Impact Assessment to ensure they were not detrimental to staff on the basis of any protected characteristics as defined in the Equality Act 2010. The ICB regularly monitors the diversity of its workforce.

It was agreed the CCG's existing HR policies were fit for purpose and would carry forward into the ICB on its establishment. The ICB has a timetable for policy reviews and will continue to be updated in the with the review cycle. All HR policies will be reviewed in partnership with staff and Trade Union representatives through the Staff Partnership Forum, which continues to meet regularly and provides a constructive space for collaboration between staff representatives, and management.

Freedom to Speak Up

The ICB has in place policies to support staff when raising concerns, including the Freedom to Speak Up Policy, Fraud and Bribery Policy, and Bullying and Harassment Policy. Freedom to Speak Up was introduced by Sir Robert Francis following a 2015 review into NHS 'whistleblowing' processes. It incorporates whistleblowing and extends beyond that to develop cultures where concerns are identified and addressed at an early stage before people feel the need to 'blow the whistle'.

Freedom to Speak Up is hugely important to the ICB, we are committed to ensuring that a culture of speaking up is embedded throughout the organisation, and that effective processes are in place to support staff. The Freedom to Speak Up Policy provides a framework that supports a culture where staff feel comfortable to raise concerns. The policy gives guidance and advice to staff on raising a concern.

Trade Union Facility Time Reporting Requirements

The total number of employees who were relevant union officials during the period 1st July 2022 to 31st March 2023 was:

Table 20

Number of employees who were relevant union officials during the relevant period	Full time equivalent number
0	0

Other employee matters

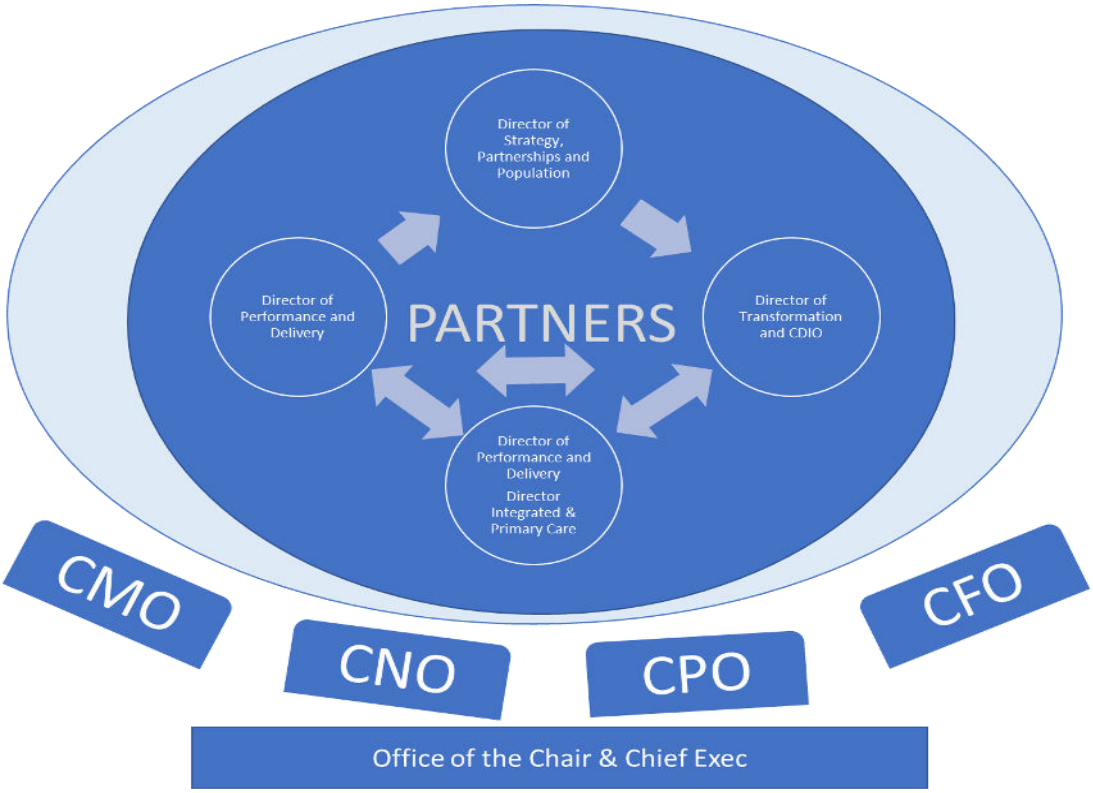
ICB Senior Executive Recruitment and Organisational Structures

An efficient and effective ICB is a key part of the success of the ICS. To ensure that the four key aims of the ICB could be delivered a programme of structural review was initiated. To enable the delivery of the ICS long-term vision and strategy four main functions of delivery were created within the ICB:

- Strategy
- Innovation and Development
- Delivery
- Review and Improvement

These functions are set in the context of the ICS four aims: improved outcomes, reducing inequalities, value for money and driving economic and social development.

The diagram below sets out how the full executive team supports the delivery of the four key functions



A full recruitment process for the executive team posts was completed in August 2022 with the exception of the Chief People Officer post which was recruited to in *November 2022.* Following the recruitment, the next step completed was the realignment of

functions from existing portfolios to the new functional ways of working. The executive team proposed a new operational structure for the ICB which was shared throughout the organisation and a phased transition process was instigated:

Phase 1 October 2022: discussions with individuals and teams about transitioning work areas, which need to move into their new directorate. This phase was completed and individuals and teams moved to their new directorates 1 November 2022.

Phase 2 November to the end of December 2022. Executives, in discussion with their teams redesigned their structures where necessary. An analysis of the new structures was completed to decide on the best change management approach to ensure that there was the least disruption to teams and individuals.

Phase 3 January 2023 to the end of February. During this period, we engaged with all staff about the new structures and carried out a formal change management consultation with affected staff. The executive team shared the feedback from the consultation with staff through an all staff “Have we Got News for You” session highlighting the changes that had been made as a result of staff comments.

Phase 4 March-May 2023 Implementation of the transition including job matching and interviews for staff affected by change.

Organisational Development

We have continued a commitment to the development and welfare of our workforce. Access to team and individual development through courses and apprenticeships is facilitated through our executive-led Learning and Development Panel.

The Learning and Development Panel approved several professional development opportunities for staff which included: NHS England BBC Foundation, Best Assessor Training, Elizabeth Garret Anderson Masters level qualification with the NHS Leadership Academy, Rosalind Franklin with the NHS Leadership Academy.

We continue to collaborate with system partners with the NHS Graduate Management Scheme. In 2022/23 we welcomed a graduate trainee to our Programme Management Office. The orientation programme and bid is held as an exemplar by the Leadership Academy for its wider system partnership approach and included the involvement in NBT, Sirona, Health Education England and Brisdoc exposing the trainee graduates to

the life journey of a patient. In 2023, the scheme was expanded further and a number of Primary Care providers are now participating.

We are also committed to ensuring all staff have completed their statutory and mandatory training. Corporate induction continues with sessions being delivered on Teams every other month.

Staff Partnership Forum

The ICB has a Staff Partnership Forum (SPF) which consists of staff members across varying levels of the organisation, with each Directorate represented by at least one staff member. The SPF provides a space for consultation and engagement on matters of mutual interest between senior management and colleagues, this could include organisational development plans and actions, formal consultations, and policy changes. During the period July 2022 and March 2023, the SPF engaged in the development of the ICB SPF terms of reference, ICB transition plan, ICB people strategy and plan, hybrid ways of working and Trade Union recognition agreement.

Health, Safety and Welfare

Recognising the potential impact of organisational change on staff, the ICB retained its focus on clear and regular engagement with staff through its routine channels. In addition, information and support for those in need were made available and broadcast to colleagues using the intranet. Signposting to employee assistance programme, mental health first aider and the staff partnership forum representatives was prevalent. During the period, we participated in the NHS National Staff Survey and ran staff temperature check surveys. Results indicated that through the transition period levels of engagement were high. We continued to make equipment available to individuals to support health and safety while working remotely, including the continued availability.

The ICB continues with its commitment to supporting the health and wellbeing of its workforce through a combination of internal and external activities and initiatives. In 2023 we provided our Mental Health First Aiders (MHFAs) refresher training. Our Mental Health First Aiders help provide for the wellbeing and psychological safety of our staff, and to be a potential first point of contact for any staff member who may be dealing with a mental health challenge.

Expenditure on consultancy

The consultancy expenditure for the financial period 1 July 2022 to 31 March 2023 was £624,000 and this can be analysed as follows:

Table 21 Consultancy Expenditure

Consultancy Category	1 July 2022 to 31st March 2023 £'000
Finance	45
Human Resources, Training and Education	0
Technical	136
Organisation and Change Management	6
Procurement	0
Property and Construction	2
Strategy	435
Total	**624**

Off-payroll engagements

NHS bodies are required to include disclosures about their off-payroll engagements, and the details for the ICB are set out in the tables below.

Table 22 Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31st March 2023 for more than £245* per day:

	Number
Number of existing engagements as of 31st March 2023	4
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	1

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 23: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 July 2022 to 31 March 2023 for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 to 31 March 2023	45
Of which:	
No. not subject to off-payroll legislation[2]	39
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	6
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	-
the number of engagements reassessed for compliance or assurance purposes during the year	1
Of which: no. of engagements that saw a change to IR35 status following review	-

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 24: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 July 2022 to 31 March 2023

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period[1]	-
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements. [2]	16

Exit packages

This statement is audited by the external auditors and is covered by the Audit Opinion issued on ICB's financial statements.

Table 25: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	-	-	-	-	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	-	-	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	1	122,667	-	-	1	122,667	-	-
£150,001 – £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	1	122,667	-	-	1	122,667	-	-
				Agrees to table 26 below				

Redundancy and other departure cost have been paid in accordance with the provisions of The NHS Terms and Conditions of Service (Agenda for Change). Exit costs in this note are the full costs of departures agreed in the year. Where Bristol, North

Somerset and South Gloucestershire ICB has agreed early retirements, the additional costs were met by the ICB and not by the Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not include in the table.

These tables report the number and value of exit packages agreed in financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Table 26: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice*		
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval**	1	123
TOTAL	**1**	**123**

Agrees to total in table 25

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and £122,667 relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

NHS Bristol, North Somerset and South Gloucestershire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at p114. An audit certificate and report are also included in this Annual Report at page 189.

ANNUAL ACCOUNTS

Shane Devlin

Accountable Officer

29 June 2023

CONTENTS

Statement of Comprehensive Net Expenditure for the nine months ended 31 March 2023

	Note	2022-23 31-Mar-23 £'000
Income from sale of goods and services	3	(7,975)
Other operating income	3	-
Total operating income		**(7,975)**
Staff costs	4	25,642
Purchase of goods and services	5	1,459,838
Depreciation and impairment charges	5	441
Provision expense	5	5,562
Other operating expenditure	5	6,473
Total operating expenditure		**1,497,956**
Net Operating Expenditure		**1,489,981**
Finance expense	7	1
Comprehensive Net Expenditure for the period		**1,489,982**

The notes on pages 121 to 168 form part of this statement.

Statement of Financial Position as at 31 March 2023

	Note	2022-23 Closing balance 31-Mar-23 £'000	2022-23 Opening balance 1-Jul-22 £'000
Non-current assets			
Property, plant and equipment	9	384	176
Right-of-use Assets	10	104	416
Intangible assets	11	-	64
Total non-current assets		**488**	**656**
Current assets			
Trade and other receivables	12	13,617	11,839
Cash and cash equivalents	13	81	102
Total current assets		**13,698**	**11,941**
Total assets		**14,186**	**12,597**
Current liabilities			
Trade and other payables	14	(126,757)	(95,917)
Lease liabilities	10	(104)	(416)
Provisions	15	(13,301)	(8,230)
Total current liabilities		**(140,162)**	**(104,563)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(125,976)**	**(91,966)**
Total Assets less Total Liabilities		**(125,976)**	**(91,966)**
Financed by Taxpayers' Equity			
General fund		(125,976)	(91,966)
Total taxpayers' equity		**(125,976)**	**(91,966)**

The notes on pages 121 to 168 form part of this statement.

The financial statements on pages 114 to 168 were approved by the Audit, Governance and RiskCommittee on 20 June 2023 with delegated authority from the Board and signed on its behalf by:

Chief Accountable Officer
Shane Devlin

Statement of Changes In Taxpayers Equity for the nine months ended 31 March 2023

	Note	General fund reserves
		£'000
Balance at 1 July 2022		**-**
Changes in NHS Integrated Care Board taxpayers' equity for 2022-23		
Net recognised expenditure for the nine months		(1,489,982)
Transfers by modified absorption to (from) other bodies	8	(91,966)
Net funding		1,455,972
Balance at 31 March 2023		**(125,976)**

The notes on pages 121 to 168 form part of this statement.

Statement of Cash Flows for the nine months ended 31 March 2023

	Note	2022-23 31-Mar-23 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial period		(1,489,982)
Depreciation and amortisation	5	441
Transfer from other public bodies under absorption	8	(84,078)
(Increase)/decrease in trade & other receivables	12	(13,617)
Increase/(decrease) in trade & other payables	14	126,723
Provisions utilised	15	(491)
Increase/(decrease) in provisions	15	5,562
Net Cash Inflow (Outflow) from Operating Activities		**(1,455,442)**
Cash Flows from Investing Activities		
Interest received		1
(Payments) for property, plant and equipment	9	(239)
Net Cash Inflow (Outflow) from Investing Activities		(238)
Net Cash Inflow (Outflow) before Financing		**(1,455,680)**
Cash Flows from Financing Activities		
Net Funding Received		1,455,972
Repayment of lease liabilities	10	(313)
Net Cash Inflow (Outflow) from Financing Activities		**1,455,659**
Net Increase (Decrease) in Cash & Cash Equivalents at 31 March		**(21)**
Cash & Cash Equivalents at the Beginning of the Financial Period		102
Cash & Cash Equivalents at the End of the Financial Period	13	**81**

The notes on pages 121 to 168 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Integrated Care Board for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Organisational Transfer

NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board was established with effect from 1 July 2022 by NHS England. NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group was dissolved on 30 June 2022.

For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach should be applied. For these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.2 Going Concern

These accounts have been prepared on a going concern basis.

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

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

When clinical commissioning group ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial

statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.3 Accounting Convention

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Better Care Fund Budgets

The Integrated Care Board and Bristol City Council, North Somerset Council and South Gloucestershire Council have agreed to treat the Better Care Fund as a non-pooled fund. The terms of this are set out in the section 75 agreement. Both parties have chosen to contract with individual providers without reference to each other using their own sources of funding alone and it is for this reason that neither party considers they are operating a pooled budget.

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the Integrated Care Board's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. These are regularly reviewed. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical Judgements in Applying Accounting Policies

In applying the Integrated Care Board's accounting policies, management has not made any critical judgements that that have a significant effect on the amounts recognised in the financial statements.

1.6.2 Key Sources of Estimation Uncertainty

There are no other sources of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year that require disclosure.

1.7 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board.

1.8 Revenue

The Integrated Care Board's financial position is controlled by a limit on net expenditure rather than funding from DHSC. As such the Integrated Care Board's income from other activities is very limited with the most significant element being R&D income. The Integrated Care Board does not enter into long term revenue contracts (most income arises from recharging past performance) and so the assessment indicates that there is no impact on income recognition from adopting IFRS 15.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

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

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

1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

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

1.10 Purchase of Goods, Services and Other Expenses

The purchase of goods, services and other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Integrated Care Board;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 Measurement

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.11.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Integrated Care Board's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to the Integrated Care Board;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.13 Depreciation, Amortisation & Impairments

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Integrated Care Board expects to obtain economic benefits or service potential from the asset.

This is specific to the Integrated Care Board and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the Integrated Care Board checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 Leases

A lease is a contract, or part of a contract, that conveys the right of control the use of an asset for a period of time in exchange for consideration. The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.14.1 The Integrated Care Board as Lessee

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

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

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16 (0.95% in the calendar year 2022).

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and,
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement of the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

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

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

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

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the “Depreciation amortisation and impairment” policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration. For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value (value when new less than £5,000) and short-term of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.15 Cash & Cash Equivalents

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

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

1.16 Provisions

Provisions are recognised when the Integrated Care Board has a present legal or constructive obligation as a result of a past event, it is probable that the Integrated Care Board will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date, a nominal:

- short-term rate of 3.27% (2021-22: -0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- long-term rate of 3.51% (2021-22: 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Integrated Care Board has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.17 Clinical Negligence Costs

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

1.18 Non-clinical Risk Pooling

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.19 Continuing healthcare risk pooling

Claims that have arisen since April 2013 with a retrospective element dating back to a maximum of 1.4.2013, have been assessed and, if appropriate, paid from the current year budget. Therefore, in each accounting period there may be some costs relating to previous years but the budget has funding for this (based on historical spend being built into the baseline) which obviates the need for a provision. It is also very difficult to estimate the level of retrospective liabilities as cases are not known until a claim is made and an estimate cannot be made with any certainty.

1.20 Financial Assets

Financial assets are recognised when the Integrated Care Board becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

1.20.1 Financial Assets at Amortised cost

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

1.20.2 Financial assets at fair value through other comprehensive income

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.20.3 Financial assets at fair value through profit and loss

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.20.4 Impairment

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

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

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

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

1.21 Financial Liabilities

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

1.21.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.21.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Integrated Care Board’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.21.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are

carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 Value Added Tax

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

1.23 Foreign Currencies

The Integrated Care Board's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2023. Resulting exchange gains and losses for either of these are recognised in the Integrated Care Board's surplus/deficit in the period in which they arise.

1.24 Losses & Special Payments

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

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

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.27 Contingent liabilities

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

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

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

IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Financial Performance

2.1 Financial Performance for the nine months ended 31 March 2023

The financial year 2022/23 was another unique one for the NHS, our patients and population, and partners in social care, public health commissioners and providers as we started our recovery from the unprecedented impact of Covid-19 pandemic. Some notable issues were as follows:

- the first where the NHS 'system by default' financial framework delivery and performance regime was in place.
- the demise of BNSSG CCG and the establishment of BNSSG ICB from 1 July 2022.
- recovery of core services, while continuing to live with Covid, and a return to 'routine' population-based NHS funding allocations.
- continued progress towards NHS Long Term Plan ambitions.
- significant inflationary cost pressures and multiple in year changes to NHS pay awards, tax and NI thresholds.

It is very pleasing to report that in this challenging context the ICB met all its core financial duties for the year; as well as meeting the financial duties across the Integrated Care System.

Whilst the ICB is audited as a statutory public body and has prepared its accounts for the period 1st July 22 to 31 March 23, NHS England's performance management regime works on an annualised basis, taking into account the financial position of the ICB, the predecessor CCG and constituent NHS partner bodies. The ICB novated what were generally annual commissioning contracts with providers and prepared monthly managements accounts with the aggregate of CCG and ICB budget and expenditure positions and used this to hold budget holders to account and to identify, address and mitigate emerging pressures. It should also be noted that whilst the ICB plans focus its population, the providers in the ICS have significant inflows of patients along with teaching and research income, notably for specialised services on a regional and occasionally national footprint. Avon and Wiltshire Mental Health Partnership also has income and assets related to the Bath, Swindon and Wiltshire ICB population footprint.

The annual financial plan for 22/23 was prepared as a system financial plan, and useful lessons were learned about governance processes, joint decision-making across multiple stakeholders and shared ownership of planning and delivery. The final allocations and a balanced financial plan for 22/23 was approved by the predecessor CCG Governing Body later than desired in June 2022, when funding for excess cost inflation and for Elective Recovery was confirmed with NHS

England. The opportunity to engage partner Boards and incoming ICB Non-Executive and Executive Directors was taken.

Within this context the ICB has reported a small surplus of £3k (0.00%) against the 9 month Revenue Resource Limit of £1,489,985k. The draft financial statements report the total system revenue financial position as a surplus of £349k, as analysed below:

Organisation	**Surplus / (Deficit)**
	£000's
Bristol, North Somerset and South Gloucestershire ICB (Q2-Q4)	**3**
Bristol, North Somerset and South Gloucestershire ICB (Q1)	-
Net Commissioning sector	***3***
University Hospitals Bristol and Weston NHS Foundation Trust	21
North Bristol NHS Trust	315
Avon and Wiltshire Mental Health Partnership NHS Trust	9
Net Provider sector	***346***
Total System	***349***

The goal of the system was to ensure breakeven for each organisation and a commitment to shared system working and management of financial & operational risk.

This is the third successive year that the ICB and predecessor CCG has delivered a balanced financial position. As well as demonstrating financial control and value for the taxpayer, this is important because the predecessor CCGs had accumulated deficits against allocations of £116m; and NHSE have confirmed that delivering breakeven or better in both financial years 22/23 and 23/24 will result in the cancellation of this debt and remove the need to pay back in future years.

2.2 Financial Performance targets for the period ended 31 March 2023

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended), with BNSSG ICB's performance against those duties as follows:

9 months - 01 Jul 2022 to 31 March 23	Target £'000	Performance £'000	Variance £'000	Achieved
Expenditure not to exceed income	1,498,234	1,498,231	3	Yes
Capital resource use does not exceed the amount specified in Directions	273	273	-	Yes
Revenue resource use does not exceed the amount specified in Directions	1,489,985	1,489,982	3	Yes
Revenue administration resource use does not exceed the amount specified in Directions	15,341	13,806	1,535	Yes

Full year 2022/2023 (including BNSSG CCG to 30 June 2022)	Target £'000	Performance £'000	Variance £'000	Achieved
Expenditure not to exceed income	1,955,360	1,955,357	3	Yes
Capital resource use does not exceed the amount specified in Directions	273	273	-	Yes
Revenue resource use does not exceed the amount specified in Directions	1,943,961	1,943,958	3	Yes
Revenue administration resource use does not exceed the amount specified in Directions	20,798	19,263	1,535	Yes

There were no capital or revenue resources on specified matters in 2021-22 and 2020-21.

It is allowable to use Running Costs allocations to support programme expenditure.

3.1 Operating Income

	2022-23 31-Mar-23 Total £'000
Income from sale of goods and services (contracts)	
Non-patient care services to other bodies - *note 1*	6,013
Other contract income	1,962
Total income from sale of goods and services	**7,975**
Total Operating Income	**7,975**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Integrated Care Board and credited to the General Fund.

Revenue is totally from the supply of services. The Integrated Care Board receives no money from sale of goods.

Notes

1. £5.9m of this revenue figure relates to income from the Department of Health for Research and Development.

3.2 Disaggregation of Income – Income from sale of goods and services (contracts)

	2022-23	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Source of Revenue		
NHS	155	1,940
Non NHS	5,858	22
Total	**6,013**	**1,962**

	2022-23	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Timing of Revenue		
Point in time	6,013	1,962
Over time	-	-
Total	**6,013**	**1,962**

4. Employee benefits and staff numbers

4.1 Employee benefits

	2022-23		
	Permanent Employees	**Other**	**Total**
	£'000	**£'000**	**£'000**
Employee benefits			
Salaries and wages	16,693	3,872	20,565
Social security costs	1,948	-	1,948
Employer contributions to NHS Pension scheme	3,049	-	3,049
Apprenticeship levy	80	-	80
Gross employee benefits expenditure	**21,770**	**3,872**	**25,642**

There were no capitalised staff costs in the nine months ended 31 March 2023.

4.2 Average number of people employed

	Permanently employed Number	**Other Number**	**Total Number**
2022-23	465	54	519

There were no whole time equivalent people engaged on capital projects in the nine months ended 31 March 2023.

4.3 Staff annual leave accrual balances

	Permanent Staff £'000
Employee accrued benefits liability at 31 March 2023	125

The accrued benefits liability balance related to permanent staff only; no temporary or agency staff accrued annual leave benefits.

4.4 Exit packages agreed in the financial period

Exit payments for the nine months ending 31 March 2023.

	2022-23					
	Compulsory redundancies		Other agreed departures		Total	
	No.	£	No.	£	No.	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	122,667	-	-	1	122,667
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**122,667**	**-**	**-**	**1**	**122,667**

There were no departures where special payments were made and no other agreed departures in the period.

The above values include any non-contractual severance payments made following judicial mediation. No payments were made relating to non-contractual payments in lieu of notice (£0).

As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS terms and conditions of service (Agenda for Change). Please see the Annual Report for further details (section Compensation on early retirement of for loss of office).

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

No non-contractual payments (£)) were made to individuals where the payment value was more than 12 months' of their annual salary.

The Annual Report includes the Remuneration Report, which includes the disclosure of exit payments payable to individuals named in that report.

4.5 Pension costs

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

Both are unfunded defined benefit schemes that cover NHS employers, GP Practices and other bodies allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the Integrated Care Board of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating Expenditure

	2022-23 31-Mar-23 Total £'000
Purchase of goods and services	
Services from other ICBs and NHS England	5,658
Services from foundation trusts	389,635
Services from other NHS trusts	442,344
Services from Other WGA bodies	1,078
Purchase of healthcare from non-NHS bodies	358,863
Purchase of social care	4,173
Prescribing costs	110,575
GPMS/APMS and PCTMS	138,440
Supplies and services – clinical	3,293
Supplies and services – general - *note 1*	(174)
Consultancy services	624
Establishment	1,050
Transport	9
Premises	2,321
Audit fees - *notes 2, 3*	198
Other non statutory audit expenditure	
· Internal audit services	-
· Other services	-
Other professional fees - *note 4*	1,052
Legal fees	129
Education, training and conferences	570
Total Purchase of goods and services	**1,459,838**
Depreciation and impairment charges	
Depreciation	377
Amortisation	64
Total Depreciation and impairment charges	**441**
Provision expense	
Change in discount rate	
Provisions	5,562
Total Provision expense	**5,562**
Other Operating Expenditure	
Chair and Non Executive Members	124
Grants to Other bodies - *note 5*	188
Research and development (excluding staff costs)	6,079
Expected credit loss on receivables	70
Other expenditure	12
Total Other Operating Expenditure	**6,473**
Total Operating Expenditure	**1,472,314**

Notes

1. Negative expenditure reported on this line is caused by the movement on the annual leave accrual between 30 June 2022 and 31 March 2023.

2. External audit liability is capped at £2m.

3. External audit fees, including VAT, £198,000. The gross cost is £228,000 (£190,000 net) for the 9 month ICB audit and an estimated £18,000 (£15,000 net) for MHIS audit, which is offset by an over accrual on the final CCG audit to 30th June 2022 due to the difference between quotes received in June 2022 to enable the cost of the 3 month audit to be estimated and the final tendered price from the appointed auditors in October 2022.

4. Internal Audit services are provided by an external provider RSM Risk Assurance Services LLP and fees totaled £46,800 net of VAT. This is included in Other professional fees.

5. Grants to other bodies reflects capital grants from NHSE to the community provider.

6.1 Better Payment Practice Code

Measure of compliance	2022-23 31-Mar-23	
	No.	**£'000**
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the period	21,330	505,337
Total Non-NHS Trade Invoices paid within target	20,946	496,651
Percentage of Non-NHS Trade invoices paid within target	**98%**	**98%**
NHS Payables		
Total NHS Trade invoices paid in the period	824	853,412
Total NHS Trade invoices paid within target	816	853,379
Percentage of NHS Trade Invoices paid within target	**99%**	**100%**

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

There were no payments made from claims under Late Payment of Commercial Debts (Interest) Act 1998.

7. Finance Costs

	2022-23 31-Mar-23 Total £'000
Interest on lease liabilities	1
Total finance costs	**1**

8 Net Gain (Loss) on Transfer by Modified Absorption

NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board was established with effect from 1 July 2022 by NHS England. NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group was dissolved on 30 June 2022.

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

The table below identifies the Statement of Financial Position at 30 June 2022 for NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.

	2022-23 31-Mar-23 £'000
Transfer of Property, plant and equipment	176
Transfer of Right of use asset *	416
Transfer of Intangibles	64
Transfer of Cash and cash equivalents	102
Transfer of Receivables *	11,839
Transfer of Payables *	(96,333)
Transfer of Provisions	(8,230)
Net gain (loss) on transfer by Absorption	(91,966)

The balances that feed into the cashflow statement are starred * = £84,078k
Payables transferred includes £95,917k Current trade payables and £416k lease liability.

9. Property, plant and equipment

	Total 2022-23 31-Mar-23 £'000
Cost or valuation at 1 July 2022	-
Transfer from other public bodies under absorption	749
Adjusted cost or valuation at 1 July 2022	**749**
Additions purchased	273
Cost or Valuation at 31 March 2023	**1,022**
Depreciation at 1 July 2022	-
Transfer from other public bodies under absorption	573
Charged during the period	65
Depreciation at 31 March 2023	**638**
Net Book Value at 31 March 2023	**384**
Purchased	384
Total at 31 March 2023	**384**
Asset financing:	
Owned	384
Total at 31 March 2023	**384**

All property, plant and equipment held by the ICB at 31 March 2023 relates to Information Technology assets.

Opening balance at 1 July 22

	Information technology £'000	Furniture & fittings £'000	Total 01-Jul-22 £'000
Cost or valuation at 01 April 2022	907	100	1,007
Disposals other than by sale	(158)	(100)	(258)
Cost/Valuation at 30 June 2022	**749**	**-**	**749**
Depreciation 01 April 2022	709	100	809
Disposals other than by sale	(158)	(100)	(258)
Charged during the year	22	-	22
Depreciation at 30 June 2022	**573**	**-**	**573**
Net Book Value at 30 June 2022	**176**	**-**	**176**
Purchased	176	-	176
Total at 30 June 2022	**176**	**-**	**176**
Asset financing:			
Owned	176	-	176
Total at 30 June 2022	**176**	**-**	**176**

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	1	5

10. Leases

10.1 Right-of-use assets

	2022-23 Closing balance 31-Mar-23 Buildings £'000	2022-23 Opening balance 1-Jul-22 Buildings £'000
Cost opening balance	-	-
Transfer from other public bodies under absorption	520	-
IFRS 16 Adjustment	-	520
Cost closing balance	**520**	**520**
Depreciation opening balance	-	-
Transfer from other public bodies under absorption	104	-
Charged during the period	312	104
Depreciation closing balance	**416**	**104**
Net Book Value closing balance	**104**	**416**

10.2 Lease liabilities

	2022-23 Closing balance 31-Mar-23 Leased from NHS Property Services £'000	2022-23 Opening balance 1-Jul-22 Leased from NHS Property Services £'000
Lease liabilities opening balance	-	-
Transfer from other public bodies under absorption	(416)	-
IFRS 16 Adjustment	-	(519)
Adjusted lease liabilities opening balance	**(416)**	**(519)**
IFRS16 Transition Adjustment		
Interest expense relating to lease liabilities	(1)	(1)
Repayment of lease liabilities (capital and interest)	313	104
Lease liabilities at 31 March 2023	**(104)**	**(416)**

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Obligations Leased from NHS Property Services 31-Mar-23 £'000
Within one year	(104)
Between one and five	-
After five years	-
Total	**(104)**

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	SoCNE 31-Mar-23 £'000
Depreciation expense on right-of-use asset	312
Interest expense on lease liabilities	1

10.5 Amounts recognised in cashflow

2022-23	SOCF 31-Mar-23 £'000
Total cash outflow on leases under IFRS 16	313

10.6 Future cash outflows to which the ICB is exposed

The current right of use asset relates to the lease on the ICB's office accommodation, which expires in June 2023. The ICB is in the process of negotiating a new lease arrangement.

11 Intangible non-current assets

	2022-23 Closing balance 31-Mar-23	2022-23 Opening balance 1-Jul-22
	Computer software: purchased	Computer software: purchased
	£'000	£'000
Cost or valuation opening balance	-	232
Transfer from other public bodies under absorption	170	-
Disposals other than by sale	-	(62)
Cost or valuation closing balance	**170**	**170**
Amortisation opening balance	-	147
Transfer from other public bodies under absorption	106	
Disposals other than by sale	-	(62)
Charged during the period	64	21
Amortisation closing balance	**170**	**106**
Net Book Value closing balance	**-**	**64**
Purchased	-	64
Total at 31 March 2023	**-**	**64**

11.1 Economic Lives

	Minimum Life (Years)	Maximum Life (Years)
Computer software: purchased	0	2

12.1 Trade and other receivables

	2022-23 Closing balance 31-Mar-23 Current £'000	2022-23 Opening balance 1-Jul-22 Current £'000
NHS receivables: Revenue	4,002	1,187
NHS prepayments	706	706
NHS accrued income	-	746
Non-NHS and Other WGA receivables: Revenue	5,934	2,444
Non-NHS and Other WGA prepayments	2,086	2,570
Non-NHS and Other WGA accrued income	576	3,927
Expected credit loss allowance-receivables	(73)	(3)
VAT	383	253
Other receivables and accruals	3	9
Total Current trade & other receivables	**13,617**	**11,839**

There are no non-current trade receivables.
There are no prepaid pensions contributions at the 31 March 2023.

12.2 Receivables past their due date but not impaired

	2022-23	
	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000
By up to three months	-	376
By three to six months	-	-
By more than six months	74	712
Total	**74**	**1,088**

12.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies
	£'000
Balance at 1 July 2022	-
Lifetime expected credit losses on trade and other receivables-Stage 2	(73)
Allowance for credit losses at 31 March 2023	**(73)**

12.4 Provision matrix on lifetime credit loss

Non NHS Debt	% Lifetime expected credit loss rate	31-Mar-23 £'000 Gross Carrying amount	£'000 Lifetime expected credit loss
Current	-	326	-
1-30 days	-	-	-
31-60 days	2	6	-
61-90 days	10	-	-
90-365 days	10	710	71
Greater than 365 days	100	2	2
Total expected credit loss		**1,044**	**73**

The Integrated Care Board did not hold any collateral against receivables outstanding at 31 March 2023.

13. Cash and cash equivalents

	2022-23 Closing balance 31-Mar-23 £'000	2022-23 Opening balance 01-Jul-22 £'000
Opening balance	-	46
Transfer from other public bodies under absorption	102	-
Adjusted opening balance	**102**	**46**
Net change in period	(21)	56
Closing balance	**81**	**102**
Made up of:		
Cash with the Government Banking Service	80	101
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**81**	**102**

14. Trade and other payables

	2022-23 Closing balance 31-Mar-23 £'000	2022-23 Opening balance 01-Jul-22 £'000
NHS payables: Revenue	4,829	12,036
NHS accruals	398	3,563
Non-NHS and Other WGA payables: Revenue	57,048	22,459
Non-NHS and Other WGA payables: Capital	34	-
Non-NHS and Other WGA accruals	59,591	55,036
Non-NHS and Other WGA deferred income	158	-
Social security costs	343	371
Tax	326	296
Other payables and accruals	4,030	2,156
Total Current Trade & Other Payables	**126,757**	**95,917**

There are no non-current trade and other payables.

There are no liabilities included in the above for any person due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £2,330,667 outstanding pension contributions at 31 March 2023 (£1,966,713 as at 30 June 2022).

15 Provisions

	2022-23 Closing balance 31-Mar-23 £'000	2022-23 Opening balance 01-Jul-22 £'000
Current		
Restructuring	300	419
Legal claims	4,761	4,948
Other	8,240	2,863
Total	**13,301**	**8,230**

There are no non-current provisions.

	Restructuring £'000	Legal Claims £'000	Other £'000	Total £'000
Balance at 1 July 2022	**-**	**-**	**-**	**-**
Transfer from other public bodies under absorption	419	4,948	2,863	8,230
Adjusted balance at 1 July 2022	**419**	**4,948**	**2,863**	**8,230**
Arising during the period	300	180	5,376	**5,856**
Utilised during the period	(125)	(366)	-	**(491)**
Reversed unused	(294)	-	-	**(294)**
Change in discount rate				
Balance at 31 March 2023	**300**	**4,762**	**8,239**	**13,301**
Expected timing of cash flows:				
Within one year	300	4,762	8,239	13,301
Between one and five years	-	-	-	-
After five years	-	-	-	-
Balance at 31 March 2023	**300**	**4,762**	**8,239**	**13,301**

The Legal provisions relate to outstanding contract challenges with providers. One contract challenge has been finalised during the period.

The Other provision relates to;

- £4,407k for General Practitioner service charge payments disputed with NHS Property Services
- £756k for dilapidations associated with the Head Office and a GP practice.

• £3,077k to provide a proportion of the non-consolidated pay offer to staff at the Community Provider as currently they do not fall within the scope of the national offer.

	Restructuring	Legal Claims	Other	Total
	£'000	£'000	£'000	£'000
Balance at 01 April 2022	**943**	**5,210**	**2,863**	**9,016**
Arising during the year	-	-	-	**-**
Utilised during the year	-	-	-	**-**
Reversed unused	(524)	(262)	-	**(786)**
Change in discount rate	-	-	-	**-**
Balance at 30 June 2022	**419**	**4,948**	**2,863**	**8,230**
Expected timing of cash flows:				
Within one year	419	4,948	2,863	**8,230**
Between one and five years	-	-	-	**-**
After five years	-	-	-	**-**
Balance at 30 June 2022	**419**	**4,948**	**2,863**	**8,230**

16. Financial instruments

16.1 Financial risk management

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

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Integrated Care Board standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the Integrated Care Board and internal auditors.

16.1.1 Currency risk

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

16.1.2 Interest rate risk

The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the Integrated Care Board's revenue comes from parliamentary funding, the Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 Liquidity risk

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

16.1.5 Financial Instruments

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

16.2 Financial assets

	Financial Assets measured at amortised cost	
	2022-23 Closing balance 31-Mar-23 £'000	2022-23 Opening balance 01-Jul-22 £'000
Trade and other receivables with NHSE bodies	2,952	1,093
Trade and other receivables with other DHSC group bodies	1,734	893
Trade and other receivables with external bodies	5,829	6,326
Cash and cash equivalents	81	102
Total at 31 March 2023	**10,596**	**8,414**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
	2022-23 Closing balance 31-Mar-23 £'000	2022-23 Opening balance 01-Jul-22 £'000
Trade and other payables with NHSE bodies	(1,314)	(943)
Trade and other payables with other DHSC group bodies	(3,983)	(15,612)
Trade and other payables with external bodies	(120,738)	(78,694)

Other financial liabilities	-	(416)
Total at 31 March 2023	**(126,035)**	**(95,665)**

16.4 Maturity of Financial liabilities

	2022-23 Closing Balance 31-Mar-23		
	Payable to DHSC	**Payable to Other bodies**	**Total**
	£'000	**£'000**	**£'000**
In one year or less	5,297	120,738	126,035
Total at 31 March 2023	**5,297**	**120,738**	**126,035**

	2022-23 Opening Balance 01-Jul-22		
	Payable to DHSC	**Payable to Other bodies**	**Total**
	£'000	**£'000**	**£'000**
In one year or less	16,555	79,110	95,665
Total at 1 July 2022	**16,555**	**79,110**	**95,665**

17. Operating segments

	2022-23 Commissioning Healthcare
	£'000
Gross expenditure	1,497,957
Income	(7,975)
Net expenditure	1,489,982
Total assets	14,186
Total liabilities	(140,162)
Net assets	(125,976)

17.1 Reconciliation between Operating Segments and SoCNE

	2022-23
	£'000
Total net expenditure reported for operating segments	1,489,982
Total net expenditure per the Statement of Comprehensive Net Expenditure	1,489,982

17.2 Reconciliation between Operating Segments and SoFP

	2022-23
	£'000
Total assets reported for operating segments	14,186
Total assets per Statement of Financial Position	14,186

	2022-23
	£'000
Total liabilities reported for operating segments	(140,162)
Total liabilities per Statement of Financial Position	(140,162)

18. Related party transactions

Details of related party transactions with individuals are as follows:

	2022-23			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
"Deborah El-Sayed (Director of Transformation and Chief Digital Information Officer) - Bristish Red Cross	369	(8)	115	-
Deborah El-Sayed is a trustee for British Red Cross"	196	(205)	-	-
Jonathan Hayes (Chair of the GP Collaborative Board) - Edgemont View Ltd	950	(31)	212	(5)
Jonathan Hayes is a partner at a practice where partners are co-owners of Edgemont View Nursing Home.	1,574	(777)	887	-
Jonathan Hayes (Chair of the GP Collaborative Board) - GP Care	1,349	-	798	-

The Department of Health and Social Care is the parent department and is regarded as a related party. During the 9 nine months to 31 March 2023 the Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:
• NHS England;
• NHS Foundation Trusts - significant parties University Hospitals Bristol and Weston NHS FT & South Western Ambulance FT;
• NHS Trusts - significant parties North Bristol NHS Trust and Avon & Wiltshire Mental Health Partnership
• NHS Litigation Authority; and,
• NHS Business Services Authority.

The Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies during the period to 31 March 2023. The transactions with Bristol City Council, North Somerset Council and South Gloucestershire Council have a net spend of £91.825m and the main services this relates to are: Better Care Fund and Other (£40.106m); Funded Nursing Care (£19.758m); and all groups of Complex Care clients (£31.961m).

Expenditure with Local Authorities

Local Authority	**2022-23**
	£m
Bristol City Council	31.8
North Somerset Council	39.4
South Gloucestershire Council	19.8
Total	**91.0**

19. Partnership arrangements

The Integrated Care Board has partnership arrangements with Bristol City Council, North Somerset Council and South Gloucestershire Council for the delivery of the Better Care Fund for the provision of community and mental health services together with continuing and social care. The arrangements are made in accordance with S75 of the NHS Act 2006 and any surplus or deficits are the responsibility of the respective partners. Each of the partner bodies is responsible for managing the individual schemes for which they have lead responsibility.

The funding and expenditure for each BCF are:

Bristol City Council	**2022-23**
	£'000
Funding provided to partnership budgets	27,632
Additional NHS contribution	981
ASC discharge funding	3,428
ICB funding to council for protection of adult social care	(14,366)
Expenditure from partnership arrangement	**17,675**

North Somerset Council	**2022-23**
	£'000
Funding provided to partnership budgets	13,114
Additional NHS contribution	1,031
ASC discharge funding	2,362
ICB funding to council for protection of adult social care	(5,747)
Expenditure from partnership arrangement	**10,760**

South Gloucestershire Council	**2022-23**
	£'000
Funding provided to partnership budgets	13,442
Additional NHS contribution	565
ASC discharge funding	2,526
ICB funding to council for protection of adult social care	(4,862)
Expenditure from partnership arrangement	**11,671**

20. Losses and special payments

The ICB made a fruitless payment in 22/23 of £215,000 relating to a compensation payment. This was fully covered by the release of a provision created in 21/22.

21. Contingences

Contingent Liabilities

	2022-23 31 Mar-23 £'000
Continuing Healthcare	799

The contingent liability relates to continuing healthcare claims. The uncertainty relates to the eligibility of outstanding historic claims. Whilst possible, it has been deemed unlikely these amounts will be reimbursed. It is not practical to provide an estimate of the financial effect.

22. Events after the reporting period

As from 1 April 2023, additional services have been delegated to the ICB from NHSE with an expected annual value of £84.6m.

NHS BRISTOL, NORTH SOMERSET & SOUTH GLOUCESTERSHIRE ICB

Annual internal audit report 2022/23

Draft

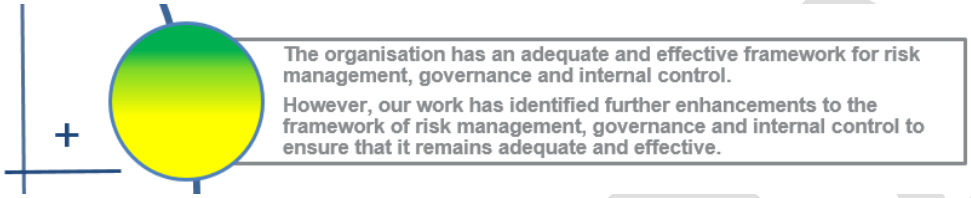
13 June 2023

THE ANNUAL INTERNAL AUDIT OPINION

This report provides an annual internal audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance reporting.

The opinion

For the nine months ended 31 March 2023 the head of internal audit opinion for NHS Bristol North Somerset South Gloucestershire (BNSSG) ICB is as follows:



Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

It remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be a substitute for management responsibility around the design and effective operation of these systems.

Scope and limitations of our work

The formation of our draft opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- internal audit has not reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from an organisation-led assurance framework (initially inherited from the Clinical Commissioning Group). The assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance; and
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention.

FACTORS AND FINDINGS WHICH HAVE INFORMED OUR OPINION

Based on the work undertaken during 2022/23 since the transition from the CCG to the ICB on 1 July 2022, there are a number of areas of internal control where improvements could be made to ensure the control frameworks in place are designed to meet the ICB's objectives, and controls are generally being applied consistently. Despite this, we have seen significant progress in embedding of system working, and system processes being adopted.

We have provided two **reasonable assurance** opinions, one in the annual **Key Financial Controls** review and one in an audit of **System Performance Management** that was complete as part of the 2022/23 internal audit plan. The financial controls review found a sound control framework with actions agreed around regular review of finance system access; and formally documenting the debt collection process. The system performance management audit highlighted that whilst there is not a formal system performance management framework in place, this was being worked on via a consultancy review to align to the system operational plan. We also agreed improvement actions around providing regular updates on the project to embed new systems and live data sets across the ICS to ensure progress remains on track and effective; as well as an action to review some of the governance forums attendance in light of new place based governance structures being rolled out to ensure performance is monitored by the right people at the right time to be most effective.

During the year we undertook a review of **Financial Sustainability**, reviewing the ICB's self-assessment against the HFMA guidance. The self-assessment itself identified a number of areas where the ICB recognised the need for improvement, and this is being monitored via an action plan which is presented to the Audit, Governance and Risk Committee for scrutiny and assurance. We confirmed that the self- assessment had been completed accurately and appropriately.

We also undertook a review of the ICB's **risk management and governance** arrangements, which resulted in a management letter which identified three suggested areas of improvement, to feed into the development of the new Risk Management Framework which was still in progress at year end. Whilst we were able to see that directorate and corporate risk was being monitored via the executive team and the Committees, there was no presentation of the Corporate Risk Register to the Board during the year. We did however evidence that the ICB was enabling system wide engagement in system risk management and assurance which forms the basis of the new framework.

We were requested by management to undertake an audit of the ICB's use of agency staff, which resulted in a partial assurance opinion. This means the Governing Body can take **partial assurance** that the controls to manage risks were suitably designed and consistently applied, and that action was needed to strengthen the control framework to manage the identified risks.

Agency Arrangements

Our audit fieldwork concluded that there had been a lack of a centralised process and definition of responsibilities for managing agency usage and spend across the ICB. This was validated through evidence / records either not existing or staff not being able to find the necessary documents to support that agency staff had been engaged at the right costs and had the right paperwork in place. We found that information was being owned and held by different teams and individuals across the ICB, and at the time of audit it was unclear exactly where responsibility and ultimate oversight for any of the associated processes sits. This is borne of a historic lack of internal HR resource within the CCG previously. However, in the ICB there is now a People Directorate meaning these responsibilities can be more directly actioned. Without such central oversight and ultimate ownership of processes, for example budget holders having adequate training and guidance of how to engage agency staff and at what rate, detailed scrutiny of pay rates agreed with agencies and knowing exact levels of agency spend, the Board cannot take assurance that this area is being appropriately controlled. Two 'high' and five 'medium' priority

actions were agreed with management to address the weaknesses and risks identified during the audit. We will follow these up to confirm when implemented and report back to the Audit Committee.

Throughout the year internal audit has tracked the implementation of previously agreed management actions and reports the position to each Audit, Governance and Risk Committee. **Reasonable progress** has been made in implementing management actions, with three 'high', seven 'medium' and two 'low' priority actions currently ongoing in the following areas:

- Risk Management
- Safeguarding
- Recruitment
- Appraisals
- Financial Controls
- Agency Arrangements

Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken to date on the ICB's system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). The ICB may wish to consider any issues raised around the Agency Arrangements review, referred to above, when determining whether anything should be highlighted within the Annual Governance Statement. The ICB should also consider whether any other issues have arisen as well as recognise the challenging environment within which the ICB is operating, including the results of any external reviews, as well as the reduced reporting to Board on risk management and assurance in year.

THE BASIS OF OUR INTERNAL AUDIT OPINION

As well as those headlines previously discussed, the following areas have helped to inform our opinion. A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

Acceptance of internal audit management actions

Management have agreed actions to address all of the findings reported by the internal audit service during.

Implementation of internal audit management actions

Throughout the year internal audit has tracked the implementation of previously agreed management actions and reports the position to each Audit, Governance and Risk Committee. **Reasonable progress** has been made in implementing management actions, with three 'high', seven 'medium' and two 'low' priority actions currently ongoing.

Working with other assurance providers

In forming our opinion, we have not placed any direct reliance on other assurance providers other than through consideration of the service auditor reports received. We have liaised with the Local Counter Fraud Specialist and External Audit as appropriate during the course of the year. The service auditor reports considered are as follows.

Service auditor reports

We reviewed the Service Auditor Report from the internal auditors of NHS Shared Business Services who provide services to the ICB. This was an unqualified report.

We reviewed the Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering financial, payroll and non-clinical procurement services, and noted one exception was identified relating to HR / Payroll access to ESR. Despite this exception, the service auditors did not feel this impacted on the effectiveness of the control framework; therefore this has not impacted on our opinion. .

We reviewed the Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering CQRS (calculating quality reporting systems) services. Whilst the report resulted in a qualified opinion due to four exceptions identified around infrastructure service account passwords; approval for national system changes; and a changed interface not having a documented technical specification, it was note felt the findings were of sufficient significance to undermine our overall opinion for the ICB.

The Service Auditor Report from the internal auditors for NHS England in regard to GP Payments highlighted two control exceptions but was otherwise satisfactory. Neither exception was sufficiently significant to impact the Head of Internal Audit Opinion for the ICB.

We reviewed the Service Auditor Report from the internal auditors for the NHS Business Services Authority for Prescriptions Payments Process. The report identified one exception around ineffective processes to ensure access to applications was appropriate by deactivating leavers in a timely manner. Despite this finding, this report has not impacted on our opinion.

We reviewed the Service Auditor Report in relation to Capita for Primary Care Support Services. The report showed a significantly reduced number of exceptions from 93 in 2021/22 to 11 in 2022/23 and a reduced number of control objectives qualified from 4 to 2, therefore this has not impacted on our overall Head of Internal Audit Opinion.

We reviewed the Service Auditor Report from the internal auditors of ESR (Electronic Staff Record Programme) who provide a single payroll and Human Resources management system to the ICB. Three qualifications to the opinion were noted regarding 1) authorisation and revocation of logical access; 2) tracking and resolution of NHS Hub availability issues; and 3) weaknesses around the physical security and maintenance of a data centre.

OUR PERFORMANCE

Wider value adding delivery

Area of work	How has this added value?
Internal Audit agility	To ensure internal audit continues to be focused and reflects changes in risk prioritisation we made a number of in-year changes to the internal audit plan. All changes were reported to and agreed by the Audit, Governance and Risk Committee and management.
Data Analytics	We used data analytics in our financial controls work, not only to provide holistic assurance and identify significant outliers but to help improve the centralised controls. This also made the audit process more efficient and required less burden on the finance staff.
Health Matters	As part of our client service commitment, during 2022/23 we have issued our NHS sector client briefings and provided our quarterly NHS publication 'Health Matters' which provides insights into topical issues within the sector.
ICS Workshop – System Risk	We facilitated an ICS Workshop in January 2023 on system risk management. This was a workshop involving a number of employees, Non-Executive members, Board members and other key stakeholders in the BNSSG system. The event was used to assist with the population and identification of the high level risks in the system.
Healthcare benchmarking	We have shared benchmarking information with the ICB including our annual report on the outcomes of Internal Audit opinions across our NHS client base. We have also shared benchmarking and good practice in each audit assignment, whether in the body of the report or via conversation and feedback during audit meetings.
Audit Committee involvement	We contributed to the discussions at the Audit, Governance and Risk Committee on various items on the agenda to ensure that the ICB benefits from wider input, in order to strengthen its governance arrangements.
Webinars	We have invited the ICB to various webinars across the year to share sector and wider good practice and help to communicate emerging risks and issues.
RSM's NED Network	We have launched RSM's NED Network to provide the non-executive director and interim community a place to network, share ideas, attend insightful and relevant events and read key content.

Conflicts of interest

RSM has not undertaken any work or activity during 2022/23 that would lead us to declare any conflict of interest.

Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS).

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our risk assurance service line commissioned an external independent review of our internal audit services in 2021 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF), and the Internal Audit Code of Practice, as published by the Global Institute of Internal Auditors (IIA) and the Chartered IIA, on which PSIAS is based.

The external review concluded that RSM 'generally conforms* to the requirements of the IIA Standards' and that 'RSM IA also generally conforms with the other Professional Standards and the IIA Code of Ethics. There were no instances of non-conformance with any of the Professional Standards'.

* The rating of 'generally conforms' is the highest rating that can be achieved, in line with the IIA's EQA assessment model.

Quality assurance and continual improvement

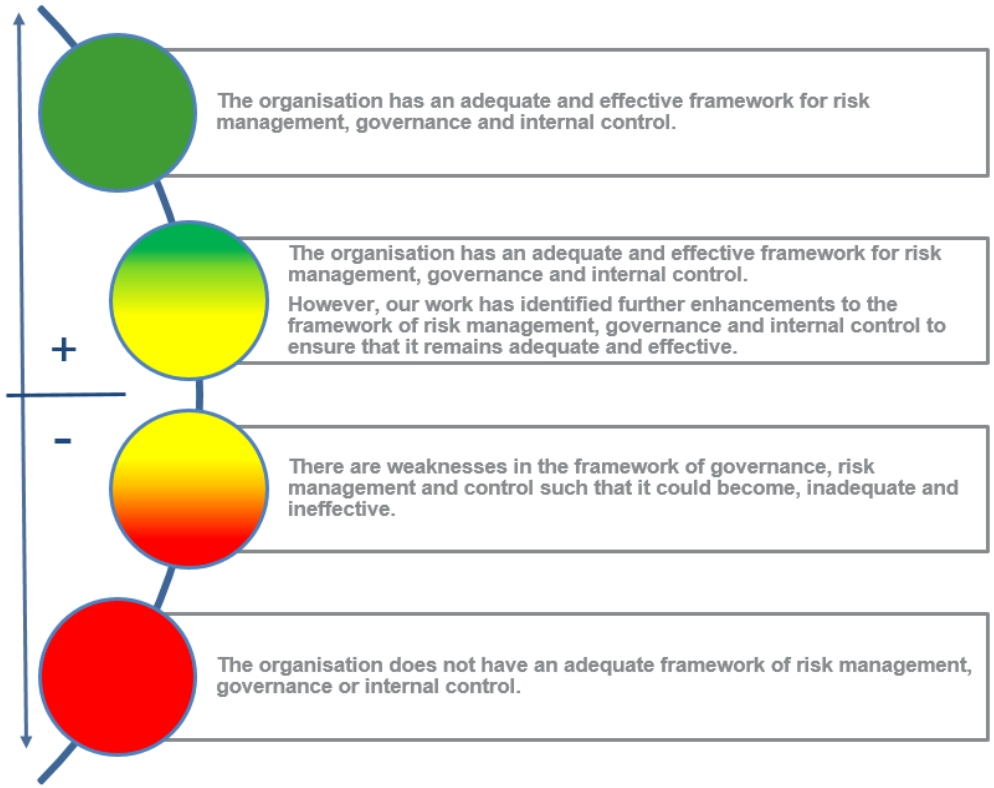
To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

Resulting from the programme in 2022/23, there are no areas which we believe warrant flagging to your attention as impacting on the quality of the service we provide to you.

In addition to this, any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments is also taken into consideration to continually improve the service we provide and inform any training requirements.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.

Annual opinions	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • limitations in the individual audit assignments; • the adequacy and effectiveness of the risk management and / or governance control framework; • the impact of weakness identified; • the level of risk exposure; and • the response to management actions raised and timeliness of actions taken.

APPENDIX B: SUMMARY OF INTERNAL AUDIT WORK COMPLETED 2022/23

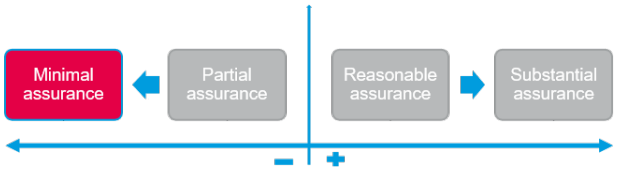
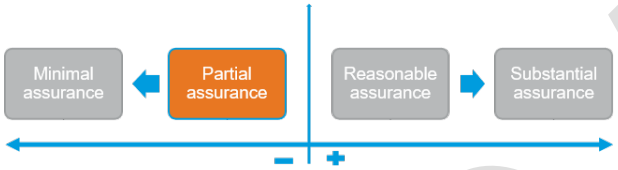
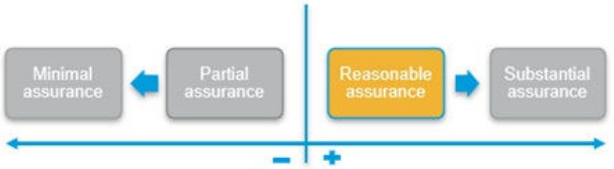
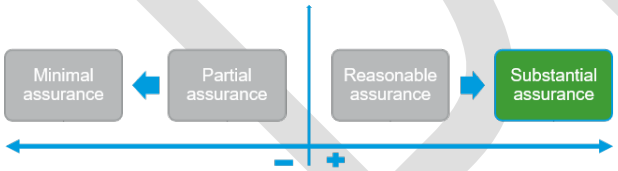
All of the assurance levels and outcomes provided above should be considered in the context of the scope, and the limitation of scope, set out in the individual assignment report.

Assignment	Executive lead	Assurance level	Actions agreed			
			A	L	M	H
Financial Sustainability (2.22/23)	Sarah Truelove - CFO	Advisory [●]	0	-	-	-
Agency Arrangements (3.22/23)	Julie Bacon – Interim Chief People Officer	Partial Assurance [●]	-	0	5	2
Financial Controls (4.22/23)	Sarah Truelove - CFO	Reasonable Assurance [●]	-	1	2	0
Risk Management Letter (5.22/23)	Sarah Truelove - CFO	Advisory [●]	3	0	0	0
System Performance Management (6.22/23)	Lisa Manson – Director of Performance & Delivery	Reasonable Assurance [●]	-	5	2	0

** Report 1.22/23 refers to the **Top Up Testing** audit which was undertaken as part of the three-month CCG Internal Audit programme to 30 June 2023, therefore does not impact on this head of internal audit opinion and annual report.*

APPENDIX C: OPINION CLASSIFICATION

We use the following levels of opinion classification within our internal audit reports, reflecting the level of assurance the board can take:

	Taking account of the issues identified, the board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

YOUR INTERNAL AUDIT TEAM

Nick Atkinson

Nick.atkinson@rsmuk.com

07730 300307

Vickie Gould

Victoria.gould@rsmuk.com

07740 631140

rsmuk.com

EXECUTIVE SUMMARY – SYSTEM PERFORMANCE MANAGEMENT

Assignment	Opinion issued	Actions agreed		
		L	M	H
System Performance Management (6.22/23)	Reasonable Assurance	3	2	0

Background

Following the passing of the 2022 Health and Care Act, Integrated Care Systems (ICSs) (also referred to within this report as the 'System') were formalised as legal entities with statutory powers and responsibilities, that bring together NHS organisations, local authorities and others to collectively improve health and reduce inequalities across geographical areas. ICSs comprise of two key components consisting of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs).

On the 1 July 2022, all Clinical Commissioning Groups (CCGs) were abolished and ICBs were legally established. Whilst an ICB may choose to delegate some of its functions to place-based committees, the ICB is directly and formally accountable to NHS England (NHSE) for NHS spend and performance within the System.

The objectives of the 'Healthier Together' System (ICS), are to work together with local partner organisations (including local authorities in the BNSSG area, NHS Trusts, GP providers and the ICB) to improve health and wellbeing, reduce inequalities and provide integrated services for the people living in the BNSSG area. The ICS have a draft Joint Forward Plan that aims to:

- Improve the health and wellbeing of the BNSSG population;
- Provide high-quality services that are fair and accessible to everyone; and
- To make the health and social care system more efficient and sustainable.

The Joint Forward Plan details the deliverables, metrics and sets out how the System will measure success, that meets the requirements for the NHS Long Term Plan and NHS Planning Guidance. The ICB uses the Systems Outcomes Framework to measure its progress, using outcome indicators that link back to the systems' strategic objectives.

The purpose of this audit was to review the ICB processes in place that ensure effective performance management of the BNSSG System. This includes a review on the framework that supports the delivery of performance across operational areas, quality and finance.

The Business Intelligence (BI) team are responsible for reporting on key National Statistics which are used to report through the ICB's governance structure. Key performance metrics include indicators from various frameworks, plans and standards (such as the Oversight Framework, NHS Long Term Plan and Operational Plan).

Nationally reported data (validated data) is used to formally report performance and is pulled from NHS Digital, National Statistics and provider Board papers. Unvalidated data (live data) is used in the ICB's daily performance management of operational areas using an external system 'Alamac' that collates System data from partners EPR (electronic patient records) systems such as South Western Ambulance Service NHS Foundation Trust (SWAST) and RiO. This provides live dashboard information (daily) on key metrics that include: calls coming through 999, the position of the SWAST ambulance service, section 136 beds available (for mental health) and Decision to Admit (DTA).

Currently the main key performance indicators (KPIs) tracked through the System focus on NHSE's Urgent and Emergency Care (UEC) recovery action plan, and six national winter metrics. The UEC recovery action plan sets out how the System will work together to ensure UEC services have resilience by:

Supporting 999 and 111 services	Improving in-hospital flow and discharge (System wide)
Supporting primary care and community health services to help manage the demand for UEC services	Supporting adult and children's mental health needs
Supporting greater use of Urgent Treatment Centres (UTCs)	Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
Increasing support for Children and Young People	Reviewing staff Covid isolation rules
Using communications to support the public to choose services wisely	Ensuring a sustainable workforce

The six national winter metrics report on:

- category 2 ambulance response times, (category 2 incidents are serious incidents including strokes or chest pain and the response target is 18 minutes);
- average hours lost to ambulance handover delays per day (ambulances stuck outside A&E can't respond to incidents in the community, impacting response times);
- percentage of beds occupied by patients who no longer meet the criteria to reside (delays to discharging patients to the care sector or community, impacting the number of beds available to receive new patients in ambulances);
- adult general and acute type 1 bed occupancy adjusted for void beds 2. (inability to discharge patients in a timely manner, having a knock on effect to bed occupancy);
- 111 call abandonment (where callers abandon their calls due to increased waiting times); and
- mean 999 call answering times (the increase in the number of 999 ambulance calls received and the increase to the duration of time it is taking to answer those calls compared to previous years).

The governance over performance management within the ICB, includes various groups and committees responsible for reviewing operational performance data from across the System, where assurances or risks are reported to the ICB's Outcomes Quality and Performance Committee (OQPC) (an ICB established meeting attended by System partners) and to the Board.

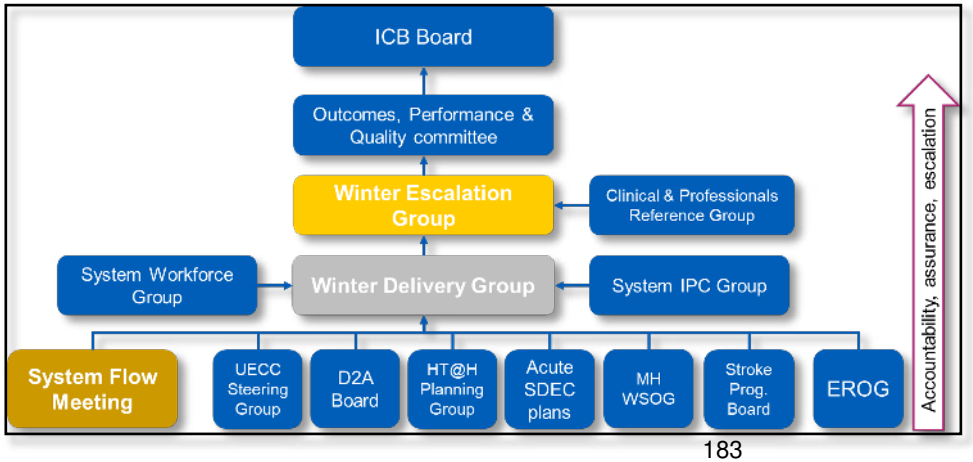
Conclusion

The ICB has developed clear reporting lines within the System (as shown in the Healthier Together flow chart included in Appendix A) where performance management takes place, System partners are engaged and analytical data utilised to support decision making (for the most part). The ICB has room to develop this further by:

- clarifying roles and responsibilities of individuals contributing to System meetings;
- clearly identifying all performance metrics, the ICB have oversight of and highlighting the links and interdependencies metrics have with various workstreams and frameworks;
- applying a structured approach to all performance monitoring meetings and ensuring analytical performance data is used for decision making;
- ensuring consistent attendance from System partners to key performance meetings to ensure effective governance and oversight; and
- continuing to develop how the ICB collates and presents operational data to enable faster and more reliable reporting.

Although nationally we have not seen a formal performance management framework in place for ICBs, we identified good practice in how the ICB applies kitemarking to the data used in reporting, to easily identify the current RAG status of key performance indicators (KPIs).

Whilst there is currently no formal System performance management framework in place, we found evidence that the controls in place were effective, with room for improvement.



Key findings

We identified the following findings:

The ICB manages system performance through various groups and delivery Boards but does not currently have a performance management framework in place.

The ICB's BI team are responsible for collating performance data and presenting it in workbooks, dashboards and reports that are used in System meetings. We noted that whilst the ICB does not have a process for assuring itself that data and information is complete, the Director of Performance and Delivery has access to live system data (such as the Emergency Department and Ambulances) that refreshes every 15 minutes, and there is a balance to having real time data to respond to, and having validated but delayed data. From attending a meeting of the Winter Delivery Group (WDG) on 8 February 2023, it materialised that AWP was missed off the data dashboard. We identified the reason behind this was due to the fact AWP does not currently have a live system that can provide rapid data but instead provide monthly data, however, work is being undertaken to enable this from August 2023. Due to the manual nature in how unvalidated data is recorded by providers, there is a risk to the accuracy and reliability of the data being used to inform daily operational decisions but the ICB are in the process of rolling out a new system that will enable all providers to access live rapid data.

BNSSG ICB has established a System Flow Meeting (SFM) to manage the day-to-day operational pressures associated with winter. Alongside the Winter Escalation Framework, the aim of the SFM is to ensure the System keep on track with winter plans (covering the six national winter metrics) and UEC action plan. The SFM meet daily and escalate operational issues to the Winter Delivery Group. The metrics include (but are not limited to):

- 111 calls;
- 999 call answering times and call handler rota;
- category 2 ambulance activity and resourcing;
- ambulance handover delays and acute queuing capacity;
- bed occupancy and discharge metrics; and
- no criteria to reside.

We observed the performance metrics reported on (by exception) were listed and covered the six national winter metrics as required and found SFM and System escalation call notes evidenced how operational pressures were managed within meetings. Each System partner reported on metrics relevant to them which included numbers in the emergency department (ED), number of ambulances and the waiting times, staffing, discharges and bed mapping. We observed the ICB were able to clearly demonstrate how it used daily performance data, extracted from a web-based tool 'Alamac', (accessible to all System providers), to inform and escalate operational issues.

We noted that whilst this data is unvalidated data, (due to it being live real-time data input by System providers daily), the ICBs BI team actively chase providers for their daily submissions (by 10am) to ensure all data is available for an operational SFM at 11am.

The Winter Delivery Group (WDG) is formed of representatives from each System provider and meets weekly to provide assurance or escalate issues on whether winter plans are kept on track. We identified the action logs used to track progress of the group's actions (relating to winter metrics tracking ad escalations) did not include a completion deadline to aid monitoring.

The Winter Escalation Group (WEG) is responsible for reviewing key performance metrics, taking strategic decisions when variances are likely to impact other elements of System plans or impact patient care, and provide assurance that outcomes and performance of services are being delivered. The WEG's aim is to ensure the delivery of the System's key priorities for 2022/23. We identified the group (attended by key leaders from across the System partners) have access to the live operational data to support decision making. We acknowledged the ICB's preference to have a non-structured agenda to enable exception reporting (on national winter metrics), to ensure escalations to be reactive to live performance / issues can be addressed timely and minimise duplication on reporting.

Performance and delivery across the System is also managed through a number of ICB led groups / delivery boards that provide updates and recommendations to the Planning and Oversight Group (POG). Whilst we can see the ICB are engaging System partners in performance monitoring it was not clear on the roles and responsibilities of individuals responsible for providing the data or escalating to POG.

The Planning and Oversight Group (POG) oversee the operational and financial delivery and planning aspects of System. The POG report to the Healthier Together (System) Executive Group in accordance with the Systems Governance structure. Whilst we found POG meetings to be effective for the system areas being discussed and evidenced the use of relevant data to support decision making (provided by the BI team), the ICB cannot be assured that POG are ensuring all system areas cycled for review, are receiving the appropriate level of operational oversight over performance as proposed in the forward planner. We identified the reason planned system area reviews had not been included in agendas in line with the forward plan, was due to the challenge of getting the relevant area leads to provide updates and attend meetings as planned.

The System Outcomes Quality and Performance Committee (OQPC) has been established by the ICB and are responsible for scrutinising and providing assurance on the System's quality and performance governance and internal control, to effectively deliver its strategic objectives. We identified, not all System representatives were in regular attendance to OQPC meetings but noted the OQPC ToR did not state the minimum requirements for attendance by its members. Without attendance from all System partners, the meeting cannot be effective. Additionally, we found that actions raised from meetings were not consistently added to both the committee action log and clearly documented within the minutes.

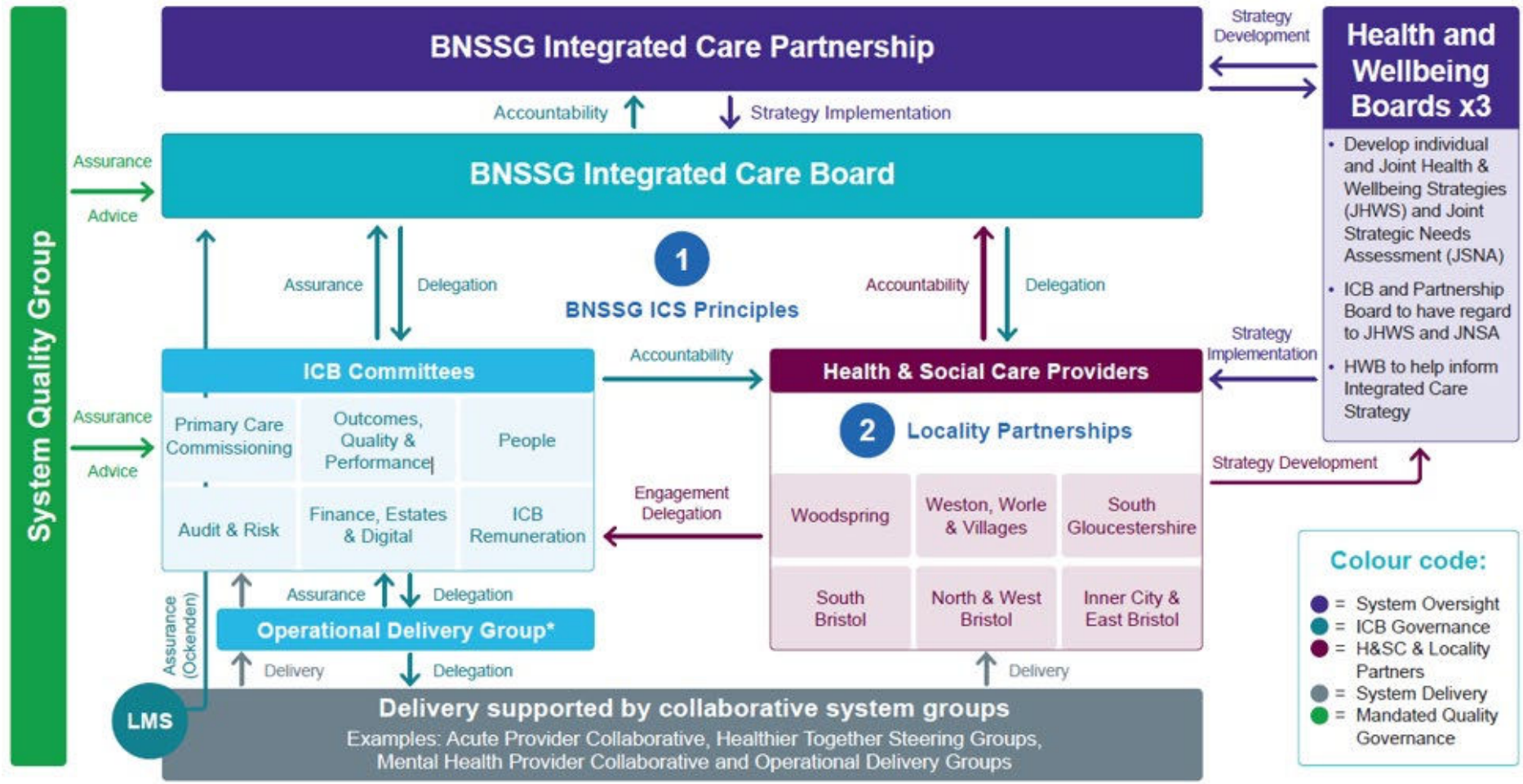
ACTION PLAN

Management Action 1	Following the work of consultancy firm 29 Forward, the ICB will have a formal performance management framework or performance reporting and management guidance that sets out: • KPI metrics the System should be monitoring and reporting on (with clear links to the various frameworks each metric is associated with); • Where source data and data validation comes from for each KPI; • the role and responsibilities of stakeholders responsible for providing or reporting on KPI data (including any timescales that need adhering to); • defining mandatory meeting attendance to enable effective triangulation of information; • the forums and governance for where KPI performance data is used for decision making and where responsibility for performance sits, aligned to the System Operational Plan; • the requirements for how KPI performance data should be presented in reports; and • ensure its forward planning of how it oversees delivery of System priorities is realistic to ensure each System area receives the appropriate level of oversight required to take assurance over its operational performance.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** 31 March 2024	**Priority:** **Medium**

Management Action 2	The ICB will provide regular updates on the roll out of the Care Traffic Control Centre (CTCC) and provide insight into the reliability of data currently utilised until the new system is embedded and working as intended. This project will be an ongoing development over the next two year and is reliant on System partners.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** Ongoing – six monthly check-ins on progress	**Priority:** **Low**
Management Action 3	The ICB will issue a reminder to ensure all action logs used to track progress of actions through to completion will include a proposed completion deadline to aid monitoring.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** 30 September 2023	**Priority:** **Low**
Management Action 4	ICB management will review attendance at POG meetings and the ability to deliver against the original set forward plan for areas covered by the Group. This will be reviewed against the developing ICS governance structure (introduction of Health Improvement Boards) to ensure the forums remain appropriate and best use of time for key personnel from the ICB and System partners.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** 30 September 2023	**Priority:** **Medium**
Management Action 5	The ICB will review the ToR for the OQPC to include the minimum mandatory requirements expected from its members for attending meetings. The OQPC Chair will monitor attendance (as required by the ToR) and escalate individuals who breach the terms.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** 30 September 2023	**Priority:** **Low**

APPENDIX A: HEALTHIER TOGETHER 'SYSTEM' GOVERNANCE AND OPERTING MODEL

The flow chart below shows where System quality sits across the BNSSG ICS.



Independent auditor's report to the members of the Board of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB)

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (the 'ICB') for the period ended 31 March 2023, which comprise the Statement of Comprehensive Net Expenditure for the nine months ended 31st March 2023, the Statement of Financial Position as at 31st March 2023, the Statement of Changes in Taxpayers Equity for the nine months ended 31st March 2023, the Statement of Cash Flows for the nine months ended 31st March 2023 and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern

to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

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

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

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

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

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

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, set out on pages 57 to 58, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).

We enquired of management and the Audit and Risk committee, concerning the ICB's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;
- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:

- high risk journals including consideration of closing entries, entries posted after year end, manual jorunals and jornals that have a material impact on reported outturn along with a number of other risk factors. We considered whether there was any potential management bias in accounting estimates or any significant transactions with related parties which could give rise to an indication of management override.

Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- journal entry testing, with a focus on unusual journal entries using criteria based on our knowledge of the entity and the risk factors identified.
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual and the recognition of expenditure between the three and nine month accounts.
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

The team communicated with management and the Audit and Risk Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual.

Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the ICB operates
- understanding of the legal and regulatory requirements specific to the ICB including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.

In assessing the potential risks of material misstatement, we obtained an understanding of:

- the ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- the ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

Responsibilities of the Accountable Officer

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

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

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

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

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

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

We cannot formally conclude the audit and issue an audit certificate for NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice

until we have completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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

JD Roberts

Jon Roberts, Key Audit Partner

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

Bristol

29 June 2023