BNSSG ICB Audit and Risk Committee Meeting

Minutes of the meeting held on 10th March 2025 at 10.00am via Microsoft Teams

Minutes

Present		
John Cappock	Audit Committee Chair - Non-Executive Member	JCa
Jaya Chakrabarti	Non-Executive Member – People	JCh
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Alison Moon	Non-Executive Member – Primary Care	AM
Jeff Farrar	Chair, BNSSG	JF
Apologies		
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Lorna Harrison	Sirona	LH
Steve West	Non-Executive Member – Finance, Estates and Digital	SW
Sarah Smith	Local Counter Fraud Service, ASW Assurance	SS
Rob Hayday	Chief of Staff, BNSSG ICB	RH
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Deborah El-Sayed	Chief Transformation and Digital Information Officer, BNSSG	DES
In attendance		
Nick Atkinson	Head of Internal Audit, RSM	NA
Matt Backler	Deputy Director of Finance, BNSSG	MB
Seb Habibi	Senior manager Transformation and Digital, BNSSG ICB	SH
Connor Evans	Executive PA, BNSSG ICB	CE
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Nic Saunders	Head of System Planning, BNSSG ICB	NS
Rosi Shepherd	Chief Nurse Officer, BNSSG ICB	RS
Gareth Cotterell	Local Counter Fraud Service, ASW Assurance	GC
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Anne Tutt	NHS University Hospitals Bristol and Weston Foundation Trust Non-Executive Member	AT
Victoria Gould	RSM	VG
Beth Bowers	Audit Director, Grant Thornton	BB
Emma Brown	Head of Financial Services, BNSSG ICB	EB
Kerrie Darvill	Intelligence Centre Programme Director, BNSSG ICB	KD
Hannah Layton	Head of Transformation and Digital PMO, BNSSG ICB	HL

Sophie Reason	BNSSG ICB	SR

	Item	Action
1	**Welcome and Apologies** John Cappock (JCa) welcomed everyone to the meeting. Apologies were noted as above. JCa thanked departing members of the Audit and Risk Committee for their contributions. Jo Walker (JW) would no longer be in attendance due to leaving her role as Chief Executive for North Somerset Council. Gareth Cottrell (GC) would be retiring from the NHS so this would be his last meeting. Nick Atkinson (NA) noted that Victoria Gould (VG) would also be leaving, making it her final meeting. JCa noted that Sarah Truelove (ST) would be leaving BNSSG later this year however this would not be her final meeting. JCa welcomed Sophie Reason (SR) a management trainee who would be observing the meeting. JCa informed the committee that RSM had been renewed for a further three years following the internal audit tender process.	
2	**Declarations of Interest** Nothing declared	
3	**Minutes of the previous meeting held and Action Log** The minutes of the previous meeting were agreed as a correct record following minor amendments. The Committee reviewed the action log: Terms of Reference – JCa noted that Rob Hayday (RH) had sought advice from NHS England on the constitution. Remain open. **All other open actions were closed**	

	Item	Action
4.1	**Internal Audit Progress Report** NA presented three reports: System Quality, Financial Controls, and Primary Care Commissioning Framework. NA highlighted positive outcomes and areas for improvement noting a few outstanding areas where dates had been changed however the process was better established with more clarity on deadlines and visibility of updates. <u>System Quality</u> NA noted a positive review despite the complex nature due to governance arrangements. Rosi Shepherd (RS) explained that the regional team were comfortable with the system quality group arrangements. Ellen Donovan (ED) was pleased to see the positive audit report. ED raised a point with regards to the risk management framework and risk registers going to committee. ED asked for confirmation on the approach that the Audit and Risk Committee would take to identify deep dives discussions from the corporate risk register. **Action: ST noted that RH reported to Shane Devlin on the corporate risk register. ST to clarify the position with RH and report back before the April meeting.** JC noted it was a good outcome with helpful findings and nothing of great concern to raise. <u>Financial Controls</u> NK noted a positive report with substantial assurance and one best practice recommendation to consider. ST commended the team for their work on the Financial Controls audit. <u>Primary Care Commissioning Framework</u> NK noted a self-assessment which the ICB would need to complete. There were a few recommendations to note but NK highlighted a good reflection of practice.	**ST/RH**

	Item	Action
	David Jarrett (DJ) noted that the areas drawn out in the report were helpful to reflect on. Alison Moon (AM) noted a timely and helpful report. With regards to the self-assessment, AM asked colleagues to consider confidence the against red, amber and green actions. ED asked DJ about ICB evidence around the oversight of waiting lists and if other systems across England were also rated as red. DJ noted that some areas were self-assessed as red in the report. DJ noted the continued and development of the relationship with the NHS England commissioning hub. **Action: DJ to ask the commissioning hub for an example on waiting lists to share with the committee.** **The Audit and Risk Committee received the Internal Audit Progress Report and discussed the finalised audit reports**	**DJ**
4.2	**Draft Head of Internal Audit Opinion** NA presented the draft head of internal audit opinion, indicating a positive assessment and improved follow-up processes. JCa appreciated the progress and the ability to take a broader ICS perspective. Anne Tutt (AT) inquired about steps to achieve the next level of assurance. NA explained the need for better follow-up, more green opinions, and a focus on high-risk areas. JCa noted the balance between holding executives to account whilst managing the requirement to hold a safe space and highlight areas of concern which had generally led to good outcomes. JCa was happy with progress made but stressed that the need to not become complacent. **The Audit and Risk Committee received the Draft Head of Internal Audit Opinion**	
4.3	**Internal Audit Action tracker**	

	Item	Action
	JCa opened the item on the Internal Audit Action Tracker. Following a pre meet with ST and Nic Saunder (NS), JCa felt that a verbal update would not be sufficient for the Audit and Risk Committee. JCa thanked the team for pulling a report together which was helpful and provided assurance. Kerrie Darvill (KD) reported an improved position over the last 6 weeks. KD noted that delays caused in 23/24 were due to recommendations which came to a surprise to the Commissioning Support Unit (CSU). The aim was to ensure that evidence pulled together for the toolkit met the audit requirements. NK agreed that the process was more challenging this year however agreeing to more realistic timelines would help the process. AM thanked KD for the update. AM highlighted that there was no differentiation between high, medium or low level in terms of a 6-month blanket extension. KD noted that typically high-level actions would have shorter deadlines and acknowledged that this would be managed differently in the future. ST reflected on a conversation at the Extended Leadership Team Meeting where they discussed achievable time scales and making the decision to push back on recommendations where necessary. NK agreed with KD that clarity of audit processes upfront would be helpful, particularly when third parties were involved. ED raised a point with regards to escalation processes with CSU. KD clarified that a session was scheduled with CSU for the 25/26 audit which would be attended by Deborah El-Sayed. <u>Project Gateway</u> Seb Habibi (SH) joined the meeting and explained that the PMO team had been responsible for coordinating the management response to the audit report. SH highlighted that the scope of the audit, titled Project Gateway, was interesting and had been divided into two parts. Part one focused on the gateway process, while part two looked more broadly at project assurance, whether projects were going through the gateway process or not. SH noted that this broadening of scope was particularly insightful.	

	Item	Action
	SH mentioned that the broadening of the audit scope meant that no single directorate could respond to the report. Instead, it required a cross-organisational effort, with a task and finish group from the Extended Leadership Team taking on the task. This group developed the responses and reported to the Executive Team. A summary report was shared with RSM. JCa thanked SH for the report and commented on the helpfulness of the process. He mentioned that the work was complementary to recent board conversations about system engagement and landing system priorities ED asked about assurance, specifically mentioning proportionate control and the layers of agreement required before decisions could be made. ED inquired about the assurance being delivered at the place level and asked for more details on what that meant. SH responded by explaining that a one-size-fits-all approach would not work due to the varying scales, complexities, and risks of projects. SH emphasised the role of locality partnership boards and health and well-being boards in providing place-based assurance. SH also mentioned that projects exceeding certain thresholds would receive additional scrutiny from the System Executive Group. JCa invited Hannah Layton (HL) to share her comments. HL reinforced the points made by SH and mentioned that they had built a platform in Microsoft Lists for quarterly reporting across the organisation for all change projects. This platform was currently being tested with a working group across the directorate. JCa thanked colleagues for the update. **The Audit and Risk Committee received the Internal Audit Action tracker report.**	
5.1	**External Auditor Update** Beth Bowers (BB) presented the annual external audit plan, outlining significant risks, progress against prior year recommendations, and changes in the audit team. ST emphasised the importance of communication to meet audit deadlines, strengthen relationships and resolve any arising concerns.	

	Item	Action
	Matt Backler (MB) highlighted that the deadline for submission was 23rd Jun 2025. JCa noted that it was helpful to see progress year on year. There was confidence that any areas of significant weakness had been through the Finance, Estates and Digital Committee. **The Audit and Risk Committee received the update.**	
6.1	**Counter Fraud Progress Report** GC provided the counter fraud update, highlighting the importance of the Economic Crime and Corporate Transparency Act and the increase in referrals post-COVID. JCa suggested reviewing the functional standard questions during the next sign-off phase. ED inquired about emerging trends, and GC mentioned the ongoing issue of bank mandate fraud and the increase in referrals related to sick leave abuse. GC thanked ICB communications team in supporting counter fraud messaging. JCa noted a satisfactory response and highlighted the need to keep under review. JCa stated that it had been helpful to see front foot, close working with the communications team. **The Audit and Risk Committee received the Counter Fraud Interim Report**	
6.2	**Counter Fraud Plan and Security Management Plan** GC presented the counter fraud plan for 2025-2026, which was approved by the committee. The plan incorporated the implications of the Economic Crime and Corporate Transparency Act and the new government counter fraud profession qualification. AM was supportive of the plan and queried if there should be a split between strategic governance, proactive, reactive and national. ST explained that the approach could be adjusted based on notifications of potential fraud. The aim would be to balance proactive and reactive work, emphasising learning from reactive cases to improve future proactive measures.	

	Item	Action
	ED noted positive progress on functional standards. GC mentioned a growing trend in bank mandate fraud, with ICB being a victim two years ago and another client recently affected. In 2023/24, the team had 93 referrals and 155 this year so far, with sick leave abuse being the most common referral. Jaya Chakrarbarti (JC) referred to the workforce reports and queried if any adjustments had been made based on past reports. **Action: Counter Fraud Team to quantify and share results with JC and Jo Hicks (Chief People Officer).** **The Audit and Risk Committee received the Counter Fraud Plan and Security Management Plan**	**GC/VG**
7.1	**ICB Annual Accounts process / year End planning** ST reviewed a high-level timeline for the year-end planning process, with detailed planning to be discussed in April. MB emphasised the need for a streamlined process to meet the tight deadlines. **The Audit and Risk Committee received the ICB Annual Accounts process / year End planning report.**	
7.2	**Review Risk Management Framework** JCa noted the ICB Board approved Specialist Commissioning Delegations and increased risk appetites. JCa mentioned the need for a dynamic approach and the use of the non-executives to provide challenge. ED referred to the committee review of the corporate risk register on pages 203-204, questioning its inclusion at the Outcomes, Quality and Performance Committee. (action picked up under internal audit update). AM supported the change in risk appetite and asked about separating the safety and quality elements. AM noted that Primary Care Committee governance was missing from the report. ST explained that it was in the paper but without a separate header.	**ST/RH**

	Item	Action
	Action: ST/ RH to ensure primary care was correctly reflected in the paper. **Action: RH to meet with Shane Devlin to clarify decision on split between safety and quality with regards to risk appetite.** **Action: Risk management framework to return to the April meeting** **The Audit and Risk Committee Reviewed the Risk Management Framework**	**RH** **JCa**
8.1	**ISFE 2** MB provided an update on ISFE 2, indicating a potential mid-year implementation. He noted the pros and cons of a mid-year implementation and the ongoing user acceptance testing. **The Audit and Risk Committee received the ISFE 2 report**	
8.2	**Losses and Special Payments Register** Emma Brown (EB) highlighted a dispute with regards to staff leaving the ICB and how much money would need to be repaid. JCa queried if there were any lesson learned. EB noted that the initial issue was caused by the late submission of change of assignment forms. A new leavers form was being produced to make the process more streamlined. EB noted a secondary case related to member of staff who died before payment could be made. In this case, the ICB wrote off the debt. EB highlighted an unusual loss this quarter in relation to BT invoices. The ICB agreed to pay interest in relation to late payments. MB queried if the level of detail provided to committee on salary overpayments was correct. VG confirmed that other NHS clients did provide a summary to their audit committee. Suggestion made to move towards a high-level summary on a regular basis.	

	Item	Action
	The Audit and Risk Committee noted the Losses and Special Payments Register	
9	**Matter for Information** The Committee received the following matters for information: • Claims and Litigation Report • Information Rights Report • Waiver of Standing Financial Instructions • Audit and Risk Committee Workplan	
10	**Reflection on Effectiveness of Committee Meeting** JCa handover over to GC to provide reflections on the effectiveness of the meeting. • Focus from beginning to end. • Good level of engagement. • Good quality of papers. • Opportunity to ask questions. • Moments of humour which helped flow. • Head of internal audit opinion was important for the ICB. •	
	Date of Next Meeting Friday 11 April 2025	

Connor Evans, Executive PA, December 2025

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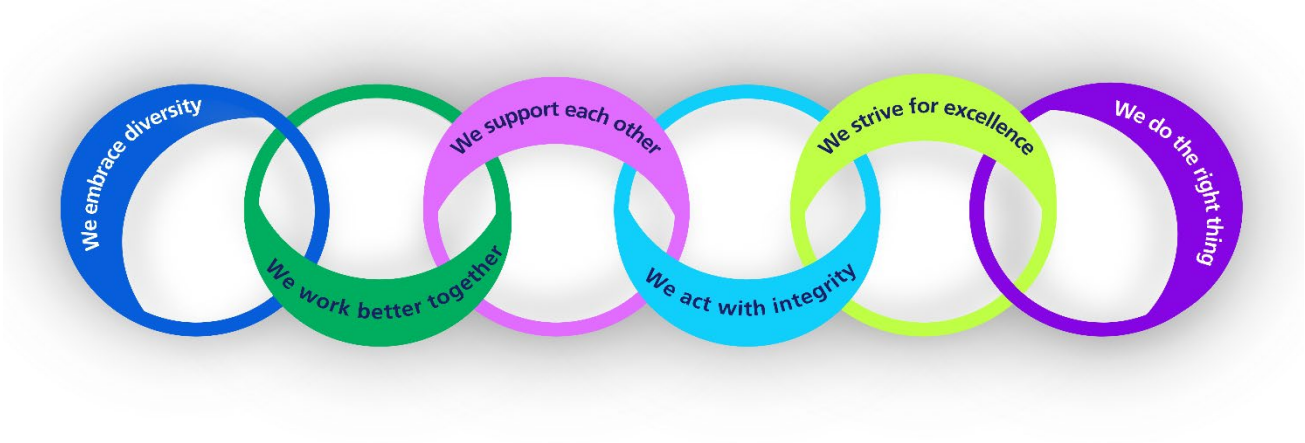
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Risk Management Framework



Together we are BNSSG

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	54
Responsible Executive Director:	Shane Devlin, CEO

Author and Job Title:	Rob Hayday, Chief of Staff
Date Approved:	01/02/2024 – to be adjusted to 1 May 2025 following Board approval
Approved by:	ICB Board
Date of next review:	February 2026 – to be adjusted to May 2026 following Board Approval

Policy Review Checklist

	Yes/ No/NA	Supporting information
Has an Equality Impact Assessment Screening been completed?	Yes	See section 14.1
Has the review taken account of latest Guidance/Legislation?	Yes	
Has legal advice been sought?	N/A	
Has HR been consulted?	N/A	
Have training issues been addressed?	Yes	
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by Staff Partnership Forum?	N/A	
Are there financial issues and have they been addressed?	No	
What engagement has there been with patients/members of the public in preparing this policy?	N/A	
Are there linked policies and procedures?	No	

	Yes/ No/NA	Supporting information
Has the lead Executive Director approved the policy?	Yes	
Which Committees have assured the policy?	Yes	Audit and Risk Committee will review this policy in February 2025
Has an implementation plan been provided?	Yes	See section 14.1
How will the policy be shared?		Published on website
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	
Has a DPIA been considered in regards to this policy?	Yes	
Have Data Protection implications have been considered?	Yes	

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Risk Management Framework

1 Introduction

This framework describes the arrangements that NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) has in place to manage risk. The framework supports the consistent, robust identification and management of risks and opportunities within accepted levels across the ICB. The framework supports openness, challenge, innovation and excellence in the achievement of the ICB's objectives. The Risk Management Framework sets out the ICB approach to risk management including the systematic identification, assessment, treatment and monitoring of risk.

The ICB is a sovereign organisation withing the Integrated Care System (ICS) which is made up of many other partner organisations which will each have their own risk management arrangements. For effective delivery of health and care to the population in BNSSG as set out in our ICS Strategy, it is important that system risks are appropriately identified, recorded and mitigated. This framework sets out the approach to doing this.

This framework incorporates the key principles described in "The Orange Book – Management of Risk – Principles and Concepts" (HM Government 2020)

- Risk management is an essential part of governance and leadership, fundamental to how the organisation is directed, managed and controlled at all levels
- Risk management is integral to all organisational activities, supporting decision-making and the achievement of objectives, incorporated within strategic and operational planning processes at all levels across the organisation
- Risk management is collaborative and informed by the best available information and expertise
- Risk management processes include: risk identification and assessment, risk treatment, risk reporting and continual improvement

The ICB will:

- ensure all staff are provided with appropriate guidance and training on the principles of risk management and their responsibilities to implement risk management effectively
- foster a culture of openness that encourages organisation wide learning.
- develop an appropriate risk management culture and will regularly review and monitor the implementation and effectiveness of the risk management process.

The ICB recognises it is impossible to eliminate all risk from its activities and that systems of control should not stifle innovation and the imaginative use of limited resources to achieve health benefits for the population of Bristol, North Somerset and South Gloucestershire. To this end the ICB Board has agreed its risk appetite which is intended to inform decision making.

The ICB acknowledges the need for all of its commissioned services to have in place rigorous risk management systems and processes as described in the Francis Report (May 2013).

Our risk culture and our risk management framework supports our values through an open, fair and positive learning culture.

2 Purpose and scope

This framework applies to all areas of our operations and to all ICB staff, regardless of whether they are directly employed or not . For the purposes of this document 'employees' includes BNSSG ICB staff, ICB Board members, executive officers, Independent Non Executive Members (including co-opted members), those with honorary contracts, volunteers, contractors and trainees. The scope of the framework also encompasses arrangements relating to functions delegated by NHS England to the ICB.

The purpose of this framework is to:

- Ensure robust governance and risk management arrangements to support the delivery of the ICB's and the ICS's strategic and operational objectives
- Ensure commissioning of high quality and safe patient care and maximise the resources available for patient services
- Develop a proactive approach to identification of understanding of risks inherent in and external to the ICB
- Minimise the ICB's exposure to financial risk
- Maintain an effective system of internal control across the ICB
- Reduce risks to the health, safety and welfare of patients, staff and those who may be affected by the ICB's activities, to the lowest level it is reasonably practicable to achieve
- Ensure that risks are managed effectively, consistently and systematically throughout the ICB
- Set a risk appetite, ie the extent to which the ICB accepts levels of risk exposure in the pursuit of their objectives. Risk appetite is contextual, for example, the acceptance level may be higher in cases where significant change is involved
- Clearly define roles, responsibility, ownership of risks and associated action plans for the management of risk
- Comply with national standards regarding risk management

The ICB is committed to the continued development of partnership working and will work closely with all partner organisations to achieve a shared ownership of risks facing the health economy and the solutions that are implemented.

The ICB expects risk management to be a priority for all those organisations from whom the ICB commissions services and will require evidence of robust risk management systems.

Risks will fall into one of four categories as defined in the table below:

ICB Risk Register	Operational
	Strategic
ICS Risk Register	Operational
	Strategic

3 Definitions/explanations of terms used

The following definitions are taken from the Australian/New Zealand Standard for Risk Management AS/NZS 4360:2004

Risk: “the chance of something happening that will have an impact on objectives.” Risk may have a positive or negative impact.

Risk identification: “the process of determining what, where, when, why and how something could happen”

Risk analysis: “the systematic process to understand the nature of and to deduce the level of risk”

Risk evaluation: “the process of comparing the level of risk against risk criteria”

Risk criteria: “the terms of reference used to assess the significance of risk”. These can include costs and benefits, legal and statutory requirements, and other aspects such as the concerns of stakeholders.

Risk assessment; “the overall process of risk identification, risk analysis and risk evaluation”

Risk management: “the culture, processes and structures that are directed towards effective management of potential opportunities and adverse effects.”

Risk management process: “the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and reviewing risk’.

Risk Appetite: 'the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point on time' (HMT Orange Book 2005).

In addition, to the above, with the introduction of the ICB and the ICS in July 2022, it is recognised that there will be risks to the delivery of ICS business that require mitigation through collective responsibility. The following is the definition of an ICS risk.

An ICS risk is a risk **held in common** between health and/or care partner organisations which cannot be controlled or mitigated by sovereign partners in isolation.

ICS risks will be managed through the collective identification, assessment and mitigation of risks where improved outcomes can be achieved by ICS partners working together through shared accountability arrangements.

4 Risk Appetite

We recognise that decisions about our level of exposure to risk must be taken in context. We are committed, however, to a proactive approach and will take risks where we are persuaded that there is potential for benefit to patient outcomes/experience, service quality and/or value for money. We will not compromise patient safety; where we engage in risk strategies we will ensure they are actively monitored and managed. We will not hesitate to withdraw our exposure if benefits fail to materialise.

Our risk appetite takes into account our capacity for risk, that is, the amount of risk we are able to shoulder before we breach our statutory obligations and duties. Our capacity for risk is also delineated by the risks our stakeholders are willing to bear.

Our risk appetite statement is dynamic and its drafting is an iterative process that reflects the challenging environment facing the ICB and the wider NHS. We will review our risk appetite statement at least annually.

The risk appetite is set by the ICB Board.

The Good Governance Institute has produced Board guidance on risk appetite which has been used to develop the following risk appetite statements for use across the ICS which were agreed by the ICB Board.

Domain	Risk Appetite Statement 2025/26	Risk Appetite Level 2025/26
Finance How will we use our resources? Value for money	We will invest for the best possible return and accept the possibility of increased financial risk.	SEEK
Regulatory How will we be perceived by our regulators? Compliance	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks	SEEK
Quality How will we delivery safe services? Quality of services Outcomes	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation	OPEN
Reputational How will we be perceived by the public and our partners?	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	SEEK
People How will we be perceived	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	SEEK

by our workforce?		

5 ICB Governance Structure

The ICB has in place a constitution that describes the governance arrangements established to ensure that it meets its duties and obligations. These arrangements include the ICB Board underpinned by supporting committees. Key committees with responsibility for the management of risks are the Audit and Risk Committee, the Outcomes, Quality and Performance Committee, Finance, Estates and Digital Committee, Primary Care Committee and the Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee. The Joint Committee, hosted by Somerset ICB as principal commissioner, convened to support the regionally delegated Specialised Commissioning arrangements, is also a formal committee of BNSSG ICB. These committees are responsible for the review and scrutiny of specific risks, seeking assurance that risks are properly managed and setting agendas for meetings accordingly. If a committee is not assured that risks are being properly managed that concern is to be escalated to the ICB Board.

The ICB Board

The ICB Board has a duty to assure itself that the ICB has properly identified the risks it faces and that the ICB has appropriate controls in place to manage those risks. The ICB Board will:

- Demonstrate leadership, active involvement and support for risk management
- Ensure roles and responsibilities for risk management are clear
- Ensure it is satisfied that key and emerging risks to the ICB have been identified and managed appropriately
- Ensure that there is a structure in place for the effective management of risk throughout the ICB
- Review and approve the Risk Management Framework on an annual basis
- Identify strategic objectives and the principal risks to these
- Establish a ICB Board Assurance Framework
- Review and approve the level of risk the ICB is willing to accept
- Review ICB and ICS risks – strategic and operational reported via the Corporate Risk Register at least quarterly and
- Exercise challenge regarding risks and the effectiveness of controls and mitigations
- Seek assurance regarding risks and the effectiveness of controls and mitigations

- Ensures the ICB's risk appetite is defined and clearly communicated

Notwithstanding the requirements set out above, significant issues will be bought to the ICB Board's attention more rapidly when required and all ICB Board reports include a section for the balanced assessment of risks. The ICB Board will monitor the quality of information received to ensure it is sufficient to allow for effective decision-making.

The ICB Board must be informed of and where necessary, consulted on all significant risks that arise from the commissioning of services. Risks associated with commissioned services must be systematically identified, assessed and analysed in the same way as other risks to the organisation. Risks relating to commissioned services assessed as scoring 15 or over will be escalated to the Corporate Risk Register to provide a complete risk profile of the organisation to ICB Board. The Corporate Risk Register will also include those risks scoring 15 and above which relate to functions delegated to the ICB from NHS England. Such risks will be identified through the use of the ICB directorate risk registers utilising information supplied by external parties engaged in activities to support BNSSG discharge its delegated commissioning responsibilities.

The Audit and Risk Committee

The Audit and Risk Committee is accountable to the ICB Board and provides an independent and objective view of our systems, information and compliance with laws, regulations and obligations. The Committee is responsible for agreeing the scope of the annual internal audit programme to obtain assurance regarding the ICB's internal system of control. The Audit and Risk Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the ICB's activities. The Audit and Risk Committee reviews the Corporate Risk Register as standing agenda items at its meetings.

The Outcomes, Performance and Quality Committee

The Committee is accountable to the ICB Board. It oversees and seeks assurances on the systems and processes which the ICB uses to ensure patient safety and improve the quality of services for its population. The Committee also oversees and seeks assurance on the delivery of outcomes and matters related to performance. The Committee is responsible for the review and scrutiny of risks that are relevant to its business, and ensuring that appropriate and effective mitigating actions are in place. The Committee reviews and monitors risks relating to outcomes, performance quality, patient safety and patient experience. Risks assigned to the Committee for review are indicated the Corporate Risk Register. .

The Finance, Estates and Digital Committee

The Committee is accountable to the ICB Board and makes recommendations to the ICB Board so that set financial objectives are achieved. The Committee monitors financial activity and budgets and progress against plan. The Committee has oversight of risks that relate to strategic financial risks. The Committee is responsible for the review and scrutiny of risks that are relevant to its business, and ensuring that appropriate and effective mitigating actions are in place Risks assigned to the Committee for review are indicated on the Corporate Risk Register

The Primary Care Committee

The Primary Care Committee oversees and seeks assurance on issues relating to the commissioning of primary care services under delegated authority from NHS England. The Committee is responsible for the review and scrutiny of risks that are relevant to its business, and ensuring that appropriate and effective mitigating actions are in place.

The People Committee

The People Committee oversees and seeks assurance on matters associated with system and ICB workforce. It challenges and scrutinises workforce risks, ensuring they are understood and mitigating actions are identified and implemented.

The SHIPPH Committee

The purpose of the SHIPPH committee is to provide oversight, assurance and support for the ICS's efforts towards tackling health inequalities and embedding preventative approaches.

The Joint Committee for Specialised Commissioning

The role of the Joint Committee is to provide strategic decision-making, leadership and oversight for the Joint Specialised Services and any associated activities. The Joint Committee will safely, effectively, efficiently and economically discharge the Joint Functions and deliver the Joint Specialised Services.

ICS Governance and the management of system risks

The System Executive Group (SEG) will oversee the delivery of the of the ICS Strategy will identify and take mitigating action for ICS strategic risks. These will be shared with the ICB Board as part of routine reporting.

SEG has established groups comprising members from partner organisations. These groups, including the Health and Care Improvement Groups and their subordinate Operational Delivery Groups will prioritise activities and deliver defined outputs. They will also be responsible for identifying ICS operational system risks.

ICS operational risks can also be identified through other sources, including those relating to quality and Emergency Planning, Resilience and Response.

ICS risks will be held in the ICB on a central risk register which will be compiled in the Office of the Chair and Chief Executive directorate alongside the ICB risk register.

6 Responsibilities and Accountabilities

All staff

The management of risk is one of the fundamental duties of all employees who must have a sense of ownership for, and commitment to, identifying and minimising risks. The day to day management of risk is the responsibility of all staff

All staff must:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the ICB's business
- Comply with the ICB's policies, procedures and guidelines
- Ensure incidents, claims and complaints are reported using the appropriate procedures
- Be responsible for completing/attending mandatory, statutory and relevant education and training events
- Participate in the risk management process in a timely way, including the assessment of risk within their area of work and the notification to their line manager of any perceived risk which may not have been assessed
- Be aware of the Risk Management Framework, risk appetite and processes and comply with them.
- Engage with system partners to ensure the common understanding of ICS risk description and responsibilities for mitigating actions. One organisation cannot describe a system risk and/or its treatment without engaging stakeholders effectively.

Project Management

The ICB has adopted a Programme Management Office (PMO) approach and the management of risk is embedded in this process. Project risk management enables the systematic identification, clarification and management of risk through the lifespan of a project. Project risk management helps to both control the probability of

an adverse event materialising and mitigate the impact of an adverse risk event. Where Projects are managed as a Programme then there may be a need for risk assessment at both Project and Programme level as Projects may be interdependent.

Managers

Managers at all levels have a responsibility to ensure that they are familiar with the Risk Management Framework, including the timely maintenance of risk registers, risk assessment methods and risk scoring.

- Managers are accountable for the day-to-day management of risks within their respective areas of responsibility, including assurance that appropriate controls are in place and that action plans are owned, being progressed and monitored.
- Managers with line-management responsibilities must ensure that their staff are aware of the Risk Management Framework and their individual responsibilities for managing risks. This requirement is important when delivering local induction for new starters.

Risk Leads

Risk leads responsibilities include:

- embedding risk management processes across their directorates/teams.
- raising awareness of the Risk Management Framework across their directorates/teams
- Taking a lead role in the maintenance of risk registers and ensuring risks that meet the tolerance level of 15 or higher are escalated and managed on the Corporate Risk Register

The Chief of Staff

The Chief of Staff is responsible for:

- Developing and overseeing effective risk management systems including timetabling activities for others' contributions
- Developing a Risk Management Framework and associated policies and procedures
- Working with Executives, Risk Owners and Senior Managers to co-ordinate and implement the Risk Management Framework
- Establishing and maintaining an effective risk register process which captures ICB and ICS risks
- Raising awareness regarding the management of risk, the Risk Management Framework and the tools used by the ICB to facilitate risk management

- Support staff in the implementation of the Risk Management Framework and Policy and the tools used by the ICB to facilitate risk management
- Ensure appropriate training and development for staff is in place as required
- Convening the ICS Risk Managers Network.

ICS Risk Managers Network

To support the collaborative approach to the oversight, identification, management and control of ICS Risks, the ICS Partner Risk Managers Network will:.

- Share collective responsibility for the identification, controls and mitigations of ICS Risks and the maintenance of an ICS Risk Register.
- Share insights and learning.
- Moderate and standardise ICS Risk assessments and provide feedback..

The network will be coordinated and supported by the ICB's Chief of Staff. It will report to the System Executive Group and seek scrutiny/assurance from the ICBs Audit & Risk Committee. The network will meet on a quarterly basis at least.

The ICB Executive Team

The Executive team is responsible for identifying operational and strategic risks to be placed on the Corporate Risk Register. The Executive Team meetings are the forum for peer review of the Corporate Risk Register at least quarterly. Directors will incorporate risk management within all aspects of their work and are responsible for directing the implementation of the ICB Risk Management Framework by:

- Demonstrating leadership, active involvement and support for risk management
- Ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility
- Setting personal objectives for risk management and monitoring their achievement
- Ensuring risk are identified and managed, and mitigating actions implemented in functions for which they are accountable
- Ensuring action plans for risks relating to their respective areas and associated committees are prepared and reviewed on a regular basis
- Ensuring that the agendas for committee meetings are driven by the risk associated with the terms of reference of each committee, and that sponsored

reports to the committees contain relevant information about risks and their mitigations associated with that committee.

- Ensuring a Directorate Risk Register is established and maintained that relates to their areas of responsibility and to involve staff in this process to promote ownership of the risks identified
- Signing off Directorate Risk Registers
- To ensure Directorate Risk Leads and Directorate Risk Administrators are identified to support the implementation of the Risk Management Framework within the directorate.
- Ensuring risks are escalated when they are of a strategic nature to the Corporate Risk Register, and the attention of the ICB Board and its committees..

The Chief Executive - Accountable Officer

The Chief Executive has overall responsibility for having an effective risk management system in place within the ICB and across the ICS that enables the maintenance of a sound system of internal control. The system of internal controls supports the achievement of the ICB's strategic objectives. The Chief Executive has responsibility for ensuring the ICB meets all statutory requirements and adheres to guidance issued by the Department of Health in respect of Governance. The Chief Executive is specifically responsible for:

- Continually promoting risk management and demonstrating leadership, involvement and support,
- Ensuring an appropriate committee structure is in place with regular reports to the ICB Board and Primary Care Committee
- Ensuring roles and responsibilities regarding risk management are communicated, understood and embedded at all levels,
- Ensuring that directors and senior managers are appointed with managerial responsibility for risk management
- Ensuring appropriate policies, procedures and guidelines are in place and operated throughout the ICB
- Chairing the SEG and its oversight of ICS risks

The Director with Lead for Risk Management

The Director with lead for risk management is the Chief Executive. The Director with lead for risk management facilitates the risk management process and:

- Ensures there is an effective risk management system in place throughout the ICB
- Ensuring all risk registers are regularly reviewed and updated

- Ensuring that there is appropriate external review of the ICB's risk management systems and that any recommendations are acted on
- Has responsibility for Information Governance arrangements within the ICB and is the Senior Information Risk Owner (SIRO).

The Independent Non Executive Member with lead role for Audit and Risk

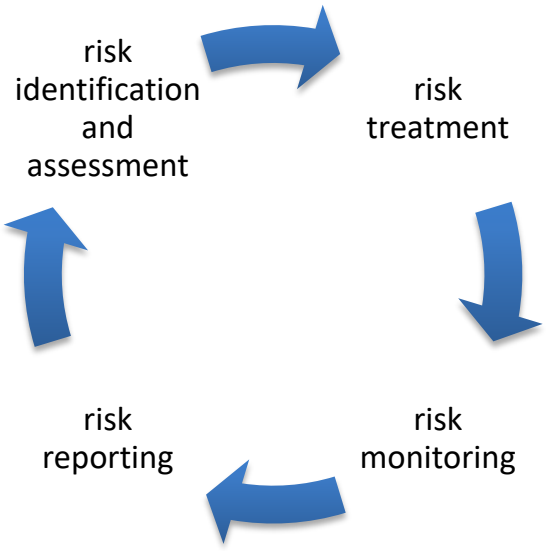
The INEM on the ICB Board with the lead role for overseeing audit, governance and risk will have the skills, knowledge and experience to assess and confirm that appropriate systems of internal control and assurance are in place for all aspects of governance including financial and risk management.

7 Risk Management Process

Risk management processes will be conducted systematically, iteratively and in collaboratively. They will draw on the knowledge and views of experts and stakeholders. To support risk management there will be appropriate communication and consultation with internal and external stakeholders. Communication will support sharing of information and promoting awareness and understanding of risks. Communication and consultation with appropriate stakeholders will assist the understanding of the risks faced, the basis for decision-making and the reasons why particular actions are required. Communication and consultation will:

- Bring together different functions and areas of professional expertise in the management of risk
- Ensure that different views are appropriately considered
- Provide sufficient information and evidence to support oversight and decision-making
- Build a sense of ownership and inclusion among those affected by risk

The risk management process structure



(HM Government 'The Orange Book')

Risk assessment incorporates risk analysis and risk evaluation

7.1 Risk Identification

The following factors and the relationships between them should be considered when identifying risks:

- Tangible and intangible sources of risk
- Changes in the internal and external context
- Uncertainties and assumptions within options, strategies and plans
- Indicators of emerging risks
- Limitations of knowledge and reliability of information

Each Directorate will ensure that risks are identified within their area of business and escalated where appropriate. This will include risks identified by external parties involved in supporting the ICB discharge its functions delegated by NHS England including Somerset ICB utilising risk management frameworks agreed as part of delegation arrangements which support this framework and feed into the ICB directorate risk register process. The description of risks will follow best practice:

If (cause) **then** (risk event) **resulting in** (effect/impact)

Risks will be proactively identified through (but not limited to):

- Top-down assessment of strategic risks involving ICB Board, System Executive Group, ICB Committees, ICB Executive Team and wider management, Health Care Improvement Groups and the wider ICS for a.
- Bottom up reporting and risk discussions
- Project risks identified by the Programme Management approach
- Assessment of emerging risks and horizon scanning
- Risk identification to support business planning and determining strategic priorities

When a risk has been identified and described, risk ownership needs to be agreed and assigned. A member of the Executive Team will own the ICB risk and identify an appropriate lead. ICS risk ownership will be identified as part of the risk identification process and may be shared.

7.2 Risk Analysis

Risk analysis supports a detailed consideration of the nature and level of risk. To ensure a consistent interpretation and application when defining the level of risk the

ICB has adopted a risk scoring matrix and the categories of risk set out in the NPSA "A Risk matrix for Managers" (2208)

The risk analysis takes into account an assessment of the likelihood of a risk occurring and the consequences should the event happen.

7.3 Risk Evaluation and Treatment

Risk evaluation involves comparing the results of a risk analysis with the ICB's tolerance and appetite for risk. This supports decisions regarding what action is required. Options may involve:

- Avoiding the risk by deciding not to start or continue with the activity (terminating)
- Taking or increasing the risk in order to gain an opportunity (tolerating)
- Retaining the risk by informed decision making (tolerating)
- Changing the likelihood or consequences (treating)
- Sharing the risk with partners (transferring)

The risk assessment process will result in:

- A risk description – including whether the risk affects the ICS or ICB and whether it is strategic or operational.
- Risk scores for the unmitigated risk and for the current risk
- The controls already in place to manage the risk
- The actions required to treat the risk
- The risk owner and risk lead who are accountable and responsible for implementing the actions
- Key performance measures and control indicators
- When actions are expected to be undertaken and completed
- The target level of risk, which is the level of risk following the application of existing controls and additional mitigations.

The outputs of the risk assessment are reported through the ICB and ICS risk registers.

7.4 Risk Monitoring

The ongoing monitoring of risks and risk treatments provides an understanding of the extent to which the controls in place and additional mitigating actions are operating. This provides assurance about the management of risks. The outcomes of the management actions taken will be reported in performance reports and in other subject specific reports received by the ICB Board, its Committees, System Executive Group, HCIGs and other ICS fora. The impact of management actions will also be reported as the current risk score on registers.

7.5 Risk Reporting

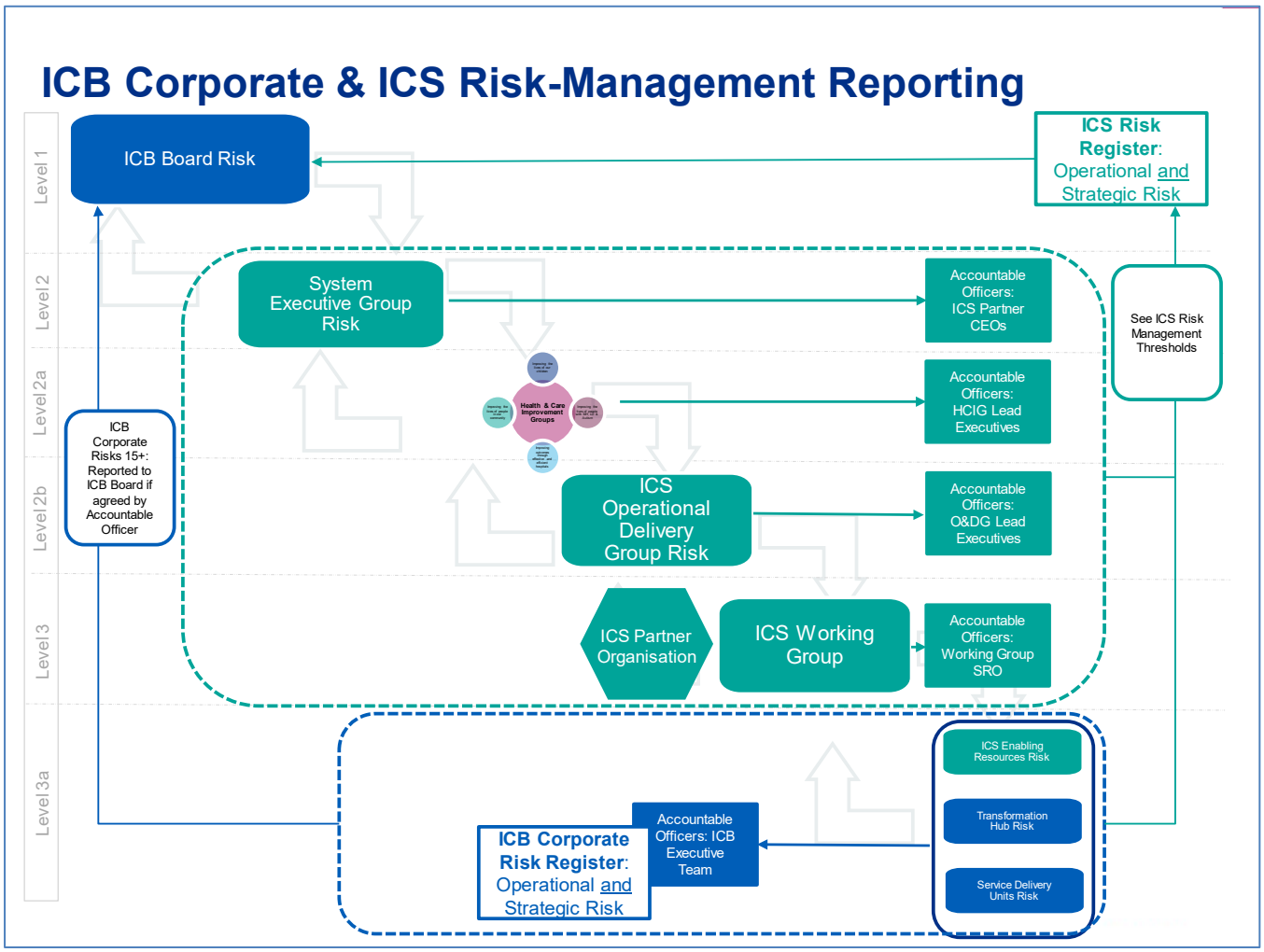
Risks are reported to the ICB Board and Committees through the Corporate Risk Register and the ICB Board Assurance Framework. Risks are also highlighted in specific reports to the ICB Board and Committees; in this case risks will also be reported on the appropriate registers.

The ICB Corporate Risk Register is underpinned by Directorate Risk Registers. Directorate, Project and Corporate Risk Registers. Information on risks sourced from external parties including Somerset ICB feeds into the directorate risk registers.

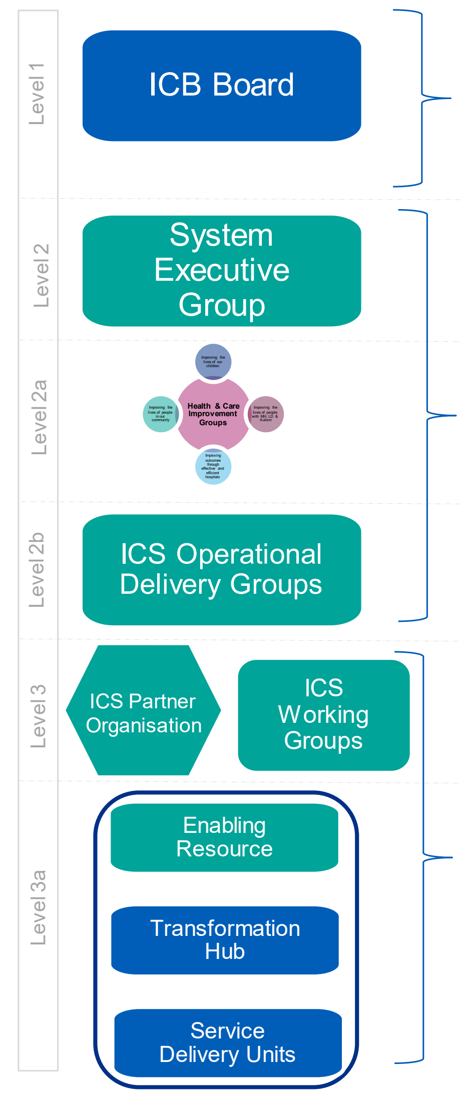
ICS risk registers will be underpinned by registers produced by Health and Care Improvement Groups and other system fora

Risk registers are 'live' documents and will be updated whenever a new risk is identified or the level of a risk is considered to have changed, as well as at defined points in the risk reporting cycle..

The diagram below sets out the reporting arrangements for ICB and ICS risks.



Risks will be escalated in line with the following thresholds



Consequence / Impact	Likelihood				
	Rare = 1	Unlikely = 2	Possible = 3	Likely = 4	Almost Certain = 5
Catastrophic = 5	5	10	15	20	25
Major = 4	4	8	12	16	20
Moderate = 3	3	6	9	12	15
Minor = 2	2	4	6	8	10
Negligible = 1	1	2	3	4	5

Consequence / Impact	Likelihood				
	Rare = 1	Unlikely = 2	Possible = 3	Likely = 4	Almost Certain = 5
Catastrophic = 5	5	10	15	20	25
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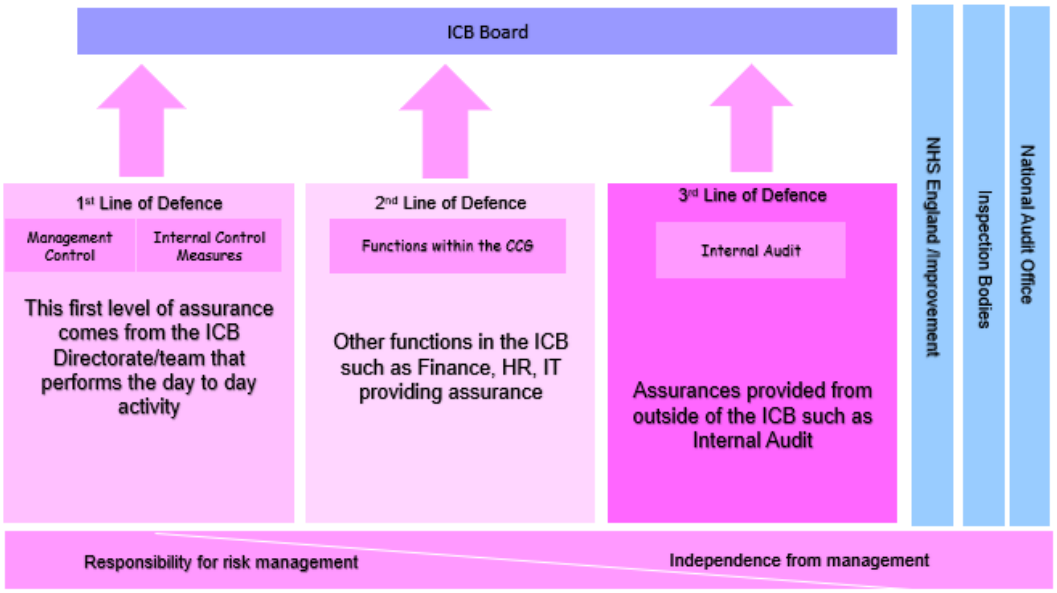
Moderate = 3	3	6	9	12	15
Minor = 2	2	4	6	8	10
Negligible = 1	1	2	3	4	5

7.6 Levels of Assurance

Assurance is the sufficient and appropriate evidence that a risk is well managed and being mitigated. Assurance may be either positive or negative and may be generated either internally or externally. Assurance provided by external bodies is considered to be stronger sources of assurance. The “three lines of defence” model (HM Government ‘The Orange Book’) describes how risk management responsibilities and assurances combine. The ICB Board is not a line of defence as it has responsibility and accountability for setting the ICB’s objectives, strategies to achieve

these objectives and establishing roles, structures and process to manage risks in achieving objectives. The following diagram explains the relationship between the challenge and scrutiny function of the ICB Board and the three sources of assurance it receives.



(Adapted from HM Government "The Orange Book" 2020)

8 Training requirements

To ensure the successful implementation of the Risk Management Framework employees will receive risk management training relevant to their roles and responsibilities. Additionally the ICB will ensure:

- Annual Risk Management Training for the ICB Board and Executive
- Risk management training as part of the Programme Management Office approach with support from the Corporate Services function
- Annual awareness sessions for Directorates provided by the Corporate Services function with support from the Directorate Risk Leads

9 Equality & Health Inequality Impact Assessment

A completed Equality Health Impact Assessment has been completed separate to this document..

10 Implementation and Monitoring Compliance and Effectiveness

The ICB will monitor compliance and the effectiveness of this Framework through the overview and scrutiny of the ICB Board and the Audit, and Risk Committee and through the annual review of governance arrangements. An implementation plan is included below.

11 Countering Fraud, Bribery and Corruption

The ICB is committed to reducing and preventing fraud, bribery and corruption in the NHS and ensuring that funds stolen by these means are put back into patient care. During the development of this policy document, we have given consideration to how fraud, bribery or corruption may occur in this area. We have ensured that our processes will assist in preventing, detecting and deterring fraud, bribery and corruption and considered what our responses to allegation of incidents of any such acts would be.

In the event that fraud, bribery or corruption is reasonably suspected, and in accordance with the Local Counter Fraud, Bribery and Corruption Policy, a referral will be made to the ICB's Local Counter Fraud Specialist for investigation. The ICB reserves the right to prosecute where fraud, bribery or corruption is suspected to have taken place. In cases involving any type of loss (financial or other), the ICB will take action to recover those losses by working with law enforcement agencies and investigators in both criminal and/or civil courts.

12 References, acknowledgements and associated documents

ICB Constitution, Standing Orders and Scheme of Reservation and Delegation

Standing Financial Instructions

Conflicts of Interest Policy

Gifts and Hospitality Policy

Health and Safety Policy

Incident Report Policy

Serious Incident Reporting Policy

Freedom to Speak Up Policy

Management of Compliments, General Enquiries and Complaints Policy

13 Appendices

Appendix 1 Implementation Plan

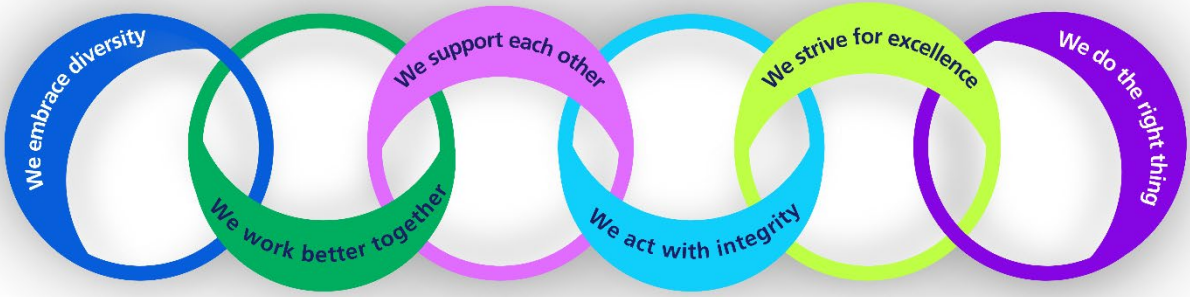
13.1 Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
Executive Directors	Ensure awareness of responsibilities of • ICB process to ensure compliance • Individual Executive Director responsibilities • Directorate responsibilities	Risk Management included on Exec Team agenda ongoing support in 1:1 with Chief of Staff	Chief of Staff	May 2025	May 2025	
Risk Leads	ensure risk leads aware of requirements of role including supporting directorates with risk management process and risk management training	updates through risk leads meetings	Chief of Staff	May 2025	May 2025	
All Staff	Ensure awareness of ICB processes and procedures	Once agreed by Board in May 2025: Framework to be placed on website/Hub Information about the policy and ICB process to be communicated through internal newsletter Awareness raising with directorates at appropriate team meetings	Chief of Staff	May 2025	May 2025	

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Local Counter Fraud, Bribery and Corruption Policy



Together we are BNSSG

Complete the blank cells in the table below. The rest will be added by the corporate team once the policy approved and before it is added to the website.	
Policy ref no:	To be filled in by Corporate Services
Responsible Executive Director:	Sarah Truelove, Deputy Chief Executive / Chief Finance Officer
Author and Job Title:	Sarah Smith, Senior Local Counter Fraud Specialist
Date Approved:	To be filled in by Corporate Services
Approved by:	To be filled in by Corporate Services
Date of next review:	To be filled in by Corporate Services

Policy Review Checklist

	Yes/No/NA	Supporting information
Has an Equality Impact Assessment Screening been completed?	Yes	
Has the review taken account of latest Guidance/Legislation?	Yes	Template and guidance provided by NHS Counter Fraud Authority
Has legal advice been sought?	N/A	
Has HR been consulted?	Yes	Through review at BNSSG CPRG
Have training issues been addressed?	Yes	Through Implementation Plan & E-Learning
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by Staff Partnership Forum?	No	Not required
Are there financial issues and have they been addressed?	N/A	The policy is intended to safeguard NHS resources.
What engagement has there been with patients/members of the public in preparing this policy?	N/A	
Are there linked policies and procedures?	Yes	See associated policies section
Has the lead Executive Director approved the policy?	**Yes**	**For CFO Review**
Which Committees have assured the policy?	Yes	Previous iterations seen by ICB AGR Committee
Has an implementation plan been provided?	Yes	
How will the policy be shared with staff	-	Intranet and Website
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	Awareness of the policy will be tested upon completion of eLearning and a staff survey
Has a DPIA been considered in regard to this policy?	N/A	IG inputs to the policy through membership of CPRG
Have Data Protection implications have been considered?	Yes	IG inputs to the policy through membership of CPRG

Version	Date	Consultation

Table of contents

Local Counter Fraud, Bribery and Corruption Policy

1 Introduction

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

The NHS Counter Fraud Authority (NHSCFA) is charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group. As a special health authority focused entirely on counter fraud work, the NHSCFA is independent from other NHS bodies and directly accountable to the Cabinet Office.

The aim is to protect staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. Ultimately, this helps to ensure the proper use of valuable NHS resources and a safer, more secure environment in which to deliver and receive care.

BNSSG ICB does not tolerate fraud, bribery or corruption. The aim is to eliminate all NHS fraud, bribery and corruption as far as possible. To meet its objectives, it has adopted the operational framework developed by the NHSCFA:

Governance - supporting a zero-tolerance approach to wrongdoing; makes this clear to all staff; and monitors, at the very top of the organisation, the effectiveness of the arrangements in place. BNSSG ICB will appoint a qualified Local Counter Fraud Specialist (LCFS) to support this commitment.

Proactive - setting clear policies and a code of conduct for all staff; raising awareness of the risks; and liaising with other organisations to develop a shared resistance to wrongdoing. Undertaking comprehensive risk assessments of existing systems and processes, auditing and review of records and completing of proactive exercises to detect fraud.

Reactive - investigating allegations and indications of wrongdoing; and seeking appropriate sanctions if wrongdoing is detected.

1.1 BNSSG ICB Values

This policy supports the values of the organisation by informing staff of their responsibility to act with integrity and to do the right thing. The ICB is committed to reducing the level of fraud, bribery and corruption within the NHS to increase the resources available for providing better patient care.

2 Purpose and scope

This policy details how staff should conduct themselves whilst working for the ICB, and raises awareness of fraud, bribery and corruption offences and the reporting lines available for staff who wish to report and suspicions of illicit activity.

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

- Improve the knowledge and understanding of all employees in BNSSG ICB, irrespective of their position, about the risk of fraud, bribery and corruption within the organisation and its unacceptability.
- Assist in promoting a climate of openness and a culture and environment where staff feel able to raise concerns sensibly and responsibly.
- Ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following: criminal prosecution, civil prosecution or internal/external disciplinary action.
- To reduce the occurrence of fraud, bribery and corruption at the ICB.

This policy applies to all employees of BNSSG ICB, regardless of position held, as well as any individual performing duties on behalf of the ICB, including those with honorary contracts, consultants, vendors, contractors, and/or any other parties who have a business relationship with BNSSG ICB. It will be brought to the attention of all employees and form part of the induction process for new staff.

3 Duties – legal framework for this policy

All organisations providing NHS services are required to put in place appropriate counter fraud, bribery and corruption measures to prevent, detect, deter and investigate fraud, bribery and corruption.

NHS Counter Fraud Authority (NHSCFA)

The NHSCFA is responsible for the detection, investigation and prevention of fraud and economic crime within the NHS. Its aim is to lead the fight against fraud affecting the NHS and the wider health and social care sector, by using intelligence to understand the nature of fraud risks, investigate serious and complex fraud, reduce its impact and drive forward improvements.

The ICB will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy and the NHSCFA Digital Fraud Manual, (available to the Chief Finance Officer and Local Counter Fraud Specialist (LCFS) only).

'Applying Appropriate Sanctions Consistently' published by NHSCFA and any other relevant guidance or advice issued by NHSCFA. Available at: https://cfa.nhs.uk/about-nhscfa/corporate-publications

The NHSCFA has also produced its Counter Fraud, Bribery and Corruption Strategy which sets out its vision and purpose, and can be found at:https://cfa.nhs.uk/about-nhscfa/corporate-publications/strategy-2023-26

All work planned and undertaken by the ICB in relation to fraud, bribery and corruption aligns to this strategy.

Government Functional Standard for Counter Fraud

The Government Functional Standard for Counter Fraud (GovS013), and specific NHS adjustments sets out the requirements placed on NHS organisations to aid fighting fraud. The requirements can be found at: https://cfa.nhs.uk/government-functional-standard/NHS-requirements

This policy document is written in accordance with these requirements and in line with the NHSCFA model policy template. The NHSCFA carries out regular engagements to check the requirements are being followed at all NHS organisations.

Economic Crime

Economic Crime can be defined as illegal acts committed by an individual or a group of individuals to obtain a financial or professional advantage. In such crimes, the offender's principal motive is economic gain. This term is the overarching name for crimes such as Fraud, Bribery and Corruption.

Fraud

The Fraud Act 2006 represents a fundamental shift in the elements required to prove a fraud offence. It is no longer necessary to prove that a person has been deceived. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss.

The offence of fraud can be committed in three ways:

- Fraud by false representation (Section 2) – lying about something using any means, e.g. by words or actions.
- Fraud by failing to disclose information (Section 3) – not saying something when you have a legal duty to do so.

- Fraud by abuse of position (Section 4) – abusing a position where there is an expectation to safeguard another person or organisation.

Bribery and Corruption

The Bribery Act received assent in 2010 and repealed previous anti-bribery/corruption legislation. It covers the public and private sector. The purpose of the legislation is to simplify the law on bribery and to allow a more effective response to bribery offences that occur either in the UK or abroad.

The main offences covered by the Act are:

1. An offence of active bribery (i.e. giving, promising or offering a bribe), which applies in the public or private sector.
2. An offence of passive bribery (i.e. requesting, agreeing to receive or accepting a bribe), which applies in the public or private sector.
3. A specific offence of bribing a foreign public official.
4. A new 'corporate' offence which applies where a corporate body or partnership fails to prevent persons performing services on their behalf from paying bribes.

Economic Crime & Corporate Transparency Act

The Economic Crime & Transparency Act 2023 (ECCT Act) creates a new corporate criminal offence, the 'failure to prevent fraud' offence. This offence is intended to hold large organisations to account if they profit from fraud and comes into effect on 1 September 2025.

Under the offence, large organisations may be held criminally liable where an employee, agent, subsidiary or other "associated person" commits a fraud intending to benefit the organisation.

The corporate offence is irrespective of whether or not there was management knowledge of the primary offence.

In the event of a prosecution, the organisation will have to demonstrate that reasonable fraud prevention measures were in place at the time the fraud was committed; the 'reasonable procedures' defence.

4 Responsibilities and Accountabilities

BNSSG ICB will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, the NHSCFA Digital Fraud Manual, (available to the CFO and LCFS only), the policy statement Applying Appropriate Sanctions Consistently published by NHSCFA and any other relevant guidance or advice issued by NHSCFA.

The **Board of the ICB** is responsible for gaining assurance that:

- BNSSG ICB has adopted and is operating adequate procedures and controls to deter and prevent wrongdoing from occurring, in compliance with the Government Functional Standard requirements.

- Adequate arrangements are in place to ensure that all staff are aware of the standards of personal and professional behaviour expected of them; and that all staff have access to this policy.

The **Audit and Risk Committee** is responsible for gaining assurance that:

- BNSSG ICB has appointed a qualified Local Counter Fraud Specialist (LCFS) to lead the drive to maintain and improve the standards and processes for deterring, detecting and investigating wrongdoings; and seek prosecution where wrongdoing is discovered.
- The annual counter fraud work plan is adequate and provides a reasonable balance between raising fraud awareness across BNSSG ICB and evaluating the effectiveness of BNSSG ICB's counter-fraud systems and controls.
- It receives periodical reports from the LCFS on the progress against the work plan and update of the progress of any investigations.
- It receives a formal annual report of BNSSG ICB's compliance with the standards set by NHSCFA.

The **Chief Financial Officer** is the lead for all anti-fraud, bribery and corruption work at BNSSG ICB, monitors and ensures compliance with Government Functional Standards and is responsible for:

- Ensuring that an annual risk assessment is carried out by the BNSSG ICB, using the tools provided by NHSCFA.
- Managing the continuity of appointment of a qualified LCFS to the BNSSG ICB; and ensuring that the counter-fraud service continues to be delivered in the event of the departure, or long-term absence of the appointed LCFS.
- Overseeing the delivery of services from the LCFS including induction and any relevant training or promotional activities.
- Providing the relevant required support to the LCFS in any investigations that they carry out.
- Depending on the outcome of investigations (whether on an interim/on-going or concluding basis) and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.
- Informing and consulting with the Chief Executive in cases where the loss may be above the agreed limit or where the incident may lead to adverse publicity.

All managers responsible for commissioning or procuring services will ensure that:

- Special regard is paid to the requirements of the Bribery Act 2010: that all organisations from which services are procured have proportionate controls and checks on their staff to deter and prevent all forms of wrongdoing, including bribery in favour of BNSSG ICB and bribery that does not benefit BNSSG ICB.
- Special regard, as of 1 September 2025, is paid to the requirements of the Economic Crime & Corporate Transparency Act 2023: that all agents, subsidiaries or other

'associated persons' from which services are procured and who are part of supply chains providing services for or on behalf of the ICB, should be asked to demonstrate compliance with the with the Act. **(Note: Sec 2.3.2 of Nov 24 ECCT Guidance).**

All staff are required to:

- Act in accordance with the standards laid down by their professional institutes, where applicable, and have a personal responsibility to ensure that they are familiar with them.
- Have a duty to protect the assets of BNSSG ICB, including information, goodwill and property.
- Comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality.
- Avoid acting in any way that might cause others to allege or suspect them of dishonesty.
- Behave in a way that would not give cause for others to doubt that BNSSG ICB's employees deal fairly and impartially with official matters.
- Be alert to the possibility that others might be attempting to deceive.
- Ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, receipts or dealing with contractors or suppliers.
- Reporting any suspected fraud or corruption, or any suspicious acts or events, to the nominated LCFS.

Managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud, bribery and corruption therefore primarily rests with managers but requires the co-operation of all employees. As part of their responsibility, managers need to:

- Ensure that procedures to guard against fraud and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption. If they have any doubts, they must seek advice from the nominated LCFS.
- Managers must instil and encourage an anti-fraud, anti-bribery and anti-corruption culture within their team and ensure that information on procedures is made available to all employees as part of local induction and on an ongoing basis. The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.
- All instances of actual or suspected fraud or corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, managers

must not attempt to investigate the allegation themselves; they have the clear responsibility to refer the concerns to the LCFS as soon as possible.

- Inform staff of BNSSG ICB's code of business conduct and Fraud, and Bribery policy as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms.
- Ensure that all employees and others engaged in ICB business for whom they are accountable are made aware of the requirements of the policy.
- Assess the types of risk involved in the operations for which they are responsible.
- Ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively.
- Ensure that any computer equipment, software programs, applications and peripherals are only used or accessed by properly authorised employees for legitimate ICB related business (in accordance with relevant ICB IT & Information Governance Policies). Furthermore, that any access to petty cash by employees is linked to the performance of their duties within BNSSG ICB and properly recorded as per ICB Standing Financial Instructions and SOP's.
- Be aware of BNSSG ICB's Fraud and Bribery policy and the rules and guidance covering the control of specific items of expenditure and receipts.
- Identify financially sensitive posts and post-holders, to include those that have responsibilities for making financial decisions or are involved in procurement or the management of assets; and ensure they are aware of responsibilities and understand systems and controls.
- Ensure that controls are being complied with.
- Contribute to their Director's assessment of the risks and controls within their business area, which feeds into BNSSG ICB's and the Department of Health Accounting Officer's overall statements of accountability and internal control.

The Local Counter Fraud Specialist (LCFS)

Government Functional Standard GovS 013: Counter Fraud set out the expectations for the management of fraud, bribery and corruption risks across government. All NHS organisations must comply with specific NHS requirements within this standard, set out by the Cabinet Office. One requirement is that all NHS organisations must have an appropriately qualified and nominated Local Counter Fraud Specialist (LCFS).

NHSCFA provides the NHSCFA Counter Fraud Manual to both LCFS and Chief Financial Officers. This details how counter fraud work should be delivered in order to comply with the requirements of the Counter Fraud Functional Standards.

The Local Counter Fraud Specialist is required to:

- Regularly report on progress against the Counter Fraud Workplan to the Audit and Risk Committee.
- Regularly report to the CFO on the progress of the investigation and when/if referral to the police is required.
- Ensure that the Chief Financial Officer is informed about all referrals/cases.
- Be responsible for the day-to-day implementation of the NHSCFA operational framework, in particular, the investigation of all suspicions of fraud.
- In consultation with the Chief Financial Officer report any case to the police or NHSCFA as agreed and in accordance with the NHSCFA Counter Fraud and Corruption Manual.
- Report any case and the outcome of the investigation through NHSCFA's national case management system, CLUE.
- Ensure that other relevant parties are informed where necessary, e.g. Human Resources (HR) will be informed if an employee is the subject of a referral. In this situation, the LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation by HR.
- Ensure that BNSSG ICB's incident and losses reporting systems are followed.
- Ensure that any system weaknesses identified as part of an investigation are followed up with management and reported to internal audit.
- Adhere to the Counter Fraud Professional Accreditation Board (CFPAB's) Principles of Professional Conduct as set out in the NHSCFA Counter Fraud and Corruption Manual.
- Ensure that the Chief Financial Officer is informed of NHSCFA investigations, including progress updates.
- Report any case and the outcome of the investigation to the Chief Financial Officer, as well as to the Audit & Risk Committee.
- Liaise on a regular basis with key points of contact in the ICB and supporting organisations as required.
- The LCFS shall be responsible, in discussion with the Chief Financial Officer, for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.
- Provision of induction, training and other activities to support understanding and adoption of LCFS matters including this policy.

Internal and External Audit are responsible for:

- Passing any suspicions of fraud immediately to the nominated LCFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems.

Human Resources are responsible for:

- Liaising closely with managers and the LCFS from the outset if an employee is suspected of being involved in fraud, bribery or corruption, in accordance with agreed liaison protocols. HR staff are responsible for ensuring the appropriate use of BNSSG ICB's Disciplinary Policy.
- Advising those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LCFS and HR will be essential to ensure that any parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a coordinated manner.
- Taking steps at the recruitment stage to establish, as far as possible, the previous record of potential employees, as well as the veracity of required qualifications and memberships of professional bodies, in terms of their propriety and integrity. In this regard, temporary and fixed-term contract employees are treated in the same manner as permanent employees. Such information will be shared with recruiting managers.

Outsourced Contract Leads will:

- Ensure that the contractor is aware of their responsibility to contact the LCFS immediately in all cases where there is suspicion of fraud, bribery and/or corruption, or any other concern which could pose a fraud risk.

Information Management and Technology will:

- Contact the LCFS immediately in all cases where there is suspicion that IT equipment is being used for fraudulent purposes. HR will also be informed if there is a suspicion that an employee is involved.

Procurement will:

- Contact the LCFS immediately in all cases where there is suspicion of fraud, bribery or corruption within the procurement process.

The **Counter Fraud Champion (**ICB Audit & Risk Committee Chair**)** is responsible for:

- Promoting awareness of fraud, bribery and corruption across the ICB.
- Understanding the threat posed by fraud, bribery and corruption.
- Understanding best practice in counter fraud work.
- Supporting the LCFS in their work, whilst also ensuring the accountability of the LCFS.

5 Definitions/explanations of terms used

NHS Counter Fraud Authority (NHSCFA)

The NHSCFA is responsible for the detection, investigation and prevention of fraud and economic crime within the NHS. Its aim is to lead the fight against fraud affecting the NHS and the wider health and social care sector, by using intelligence to understand the nature of fraud risks, investigate serious and complex fraud, reduce its impact and drive forward improvements.

Government Functional Standard for Counter Fraud

The Government Functional Standard for Counter Fraud (GovS013), and specific NHS adjustments sets out the requirements placed on NHS organisations to aid fighting fraud. The organisation is required to submit an annual self-assessment of compliance with the standards.

Economic Crime

Economic Crime can be defined as illegal acts committed by an individual or a group of individuals to obtain a financial or professional advantage. In such crimes, the offender's principal motive is economic gain. This term is the overarching name for crimes such as Fraud, Bribery and Corruption.

Fraud

The Fraud Act 2006 defines fraud as dishonestly obtaining a benefit or causing a loss by deception, false representation or abuse of position.

Bribery

The Bribery Act 2010 defines a bribe as any advantage given to influence a person in the carrying out of a function, usually connected with their work or office. More simply it is the crime of giving someone money or something else of value to persuade them to do something for you.

Corruption

Corruption is dishonest behaviour, especially by those in positions of power.

Local Counter Fraud Specialist (LCFS)

One requirement of the Government Functional Standard is that all NHS organisations must have an appropriately qualified and nominated Local Counter Fraud Specialist (LCFS).

Counter Fraud Champion (CFC)

The Counter Fraud Champion is a nominated role and should be held by a person who is senior, directly employed by the organisation and has enough influence to raise awareness of fraud.

Fraud Champions will support and promote the fight against fraud at a strategic level and with other colleagues in their own organisation. Fraud Champions will support the LCFS in the work they already do.

6 The Response Plan

If an employee has any of the concerns mentioned in this document, they must inform the nominated LCFS (contact details available on The Hub) or BNSSG ICB's Chief Financial Officer, unless the Chief Financial Officer or LCFS is implicated. If that is the case, they should report it to the Audit Chair or Chief Executive, who will decide on the action to be taken.

Employees can also call the NHSCFA Fraud and Corruption Reporting Line on Freephone 0800 028 40 60. This provides an easily accessible route for the reporting of genuine suspicions of fraud within or affecting the NHS. It allows NHS staff who are unsure of internal reporting procedures, to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

Additionally, members of staff are able to report suspicions of fraud, bribery or corruption via the NHSCFA online reporting facility at: https://cfa.nhs.uk/report-fraud

Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.

The LCFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

Disciplinary Action

The disciplinary procedures of BNSSG ICB must be followed if an employee is suspected of being involved in a fraudulent or otherwise illegal act.

It should be noted, however, that the duty to follow disciplinary procedures will not override the need for legal action to be taken (e.g. consideration of criminal action). In the event of doubt, legal statute will prevail.

Police involvement

In accordance with the NHSCFA Digital Fraud Manual, the Chief Financial Officer, in conjunction with the LCFS, will decide whether or not a case should be referred to the police. Any referral to the police will not prohibit action being taken under the local disciplinary procedures of BNSSG ICB.

Managing the investigation

The LCFS, in consultation with BNSSG ICB's Chief Financial Officer, will investigate an allegation in accordance with procedures documented in the NHSCFA Digital Fraud Manual.

The LCFS must be aware that staff under an investigation that could lead to disciplinary action have the right to be represented at all stages. In certain circumstances, evidence may best be protected by the LCFS recommending to BNSSG ICB that the staff member is suspended from duty. BNSSG ICB will make a decision based on HR advice on the disciplinary options, which include suspension.

BNSSG ICB will follow its disciplinary procedure if there is evidence that an employee has committed an act of fraud, bribery or corruption.

Criminal and Disciplinary Investigations may take place at the same time. Parallel investigations are supported by NHSCFA where disciplinary sanctions could reduce the risk of further financial loss or risks to patient safety. The LCFS and the ICB's Human Resources function will liaise to ensure that appropriate sanctions are pursued.

Gathering Evidence

The LCFS will take control of any physical evidence, and record this in accordance with the procedures outlined in the NHSCFA Digital Fraud Manual. If evidence consists of several items, such as many documents, LCFS's should record each one with a separate reference number corresponding to the written record. Note that in criminal actions, evidence on or obtained from electronic media needs a document confirming its accuracy.

Interviews under caution or to gather evidence will only be carried out by the LCFS, if appropriate or, the investigating Police Officer in accordance with the Police and Criminal Evidence Act 1984 (PACE). The LCFS will take written statements where necessary.

All employees have a right to be represented at internal disciplinary interviews by a trade union representative or accompanied by a friend, colleague or any other person of their choice, not acting in a legal capacity in connection with the case.

The application of the Fraud and Bribery Policy will at all times be in tandem with all other appropriate BNSSG ICB policies, e.g. Detailed Financial Policies, Conflict of Interests Policy, Gifts and Hospitality Policy and Standing Orders (SOs).

7 Recovery of Losses due to Fraud, Bribery and Corruption

Redress allows resources that are lost to fraud and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

The seeking of financial redress or recovery of losses will always be considered in cases of fraud or corruption that are investigated by either the LCFS or NHSCFA where a loss is identified. Redress can take the form of confiscation and compensation orders, a civil order for repayment, or a local agreement between the organisation and the offender to repay monies lost. The decisions will be taken in light of the particular circumstances of each case.

8 Sanctions

The types of sanction that may apply when an offence has occurred are:

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

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

Disciplinary – Where events giving rise to disciplinary action are the subject of legal proceedings, the ICB may take disciplinary action before such legal proceedings are concluded. This will depend on advice from the police or other prosecuting bodies, including the LCFS on whether it is appropriate to continue with the ICB's disciplinary process.

Professional body disciplinary – If warranted, staff may be reported to their professional body as a result of a successful investigation and/or prosecution

9 Reporting the Results of an Investigation

The investigation process requires the LCFS to review the systems in operation to determine whether there are any inherent weaknesses. Any such weaknesses identified should be corrected immediately.

If fraud, bribery or corruption is found to have occurred, the LCFS will prepare a report for the Chief Financial Officer setting out the following details:

- The circumstances.
- The investigation process.
- The estimated loss.
- The steps taken to prevent a recurrence.
- The steps taken to recover the loss.

This report should also be available to BNSSG ICB's Audit and Risk Committee and Board.

10 Training requirements

Associated Fraud, Bribery and Corruption eLearning is mandatory for all ICB staff and covers elements of this policy. Staff awareness will be measured through analysis of compliance rates for completion of the eLearning available via the ICB's education platform or application and through the Counter Fraud Staff Survey, created by ASW Assurance.

11 Equality Impact Assessment

An Equality Impact Assessment has been completed for this policy and can be found at Appendix A.

12 Implementation and Monitoring Compliance and Effectiveness

An implementation plan is discussed in the Appendices of the policy

Monitoring of Compliance and Effectiveness will be conducted via the assessment of completion rates for mandatory Counter Fraud eLearning and a staff survey.

13 Countering Fraud, Bribery and Corruption

The ICB is committed to reducing and preventing fraud, bribery and corruption in the NHS and ensuring that funds stolen by these means are put back into patient care. During the development of this policy document, we have given consideration to how the risk to the organisation from fraud, bribery or corruption may be mitigated by an effective policy.

We have sought to ensure that knowledge and awareness of the policy will assist in preventing, detecting and deterring fraud, bribery and corruption and made reference to the roles and responsibilities of those working for or on behalf of the organisation in aiding and promoting the Counter Fraud, Bribery and Corruption agenda within the ICB.

References, acknowledgements and associated documents

The following list is not exhaustive:

- The Fraud Act 2006
- The Bribery Act 2010
- The Economic Crime & Transparency Act 2023
- Standing Financial Orders
- Detailed Financial Policies
- Conflict of Interests Policy
- Gifts and Hospitality Policy

- Information Governance Policy
- Disciplinary Policy
- Raising Concerns (Whistleblowing) Policy
- Recruitment Policy
- Grievance Policy

14 Appendices

Equality Impact Assessment

Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
ICB Board	Ensure ICB Board is aware of the ICB's responsibilities for countering Fraud, Bribery and Corruption.	Policy and Cover paper to be presented by the ICB Board after approval by Audit, Governance and Risk Committee.	LCFS	Upon approval at AGRC	Unknown	LCFS time AGRC time GB time
All staff	Ensure that all staff are aware of the policy and its contents.	Launch via ICB staff newsletter and via intranet.	LCFS	Upon approval of Board.	Unknown	LCFS Time Comms Time
Patients, public and contractors	Ensure awareness of the policy and the ICB's stance towards fraud, bribery and corruption.	Launch policy on ICB website to ensure availability to external groups.	LCFS	As above	Unknown	LCFS Time Comms Time
Contract Leads	Ensure all contract leads for outsourced contracts make contractors aware of their responsibilities.	Contact all contract leads for outsourced contracts.	LCFS	Upon approval of policy	Unknown	LCFS time Contract leads time.
All Procurement Leads, Managers that commission services on behalf of ICB and CSU Procurement Managers	Ensure requirements of ECCT Regulations are covered adequately in Policy, commissioning of services documentation suite and procurement of services.	Ensure that adequate procurement policy, contracting documents and related training is developed, approved and implemented prior to ECCT regulations start date September 2025.	LCFS through Procurement Oversight Group, ICB & CSU Procurement Lead	1 September 2025	Unknown	LCFS Time, Procurement Leads Time, Procurement Oversight Group Time

Equality & Health Inequality Impact Assessment

Other documents required to complete the Equality & Health Inequality Impact Assessment:

- **Equality & Health Inequality Impact Assessment Guidance**
- **Equality & Health Inequality Impact Assessment Resources**

Please ensure you read the guidance and resources in full before attempting to complete this template.

Title of proposal: Local Counter Fraud, Bribery and Corruption Policy				Date: 03/04/2025
☐x Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (please state)
EHIA type:	Screening EHIA ☐	Full EHIA x	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes ☐ No x
Is the policy under:	Development ☐	Implementation ☐	Review ☐X	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? Staff, patients, service users, carers/family, general public, partner organisations				
Lead person(s) completing this assessment: Sarah Smith				
Lead person job title(s) and service area: Senior Local Counter Fraud Specialist				

Step 1: Outline

1.1 Briefly describe the proposal

Give a brief description of the context, purpose, aims and objectives of the proposal. Describe what services are currently being provided. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new proposal or change to an existing one and the key decision that will be informed by the EHIA (e.g. whether or not to proceed with the proposal to publish an employee handbook)

This is a policy to set out how and why the ICB will adhere to its obligations to protect the public funds it administers from loss due to fraud, bribery and corruption. The ICB currently contracts a qualified Local Counter Fraud Specialist (LCFS) to undertake work within the organisation to prevent, detect, deter and investigate fraud, bribery and corruption and this policy defines the role of the ICB, its staff and the LCFS in working towards this common goal. Recent and future changes in legislation require updates to the policy and increased awareness of the risk of fraud, bribery and corruption to the ICB and NHS system partners.

Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:
Fraud, bribery and corruption are risks which, when successful diverts public funds away from patient care. This policy does not relate to Health Inequalities. It does not impact different groups of people in respect of Health Inequalities.
Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.
N/A Not Applicable in relation to patients. Policy has been through CPRG.
Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? No Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.
The policy will be available through usual communications routes with AIS considered.

Step 2: Impact

2.1 Could the proposal have a positive or negative impact on any of the protected characteristic groups or other relevant groups?

Although some of your conclusions will be widely known and accepted (e.g. need for accessible information), your analysis should include evidence to support your statements to aid the decision-maker – references and links to documents can be listed in section 4.1. Evidence might include insights from your engagement, focus groups, stakeholder meeting notes, surveys, research paper, national directives, expert opinion etc. If there is insufficient evidence, state this and include an action to find out more in the action plan in Step 3. In addition to having due regard for the Equality Act 2010 Public Sector Equality Duty to eliminate unlawful discrimination, advance equality and foster good relationship between protected groups; you must also have due regard to the principles of the Armed Forces Act 2021 including regarding the unique obligations and sacrifices they make, removing disadvantage and making special provision to ensure services and employment opportunities are accessible.

Positive Impact:

☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)

Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here:

The ICB recognises its responsibility to safeguard public funds from the risks posed by fraud, bribery and corruption. This policy provides guidance on fraud, bribery and corruption related matters, across all groups.

Negative Impact

☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)

Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here:

Access to policy by employees whose first language is not English can be mitigated through discussion with line manager. Neurodiverse employees can access policy through use of screen readers.

Where staff with learning disabilities have challenges accessing e-learning, this is mitigated through 1:1 engagement with staff line manager to ehance understanding of the policy.

(you can share further details and mitigations below in 2.2)

No Effect

Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if ‘not applicable’

Not applicable

2.2 Outline any negative impacts of the proposal on people based on their protected characteristic or other relevant characteristic. Consider how you might level the 'playing field' for all people

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
Neurodiverse	Some staff may require specialist physical adaptations to *access* policy on computer screens.	Screen Readers
Learning Disabilities	Some staff with learning difficulties may have challenges accessing counter fraud e-learning.	Mitigated through 1:1 engagement with line manager on policy.

2.3 Outline any benefits of the proposal for people based on their protected or other relevant characteristics?

Outline any potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our Public Sector Equality Duty to:

To eliminating discrimination, harassment and victimisation.	Positive	☐
	Negative	☐
	No effect	X
Please describe: Not applicable		

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	X
	Negative	X
	No effect	☐
Please describe: This will provide reasonable adjustments for all staff and has both potential positive and negative impacts for those with protected characteristics as laid out above.		

To foster good relations between people who share a protected characteristic and those who don't (e.g. does the project raise any issues for community cohesion, or linked to current topics that are contentious in society; will it affect relationships between any groups)	Positive	☐
	Negative	☐
	No effect	X
Please describe: Not Applicable		

Step 3: Action Plan

3.1 What actions will you take to mitigate the negative impact outlined above?

Action	Timeframe	Success Measure	Lead
Promote the availability of support through the reasonable adjustment process	Ongoing	Staff using reasonable adjustments process.	R Hayday

3.2 How and when will you review the action plan (include specific dates)?

The action is open ended.

Step 4: Impact

4.1 What are the main conclusions of this Equality & Health Inequality Impact Assessment?

Share a brief summary of the positive impact the project will make and any negative impact and mitigations, e.g. what steps you have been taken to improve accessibility, and what recommendations you are making to the decision maker.

Explain how the EHIA has informed, influenced or changed the proposal and include a recommendation for the decision maker

Consideration of the EHIA has not changed the proposed policy as it is a policy designed to mitigate the risks to the ICB and the funds it administers which are posed by fraud, bribery and corruption. The EHIA has reinforced the importance of the reasonable adjustments process.

Select a recommended course of action:	
Outcome 1: Proceed – no potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified. E.g. proposal is not likely to have any detrimental impact on any group	☐
Outcome 2: Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity and fostering good relations or breach of human rights articles. E.g. arrangements put in place to produce a BSL video to promote changes to a service	X
Outcome 3: Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out). E.g. pilot benefits one neighbourhood due to funding restrictions	☐
Outcome 4: Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified. E.g. dress code policy discriminates against people who practice particular religions; new service that proposes to detain patient but insufficient evidence of safeguarding or human rights considerations in place	☐

Step 5: Review

All Equality & Health Inequality Impact Assessments should be reviewed internally and obtain sign off to show an organisational commitment.

Reviewer's Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)
Add comments here
Equality Officer Name:

Equality and Inclusion Team Signature:
Date:

Equality Delivery System 2022

Equality, Diversity & Inclusion is an evidence-based practice, Healthier Together partners are committed to demonstrating how we have taken steps to improve patient and service user access, experience and outcomes and how we have created an inclusive working environment for our staff, including supporting our workforce to have healthy and fulfilled lives. Please indicate which Domain your project will deliver against:

Domain 1 – Commissioned & Provided services

- 1A: People can readily access the service.
- 1B: Individual people's health needs are met
- 1C: When people use the service, they are free from harm.
- 1D:People report positive experiences of the service.

Domain 2 – Workforce health and wellbeing

- 2A: When at work, staff are provided with support to promote healthy lifestyles and manage their long term conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
- 2D: Staff recommend the organisation as a place to work

Domain 3 – Inclusive Leadership

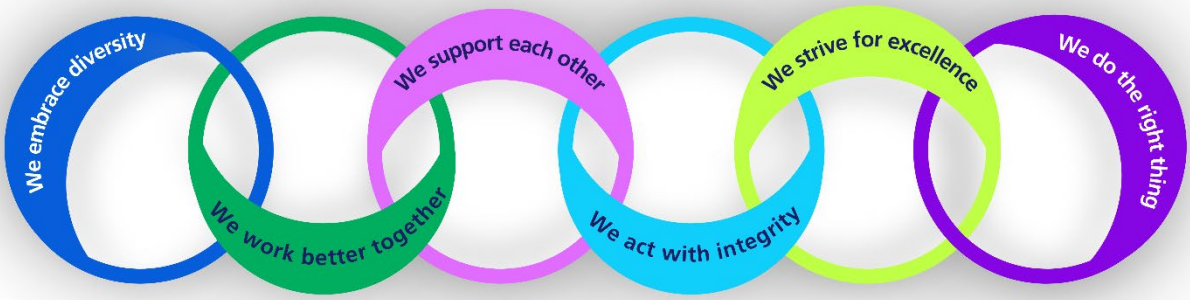
- 3A: Board members and senior leaders (Band 9 and VSM) routinely demonstrate their commitment to equality.
- 3B: Board/Committee papers (including minutes) identify equality related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Add comments here

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Security Policy



Together we are BNSSG

Complete the blank cells in the table below. The rest will be added by the corporate team once the policy approved and before it is added to the website.	
Policy ref no:	To be filled in by Corporate Services
Responsible Executive Director:	Sarah Truelove, Deputy Chief Executive Officer and Chief Finance Officer
Author and Job Title:	Sarah Smith, Senior Local Counter Fraud Specialist
Date Approved:	To be filled in by Corporate Services
Approved by:	To be filled in by Corporate Services
Date of next review:	

Policy Review Checklist

	Yes/No/NA	Supporting information
Has an Equality Impact Assessment Screening been completed?	Yes	See Appendix A
Has the review taken account of latest Guidance/Legislation?	Yes	Produced by LCFS
Has legal advice been sought?	N/A	
Has HR been consulted?	Yes	At CPRG
Have training issues been addressed?	Yes	See implementation plan – via the Hub
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by Staff Partnership Forum?	N/A	
Are there financial issues and have they been addressed?	N/A	
What engagement has there been with patients/members of the public in preparing this policy?	N/A	Not required
Are there linked policies and procedures?	Yes	See Associated Policies Section
Has the lead Executive Director approved the policy?	Yes	Shane Devlin
Which Committees have assured the policy?	Yes	Audit and Risk Committee at is meeting in April 2025
Has an implementation plan been provided?	Yes	
How will the policy be shared with staff		See implementation plan – via the Hub
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	
Has a DPIA been considered in regards to this policy?	Yes	Not required
Have Data Protection implications have been considered?	Yes	Through input at the Corporate Policy Review Group

Version	Date	Consultation

Table of contents

Security Policy

1 Introduction

Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) is committed to promoting the security of its staff, and its assets. This policy has been produced by the Local Counter Fraud Specialist (LCFS) and is intended for use by all employees on all ICB security matters.

BNSSG ICB aims to provide a safe office working environment, where staff, clients and visitors can be confident of their personal safety and security of their possessions and where the ICB can be assured of the security of its buildings and assets. The ICB has a separate policy on Health and Safety which is supported through the provision included in this policy. The ICB operations are run from one site there is a dependency on landlords and other tenants for the provision of a secure working environment. Collaboration between relevant stakeholders will be required to maintain effective security together with, the adherence of staff to the guidance set out within this policy. Staff also work from domestic settings as dictated by the Hybrid Working Policy.

All ICB employees are responsible for ensuring that security procedures are adhered to at all times and will secure assets. Managers should take a leading role in promoting a pro-security culture to ensure the safety of all colleagues including covering key aspects as part of local induction.

BNSSG ICB does not tolerate violence and aggression towards staff the theft of (or criminal damage to) ICB assets or the criminal damage of ICB premises

Effective security management is linked to other policy areas, including fraud and bribery, bullying and harassment, counter terrorism and PREVENT, incident reporting, site security, conflict resolution, emergency preparedness, resilience and response (EPRR), personal safety and lone working.

1.1 BNSSG ICB Values

This policy supports the ICB values by ensuring that the ICB does the right thing, acts with integrity and assists the ICB in promoting a culture of support.

2 Purpose and scope

The ICB recognises its responsibility to provide a safe and secure working environment for all employees. This policy relates to all matters of security including the security of staff, property and assets. The overall aims of this policy are to:

- Improve the knowledge and understanding of all employees in BNSSG ICB, irrespective of their position, about security within the organisation.
- Assist in promoting a climate of openness and a pro-security culture where staff feel able to raise concerns sensibly and responsibly.
- Ensure the appropriate sanctions are considered following an investigation. Breach of this policy may lead to disciplinary action.

This policy applies to:

- All ICB employees (including temporary staff, students, apprentices, trainees, agency staff, seconded staff, self-employed consultants, sessional staff or those on short term or honorary contracts, self-employed consultants and individuals working for the ICB under a contract for services).
- Any work experience staff or volunteers.

3 Duties – legal framework for this policy

There is currently no NHS Security Standard and therefore no mandatory requirement for NHS organisations to employ a qualified LSMS however, the ICB retains an inherent obligation to protect and safeguard its staff and its assets, and does so by ensuring it puts in place and maintains suitable security arrangements and policies which address the risks associated with security, employee and public safety.

4 Responsibilities and Accountabilities

Security is the responsibility of all staff in not only safeguarding themselves and their property, but also property belonging to the ICB. The primary objectives of security management are:

- The prevention of violent or aggressive behaviour towards ICB staff, clients and visitors;
- The reporting of these incidents and compliance with any resulting investigation
- The protection of life from malicious criminal activity or other hazards.
- The protection of premises and assets against theft and damage.
- The detection and reporting of suspected offenders committing offences against clients, staff, property or private property within ICB premises.
- The education of all staff in security awareness.
- The smooth and uninterrupted delivery of health care and commissioning services.

The BNSSG ICB Board is responsible for gaining assurance that:

- Adequate arrangements are in place to ensure that all staff are aware of the standards of personal and professional behaviour expected of them; and that all staff have access to this policy.

The **BNSSG ICB Audit Governance and Risk Committee** is responsible for gaining assurance that:

- The BNSSG ICB has a robust policy and effective controls in place to adequately mitigate the risks of security related incidents.

The Chief Financial Officer is the lead for all Security Management work in BNSSG ICB, and monitors, ensures compliance with this policy and is responsible for:

- Ensuring the ICB has a suitably robust policy and effective controls in place to adequately mitigate the risks of security related incidents.
- Ensuring the ICB reports any such incidents to the relevant investigating authority and complies with any resulting investigation.
- Informing appropriate senior management, accordingly, depending on the outcome of investigations (whether on an interim and/or ongoing or concluding basis) and/or the potential significance of suspicions that have been raised.
- Ensuring the ICB gains assurance that providers awarded contracts with the ICB have suitable security arrangements in place.

Individual members of staff are required to:

- Actively co-operate with managers to achieve the aims and objectives of this policy, and to familiarise themselves with:
    - Any special security requirements relating to their work, team or place of work; and
    - The action to take in the event of a security incident.
- Safeguard themselves, colleagues, visitors and patients so far as is reasonably practicable against risks to their own security and ensure that equipment and property are not put in jeopardy by their actions or omissions, either by instruction, example or behaviour.
- Comply with all training requirements concerning security issues
- Ensure all visitors are wearing appropriate visitor badges and have signed in at reception when they collect them.
- Ensure that ICB ID is worn and visible whenever on ICB premises or on ICB business – except when doing so would place the individual at risk.
- Notify their line manager of any potential security problems and report all incidents involving criminal activity to the appropriate manager.
- Ensure all doors into the offices are secure at all times and not left open. Any issues with security doors should be reported to the Corporate Services Team Office Manager or site manager immediately so these can be resolved.
- Report any crime or breach of security.
- Maintain records which support security including calendars and contact details
- Safely taking steps to challenge individuals who are not recognised and are not wearing ID.

Managers at all levels have a responsibility to :

- Ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively.
- Complete any risk assessments required in relation to the security of staff, premises or assets.
- Ensure that security issues known to them are reported accordingly.
- Ensure that every member of staff obtains a security ID badge and that the badge is worn and visible at all times whilst the staff member is on ICB premises or on ICB business.
- Ensure that members of their team are ensuring that all visitors have visitor badges and have signed in at reception when being collected.
- Ensure that all employees for whom they are accountable for, are made aware of the requirements of the policy as part of local induction and on an ongoing basis.
- Arranging retrieval of assets and ID badges at the end of employment.

5 Security Procedure

5.1 Staff Identification

- Every employee, including temporary employees will be issued with an identification badge on commencement of employment with the ICB, which must be worn and made visible at all times whilst on ICB premises or on official business.
- Each member of staff is personally responsible for their ID badge, security access fob(s), smart cards and their validity. Any radical changes in physical appearance, job title or department must result in the issue of a new ID badge triggered by the individual.
- ID badge, security access fob(s), smart cards and any equipment including laptops must be returned to the ICB when a member of staff leaves the employment of the ICB. It is the responsibility of the line manager to recover all items from the member of staff concerned and return items to Corporate Services.
- External visitors must be escorted while on site and wear a visitor badge at all times. The member of staff who is responsible for the visitor must notify the reception staff that they are expecting a visitor and arrange for the individual(s) to be met at reception. Visitor badges must be signed in upon issue and signed out upon return.
- Lost or missing ID badges, security access fob(s) or smart cards should be reported immediately via the ICB incident reporting system. Should a reported lost badge be subsequently found; the original must be returned to the ICB and the incident report updated.

5.2 Access and Egress

- Access to BNSSG ICB offices is restricted via the use of electronic ID badges (swipe cards).

- Electronic ID badges must not be swapped, loaned or given to unauthorised personnel at any time.
- Tailgating - All staff must challenge any unknown/unfamiliar person attempting to gain access. Especially if an ID badge or visitor permit is not visible.

Lock Down of 100 Temple Street Building

- A Lockdown protocol produced in conjunction with building tenants exists and is published on the Hub.

Security of Goods

- Goods received into the organisation must be checked against delivery notes prior to signing for acceptance. Arrangements will involve close working with the landlord.
- All ICB departments expecting good to be delivered goods must ensure that there are procedures in place to monitor the receipt of goods and safe/secure systems are in place to protect goods from theft or misappropriation.
-

Security of Personal Belongings

- All staff should ensure that personal belongings are stored in a secure location, for example in locked cupboards, desks or drawers. In the absence of negligence, the ICB cannot be held responsible for the theft of personal items and cannot accept responsibility for loss or damage to staff property.

Security of Motor Vehicles, bicycles and scooters

- The ICB cannot accept liability for any private motor vehicle or its contents when parked on a ICB occupied site or when the car is being used by an employee on ICB business.
- Managers should ensure that all staff have appropriate insurance to use their motor vehicles for business, which should be confirmed prior to authorising any mileage claims. Refer to Travel and Expenses policy and the pre-requisite submission of relevant documents on the EASY expenses system.
- The ICB cannot accept liability for any bicycle, scooter, or associated equipment when left on a ICB site or when it is used by an employee on ICB business

ICB Property and Assets

- Where appropriate, items should be placed on an asset register as dictated by the finance department. This is likely to be only for capital items. SCW maintain a register of assets for laptops.
- Managers should review ICB property held by their department on a regular basis to ensure that all items are securely managed and retrieved when no longer required.
- All managers and staff should take reasonable steps to safeguard ICB property whilst it is in their care. It is an offence for members of staff to remove property belonging to the ICB without prior authority from their line manager or the custodian

of the equipment. Failure to seek authority could result in disciplinary action and/or criminal proceedings being undertaken.

6 Violence and Aggression

The ICB has a duty to provide a safe and secure environment for all employees and visitors and will not tolerate violence and abusive behaviour nor any behaviour which conflict with the values of the organisation.

The ICB takes a very serious view of violence, abuse and aggression at work and realises its responsibility to protect employees and others who may be subjected to action of violence, abuse or aggression whether or not the act results in physical or non-physical assault.

Any member of the public, patients or otherwise who are violent towards ICB staff may have sanctions taken against them, be refused services, and/or taken to court by the ICB in line with national guidance.

7 CCTV

External CCTV is in place on premises occupied by the ICB. This is managed by the landlord who owns the building and the CCTV system. All requests for access to CCTV images must be made to the landlord.

8 Emergency Preparedness, Resilience and Response

A significant incident or emergency can be described as any event that cannot be managed within routine service arrangements. Each requires the implementation of special procedures and may involve one or more of the emergency services, the wider NHS or a local authority. In the event of a significant security threat, please refer to the Emergency Preparedness, Resilience & Response Plan and Business Continuity Plan for further information.

9 Bomb Threats

The vast majority of bomb threats are hoaxes. Making such malicious calls is an offence contrary to Section 51 of the Criminal Law Act 1977 and should always be reported to the police. Any member of staff receiving such a call should seek the immediate advice of the most senior manager available.

For immediate guidance on how to deal with bomb threats, go to the gov.uk website. This can be found at: https://www.gov.uk/government/publications/bomb-threats-guidance

A bomb threat checklist for action to be taken on receipt of a bomb threat is also available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/552301/Bomb_Threats_Form_5474.pdf

10 Reporting of Security Incidents

All employees have a responsibility to report all crimes and breaches of security and should refer to the relevant Incident Reporting Policy.

All security related incidents and near misses should be reported on Datix relevant line manager, if urgent but not criminal.

All incidents of crime should be reported initially to the relevant line manager and reported on Datix. In cases of violence and aggression or threat to staff and/or visitor safety, the police should be contacted immediately. The LCFS should be notified as soon as possible by telephone or email of any suspicions of fraud, bribery or corruption, and security incident.

Examples of reportable incidents and the processes to follow are below:

Assault or abuse of a staff member or visitor:

All incidents of this type must be reported through the ICB incident reporting system as soon as possible. All physical assaults towards staff should be reported by the appropriate manager through the incident reporting system.

Visitors and staff should always be asked if they wish for the police to be involved.

Security incident/crime is in progress:

Staff safety is paramount, and therefore staff should go to a place of safety. The incident should be reported to the police immediately, and then to the senior manager on site. An incident must be logged into the incident reporting system as soon as possible.

Criminal incident discovered after the offence has occurred:

These incidents which may include theft of loss of assets/property should be reported as soon as the crime is discovered, as per the incident reporting process. The manager should then inform the police.

Data Breaches – including Theft of identifiable information:

This must be reported immediately to the Data Protection Officer and the IG manager and recorded on Datix.

11 Assisting Police Investigations

Occasionally, the Police may contact the ICB for information relating to an ongoing investigation. Any individual who is contacted in such a manner should refer the police to the LCFS or Chief Finance Officer as the initial point of contact.

Staff should obtain guidance from Information Governance should they be asked to disclose confidential information to the police.

PREVENT

The ICB should have due regard to compliance with the requirements of the PREVENT guidance for England and Wales. Regarding security management this will include:

- Ensuring that if there are concerns around rooms or buildings being used for radicalisation or terrorism, that these are reported immediately to an appropriate individual within the ICB.
- Ensuring staff have received PREVENT training as per the PREVENT policy, and that as a result of this training, staff report issues to relevant managers for escalation.
- Ensuring that there is an identified PREVENT lead.

The ICB has a separate PREVENT policy.

12 Training Requirements

All staff should be made aware of the policy, their responsibility to adhere to the guidance given and to report security incidents and crime in the NHS..

For those with additional responsibilities e.g. fire safety, PREVENT, relevant role appropriate training will be provided by the ICB.

13 Equality Impact Assessment

An Equality Impact Assessment has not been carried out in relation to this policy, as the Equality Impact Screening anticipated no barriers to accessing the policy and a fair approach to Security Management once implemented. This screening can be found at Appendix A.

14 Implementation and Monitoring Compliance and Effectiveness

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
ICB Board	Ensure ICB Board is aware of the ICB's responsibilities Security Management.	Policy and Cover paper to be presented by the ICB Board after approval by Audit, Governance and Risk Committee.	LCFS /RH	Upon approval at AGRC	April 25	LCFS time AGRC time
Staff	Awareness of policy	Information included in the Voice	RH	May 25	June 25	Comms support
Staff	Access to policy	Available on the Hub	RH	May 25	Jun 25	Comms support

15 Countering Fraud, Bribery and Corruption

The ICB is committed to reducing and preventing fraud, bribery and corruption in the NHS and ensuring that funds stolen by these means are put back into patient care. During the development of this policy document, we have given consideration to how fraud, bribery or corruption may occur in this area. We have ensured that our processes will assist in preventing, detecting and deterring fraud, bribery and corruption and considered what our responses to allegation of incidents of any such acts would be.

In the event that fraud, bribery or corruption is reasonably suspected, and in accordance with the Local Counter Fraud, Bribery and Corruption Policy, the relevant Team will refer the matter to the ICB's Local Counter Fraud Specialist for investigation and reserve the right to prosecute where fraud, bribery or corruption is suspected to have taken place. In cases involving any type of loss (financial or other), the ICB will take action to recover those losses by working with law enforcement agencies and investigators in both criminal and/or civil courts.

16 References, acknowledgements and associated documents

The following list is not exhaustive:

- Safeguarding Policy
- Health and Safety Policy
- Business Continuity Plan
- Incident Reporting
- Bullying and Harassment Policy
- Disciplinary Policy
- PREVENT Policy
- EPRR Plan
- SCW policies reviewed by the ICB Information Governance Group.
- Acceptable Use of IT Policy

17 Appendices

Equality Impact Assessment – Appendix A

APPENDIX A

Equality & Health Inequality Impact Assessment

Other documents required to complete the Equality & Health Inequality Impact Assessment:

- **Equality & Health Inequality Impact Assessment Guidance**
- **Equality & Health Inequality Impact Assessment Resources**

Please ensure you read the guidance and resources in full before attempting to complete this template.

Title of proposal: Security Policy				Date: 3 April 2025
X Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (please state)
EHIA type:	Screening EHIA ☐	Full EHIA ☐	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes X No ☐
Is the policy under:	Development ☐	Implementation ☐	Review X	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? Staff				
Lead person(s) completing this assessment: Sarah Smith				
Lead person job title(s) and service area: Senior Local Counter Fraud Specialist (ASW Assurance)				

Step 1: Outline

1.1 Briefly describe the proposal

Give a brief description of the context, purpose, aims and objectives of the proposal. Describe what services are currently being provided. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new proposal or change to an existing one and the key decision that will be informed by the EHIA (e.g. whether or not to proceed with the proposal to publish an employee handbook)

This is a review and update of the existing Security Policy. The ICB recognises its responsibility to provide a safe and secure working environment for all employees. This policy relates to all matters of security including the security of staff, property and assets. The overall aims of this policy are to:

- Improve the knowledge and understanding of all employees in BNSSG ICB, irrespective of their position, about security within the organisation.
- Assist in promoting a climate of openness and a pro-security culture where staff feel able to raise concerns sensibly and responsibly.
- Ensure the appropriate sanctions are considered following an investigation. Breach of this policy may lead to disciplinary action.

Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:
This policy does not relate to Health Inequalities. It does not impact different groups of people in respect of Health Inequalities.
Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.
Not Applicable in relation to patients. Policy has been through CPRG.
Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.
The policy will be available through usual communications routes with AIS considered.

Step 2: Impact

2.1 Could the proposal have a positive or negative impact on any of the protected characteristic groups or other relevant groups?

Although some of your conclusions will be widely known and accepted (e.g. need for accessible information), your analysis should include evidence to support your statements to aid the decision-maker – references and links to documents can be listed in section 4.1. Evidence might include insights from your engagement, focus groups, stakeholder meeting notes, surveys, research paper, national directives, expert opinion etc. If there is insufficient evidence, state this and include an action to find out more in the action plan in Step 3. In addition to having due regard for the Equality Act 2010 Public Sector Equality Duty to eliminate unlawful discrimination, advance equality and foster good relationship between protected groups; you must also have due regard to the principles of the Armed Forces Act 2021 including regarding the unique obligations and sacrifices they make, removing disadvantage and making special provision to ensure services and employment opportunities are accessible.

Positive Impact:				
☐ Sex	☐ Race	X Disability	☐ Religion & Belief	☐ Sexual Orientation

☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: The ICB recognises its responsibility to provide a safe and secure working environment for all employees. This policy provides guidance on security related matters, across all groups.				
Negative Impact				
☐ Sex	☐ Race	X Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: Access to policy by employees whose first language is not English can be mitigated through discussion with line manager. Neurodiverse employees can access policy through use of screen readers. (you can share further details and mitigations below in 2.2)				
No Effect				
Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable' Not Applicable				

2.2 Outline any negative impacts of the proposal on people based on their protected characteristic or other relevant characteristic. Consider how you might level the 'playing field' for all people

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
Neurodiverse	Some staff may require specialist physical adaptations to *access* policy on computer screens.	Screen Readers

2.3 Outline any benefits of the proposal for people based on their protected or other relevant characteristics?

Outline any potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our Public Sector Equality Duty to:

To eliminating discrimination, harassment and victimisation.	Positive	☐
	Negative	☐
	No effect	X
Please describe: Not Applicable		

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	X
	Negative	X
	No effect	
Please describe: This will provide reasonable adjustments for all staff and has both potential positive and negative impacts for those with protected characteristics as laid out above.		

To foster good relations between people who share a protected characteristic and those who don't (e.g. does the project raise any issues for community cohesion, or linked to current topics that are contentious in society; will it affect relationships between any groups)	Positive	☐
	Negative	☐
	No effect	X
Please describe: Not Applicable		

Step 3: Action Plan

3.1 What actions will you take to mitigate the negative impact outlined above?

Action	Timeframe	Success Measure	Lead
Promote the availability of support through the reasonable adjustment process	Ongoing	Staff using reasonable adjustments process.	R Heyday

3.2 How and when will you review the action plan (include specific dates)?

The action is open ended.

Step 4: Impact

4.1 What are the main conclusions of this Equality & Health Inequality Impact Assessment?

Share a brief summary of the positive impact the project will make and any negative impact and mitigations, e.g. what steps you have been taken to improve accessibility, and what recommendations you are making to the decision maker.

Explain how the EHIA has informed, influenced or changed the proposal and include a recommendation for the decision maker

Consideration of the EHIA has not changed the proposed policy as it is a policy designed to keep all staff within their working environment. The EHIA has reinforced the importance of the reasonable adjustments process.

Select a recommended course of action:	
Outcome 1: Proceed – no potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified. E.g. proposal is not likely to have any detrimental impact on any group	☐
Outcome 2: Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity and fostering good relations or breach of human rights articles. E.g. arrangements put in place to produce a BSL video to promote changes to a service	X
Outcome 3: Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out). E.g. pilot benefits one neighbourhood due to funding restrictions	☐
Outcome 4: Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified. E.g. dress code policy discriminates against people who practice particular religions; new service that proposes to detain patient but insufficient evidence of safeguarding or human rights considerations in place	☐

Step 5: Review

All Equality & Health Inequality Impact Assessments should be reviewed internally and obtain sign off to show an organisational commitment.

Reviewer's Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)
Policy discussed – some aspects covered in fuller depth in alternate policies. Noted that as the building is not BNSSG ICB owned a number of access aspects would be covered by property service / Bristol City Council. Add comments here
Equality Officer Name: Samantha Hill

Equality and Inclusion Team Signature: 
Date: 07/04/2025

Equality Delivery System 2022

Equality, Diversity & Inclusion is an evidence-based practice, Healthier Together partners are committed to demonstrating how we have taken steps to improve patient and service user access, experience and outcomes and how we have created an inclusive working environment for our staff, including supporting our workforce to have healthy and fulfilled lives. Please indicate which Domain your project will deliver against:

Domain 1 – Commissioned & Provided services

- 1A: People can readily access the service.
- 1B: Individual people's health needs are met
- 1C: When people use the service, they are free from harm.
- 1D:People report positive experiences of the service.

Domain 2 – Workforce health and wellbeing

- 2A: When at work, staff are provided with support to promote healthy lifestyles and manage their long term conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
- 2D: Staff recommend the organisation as a place to work

Domain 3 – Inclusive Leadership

- 3A: Board members and senior leaders (Band 9 and VSM) routinely demonstrate their commitment to equality.
- 3B: Board/Committee papers (including minutes) identify equality related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Add comments here