Bristol, North Somerset and South Gloucestershire Integrated Care Board

BNSSG ICB Board Meeting

Date: Friday 1st July 2022
Time: 9.30am
The ICB Board will meet virtually. The meeting will be accessible to members of the public. Please see website for more details.

Agenda

			Sponsor
1	9:30	**Welcome and Apologies**	Chair
2		**Declarations of Interest** To consider declarations of interests and any conflicts of interest arising from this agenda	Chair
3	9:35	**Chief Executive Officers Briefing**	CEO
4		**Governance matters**	
4.1	9:50	Establishment of the ICB Board Members *To note the appointments*	CPO
4.2	9:55	BNSSG ICB Constitution *To receive the Constitution as authorised by NHSEI*	Chair
4.3	10:00	Scheme of Reservation and Delegation and Functions and Decisions Map *To approve*	CEO
4.4	10:05	ICB Committee Terms of Reference *To approve*	Chairs of Committees
4.5	10:35	Standing Financial Instructions *To approve*	CFO
		Policies	
4.6	10:45	Core Policies - Conflicts of Interest and Gifts and Hospitality Policies - Risk Management Framework *To approve*	CPO and CFO
4.7	11:05	Hand over from CCG – Due Diligence Assurance *To receive*	CPO
	11:20	**Break**	

			Sponsor
5		**Finance**	
5.1	11:30	Operational Plan and Budget 2022/23 *To approve*	CFO
6		**Outcomes, Quality and Performance**	
6.1	11:50	Single Oversight Framework and Scorecard *To review and discuss*	CNO and Chair of Outcome, Quality and Performance Committee
7		**ICB Board Meetings**	Chair
7.1	12:35	Action Log *To review*	Chair
7.2	12:50	Standing Items for Future Meetings *To review*	Chair
8	13:00	**Questions from Members of the Public**	Chair
9	13:20	Any Other Business	Chair
10	13:30	Close	
		Date of Next Meeting 01 September 2022, 09:30am Location to be confirmed	

Please enter dates as 00.00.15
NB: It is the responsibility of all employees to report any conflicts or perceived conflicts as soon as they become aware of them and within 28 days.

By completing this register you are committing to the following statement;

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG's Constitution and published accordingly.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Surname	First Name	Role	Employment Type	Submission Type	Type of Interest	Details of Interest	Who interest is held by	Date interest Valid From	Date Interest Valid to (if applicable)	Special Action Taken
Bacon	Julie	Director of People and Transition	Empoyee	On appointment	No interests to declare	No interests to declare	No interests to declare	04.09.21		
Bradbury	Colin	Area Director (North Somerset Area)	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	03.05.18		
Brindle	Peter	Medical Director - BNSSG CCG	Employee	On appointment	Financial Interest	Locum GP - GP Practices across BNSSG Work undertaken as part of a medical chambers	Personal Interest	14.04.21		
			Employee	On appointment	Financial Interest	Shareholder in GP Care.	Personal Interest	14.04.21		
			Employee	On appointment	Financial Interest	Honorary posts at the Universities of Bristol and the West of England. Occasional co-applicant in a grant application or a co-author on a paper.	Personal Interest	14.04.21		
Cappock	John	Independent Non Eexecutive Member - BNSSG ICB	Employee	On appointment	Indirect Interest	Family member is employed by South Gloucestershire Council	Interest of Close Family Member	25.06.22		
			Employee	On appointment	Indirect Interest	Family member is employed by Keys Group	Interest of Close Family Member	25.06.23		
			Employee	On appointment	Financial Interest	Independent member, Audit, Risk and Finance, of the General Optical Council	Personal Interest	25.06.24		
Devlin	Shane	ICB Chief Executive	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	24.06.22		
Donovan	Ellen	Non Executive Member - Quality BNSSG ICB	Employee	On appointment	Non Financial Professional	Human Tissue Authority	Personal Interest	09.05.22		
				On appointment	Non Financial Professional	Welsh Government	Personal Interest	09.05.22		
El-Sayed	Deborah	Director of Transformation	Employee	On appointment	Indirect Interest	Close family member works for Graphnet	Interest of Close Family Member	18.07.19		
Farrar	Jeffrey	Designate ICB Chair	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	16.02.22		
Hardisty	Dominic	Chief Executive AWP NHS Trust	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	24.06.22		
Jackson	Mike	Bristol City Council	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	02.12.21		
Jarrett	David	Area Director (South Gloucestershire & Bristol) - BNSSG CCG	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	28.08.18		
Kane	Maria	North Bristol NHS Trust	Employee	On appointment	Non Financial Professional	CHKS advisory services	Personal Interest	23.06.22		
Manson	Lisa	Director of Commissioning - BNSSG CCG	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	17.04.18		
Medhurst	Joanne	Chief Medical Officer BNSSG ICB	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	27.06.22		
Moon	Alison	Non Executive Member	Employee	On appointment	Non-Financial Professional Interest	Non Executive Director, Glos Hospitals NHS Foundation trusts	Personal Interest	27.06.22		
				On appointment	Financial Interest	North Bristol NHS Trust Bank – (Ashton Gate mass vaccination centre)	Personal Interest	27.06.22		
Perry	Dave	South Gloucestershire Council	Employee	On appointment	Financial Interest	Employee of South Gloucestershire Council	Personal Interest	27.06.22		
				On appointment	Non - Financial Interest	Member of the Association of Local Authority Chief Executives	Personal Interest	27.06.22		
				On appointment	Non - Financial Interest	Member of SOLACE	Personal Interest	27.06.22		
				On appointment	Non - Financial Interest	Member of CIPFA	Personal Interest	27.06.22		
Sharma	Julie	Acting CEO of Sirona Care & Health	Employee	On appointment	Financial Interest	Chief Executive of Sirona which is a Community Interest Company which holds a significant contract with the ICB.	Personal Interest	26.06.22		
Shepherd	Rosi	Director of Nurse and Quality - BNSSG CCG	Employee	On appointment	Non-Financial Personal Interest	Member of Balcarras Multi-Academy Trust	Personal Interest	08.12.20		
				On appointment	Indirect Interest	Family Member works at SpaMedica	Interest of Close Family Member	14.01.20		
Taylor	Ruth	One Care	Employee	On appointment	Indirect Interest	Close Family Member Works for Homeles Health Service	Interest of Close Family Member	23.06.22		
Truelove	Sarah	Chief Finance Officer & Deputy CEO - BNSSG CCG	Employee	On appointment	Non-Financial Professional Interest	Director of Bristol Infracare LIFT LTD	Personal Interest	23.06.22		
			Employee	On appointment	Indirect Interest	Close family member works for AWP MH Partnership	Interest of Close Family Member	23.06.22		
			Employee	On appointment	Non-Financial Personal Interest	School Govenor for the Corsham School	Personal Interest	23.06.22		
Walker	Jo	North Somerset Council	Employee	On appointment	No interests to declare	No interests to declare	No interests to declare	02.12.21		
Yafele	Eugine	CEO University Hospitals Bristol and Weston NHS Foundation Trust	Employee	On appointment	Nothing to Declare	Nothing to Declare	No interests to declare	23.06.22		

Bristol, North Somerset and South Gloucestershire Integrated Care Board

Meeting of the ICB Board

Date: Friday 1st July 2022
Time: 9:30am
The ICB Board will meet virtually. The meeting will be accessible to members of the public. Please see website for more details.

Agenda Number :	4.1		
Title:	Appointment of Members of the Integrated Care Board		
Confidential Papers	**Commercially Sensitive**	No	
	Legally Sensitive	No	
	Contains Patient Identifiable data	No	
	Financially Sensitive	No	
	Time Sensitive – not for public release at this time	No	
	Other (Please state)	No	
Purpose: Decision			
Key Points for Discussion:			

It is a statutory requirement for the Integrated Care Board to have board members in accordance with its constitution. These are:

- Executive Members
- Non-Executive members
- Partner members
- Other members

Although these members have been recruited through a national campaign or a local nominations process and some commenced their employment / engagement with the CCG in a designate capacity, there is a requirement for these appointments to be formally approved on day one of the existence of the Integrated Care Board, prior to the new ICB Board meeting.

An appointments committee consisting of the Chair, Chief Executive and HR Advisor, met prior to this meeting and confirmed the following appointments:

Chief Executive (confirmed by the Chair)

Executive Directors

- Chief Financial Officer and Deputy Chief Executive – Sarah Truelove
- Chief Medical Officer – Dr Joanne Medhurst (from 1 August 20220

- Chief Nursing Officer – Rosi Shepherd

Acting Executives

- Chief Medical Officer – Dr Peter Brindle (from 1 July to 31 July 2022)
- Chief People Officer – Julie Bacon (until a substantive appointee is in post)
- Chief Digital Information Officer – Deborah El-Sayed (until a substantive appointee is in post)

Non-Executive Members:

- John Cappock
- Jaya Chakrabarti
- Ellen Donovan
- Alison Moon
- Steve West

Partner Members

Partner Members: Local Authorities:

Role on ICB board: providing knowledge and perspective of…	**Agreed representative**
Urban Communities	Mike Jackson: Chief Executive, Bristol City Council
Coastal Communities	Jo Walker: Chief Executive, North Somerset Council
Rural Communities	Dave Perry: Chief Executive, South Gloucestershire Council

Partner Members: NHS Trusts and Foundation Trusts:

Role on ICB board: providing knowledge and perspective of…	**Agreed representative**
Acute and Community Mental Health Services	Dominic Hardisty: Chief Executive, Avon and Wiltshire Mental Health Partnership NHS Trust
Acute Secondary Care Services	Maria Kane: Chief Executive, North Bristol NHS Trust
Acute Tertiary Care Services	Eugine Yafele: Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust
Ambulance Services	Will Warrender: Chief Executive, South West Ambulance Service NHS Foundation Trust

Partner Members: Providers of Primary Medical Services

Role on ICB board: providing an understanding of…	**Agreed representative**
Primary Care in the area	Dr Jon Hayes Chair, GP Collaborative Board

Other Members:

Role on ICB board: providing knowledge and perspective of…	Agreed representative
Adult and Children's Community services	Julie Sharma: Chief Executive, Sirona care & health

Recommendations:	That the confirmed appointments to the Board of the Bristol, North Somerset and South Gloucestershire Integrated Care Board are noted
Previously Considered By and feedback:	Appointments Committee – 1 July 2022.
Management of Declared Interest:	Shane Devlin – appointment of Chief Executive. Julie Bacon; Appointment of Acting Chief People Officer
Risk and Assurance:	n/a
Financial / Resource Implications:	n/a
Legal, Policy and Regulatory Requirements:	Appointments to the Board of the Integrated Care Board are a statutory requirement
How does this reduce Health Inequalities:	Reduction of health inequalities is a key aim of the ICB.
How does this impact on Equality & diversity	The ICB will continue to deliver its Public Sector Equality Duty.
Patient and Public Involvement:	n/a
Communications and Engagement:	n/a
Author(s):	Julie Bacon: Interim Director of People and Transition
Sponsoring Director / INEM / Partner Member:	Dr Jeff Farrar: Chair

Bristol, North Somerset and South Gloucestershire Integrated Care Board

Meeting of ICB Board

Date: 01 July 2022
Time: 09:30
Location: MS Teams

Agenda Number :	4.2	
Title:	BNSSG ICB Constitution	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Decision – For Approval		
Key Points for Discussion:		
The BNSSG Constitution has been developed from the model constitution provided by NHS England and Improvement (NHSEI). This final version has been reviewed and approved by the NHSEI South West Regional Director. The BNSSG Integrated Care Board (ICB) will be established on 1st July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to the document.		

Recommendations:	To receive and approve: • BNSSG Integrated Care Board Constitution
Previously Considered By and feedback:	Approved by NHSEI South West Regional Team and Director
Management of Declared Interest:	There are no actual or potential conflicts of interest related to the contents of this paper.
Risk and Assurance:	ICB Risk Management is detailed in the Risk Management Framework, referenced in the BNSSG ICB Constitution as a constituent document of the BNSSG Governance Handbook
Financial / Resource Implications:	There are no finance or other resources implications.

Legal, Policy and Regulatory Requirements:	The BNSSG ICB Constitution has been developed from the model Constitution provided by NHSEI. Legal advice has been sought where appropriate to ensure compliance with ICB establishment legislation and guidance and all statutory and mandatory requirements.
How does this reduce Health Inequalities:	This document has been developed in the context of the four core purposes of Integrated Care Systems: **a) improve outcomes in population health and healthcare** **b) tackle inequalities in outcomes, experience and access** c) enhance productivity and value for money d) help the NHS support broader social and economic development.
How does this impact on Equality & diversity	The new model constitution has been developed by NHSEI with significant legal input to ensure that it meets with all legal requirements including equalities considerations. This document has been developed in the context of the four core purposes of Integrated Care Systems: **a) improve outcomes in population health and healthcare** **b) tackle inequalities in outcomes, experience and access** c) enhance productivity and value for money d) help the NHS support broader social and economic development.
Patient and Public Involvement:	Patient and Public Involvement in the drafting of the model constitution have been managed by NHSEI. The BNSSG ICB Constitution sets out the arrangements for Public Involvement in section 9.
Communications and Engagement:	The BNSSG ICB Constitution will be published on the BNSSG ICB Website from 01 July 2022.
Author(s):	NHSEI – Model Constitution Sarah Carr, BNSSG CCG Company Secretary
Sponsoring Director / Board Member:	Jeff Farrar, ICB Chair

NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board

CONSTITUTION (v1)

Version	Date approved by the ICB	Effective date
V1.0	**N/A**	**July 1st 2022**

CONTENTS

1. Introduction

1.1 Background

1.1.1 NHS England has set out the following as the four core purposes of Integrated Care Systems:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

The Integrated Care Board will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.1.2 NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board serves a population of approximately one million people living within distinct and different communities. The Integrated Care Board brings together the wider partnership of health and care organisations that have come together to plan and deliver joined up services and improve the health and wellbeing of people who live within Bristol, North Somerset and South Gloucestershire.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is coterminous with the local government areas of the City of Bristol, District of North Somerset and District of South Gloucestershire. The ICB is responsible for both the registered and the non-registered population within this geographical area.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at www.bnssg.icb.nhs.net.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z44 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1st July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and

b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chair or Chief Executive may periodically propose amendments to this Constitution which shall be considered for approval by the board

b) The Audit and Risk Committee may propose amendments to this Constitution as part of the annual review of the Constitution (as set out in the Scheme of Reservation and Delegation and Audit and Risk Committee Terms of Reference) which shall be considered by for approval by the board.

1.6.3 Proposed amendments shall be considered:

a) Provided that two-thirds of the Board Members are present at the meeting where the amendment is being discussed and that at least half of the Board members (to include at least one executive member, one partner member and one Independent Non-Executive Member) vote in favour of the amendment

b) Provided that any amendment does not contravene a statutory provision, direction made by the Secretary of State or guidance issued by NHS England

c) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) Standing orders– which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) The Scheme of Reservation and Delegation (SoRD) – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) Functions and Decision map – a high level structural chart that sets out which key decisions are delegated and taken by which part

or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions –** which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook –** This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
- The above documents a) – c)
- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2
- Key policies including those listed below
- Role descriptions for members of the Board as set out in 3 below

e) **Key policy documents** which should also be included in the Governance Handbook or linked to it – including:
- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement
- Information Governance Policies
- Risk Management Framework

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section three.

2.1.2 Further information about the individuals who fulfil these roles can be found on the ICB website: www.bnssg.icb.nhs.net.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board Members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:

a) Three executive members, namely:
- Chief Finance Officer
- Chief Medical Officer
- Chief Nursing Officer

b) At least two[18] non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has 8 Partner Members.

a) 4 Partner members NHS and Foundation Trusts
b) 1 Partner member Primary medical services
c) 3 Partner members Local Authorities

2.2.2 The ICB has also appointed the following further Ordinary Members: to the board

a) 5 Non-Executive Members

b) Chief Finance Officer
c) Chief Medical Officer
d) Chief Nursing Officer
e) 1 Other Member – Community Services

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) 4 Partner members NHS and Foundation Trusts
d) 1 Partner member Primary medical services
e) 3 Partner members Local Authorities
f) 5 Non-Executive Members
g) Chief Finance Officer
h) Chief Medical Officer
i) Chief Nursing Officer
j) 1 Other Member – Community Services

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board to effectively carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. Invited participants will include but not be limited to One Care, Healthwatch and the Executive Directors of the ICB.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. Any such person may not address the meeting and may not vote.

2.3.4 Participants and/ or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"

b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)

c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

d) All individuals appointed to roles on the Board are responsible for familiarising themselves with the eligibility and ineligibility requirements, confirming their eligibility prior to appointment and immediately notifying the Chair of the ICB of a change of circumstances that may render them no longer eligible

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence, or

b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A health care professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which

the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under—

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.

b) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.

b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair for the first term will be two years and after this first term of office a further two terms may be served for a maximum of three years each. The maximum period of office that the Chair may serve is eight years.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

b) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook

3.4.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply

b) Subject to clause 3.4.3(a), they hold any other employment or executive role

3.5 Partner Members - NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or if the forward plan condition is not met) the level of services provided condition.

a) Avon and Wiltshire Mental Health Partnership Trust (AWP)

b) North Bristol NHS Trust (NBT)

c) South Western Ambulance Service NHS Foundation Trust (SWASFT)

d) University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an Executive Director from an NHS Trust or Foundation Trust within the ICB's area

b) One of the Partner Member roles will be filled by an individual who will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness (2.2.4 above)

c) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook

d) and any other criteria as may be set out in any NHS England guidance

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply

b) and any exclusion criteria set out in NHS E guidance

3.5.4 These members will be appointed by a panel convened by the Chief Executive subject to the approval of the Chair

3.5.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make **1** nomination.
- Eligible organisations may nominate individuals from their own organisation or another organisation

- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within **5** working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. if they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment

c) Chair's approval
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

The term of office for these Partner Members will be three years and the total number of terms they may serve is two. There shall be flexibility for the Chair to confer an additional 24 months term of office to provide continuity in exceptional circumstances where required. A full nomination and appointment process shall be run at the end of each full term of office.

3.6 Partner Member(s)- Providers of Primary Medical Services.

3.6.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health services within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.6.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Bring an understanding of primary care in the area, including primary dental, community and optometry providers as well as primary care networks and general practice

b) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook

c) and any other criteria set out by NHS England's guidance.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

b) and any criteria set out in NHS E guidance

3.6.5 This member will be appointed by a panel convened by the Chief Executive subject to the approval of the Chair.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make **1** nomination.
- The nomination of an individual must be seconded by **10** other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within **5** working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
- In the event that there is more than one suitable nominee, the panel will select the most suitable for the appointment.

c) Chair's approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.7 The term of office for this Partner Member will be three years and the total number of terms they may service is two terms. There shall be flexibility for the Chair to confer an additional 24 months term of office to provide continuity in exceptional circumstances where required. A full nomination and appointment process shall be run at the end of each full term of office.

3.7 Partner Members - local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas that coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Bristol City Council (BCC)
b) North Somerset Council (NSC)
c) South Gloucestershire Council (SGC).

3.7.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1
b) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
c) and any other criteria set out by NHS England's guidance.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) and any criteria set out in NHS E guidance.

3.7.4 This member will be appointed by a panel convened by the Chief Executive subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make 1 nomination.
   - Eligible organisations may nominate individuals from their own organisation or another organisation
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within **5** working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for the appointment.

c) Chair's approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.6 The term of office for these Partner Members will be three years and the total number of terms they may service is two terms. There shall be flexibility for the Chair to confer an additional 24 months term of office to provide continuity in exceptional circumstances where required. A full nomination and appointment process shall be run at the end of each full term of office.

3.8 Chief Medical Officer

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner
c) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
d) and any other criteria set out by NHS England's guidance.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) and any criteria set out in NHS E guidance.

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.9 Chief Nursing Officer

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse
c) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
d) and any other criteria set out by NHS England's guidance.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) and any criteria set out in NHS E guidance.

3.9.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.10 Chief Finance Officer

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Specify any other criteria set out by NHS England's guidance
c) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) and any criteria set out in NHS E guidance.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.11 Five Non-Executive Members

3.11.1 The ICB will appoint five Non-Executive Members

3.11.2 These members will be appointed by the Chair.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Not be employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee
e) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
f) and any other criteria set out by NHS England's guidance.

3.11.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area
c) and any criteria set out in NHS England guidance.

3.11.5 The term of office for a Non-Executive Member will be three years and the total number of terms an individual may serve is two terms. There shall be

flexibility for the Chair to confer an additional 24 months term of office to provide continuity in exceptional circumstances where required. After a maximum period of eight years a non-executive member shall stand down to ensure on-going independence.

3.11.6 Initial appointments may be for a shorter period in order to avoid all Non-Executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.11.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-Executive Member up to the maximum number of terms permitted for their role.

3.12 Other Board Members

3.12.1 This member will provide the perspective of Adult and Children's Community Health Services.

3.12.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an Executive Board Member from a provider of Adult and Children's Community Health Services within the ICB's area
b) Be an Executive Director from a provider of Adult and Children's Community Health Services that provides the majority of specific services to the population within the ICB's area
c) Fulfil the eligibility criteria set out in the role description included in the Governance Handbook
d) And any other criteria set out by NHS England's guidance.

3.12.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) and any criteria set out in NHS E guidance.

3.12.4 This member will be appointed in line by a panel convened by the Chief Executive subject to the approval of the Chair.

3.12.5 The appointment process will be as follows:

a) Nomination:
   - When a vacancy arises, eligible organisations described at 3.12.2 and listed in the Governance Handbook will be invited to make 1 nomination.
   - Eligible organisations may nominate individuals from their own organisation or another organisation

b) Assessment, selection, and appointment subject to approval of the Chair under c)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.12.2 and 3.12.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for the appointment.

c) Chair's approval
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.12.6 The term of office for this Other Member will be three years and the total number of terms they may service is two terms. There shall be flexibility for the Chair to confer an additional 24 months term of office to provide continuity in exceptional circumstances where required. A full nomination and appointment process shall be run at the end of each full term of office.

3.13 Board Members: Removal from Office.

3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance
b) If they fail to attend a minimum of 60% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICBS (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body.

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.3 apply.

3.13.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

3.13.7.1 terminate the appointment of the ICB's Chief Executive; and

3.13.7.2 direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-Executive Members will be set by the Remuneration Committee, which will be constituted such that conflicted individuals can recluse themselves appropriately. The Remuneration Committee Terms of Reference detail the membership that will allow for conflicted members to recluse themselves from decision making; these terms of reference are included in the Governance Handbook.

3.14.2 Other terms of appointment will be determined by the Remuneration Committee.

3.14.3 Terms of appointment of the Chair will be determined by NHS England.

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as "designate ordinary members" prior to the ICB being established.

3.15.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5-3.7.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.12 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and [one other] will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12

4 Arrangements for the Exercise of our Functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full on the ICB website: www.bnssg.icb.nhs.net.

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the Board;
b) those functions that have been delegated to an individual or to committees and sub committees
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published on the ICB website: www.bnssg.icb.nhs.net.

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

a) Provide Committee Chairs' reports to the board highlighting decisions and assurances
b) Submit annual reports to the board
c) Comply with internal audit findings
d) Complete, at least annually, committee effectiveness reviews.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector of otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit and Risk Committee:** This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Non-Executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters. The Chair of the ICB may not be a member of the Audit and Risk Committee.

b) **Remuneration Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB, with the exceptions at 3.13.1.

The Remuneration Committee will be chaired by a Non-Executive Member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another

ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs published in the Governance Handbook

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest, which are in line with NHS England Guidance on Conflicts of Interest. The ICB policies and procedures are published on the website and included in the Governance Handbook.

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest

b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest

c) Support the rigorous application of conflict of interest principles and policies

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation

e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the following principles:

a) Conduct business in line with available guidance and ICB policy.

b) Be proactive, not reactive**:** seeking to anticipate, identify and minimise the risk of conflicts of interest at the earliest possible opportunity

c) Be balanced, sensible and proportionate: Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair whilst not being overly constraining, complex or cumbersome

d) Be transparent: Document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident

e) Create an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB

b) Members of the board's committees and sub-committees

c) Its employees/

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles)
c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 In discharging its functions the ICB will abide by the following principles:

a) We act with honesty and integrity
b) We work in an open way and establish clear and transparent accountability for decisions, always acting in the service of the best

outcomes for the people of Bristol, North Somerset and South Gloucestershire

c) We adhere to a collective model of accountability, where we hold each other mutually accountable for respective contributions to shared objectives.

7.3 Meetings and publications

7.3.1 Board meetings and committees composed entirely of board members or which include all board members will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published on the ICB website: www.bnssg.icb.nhs.net.

7.3.3 Annual accounts will be externally audited and published on the ICB website: www.bnssg.icb.nhs.net.

7.3.4 A clear complaints process will be published on the ICB website: www.bnssg.icb.nhs.net.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and governance handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests
- Standards of Business Conduct
- Policy for public involvement and engagement
- Information Governance Policies
- Risk Management Framework
- Scheme of Reservation and Delegation
- Standing Financial Instructions
- Functions and Decisions Map
- Board Member role descriptions.

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- section 14Z34 to 14Z45 (general duties of Integrated Care Boards

- sections 223GB and 223N (financial duties).

And

a) proposed steps to implement the three joint local health and wellbeing strategies.

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-Executive Members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime, including complying with existing procurement rules until the provider selection regime comes into effect:

a) Ensuring appropriate governance structures are in place to manage challenges that may follow decisions regarding provider selection
b) Publishing intentions for arranging services in advance
c) Publishing contracts awarded and maintaining a record of decision making
d) Ensuring local audit arrangements are capable of auditing decisions made under the NHS Provider Selection Regime.

In support of the provider selection regime the ICB will consider all circumstances when arranging and securing services. The ICB through its governance will ensure structures are in place to manage future commissioning arrangements decisions and management of potential challenges.

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) Explain how the ICB has discharged its duties under sections 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) Review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees.

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee which is chaired by a Non-Executive Member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee but the board ensures that the Remuneration Committee has access to appropriate advice by requiring the attendance of:
a) The ICB's most senior HR advisor or nominated deputy
b) The Chief Executive or nominated deputy
c) The Chief Finance Officer or nominated deputy.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published in the Governance Handbook.

8.1.6 The duties of the Remuneration Committee include:
a) Setting the ICB pay policy (or equivalent) and standard terms and conditions
b) Making arrangements to pay employees such remuneration and allowances as it may determine

c) Set remuneration and allowances for members of the board
d) Set any allowances for members of committees or sub-committees of the ICB who are not members of the board
e) Duties described in the Committee Terms of Reference (available in the Governance Handbook).

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board
b) the development and consideration of proposals by the ICB
c) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
d) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) The ICB's annual plan will be subject to public engagement and be published in draft form for public review and comment. Details of this annual engagement process will be advertised on the ICB website.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.

c) Understand our community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

d) Build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

g) Use community development approaches that empower people and communities, making connections to social action.

h) Use co-production, insight and engagement to achieve accountable health and care services.

i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

- Being accessible and inclusive
- Embracing diversity
- Respecting and valuing the knowledge of all
- Having clarity, transparency and integrity
- Being timely and realistic
- Engaging in a two-way dialogue and feedback.

9.1.5 These arrangements, include that people and communities may:

a) Get involved in consultations. The ICB will advertise all Constitution and engagement exercises on its website. The ICB will provide the information necessary for people and communities to take an informed view on the proposals under consideration and to explain how to give views and opinions

b) Tell the ICB about views and experiences. The ICB will provide a 'contact facility' on its website to enable people to tell the ICB about their experiences and views about the provision of local health services

c) Tell Healthwatch about experiences of the quality of local health services, Healthwatch is independent from health and social care services. Their role is to ensure that local people and communities' views are heard in order to improve the experience and outcomes for people who use services. They also help monitor the quality of health services. Healthwatch can be contacted at:

https://www.healthwatchbristol.co.uk/share-your-views
https://www.healthwatchsouthglos.co.uk/share-your-views
https://www.healthwatchnorthsomerset.co.uk/share-your-views

d) Come along to public workshops and listening events and participate in surveys. The ICB holds public workshop and listening events where local people can tell the ICB what they think about its plans for changing and developing local services. Details of meetings, events and surveys will be advertised on the ICB website.

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Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

	• the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area
Chief Finance Officer	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Director of Finance
Chief Medical Officer	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Medical Director
Chief Nursing Officer	An individual who is appointed to the ICB and who will fulfil the NHSE policy requirement to appoint a Director of Nursing
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Bristol, North Somerset, and South Gloucestershire Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 1st July 2022

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause 1.6 of the ICB Constitution.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These standing orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the ICB's senior governance adviser will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next

formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1. Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2. In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two[100] days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the board. The Chair of the ICB shall appoint a Deputy Chair who will be one of the Non-Executive Members.

4.2.2. If the Chair is absent or is disqualified from participating by a conflict of interest, the Non-Executive Deputy Chair if present shall preside. If both the Chair and Deputy Chair are absent, or are disqualified from participating, or there is neither a Chair or Deputy Chair, then a

member of the Integrated Care Board shall be chosen by the members present, or by a majority of them, and shall preside local arrangement.

4.2.3. The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website.

4.4. Petitions

4.4.1. Where a petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as published in the Governance Handbook.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and may not vote on their behalf.

4.5.2. The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings

4.6.1. The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7. Quorum

4.7.1. The quorum for meetings of the board will be at least 50% of the members, including:

a) Either the Chief Executive or the Chief Finance Officer
b) At least one Independent Non-Executive Member
c) At least one Partner Member.

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3. For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8. Vacancies and defects in appointments

4.8.1. The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2. In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- The meeting will be quorate when at least 5 members are present including:
  - Either the Chief Executive or the Chief Finance Officer
  - At least one independent member
  - At least one Partner Member.

4.9. Decision making

4.9.1. The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2. Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.

b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3. Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support by NHS England.

Urgent decisions

4.9.4. In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.9.5. All board members will be notified of the decision to be taken

4.9.6. The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with at least 50% of the members, including:

- Either the Chief Executive or the Chief Finance Officer
- At least one independent member, including the Chair of Audit or Deputy Chair of Audit
- At least one Partner Member

4.9.7. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

Exception to standard decision-making arrangements

4.9.8. Proposed amendments to the ICB Constitution shall be considered:

- Provided that two-thirds of the board Members are present at the meeting where the amendment is being discussed and that at least half of the board members (to include at least one Executive Member, one Partner Member and one Non-Executive Member) vote in favour of the amendment
- Provided that any amendment does not contravene a statutory provision, direction made by the Secretary of State or guidance issued by NHS England
- Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

4.10. Minutes

4.10.1. The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1. In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the board and all meetings of committees which comprise of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2. The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 2 other members.

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

6.1.1. The ICB may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature; two signatures are required to do so, one of which is to be either the Chief Executive or the Chief Finance Officer:

a) the Chief Executive;

b) the Chair of the Integrated Care Board;

c) the Independent Deputy Chair of the Integrated Care Board; and

d) the Chief Finance Officer

6.2 Execution of a document by signature

6.2.1. The following individuals are authorised to execute a document on behalf of the group by their signature; two signatures are required to do so, one of which is to be either the Chief Executive or the Chief Finance Officer:

a) the Chief Executive;

b) the Chair of the Integrated Care Board;

c) the Independent Deputy Chair of the Integrated Care Board; and

d) the Chief Finance Officer

Bristol, North Somerset and South Gloucestershire Integrated Care Board

Meeting of ICB Board

Date: 01 July 2022
Time: 09:30
Location: MS Teams

Agenda Number :	4.3	
Title:	Scheme of Reservation and Delegation and Functions and Decisions Map	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Decision – For Approval		
Key Points for Discussion:		
The Scheme of Reservation and Delegation (SoRD) has been developed in accordance with national legislation and guidance on the establishment of Integrated Care Boards. The Functions and Decisions Map has been developed in collaboration with all system partners. Both documents were submitted in draft to NHSEI on 27 May 2022 and accepted without comment.		
Recommendations:	To approve: • SoRD • Functions and Decisions Map	
Previously Considered By and feedback:	BNSSG CCG Executive Group NHSEI South West Regional Team BNSSG System Partners	
Management of Declared Interest:	There are no actual or potential conflicts of interest related to the contents of this paper.	
Risk and Assurance:	There is a risk to the organisation if the ICB and its constituent governance structures do not fulfil their statutory and mandatory requirements.	

	The delegated authority detailed in the SoRD supports the management of ICB risk and assurance. ICB Risk Management is detailed in the Risk Management Framework, referenced in the BNSSG ICB Constitution as a constituent document of the BNSSG Governance Handbook
Financial / Resource Implications:	There are no finance or other resources implications.
Legal, Policy and Regulatory Requirements:	The SoRD has been developed in accordance with national legislation and guidance and were designed to meet the ICBs statutory and mandatory requirements.
How does this reduce Health Inequalities:	These documents have been developed in the context of the four core purposes of Integrated Care Systems: **a) improve outcomes in population health and healthcare** **b) tackle inequalities in outcomes, experience and access** c) enhance productivity and value for money d) help the NHS support broader social and economic development.
How does this impact on Equality & diversity	These documents have been developed in the context of the four core purposes of Integrated Care Systems: **a) improve outcomes in population health and healthcare** **b) tackle inequalities in outcomes, experience and access** c) enhance productivity and value for money d) help the NHS support broader social and economic development.
Patient and Public Involvement:	There has been no wider public engagement in the development of these documents. The Functions and Decisions Map presents how the citizen voice will be included and regarded in the governance structure of the ICS.
Communications and Engagement:	The SoRD and the Functions and Decisions Map will be published on the BNSSG ICB Website from 01 July 2022.
Author(s):	Sarah Carr, CCG Company Secretary Ellie Wetz, ICS Development Programme Manager Sarah Weston, ICS Development Project Manager
Sponsoring Director / Board Member:	Sarah Truelove, Deputy CEO

BNSSG ICB Draft Scheme of Reservation and Delegation v1

Table of Contents

1. Introduction

1.1 Background

NHS England has set out the following as the four core purposes of Integrated Care Systems:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

The Integrated Care Board will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

ICBs are statutory bodies and as such their powers, functions and duties are conferred, in the main, by legislation. Additional responsibilities for other functions may be conferred through delegation to the ICB from other bodies (such as NHS England and NHS Improvement).

ICBs are able to delegate to a committee or sub-committee of the board, or to an individual member of the board or an employee. The legislation gives the ICB board flexibility to appoint to ICB committees and sub-committees members who are neither ICB employees nor board members. In addition, ICBS' have the power to agree with specified other statutory organisations (NHS trusts/foundation trusts, local authorities) that they will exercise their functions on behalf of the ICB or jointly with the ICB.

This Scheme of Reservation and Delegation (SoRD) sets out those decisions that are reserved to the ICB Board and those decisions that have been delegated to ICB Committees, individuals, joint committees and other statutory organisations.

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2. Decisions and functions reserved to NHSE	Reference
The power to obtain information from the ICB and intervene where NHS England is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so	S 14Z58 of NHS Act 2006 Constitution 1.4.8
Appointment of the ICB Chair	Constitution 3.3
Removal of the ICB Chair	Constitution 3.13.6
Terminate the appointment of the Chief Executive and direct the Chair as to the appointment of a replacement where NHSE is satisfied that the ICB is failing or has failed to discharge any of its functions or there is a significant risk that the ICB will fail to do so	Constitution 3.16.7
Approval of the ICB Constitution and any changes made to it	Constitution 1.5.1 1.5.3
Variation of the ICB Constitution other than on application by the ICB	Para 15 Schedule 1B NHS Act 2006 Constitution 1.6.1b
Remuneration of ICB Chair	Constitution 3.14.1
Delegated limit for virement – for the whole ICB unlimited value: this includes all allocation changes, consequent budget changes and any change required to meet Integrated Single Financial Environment (ISFE) reporting requirements	SFIs 6.4.2

3. Decisions and functions reserved to the ICB Board	Reference
Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's Constitution, including the Standing Orders	s14Z25 (5) and s1B NHS Act (2006) Constitution 1.6.1a, 1.6.3
Require and receive the declaration of interests from members of the ICB Board	s14Z30 NHS Act (2006) Constitution s6.3
Receive reports from committees that the ICB is required by statute or other regulation to establish and take action upon those reports as necessary	Constitution 4.6.4
Approve any urgent decisions taken by the chair of the ICB Board for ratification in public session	SO s4.9.4 – 4.9.7
Approve the ICBs overarching scheme of reservation and delegation, which sets out those decisions of the ICB reserved to the IBC Board and those delegated to the • committees and any joint committees of the ICB, or • its employees	Constitution 4.3, 4.4 4.6, 4.7
Approve Standing Financial Instructions (SFIs)	Constitution 5.2
Approve Functions and Decisions Map	Constitution 4.5
Appoint and dismiss committees of the ICB that are directly responsible to the Board	Constitution 4.6.1
Establish Terms of Reference and reporting arrangements for all of the committees of the Board	Constitution 4.6.3
Receive reports from committees of the ICB including those which the ICB is required by its Constitution, or by NHS England, or the Secretary of State or by any other legislation, regulations, directions or guidance to establish and to take appropriate action	Constitution 4.6
Confirm the recommendations of committees where committees do not have executive powers	Constitution 4.6

3. Decisions and functions reserved to the ICB Board	Reference
Delegate executive powers to be exercised by any of its members or employees	Constitution 4.3.1
Approval of the ICB Long Term Plan and annual operational plan, including financial plans	Constitution 7.3.8
Approval of the ICB's Annual Report and Accounts	Constitution 7.5
Approval of the arrangements for discharging the ICB's statutory financial duties.	Constitution 5.2
Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.	s14Z34 NHS Act (2006) Constitution 1.4.5, 1.4.7, 4.2.1, 4.2.2
Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.	Constitution 1.4.5, 1.4.7, 4.2.1, 4.2.2
Approval of the ICB's arrangements for the management of risk	Constitution 4.2.2
Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB.	Constitution 4.2.2
Approval of the ICB's corporate budgets that meet the ICB's financial duties	Constitution 4.2.2
Approve arrangements with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB.	Constitution 4.3.2,
Approve arrangements for the functions to be exercised by a joint committee and/or for the establishment of a pooled fund to fund those functions (section 65Z6).	Constitution 4.3.2, 4.3.3

3. Decisions and functions reserved to the ICB Board	Reference
The exercise of Delegated Functions to empower the ICB to commission a range of primary care services for the people of BNSSG as described in the Delegation Agreement and delegated by NHS England to the ICB	S65Z5 NHS Act 2006
Establish effective, safe, efficient, and economic arrangements for the discharge of Delegated Functions	S65Z5 NHS Act 2006
Consideration of whether any of the Delegated Functions in respect of Primary Medical Services,	S65Z5 NHS Act 2006
Develop an operational scheme of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions (this may be included in this Scheme of Reservation and Delegation) and determining the arrangements for the exercise of the Delegation Functions	S65Z5 NHS Act 2006
Ensuring the ICB compliance with the NHS Provider Selection Regime including approval of the ICB's Procurement Policy	Constitution 7.4.3
Approving arrangements for handling complaints and ensuring publication of the process	Constitution 7.3.4
Approving arrangements for handling Freedom of Information requests.	Constitution 7.3.5
Approve management policies including Human Resource polices	Constitution 8
Approve the arrangements for discharging the ICB's statutory duties as an employer, including Human Resource and employment policies	Constitution 8 SFI 8
Endorse the ICB internal audit charter and annual audit plan on the recommendation of the ICB Accountable Officer and audit and risk committee	SFI's 10.2
Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with the formal authorisation of tenders and competitive quotations over the total value of (contract life cycle) £1 million and over	SFIs 7.2.1

3. Decisions and functions reserved to the ICB Board	Reference
Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with formal authorisation and awarding of a contract may be decided within +/- 10 percent of the authorised tender value of (contract life cycle inc VAT) £1 million and over	SFIs 7.5
Signing of all contracts over £1 million (contract life including VAT) Chief Executive and Chief Finance Officer at the direction of the ICB Board and recorded in the relevant minute	SFIs 7.5
Approve the ICB's arrangements for business continuity, and for emergency planning.	Civil Contingencies Act 2004
Delegated limit for virement – for the whole ICB unlimited value: this includes Annual Operating Plan and any business cases/ proposals agreed by the Board.	SFIs 6.4.2
Formal authorisation of tenders and competitive quotations to the total value of (contract life cycle inc. VAT) over £1million	SFIs 8.2.1
Formal authorisation and awarding of a contract may be decided within a +/- 10 percent of the authorised tender value of (contact life cycle inc. VAT) over £1million	SFIs 8.8.1
All tenders that will, or are forecast to, exceed the budget of that tender or the designated budget holder shall be escalated to the next level up. Where the actual contract value is greater than +/- 10 percent of the authorised tender value authorisation limit (contract life cycle inc. VAT) is over £1million	SFIs 8.8.2
A member of the ICB Board will be required to be one of the two approved persons present for the opening of tenders estimated above £500K (contract life cycle)	SFIs 9.3.1 b)
Approval of schemes with a capital value of (contract life cycle inc. VAT) great than £5m	SFIs 12.1.5

4. Decisions and functions reserved to the ICB Chair		Reference
NHSE	Appointment of the ICB Chair	Constitution 3.3
NHSE	Removal of the ICB Chair	Constitution 3.12.6

4. Decisions and functions reserved to the ICB Chair		Reference
NHSE	Terminate the appointment of the Chief Executive and direct the Chair as to the appointment of a replacement where NHSE is satisfied that the ICB is failing or has failed to discharge any of its functions or there is a significant risk that the ICB will fail to do so	Constitution 3.12.7
Chair	Appointment of the Chief Executive	Constitution 3.4
Chair	Approval of appointment of partner members of the ICB Board	Constitution 3.5 - 3.7 inc
Chair	Appointment of Independent Non-Executive members of the ICB Board	Constitution 3.11
Chair	Approval of appointment of Chief Medical Officer	Constitution 3.8
Chair	Approval of appointment of Chief Nursing Officer	Constitution 3.9
Chair	Approval of appointment of Chief Finance Officer	Constitution 3.10

5. Decisions and functions delegated by the Board to the ICB Committees

Decisions and functions delegated by the Board to the ICB Audit Committee	Reference
Establish an auditor panel as a sub group to ensure the contract arrangements, including the procurement and selection, with the External Auditors is appropriate	SFIs 3.3.2x
Approve the appointment and removal of the ICBs Internal Auditors, the level of remuneration and terms of engagement	SFIs 10.2
Endorse and recommend the ICB internal audit charter and annual audit plan, to the ICB board	SFIs 10.2
Review the adequacy and effectiveness of the ICB's system of integrated governance, risk management and internal control across the whole of the ICB's activities	SFIs 3.3.2f
ensure there is an effective internal audit function including; costs of audit services, performance of service, review and approval of the annual internal audit plan, the findings of audit work including the Head of Internal Audit Opinion and management responses to these, adequate resourcing of the function.	SFIs 3.3.2a
Review the work and findings of the External Auditor and management responses	SFIs 3.3.2b
Review schedules of losses and compensations and make recommendations to the Board	SFIs 3.3.2h
Review the annual report and financial statements prior to submission to the Board	SFIs 3.3.2j
To be assured that the ICB has adequate arrangements in place for the counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.	Committee Terms of Reference: 6
To be assured that the ICB has adequate arrangements in place for Freedom to Speak Up	Committee Terms of Reference: 6
To be assured that the ICB has adequate arrangements in place for Information Governance	Committee Terms of Reference: 6

To monitor the integrity of financial statements of the ICB and any formal announcements relating to its financial performance, ensure systems for financial reporting to the Board are subject to review	Committee Terms of Reference: 6
To be assured that the ICB has adequate arrangements for the management of declared interests and conflicts of interest, including gifts and hospitality	Committee Terms of Reference: 6

Decisions and functions delegated by the Board to the ICB Remuneration Committee	**Reference**
Determine all aspects of remuneration for the Chief Executive, Directors and other Very Senior Managers including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference: 6
Determine arrangements for termination of employment and other contractual terms and non-contractual terms for the Chief Executive, Directors and other Very Senior Managers	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference: 6
Determine all aspects of remuneration for the Independent Non-Executive members of the ICB Board	17 to 19 of Schedule 1B NHS Act 2006 s3.13.1 Constitution Committee Terms of Reference: 6
Terms of appointment for ICB Board members	s3.13.1 Constitution Committee Terms of Reference: 6

Determine the ICB pay policy for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference: 6
Oversee contractual arrangements for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference: 6
Determine arrangements for termination payments and any special payments for all staff	17 to 19 of Schedule 1B NHS Act 2006 Committee Terms of Reference: 6

Decisions and functions delegated by the Board to the ICB Finance, Digital, and Estates Committee	**Reference**
Develop and recommend to the ICB Board annual, medium and long term plans	SFIs 3.4.3 (1) Committee terms of reference: 2
Develop and recommend to the ICB Board Standing Financial Policies	SFIs 3.4.3 (2) Committee terms of reference: 2
Develop and recommend to the ICB Board resource allocation approach	SFIs 3.4.3 (1) Committee terms of reference: 2
Oversight of procurement exercises where contracts have an estimate value (over life cycle) £1 million or where there is a significant reputational or service issue and make recommendations to ICB Board	SFIs 3.4.3 (2) Committee terms of reference: 2

Decisions and functions delegated by the Board to the ICB Outcomes, Quality and Performance Committee	Reference
Develop and recommend to the ICB Board the key outcomes, quality and performance priorities to be included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care	Committee terms of reference: 5
Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Outcomes, Quality and Performance Committee	Committee terms of reference: 5

Decisions and functions delegated by the Board to the ICB People Committee	Reference
Deliver its purpose as set out in these terms of reference	Committee terms of reference: 2
Investigate any activity within its terms of reference	Committee terms of reference: 2
Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference	Committee terms of reference: 2
Commission any reports it deems necessary to help fulfil its obligations	Committee terms of reference: 2
Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice	Committee terms of reference: 2
Create sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such sub-groups in accordance with the ICB's constitution, standing orders and SoRD. The committee may not delegate any of its accountabilities to such sub-groups	Committee terms of reference: 2

Decisions and functions delegated by the Board to the ICB Primary Care Commissioning Committee	Reference
Decisions in relation to the commissioning, management, planning (including carrying out needs assessments), and undertaking reviews, of Primary Medical Services and other ancillary activities that are necessary to exercise the delegated functions	Committee terms of reference: 5
The management of Delegated Funds in relation to Primary Medical Services	Committee terms of reference: 5
Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies	Committee terms of reference: 5
Design and commission Enhanced Services, including re-commissioning of services (in line with the ICB SFIs	Committee terms of reference: 5
Design and offer Local Incentive Schemes for Primary Medical Services providers (in line with the ICB SFIs (put in reference)	Committee terms of reference: 5
Make decisions on discretionary payments or support	Committee terms of reference: 5
Review ICB plans for Primary Care Networks	Committee terms of reference: 5
Approve Primary Medical Services provider mergers and closures	Committee terms of reference: 5

6. Decisions and functions delegated to individual board members and employees

Individual	Decisions and functions delegated to the individual	Reference
Chief Executive Officer	Convening a panel to advise on the appointment of ICB Board partner members	Constitution 3.5 - 3.7 inc

Chief Executive Officer	Endorse and recommend the ICB internal audit charter and annual audit plan to the audit and risk committee and the ICB Board	SFIs 10.2
Chief Executive Officer and Chief Finance Officer	Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with the formal authorisation of tenders and competitive quotations over the total value of (contract life cycle) over £500k and up to £1 million	SFIs 8.2.1
Chief Executive Officer and Chief Finance Officer	Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with formal authorisation and awarding of a contract may be decided within +/- 10 percent of the authorised tender value of (contract life cycle inc. VAT) over £500k and up to £1 million	SFIs 8.8.1
Chief Executive Officer and Chief Finance Officer	Signing of all contracts over £1 million (contract life cycle inc. VAT) Chief Executive and Chief Finance Officer at the direction of the ICB Board and recorded in the relevant minute	SFIs 8.8.4, 8.8.5
Chief Executive Officer and Chief Finance Officer	Signing of all contracts over £500k and up to £1 million (contract life including VAT) Chief Executive and Chief Finance Officer or their nominated deputies and formal authorisation must be put in writing	SFIs 8.8.4
Chief Finance Officer	Preparation and audit of annual accounts;	SFIs 3.2
Chief Finance Officer	Adherence to the directions from NHS England in relation to accounts preparation;	SFIs 3.2
Chief Finance Officer	Ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;	SFIs 3.2
Chief Finance Officer	Ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;	SFIs 3.2

Chief Finance Officer	Meeting statutory requirements relating to taxation;	SFIs 3.2
Chief Finance Officer	Ensuring that there are suitable financial systems in place	SFIs 3.2 SFIs 6
Chief Finance Officer	Meeting the financial targets set for the ICB by NHS England;	SFIs 3.2
Chief Finance Officer	Ensuring the Governance statement and Annual Accounts & Reports are signed	SFIs 3.2
Chief Finance Officer	Ensuring that planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;	SFIs 3.2
Chief Finance Officer	Making use of benchmarking to make sure that funds are deployed as effectively as possible;	SFIs 3.2
Chief Finance Officer	Executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;	SFIs 3.2
Chief Finance Officer	Specific responsibilities and delegation of authority to specific job titles are confirmed;	SFIs 3.2
Chief Finance Officer	Providing financial leadership and ensuring financial performance of the ICB;	SFIs 3.2
Chief Finance Officer	Identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions;	SFIs 3.2
Chief People Officer	Defining and delivering the overall human resources strategy and objectives	SFIs 8.1.2

All Executive Directors	Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with the formal authorisation of tenders and competitive quotations over the total value of (contract life cycle) up to and including £500K	SFIs 8.2.1
All Executive Directors	Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with formal authorisation and awarding of a contract may be decided within +/- 10 percent of the authorised tender value of (contract life cycle inc. VAT) up to and including £500K	SFIs 8.8.1
All Executive Directors	Signing of all contracts up to and including £500K (contract life cycle inc. VAT) by two Directors	SFIs 8.8.3
All Budget Holders	Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with the formal authorisation of tenders and competitive quotations over the total value of (contract life cycle inc. VAT) up to and including £50K	SFIs 8.2.1
All Budget Holders	Providing all the conditions and circumstances set out in ICB Standing Financial Instructions have been fully complied with formal authorisation and awarding of a contract may be decided within +/- 10 percent of the authorised tender value of (contract life cycle inc VAT) up to and including £50K	SFIs 8.8.1
All Budget Holders	Signing of all contracts up to and including £50K (contract life including VAT) by two Budget Holders	SFIs 8.8.3
Chief Executive Officer and Chief Finance Officer	Delegated limit for virement – for the whole ICB to a value over £500K and below £1 million: includes any committee that approves expenditure where the Chief Executive Officer or Chief Finance Officer or their appointed nominee is present	SFIs 6.4.2

Chief Finance Officer	Delegated limit for virement – for the whole ICB to a value below £500K includes any committee that approves expenditure where the Chief Finance Officer or their appointed nominee is present	SFIs 6.4.2
All Executive Directors	Delegated limit for virement – for their directorate to a value of up to £250K	SFIs 6.4.2
All Assistant Directors	Delegated limit for virement – for their directorate up to a value of £25K	SFIs 6.4.2
All Budget Holders	Delegated limit for virement – for their service up to a value of £10K	SFIs 6.4.2
All appropriately nominated managers	Responsibility for: a. submitting time records, and other notifications in accordance with agreed timetables; b. completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer including approval of expenses; c. submitting termination forms in the prescribed format immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately	SFIs 10.4.3
All appropriately nominated officers	Delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. Where a role is as a ICB Board Member or senior official, these must be in line with the 2012 HMT Review of Tax Arrangements for Public Sector Appointees, the HMT guidance "Managing Public Money" instructions from the Department of Health for the reimbursement of ICB Board members and senior officials, and the ICB Constitution	SFIs 8.7.1
All appropriately nominated officers	The Board shall delegate responsibility to an officer for: a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and b. dealing with variations to, or termination of, contracts of employment	SFIs 10.5.1

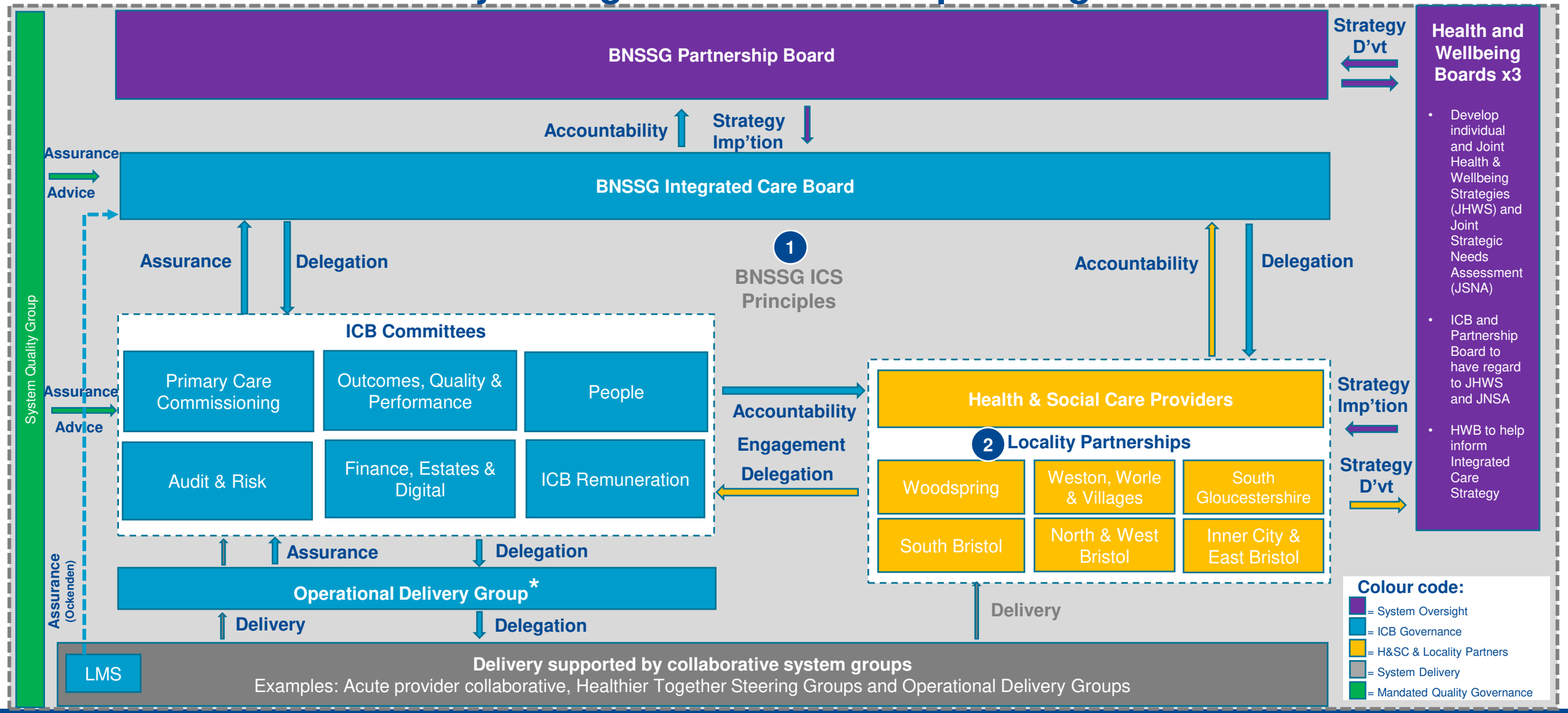
Chief Finance Officer	Responsibility for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. The Operational Scheme of Reservation and Delegation sets out levels of delegated authority for payment authorisation in the following instances: a. Budget already approved by the ICB Board e.g. payments to NHS bodies arising from agreement of NHS Contracts. b. Payments to NHS bodies where there is no contract in place	SFIs 11.2.2
Chief Executive Officer and Chief Finance Officer	Approval of capital schemes to the total value of (contract life cycle inc. VAT) between £500K and £5m (both Chief Executive Officer and Chief Finance Officer required)	SFIs 12.1.5
Chief Finance Officer	Approval of capital schemes to the total value of (contract life cycle inc. VAT) up to £500K	SFIs 12.1.5
ICB Corporate Secretary	Approval of defence document or offers of settlement in line with legal advice and NHS R advice for claims assessed as under the value of £50K	SFIs 18.2.2
Chief Executive Officer or Chief Finance Officer	Approval of defence document or offers of settlement in line with legal advice and NHS R advice for claims assessed as over the value of £500K up to £1 million	SFIs 18.2.3
Chief Executive Officer and Chief Finance Officer and with advice from Chair of Audit, Governance & Risk	Approval of defence document or offers of settlement in line with legal advice and NHS R advice for claims assessed at over the value of £1 million	SFIs 18.2.3

7. Decisions and functions delegated to be exercised jointly		
Joint Committee	**decisions and functions delegated to the joint committee**	**Reference**
	Future iterations will reference the ICP board as being a jointly established committee of the ICB and local authorities once terms of reference finalised across partners. This reflects the Health and Care Act provisions	

8. Decisions and functions delegated by the Board to other statutory bodies		
Statutory Body	**Decisions and functions delegated to other statutory bodies**	**Reference**
	None	

9. Decisions and functions delegated to the board by other organisations		
Delegating Body	**Decisions and functions delegated by other organisations**	**Reference**
	None	

BNSSG ICS: Future system governance and operating model



Healthier Together

Key:

- **Strategy Development** = Input into system forward-planning
- **Strategy Implementation** = The delegation of the implementation of system strategy
- **Delegation** = The delegation of functions to deliver strategy or operational plans
- **Accountability** = Responsibility for implementation, delivery and outcomes of operational and strategic plans
- **Assurance** = Confirmation that systems, processes and behaviours are in place and appropriate to deliver the functions
- **Advice** = Strategic input and guidance into system decision making. Assurance must be given that this advice and guidance has been given due regard
- **Engagement** = Collation of advice, views and opinions, which are then used to inform, develop and/or implement delivery
- **Delivery** = Outputs from workstreams/ programmes/ working groups

*Form & function to be finalised

1 Principles for how we work together as an ICS

HT MOU_Dec2021

Individuals @ the Centre	1. We work to achieve **our vision** to meet our citizens' needs by working together within our joint resources, as one health and care system. We will develop a model of care and wellbeing that **places the individual at its heart**, using the combined strengths of health and social care. **2. Citizens** are integral to the design, co-production and delivery of services 3. We involve people, communities, clinicians and professionals in all decision-making processes. 4. We will take collective, considered risks to cease specific activity to release funds for **prevention, earlier intervention and for the reduction of health inequalities.** 5. We will focus on the causes of inequality and not just the symptoms, ensuring **equalities is embedded** in all that we do.
Subsidiarity	**6. Decisions taken closer to the communities** they affect are likely to lead to better outcomes. The default expectation should be for decisions to be taken as close to communities as possible, except where there are clear and agreed benefits to working at greater scale**.**
Collaboration	**7. Collaboration between partners in a place** across health, care services, public health, and the voluntary sector can overcome competing objectives and separate funding flows to help address health and social inequalities, improve outcomes, transform people's experience, and improve value for the tax payer. **8. Collaboration between providers** across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity. 9. Through **collaboration as a system** we will be better placed to ensure the system, places, and individual organisations are able to make best use of resources 10. We **prioritise investments based on value**, ensuring equitable and efficient resource allocation, and we take shared ownership in achieving this.
Mutual Accountability & Equality	11. We are coming together under a distributed leadership model and we are committed to working together as an **equal partnership.** 12. We have a **common understanding** of the challenges to be addressed collectively and the impact organisations can have across other parts of the system. We engage in honest, respectful, and open dialogue, seeking to understand all perspectives and recognising individual organisations agendas and priorities. We accept that diverse perspectives may create dissonance, and we seek to understand and work through any disharmony, and move to conclusions and action in service of our citizens. We strive to **bring the best of each organisation** to the partnership. 13. We adhere to a **collective model of accountability**, where we hold each other mutually accountable for our respective contributions to shared objectives. 14. We develop a **shared approach to risk management taking collective responsibility** for driving necessary change while mitigating the risks of that change for individual organisations.
Transparency	15. We **pool information** openly, transparently, early, and as accurately and completely as practical to ensure one version of the truth 16. We work in an open way and establish **clear and transparent accountability for decisions.**

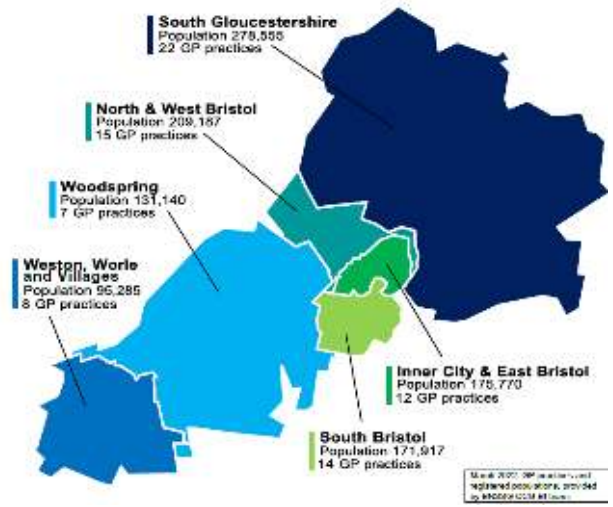
❷ BNSSG Locality Partnerships

Locality Partnerships

- Woodspring
- Weston, Worle & Villages
- South Gloucestershire
- South Bristol
- North & West Bristol
- Inner City & East Bristol

Place-based Leadership in each Locality:

- Clinical Chair
- Delivery Director



Place-Based Governance

Health & Wellbeing Boards

- North Somerset
- South Glos
- Bristol

BNSSG Integrated Care Board

Accountability

Delegation

Locality Partnership Boards

- Woodspring
- Weston, Worle & Villages
- South Glos
- Inner City & East Bristol
- North & West Bristol
- South Bristol

Healthier Together Integrated Care Steering Group

Delivery

Locality Partnerships Delivery Group

Locality Partnership Delivery Teams

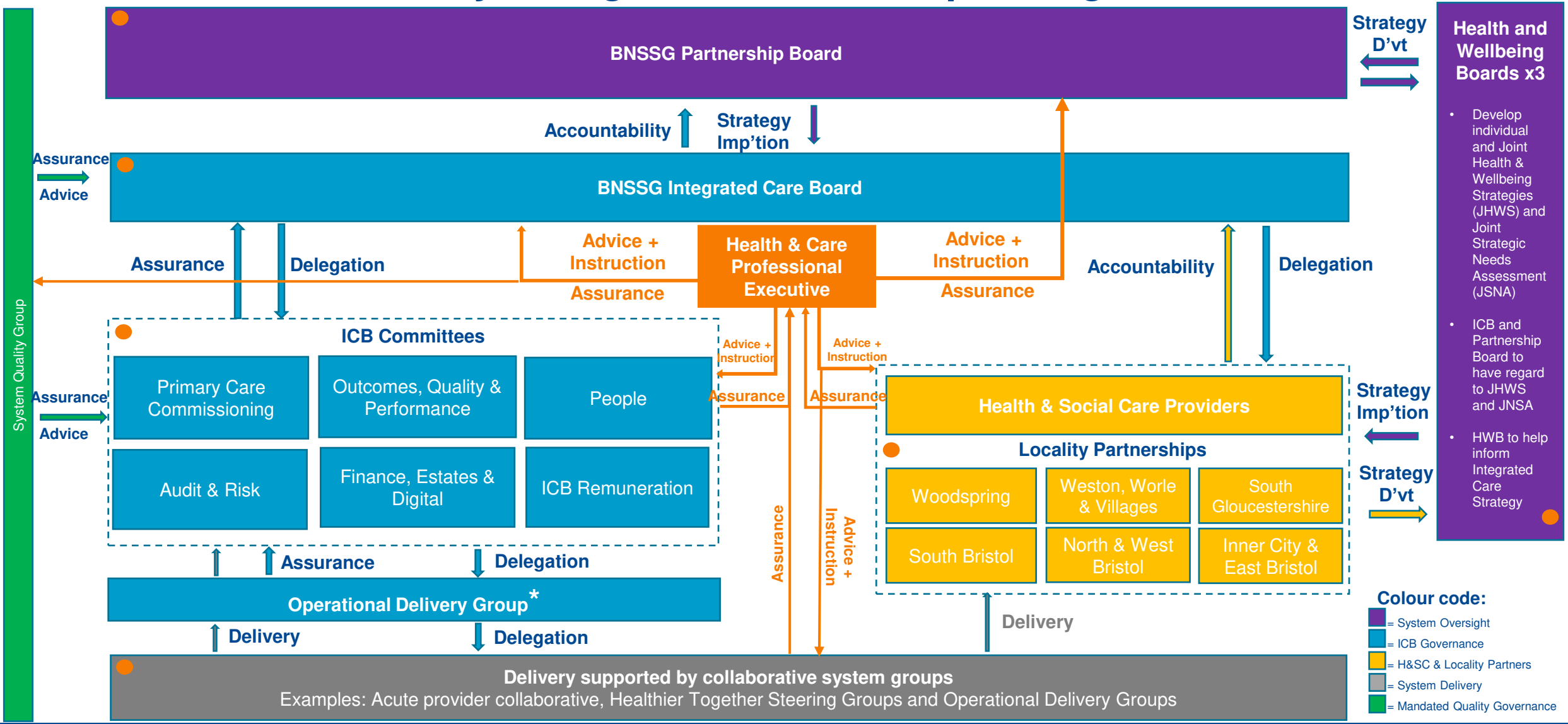
- Woodspring
- Weston, Worle & Villages
- South Glos
- Inner City & East Bristol
- North & West Bristol
- South Bristol

Colour code:

- = System Oversight
- = H&SC & Locality Partners
- = System Delivery
- = ICB Governance

Healthier Together

BNSSG ICS: Future system governance and operating model



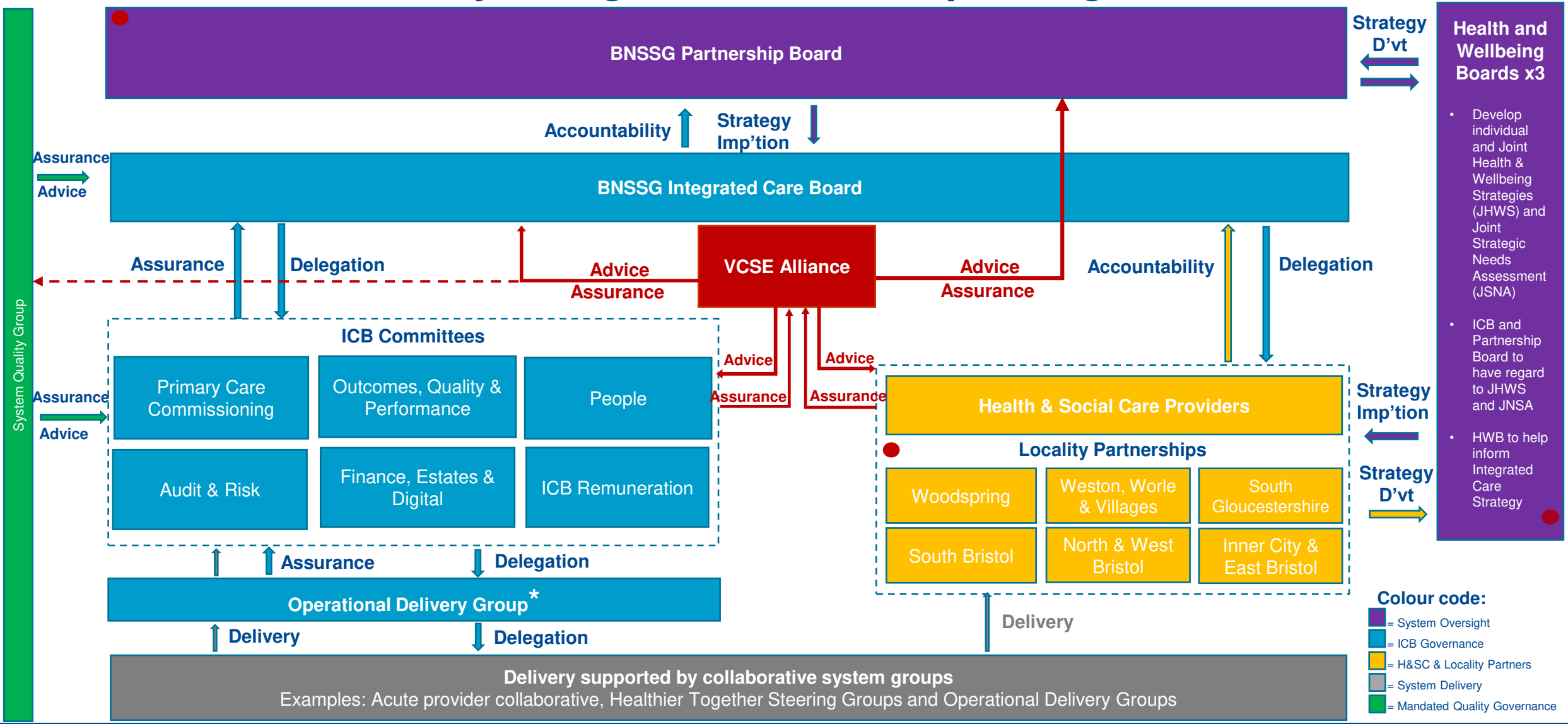
Healthier Together

Key:

- **Strategy Development** = Input into system forward-planning
- **Strategy Implementation** = The delegation of the implementation of system strategy
- **Delegation** = The delegation of functions to deliver strategy or operational plans
- **Accountability** = Responsibility for implementation, delivery and outcomes of operational and strategic plans
- **Assurance** = Confirmation that systems, processes and behaviours are in place and appropriate to deliver the functions
- **Advice** = Strategic input and guidance into system decision making. Assurance must be given that this advice and guidance has been given due regard
- **Engagement** = Collation of advice, views and opinions, which are then used to inform, develop and/or implement delivery
- **Delivery** = Outputs from workstreams/ programmes/ working groups
- = Health & Care Professionals representation in core system groups

*Form & function to be finalised

BNSSG ICS: Future system governance and operating model



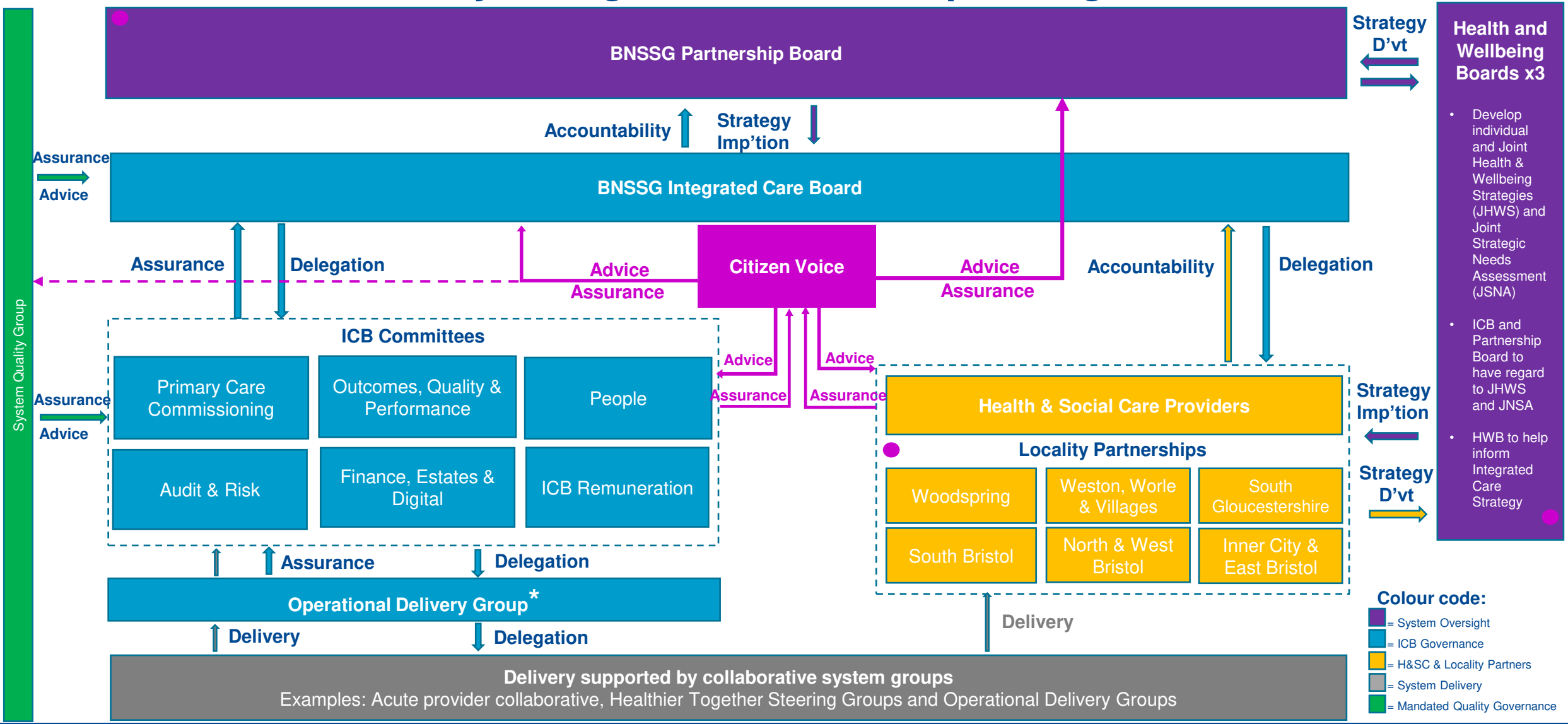
Healthier Together

Key:

- **Strategy Development** = Input into system forward-planning
- **Strategy Implementation** = The delegation of the implementation of system strategy
- **Delegation** = The delegation of functions to deliver strategy or operational plans
- **Accountability** = Responsibility for implementation, delivery and outcomes of operational and strategic plans
- **Assurance** = Confirmation that systems, processes and behaviours are in place and appropriate to deliver the functions
- **Advice** = Strategic input and guidance into system decision making. Assurance must be given that this advice and guidance has been given due regard
- **Engagement** = Collation of advice, views and opinions, which are then used to inform, develop and/or implement delivery
- **Delivery** = Outputs from workstreams/ programmes/ working groups
- = VCSE representation in core system groups

*Form & function to be finalised

BNSSG ICS: Future system governance and operating model



Healthier Together

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- **Advice** = Strategic input and guidance into system decision making. Assurance must be given that this advice and guidance has been given due regard
- **Engagement** = Collation of advice, views and opinions, which are then used to inform, develop and/or implement delivery
- **Delivery** = Outputs from workstreams/ programmes/ working groups
- = Citizen Voice representation in core system groups

*Form & function to be finalised

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of ICB Board

Date: 01 July 2022
Time: 09:30
Location: MS Teams

Agenda Number :	4.4	
Title:	ICB Committee Terms of Reference	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Decision – For Approval		
Key Points for Discussion:		
The Terms of Reference for all Integrated Care Board (ICB) Committees (including the statutory Audit Committee and Remuneration Committee) are included in the ICB Governance Handbook. The Committee Terms of Reference have been developed in collaboration with ICB designate Independent Non-Executive Members (INEMs) as Chairs of these Committees and CCG Executive Leads. The Committee Terms of Reference reflect the Scheme of Reservation and Delegation also included in the ICB Governance Handbook All Terms of Reference were submitted in draft to NHSEI on 27 May 2022 and accepted without comment		
Recommendations:	To receive and approve the Terms of Reference for: • Audit Committee • Remuneration Committee • Finance, Estates and Digital Committee • Outcomes, Quality and Performance Committee • Primary Care Commissioning Committee • People Committee	
Previously Considered By and feedback:	BNSSG CCG Executive Group NHSEI South West Regional Team	
Management of Declared Interest:	There are no actual or potential conflicts of interest related to the contents of this paper. Each Terms of Reference sets out the management of conflicts of interest for each Committee.	

Risk and Assurance:	There is a risk to the organisation if committees do not work to their statutory and mandatory requirements. The Terms of Reference are in-line with good practice and mitigate this risk. Each Terms of Reference aligns to the Scheme of Reservation and Delegation and Risk Management Framework included in the ICB Governance Handbook.
Financial / Resource Implications:	There are no finance or other resources implications.
Legal, Policy and Regulatory Requirements:	Each Terms of Reference were developed using the model template provided by NHSEI. The Terms of Reference are in-line with good practice and designed to meet the ICBs statutory and mandatory requirements.
How does this reduce Health Inequalities:	These documents have been developed in the context of the four core purposes of Integrated Care Systems: **a) improve outcomes in population health and healthcare** **b) tackle inequalities in outcomes, experience and access** c) enhance productivity and value for money d) help the NHS support broader social and economic development.
How does this impact on Equality & diversity	These documents have been developed in the context of the four core purposes of Integrated Care Systems: **a) improve outcomes in population health and healthcare** **b) tackle inequalities in outcomes, experience and access** c) enhance productivity and value for money d) help the NHS support broader social and economic development.
Patient and Public Involvement:	There has been no wider public engagement. Patient and Public Involvement in each Committee is articulated in the Membership section of the Terms of Reference where appropriate.
Communications and Engagement:	The Terms of Reference will be published on the BNSSG ICB Website from 01 July 2022.
Author(s):	Committee INEMs and CCG Executive Leads
Sponsoring Director / Board Member:	INEMs – Chairs of the Committees

Audit Committee Terms of Reference

1. Introduction

Constitution:

The Audit Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

Purpose:

The aims of the ICB are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management, and internal control processes within the ICB.

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Audit Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

2. Delegated Authority

The Audit Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;

- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, other than for the following exceptions:
add any exceptions agreed by the board

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

Neither the Chair of the Board, nor employees of the ICB will be members of the Committee. Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair:
In accordance with the constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee. Committee members may appoint a Vice Chair who [ICB to add any local specifications about who may be vice chair].

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4. The members of the Audit committee are:

TBC

5. In attendance (if required)

Attendees:

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Director of Finance or their nominated deputy;
- Representatives of both internal and external audit;
- Individuals who lead on risk management and counter fraud matters;
- [add other relevant attendees]

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

The Chief Executive should be invited to attend the meeting at least annually.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

Attendance:
Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

Access:
Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit Committee.

6. Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

7. Quoracy

For a meeting to be quorate a minimum of two Non-Executive Members of the Board are required, including the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decisions making and voting:
Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

8. Frequency of meetings

The Audit Committee will meet five/ four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Remit and Responsibilities

The Committee's duties can be categorised as follows.

Integrated governance, risk management and internal control:
To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

To have oversight of system risks where they relate to the achievement of the ICB's objectives.

To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

To identify opportunities to improve governance, risk management and internal control processes across the ICB.

Internal audit:
To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit:
To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions:

To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud:
To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Freedom to Speak Up:
To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG):
To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial reporting:
To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

Conflicts of Interest:
The chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.
The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Management of Information Rights:
The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of Information Rights are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to Information Rights.

Management:
To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication:
To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

10. Behaviours and Conduct

ICB values:

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity:

Members must demonstrably consider the equality and diversity implications of decisions they make.

11. Reporting Requirements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Audit Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework;
- The completeness and 'embeddedness' of risk management in the organisation;
- The integration of governance arrangements;
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
- The robustness of the processes behind the quality accounts.

12. Review of Terms of Reference

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

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Remuneration Committee Terms of Reference

1. Introduction

Constitution:

The Remuneration Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

Purpose:

The aims of the ICB are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors.

2. Delegated Authority

The Remuneration Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation but

may /not delegate any decisions to such groups.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Committee membership will be drawn from the Non-Executive Members and the Partner Members of the Board. As a minimum and, with the exception of the Audit Chair as below, all Non-Executive Members will be appointed to the Committee. Four Partner Members will be appointed to the Committee so that Non-Executive Members may recluse themselves from decision making in the event that they are conflicted. When arranging Committee meetings, it will be made clear whether the business under discussion will require the attendance of the Partner Members (see Quoracy below):

- The Chair of the Audit Committee may not be a member of the Remuneration Committee.
- The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair:

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. Committee members may appoint a Vice Chair from amongst the members. In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

4. The members of the Remuneration Committee are:

Name:	Organisation	BNSSG ICB Board Membership
Ellen Donovan (Chair)	N/A	BNSSG ICB Board Independent Non-Executive Member (INEM)
Jaya Chakrabarti	N/A	BNSSG ICB Board INEM
Alison Moon	N/A	BNSSG ICB Board INEM
Steve West	N/A	BNSSG ICB Board INEM
Jeff Farrar	BNSSG ICB	Chair
Maria Kane	North Bristol NHS Trust	Providing knowledge and perspective of Acute Tertiary Care Services
Dominic Hardisty	Avon and Wiltshire Mental Health Partnership Mental Health Trust	Providing knowledge and perspective of Acute and Community Mental Health Services.

Mike Jackson	Bristol City Council	Providing knowledge and perspective of Urban Communities
Jonathan Hayes*	GP Collaborative Board	Providing knowledge and perspective of Primary Medical Services

* Subject to appointment on the ICB Board via the joint nomination process.

5. In attendance (if required)

Attendees:

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy
- Director of Finance or their nominated deputy
- Chief Executive or their nominated deputy

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

No individual should be present during any discussion relating to:

- Any aspect of their own pay;
- Any aspect of the pay of others when it has an impact on them.

6. Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings

7. Quoracy

For a meeting to be quorate a minimum of three Non-Executive Members is required, including the Chair or Vice Chair of the Committee. If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that

individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

If, due to a conflict of interest, all Non-Executive Members are unable to participate, the meeting will be quorate with three Partner Members present. These members will choose a chair for that meeting from amongst the members present.

Decision making and voting:
Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

8. Frequency of meetings

The Committee will meet in private. The Committee will meet at least once each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Remit and Responsibilities

The Committee's duties are as follows:

For the Chief Executive, Directors and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For the Non-Executive Members:

- Determine all aspects of remuneration

For Board members:

- Terms of appointment

For all staff:

- Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);
- Oversee contractual arrangements;
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

10. Behaviours and Conduct

Benchmarking and guidance:
The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB values:
Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion:
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

11. Reporting Requirements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Remuneration Committee will submit copies of its minutes to the Board following each of its meetings. Where minutes and reports identify individuals, they will not be made public and will be presented at part B of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

12. Review of Terms of Reference

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Delete this text and key in Author's name

Delete this text and key in Date

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Strategic Finance, Estates and Digital Committee Terms of Reference

1. Introduction

Constitution:

The Strategic Finance, Estates and Digital Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

Purpose:

The aims of the ICB are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The purpose of the Committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial strategy and operational plan. This includes:

- financial performance of the ICB
- financial performance of NHS organisations within the ICB footprint

Providing financial advice to the Integrated Care System Partnership Board to enable the development of a financially sustainable Strategy

Develop financial strategy and plan for the ICB with due regard for the Strategy of the Integrated Care System Partnership Board and associated Health & Wellbeing Boards

These dual roles may be reflected in separate sections of the Committee's agendas, have due regard for managing any real or perceived conflicts of interest.

The Strategic Finance, Estates and Digital Committee has no executive powers, other than those delegated in the Scheme of Reservation or Delegation and specified in these terms of reference.

2. Delegated Authority

The Strategic Finance, Estates and Digital Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Commission any report it deems necessary to fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create standing or task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD), in the first instance:
    - ICB Director of Finance Group
    - ICB Estates Steering Group
    - ICB Digital Steering Group

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the SoRD will prevail over these terms of reference other than the Committee being permitted to meet in private.

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Executive members of the Committee can send a nominated deputy to the meeting. These individuals must be able to operate with full authority over any issue arising at the meeting. Members will possess between them knowledge, skills and experience in:

- accounting
- risk management
- and additional technical or specialist issues pertinent to the ICB's business, notably provision of clinical services; population health management; legal, regulatory and financial governance of NHS and Local Authority Social Care & Public Health services and statutory functions

When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair:

In accordance with the constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. The Chair of the Committee shall be independent and therefore may not chair any other committees.

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.
The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4. The members of the Strategic Finance, Estates and Digital Committee are:

- The Non-Executive Member who leads on Strategic Finance, Estates and DigitalThe independent member who leads on Audit, Governance and Risk
- A Director of Public Health from a partner local authority
- A Section 151 Officer from another partner local authority
- Chief Executive (ICB Accountable Officer)
- Chief Finance Officer
- Chief Medical Officer
- The ICB Director of Transformation & Chief Digital Information Officer

5. In attendance

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee may also be attended by other invited and appropriately nominated individuals who are not members of the Committee. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including other ICB Executive Directors; Chairs of ICB Directors of Finance Group, Estates Steering Group, Digital Steering Group; Representatives of Health and Wellbeing Board; Representatives of Providers, Provider Collaboratives and Locality Partnerships (Place based partnerships); Directors of Adults and Children's Social Care; Senior Finance, Estates and Digital Department officers.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

Attendance:
Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

6. Administration

The Committee shall be supported with a secretariat function from the ICB Finance, Information & Corporate Directorate (FICS Directorate). Which will include ensuring that:

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- attendance of those invited to each meeting is monitored and those that do not meet the minimum attendance requirements are highlighting to the Chair

- records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- preparation, collation and circulation of papers in good time
- good quality minutes are taken in accordance with the standing orders and agreed with the chair so that a record are kept of matters arising, action points and issues carried forward
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues/ areas of interest/ policy developments
- action points are taken forward between meetings and progress against those is monitored.

7. Quoracy

For a meeting to be quorate a minimum of 3 members is required, including one of ICB Non-Executive members; and one of Chief Executive or Chief Finance Officer

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision-making and voting:
Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Where any such action has been taken between meetings, then these will be reported to the next meeting.

8. Frequency of meetings

The Strategic Finance, Estates and Digital Committee will meet at least 6 times a year. Initial work programme expects to meet once per month for 2hours. Arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.
The Board, Chair or Chief Executive may ask the Strategic Finance, Estates and Digital Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Remit and Responsibilities

The Committee's duties are as follows:

System financial management framework:

- to set the strategic financial framework of the ICB and monitor performance against it
- to develop and keep under review the system Long Term Plan
- to develop the ICB financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance
- to ensure health and social inequalities are taken into account in financial decision-making
- Participate in the development of the ICS financial framework with an awareness of the funding, cost pressures and risks which impact on delivery

Resource allocations (Revenue & Capital):

- to develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the ICS strategy and recommend this to the ICB Board
- to advise on and oversee the process regarding the deployment of NHS England Service Development Funding and other ad-hoc allocations
- to work with ICS partners to identify and allocate resources where appropriate to address finance and performance related issues that may arise
- to work with ICS partners to consider major investment/disinvestment outlined in business cases for material service change or efficiency schemes and to agree a process for sign off in line with the ICB Standing Financial Instructions and Scheme of Reservation and Delegation
- to monitor the NHS system capital programme against the capital envelope, taking action to ensure that it is appropriately and completely used
- to ensure oversight of future prioritisation and capital funding bids
- Recommend approach to decisions regarding delegation of budgetary responsibility to place and to provider collaboratives

National framework:

- to advise the ICB on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICB can be best used within the system to achieve the best outcomes for the local population
- to oversee preparation of national ICB level financial submissions and recommend these to ICB Board
- to ensure the required preparatory work is scheduled to meet national planning timelines

Financial monitoring information:

- to develop a reporting framework for the ICB as a statutory body, using the chart of accounts devised by NHSE and the integrated single financial environment (ISFE) and the ICB as a system of bodies.
- to articulate the financial position and financial impacts (both short and long-term) to support decision-making

- to work with ICB partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements
- to work with ICB partners to seek assurance over the financial reports from system bodies and provide feedback to them (being clear on how this role interacts with that of the audit committee)
- to oversee the development of financial and activity modelling to support the ICB priority areas
- to develop annual, medium and long-term financial plans which demonstrate ongoing value and recovery and recommend these to the ICB Board
- to develop an understanding of where costs sit across the system, system cost drivers and the impacts of service change on costs
- understanding the financial and performance impact of transformational changes on individual originations and the wider system
- to ensure appropriate information is available to manage financial issues, risks and opportunities across the ICB
- manage financial and associated risks and the Board Assurance Framework, ensuring that appropriate and effective mitigating actions are in place.

Performance:

- to oversee the management of the system financial target and the ICB ’s own financial targets
- to agree key outcomes to assess delivery of the ICB financial strategy
- to monitor and report to the ICB Board overall financial performance against national and local metrics, highlighting areas of concern
- to monitor and report to the ICB Board key service performance which should be taken into account when assessing the financial position
- to ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements

System efficiencies:

- to ensure system efficiencies are identified and monitored across the ICB, in particular opportunities at system level where the scale of the ICS partners together and the ability to work across organisations can be leveraged
- to ensure financial resources are used in an efficient way to deliver the objectives of the ICB
- to review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans

Communication:

- to co-ordinate and manage communications on financial governance with stakeholders internally and externally
- to develop an approach with partners, including the ICB health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood

People:

- to develop a system finance staff development strategy to ensure excellence by attracting and retaining the best finance talent

Estates:

- to oversee the development of the ICB estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers and recommend it to the ICB Board
- to gain assurance that the estates plan is built into ICS financial framework
- to ensure effective oversight of future prioritisation and capital funding bids

Digital:

- to oversee the development of the ICB Digital strategy and plan to ensure it properly balances clinical, strategic and affordability drivers and recommend it to the ICB Board
- to gain assurance that the digital plan is built into ICS financial framework
- to ensure effective oversight of future prioritisation and capital funding bids

Procurement:

- Oversight of procurement exercises (including Invitation to Tender, Evaluation, Preferred Bidder Appointment and Contract Award) where contracts with an estimated value above £1m or where there is a significant reputational or service issue and make recommendations to the ICB Board

10. Behaviours and Conduct

ICB values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

Conflicts of interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

11. Reporting Requirements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

12. Review of Terms of Reference

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

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Bristol, North Somerset and South Gloucestershire Integrated Care Board

Outcomes, Quality and Performance Committee Terms of Reference

1. Introduction

Constitution:

The Outcomes, Quality and Performance Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive chaired committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

Purpose:

The aims of the ICB are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The Outcomes, Quality and Performance Committee has been established to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in outcomes, performance, and the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB that there is, an effective system of quality and performance governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

2. Delegated Authority

The Outcomes, Quality and Performance Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Outcomes, Quality and Performance Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including one who is a Non-Executive Member of the Board (from the ICB) and will act as Chair. Other attendees of the Committee need not be members of the Board, but they may be, and will be drawn from ICB Partner or Other members (as outlined in the Constitution).

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Chair and Vice Chair:

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

If a Chair has a conflict of interest, then the Vice-Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4. The members of the Outcomes, Quality and Performance committee are:

- Non-Executive Director (Chair)
- Provider Non-Executive Director (Vice-Chair)
- ICB Chief Nursing Officer
- ICB Chief Medical Officer
- ICB Director tbc (director with responsibility for performance)
- 1 acute provider representative
- 1 community provider representative
- 1 mental health provider representative
- 1 local authority representative
- 1 primary care representative
- 1 patient voice representative

5. Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary

- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those actions is monitored.

6. Quoracy

There will be a minimum of one Non-Executive Member, plus at least the Chief Nursing Officer or Chief Medical Director, the ICB Director with responsibility for performance or their deputy.

Decision making and voting:

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

7. Frequency of meetings

The Outcomes, Quality and Performance Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

8. Remit and Responsibilities

The responsibilities of the Outcomes, Quality and Performance Committee will be authorised by the ICB Board. The Committee will:

- Oversee and seek assurance on the effective delivery of the ICB Operational Plan
- Be assured that there are robust structures and processes in place for the effective planning, management and improvement of outcomes, quality and performance and that the structures operate effectively, and timely action is taken to address areas of concern
- Agree and recommend to the ICB Board key outcomes, quality and performance priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care
- Scrutinise robustness of arrangements, compliance with and monitor delivery of the ICB key statutory requirements relevant to outcomes, quality and performance
- Scrutinise and challenge those risks on the BAF and Corporate Risk Register which relate to outcomes, quality, performance, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner
- Oversee and scrutinise the ICB's response to all relevant (as applicable to outcomes, quality and performance) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies

(e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained

- To be assured that people drawing on services are systematically and effectively involved as equal partners in outcomes quality and performance activities
- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Outcomes, Quality and Performance Committee
- Scrutinise robustness of arrangements, compliance with and monitor delivery of the ICB key statutory requirements relevant to outcomes, quality and performance including Emergency Preparedness, Resilience and Response

9. Behaviours and Conduct

ICB values:
Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity:
Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Declarations of Interest

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

11. Reporting Requirements

The Outcomes, Quality and Performance Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement

The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

12. Review of Terms of Reference

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed after six months at least annually thereafter. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

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Primary Care Commissioning Committee Terms of Reference

1. Introduction

Constitution:

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 1 to these Terms of Reference to the ICB.

The Primary Care Commissioning Committee, PCCC (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution and in accordance with Delegations made under section 65Z5 of the 2006 NHS Act(see Appendix 1) as amended by the Health and Care Act 2022.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB

Purpose:

The aims of the ICB are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The purpose of the Committee is to contribute to the overall delivery of the ICB objectives and population outcomes by managing the delivery of those elements of the primary care healthcare services delegated by NHS England to the ICB.

The aim will be to deliver to the people of BNSSG, on behalf of the ICB, services that are of high quality, clinically effective and safe, within available resources

The committee will embed the ICB principles of engaging with and embedding the voice of our local population in co-production and understanding of local need.

In addition, the committee will have responsibility for the oversight and delivery of the BNSSG Primary Care Strategy and its core deliverables of:

i. Workforce development
ii. Reducing Unwarranted Variation
iii. Developing Integrated models of care

iv. Supporting Infrastructure

The Committee will also have oversight of Primary Care Operational Planning and the impact of service and workforce change across the system on primary care services .

The Committee is responsible for the commissioning of primary care and has delegated responsibility from the ICB to fulfil this function. NHS England may at some point delegate authority to the ICB for the commissioning of primary dental services, primary pharmacy and ophthalmic services. The Primary Care Commissioning Committee will at the point of delegation of these services to the ICB, review its terms of reference and include these services within its committee remit.

2. Delegated Authority

The Primary care Commissioning Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such sub-groups in accordance with the ICB's constitution, standing orders and SoRD. The committee may not delegate any of its accountabilities to such sub-groups.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the Committee being permitted to meet in private.

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

Chair and Vice Chair:

In accordance with the constitution, the Committee will be chaired by a Non-Executive Member of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

The Chair will be responsible for agreeing the agenda with the support of the lead Director for Primary Care and ensuring matters discussed meet the objectives as set out in these ToR.

4. The members of the Primary Care Commissioning Committee are:

- Non-Executive Member of the ICB (chair)
- Non-Executive Member (TBC: drawn from Partner members)

- ICB Chief Medical Officer
- ICB Chief Nursing Office
- ICB Chief Financial Officer
- ICB Director/s with responsibility for Primary Care

5. In attendance

The following members may be in attendance at meetings:

- NHS England representative
- A BNSSG Healthwatch representative
- A representative of the General Practice Collaborative Board (GPCB)
- A representative of Locality Partnerships
- A Public Health representative of the BNSSG Health and Wellbeing Boards (to be nominated by the three local authorities)
- LMC Chair or Chief Executive
- ICB Head of Medicines Optimisation
- ICB Clinical Lead for Primary Care Development
- A Patient and Public Involvement (PPI) representative
- A representative of the ICB medicines optimisation team

Other persons may be invited to attend, as appropriate, to enable the Committee to discharge its functions effectively. The Committee may also invite guests to attend to present information and/or provide the expertise necessary for the Committee to fulfil its responsibilities.

The Corporate Secretary or their deputy will be in attendance at all meetings to advise the Committee on governance matters.

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair. Suitable alternatives can also attend for members in agreement with the Chair

6. Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

7. Quoracy

A quorum shall be 4 voting members, to include at least one independent member and an executive member.

Decision making and voting:
Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

8. Frequency of meetings

The Committee will meet in private.

The Committee will meet alternate months. Additional meetings may take place as required.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Remit and Responsibilities

The Committee will make collective decisions on the review, planning and procurement of primary care services in BNSSG, under delegated authority from NHS England. This includes the following activities:

a) The award of GMS, PMS and APMS contracts. This includes: the design of PMS and APMS contracts; and monitoring of contracts;
b) Locally defined and designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
c) Making decision regarding local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
d) Procurement of new practice provision;
e) Discretionary payment (e.g., returner/retainer schemes); Approving practice mergers;
f) Primary Care Estates Strategy;
g) Premises improvement grants and capital developments;
h) Contractual action such as issuing breach/remedial notices and removing a contract;
i) Delivery of the BNSSG Primary Care Strategy
j) Planning and delivery of the primary care aspects of the ICS Integrating Pharmacy and Medicine optimisation plan (IPMO) and Medicine optimisation strategy

In securing the provision of comprehensive and high quality primary medical services in BNSSG, the committee will carry out the following activities:

- Planning, including needs assessment, primary medical care services in BNSSG
- Undertaking reviews of primary medical care services in BNSSG
- Review the ICB plans for the management of the Primary Care Network Contract Directed Enhanced Services and receive assurances that the planning of Primary Care Networks in BNSSG comply with published specifications and guidance including
- Providing oversight of the financial planning and budget management for the commissioning of primary medical care services in BNSSG
- Promote continuous quality improvement through learning, improvement methodologies, research, innovation, citizen insights and data driven improvement initiatives

The Committee shall report on and make recommendations to the ICB on the following:

i. Progress towards delivery of the BNSGG Primary Care Strategy
ii. Planning primary medical care services in BNSSG (including needs assessment)

10. Reporting Requirements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

The ICB Primary Care Operational Group (PCOG) shall undertake the operational management, implementation and oversight of the nationally defined primary care contracts and the primary care workstreams. In addition, the PCOG will also monitor complaints and quality

The Primary Care Operational Group shall report and escalate via exception report to the Committee and submit the minutes of their meetings to the Committee for review

11. Behaviours and Conduct

ICB values:
Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion:
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

Conflicts of interest:
In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair

considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

12. Review of Terms of Reference

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

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Appendix 1

Schedule 1 –Delegated Functions

a) decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

i) decisions in relation to Enhanced Services;

ii) decisions in relation to Local Incentive Schemes (including the design of such schemes);

iii) decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;

iv) decisions about 'discretionary' payments;

v) decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

b) the approval of practice mergers;
c) planning primary medical care services in the Area, including carrying out needs assessments;
d) undertaking reviews of primary medical care services in the Area;
e) decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
f) management of the Delegated Funds in the Area;
g) Premises Costs Directions functions;
h) co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
i) such other ancillary activities as are necessary in order to exercise the Delegated Functions.

Schedule 2- Reserved Functions

a) management of the national performers list;
b) management of the revalidation and appraisal process;
c) administration of payments in circumstances where a performer is suspended and related performers list management activities;
d) Capital Expenditure functions;
e) section 7A functions under the NHS Act;
f) functions in relation to complaints management;
g) decisions in relation to the Prime Minister's Challenge Fund; and
h) such other ancillary activities that are necessary in order to exercise the Reserved Functions;

People Committee Terms of Reference

1. Introduction

Constitution:

The People Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

Purpose:

The aims of the ICB are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The purpose of our People Committee is to support our Integrated Care System workforce of 50,000 people through our integrated care board team of 500 people and Partners in order to deliver and maintain the wellbeing of our 1,000,000 citizens in Bristol, North Somerset and South Gloucestershire.

To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy and delivery of the ICS People Strategy and Plan and the People Strategy and Plan for the ICB specifically.

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Committee has a dual purpose, as its role pertains both to ICS organisations across the system and specifically to the ICB employed staff.

ICS System-wide vision and purpose:

Our vision for every single person within our 50,000 to feel safe, valued and supported in their roles and responsibilities to successfully improve the health and wellbeing of our 1,000,000 citizens.

Oversee governance and resourcing of system and national workforce priorities and including the 10 People Requirements of an ICB and the People Promise and provide assurance of delivery against agreed Workforce Priorities through the People Steering Group

ICB Organisational vision and purpose:
Our vision is for every member of our 500 people to feel supported, empowered and motivated to improve the health and wellbeing of our 1,000,000 citizens.

Ensure that there is appropriate alignment between the ICS and priorities and those of the ICB pertaining to staff employed by the ICB, including:

- a relevant and robust ICB people strategy and plan which aligns with the ICS priorities
- the ICB's culture, inclusion and talent management approaches are targeted and monitored appropriately and that the ICB is "Well Led"

The Board may delegate further functions to the Committee as required

2. Delegated Authority

The People Committee is authorised by the Board to:

- Deliver its purpose as set out in these terms of reference
- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create sub-groups in order to take forward specific programmes of work as considered necessary by the Committee members. The Committee shall determine the membership and terms of reference of any such sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD). The committee may not delegate any of its accountabilities to such sub-groups.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the SoRD will prevail over these terms of reference other than the committee being permitted to meet in private.

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including one who is a Non-Executive Member of the ICB Board. Other members of the Committee need not be members of the Board, but they may be.

Chair and Vice Chair:
In accordance with the constitution, the Committee will be chaired by Non-Executive Member of the ICB appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee. Committee members may appoint a Vice Chair from amongst the Non-Executive Member, partners or system NED members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees:
Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by individuals “in attendance” who are not members of the Committee for all or part of a meeting as and when appropriate.
The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers

4. The members of the People Committee are:

The membership of the Committee shall comprise membership which may include

a. ICS system wide:

- Non-Executive Member of the ICB (chair)
- ICB Chief People Officer
- ICB Chief Medical Officer
- ICB Chief Nursing Officer
- Chair of People Committee* UHBW
- Chair of People Committee* NBT
- Chair of People Committee* Sirona
- Chair of People Committee* AWPPrimary Care Representative
- ICB Local Authority Partner
- Chair of People Steering Group

b. ICB Organisation:

- Non-Executive Member of the ICB (chair)
- ICB Chief People Officer

- Executive directors of the ICB

5. In attendance

a. ICS system wide:

- ICS People Programme SROs
- People Programme Officers as required.

b. ICB Organisation:

- HR and Inclusion Officers as required.

6. Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

7. Quoracy

For a meeting to be quorate a minimum of two people are required from the following: Non-Executive Members, ICB partners members or provider People Committee chairs members. One attendee must be the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting:

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

8. Frequency of meetings

The Committee will meet in private.

The Committee will meet alternate months for each of the two components, a. ICS system wide, and b. ICB organisation, and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Remit and Responsibilities

The Committee's duties are as follows:

ICS system-wide:

- Develop and recommend to the ICB Board the ICS People Strategy and Plan and monitor its implementation across the system.
- Agreement of the formal governance and accountability arrangements for people and workforce functions in the ICS, including appointing senior responsible officers (SROs).
- Ensure there is appropriate trade union and staff engagement with the ICS People Programme
- Oversight of how and where specific people responsibilities are delivered and funded within the ICS and hold providers and SROs to account for delivery on agreed priorities
- Assuring the delivery of the 10 People Functions of an ICS which may change but currently include:
    1) Supporting the health and wellbeing of all staff
    2) Growing the workforce for the future
    3) Supporting inclusion and belonging for all
    4) Supporting leadership at all levels
    5) Educating, training and developing people, and managing talent
    6) Leading workforce transformation and new ways of working
    7) Driving and supporting broader social and economic development
    8) Transforming people Services
    9) Leading coordinated workforce planning
    10) Supporting system design and development

- Oversee the assessment of the ICS's readiness, capacity, and capability to deliver the people function.
- Oversee the ICS Leadership and Talent Board: accountable for the development and delivery of the ICS talent strategy.
- Ensure there is a clear understanding of the ICB and system strategic workforce priorities and that plans are in place to deliver these
- Provide assurance that legislative and regulatory requirements relating to workforce are understood and met.

- Challenge and scrutinise workforce risks, ensuring they are understood and mitigating actions are identified and implemented.
- Monitor key workforce metrics to ensure that the expected standards are being delivered;
- Provide assurance to the ICB Board on the ICBs' equalities and diversity strategy, and equality delivery systems.

ICB Organisation:

- Ensure that there is appropriate alignment between the ICS and priorities and those of the ICB pertaining to staff employed by the ICB, including:
  - Development of a relevant and robust people strategy and plan which aligns with the ICS priorities, and recommend that strategy to the ICB Board
  - Monitor the implementation of the ICB people strategy and plan
  - Ensure the ICB's culture, inclusion and talent management approaches are targeted and monitored appropriately and that the ICB is "Well Led"

10. Behaviours and Conduct

Benchmarking and guidance:
The Committee will take proper account of National guidance, best practice and appropriate benchmarking.

ICB values:
Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion:
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

11. Reporting Requirements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders

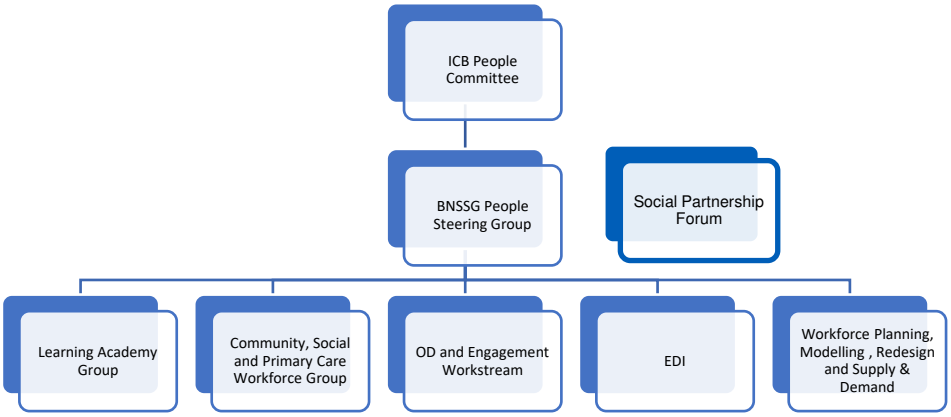
The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

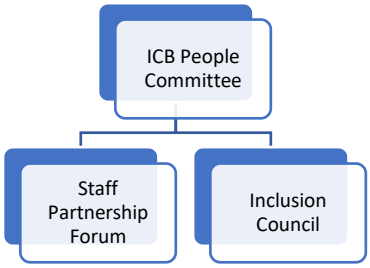
Accountability will be different for the elements of the People Committee pertaining to the ICS system wide and the ICB organisation

ICS System wide

Delivery will be through the People Steering Group which will be accountable to the People Committee.



ICB Organisation:



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Bristol, North Somerset and South Gloucestershire Integrated Care Board

Meeting of ICB Board

Date: 1 July 2022
Time: 9.30am
Location: MS Teams

Agenda Number :	4.5	
Title:	ICB Standing Financial Instructions	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No

Purpose: Decision – For Approval

Key Points for Discussion:

The Standing Financial Instructions (SFIs) are a core document which ICBs are required to have in place. The document has been developed in line with national guidance and with oversight from NHSEI as part of the oversight arrangements for ICBs' readiness to operate.

The SFIs form part of the Governance Handbook which will be published on the ICBs website.

Recommendations:	To approve the ICB Standing Financial Instructions
Previously Considered By and feedback:	The ICB Chair and CEO have been involved in the development of the SFIs. NHSEI have also reviewed the document.
Management of Declared Interest:	There are no actual or potential conflicts of interest related to the contents of this paper.
Risk and Assurance:	There is a risk to the organisation if SFIs are not agreed and in use. These SFIs are in-line with requirements and mitigate this risk.

Financial / Resource Implications:	There are no finance or other resources implications associated with the production of the SFIs. The SFIs set out arrangements for managing resources.
Legal, Policy and Regulatory Requirements:	The SFIs are in-line with good practice and designed to meet the ICBs statutory and mandatory requirements.
How does this reduce Health Inequalities:	N/A
How does this impact on Equality & diversity	N/A
Patient and Public Involvement:	There has been no wider public engagement in the development of the SFIs
Communications and Engagement:	The SFIs will be shared for use across the ICB through routine channels of communication which will mirror those in use in the CCG. These include the website, intranet, Have we Got News For You and other briefings, as well as the Voice.
Author(s):	Sarah Carr, Corporate Secretary Catherine Cookson, Associate Chief Finance Officer
Sponsoring Director / Board Member:	Sarah Truelove, Deputy CEO

Classification: Official

Publication approval reference:

BNSSG Integrated Care Board

Standing Financial Instructions

Version 1.0, 1 July 2022

Contents

1. Purpose and statutory framework

1.1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the integrated Care Board's (ICB) constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.

1.1.2 In accordance with the Act as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

1.1.3 The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently, and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.1.4 SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient, and economical services.

1.1.5 The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.1.6 Each ICB is established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

1.1.7 All members of the ICB (its board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all Officers on the intranet and internet website for each statutory body.

1.1.8 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the chief executive or the chief financial officer must be sought before acting.

1.1.9 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

2. Scope

2.1.1 All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes, permanent employees, secondees and contract workers.

2.1.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.1.3 Any reference to an enactment is a reference to that enactment as amended.

2.1.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

3.1 Staff

3.1.1 All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisations property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity, and value for money in the use of resources; and
- conforming to the requirements of these SFIs

3.2 Accountable Officer

3.2.1 The ICB constitution provides for the appointment of the chief executive by the ICB chair. The chief executive is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of ICBs allocated resources.

3.2.2 The chief financial officer reports directly to the ICB chief executive officer and is professionally accountable to the NHS England regional finance director

3.2.3 The chief executive will delegate to the chief financial officer the following responsibilities (see also section 4) in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)

- meets the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- the Governance statement and annual accounts & reports are signed;
- planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the chief financial officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit and risk assurance committee

3.3.1 The board and accountable officer should be supported by an audit and risk assurance committee, which should provide proactive support to the board in advising on:

- the management of key risks
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of the ICB;
- the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

3.3.2 In accordance with ICB Constitution the ICB Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook to perform the following tasks:

a. ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit, and Risk Committee, Chief Executive Officer and ICB Board;

b. reviewing the work and findings of the External Auditor appointed by the ICB and considering the implications of and management's responses to their work;

c. reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the organisation;

d. ensuring that the systems for financial reporting to the ICB Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the ICB Board;

e. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

f. reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

g. monitoring compliance with ICB Constitution, Standing Financial Instructions and Prime Financial Policies;

h. reviewing schedules of losses and compensations and making recommendations to the ICB Board;

i. reviewing schedules of assets and liabilities;

j. reviewing the annual report and annual financial statements prior to submission to the ICB Board focusing particularly on:

   - the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
   - changes in, and compliance with, accounting policies and practices;
   - unadjusted mis-statements in the financial statements;
   - major judgmental areas;
   - significant adjustments resulting from audit.

k. reviewing the annual financial statements and recommend their approval to the ICB Board;

l. reviewing the External Auditors' report on the financial statements and the annual management letter;

m. conducting a review of the ICB's major accounting policies;

n. reviewing any incident of fraud or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the ICB's published financial accounts or reputation;

o. reviewing any objectives and effectiveness of the internal audit services including its working relationship with External Auditors;

p. reviewing major findings from internal and External Audit reports and ensure appropriate action is taken;

q. reviewing 'value for money' audits reporting on the effectiveness and efficiency of the selected departments or activities;

r. reviewing the mechanisms and levels of authority (e.g. ICB Constitution, Standing Financial Instructions, Delegated limits) and make recommendations to the ICB Board;

s. reviewing the scope of both internal and External Audit including the agreement on the number of audits per year for approval by the ICB delegated Board;

t. investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation;

u. reviewing waivers to ICB Constitution;

v. reviewing hospitality and sponsorship registers;

w. reviewing the information prepared to support the Annual Governance Statement prepared on behalf of the ICB Board and advising the ICB Board accordingly

x. establish an auditor panel as a sub group of the Audit and Risk Committee to ensure the contract arrangements, including the procurement and selection, with the External Auditors is appropriate

3.3.3 The minutes of the Audit and Risk Committee meetings shall be formally recorded by the ICB Corporate Secretary and submitted to the ICB Board. The Chair of the Committee shall draw to the attention of the ICB Board any issues that require disclosure to the full ICB Board, or require executive action. The Committee will report to the ICB Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation and the integration of governance arrangements.

3.3.4 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit and Risk Committee should raise the matter at a full meeting of the ICB Board. Exceptionally, the matter may need to be referred to the Department of Health.

3.4 Strategic Finance, Estates and Digital committee

3.4.1 The Strategic Finance, Estates and Digital Committee is accountable to the ICB Board. The ICB Board shall approve and keep under review the terms of reference for the Finance, Estates and Digital Committee, including information on the membership of the Finance, Estates and Digital Committee. The chair of the Finance, Estates and Digital Committee will be an Independent Non-Executive Member.

3.4.2 The Finance, Estates and Digital Committee shall support the ICB Board through its purpose;

To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial strategy and operational plan. This includes:

- financial performance of the ICB
- financial performance of NHS organisations within the ICB footprint

Providing financial advice to the Integrated Care System Partnership Board to enable the development of a financially sustainable Strategy

Develop financial strategy and plan for the ICB with due regard for the Strategy of the Integrated Care System Partnership Board and associated Health & Wellbeing Boards

3.4.3 The ICB Board has delegated authority to the Finance Committee as described in the Reservation and Delegation Scheme:

1. Strategy and Planning
    - Recommend annual, medium-term and Long-Term financial plans to the ICB Board.
    - Recommend the approach for resource allocation to the ICB Board

2. Regulation and Control
   - Prepare Standing Financial Instructions (SFIs)
   - Oversight of procurement exercises with an estimated value over the contract life cycle of £1 million and make recommendations to the ICB Board

4. Annual reporting and accounts

4.1 Reporting

4.1.1 The chief financial officer will ensure, on behalf of the Accountable Officer and ICB board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;

4.1.2 An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
- review any steps that the board has taken to implement any joint local health and wellbeing strategy.

4.1.3 NHS England may give directions to the ICB as to the form and content of an annual report.

4.1.4 The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

4.2 Internal audit

The chief executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the chief financial officer to ensure that:

- all internal audit services provided under arrangements proposed by the chief financial officer are approved by the Audit and Risk Assurance Committee, on behalf of the ICB board;

- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);

- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, audit and risk assurance committee and board;

- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;

- the head of internal audit should attend audit and risk assurance committee meetings and have a right of access to all audit and risk assurance committee members, the Chair and chief executive of the ICB.

- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

4.3 External audit

The chief financial officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;

- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and

- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

5. Financial systems and processes

5.1 Provision of finance systems

5.1.1 The chief financial officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

5.1.2 The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

5.1.3 As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE"). This is the required accounting system for use by ICBs, Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

5.1.4 The Chief Financial officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice e.g. e-invoicing
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;

- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;

- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and

- where another health organisation or any other agency provides a computer service for financial applications, the chief finance officer shall periodically seek assurances that adequate controls are in operation.

6. Planning, Budgets and Budgetary Control

6.1 Planning

6.1.1 Prior to the start of the financial year the Chief Finance Officer, on behalf of the Accountable Officer, will prepare an Annual Plan for approval by the ICB Board and NHSEI.

6.1.2 The annual plan will be developed in line with the ICS's Medium Term plan and the NHS Long term plan objectives and will:

a. be in accordance with the aims and objectives set out in the ICB's strategy;

b. ensure the achievement of the ICB statutory duty to breakeven, within the ICS's duty to breakeven

c. accord with workload and manpower plans;

d. be prepared within the limits of available funds;

e. identify potential risks

6.1.3 The approved annual plan will be the basis for setting the detailed budget plan and delegated budgets to approved budget holders.

6.1.4 The Chief Finance Officer will ensure that financial performance is monitored against budget and plan and communicated to appropriate Boards and Committees

6.1.5 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

6.2 Budgetary control and reporting

6.2.1 The chief financial officer is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

6.2.2 The chief financial officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

6.2.3 The chief financial officer will ensure:

- the promotion of compliance to the SFIs through a financial governance framework;
- the promotion of long term financial heath for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long term plan objectives.

6.2.4 In addition, the chief financial officer should have financial leadership responsibility for the following statutory duties:

- that of the ICB, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year;
    - local capital resource use does not exceed the limit specified in a direction by NHS England;
    - local revenue resource use does not exceed the limit specified in a direction by NHS England;
- the duty of the ICB to perform its functions as to secure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

6.2.5 The chief financial officer and *any senior officer responsible* for finance within the ICB should also promote a culture where budget holders and decision makers consult their heads of finance in key strategic decisions that carry a financial impact.

6.3 Budget holder responsibilities

6.3.1 Each Budget Holder is responsible for ensuring that:

a. they sign off their budget, as approved through the approved annual plan, at the start of the year and provide accurate forecasts of out-turn during the course of the year;

b. any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board and to provide full variance analysis from budgeted plan and corrective actions;

c. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

d. no permanent employees are appointed without the approval of the Chief Executive Officer other than those provided for within the available resources and manpower establishment as approved by the Board;

e. they participate in finance training to develop the skills and knowledge necessary to discharge their financial management duties;

f. they use the ICB's finance systems as required;

g. where matters of financial control risk are identified, they are communicated to the Finance Team as a matter of urgency;

h. they are accountable for their budgets and financial performance, even where contracts are negotiated on behalf of the ICB by another institution;

i. they take responsibility for ensuring that new members of staff are paid the correct salary and for making sure that final payments to and from employees are correct;

j. ensuring that the prices paid for goods are correct, represent value for money, that procedures are followed to prevent fraud and that all invoices are appropriately authorised and that the goods and services received are correct;

k. aware of the ICB's medium term plan and the impact of in year commitments on future years' planning assumptions.

l. they are available to work with the auditors and respond to questions or recommendations

6.3.2 The Executive Team is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

6.4 Virement

6.4.1 Virements cover all budget transfers carried out in the financial year apart from those enacting the Annual Plan

6.4.2 Delegated limits for virement are

a. NHS England for the whole ICB unlimited value: this includes all allocation changes consequent budget changes and any change required to meet Integrated Single Financial Environment (ISFE) reporting requirements;

b. Board for the whole ICB unlimited value: this includes Annual Operating Plan and any business cases/proposals agreed by the Board;

c. Chief Executive Officer and Chief Financial Officer for the whole ICB to a value over £500k and below £1 million: includes any committee that approves expenditure where the Chief Executive Officer or Chief Financial Officer or their appointed nominee is present;

d. Chief Financial Officer for the whole ICB to a value below £500k includes any committee that approves expenditure where the Chief Financial Officer or their appointed nominee is present;

e. Director for their directorate to a value of up to £250k;

f. Assistant Director for their directorate to a value of up to £25k;

g. Budget Holder for their service up to a value of £10k.

6.4.3 Approval in line with the delegated limits will be evidenced through email from appropriate budget holder or meeting minutes. Evidence of NHS England directed changes will be in the form of allocation reconciliation, email directing the change or guidance published by NHSEI.

6.4.4 All budget journals will be signed by the Chief Financial Officers nominated deputy.

6.4.5 Finance will make the following technical adjustments as they become necessary:

a. Contract value adjustments

b. Corrections

c. Phasing

d. Reallocation of unused budgets back to reserves

6.5 Reserves

6.5.1 Reserves cover all expenditure budgets not currently allocated to a budget holder and are held centrally.:

6.6 Capital expenditure

6.6.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

6.7 Monitoring returns

6.7.1 The Chief Executive Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the ICB's designated external regulators.

7. Income, banking arrangements and debt recovery

7.1 Income

7.1.1 An ICB has power to do anything specified in section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

7.1.2 The chief financial officer is responsible for:

- ensuring order to bank practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the Shared Services provider; and

- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks;

7.1.3 With regard to fees and charges the ICB shall follow the Department of Health's advice in the Costing Manual in setting prices for NHS service agreements

7.1.4 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.1.5 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions

7.2 Banking

7.2.1 The CFO is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

7.2.2 The chief financial officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and

- the ICB has effective cash management policies and procedures in place.

7.3 Debt management

7.3.1 The chief financial officer is responsible for the ICB debt management strategy.

7.3.2 This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;

- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the ICB board every 12 months to ensure relevance and provide assurance;

- accountability to the ICB board that debt is being managed effectively;

- accountabilities and responsibilities are defined with regards to debt management to budget holders; and

- responsibility to appoint a senior officer responsible for day to day management of debt.

7.4 Security of cash

7.4.1 The chief financial officer is responsible for:

a. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b. ordering and securely controlling any such stationery;

c. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d. prescribing systems and procedures for handling cash and negotiable securities on behalf of the ICB.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

7.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the ICB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the ICB from responsibility for any loss.

8. Procurement and purchasing

8.1 Principles

8.1.1 The chief financial officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

8.1.2 The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.

8.1.3 The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

8.1.4 The ICB must have a Procurement Policy which sets out all of the legislative requirements.

8.1.5 All revenue and non-pay expenditure must be approved, in accordance with the ICB business case policy, prior to an agreement being made with a third party that enters a commitment to future expenditure.

8.1.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

8.1.7 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

8.1.8 The ICB shall undertake any contract variations or extensions in accordance with PCR 2015 and the ICB procurement policy.

8.1.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the audit and risk assurance committee.

8.1.10 The ICB will consider obtaining expert support as appropriate to ensure compliance when engaging in tendering procedures

8.2 Authorisation to tender and seek competitive quotations

8.2.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with formal authorisation of tenders and competitive quotations may be given by the following staff to the total value of (contract life cycle inc VAT):

- Designated Budget Holders up to £50k
- Directors up to £500k
- Chief Finance Officer or Chief Executive Officer up to £1m
- ICB Board over £1m

8.3 Formal competitive tendering

8.3.1 General Applicability

Subject always to paragraph 9.2 above, the ICB shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health);
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals

8.3.2 Health Care Services

Where the ICB elects to invite tenders for the supply of healthcare services the ICB Constitution and these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure

8.3.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

a. the estimated expenditure or income does not, or is not reasonably expected to, exceed £50K (contract life cycle); or

b. where the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with;

c. regarding disposals as set out in Standing Financial Instructions No. 8.6

- Formal tendering procedures may be waived in the following circumstances:

d. in very exceptional circumstances where the Chief Executive Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record;

e. where the requirement is covered by an existing contract;

f. where the Cabinet Office framework agreements are in place and have been approved by the ICB Board;

g. where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

h. where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender;

i. where specialist expertise is required and is available from only one source;

j. when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

k. there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

l. for the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

m. where allowed and provided for in the Capital Investment Manual;

8.3.4 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

8.3.5 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB record and reported to the Audit, Governance and Risk Committee at each meeting.

8.3.6 Fair and Adequate Competition. Where the exceptions set out in SFI No. 8.3.3 apply, the ICB shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.3.7 List of Approved Firms The ICB shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on appropriate frameworks or that are otherwise confirmed as qualified. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive Officer.

8.3.8 Items which subsequently breach thresholds after original approval. Items estimated to be below the limits set in these SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive Officer, and be recorded in an appropriate ICB record.

8.4 Quotations: Competitive and non-competitive

8.4.1 General Position on Quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5k but not exceed £50k over the life time of the contract.

8.4.2 Competitive Quotations

a. Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the ICB;

b. Quotations should be in writing unless the Chief Executive Officer or his/her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

c. All quotations should be treated as confidential and should be retained for inspection.

d. The Chief Executive Officer or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the ICB, or the highest if payment is to be received by the ICB, then the choice made and the reasons why should be recorded in a permanent record.

8.4.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

a. the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the Responsible Officer, possible or desirable to obtain competitive quotations;

b. the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

c. miscellaneous services, supplies and disposals;

e. where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

8.4.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive Officer or Chief Finance Officer.

8.5 Where formal competitive tendering/quotation is not required

8.5.1 Where a competitive tendering or a competitive quotation is below the limits set out in these Standing Financial Instructions, the ICB should adopt one of the following alternatives:

a. the ICB shall use the NHS Supply Chain, Cabinet Office contracts or frameworks for procurement of all goods and services unless the Chief Executive Officer or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.
b. if the ICB does not use the NHS Supply Chain, Cabinet Office contracts or frameworks for procurement - where tenders or quotations are not required, because the life cycle expenditure is below £50,000, the ICB shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

8.6 Disposals (cross reference to SFI 13.2)

8.6.1 Where Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a. any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive Officer or their nominated officer;

b. obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the ICB;

c. items to be disposed of with an estimated sale value of less than £1K, this figure to be reviewed on a periodic basis;

d. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

e. land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance.

8.7 Personnel, agency, or temporary staff contracts

8.7.1 The Chief Executive Officer shall ensure compliance with instructions issued by Department of Health and NHS England. The Chief Executive Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. Where a role is as a ICB Board Member or senior official, these must be in line with the 2012 HMT Review of Tax Arrangements for Public Sector Appointees, the HMT guidance "Managing Public Money" instructions from the Department of Health for the reimbursement of ICB Board members and senior officials, and the ICB Constitution.

8.8 Authorisation of contracts

8.8.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with formal authorisation and awarding of a contract may be decided by the following staff within +/- 10 percent of the authorised tender value as follows (contract life cycle inc VAT):

- Designated Budget Holders up to £50k
- Directors up to £500k
- Chief Executive Officer or Chief Finance Officer up to £1m
- ICB Board over £1m

8.8.2 All tenders that will, or are forecast to, exceed the budget of that tender or the designated budget holder shall be escalated to the next level up. Where the actual contract value is greater than +/- 10 percent of the authorised tender value authorisation limits are as follows (contract life cycle inc VAT):

- Designated Budget Holders up to £50k
- Directors up to £500k
- Chief Executive Officer or Chief Finance Officer up to £1m
- ICB Board over £1m

8.8.3 Two signatures are required for contracts. These are:

- Two designated budget holders up to £50k
- Two Directors up to £500k

8.8.4 Contracts over £500k (contract life cycle inc VAT) must be signed by the Chief Executive Officer or the Chief Finance Officer or their nominated deputies. Formal authorisation must be put in writing.

8.8.5 In the case of authorisation by the ICB Board this shall be recorded in their minutes.

8.9 Compliance requirements for all contracts

8.9.1 The Board may only enter into contracts on behalf of the ICB within the statutory powers delegated to it by the Secretary of State and shall comply with:

a. the ICB's Constitution and Standing Financial Instructions;

b. Directives and other statutory provisions, so long as they continue to apply as a matter of law;

c. such of the NHS Standard Contract Conditions as are applicable;

d. Care Quality Commission guidance;

e. contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

f. where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;

g. in all contracts made by the ICB, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive Officer shall nominate an officer who shall oversee and manage each contract on behalf of the ICB.

8.10 Healthcare Service Agreements (cross reference with SFI 8.3.2)

8.10.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with current legislation and guidance and administered by the ICB. Service agreements are not contracts in law and are not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law

8.10.2 The Chief Executive Officer shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

9. Contracting/Tendering Procedure

9.1 Invitation to tender

9.1.1 Where e-tendering is not used, all invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

9.1.2 All invitations to tender shall state that no tender will be accepted unless:

- submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the ICB (or the word "tender" followed by the subject to which it related) and by the latest date and time for the receipt of such tender addressed to the Chief Executive Officer or nominated Manager;

- that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer;

- where an e-tendering software package is used the supplier's response will be completed on-line and uploaded into a secure electronic mailbox until the opening time.

9.1.3 Every tender for goods, materials, services or disposals shall embody such elements of the NHS Standard Contract Conditions as are applicable

9.1.4 Every tender must have given, or give a written undertaking, not to engage in collusive tendering or other restrictive practices.

9.2 Receipt and safe custody of tenders

9.2.1 The Chief Executive Officer or his/her nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening

9.2.2 The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

9.2.3 An audit log within the e-tendering system will record the date and time the offer documents are received.

9.3 Opening tenders and register of tenders

9.3.1 Where e-tendering is not used:

a. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive Officer and not from the originating department.

b. A member of the ICB Board will be required to be one of the two approved persons present for the opening of tenders estimated above £500k (contract life cycle). The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the ICB's Scheme of Delegation.

c. The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

d. The involvement of Finance staff in the preparation of a tender proposal will not preclude the Chief Finance Officer or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

e. Executive Team will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

f. The ICB's Company Secretary or equivalent role will count as a Director for the purposes of opening tenders.

g. Every tender received shall be marked with the date of opening and initialled by those present at the opening. Where an electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening.

h. A register shall be maintained by the Chief Executive Officer, or a person authorised by them, to show for each set of competitive tender invitations dispatched:

- the name of all firms or individuals invited;
- the names of firms or individuals from which tenders have been received;
- the date the tenders were received and opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender and suitably initialled.

Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be easily read or understood.

i. Incomplete tenders, i.e., those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders (SFI No. 9.5 below).

9.4 Admissibility

9.4.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive Officer.

9.4.2 Where only one tender is sought and/or received, the Chief Executive Officer and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the ICB

9.5 Late tenders

9.5.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive Officer or his/her nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer

9.5.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive Officer or his/her nominated officer or if the process of evaluation and adjudication has not started

9.5.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive Officer or his/her nominated officer.

9.5.4 Accepted late tenders will be reported to the Board.

9.6 Acceptance of formal tenders

9.6.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his/her tender before the award of a contract will not disqualify the tender.

9.6.2 The lowest tender, if payment is to be made by the ICB, or the highest, if payment is to be received by the ICB, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- experience and qualifications of team members;
- understanding of client's needs;
- feasibility and credibility of proposed approach;
- ability to complete the project on time.

9.6.3 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

9.6.4 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB and which is not in accordance with these Instructions except with the authorisation of the Chief Executive Officer.

9.6.5 The use of these procedures must demonstrate that the award of the contract was:

- not in excess of the going market rate / price current at the time the contract was awarded;
- that best value for money was achieved.

9.6.6 All Tenders should be treated as confidential and should be retained for inspection.

9.7 Tender reports to the ICB Board

9.7.1 Reports to the ICB Board will be made on an exceptional circumstance basis only..

9.7.2 Operationally the CPO will be responsible for;

- defining and delivering the organisation's overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

10. Staff costs and staff related non pay expenditure

10.1 Remuneration and terms of service

10.1.1 In accordance with ICB Constitution the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report).

10.1.2 The Committee will operate within the scheme of delegation agreed and agreed terms of reference:

a. advise the Board about appropriate remuneration and terms of service for the Chief Executive Officer, other officer members and clinical leads employed by the ICB including:

   - all aspects of salary (including any performance-related elements/ bonuses);
   - provisions for other benefits, including pensions and cars;
   - arrangements for termination of employment and other contractual terms;

b. make such recommendations to the Board on the remuneration and terms of service of officer members of the Board and members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the ICB - having proper regard to the ICB's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

c. monitor and evaluate the performance of individual officer members and clinical members of the Board;

d. advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate

10.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

10.1.4 The Board will consider and need to approve proposals presented by the Chief Executive Officer for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

10.1.5 The ICB will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

10.2 Funded establishment

10.2.1 The staffing plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive Officer or his/her nominated deputy.

10.3 Staff appointments

10.3.1 No officer or Member of the ICB Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a. unless authorised to do so by the Chief Executive Officer; and

b. within the limit of their approved budget and funded establishment.

10.3.2 The Board will approve procedures presented by the Chief Executive Officer for the determination of commencing pay rates, condition of service, etc. for employees.

10.4 Processing payroll

10.4.1 The Chief Finance Officer is responsible for:

a. specifying timetables for submission of properly authorised time records and other notifications;

b. agreeing with HR policies for the final determination of pay;

c. making payment on agreed dates;

d. agreeing methods of payment;

10.4.2 The Chief Finance Officer will issue instructions regarding:

a. verification and documentation of data;

b. the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d. security and confidentiality of payroll information;

e. checks to be applied to completed payroll before and after payment;

f. authority to release payroll data under the provisions of the Data Protection Act;

g. methods of payment available to various categories of employee and officers;

h. procedures for payment by cheque, bank credit, or cash to employees and officers;

i. procedures for the recall of cheques and bank credits;

j. pay advances and their recovery including Salary Sacrifice;

k. maintenance of regular and independent reconciliation of pay control accounts;

l. separation of duties of preparing records and handling cash;

m. a system to ensure the recovery from those leaving the employment of the ICB of sums of money and property

10.4.3 Appropriately nominated managers have delegated responsibility for:

a. submitting time records, and other notifications in accordance with agreed timetables;

b. completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer including approval of expenses;

c. submitting termination forms in the prescribed format immediately upon knowing the effective date of an employees or officer’s resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately

10.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of employment

10.5.1 The Board shall delegate responsibility to an officer for:

a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b. dealing with variations to, or termination of, contracts of employment.

11. Non pay expenditure

11.1 Delegation of Authority

11.1.1 The ICB Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive Officer will determine the level of delegation to budget managers.

11.1.2 The Chief Executive Officer will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

11.1.3 The Chief Executive Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services in accordance with NHS England guidance.

11.2 Choice, Requestioning, Ordering, Receipt and Payment for Goods (see overlay with SFI 9)

11.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the ICB. In so doing, the advice of the ICB's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive Officer) shall be consulted.

11.2.2 System of Payment and Payment Verification

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Operational Scheme of Reservation and Delegation sets out levels of delegated authority for payment authorisation in the following instances:

a. Budget already approved by the ICB Board e.g. payments to NHS bodies arising from agreement of NHS Contracts.
b. Payments to NHS bodies where there is no contract in place.

11.2.3 The Chief Finance Officer will

a. prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

b. be responsible for the prompt payment of all properly authorised accounts and claims;

c. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

d. be responsible for ensuring a timetable and system for submission of accounts to the Audit and Risk Committee

e. be responsible for issuing instructions to employees regarding the handling and payment of accounts within the Finance Department.

f. be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 11.2.5 below.

11.2.4 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

a. all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

b. contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement, so long as they continue to apply as a matter of law;

c. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

d. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to the Chief Executive Officer or employees, other than:

   - isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
   - conventional hospitality, such as lunches in the course of working visits;

   This provision needs to be read in conjunction with Section 6 of the ICB Constitution and the principles outlined in the national guidance contained in HSG 93(5) “Standards of Business Conduct for NHS Staff”; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional

Conduct relating to hospitality/gifts from pharmaceutical/external industry; the Bribery Act 2010 and the relevant ICB policies.

e. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive Officer;

f. all goods, services, or works are ordered via the Oracle I-Procurement Purchase to Pay system or on an official order except works and services executed in accordance with a contract and purchases from petty cash or cash equivalent;

g. verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive Officer and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order".

h. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

- goods are not taken on trial or loan in circumstances that could commit the ICB to a future uncompetitive purchase;
- changes to the list of members/employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

i. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

j. petty cash records are maintained in a form as determined by the Chief Finance Officer.

11.2.5 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

a. the financial advantages outweigh the disadvantages. Prepayments will constitute payments made in advance for periods greater than one month.

b. the appropriate officer member of the ICB must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the ICB if the supplier is at some time during the course of the prepayment agreement unable to meet its commitments;

c. the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules, so long as they continue to apply as a matter of law, where the contract is above a stipulated financial threshold);

d. the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive Officer if problems are encountered.

The finance team will assess all prepayments and take a judgement on monthly adjustments based on a de minimis value of £100k.

11.2.6 Official Orders

Official orders must be made via the Oracle I-Procurement Purchase to Pay system. Where paper-based ordering systems are retained, they must:

- be consecutively numbered;
- be in a form approved by the Chief Finance Officer;
- state the ICB's terms and conditions of trade;
- only be issued to, and used by, those duly authorised by the Chief Executive Officer.

11.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

11.3.1 Payments to local authorities and voluntary organisations made under the powers of section 75 or 256, as appropriate, of the NHS Act 2006 as amended shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with that Act.

12. Capital Investments, security of assets and Grants

12.1 Capital investment

12.1.1 The chief financial officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the chief financial officer is responsible for ensuring there are processes in place to ensure that a business case is produced.
- the accountability of ICB property assets and for managing property.

12.1.2 The ICB shall ensure there is a property governance and management framework, which

- confirms the ICB asset portfolio supports its business objectives; and
- complies with NHS England policies and directives and with this standard

12.1.3 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant;
- authority to enter into leasing arrangements.

12.1.4 Advice should be sought from the chief financial officer or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

12.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with approval of capital schemes may be given by the following staff to the total value of (contract life cycle inc VAT):

- a capital value up to £500k will require sign off by the Chief Finance Officer.
- a capital value between £500k and £5m (contract life cycle inc VAT) will require sign off by the Chief Executive Officer and the Chief Finance Officer.
- All schemes with a capital value of greater than £5m will require sign off by the Board.

12.1.6 Advice should be sought from the chief financial officer or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

12.1.7 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money. (see overlap with SFI 13.2)

12.2 Asset registers

12.2.1 The Chief Executive Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year

12.2.2 The ICB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health.

12.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b. stores, requisitions and wages records for own materials and labour including appropriate overheads;

c. lease agreements in respect of assets held under a finance lease and capitalised.

12.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.2.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.2.6 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual issued by the Department of Health.

12.3 Security of assets

12.3.1 The overall control of fixed assets is the responsibility of the Chief Executive Officer.

12.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

a. recording managerial responsibility for each asset;

b. identification of additions and disposals;

c. identification of all repairs and maintenance expenses;

d. physical security of assets;

e. periodic verification of the existence of, condition of, and title to, assets recorded;

f. identification and reporting of all costs associated with the retention of an asset;

g. reporting

12.3.3 . All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

12.3.4 Whilst each employee and officer has a responsibility for the security of property of the ICB, it is the responsibility of the Board and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

12.3.5 Whilst each employee and officer has a responsibility for the security of property of the ICB, it is the responsibility of the Board and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

12.3.6 Any damage to the ICB's premises and equipment, or any loss of equipment, stores or supplies must be reported by Board and employees in accordance with the procedure for reporting losses.

12.3.7 Where practical, assets should be marked as ICB property.

12.4 Grants

12.4.1 The chief financial officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a Local Authority or voluntary organisation, by way of a grant or loan.

13. Losses, special payments and disposals

13.1 Losses and Special Payments

13.1.1 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

13.1.2 The chief financial officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

13.1.3 The ICB must act in accordance with the guidance and delegated limits in relation to losses and special payments, as set out in NHSEI guidance.

13.1.4 NHS England has the statutory power to require an integrated care board to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

13.1.5 As part of the new compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments) that have been agreed and/or made during the year;
- that NHS England and HMT approvals have been obtained before any offers, whether verbally or in writing, are made; and
- adherence to the special severance payments guidance as published by NHS England.

13.1.6 All losses and special payments (including special severance payments) must be reported to the ICB Audit and Risk Assurance Committee and NHS England noting that ICBs do not have a delegated limit to approve losses or special payments.

13.1.7 For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide.

13.1.8 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Chief Executive Officer and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive Officer. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS and Operational Fraud Team (OFT) in accordance with Secretary of State for Health and Social Care's Directions.

13.2 Disposals

13.2.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

13.2.2 When it is decided to dispose of a ICB asset, the Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

13.2.3 All unserviceable articles shall be:

a. condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

b. recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

13.2.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

13.2.5 All property or land disposals will require approval by the ICB Board

14. Fraud, bribery and corruption (Economic crime)

14.1 Overview

14.1.1 The ICB is committed to identifying, investigating and preventing economic crime

14.1.2 The ICB chief financial officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the board and audit committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the board. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.

14.2 Suspected fraud

14.2.1 The Chief Finance Officer must notify the NHS CFS and the External Auditor of all frauds

14.2.2 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

a. the Board, and

b. the External Auditor.

14.2.3 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

14.2.4 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the ICB's interests in bankruptcies and company liquidations.

14.2.5 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

14.2.6 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.7 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

14.2.8 All losses and special payments must be reported to the Audit, Governance and Risk Committee at every meeting.

14.3 Recovery of fraud losses

14.3.1 Initially, recovery of any losses arising from fraudulent activity are followed up by Shared Business Services (SBS) using their recovery policy. Recoveries would be reported to the Local Counter Fraud Specialist (LCFS) to be recorded on the national NHS Protect investigation management system and included in the LCFS annual report to Audit, Governance and Risk Committee

15. Digital

15.1 Responsibilities and duties of the Chief Finance Officer

15.1.1 The Chief Finance Officer is responsible for the accuracy and security of the computerised financial data of the ICB whether this is 'in house' or hosted in an outsourced arrangement, and shall:

a. devise and implement any necessary procedures to ensure reasonable protection of the ICB's data, programs and computer hardware for which the Chief Finance Officer is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

b. ensure that reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider

15.1.2 The Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

15.1.3 The Corporate Secretary or equivalent role shall publish and maintain a Freedom of Information (FOI) Publication Scheme or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the ICB that are made publicly available.

15.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

15.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of ICBs in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer:

a. details of the outline design of the system including Information Governance considerations;

b. in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.3 Contracts for digital services with other health bodies or outside agencies

15.3.1 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

15.4 Requirements for computer systems which have an impact on corporate financial systems

15.4.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

a. systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c. only relevant staff have access to such data;

d. such computer audit reviews as are considered necessary are being carried out:

16. Acceptance of Gifts

16.1 Overview

16.1.1 The Chief Finance Officer shall ensure that all staff are made aware of the ICB policy on acceptance of gifts and other benefits in kind by staff which will be in line with the Bribery Act 2010. This policy follows the guidance contained in the NHS England Policy for Managing Conflicts of Interest 2017; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry and is also deemed to be an integral part of these ICB Constitution and Standing Financial Instructions.

16.1.2 Further details can be found in the Code of Business Conduct and the ICB Constitution.

17. Retention of records

17.1 Overview

17.1.1 The Chief Executive Officer shall be responsible for maintaining archives for all records required to be retained in accordance with “Records Management Code of Practice for Health and Social care 2016.

17.1.2 The records held in archives shall be capable of retrieval by authorised persons.

17.1.3 Records held in accordance with NHS Code of Practice - Records Management 2006, shall only be destroyed at the express instigation of the Chief Executive Officer. Detail shall be maintained of records so destroyed.

18. Risk Management, legal and insurance

18.1 Risk management

18.1.1 The Chief Executive Officer shall ensure that the ICB has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board. The programme of risk management shall include:

a. process for identifying and quantifying risks and potential liabilities;

b. engendering among all levels of staff a positive attitude towards the control of risk;

c. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d. contingency plans to offset the impact of adverse events;

e. audit arrangements including; internal audit, clinical audit, health and safety review;

f. a clear indication of which risks shall be insured;

g. arrangements to review the risk management programme.

18.1.2 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by current Department of Health guidance.

18.2 Legal

18.2.1 This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors;
- approval and signing of documents which will be necessary in legal proceedings; and
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

18.2.2 For claims assessed as under the value of £50k the corporate secretary will approve defence documents and or offers of settlement in line with legal advice and NHS R advice.

18.2.3 For claims assessed as over the value of £500k up to £1 million the Chief Financial Officer or Chief Executive Officer will approve defence documents and or offers of settlement in line with legal advice and NHSR advice.

18.2.4 For claims assessed as over the value of £1 million the Chief Executive Officer, Chief Financial Officer and with the advice of the Chair of Audit, Governance and Risk will approve defence documents and or offers of settlement in line with legal advice and NHSR advice.

18.3 Insurance

18.3.1 The ICB Board shall decide if the ICB will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the ICB Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

18.3.2 ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the accountable officer. However, the exceptions when ICBs may enter into insurance arrangements are;

a. insuring motor vehicles owned by the ICB including insuring third party liability arising from their use;

b. where the ICB is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

c. where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the ICB for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning a ICB's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

18.3.3 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

18.3.4 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

18.3.5 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Bristol, North Somerset and South Gloucestershire Integrated Care Board

Meeting of ICB Board

Date: 1 July 2022
Time: 9.30am
Location: MS Teams

Agenda Number :	4.6	
Title:	ICB Core Policies	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No

Purpose: Decision

Key Points for Discussion:

The ICB, like its predecessor organisation, the CCG, is required to have policies in place to support the good governance of the organisation. CCG Policies have been used to develop the suite of policies for adoption by the ICB. Some have been revised specifically for the ICB and are itemised for agreement and appended to this paper. Others, including some that are required by legislation eg Disciplinary, Grievance and Appeal, are recommended for adoption by the ICB

Policies can be split into two categories – commissioning and corporate. This paper covers both. Information has been drawn from the CCG's policy register.

This document identifies policies for approval by the ICB – see recommendations below. It also sets out initial arrangements for the management of policies going forward in the ICB. These are subject to change as the organisation develops. This will involve a continuation of the Corporate Policy Review Group and the use of the Policy Framework, previously agreed through the CCG's audit committee. This will require revision to recognise the difference in the committees of the CCG and those in the ICB.

NB The Standing Financial Instructions, another core ICB policy, is presented to this board meeting for agreement under separate agenda item

Recommendations:	The ICB Board is asked to 1. Agree the ICB Conflict of Interest Policy 2. Agree the ICB Gifts and Hospitality Policy 3. Agree the Risk Management Framework

	4. Agree the adoption of CCG policies, noting that changes will be made in line with review arrangements to include ICB branding.
Previously Considered By and feedback :	The CCG Executive Team agreed the proposal for the transfer of policies which was developed through the Transition Programme. The ICB Chair and CEO have been involved in the development of policies presented to this board for agreement.
Management of Declared Interest:	There are no actual or potential conflicts of interest related to the contents of this paper. The Conflicts of Interest Policy sets out arrangements for the management of any conflicts.
Risk and Assurance:	There is a risk to the organisation if policies are not agreed and communicated for use.
Financial / Resource Implications:	There are no finance or other resource implications associated with the production of these policies.
Legal, Policy and Regulatory Requirements:	The ICB is required to have policies in place and the requirements are covered by the agreement of the recommendations. Policies have been developed in line with national or legal requirements.
How does this reduce Health Inequalities:	As part of policy development individual Equality Impact Assessment have been conducted. This has been a routine requirement in the CCG and will continue in the ICB.
How does this impact on Equality & diversity	As part of policy development individual Equality Impact Assessment have been conducted. This has been a routine requirement in the CCG and will continue in the ICB.
Patient and Public Involvement:	There has been no public engagement in the development of this paper.
Communications and Engagement:	Policies will be shared for use across the ICB through routine channels of communication which will mirror those in use in the CCG. These include the website, intranet, Have we Got News For You and other briefings, as well as the Voice. Some policies will be published on the ICB website in line with requirements.
Author(s):	Rob Hayday, Associate Director of Corporate Services
Sponsoring Director / Board Member:	Julie Bacon, Interim Director of People and Transition Sarah Truelove, Deputy CEO

Agenda item: 4.6
Report title: Core Policies

1. Background

In the CCG, a range of policies existed which can be broken down into two broad categories – Commissioning Policies and Corporate Policies. Policies are developed and approved through a number of routes in the CCG in line with the Policy Framework agreed through the Audit Committee. As part of the Transition Programme and associated documents like the Readiness to Operate Statement and the Due Diligence Checklist, the ICB is required to have its own policies and work has been undertaken to ensure that this happens. In the main, this will be a lift and shift arrangement pending future revisions as the ICB develops.

2. Policies which support the ICB Governance Handbook requirements

Alongside the ICB's constitution is the requirement for a Governance Handbook. This is available on the ICB website and has been developed. Once agreed, the following policies will be linked to the Governance handbook:
ICB Conflict of Interest Policy – annex A
ICB Gifts and Hospitality Policy – Annex B
ICB Risk Management Framework
The ICB is required to have these policies and they have been developed through the Transition Programme. Through its oversight of the transition arrangements, NHSEI have had involvement in policy development. These items are presented for agreement by the ICB Board. Items 1 and 2 address the requirement for the ICB to have a Standards of Business Conduct policy.

Other policies associated with Information Governance and Individual Rights will be lifted from CCG corporate polices, rebranded and included in the ICB Governance handbook.

3. ICB Commissioning Policies

These policies govern the provision of treatment for patients and are developed and maintained in the Medical Directorate. This suite of policies is presented in list form with the recommendation that they are adopted by the ICB and are rebranded in due course. – please refer to Annex D

4. ICB Corporate Policies

Corporate Services maintains a register of corporate policies which govern other areas of ICB operation. This includes HR policies which will transfer to the ICB as part of the TUPE transfer of staff from the CCG. For most staff that have TUPE transferred to the ICB most CCG HR policies are not contractual, the ICB may subsequently revise these. However, it should be noted that there are some legacy HR polices relating to TUPE arrangements which are deemed contractual for a few staff. As part of any review arrangements to harmonise policies, consideration will be

given to how to address any legacy requirements. As with all HR policy development, the Staff Partnership Forum (which is to be established in the ICB) will be involved. Some HR policies are required by employment legislation and include: Disciplinary, Grievance and Appeal.

Other corporate policies cover Information Governance and IT requirements and support the organisation's obligations to submit an annual Data Security Protection Toolkit and respond to Freedom of Information Requests and Subject Access Requests.

Please refer to Annex D for list of corporate and commissioning policies.

5. Policy Framework and the Corporate Policy Review Group

A framework setting out the route and responsibilities for policy development existed in the CCG. It is proposed that this is revised to reflect the ICB committees and used initially in the ICB pending any further review as the organisation develops.

Corporate Policy development involves the Corporate Policy Review Group. This body comprises members of the corporate services team and representatives from HR, IG and counter fraud/security to support the development and review of policies. The Staff Partnership Forum also have a role in this work.. It is proposed that these arrangements continue in the ICB.

6. Financial resource implications

There are no finance or other resource implications associated with the production of these policies.

7. Legal implications

The ICB is required to have policies in place and the requirements are covered by the agreement of the recommendations. Policies have been developed in line with national or legal requirements.

8. Risk implications

There is a risk to the organisation if policies are not agreed and communicated for use.

9. How does this reduce health inequalities

This proposal alone does not address health inequalities. As part of policy development individual Equality Impact Assessment have been conducted. This has been a routine requirement in the CCG and will continue in the ICB.

10. How does this impact on Equality and Diversity?

This proposal alone does not impact Equality and Diversity. As part of policy development individual Equality Impact Assessment have been conducted. This has been a routine requirement in the CCG and will continue in the ICB.

11. Consultation and Communication including Public Involvement

There has been no public involvement in the development of this proposal.

Policies will be shared for use across the ICB through routine channels of communication which will mirror those in use in the CCG. These include the website, intranet, Have we Got News For You and other briefings, as well as the Voice. Some policies will be published on the ICB website in line with requirements.

The Intranet (currently called the Hub) will be reconfigured. Arrangements are planned by the Communications Team once the priority to address the development of the ICB website has been completed by the newly engaged supplier. In advance of the intranet development and to avoid confusion, communications to staff have been prepared to acknowledge that some documents will continue to have references to the CCG although they remain relevant to the ICB.

Through outsourced arrangements for HR and IT supplied by the CSU, certain policies are also posted on portals like ConsultHR, ConsultOD and TopDesk. Communications have also been prepared to acknowledge that some documents will continue to have references to the CCG although they remain relevant to the ICB.

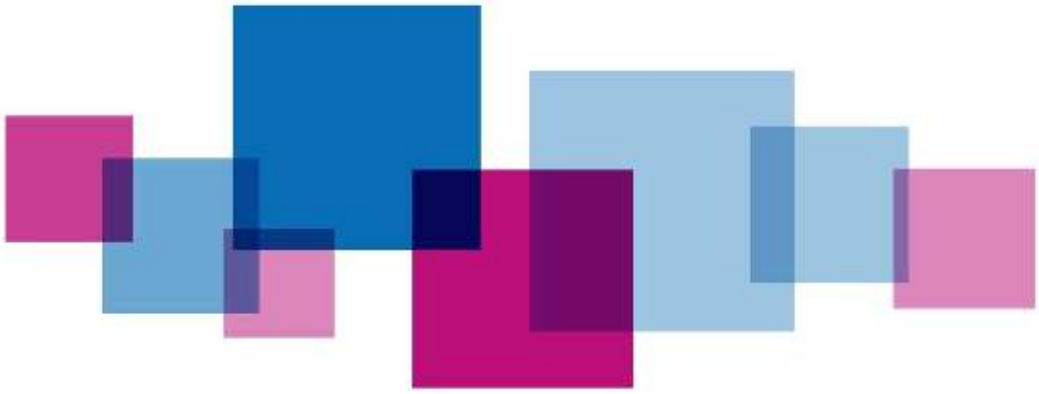
The CCG's portfolio of mandatory training which supports some areas covered by policies including safety and welfare, HR and IT/IG requirements has been extended to cover the initial ICB requirements. HR policy toolkit training also exists, and line manager briefs will continue.

Appendices

Annex A - ICB Conflict of Interest Policy
Annex B - Agree the ICB Gifts and Hospitality Policy
Annex C - Risk Management Framework
Annex D - Corporate and Commissioning Policies

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

Managing Conflicts of Interest Policy



Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	
Responsible Executive Director:	
Author and Job Title:	
Date Approved:	
Approved by:	Integrated Care Board (ICB) Board
Date of next review:	

Policy Review Checklist

	Yes/ No/NA	Supporting information
Has an Equality Impact Assessment Screening been completed?	Yes	See Appendix 1
Has the review taken account of latest Guidance/Legislation?	Yes	The policy is aligned to the Revised Statutory Guidance on Manging Conflicts of Interest in the NHS (February 2017) and the Interim Guidance on the functions and governance of the integrated care board (March 2022)
Has legal advice been sought?	No	Specialist advice has been sought from the relevant Counter Fraud service

	Yes/ No/NA	Supporting information
Has HR been consulted?	Yes	Advice has been sought from HR. HR issues arising from the application of the policy are set out in relevant HR policies and the recruitment toolkit
Have training issues been addressed?	Yes	Mandatory training requirements are detailed in the policy. NHSE provides a mandatory training package.
Are there other HR related issues that need to be considered?	No	The policy refers to relevant HR policies
Has the policy been reviewed by Staff Partnership Forum?	No	The HR issues arising from the application of the policy are set out in relevant HR policies which are considered by the Staff Partnership Forum
Are there financial issues and have they been addressed?	N/A	There are no financial issues arising from the application of the policy
What engagement has there been with patients/members of the public in preparing this policy?	N/A	The policy describes the ICB's statutory responsibilities and there has been no engagement with patients/members of the public in preparing this policy beyond that undertaken by NHSE as part of the legislative process
Are there linked policies and procedures?	Yes	Associated policies are referenced in the policy
Has the lead Executive Director approved the policy?		The Chief Financial Officer will review the policy prior to Governing Body approval

	Yes/ No/NA	Supporting information
Which Committees have assured the policy?		
Has an implementation plan been provided?	Yes	See Appendix 2
How will the policy be shared with: • Staff? • Patients? • Public?		The policy will be published on the website and internet and will be featured in internal communication. Regular prompts regarding declaring interests will be placed in internal communications.
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	Yes	The policy will be emailed to all staff. There will be a requirement for all staff to respond to the email and confirm receipt and that the policy has been read and understood.
Has a DPIA been considered in regards to this policy?	Yes	A DPIA has been developed for managing conflicts of interest
Have Data Protection implications have been considered?	Yes	The conflicts of interest register is published on the ICB website and consent for publication is included on the declarations of interest form.

Version Control ***please remove this box once approved and finalised***		
Version	**Date**	**Consultation**
V1	10/05/2022	

Table of Contents

Managing Conflicts of Interest Policy

1 Introduction

This policy describes the arrangements that NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) has in place to manage conflicts of interest. This policy reflects and supports the BNSSG ICB constitution and the Statutory Guidance on Managing Conflicts of Interest in the NHS which was issued by NHS England in February 2017 as well as the Interim guidance on the functions and governance of the Integrated Care Board issued by NHS England in March 2022.

Integrated Care Boards (ICBs) manage conflicts of interest as part of their day-to-day activities. Effective handling of conflicts of interest is crucial to give confidence to patients, tax payers, healthcare providers and Parliament that ICB commissioning decisions are robust, fair and transparent and offer value for money. It is essential to manage conflicts of interest in order to protect healthcare professionals and to maintain public trust in the NHS. Failure to manage conflicts of interest could lead to legal challenge and even criminal action in the event of fraud, bribery and corruption.

Conflicts of interest a common and sometimes unavoidable part of the delivery of healthcare and as such it may not be possible or desirable to completely eliminate them; it is how they are managed that matters. Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") sets out the minimum requirements of what both NHS England and ICBs must do in terms of managing conflicts of interest.

Commented [CS(BNSASG1]: To be confirmed

This policy reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the Act. This policy also describes the systems the ICB has in place to identify and manage conflicts of interest, and to create an environment in which staff, ICB Board and committee members, feel able, encouraged and obliged to be open, honest and upfront about actual or potential conflicts.

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In addition to complying with the guidance issued by NHS England, ICBs are also required to adhere to relevant guidance issued by professional bodies on conflicts of interest, including the British Medical Association (BMA), the Royal College of

General Practitioners, and the General Medical Council (GMC), and to procurement rules including The Public Contract Regulations 2015 and The National Health Service (procurement, patient choice and competition) (no.2) regulations 2013, as well as the Bribery Act 2010.

The principles of collaboration, transparency and subsidiarity should be at the centre of any decision making. It is expected that all those who serve as members of the ICB Board, its Committees or those who take decisions where they are acting on behalf of the public or spending public money will observe the principles of good governance in the way they do business. These are clearly defined and set out in Appendix 3.

1.1 BNSSG ICB Values

This policy supports the ICB values by ensuring the ICB does the right thing, it enables commissioners to demonstrate they are acting fairly and with integrity. The policy outlines best practice for managing conflicts of interest which enables the ICB to strive for excellence, do the right thing and demonstrate integrity.

2 Purpose and scope

The aims and objectives of this policy, in line with the statutory guidance issued by NHS England in February 2017 and the interim guidance for ICB governance issued in March 2022 are to:

- Decision-making must be geared towards meeting the statutory duties of the ICB at all times
- Safeguard clinically led commissioning, ensuring that conflicts of interest are declared and taken into account when investment decisions are made;
- Ensure that Bristol, North Somerset and South Gloucestershire ICB can demonstrate that it is acting fairly and transparently and in the best interests of patients and local populations;
- Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering their own interests
- Uphold confidence and trust in the NHS;
- Support anybody involved with ICB business to understand when conflicts (whether actual or potential) may arise and how to manage them if they do;
- Be a practical resource to help identify conflicts of interest and appropriately manage them; and
- Ensure that the ICB operates within the legal framework.

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 contracts, self-employed consultants and individuals working for the ICB under a contract for services)
- Any work experience staff or volunteers
- Members of the ICB Board, all members of the ICBs' committees, sub-committees or sub groups including co-opted members, appointed deputies and any member of committees/groups from other organisations. Where the ICB is participating in a joint committee with system partners, any interests which are declared by the committee members should be recorded on the register(s) of interest for the ICB.

These are collectively referred to as 'individuals' hereafter.

3 Duties – legal framework for this policy

Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") sets out the minimum requirements of what both NHS England and ICBs must do in terms of managing conflicts of interest.

This policy reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the Act.

Commented [CS(BNSASG3]: To be confrimed

In addition to complying with the guidance issued by NHS England, ICBs are also required to adhere to relevant guidance issued by professional bodies on conflicts of interest, including the British Medical Association (BMA), the Royal College of General Practitioners, and the General Medical Council (GMC), and to procurement rules including The Public Contract Regulations 2015 and The National Health Service (procurement, patient choice and competition) (no.2) regulations 2013, as well as the Bribery Act 2010.

4 Responsibilities and Accountabilities

Chief Executive

- Has overall accountability for the ICB's management of conflicts of interest.

Line Managers

- Ensure members of their team are aware of and follow this policy and report any potential or actual conflicts of interest to the Corporate Governance Team as they arise. Contact details for the team are at appendix 5.
- Provide basic advice including as part of local induction on how conflicts of interest should be managed, escalating queries to the Corporate Governance Team as necessary.
- Line Managers are responsible for ensuring that staff undertake their mandatory training and are aware of requirements associated with managing conflicts of interest

Corporate Secretary

- Has responsibility for the day to day management of conflicts of interest and queries in relation to these.
- Maintains the ICB register(s) of interest and other registers referred to in this policy
- Supports the Conflict of Interest Guardian to enable them to carry out their role effectively
- Provides advice, support and guidance on how conflicts of interest should be managed, and
- Ensures that the appropriate administrative processes are in place to ensure compliance with legislation and statutory guidance

Contact details for the Corporate Secretary can be found at Appendix 5.

Conflicts of Interest Guardian

This role is undertaken by the Audit and Risk Committee Chair and they will:

- Act as a conduit for staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest
- Be a safe point of contact for employees to raise any concerns in relation to this policy
- Support the rigorous application of conflict of interest principles and policies
- Provide independent advice and judgement where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
- Provide advice on minimising risks of conflicts of interest

Contact details for the Conflicts of Interest Guardian can be found at Appendix 5.

Individuals

Every individual has the responsibility to ensure that they complete annual conflicts of interest training. This training is available through the training platform.

Every individual has the responsibility to ensure that they complete a conflict of interest form on appointment and to ensure that this is kept up to date. Forms will need to be resubmitted on an annual basis unless something new arises in-year which needs to be declared. In such cases, a new declaration form must be completed and given to the Corporate Governance Team no later than 28 days after becoming aware so that the register can be updated. A Conflict of Interest form can be found at Appendix 6.

All individuals are also responsible for ensuring any conflict of interest arising from the agenda is declared at meetings they attend, regardless of this being declared on

the Conflicts of Interest register; any declarations made must be recorded in the minutes of the meeting. The Chair of the meeting must ensure that attendees are prompted to raise conflicts of interests.

There will be occasions where an individual declares an interest in good faith but, upon closer consideration, it is clear that this does not constitute a genuine conflict of interest. Your line manager, a member of the Corporate Governance team or the Conflicts of Interest Guardian will provide advice on this in line with maintaining the registers of interest and decide whether it is necessary for the interest to be declared.

Equally, there will be other occasions where the conflict of interest is profound and acute, such as where an individual has a direct financial interest which gives rise to a conflict, e.g. employment outside of the ICB or involvement with an organisation which benefits financially from contracts for the supply of goods and services to a ICB or aspires to be a new care model provider. Upon the declaration of such conflicts, consideration will be given as to whether, practically, such an interest is manageable. If it is not, the appropriate course of action may be to refuse to allow the circumstances which gave rise to the conflict to persist. This may require an individual to step down from a particular role and/or move to another role within the ICB. In such circumstances, the appropriate HR policies will be referred to and HR advice will be sought as required.

Managers Engaged in Procurements

- Ensure Conflict of Interest forms are completed by all individuals involved in the procurement process.
- Ensure Conflict of Interest forms are completed regardless of the procurement financial envelope
- Consider their own declarations of interest and conflicts that may arise as part of the procurement. Any new potential conflicts of interest should be declared to the Corporate Governance Team and declared as part of the procurement.
- Ensure conflict of interest declarations are available at all related procurement meetings
- Ensure conflict of interest mitigations are clearly documented in the minutes
- Ensure conflict of interests are declared by any members of the public or group representatives in line with Section 11.1 of this policy
- Ensure a procurement template (Appendix 8) is completed when commissioning GP services
- Ensure bidders complete a conflict of interest form (Appendix 9) as part of the procurement process
- Update the Corporate Governance Team when a procurement decision is made so that the Procurement Register can be updated and published on the ICB website.

ALL Individuals – Disclosure UK Database

Disclosure UK provides a valuable opportunity for healthcare professionals to further demonstrate their integrity in the eyes of patients and the public. All ICB staff who undertake work for pharmaceutical companies must disclose payments on the UK Disclosure database.

Any work undertaken with pharmaceutical companies must also be recorded on a Declaration of Interest Form and given to the Corporate Governance Team.

5 Definitions/explanations of terms used

A conflict of interest is defined as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act in the context of delivering, commissioning or assuring taxpayer funded health and care services is , or could be, impaired or influenced by another interest they hold" In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In such cases it is important to still manage these perceived conflicts in order to maintain public trust.

Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care and out-of-hours commissioning and involvement with integrated care organisations, as clinical commissioners may find themselves in a position of being at once commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

Interests can be captured in four different categories: Financial, Non-Financial Professional, Non-Financial Personal and Indirect. These categories are described in more detail under Appendix 4.

6 Principles

To support the management of conflicts of interest, we will:

- **Conduct business in line with available guidance and ICB policy**: Conflicts of interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;
- **Be proactive, not reactive:** Commissioners should seek to anticipate, identify and minimise the risk of conflicts of interest at the earliest possible opportunity;
- **Be balanced, sensible and proportionate:** Rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making

is transparent and fair whilst not being overly constraining, complex or cumbersome.
- **Be transparent:** Document clearly the approach and decisions taken at every stage in the commissioning cycle so that a clear audit trail is evident.
- Create an **environment and culture** where individuals feel supported and confident in declaring relevant information and raising any concerns.

In addition to the above, it must be recognised that:
- A perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring;
- If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.
- For a conflict of interest to exist, financial gain is not necessary.

7 Declaring Conflicts of Interest

As required by section 14O of the NHS Act 2006 (as amended by the 2012 Act), the ICB has made arrangements to manage conflicts and potential conflicts of interest to ensure that they do not, and do not appear to, affect the integrity of any decision-making processes.

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Individuals referred to in section 2 will be required to complete a Conflict of Interest Form (Appendix 6) in the following circumstances:

- On appointment,
- On an annual basis in line with the financial year
- On changing role, responsibility or circumstances. This must be no later than 28 days of the change being known.

Registers of Interest are maintained by the Corporate Governance Team for all of the individuals referred to in section 2 and these registers are available on the ICB website.

All interests declared will be promptly transferred to the relevant registers (within 10 working days) by the Corporate Governance Team. Where a declared interest has expired, this will remain on the public register for a minimum of 6 months although a private record of the historic interests will be retained by the ICB for a minimum of 6 years after the date on which it expired.

Members of the ICB Board and Sub-Committees will also need to abide by their own organisation's Conflict of Interest Policies.

8 Publication of Registers

The ICB will publish its Conflicts of Interest Register and the Register of Procurement Decisions (described in sections 7 and 12.5) on the website. **[Add website link]**

In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). Where an individual believes that substantial damage or distress may be caused to them or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing to the ICB Conflicts of Interest Guardian (please see appendix 5). The outcome of this request will be shared with the individual within 10 working days.

Where a decision is made not to publish information the ICB will retain a confidential un-redacted version of the register(s).

Where a decision is made to refuse a request not to publish information the individual will have the right to appeal this decision through the Grievance Policy. During this process a redacted form of the information will be published.

9 Managing Conflicts of Interest during the Recruitment Process

Everyone in the ICB has responsibility to appropriately manage conflicts of interest during the recruitment process for ICB Board Members, Committee Members, Senior Employees as well as all other staff because these roles will be involved in the decision making processes of the ICB.

9.1 Appointing ICB Board Members, Committee Members, and Senior Employees

When advertising for a ICB Board Member, Committee or Sub-Committee member or a member of senior staff, a request will be made via the recruitment team by the recruiting manager for a Conflict of Interest form to be completed by successfully shortlisted candidates, and this will need to be brought with them to their interview.

On appointing ICB Board, committee or sub-committee members and senior staff, the ICB will need to consider whether conflicts of interest should exclude individuals from being appointed to the role. This will need to be considered on a case-by-case basis and in conjunction with the principles within the ICBs Constitution.

The materiality of the interest will need to be considered, in particular whether the individual (or any person with whom they have a close association as listed in the scope of this policy) could benefit (whether financially or otherwise) from any decision the ICB might make. The ICB will also determine the extent of the interest and the nature of the appointee's proposed role within the ICB. If the interest is

related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual should not be appointed to the role.

9.2 ICB Independent Non-Executive Members

Independent Non-Executive members play a critical role, providing scrutiny, challenge and an independent voice in support of robust and transparent decision-making and management of conflicts of interest. They chair a number of ICB committees, including the Audit and Risk Committee and the Primary Care Commissioning Committee. BNSSG ICB has appointed five lay members to its ICB Board.

9.3 Other ICB Staff

All recruiting managers will need to ensure that they support obtaining the declaration of interest forms for new staff and make the necessary arrangements to manage any declared conflicts of interest.

9.4 ICB Board and Committee members from other Organisations

ICBs have been created to give statutory NHS providers, local authorities and primary medical services (general practice) nominees a role in decision-making. It should not be assumed that the ICB Board will always be conflicted because at least three members of the ICB Board must be jointly nominated (the “partner members”) It is crucial that the ICB ensures that the Boards and Committees are appropriately composed and take into account different perspectives individuals will bring from their respective sectors to help inform decision making.

10 Governance Arrangements and Decision Making

ICBs must make arrangements for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group’s decision-making.

10.1 Outside employment

The ICB will take all reasonable steps to ensure that individuals are aware of the requirement to inform the ICB if they are employed or engaged in, or wish to be employed or engaged in, any employment or consultancy work in addition to their work with the ICB. This will ensure that the ICB is aware of any potential conflict of interest and that it is managed appropriately. The NHS England statutory guidance is clear however that it is not acceptable for pharmacy advisers or other advisers, employees or consultants to the ICB on matters of procurement, to themselves be in receipt of payments from the pharmaceutical or devices sector.

Examples of work which might conflict with the business of the ICB, including part-time, temporary and fixed term contract work, include:

- Employment with another NHS body;
- Employment with another organisation which might be in a position to supply goods/services to the ICB;
- Directorship of organisations such as Primary Care Networks, or Locality Partnerships ; and
- Self-employment, including private practice, in a capacity which might conflict with the work of the ICB or which might be in a position to supply goods/services to the ICB.

Individuals are required to obtain prior permission to engage in outside employment, and the ICB reserves the right to refuse permission where it believes a conflict may arise which cannot be effectively managed. Further detail of secondary employment and how this should be requested and managed can be found in the ICBs Secondary Employment policy.

10.2 ICB Board and Committee members from other organisations

ICBs have been created to give statutory NHS providers, local authorities and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle, and whilst it should not be automatically assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations, the possibility of actual and perceived conflicts of interests arising will remain. For all decisions, ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not that outweighs the value of the knowledge they bring to the process.

11 Managing Conflicts of Interest at Meetings

The ICBs will consider the composition of decision-making forums and will clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions. In particular, the ICB will consider the perspective the individual brings and the value they add to both discussions around particular decisions and in actually taking part in the decision including the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for the local population. The ICB will manage conflicts of interest to reflect this distinction. For example, where providers hold contracts for services it would be appropriate and reasonable to involve them in discussions such as pathway design and service delivery. However, this would need to be clearly distinct from any considerations around contracting and commissioning from which they would need to be excluded.

11.1 Chairing arrangements and decision making processes

The chair of a meeting of the ICB Board or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest. In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s). In making such decisions, the chair (or vice chair or remaining non-conflicted members as above) may wish to consult with the Conflicts of Interest Guardian or another member of the ICB Board.

The ICB Board Chair, with the support of the Corporate Secretary and, if required, the Conflicts of Interest Guardian, will proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of closed sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant.

To support chairs in their role, they will have access to a Conflict of Interest register prior to meetings, which will include details of any declarations of conflicts which have already been made by members of the ICB or meeting members. An example of a meeting checklist is available at Appendix 7 which may support chairs in their role.

The chair will ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the meeting should declare any interests which are relevant to the business of the meeting regardless of whether or not these interests have previously been declared. Any new interests declared at a meeting must be included on the ICB's relevant register of interests to ensure it is up-to-date.

It is the responsibility of each individual member of the meeting to declare any relevant interests which they may have. However, should any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interest but which have not been declared should bring this to the attention of the chair who will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.

When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or vice chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. Actions to mitigate conflicts should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of

factors including the perception of any conflicts and how a decision may be reached if an individual with a perceived conflict is involved in that decision as well as the risks and benefits of having a particular individual involved in making the decision. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

- Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting;
- Requiring the individual who has a conflict of interest (including the chair or vice chair if necessary) not to attend the meeting;
- Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict;
- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s) and securing technical or local expertise from an alternative unconflicted source where possible. In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery. This may require instructions to the meeting to be cautious about or cease the use of any chat function associated with video conferencing which may remain accessible to the individual who has been excluded from or asked to leave the meeting.
- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s) or not participate in the decision-making. This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared;
- Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest, but allowing the individual to remain and participate in both the discussion and in any decisions. The rationale for inclusion should be properly documented and included in the minutes. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion. The conflicts of interest case studies include examples of material and immaterial conflicts of interest.

Where the action taken, for example exclusion, affects the quoracy of a meeting appropriate action will be taken, for example in advance of a meeting it may be possible to review the committee's Terms of Reference to understand if, with appropriate approvals, they may be amended to enable the committee to remain

quorate. If the conflict arises so that issues of quoracy may not be addressed in advance the item will be postponed until a quorum can be achieved without conflict. Advice from the Corporate Governance Team should be sought in these circumstances.

It is important that an effective record is made and kept on the form of clear minutes of any interests that arise, the agenda item concerned and their subsequent management. An example of this is shown at Appendix 7.

11.2 Committee Terms of Reference

Committee Terms of Reference must include a section on how the Committee will conduct its business in accordance with the ICB's Managing Conflicts of Interest Policy including:

Commented [CS(BNSASG5]: To be cross – referenced to ToR

- ensuring there is a section on the agenda to declare any potential conflicts of interest
- ensuring that the minutes capture the information required as per section 11.3 of this policy
- proactively considering ahead of meetings whether conflicts are likely to arise and how they should be managed including whether meeting papers should be sent to conflicted individuals in advance of the meeting

11.3 Minute taking

It is imperative that the ICB ensures complete transparency in its decision-making processes through robust record-keeping and clear minutes. If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes:

- who has the interest;
- the nature of the interest and why it gives rise to a conflict, including the magnitude of any interest;
- the items on the agenda to which the interest relates;
- how the conflict was agreed to be managed; and
- evidence that the conflict was managed as intended (for example recording the points during the meeting when particular individuals left or returned to the meeting).

12 Managing Conflicts of Interest Throughout the Commissioning Cycle

The NHS England guidance for Managing Conflicts of Interest in the NHS (February 2017) is clear that conflicts of interest need to be managed appropriately throughout the whole commissioning cycle including within the ongoing management of existing contracts and ICBs must have in place processes to ensure this happens.

At the outset of a commissioning process, all individuals involved, including those from external bodies, must complete a Conflict of Interest form, even if there is nothing to declare (Appendix 9). Completed forms must be held by the lead Procurement Manager and either the forms or a collated register must be available at every meeting.

Where Conflicts of Interest are declared, the chair of the meeting, in conjunction with the Corporate Secretary and/or Conflicts of Interest Guardian, must put in place clear arrangements to robustly manage these. This includes consideration as to which stages of the process a conflicted individual should not participate in, and, in some circumstances, whether that individual should be involved in the process at all. The steps taken must be clearly documented in the minutes (Appendix 7).

Where a conflict is identified which may impact on the management of an existing contract, a discussion must take place with the Corporate Secretary, and if necessary the Conflicts of Interest Guardian, so that steps can be put in place to manage this. Any mitigation must also be recorded in minutes that are taken.

ICBs will also need to identify as soon as possible where staff might transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest which will be managed in line with this policy and following advice from the Corporate Secretary and if necessary the ICB Conflicts of Interest Guardian.

12.1 Designing service requirements

The NHS England guidance upon which this policy is based states that ICBs have legal duties under the Act to properly involve patients and the public in their respective commissioning processes and decisions. Public involvement supports transparent and credible commissioning decisions and should happen at every stage of the commissioning cycle from needs assessment, planning and prioritisation to service design, procurement and monitoring.

Conflicts of Interest can arise from the inclusion of members of the public or particular groups who are involved in the decision making process of the ICB. As such, any member of the public or representative of a particular group involved in the influencing or decision making of the ICB will be required to complete a Declaration of Interest form regardless of a conflict being identified. This will be held by the Procurement Manager alongside any other conflict of interest forms completed as part of the procurement process.

12.2 Provider engagement

It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. Such engagement, done transparently and fairly, is entirely legal but it is important not to gear the

requirement in favour of any particular provider(s). If appropriate, the advice of an independent clinical adviser on the design of the service should be secured.

Conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if a commissioner engages selectively with only certain providers (existing or potential) in developing a service specification for a contract for which they may later bid. The ICB is particularly mindful of these issues when engaging with existing / potential providers in relation to the development of new care models and is developing a Procurement Strategy that will ensure:

- All relevant clinicians and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;
- Provider engagement follows the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent. This mitigates the risk of potential legal challenge. When available this will be published on the ICB website.
- ICB Board discussion and decision making involving provider ICB Board members will consider conflicts of interest and manage these as outlined in section 11 of this policy.

External services such as commissioning support services (CSSs) can play an important role in ensuring Procurement law is adhered to at all times, as well as helping ICBs decide the most appropriate procurement route, undertaking procurements and managing contracts in ways that manage conflicts of interest and preserve the integrity of decision-making.

To ensure transparency and assurance, any member of the Commissioning Support Service (CSS) involved in assisting the ICB with procurement will be required to complete a declaration of interest form (Appendix 6). In addition, the Commissioning Support Service as an organisation will also be required to complete a declaration of interest form at organisational level which will include any conflicts of interest they may have in relation to the work commissioned by the ICB. It is the responsibility of the Procurement Manager to ensure this is completed and is held alongside any other conflict of interest forms that are completed as part of the procurement process.

Irrespective of CSS input, the ICB is responsible for:

- Determining and signing off the specification and evaluation criteria;
- Deciding and signing off decisions on which providers are invited to tender; and
- Making final decisions on the selection of the provider.

12.3 Procuring new care models

Where new care models or other arrangements of a similar scale or scope, are being procured it is imperative that conflicts of interest are managed in line with this policy and in line with Appendix 8. Where further advice is needed, please seek advice from the Corporate Secretary.

12.4 Managing conflicts of interest relating to procurement

An area in which conflicts could arise is where a ICB commissions (or continues to commission by contract extension) healthcare services, including GP services, in which a member of the ICB Board has a financial or other interest. A procurement template attached at Appendix 8, sets out factors that the ICB must address when planning to commission general practice services and must be completed every time general practice services are commissioned. It is the responsibility of the Procurement Manager to ensure this form is completed and passed to the ICB Governance Team so the register of procurement decisions can be updated (see section 12.5).

As part of any procurement process undertaken by the ICB, bidders will be asked to declare any conflicts of interest. This enables commissioners to ensure that they comply with the principles of equal treatment and transparency. It is the responsibility of the Procurement Manager and Procurement Team to ensure this step is completed. Where a bidder has declared a conflict, advice should be sought from the Procurement Team, the Corporate Governance Team or the Conflicts of Interest Guardian as to how this should be managed to ensure that no bidder is treated differently to any other. Please see Appendix 9 for a conflict of interests for bidders/contractors template.

While it is not appropriate to publish any bidder conflicts of interest, the ICB is required under regulation 84 of the Public Contract Regulations 2015 to make and retain records of contract award decisions and key decisions that are made during the procurement process.

This includes “communications with economic operators and internal deliberations” which should include decisions made in relation to actual or perceived conflicts of interest declared by bidders. These records must be retained by the Procurement Team/Procurement Manager for a period of at least three years from the date of award of the contract.

12.5 Register of procurement decisions

To promote transparency in decision-making, and in line with the NHS England Managing Conflicts of Interest in the NHS (February 2017), the ICB will maintain a register of procurement decisions taken, either for the procurement of a new service or any extension or material variation of a current contract. This will include:

- The details of the decision;

- Who was involved in making the decision (including the name of the ICB clinical lead, the ICB contract manager, the name of the decision making committee and the name of any other individuals with decision-making responsibility);
- Summary of any conflicts of interest in relation to the decision and how these were managed; and
- The award decision taken.

It is the responsibility of Managers involved in Procurements to ensure that details of any procurement decisions taken, including single tender actions are provided to the Corporate Governance Team so that the register of procurement decisions can be maintained. Upon receipt of new information, the register of procurement decisions will be updated and published on the ICB website by the Corporate Governance Team. A template of the register is included at Appendix 10.

12.6 Contract monitoring

Please see section 11 which describes how conflicts of interests at meetings should be managed and how these should be recorded in the minutes. The NHS Standard Contract General Conditions state that providers "must ensure that, in delivering the Services, all staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest."

13 Audit of Managing Conflicts of Interests

The ICB is required to undertake an audit of their conflicts of interest management as part of their internal audit on an annual basis. This is led by the ICB's Internal Auditor and the outcome will be reflected in the ICB's Annual Governance Statement as well as forming part of the discussion at the end of year governance meeting with NHS England.

14 Raising Concerns and Breaches

It is the duty of all individuals referred to in section 2 to speak up about genuine concerns in relation to the administration of this policy and to report these concerns in line with the ICB's Freedom to Speak Up Policy. Suspicions must not be ignored or investigated directly by an individual.

We encourage anyone who is not an employee or worker of the ICB, but who wishes to report a suspected or known breach of this Policy to contact a member of the Corporate Governance Team in the first instance.

All disclosures will be treated with appropriate confidentiality at all times in accordance with ICB policies and applicable laws. Anybody making such disclosures may expect an appropriate explanation of any decisions taken as a result of any investigation.

Providers, patients and other third parties may make a complaint to NHS Improvement in relation to the ICB's conduct under the Procurement Patient Choice and Competition Regulations.

Anonymised details of breaches will be published on the ICB's website for the purpose of learning and development. The outcomes of any investigation of breaches will also be reported to the ICB Audit, and Risk Committee and NHS England.

15 Breaches of the ICB Managing Conflicts of Interest Policy

Failure to comply with the policy on conflicts of interest management can have serious implications for the ICB and any individuals concerned.

Civil implications: The ICB could face civil challenges to decisions it makes. For instance, if breaches occur during a service re-design or procurement exercise, the ICB risks a legal challenge from providers that could potentially overturn the award of a contract, lead to damages claims against the ICB, and necessitate a repeat of the procurement process. This could delay the development of better services and care for patients, waste public money and damage the ICB's reputation. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal implications: Failure to manage conflicts of interest could lead to criminal investigations into fraud, bribery and corruption offences. This could have implications for the ICB, linked organisations, and the individuals who are engaged by them.

Disciplinary implications: Individuals who fail to disclose any relevant interests or who otherwise breach the ICB's rules and policies relating to the management of conflicts of interest will be subject to investigation and, where appropriate, to disciplinary action.

Individuals should be aware that the outcomes of such action may result in the termination of their employment or position with the ICB.

Statutorily regulated healthcare professionals who work for, or are engaged by the ICB are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. Failure to comply with this policy may result in the ICB reporting such individuals to their regulator for investigation if they believe that they have acted improperly. The consequences for inappropriate action could include fitness to practise proceedings being instigated which may result in individuals being struck off by their professional regulator.

15.1 Managing breaches of this policy

All breaches of the ICB's Conflicts of Interest Policy will be subject to internal investigation in the first instance, notwithstanding any external investigations which may be necessary. Internal investigations will be completed in line with the most appropriate ICB policy.

Investigation outcomes in relation to breaches of this policy will be shared with the ICB's Audit and Risk Committee which will review any lessons to be learnt and recommendations for action. The Audit and Risk Committee will monitor the implementation of any recommendations raised from the outcomes of investigations.

Once a breach is confirmed, the Corporate Governance Team will ensure that NHS England is notified, including information about the nature of the breach and the actions taken in response. This information will also be published anonymously on the ICB's website and a communications plan will be put in place to manage any media interest. This will be managed on a case by case basis.

16 Bribery and Fraud

16.1 Bribery

The ICB takes a zero tolerance approach to bribery. The ICB policy relating to Fraud and Bribery can be found on the ICB Intranet and website. The Bribery Act 2010 defines bribery as the giving or taking of a reward in return for acting dishonestly and or in breach of the law. There are four different classifications of bribery:

- Bribing another person.
- Being bribed,
- Bribing a foreign public official; or
- Failure to prevent bribery.

Any offering, promising, giving, requesting, receipt or acceptance of a bribe by any employee when conducting business on behalf of the ICB or when representing the ICB in any capacity is strictly forbidden and is contrary to the Bribery Act 2010. Furthermore, the ICB requires all individuals to report any suspicions of the above to its Local Counter Fraud Specialist, or the NHS Counter Fraud Authority. Individuals who fail to adhere to this policy will be dealt with by means of a criminal investigation, civil recovery and/or via the ICB's disciplinary processes.

Any suspicions or concerns of acts of bribery can be reported confidentially online via https://cfa.nhs.uk/reportfraud or via the NHS Fraud and Corruption Reporting Line on 0800 028 4060. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

16.2 Fraud

The ICB has a zero tolerance approach to fraud. The ICB policy relating to Fraud and Bribery can be found on the ICB Intranet and website. The Fraud Act 2006 creates a criminal offence of fraud and defines three main ways of committing it:

- Fraud by false representation;
- Fraud by failing to disclose information; and
- Fraud by abuse of position.

In these cases, an offender's conduct must be dishonest and their intention must be to make a gain or cause a loss (or the risk of a loss) to another.

Any suspicions or concerns of acts of fraud can be reported confidentially online via https://cfa.nhs.uk/reportfraud or via the NHS Fraud and Corruption Reporting Line on 0800 028 4060. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

17 Training requirements

The information and responsibilities within this policy will be disseminated to staff by the publication of this policy on the BNSSG ICB website and intranet. Conflict of Interest training is mandatory for all individuals referred to in section 2 and is to be completed annually by all staff. Conflicts of Interest training packages are provided by NHS England. Training compliance rates will be recorded as part of the ICB's annual conflicts of interest audit. Training compliance rates for decision making staff will be reported to NHS England annually. Decision making staff are those roles defined in the Constitution as members of the ICB Board and Terms of Reference as members of the ICB Board Sub Committees.

18 Equality Impact Assessment

All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry.

19 Implementation and Monitoring Compliance and Effectiveness

An implementation plan has been prepared and is attached at appendix 2. Compliance with this policy will be monitored by the Corporate Governance team and reported quarterly to the Audit and Risk Committee. The outcomes of the mandatory annual audit will be reported to the Audit and Risk Committee.

20 References, acknowledgements and associated documents

The following related documents may be accessed through our website:

- Local Counter Fraud, Bribery and Corruption Policy
- Grievance Policy and Procedure
- Disciplinary Policy
- Gifts and Hospitality Policy
- Policy for the Sponsorship of Activities by and Joint Working with the Pharmaceutical Industry
- Freedom to Speak Up Policy
- Secondary Employment Policy

https://www.england.nhs.uk/ourwork/coi/

https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/

21 Appendices

Appendix 1 Equality Impact Assessment

Appendix 2 Implementation Plan

Appendix 3 Principles of Good Governance and Nolan Principles

Appendix 4 Types of Interest

Appendix 5 Contact details for the ICB Corporate Governance Team and Conflicts of Interest Guardian

Appendix 6 Conflict of Interest declaration form

Appendix 7 Conflict of Interest Checklist for Chairs, Meeting Members and Secretariat Support

Appendix 8 Template to be used when commissioning services from GP Practices, including provider consortia, or organisations in which GPs have a financial interest

Appendix 9 Declarations of Conflicts of Interests form for Bidders/Contractors

Appendix 10 Register of Procurement Decisions and Contracts Awarded

21.1 Equality Impact Assessment

Equality Impact Assessment Screening		
Query	Response	
What is the aim of the document?	to set out the ICB responsibilities in relation to managing conflicts of interest in line with Revised Statutory Guidance on Managing Conflicts of Interest in the NHS (February 2017) and interim guidance on the functions and governance of the ICB (March 2022) and processes to ensure compliance	
Who is the target audience of the document (which staff groups)?	All staff	
Who is it likely to impact on and how?	Staff	yes in that it describes the way in which staff are required to declare all interests as set out in the policy. It does not have an impact on staff in terms of Equalities and Human Rights (see below)
	Patients	no
	Visitors	no
	Carers	no
	Other – governors, volunteers etc	yes – all those defined as staff in the policy are required by statutory guidance to conform to the policy. It does not have an impact in terms of Equalities and Human Rights (see below)
Does the document affect one group more or less favourably than another based on the 'protected characteristics' in the Equality Act 2010:	Age (younger and older people)	no
	Disability (includes physical and sensory impairments, learning disabilities, mental health)	This policy is available in formats as requested.
	Gender (men or women)	no
	Pregnancy and maternity	no
	Race (includes ethnicity as well as gypsy travellers)	no
	Sexual Orientation (lesbian, gay and bisexual people)	no
	Transgender people	no
	Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)	no

	Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)	no – the ICB has processes in place to ensure that rights to privacy are protected

21.2 Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
ICB Board	Ensure the ICB Board is aware of ICB's responsibilities and provide assurance that appropriate process is established to ensure legal compliance	Cover paper to the policy to be presented to the ICB Board	Corporate Secretary	1st July 2022	July 2022	staff time, Governing Body time
Executive Directors	Ensure awareness of responsibilities to ensure compliance Individual Executive Director responsibilities Directorate Responsibilities	Discussion with individual directors as required	Corporate Support Officer	From 1st July 2022	Ongoing	staff time, executive director time
All Staff	Ensure awareness of ICB processes and procedures	Policy to be placed on website Information about the policy and ICB process to be placed on ICB Intranet Information about the policy and ICB process to be communicated through the ICB Staff newsletter Annual Conflicts of Interests training module	Corporate Support Officer /Training manager	From 1st July 2022	1st July 2022 - Policy to added to The Hub, and the website following approval. July 2022 – Inclusion in The Voice following approval Ongoing - Annual declarations to be collated and staff to be reminded to undertake training.	staff time training module

21.3 Principles of Good Governance and Nolan Principles

ICBs should observe the principles of good governance in the way they do business including:

- The Nolan Principles (also known as the 7 Principles of Public Life) set out below
- The Good Governance Standards for Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA)
- The seven key principles of the NHS Constitution
- The Equality Act 2010
- The UK Corporate Governance Code
- Standards for members of NHS Boards

Nolan Principles, also known as The 7 Principles of Public Life

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends;
- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit;
- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest;
- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

21.4 Types of Interest

Financial Interests

This is where an individual may get direct financial benefit from the consequences of a decision they are involved in making. This could, for example, include being:

- A director (including a non-executive director) or senior employee in another organisation which is doing, or likely to do business with an organisation in receipt of NHS funding
- A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding
- Someone in outside employment
- Someone in receipt of a secondary income
- Someone in receipt of a grant
- Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence)
- Someone in receipt of sponsored research

Non-financial professional interests

This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients
- A clinician with a special interest
- An active member of a particular specialist body
- An advisor for the Care Quality Commission or National Institute of Health and Care Excellence
- A research role

Non-financial personal interests

This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career This could include, for example, where the individual is:

- A member of a voluntary sector board or has a position of authority within a voluntary sector organisation
- A member of a lobbying or pressure group with an interest in health and care

Indirect interests

This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.This would include:

- Close family members and relatives
- Close friends and associates
- Business partners.

21.5 Contact details for the ICB Corporate Governance Team and Conflict of Interest Guardian

[TBC – Senior person responsible for Governance]	
Name	**TBC**
Title	**TBC**
Telephone No.	**TBC**
Email	**TBC**
Conflict of Interest Guardian	
Name	John Cappock
Title	Independent Non-Executive Member for Audit
Email	John.cappock@nhs.net
Corporate Governance Team	
Email	bnssg.corporate@nhs.net

21.6 Conflict of Interest form

Name:	
Organisation:	**BNSSG ICB** ☐ **Other** ☐ **(please specify)** **.....**
Position within, or relationship with, the ICB (or other organisation):	

Detail of interests held (complete all that are applicable):

If you have nothing to declare please state this below

Type of Interest* *See reverse of form for details	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates From & To		Actions to be taken to mitigate risk (to be agreed with line manager or a senior ICB manager)

The ICB is required to take steps to manage conflicts of interest that may arise; we collect this information to ensure that we are able to comply with the statutory guidance on this subject. The information collected in this form will be held securely and used for the purposes of identifying and managing conflicts of interest. Personal information will be managed in line with the General Data Protection Regulation and Data Protection Act 2018. Details of declarations of interest are published online and available on our website. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do** / **do not [delete as applicable]** give my consent for this information to published on registers that the ICB holds. If consent is NOT given please give reasons:

(Note: The ICB is unable to remove information from the public view without sufficient reason, please contact the Corporate Governance Team for advice/guidance on this)

Signed: **Date**:

Please return to **The Corporate Team,** bnssg.corporate@nhs.net

21.7 Conflict of Interest Checklist for Chairs, Meeting Members and Secretariat Support

Under the Health and Social Care Act 2012, there is a legal obligation to manage conflicts of interest appropriately. It is essential that declarations of interest and actions arising from the declarations are recorded formally and consistently across all ICB Board, committee and sub-committee meetings. This checklist has been developed with the intention of providing support in conflicts of interest management. It does not cover the requirements for declaring interests outside of the committee process.

Timing	Checklist for Chairs	Responsibility
In advance of the meeting	**1.** **The agenda** to include a standing item on declaration of interests to enable individuals to raise any issues and/or make a declaration at the meeting.	Meeting Chair and secretariat
	2. A **definition of conflicts of interest** should also be accompanied with each agenda to provide clarity for all recipients.	Meeting Chair and secretariat
	3. **Agenda** to be circulated to enable attendees (including visitors) to identify any interests relating specifically to the agenda items being considered and be in accessible format(s).	Meeting Chair and secretariat
	4. **Members should contact the Chair** as soon as an actual or potential conflict is identified.	Meeting members
	5. Chair to review **minutes from preceding meetings** i.e., sub-committee, working group, etc., detailing any conflicts of interest declared and how this was managed.	Meeting Chair
	6. A **copy of the members' declared interests** is checked to establish any actual or potential conflicts of interest that may occur during the meeting.	Meeting Chair and secretariat
During the meeting	**1.** **Check and declare the meeting is quorate** and ensure that this is noted in the minutes of the meeting.	Meeting Chair

	2. Chair requests **members to declare any interests in agenda items**- which have not already been declared, including the nature of the conflict.	Meeting Chair
	3. **Chair makes a decision** as to how to manage each interest which has been declared on a case-by-case basis, and this decision is recorded and issue any instructions about the use of chat function to ensure access to information is appropriately managed.	Meeting Chair and secretariat
	4. **As minimum requirement**, the following should be **recorded in the minutes of the meeting**: • Individual declaring the interest; • At what point the interest was declared; • The nature of the interest; • The Chair's decision and resulting action taken; • The point during the meeting at which any individuals retired from and returned to the meeting - even if an interest has not been declared.	Secretariat
	5. **Visitors in attendance** who participate in the meeting must also follow the meeting protocol and declare any interests in a timely manner.	
Following the meeting	**1.** All new interests declared at the meeting should be promptly updated onto the declaration of interest form;	Individual(s) declaring interest(s)
	2. All new completed declarations of interest should be transferred onto the register of interests.	Relevant ICB Governance Lead

Example of a Conflict of Interest being declared at a meeting and how this should be recorded

Item No	Agenda Item	Actions
1	**Chairs welcome**	
2	**Apologies for Absence**	
3	**Declarations of Interest** The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of XXX Declarations made by members of the XXX Committee are listed in the ICBs Register of Interests. The Register is available either via the ICB Governance Lead or on the ICBs website at the following link……. **Declarations of Interest from today's meeting** With reference to business to be discussed at this meeting, XX declared that he is a shareholder in XXX. The Chair declared that the meeting is quorate and that XX would not be included in any discussions on agenda item 4 due to a direct conflict of interest which could potentially lead to financial gain for MS. The Chair and XX discussed the conflict of interest, which is recorded on the register of interest, before the meeting and XX agreed to remove himself from the table and not be involved in the discussion around agenda item 4.	
4	**Item Title** XX left the meeting, excluding himself from the discussion regarding xx *discussion minutes* XX was brought back in to the meeting	

21.8 Template to be used when commissioning services from GP Practices, including organisations in which GPs have a financial interest

Service:	
Question	**Comment/Evidence**
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the ICBs proposed commissioning priorities? How does it comply with the ICBs commissioning obligations?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers?	
In respect of every conflict or potential conflict, you must record how you have managed that conflict or potential conflict. Has the management of all conflicts been recorded with a brief explanation of how they have been managed?	
Why have you chosen this procurement route e.g. single tender action?	

What additional external involvement will there be in scrutinising the proposed decisions?	
How will the ICB make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	

Additional question when qualifying a provider on a list or framework or pre selection tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	

Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualifies provider) where GP practices are likely to be qualified providers	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for proposed direct awards to GP providers	
What steps have been taken to demonstrate that the services to which the contract relates are capable of being provider by only one provider?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

21.9 Declaration of Conflicts of Interests Form for Bidders/Contractors

Name of Organisation:	
Details of Interests held:	
Type of Interest	**Details**
Provision of services or other work for the ICB or NHS England	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with the ICB or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the ICBs or any of its members' or employees' judgements, decisions or actions	

Name of Relevant Person:	(Complete for all Relevant Persons)	
Details of Interests held:		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance?**
Provision of services or other work for the ICB or NHS England		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		

Any other connection with the ICB or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the ICBs or any of its members' or employees' judgements, decisions or actions		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed: _____

On behalf of: _____

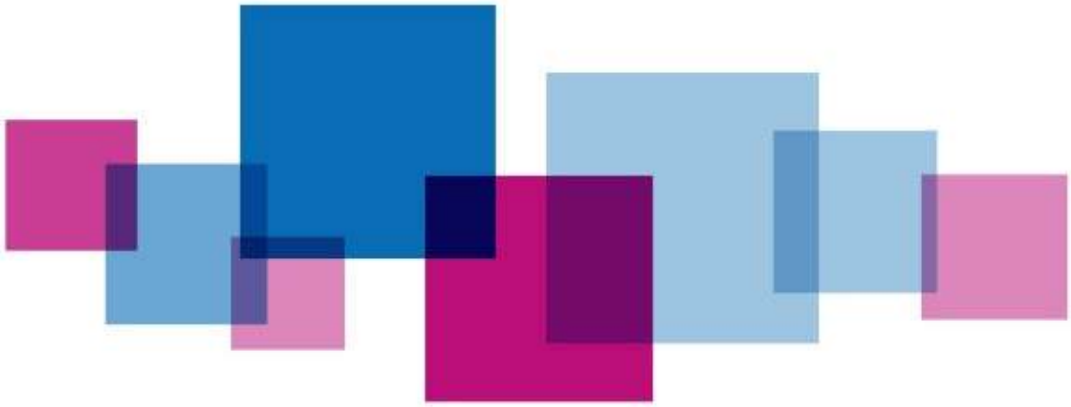
Date: _____

21.10 Register of Procurement Decisions and Contracts Awarded

ref no	contract/ service title	Procurement description	Existing contract or new (if new include details)	Procurement type	clinical lead	Executive Director	decision making process and name of decision making committee	summary of conflicts of interest declared and how managed	contract award	contract value (£) total	Contract value (£) to ICB

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Gifts and Hospitality Policy



Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	
Responsible Executive Director:	
Author and Job Title:	
Date Approved:	
Approved by:	Integrated Care Board (ICB) Board
Date of next review:	

Policy Review Checklist

	Yes/ No/NA	**Supporting information**
Has an Equality Impact Assessment Screening been completed?	Yes	See Appendix 1
Has the review taken account of latest Guidance/Legislation?	Yes	The policy is aligned to the Revised Statutory Guidance on Managing Conflicts of Interest in the NHS (February 2017)
Has legal advice been sought?	No	Specialist advice has been sought from the relevant Counter Fraud service
Has HR been consulted?	Yes	Advice has been sought from HR. HR issues arising from the application of the policy are set out in relevant HR policies and the recruitment toolkit

	Yes/ No/NA	Supporting information
Have training issues been addressed?	Yes	Mandatory training requirements are detailed in the policy. NHSE provides a mandatory training package which is completed annually.
Are there other HR related issues that need to be considered?	No	The policy refers to relevant HR policies
Has the policy been reviewed by Staff Partnership Forum?	No	The HR issues arising from the application of the policy are set out in relevant HR policies which are considered by the Staff Partnership Forum
Are there financial issues and have they been addressed?	No	There are no financial issues arising from the application of the policy
What engagement has there been with patients/members of the public in preparing this policy?	N/A	The policy describes the ICB's statutory responsibilities and there had been no engagement with patients/members of the public in preparing this policy beyond that undertaken by NHSE as part of the legislative process
Are there linked policies and procedures?	Yes	Associated policies are referenced in the policy
Has the lead Executive Director approved the policy?		The Chief Financial Officer will review the policy prior to Governing Body approval
Which Committees have assured the policy?		
Has an implementation plan been provided?	Yes	See Appendix 2
How will the policy be shared with		The policy will be published on the ICB website and intranet and will be featured in internal news communication. Regular prompts

	Yes/ No/NA	Supporting information
		regarding declaring interests will be placed in internal communications.
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	A DPIA has been completed for the gifts and hospitality process
Have Data Protection implications have been considered?	Yes	The gifts, hospitality and sponsorship register is published on the ICB website and consent for publication is included on the declaration form.

Version Control ***please remove this box once approved and finalised***		
Version	**Date**	**Consultation**
V1	19/05/2022	

Table of Contents

Gifts and Hospitality Policy

1 Introduction

This policy describes the arrangements that NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board has in place for the management of gifts and hospitality. This policy is written in line with the Statutory Guidance on Managing Conflicts of Interest in the NHS which was issued by NHS England in February 2017.

Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude, and individuals should be proud that their services are so valued. However, situations where the acceptance of gifts could give rise to conflicts of interest should be avoided as even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in line with this policy.

The NHS England Managing Conflicts of Interest Statutory Guidance the NHS 2017 defines a gift as "any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value."

The ICB has in place a Conflicts of Interest Policy that reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). This should be read in conjunction with this policy as combined, they describe the overall systems the ICB has in place to create an environment in which staff, ICB Board and committee members feel able, encouraged and obliged to be open, honest and upfront about actual or potential conflicts.

1.1 BNSSG ICB Values

The policy supports the ICB values by ensuring the ICB does the right thing, it enables commissioners to demonstrate they are acting fairly and with integrity. The policy outlines best practice for managing gifts and hospitality which enables the ICB to strive for excellence, behave with integrity and to do the right thing.

2 Purpose and scope

The aims and objectives of this policy are to:

- Safeguard clinically led commissioning, whilst ensuring objective investment decisions;

- Enable commissioners to demonstrate that they are acting fairly and transparently and in the best interests of their patients and local populations;
- Uphold confidence and trust in the NHS;
- Ensure that the ICB operates within the legal framework.

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 contracts, self-employed consultants and individuals working for the ICB under a contract for services)
- Any work experience staff or volunteers
- Members of the ICB Board, all members of the ICB's committees, sub-committees or sub groups including co-opted members, appointed deputies and any member of committees/groups from other organisations. Where the ICB is participating in a joint committee, any interests which are declared by the committee members should be recorded on the register(s) of interest

These are collectively referred to as 'individuals' hereafter.

3 Duties – legal framework for this policy

This policy is written in line with the Revised Statutory Guidance on Managing Conflicts of Interest in the NHS which was issued by NHS England in February 2017.

The ICB has in place a Conflicts of Interest Policy that reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the Act.

4 Responsibilities and Accountabilities

Chief Executive

- Has overall accountability for the ICB's management of gifts and hospitality.

Line Managers

- Provide basic advice, support and guidance on how gifts and hospitality should be managed in line with this policy and advise staff including as part of local induction.
- Ensure their team members do not accept a gift or hospitality that would create a breach of this policy

- Ensure and gifts and hospitality offered to their team which meet the criteria described in sections 6 and 7 are declared regardless of whether or not the offer is accepted
- Line Managers are responsible for ensuring that staff undertake their mandatory training and are aware of requirements associated with managing declarations of gifts and hospitality

Corporate Secretary

- Provides advice, support and guidance on how gifts and hospitality should be managed.
- Maintains the register(s) of gifts and hospitality
- Supports the Conflict of Interest Guardian to enable them to carry out their role effectively and,
- Ensures that the appropriate administrative processes are in place to ensure compliance with legislation and statutory guidance

Contact details can be found at Appendix 3.

Conflicts of Interest Guardian

This role is undertaken by the ICB Audit and Risk Committee Chair who will:

- Act as a conduit for members of the public and healthcare professionals who have any concerns with regards to the acceptance of gifts and hospitality or conflicts of interest
- Be a safe point of contact for employees or workers of the ICB to raise any concerns in relation to this policy
- Support the rigorous application of gift and hospitality principles and policies
- Provide independent advice and judgement.
- Provide advice on minimising risks of conflicts of interest

Individuals

Every individual has the responsibility to ensure that they complete annual conflicts of interest training. This training is available through the training platform.

All individuals must consider the risks associated with accepting offers of gifts, hospitality and entertainment when undertaking activities for or on behalf of the ICB and should not accept gifts that may affect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances and is especially important during procurement exercises, as the acceptance of gifts could give rise to real or perceived conflicts of interests, or accusations of unfair influence,

collusion or canvassing. All individuals are expected to declare any gifts and hospitality offered.

All individuals must declare all offers of gifts, hospitality and entertainment whether accepted or rejected.

Under no circumstances should individuals ask for any gifts.

ALL Individuals - Disclosure UK Database
Disclosure UK provides a valuable opportunity for healthcare professionals to further demonstrate their integrity in the eyes of patients and the public. All ICB staff who undertake work for pharmaceutical companies must disclose payments on the UK Disclosure database. All work undertaken with pharmaceutical companies must also be recorded on a Declaration of Interest Form.

5 Definitions/explanations of terms used

Gift	Any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value
Hospitality	Offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events etc.

6 Gifts

A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value.

As an overarching principle ICB staff should not accept gifts that may affect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances.

Any personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declined, whatever their value and whatever their source, and the

offer which has been declined must be declared to the Corporate Governance Team within 28 days so that it can be recorded in the Gifts and Hospitality register.

Gifts from suppliers or contractors doing business (or likely to do business) with the ICB should be declined, whatever their value (with the exception of low cost branded promotional aids under the value of £6 which must be declared). The individual to whom the gift was offered must declare the offer to the Corporate Governance Team within 28 days so that it can be recorded in the Gifts and Hospitality register.

Modest gifts from other sources (e.g., patients, families and service users) under a value of £50 may be accepted and do not need to be declared. ICB staff should not ask for any gifts.

Gifts over the value of £50 should only be accepted on behalf of the ICB (e.g., to the ICB's charitable funds or equivalent), not in a personal capacity. These must be declared to the Corporate Team within 28 days so they can be recorded in the Gifts and Hospitality register.

Multiple gifts from the same source over a 12-month period should be treated in the same way as gifts over £50 where the cumulative value exceeds £50.

A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known or an estimate that a reasonable person would make as to its value) and at all times keeping the overarching principle at the heart of decision making.

7 Hospitality

Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events etc.

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes outside of 'traditional' working hours. As such, individuals will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

When accepting or providing hospitality, individuals should be able to demonstrate that the acceptance or provision of hospitality would benefit the NHS or ICB. Individuals must not ask for or accept hospitality that may affect, or be seen to affect, their

professional judgement. Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event.

Caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these as there may be particular sensitivities, for example if a contract re-tender is imminent. Where there is uncertainty as to whether a gift or hospitality is acceptable, advice should always be sought from the Corporate Governance Team before an offer is accepted.

7.1 Meals and Refreshments

- Under a value of £25 may be accepted and need not be declared;
- Of a value between £25 and £75 may be accepted and must be declared;
- Over a value of £75 should be refused unless (in exceptional circumstances) Executive Director approval is given. A clear reason should be recorded in the ICBs Gifts and Hospitality register as to why it was permissible to accept;
- A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

7.2 Travel and Accommodation

- Modest offers (i.e., standard public transport rates in the UK or mileage payments in line with the NHS standard public transport mileage rate) to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared;
- Offers which go beyond modest or are of a type that the ICB may might not usually offer i.e., business class or first class travel and accommodation or foreign travel, need approval by an Executive Director and should only be accepted in exceptional circumstances. Such offers must be declared whether it is accepted or not and a clear reason should be recorded on the Gifts and Hospitality Form as to why it was permissible to accept travel and accommodation of this type

7.3 Sponsored Events

Sponsorship of ICB events by external parties is valued and offers to meet some or part of the costs of running an event secures their ability to take place, benefitting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of

interest between the organiser and the sponsor and it is important that individuals are aware of the safeguards in place to manage this. As such, the following principles must be adhered to:

- Sponsorship of ICB events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS;
- There should be no direct conflict of interest between organiser and sponsor;
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not be supplied;
- At the ICB's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency;
- The ICB should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event;
- Staff should declare their involvement with sponsored events to the Corporate Governance Team within 28 days so that the Register of Gifts, Hospitality and Sponsorship can be updated accordingly.
- A Gifts, Hospitality and Sponsorship Form (appendix 4) must be completed and given to the Corporate Governance Team.
- If there is any uncertainty regarding the acceptance of sponsorship, individuals must seek advice from their Line Manager or the Corporate Governance Team before accepting any offer.

The ICB has a separate Policy for the Sponsorship of Activities and Joint Working with the Pharmaceutical Industry that can be found on the ICB website. **[Update link]**

A Register of Gifts, Hospitality and Sponsorship template is at appendix 5 and will be made publicly available on the ICB website. **[Update link]**

Acceptance of commercial sponsorship should not in any way compromise commissioning decisions of the ICB or be dependent on the purchase or supply of goods or services. Sponsors should not have any influence over the content of ICB events, meetings, seminars, publications or training events. The ICB will not endorse individual companies or their products.

7.4 Other forms of Sponsorship

Organisations external to the ICB or NHS may sponsor posts or research. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

Where such circumstances arise, advice should be sought from the Corporate Governance Team before proceeding or continuing with any arrangement so that the conflict of interest can be appropriately managed. Further information can also be found on the NHS England website at: https://www.england.nhs.uk/ourwork/coi/

8 Declarations of Gifts and Hospitality

The ICB is required to maintain one or more registers of gifts, hospitality and sponsorship and must ensure that robust processes are in place to ensure that individuals do not accept gifts or hospitality or other benefits, which might reasonably be seen to compromise their professional judgement or integrity.

A gifts, hospitality and sponsorship register will be maintained for all of the individuals referred to in section 2 by the Corporate Governance Team and will be made publicly available on the ICB website.

In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). Where an individual believes that substantial damage or distress may be caused to them or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing to the ICB Conflicts of Interest Guardian (Appendix 3). The outcome of this request will be shared with the individual within 10 working days.

Where a decision is made not to publish information the ICB will retain a confidential un-redacted version of the register(s). Where a decision is made to refuse a request not to publish information the individual will have the right to appeal this decision

through the ICB Grievance Policy. During this process a redacted form of the information will be published.

9 Audit of Gifts and Hospitality

The ICB is required to undertake an audit of their Gifts and Hospitality management as part of its internal audit on an annual basis. This audit is completed by the ICB's Internal Auditor, and the outcome will be reflected in the ICB's Annual Governance Statement as well as forming part of the discussion at the end of year governance meeting with NHS England.

10 Raising Concerns and Breaches

It is the duty of all individuals referred to in section 2 to speak up about genuine concerns in relation to the administration of this policy and to report these concerns in line with the ICB's Freedom to Speak Up Policy. Suspicions must not be ignored or investigated directly.

Anyone who is not an employee or worker of the ICB, but who wishes to report a suspected or known breach of this policy should ensure that they comply with their own organisation's Freedom to Speak Up Policy.

All disclosures will be treated with appropriate confidentiality at all times in accordance with ICB policies and applicable laws. Anybody making such disclosures may expect an appropriate explanation of any decisions taken as a result of any investigation.

Providers, patients and other third parties may make a complaint to NHS Improvement in relation to the ICB's conduct under the Procurement Patient Choice and Competition Regulations.

Anonymised details of breaches will be published on the ICB's website for the purpose of learning and development. The outcomes of any investigation of breaches will also be reported to the Audit and Risk Committee and NHS England.

11 Breaches of the ICB's Gifts and Hospitality Policy

Failure to comply with the policy on Gifts and Hospitality can have serious implications for the ICB and any individuals concerned.

Civil implications: The ICB could face civil challenges to decisions it makes. For instance, if breaches occur during a service re-design or procurement exercise, the ICB risks a legal challenge from providers that could potentially overturn the award of a

contract, lead to damages claims against the ICB, and necessitate a repeat of the procurement process. This could delay the development of better services and care for patients, waste public money and damage the ICB's reputation. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal implications: The acceptance of inappropriate Gifts, Hospitality or Sponsorship could lead to criminal investigations into fraud, bribery and corruption. This could have implications for the ICB, linked organisations, and the individuals who are engaged by them.

Disciplinary implications: Individuals who fail to disclose any gift or hospitality offered to them in line with this policy will be subject to investigation and, where appropriate, to disciplinary action. Individuals should be aware that the outcomes of such action may result in the termination of their employment or position with the ICB.

Statutorily regulated healthcare professionals who work for or are engaged by the ICB are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest including the acceptance of gifts and hospitality. Failure to comply with this policy may result in the ICB reporting such individuals to their regulator for investigation if they believe that they have acted improperly. The consequences for inappropriate action could include fitness to practise proceedings being instigated which may result in individuals being struck off by their professional regulator.

11.1 Managing breaches of this policy

All breaches of the Gifts and Hospitality policy will be subject to internal investigation in the first instance, notwithstanding any external investigations which may be necessary. Internal investigations will be completed in line with the Freedom to Speak Up and all subsequent actions will be taken in line with relevant Human Resource policies.

Investigation outcomes in relation to breaches of this policy will be shared with the Audit and Risk Committee who will review any lessons to be learnt and recommendations for action. The Audit and Risk Committee will monitor the implementation of any recommendations raised from the outcomes of investigations.

Once a breach is confirmed, the Corporate Governance Team will ensure that NHS England is notified, including information about the nature of the breach and the actions taken in response. This information will also be published anonymously on the ICB website and communications plans will be put in place to manage any media interest. This will be managed on case by case basis.

12 Bribery and Fraud

12.1 Bribery

The ICB takes a zero tolerance approach to bribery. The ICB policy relating to Fraud and Bribery can be found on the ICB Intranet and website. The Bribery Act 2010 defines bribery as the giving or taking of a reward in return for acting dishonestly and or in breach of the law. There are four different classifications of bribery:

- Bribing another person.
- Being bribed,
- Bribing a foreign public official; or
- Failure to prevent bribery.

Any offering, promising, giving, requesting, receipt or acceptance of a bribe by any employee when conducting business on behalf of the ICB or when representing the ICB in any capacity is strictly forbidden and is contrary to the Bribery Act 2010. Furthermore, the ICB requires all individuals to report any suspicions of the above to its Local Counter Fraud Specialist, or the NHS Counter Fraud Authority. Individuals who fail to adhere to this policy will be dealt with by means of a criminal investigation, civil recovery and/or via the ICB's disciplinary processes.

Any suspicions or concerns of acts of bribery can be reported confidentially online via https://cfa.nhs.uk/reportfraud or via the NHS Fraud and Corruption Reporting Line on 0800 028 4060. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

12.2 Fraud

The ICB has a zero tolerance approach to fraud. The ICB policy relating to Fraud and Bribery can be found on the ICB Intranet and website. The Fraud Act 2006 creates a criminal offence of fraud and defines three main ways of committing it:

- Fraud by false representation;
- Fraud by failing to disclose information; and
- Fraud by abuse of position.

In these cases, an offender's conduct must be dishonest, and their intention must be to make a gain or cause a loss (or the risk of a loss) to another.

Any suspicions or concerns of acts of bribery can be reported confidentially online via https://cfa.nhs.uk/reportfraud or via the NHS Fraud and Corruption Reporting Line on 0800 028 4060. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

13 Training requirements

The information and responsibilities within this policy will be disseminated to staff by the publication of this policy on the BNSSG ICB website and intranet. Conflict of Interest training which includes Gifts and Hospitality is mandatory for all individuals referred to in section 2 and is to be completed annually by all staff. Conflicts of Interest training packages are provided by NHS England. Training compliance rates will be recorded as part of the ICB's annual conflicts of interest audit. Training compliance rates for decision making staff will be reported to NHS England annually. Decision making staff are those roles defined in the Constitution as members of the ICB Board and Terms of Reference as members of the ICB Board Sub Committees.

14 Equality Impact Assessment

All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry.

15 Implementation and Monitoring Compliance and Effectiveness

An implementation plan has been prepared and is attached at appendix 2. Compliance with this policy will be monitored by the Corporate Governance team and reported quarterly to the Audit and Risk Committee. The outcomes of the mandatory annual audit will be reported to the Audit and Risk Committee.

16 References, acknowledgements and associated documents

The following related documents may be accessed through our website:

- Local Counter Fraud, Bribery and Corruption Policy
- Grievance Policy and Procedure
- Disciplinary Policy
- Managing Conflicts of Interest Policy
- Policy for the Sponsorship of Activities by and Joint Working with the Pharmaceutical Industry
- Freedom to Speak Up Policy

17 Appendices

Appendix 1 Equality Impact Assessment

Appendix 2 Implementation Plan

Appendix 3 Contact details for the Corporate Governance Team and Conflicts of Interest Guardian

Appendix 4 Gifts, Hospitality and Sponsorship declaration form

Appendix 5 Gifts, Hospitality and Sponsorship Register template

17.1 Equality Impact Assessment

Equality Impact Assessment Screening		
Query	Response	
What is the aim of the document?	To set out the ICB responsibilities in relation to Revised Statutory Guidance on Managing Conflicts of Interest in the NHS (February 2017) and processes to ensure compliance	
Who is the target audience of the document (which staff groups)?	All staff	
Who is it likely to impact on and how?	Staff	Yes, in that is describes the way in which staff are required to declare all gifts and hospitality as set out in the policy. It does not have an impact on staff in terms of Equalities and Human Rights (see below)
	Patients	no
	Visitors	no
	Carers	no
	Other – governors, volunteers etc.	Yes – all those defined as staff in the policy are required by statutory guidance to conform to the

		policy. It does not have an impact in terms of Equalities and Human Rights (see below)
Does the document affect one group more or less favourably than another based on the 'protected characteristics' in the Equality Act 2010:	Age (younger and older people)	no
	Disability (included physical and sensory impairments. Learning disabilities. Mental health)	This policy is available in formats as requested
	Gender (men or women)	no
	Pregnancy and maternity	no
	Race (includes ethnicity as well as gypsy travellers)	no
	Sexual orientation (lesbian, gay and bisexual people)	no
	Transgender people	no
	Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)	no
	Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)	no – the ICB has processes in place to ensure that rights to privacy are protected

17.2 Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
ICB Board	Ensure the ICB Board is aware of ICB's responsibilities and provide assurance that appropriate process is established to ensure legal compliance	Cover paper to the policy to be presented to the ICB Board	Corporate Secretary	1st July 2022	July 2022	staff time, Governing Body time
Executive Directors	Ensure awareness of responsibilities to ensure compliance Individual Executive Director responsibilities Directorate Responsibilities	Discussion with individual directors as required	Corporate Support Officer	From 1st July 2022	Ongoing	staff time, executive director time
All Staff	Ensure awareness of ICB processes and procedures	Policy to be placed on website Information about the policy and ICB process to be placed on the Hub Information about the policy and ICB process to be communicated through The Voice Annual Conflicts of Interests training module	Corporate Support Officer /Training manager	From 1st July 2022	1st July 2022 - Policy to added to The Hub, and the website following approval. July 2022 – Inclusion in The Voice following approval Ongoing - Annual declarations to be collated and staff to be reminded to undertake training.	staff time training module

17.3 Contact details for ICB Governance Lead and Conflict of Interest Guardian

[TBC – Senior person responsible for Governance]	
Name	**TBC**
Title	**TBC**
Telephone No.	**TBC**
Email	**TBC**
Conflict of Interest Guardian	
Name	John Cappock
Title	Independent Non-Executive Member for Audit
Email	John.cappock@nhs.net
Corporate Governance Team	
Email	bnssg.corporate@nhs.net

17.4 Gifts, Hospitality and Sponsorship Declaration form

Recipient Name	
Position within, or relationship with, the ICB (or other organisation):	
Date of Offer	
Date of Receipt (If applicable)	
Details of Gift / Hospitality/Sponsorship	
Estimated Value (£)	
Name of person/company making the offer and nature of business	
Details of any previous offers or acceptance by this person / company	
Name of Officer reviewing and approving the declaration made and date	
Was the Gift / Hospitality/Sponsorship Accepted or Declined?	
Reason for accepting or declining	
Other Comments	

The ICB is required to take steps to manage conflicts of interest that may arise; we collect this information to ensure that we are able to comply with the statutory guidance on this subject. The information collected in this form will be held securely and used for the purposes of identifying and managing conflicts of interest. Personal information will be managed in line with the General Data Protection Regulation and Data Protection Act 2018. Details of gifts, hospitality and sponsorship are published online and available on our website. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable as and no later than 28 days after the interest arises. I am aware that if I do

not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I **do** / **do not (cross out as applicable)** give my consent for this information to be published on registers that the ICB holds. If consent is NOT given, please give reasons below:

Employee Signature:

Employee Print name:

Date:

Line Manager Signature:

Line Manager Print name:

Date:

Please return to **The Corporate Team, bnssg.corporate@nhs.net**

17.5 Gifts, Hospitality and Sponsorship Register template

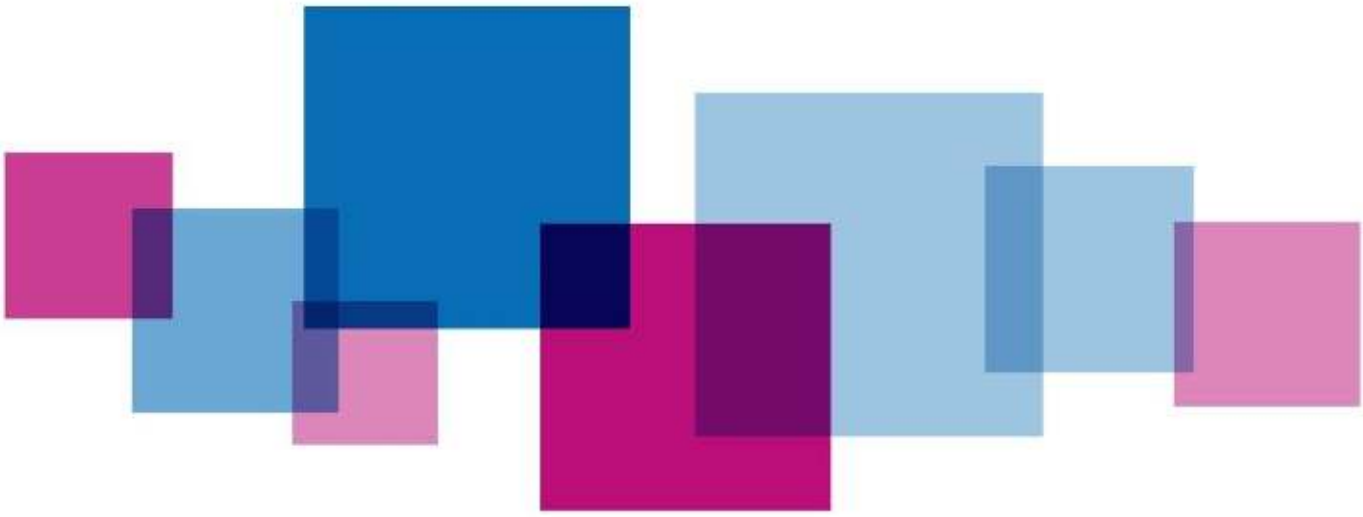
Register of Gifts, Hospitality and Sponsorship
20xx/xx

Name	Position	Date of offer	Declined or accepted	Date of receipt (if applicable)	details of gift or hospitality	estimated value	Supplier/offer or name and nature of business	Reason for Accepting or declining	details of officer reviewing/approving the declaration and date of decision if applicable

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Risk Management Framework

DRAFT V1



Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	To be filled in by Corporate Services
Responsible Executive Director:	
Author and Job Title:	
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?		
Has the review taken account of latest Guidance/Legislation?		
Has legal advice been sought?		
Has HR been consulted?		
Have training issues been addressed?		
Are there other HR related issues that need to be considered?		
Has the policy been reviewed by Staff Partnership Forum?		
Are there financial issues and		

	Yes/ No/NA	Supporting information
have they been addressed?		
What engagement has there been with patients/members of the public in preparing this policy?		
Are there linked policies and procedures?		
Has the lead Executive Director approved the policy?		
Which Committees have assured the policy?		
Has an implementation plan been provided?		
How will the policy be shared with		
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?		
Has a DPIA been considered in regards to this policy?		
Have Data Protection implications have been considered?		

Version Control ***please remove this box once approved and finalised***

Version	Date	Consultation

Table of Contents

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.

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 CG
- 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.

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).

The values of the organisation https://bnssgccg.nhs.uk/about-us/our-values/ support 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 hold a corporate or clinical role. For the purposes of this document 'employees' includes BNSSG ICB staff, ICB Board members, executive officers, lay members (including co-opted members), those with honorary contracts, volunteers, contractors and trainees.

The purpose of this framework is to:

- Ensure robust governance and risk management arrangements to support the delivery of the ICB'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.

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).

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.

5 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, Governance and Risk Committee, the Quality Committee, and Strategic Finance Committee and Clinical Executive Committee. These committees are responsible for the review and scrutiny of specific risks, seeking assurance that risks are properly managed. If a committee is not assured that risks are being properly managed that concern is to be escalated to the ICB Board. A diagram of the governance structure is at appendix 5.

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 risks reported via the ICB Board Assurance Framework and 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 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 and the ICB Board Assurance Framework as standing item 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 on both the Corporate Risk Register and the ICB Board Assurance Framework. The Committee reviews the Corporate Risk Register and ICB Board Assurance Framework as standing agenda items at its meetings.

The Finance, Digital and Estates 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 both the Corporate Risk Register and the ICB Board Assurance Framework. The Committee reviews the Corporate Risk Register and ICB Board Assurance Framework as standing agenda items at its meetings.

~~**Clinical Executive Committee**~~

~~The Clinical Executive Committee is accountable to the ICB Board and makes recommendations to the ICB Board regarding the ICB's commissioning strategy and reviews provider performance, monitoring improvements so that objectives are achieved. 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 has oversight of risks that relate to commissioning strategy and performance. The Committee reviews the Corporate Risk Register and the ICB Board Assurance Framework as a standing agenda item at its meetings.~~

The Primary Care Commissioning Committee

The Primary Care Commissioning 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 Committee reviews the Corporate Risk Register and the ICB Board Assurance Framework quarterly.

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.

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 Corporate Secretary

The Corporate Secretary 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 ICB Board Assurance Framework process
- Establishing and maintaining an effective corporate risk register process
- 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

Associate Director of Corporate Services

The Associate Director for Corporate Services is responsible for ensuring the ICB maintains a robust risk management process and will oversee the Risk Management Framework.

The Executive Team

The Executive team is responsible for identifying risks to be placed on the Corporate Risk Register and ICB Board Assurance Framework. The Executive Team meetings are the forum for peer review of the Corporate Risk Register and ICB Board Assurance Framework 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 are prepared and reviewed on a regular basis

- 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 Primary Care Commissioning Committee.

The Chief Executive - Accountable Officer

The Chief Executive has overall responsibility for having an effective risk management system in place within the ICB 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 Commissioning 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

The Director with Lead for Risk Management

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

- Ensures there is a 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 Lay Member with lead role for Audit and Risk

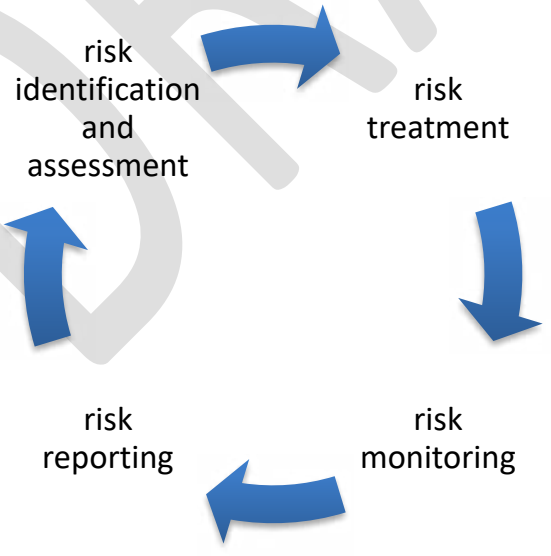
The Lay Member on the ICB Board with the lead role for overseeing audit, governance and risk will have the skills, knowledge and experience to assess and confirm that appropriate systems of internal control and assurance are in place for all aspects of governance including financial and risk management.

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. 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, Primary Care Commissioning Committee, Executive Team and wider management
- 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 risk and identify an appropriate lead.

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) (appendix 3).

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
- 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 Directorate and Corporate Risk Registers and through the ICB Board Assurance Framework.

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 and Committees. The impact of management actions will also be reported as the current risk score on Directorate Risk Registers, the Corporate Risk Register and the ICB Board Assurance Framework.

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 Corporate Risk Register is underpinned by Directorate Risk Registers. Directorate, Project and Corporate Risk Registers. Major programmes and all projects will also maintain risk registers which will be managed and reviewed by the Project Lead and reported to the Executive Director Lead. The Directorate and project 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. The Directorate and

Project Risk Registers are updated on a monthly basis. All risk owners are responsible for monitoring and updating progress to reduce risks and ensure that mitigating actions are completed. The Corporate Risk Register details the high level risks of the organisation i.e. those scoring 15 or more. (Appendix 4) Once shown on the Corporate Risk Register only the ICB Board can close the risk however ownership remains with the relevant Director and risk owner.

The reporting arrangements for the Corporate Risk Register and Directorate Risk Registers is described below:

Directorate Risk Registers		Timescale
Maintenance coordination including the addition of new risks	Designated person in each Directorate	Ongoing and at least monthly
Updating	Risk Owners	Ongoing and at least monthly
Review and Sign off	Directors	Ongoing and at least monthly
Monitoring	Directorate senior management	Ongoing
Project Risk Registers		**Timescale**
Maintenance coordination	Designated project lead	Ongoing and at least monthly
Updating	Risk Owners	Ongoing and at least monthly
Review and Sign off	Project Director	Ongoing and at least monthly
Monitoring	project senior management	Ongoing
Corporate Risk Register and ICB Board Assurance Framework		**Timescale**
Maintenance coordination	Corporate Secretary	Ongoing and at least monthly
Updating	Risk Owners	Ongoing and at least monthly
Review and sign off	Directors	Ongoing and at least monthly
Monitoring review and scrutiny of risks that are relevant to its business, and ensuring that	Finance, Digital, and Estates Committee Outcomes, Performance and Quality Committee PCCC	Monthly

appropriate and effective mitigating actions are in place		
review the establishment and maintenance of an effective system of integrated governance, risk management and internal control	Audit and Risk Committee	Each meeting
Exercise challenge regarding risks and the effectiveness of controls and mitigations Seek assurance regarding risks and the effectiveness of controls and mitigations	ICB Board	Quarterly

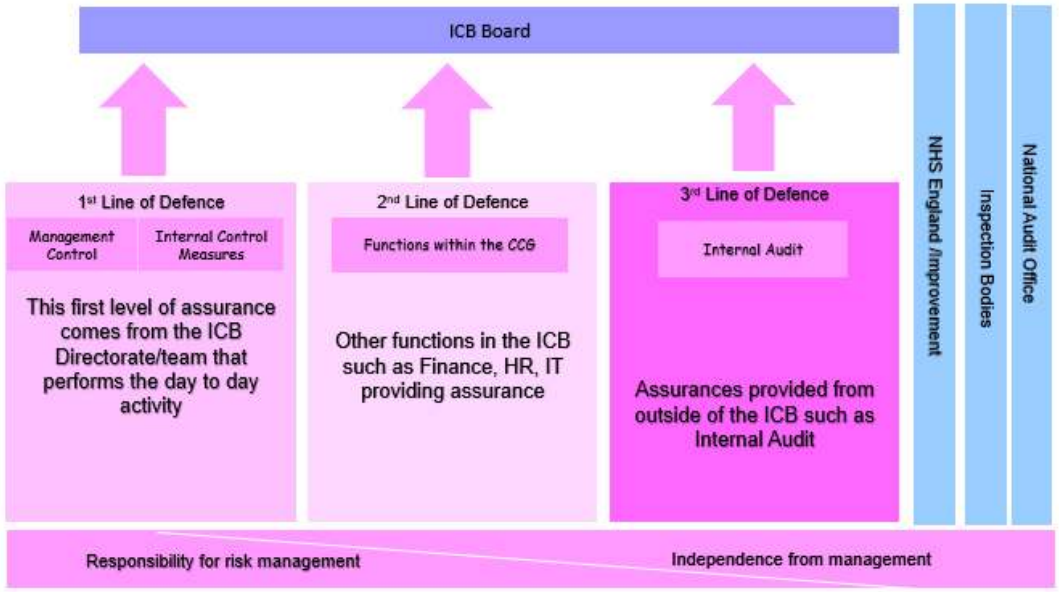
8 Assurance Framework

The principal objectives for the ICB and their associated risks, as agreed by the ICB Board, are set out in the ICB Board Assurance Framework. The ICB Board Assurance Framework enables the ICB Board to satisfy itself that risk to achieving the ICB's principal objectives are managed effectively. The ICB Board Assurance Framework identifies the controls in place to mitigate risks and the assurances available to the ICB Board that the risks are being managed. The ICB Board Assurance Framework indicates where there are potential gaps in controls and assurances and provides a summary of the actions in place to resolve these gaps. The target risk score for each risk is given on the ICB Board Assurance Framework.

The ICB Board committees: the Strategic Finance Committee, the Quality Committee, and the Clinical Executive Committee, have oversight of relevant risks on the ICB Board Assurance Framework. The committees review those risks on a monthly basis to gain assurance of progress to manage risks and close all identified gaps. The Audit and Risk Committee reviews the ICB Board Assurance Framework at each meeting as part of the maintenance of the system of integrated governance, risk management and internal control. The ICB Board receives the ICB Board Assurance Framework quarterly and seeks assurance regarding the effectiveness of controls and mitigations.

8.1 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)

8.2 Assurance Mapping

An Assurance Map provides clarity regarding the sources of assurance available:

- Providing a comparison of activities and types of assurance obtained
- Allowing for gaps in assurances to be identified
- Identifying where assurances are duplicated or repeated

The Audit and Risk Committee will receive an annual Assurance Map.

9 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

10 Equality Impact Assessment

A completed Equality Impact Assessment has been completed and is at appendix 1.

11 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, Governance and Risk Committee and through the annual review of governance arrangements. An implementation plan is at appendix 2.

12 Countering Fraud

The ICB is committed to reducing fraud in the NHS to a minimum, keeping it at that level and putting funds stolen through fraud back into patient care. Therefore, Counter Fraud risks in all relevant Directorates have been created by the Local Counter Fraud Specialist and assessed by Risk Leads.

13 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

14 Appendices

Appendix 1 Equality Impact Assessment

Appendix 2 Implementation Plan

Appendix 3 Risk Assessment Scoring Guidelines

Appendix 4 Corporate and Directorate Risk Register Template

Appendix 5 Governance Structure

14.1 Equality Impact Assessment

Equality Impact Assessment Screening		
Query	Response	
What is the aim of the document?	To set out the ICB 's Risk Management Framework, process and procedures and detail the governance arrangements and staff responsibilities	
Who is the target audience of the document (which staff groups)?	All staff	
Who is it likely to impact on and how?	Staff	yes in that it describes the way in which staff are required to declare all interests as set out in the policy. It does not have an impact on staff in terms of Equalities and Human Rights (see below)
	Patients	no
	Visitors	no
	Carers	no
	Other – governors, volunteers etc	yes – all those defined as staff in the policy are mandated to follow the framework. It does not have an impact in terms of Equalities and Human Rights (see below)
Does the document affect one group more or less favourably than another based on the 'protected characteristics' in the Equality Act 2010:	Age (younger and older people)	no
	Disability (includes physical and sensory impairments, learning disabilities, mental health)	no
	Gender (men or women)	no
	Pregnancy and maternity	no
	Race (includes ethnicity as well as gypsy travellers)	no
	Sexual Orientation (lesbian, gay and bisexual people)	no
	Transgender people	no
	Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)	no
	Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)	no – the ICB has in place to ensure that rights to privacy are protected

14.2 Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
ICB Board	Ensure GB is aware of ICB's responsibilities for risk management and provide assurance that appropriate process is established to ensure legal compliance A risk appetite statement is agreed by the ICB Board and clearly communicated across the organisation	Board training on Risk Management provided Cover paper to the policy to be presented to the ICB Board Board session in December to focus in Risk Appetite	CFO Corp Sec CFO/ Corp Sec			ICB Board /staff time ICB Board /staff time ICB Board ICB Board /staff time
AGR Committee	Ensure ARC is aware of ICB's responsibilities for risk management and provide assurance that appropriate process is established to ensure legal	Policy reviewed by ARC	corp sec			Committee /staff time

	compliance					
Executive Directors	Ensure awareness of responsibilities of • ICB process to ensure compliance • Individual Executive Director responsibilities • Directorate Responsibilities	Risk Management training ongoing support in 1:1 with corp sec	RSM corp sec			staff time
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	corp sec			
All Staff	Ensure awareness of ICB processes and procedures	Training offered by PMO Team available to all staff Framework to be placed on website Information about the policy and ICB process to be communicated through internal newsletter Awareness raising with directorates at appropriate team meetings	PMO Corp sec corp sec/Risk Leads			

Information taken from CCG Corporate Policy Register version 58 updated 24.6.22

Ref	Policy	Review Date	Note for ICB Board 1/7/22
1	Fraud and Bribery Policy	Jun-22	
2	Standing Financial Instructions	Apr-20	Will be superseded by policy to be agreed by ICB Board on 1/7/22
3	Disciplinary	Jun-25	
4	Grievance	Apr-23	
5	Managing Conflicts of Interest	Mar-22	Will be superseded by policy to be agreed by ICB Board on 1/7/22
6	Gifts and Hospitality	Mar-22	Will be superseded by policy to be agreed by ICB Board on 1/7/22
7	Records Management	Jul-21	
8	FOI Policy	Nov-21	
9	Sponsorship of Activities and Joint Working with the Pharmaceutical Industry Policy	Mar-23	
10	Information Governance Policy	Jun-24	
11	Confidentiality and Security of Information Policy	Jun-24	
12	Business Continuity Policy	Feb-22	
13	Serious Incident Requiring Investigation Policy	Dec-19	
14	Complaints Policy	May-23	
15	Safeguarding Policy	Jun-21	
16	Mental Capacity Act & Deprivation of Liberty Safeguards Policy 2018-2020 Policy	Nov-20	
17	EPRR Policy	Oct-20	
18	Policy for the development, approval and implementation of Patient Group Directions (PGDs) for use across BNSSG	Jan-21	
19	Maternity/Paternity, Adoption Leave and Shared Parental Leave	Oct-23	
20	Secondary Employment	Apr-23	
21	Appeals	Apr-23	
22	Bullying and Harassment	Oct-23	
23	Managing Performance (Capability) Policy	Oct-23	
24	Managing Sickness Absence Policy	Apr-23	
25	Travel and Expenses Policy	Apr-23	
26	Job Evaluation (Banding) Policy	Apr-23	
27	Flexible Working Policy	Apr-23	
28	Social Media Policy	Jun-22	
29	Intranet Policy	Jun-22	
30	Data Protection Impact Assessment Framework	Jan-20	
31	Information Risk Management Process	Jan-20	
32	Information Governance Management Framework and Strategy	Sep-20	
33	Information and Data Quality Policy	Mar-23	
34	Individual Rights Policy	Nov-21	For inclusion in Governance Handbook
35	Procurement Policy	Mar-21	
~~36~~	~~Commissioning Policy for Adult CHC~~ - replaced by 71	May-20	
37	Ending Employment Policy	Apr-23	
38	Annual leave and other leave	Apr-23	
39	Appraisal	Dec-23	
40	Prevent policy	Jun-21	
41	Hot Desking Policy	Jul-21	
42	Freedom to Speak Up Policy	Jul-22	

43	Health and Safety Policy	Sep-22	
44	Learning Disabilities Mortality Review (LeDeR) Policy Framework	Sep-21	
45	Security management	Oct-22	
46	Domestic abuse	Nov-21	
47	Learning and Development Policy	Apr-23	
48	Acceptable Use of IT Policy	Mar-22	
49	Clear Screen & Desk Policy	Mar-24	
50	Password Policy	Mar-22	
51	Lone Working Policy	Dec-22	
52	Pay protection	Oct-23	
53	Organsisational Change	Nov-23	
54	Risk Management Framework	Nov-21	Will be superseded by policy to be agreed by ICB Board on 1/7/22
55	Recruitment and Selection Policy	Jan-24	
56	Remote Working & Portable Devices	Dec-21	
57	System Level Security	Dec-21	
58	Continuity Management	Dec-23	
59	Network Security	Dec-21	
60	Access Control	Dec-21	
61	Anti-Virus Policy	Jul-21	
62	Asset Management	Jul-21	
63	Backup Policy	Dec-21	
64	Change Control	Jul-21	
65	Information Security	Dec-21	
66	IT Disposal	Dec-21	
67	Patch Management	Dec-21	
68	Registration Authority	Jul-21	
69	CHC Childrens' and Young People's Continuing Care Policy	Sep-21	
70	Personal Health Budgets Policy	Feb-23	
71	Individual Funded Care	Apr-23	
Legacy	Bristol CCG Funding and Study Leave Policy		
Legacy	Bristol CCG Health and Safety Policy		
Legacy	Organsisational Change Policy		
Legacy	Bristol CCG Pay Protection		
Legacy	Bristol CCG Professional Registration Policy and Procedure		
Legacy	Bristol CCG Redeployment Policy		
Legacy	Bristol CCG Redundancy Policy		
Legacy	Bristol CCG Secondment Policy		
Legacy	Bristol CCG Work-life Balance Policy		
Legacy	Patient Choice and Shared Decision-making policy		
Legacy	Supporting Attendance Policy - UHBW Legacy Policies, Contractual HT Transfer	Mar-23	
Legacy	Grievance Policy - UHBW Legacy Policies, Contractual HT Transfer	Aug-21	
Legacy	Disciplinary Policy - UHBW Legacy Policies, Contractual HT Transfer	Jun-21	
Legacy	Retirement Policy and Procedures - UHBW Legacy Policies, Contractual HT Transfer	Feb-22	
Legacy	Equality, Diversity and Human Rights policy - UHBW Legacy Policies, Contractual HT Transfer	May-22	
Legacy	Protection of pay and conditions policy - UHBW Legacy Policies, Contractual HT Transfer	May-22	

Legacy	Supporting performance policy and procedure - Contractual Policy HT Transfer	Feb-22	
Legacy	Discipline Policy and Procedure - Contractual Policy from CHC transfer from NSCP	Jun-21	
Legacy	Grievance Policy & Procedure - Contractual Policy from CHC Transfer from NSCP	Aug-21	
Legacy	Policy for Pay - Contractual Policy from CHC transfer from NSCP	Aug-21	
Legacy	Retirement Policy - Contractual Policy from CHC transfer from NSCP	May-20	
Legacy	Rostering Policy - Contractual Policy from CHC transfer from NSCP	Aug-21	

Commissioning Polices	Referral Route	Under Review now	Year Review Due
Facial Surgery and Treatments	EFR	N	2024
Female Genitalia Surgery	EFR	Y	2020
Female Sterilisation	PA	Y	2020
Fertility	CBA	Y	2020
Reversal of Vasectomy or Female Sterilisation	PA	Y	2019
Haemorrhoids	CBA	Y	2019
Vasectomy	CBA	Y	2020
Hernia Management and Repair in Adults	CBA	Y	2020
Intrauterine Coil Insertion and Removal	CBA	Y	2019
Liposuction to Reduce Fat Pockets & Deposits	EFR	Y	2024
Multiple Chemical Sensitivity (MCS) & Clinical Ecology/Environmental Medicine	EFR	Y	2024
Varicose Veins Surgery	PA	Y	2020
Chiropractic Assessment and Treatment	EFR	Y	2020
Abdominal Loose Skin Removal	EFR	Y	2020
Benign Skin Lesions	PA	Y	2019
Breast Surgery – Female	EFR	Y	2020
Breast Surgery - Male	EFR	Y	2020
Breast Reconstruction post Cancer	CBA	Y	2021
Divarication of Recti	EFR	Y	2020
CPAP for Mild OSAHS	CBA/PA	Y	2020
Dropped Foot; Surface Orthotic Functional Electrical Stimulation for Dropped Foot of Central Neurological Origin	EFR	Y	2019
Epididymal Cysts	EFR	N	2024
Exogen Devices	PA	Y	2025
Extracorporeal Shockwave Therapy (ESWT)	EFR	Y	2020
Radiofrequency Ablative Therapy for the Treatment of High Grade Dysplasia in Barrett's Oesophagus	CBA	Y	2020
Rectopexy andSTARR	IFR	N	On Hold
Ganglia Removal	EFR	Y	2020
Spinal Surgical Opinion – Referral for Assessment	PA	Y	2019

Testicular Prosthesis Insertion	EFR	N	2024
Hair Removal Policy (including Electrolysis & Laser Therapy)	EFR	Y	2022
Hyperhydrosis, Treatment of	EFR	Y	2025
Ingrown Toenail	EFR	Y	2025
Penile Conditions - Surgical Opinion and Treatment including Circumcision in all male patients under the age of 18 years	PA	N	2024
Laser Hair Removal for Pilonidal Disease	EFR	Y	2025
Nasal Surgery	PA	Y	2025
One-Step Nucleic Acid Amplification (OSNA)	CBA	Y	2020
SpyGlass® Direct Visualisation Cholangioscopy	CBA	Y	2019
Cosmetic Surgery or Treatment	EFR	Y	2020
Penile Conditions - Surgical Opinion and Treatment including Circumcision in all male patients over the age of 18 years	PA	Y	2025
Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary Incontinence in Adults	EFR	N	2024
Eye Procedure - Blepharoplasty	PA	Y	2022
Eye Procedure - Cataract referral for Assessment of Surgical Treatment	CBA	Y	2022
Eye Procedure - Chalazia	PA	Y	2022
Eye Procedure - Cosmetic Contact Lenses	EFR	Y	2023
Eye Procedure - Ectropion and Entropion	CBA	Y	2023
Anal Skin Tags	EFR	N	2023
Carpal Tunnel	CBA	Y	2022
Eye Procedure - Laser Surgery for Refractive Error	EFR	N	2023
Eye Procedure - Raised Intraocular Pressure	CBA	N	2023
Eye Procedure - Surgical Correction of Strabismus or Amblyopia in Adults	PA	Y	2022
Adenoidectomy	CBA	Y	2022
Ear Wax Removal; Referral to Secondary Care for all ages	PA	Y	2022
Dupuytren's Contracture	CBA	Y	2022

Elective Treatment in Northern Ireland, Scotland and Wales	EFR	Y	2022
Grommets – Referral for Adults over 12 with Otitis Media with Effusion	CBA/PA	Y	2022
Grommets – Referral for Children under 12 with Persistent Otitis Media with Effusion	CBA/PA	Y	2022
Grommets - Referral for children under 18 with Recurrent Otitis Media	PA	Y	2022
External Ear Surgery Policy	EFR	Y	2022
Laryngeal Surgery (Voice Box)	CBA	N	2023
Eye Procedure - Vitreous Floaters	EFR	N	2023
Multifocal Lenses	EFR	N	2023
Forefoot Surgery	CBA	N	2023
Gallbladder Removal	CBA	Y	2022
Shoulder Impingement Surgery for Subacromial Pain	CBA	N	2022
Skin Camouflage Services	PA	N	2022
Skin Contouring	EFR	N	2022
Tattoo Removal	PA	N	2022
Hip Pain including Impingement, Open or Arthroscopic Femoro-Acetabular Surgery for	CBA	N	2022
Hip Replacement Surgery	CBA	N	2022
Homeopathy	EFR	Y	2021
Hysterectomy for Menorrhagia	CBA	N	2022
Hydrocele in Males over 16 years of age	PA	N	2023
Knee Arthroscopy	CBA	N	2022
Knee Replacement Surgery (including Partial and Total Knee Replacement with or without Patella Replacement or Resurfacing)	CBA	N	2022
Low Back Pain and Sciatica in over 16s, Management of	CBA	N	2022
MRI - Open Scanner at Cobalt Health Cheltenham	CBA	N	2023
Speech and Language Therapy in Secondary Care	PA	N	2023
Palatine Uvula	EFR	N	2024
Snoring, Surgical Intervention for	EFR	N	2022

Tongue Tie Division	CBA	N	2022
Tonsillectomy; Referral for Assessment – Adults and Children	PA	N	2022
Prophalytic Mastectomy	CBA	N	2022
Prostatic Urethral Lift (UroLift® System)	CBA	N	2022
Syndactyly – surgical correction of the fingers	PA	N	2022
Temporomandibular Jaw Motion Rehabilitation Devices	EFR	Y	2022
Trigger Finger	CBA	N	2022
Weight Management – BNSSG Tier 3 and 4	CBA	Y	2022
Acupuncture	CBA	N	2024
Alfa Pumps	PA	N	2022
Management of patients moving in / out of BNSSG Area	EFR	Y	2022
Population Screening outside of National Screening Committee guidelines	EFR	Y	2022
Treatment Partially Commissioned by other Commissioners	EFR	Y	2022
MRI - Breast Screening	CBA	Y	2022
Chest Wall Deformity, (Correction of) for Cosmetic Purposes	EFR	N	2023
Chronic Fatigue Syndrome / ME Referral for Adults	CBA	N	2023
Clinical Trial - Funding for post-Clinical Trial Treatment	EFR	Y	2022
Closure of Patent Foramen Ovale for Migraine	EFR	N	2024
Diagnostic Dilatation and Curettage (D&C) in Women <40 yrs with Menorrhagia	EFR	Y	2022
Direct Access DXA Scanning to help target Treatment in Adults at Potential Risk of Osteoporotic Fracture	EFR	N	2022
Hydrocele in Males under 16 years of age	PA	N	2022
Wigs, Hairpieces and Hair Replacement Systems	EFR	Y	2020

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of the ICB Board

Date: Friday 1 July 2022
Time: 9.30am
Location: MS Teams

Agenda Number :	4.7	
Title:	Integrated Care Board (ICB) Transition Report	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	**No**
	Other (Please state)	No
Purpose: Discussion and Noting		
Key Points for Discussion and Noting:		

This paper provides a summary report on the ICB transition programme to establish the NHS BNSSG Integrated Care Board (ICB) and close the NHS BNSSG CCG. The transition completes the safe transfer of staff, assets, and liabilities from the CCG to the ICB.

The transition programme provided progress and status reports including Readiness to Operate Statements (RoS) and system development plans to NHSEI on a regular basis. It also provided frequent reports to the CCG's Strategic Finance Committee, Audit, Governance and Risk Committee and Governing Body and updates to the CCG's executive team, Strategic Development Forum and Staff Partnership Forum.

In final preparation for Readiness to Operate the following assurances were provided:

- The CCG's Chief Financial Officer signed off the due diligence checklist on 1 June
- The CCG's Accountable Officer submitted the RoS (27th May) and Due Diligence Checklist (1 June) to NHSEI and provided assurance that the ICB was ready to operate. He also submitted all the evidence and documentation which required level 3 (CEO) approval.
- On 13 June, a readiness to operate meeting was held with NHSEI, led by the Regional Director of Strategy and Transformation. No significant areas of concern were raised.
- On 14 June 2022, the Transition due diligence audit report was formally submitted and discussed at the CCG's Audit, Governance and Risk Committee.

- On 17 June 2022, the NHSEI regional transition team confirm the RoS had been moderated to show only three green actions (open actions to be completed by 1 July) and no amber or red actions. All other areas were blue (completed). This final version was submitted to the national team.

In relation to the establishment of the ICB, a letter is due to be received from the NHS England and NHS Improvement SW Regional Director, confirming that the NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board is ready to operate. This is expected on 30 June 2022.

An Establishment Order made by NHS England will take effect and bring the ICB into being at midnight at the beginning of 1 July 2022; CCGs are dissolved at the same time. Employees of the CCG TUPE transfer into the ICB at that time, together with three employees of North Bristol NHS Trust who are working in Healthier Together.

In relation to concluding matters for the closedown of NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group, the production of a 3 months set of audited accounts and an annual report remains to be finalised in accordance with national timescales.

Recommendations:	The Board is asked to receive the paper and note the content.
Previously Considered By and feedback :	None
Management of Declared Interest:	None identified
Risk and Assurance:	Risks associated with the transition programme were contained in the transition programme RAID log, which was updated weekly and, in the CCG GBAF, and in the regular status reports. The top three risks for transition we reported to NHSEI on a biweekly basis.
Financial / Resource Implications:	n/a
Legal, Policy and Regulatory Requirements:	The establishment of Integrated Care Board was dependent upon legislation receiving Royal Assent, which has now been granted
How does this reduce Health Inequalities:	Transition from the CCG to ICB is intended to further progress the system wide activities being undertaken to reduce health inequalities.
How does this impact on Equality & diversity	ICB recruitment processes are designed to achieve a more representative and diverse board membership.
Patient and Public Involvement:	n/a
Communications and Engagement:	There was a communication workstream in the transition programme. The transfer of staff has been subject to full consultation. Communications to stakeholders took place with due consideration given to NHSEI requirements. The ICB will have a new website which will include key governance documents.
Author(s):	Julie Bacon: Interim Director of People and Transition.
Sponsoring Director:	Shane Devlin: ICB CEO Designate and CCG Accountable Officer

1. Background

The transition programme to establish the NHS BNSSG Integrated Care Board (ICB), close the CCG and manage the safe transfer of staff, assets, and liabilities from the CCG to the ICB operated from October 2021. The Interim Director of People and Transition was brought in as SRO. However, work on the development of the ICS itself was managed through the Healthier Together Team. Most of the work was delivered by workstream leads who also continued to deliver in their business-as-usual role, as did the programme manager.

2. Reporting

The Transition Working Group met weekly through Q3, bi-weekly through Q4 and weekly again from 1 May 2022. Attendees included all workstream leads, NHSEI and internal audit.

During the planning stage in Autumn 2021, highlight reports were completed by workstream leads. This changed to a RAG status report from 1 January 2022 when the workstreams became more delivery focused.

A bi-weekly risk slide was submitted to Regional NHSEI, together with periodic submissions of the Readiness to Operate Statement (RoS) and the Due Diligence Checklist. Separately, the ICS development workstream periodically submitted the ICS Development Plan.

Regular updates were provided to the CCG's Executive Team, Strategic Development Forum and Staff Partnership Forum, with status reports received by the CCG's Strategic Finance Committee, the Governing Body and the Audit Committee.

3. Readiness to Operate Statement (RoS)

This is the statement regularly submitted to NHSEI in accordance with national deadlines. It is in the form of a status report with supporting narrative and evidence. There have been five versions issued and it contains 34 activity lines.

A copy of the ROS was scrutinised at the CCG Strategic Finance Committee meeting on 27 May to support the sign-off of the due diligence work. This important document supports confirmation of the ICB's readiness to operate from 1 July.

4. Due Diligence Checklist

This is a national checklist, with regular updates issued (five to date). It takes the form of a status report, narrative and evidence. The core due diligence sheet was submitted to NHSEI at the end of December 2021 and the full checklist was sign-off on 1 June 2022 by the CCG's Chief Financial Officer.

In total the Due Diligence Checklist had 16 tabs on the spreadsheet and over 450 activity lines. A large component of the checklist relates to finance and there has been a national programme in which the CCG has participated which relates to SBS and the establishment of the ICB ledger.

A live copy of the Due Diligence Checklist was made available to the Strategic Finance Committee at its meeting on 27 May 2022.

5. Evidence Repository

All documentary evidence referred to in the RoS and Due Diligence Checklist is contained in the evidence repository. Version control is strictly managed. Some documents contain personal and confidential information, such as the People Impact Assessment (PIA). An anonymised version is also available.

6. Audit Report

As part of the transition work, an audit of the Due Diligence Checklist was commissioned from RSM, the CCG internal audit providers, whose leads have been present at the Transition Programme meetings. Rather than an end of project audit being delivered, the audit took place in real time as the work was delivered in order to provide ongoing advice which the programme could respond to. This was found to be beneficial and enabled timely reinforcement of due diligence housekeeping

The final draft version of the Audit Report was made available to the meeting of the Strategic Finance Committee in May, including the management response. The final report was presented to the CCG' Audit, Governance and Risk Committee at its meeting on 14 June 2022.

7. Workstream Summaries

To assist the Strategic Finance Committee members to scrutinise the RoS and Due Diligence checklist, each workstream lead produced a summary report providing an overview of progress made in each area and final work to be completed in June, with risks, slippage and mitigations.

8. Risks

The transition programme has a RAID log (Risks, Actions, Issues and Decision). The risk log was regularly reviewed and updated. In addition, the three top risks were reported to NHSEI bi-weekly.

9 Final assurance steps

In final preparation for Readiness to Operate the following assurances were provided:

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10 Remaining CCG activity

In relation to concluding matters for the closedown of NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group, the production of a 3 months set of audited accounts and an annual report remains to be finalised in accordance with national timescales.

NHS England & NHS Improvement
(South West)
South West House
Blackbrook Park Avenue
Taunton
Somerset
TA1 2PX

Shane Devlin
Accountable Officer
Bristol, North Somerset &
South Gloucestershire CCG
shane.devlin@nhs.net

27th June 2022

Dear Shane,

CCG Annual Performance Review 2021/2022

I would like to take this opportunity to express my sincere thanks to you and your colleagues at the Clinical Commissioning Group (CCG), in what has been another challenging year for the NHS. The South West NHS England & Improvement regional team appreciates your continued good work, supporting the Level 4 incident response due to the COVID-19 Pandemic, whilst continuing to manage the smooth transfer of services to the Integrated Care System ahead of the 1st July 2022. I recognise the complexity in which the CCG has had to exercise its duties and I have ensured that these factors have been considered as part of the CCG's annual assessment for 2021/2022.

The Health and Social Care Act 2012 requires that the performance assessment must consider the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. For 2021/2022, it has been necessary to align these duties with the operational priorities set out in operational planning guidance for 2021/2022.

The annual assessment for 2021/2022 has continued to focus on the CCG contributions to local delivery of the overall system plan for recovery, with emphasis on the effectiveness of working relationships in the local system. This year's review has included reviewing evidence of delivery against the annual report submissions, key lines of enquiry, discharge of statutory duties, along with engagement with your local Health & Wellbeing Board.

This is the last time that CCGs will be assessed, as the forthcoming Health and Social Care Act 2022 will supersede this requirement due to the establishment of Integrated Care Boards (ICBs) and the decommission of Clinical Commissioning Groups on 1st July 2022.

The financial year of 2021/2022 has continued to be a particularly challenging year in every respect for the CCG, its partners, and the people of Bristol, North Somerset and South Gloucestershire. However, it is recognised that the CCG has continued to rise to the challenges along with its system partners.

In particular, I note the continued contribution of CCG leadership team and staff who have supported various elements of the wider system response, the elective recovery programme, as well as continuing to support and manage the vaccination programmes.

Despite the challenging year, there have been some positive examples of integrated working which I would like to take this opportunity to commend the CCG on.

There has been strong engagement led by the CCG in developing a targeted operating model for community mental health, that engaged patients, clinicians and carers to redesign and develop new services. The output being to enable locally designed services based on population need.

In addition, there has some outstanding performance in the area of population health management and health inequalities, and I am satisfied that the CCG has discharged its duty to reduce inequalities under Section 14T of Health & Social Care Act 2012. These areas relate to, but are not exclusive:

- an increase to 75% for annual health checks, which is the highest rate in the Southwest
- the expansion of Autism and positive behaviour service as an upstream intervention
- the co-production of products with those with learning disabilities on catheter care
- the reduction of cancer inequalities through engagement with SWAG cancer alliance and targeted lung check project, alongside the emerging new community mental health model to support reduction in health inequalities in this space
- the work with seldom heard communities such as the Somali community to shape how services can be accessed

Key successes within the past year have included (but are not limited to):

- the establishment of joint pharmacist recruitment within Medicines Optimisation team and AWP
- over 95% of community pharmacies signed up to the Community Pharmacy Patient Group Direction (PGD) Service - enabling supplies of prescription only medicines (POM)s by community pharmacists avoiding unnecessary referrals to GP practices or out of hours or urgent care providers

It's also noteworthy that the Mass Vaccination team has been nominated for an HSJ award for their outreach programme, which provides clinics in community centres and mosques, alongside targeted communications whilst working closely with community leaders, influencers and local authority.

On financial performance, the CCG met its statutory financial duties, delivered against the Mental health investment standard and met its break-even target in an environment that has been extremely challenging.

There has been a strong and continued focus on workforce, with the system people programme active and delivering against key workstreams, led by a system SRO:

- workforce planning, recruitment and retention
- supply and demand
- health and wellbeing
- Equality, diversity and inclusion
- OD, learning academy and leadership development

It is evident that the CCG has engaged and contributed to the joint health and wellbeing strategy of the three health and wellbeing boards in Bristol, North Somerset and South Gloucestershire and has demonstrated full compliance with Section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

The annual report contains a detailed governance statement, which clearly outlines, context, scope of responsibility, governance arrangements and effectiveness. The Head of Internal Audit concluded "based on the work undertaken in 2021/22 there is a generally sound system of internal control, designed to meet the CCG's objectives, and controls are generally being applied consistently".

As part of the transition phase to the ICS, the CCG is now in a strong position to handover the legacy work and corporate memory which it has formed. This will now place the ICS in a strong position, as it continues to strive to address inequalities and improve the health needs and outcomes of its local population.

Thank you once again to the Leadership team, CCG colleagues and volunteers for their continuous hard work, dedication, and contributions. We wish you all the very best for the future as we transition to our new partnership arrangements on the 1st July 2022.

You are welcome to take this letter to your Governing Body by way of demonstrating the outcome of this year end assurance process. In the meantime, please let me know if there is anything in this letter that you would like to follow up on.

Many thanks

Yours sincerely

Mark Cooke
Director of Strategy and Transformation
NHS England and NHS Improvement (South West)

Copy:
Anthony Martin, Head of Transformation (Oversight, Assurance & Regulation)

Sharon Wilson, Senior Relationship Manager (Oversight, Assurance & Regulation)

NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board
READINESS TO OPERATE STATEMENT

On the basis of a thorough review of the ICB readiness to operate statement checklist (appended) and the supporting evidence, we are satisfied that adequate preparations have been made for the legal establishment of Bristol, North Somerset and South Gloucestershire Integrated Care Board with effect from 1 July 2022.

The Bristol, North Somerset and South Gloucestershire Integrated Care Board will be ready to fulfil its statutory functions from this point. It will develop as a new statutory organisation with ongoing support from NHS England and NHS Improvement.

The Bristol, North Somerset and South Gloucestershire Integrated Care Board will work with its partners to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

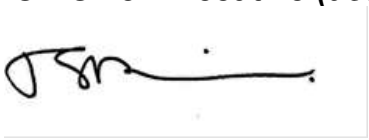
The preparations to establish the Bristol, North Somerset and South Gloucestershire Integrated Care Board and wider integrated care system arrangements, such as provider collaboratives, have been made through engagement with partner organisations.

We note that the Bristol, North Somerset and South Gloucestershire Integrated Care Partnership is also ready to be established between the Integrated Care Board and its partners from 1 July 2022.

The partner organisations in the Integrated Care Partnership are:

- Bristol City Council
- South Gloucestershire Council
- North Somerset Council
- Avon & Wiltshire Mental Health Partnership NHS Trust
- North Bristol Trust
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Bristol and Weston NHS Foundation Trust
- Sirona care & health CIC
- Primary Care Services
- Place Based Partnerships (known locally as Locality Partnerships)
- Healthwatch
- Community and VCSE Voices

ICB Chief Executive *(designate)* signature:



NHS England and NHS Improvement Regional Director signature:

Date: 17 June 2022

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of ICB Board

Date: Friday 1st July 2022
Time: 9.30am
Location: MS Teams

Agenda Number :	5.1	
Title:	Operational Plan and Revenue Budget 2022/23	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: Decision/Discussion/For Information		
Key Points for Discussion:		

This paper proposes the Final 22/23 revenue budget and updates on the operational planning submission which was completed on 20 June.

This Operational Plan was approved on 17 June for submission to NHS England by Healthier Together Executive Group together with CFOs and Finance Non-Executive Members in line with the delegation agreed by the CCG Governing Body on 17 June. The plan was submitted on 20 June. The briefing that was provided to support this sign off is included at Appendix 1-8.

This plan was developed as a whole System Financial Plan in line with the proposed duties of the new Integrated Care Board; including system level prioritisation & principles for apportioning funds.

An interim budget was approved by the CCG's SFC in March 2022; this paper updates the CCG budget to align with the System Operating Plan submitted on 20 June and sets associated budgets at detailed MDT and cost centre level.

The budget has been prepared on an annual basis, and therefore is inherited by the ICB upon the dissolution of the CCG on 30 June 2022.

This is an important budget:

- The first annual revenue budget for new ICB and will form the baseline for the ICB component of the Joint Forward Plan to be published by March 2023.
- Budget based on revised NHS Financial Framework, emerging to adapt to new health & care regulatory landscape and post-pandemic NHS financial settlement
- The first time in 2 years the NHS has been asked to prepare annual budgets
- Significant delivery milestones related to the NHS Long Term Plan and Healthier Together Medium Term Financial Plan
- Budget post the most serious operational impact of Covid pandemic and dealing with the longer term health consequences including the Elective Care backlog

The total budget for 2022/23 is proposed as £1,829,366k.

Revenue budgets for 2022/23 have been built up from the 21/22 H2 Operational Plan baseline; and with reference to the Medium-Term Financial Plan approved by Strategic Finance Committee and Healthier Together Partnership Board in Autumn 2021.

The System has prepared a balanced financial plan at both system and organisational level. However, the plan includes utilisation of £76.2m of non-recurrent actions and additional funding; and further work is required to deliver a sustainable financial position for 23/24 and the medium term.

Current NHS finance policy is that if an ICB meets its financial target to breakeven for 2022/23 and 2023/24 then the cumulative bought forward CCG deficits will be written off. This balance stands at £117m. Failure to meet his target will require additional savings equivalent to £117m, over say 5 years this would equate to £23.4m (1.3% of allocation) per annum which would put delivery of ICB objectives and strategic plans at risk.

This plan assumes delivery of £39.5m of savings to deliver a balanced financial plan and ensure the underlying position of the CCG remains aligned to the Long Term Plan. This requirement is made up by:

- £10.9m 1.1% business as usual efficiency in Healthier Together NHS provider partners and Sirona
- £3.2m further savings to reduce recurrent provider deficit positions
- £13.3m Transformational Savings requiring collaboration between Healthier Together providers and CCG/ICB
- and £11.9m Savings related to services directly commissioned or delivered by ICB.

Whilst there are challenging and stretching delivery plans, there are no unidentified savings targets within the CCG plan.

There will be no general continency budgets for 2022/23.

The System has identified a further £50.9m of gross financial risks to its plan, of which £15.2m relate directly to CCG budgets; offset by £19.9m of identified mitigations and £17.5m productivity challenge for Elective Recovery. This net risk of £13.5m represents less than 0.5% of allocation and is judged by the Finance teams to be manageable through additional executive management actions and use of in year financial management actions; and therefore presented as a balanced financial plan.	
Recommendations:	To NOTE the operational plan position submitted on 20 June, which was signed off through delegated approval by CEOs, CFOs and Finance Non-Executive Directors. To NOTE the key assumptions, principles, risks and mitigations underpinning the ICB-led aspects of the financial plan. To NOTE the impact on direct ICB Savings requirements To NOTE the underlying system financial deficit of £76.2m and requirement for further management action to mitigate this for 23/24 and the medium-term To APPROVE the financial governance principles for managing the budget during 2022/23 To APPROVE the final budgets for 2022/23
Previously Considered By and feedback :	Healthier Together DoFs and Deputy DoFs Groups Healthier Together CEOs Group (and joint session with Finance Cttee Chairs 17 June 2022) Strategic Finance Committee March 2022 and June 2022
Management of Declared Interest:	Declarations of interest stated in meeting and recorded in Committee minutes.
Risk and Assurance:	Financial risks are referenced in the main report The latest System Financial Plan was submitted to NHS England on on 20 June for assurance and approval
Financial / Resource Implications:	This paper presents the financial position of the Bristol, North Somerset and South Gloucestershire CCG, and in some instances the wider Healthier Together partnership. Current NHS finance policy is that if an ICB meets its financial target to breakeven for 2022/23 and 2023/24 then cumulative bought forward CCG deficits will be written off. This balance stands at £117m. Failure to meet his target will require additional savings equivalent to £117m, over say 5 years this would equate to £23.4m (1.3% of allocation) per annum which would put delivery of ICB objectives and strategic plans at risk.

Legal, Policy and Regulatory Requirements:	Section 223H of the Health and Social Care Act 2012 sets out the duty for CCGs to break even on their commissioning budget for both revenue and capital. BNSSG is required not to exceed the cash limit set by NHS England, which restricts the amount of cash drawings that the CCG can make in the financial year. The CCG must also comply with relevant accounting standards. These duties will remain upon transition to ICB, together with a statutory duty to breakeven even upon the whole 'system' incorporating NHS Trusts and NHS Foundation Trusts, ICB Running Costs and Delegated Primary Care allocations. It should be noted that this duty encompasses all revenue and capital funding for UHBW, NBT and AWP including material funds related to services commissioned by NHSE England (Secondary Care Dental, Specialised Commissioning, including provider collaboratives and Heath & Justice) as well Other ICBs (notably BSW ICB and AWP)
How does this reduce Health Inequalities:	The budget aims to reduce Health Inequalities in two specific ways: 1. Key base case budget principles increase relative investment in Primary Care and Mental Health. Both key programme spend where Health Inequalities currently exist. 2. Reducing Health Inequalities is a key priority when developing the operational plan
How does this impact on Equality & diversity	Equality Impact Assessment are undertaken for key changes in the plan, such as savings plans.
Patient and Public Involvement:	Patient and Public Involvement was not sought specifically in the development of this plan. PPI is embedded within key change programmes included in the plan.
Communications and Engagement:	The financial position of the CCG is subject to regular reporting and review by the Strategic Finance Committee and Public Governing Body. In addition, the CCG has regular meetings with NHSE to review performance throughout the year.
Author(s):	Jonathan Lund, Deputy CFO
Sponsoring Director / Clinical Lead / Lay Member:	Sarah Truelove, Deputy Chief Executive and Chief Finance Officer

Agenda item: 5.1
Report title: 2022/23 Budgets

1. Executive Summary

This paper proposes the Final 22/23 revenue budget.

An interim budget was approved by SFC in March 2022; this paper updates the CCG budget to align with the System Operating Plan submitted on 20 June and sets associated budgets at detailed MDT and cost centre level.

This Operational Plan was approved for submission to NHS England by Healthier Together Executive Group on 17 June. The plan was submitted on 20 June.

This plan was developed as a whole System Financial Plan in line with the proposed duties of the new Integrated Care Board; including system level prioritisation & principles for apportioning funds.

The budget has been prepared on an annual basis, and therefore will be inherited by the ICB upon the dissolution of the CCG on 30 June 2022.

This is an important budget:

- The first annual revenue budget for new ICB and will form the baseline for the ICB component of the Joint Forward Plan to be published by March 2023.
- Budget based on revised NHS Financial Framework, emerging to adapt to new health & care regulatory landscape and post-pandemic NHS financial settlement
- The first time in 2 years this NHS has been asked to prepare annual budgets
- Significant delivery milestones related to the NHS Long Term Plan and Healthier Together Medium Term Financial Plan
- Budget post the most serious operational impact of Covid pandemic and dealing with the longer term consequences such as Elective Care backlog

The total budget for 2022/23 is proposed as £1,857,122k.

Revenue budgets for 2022/23 have been built up from the 21/22 H2 Operational Plan baseline; and with reference to the Medium-Term Financial Plan approved by Strategic Finance Committee and Healthier Together Partnership Board in Autumn 2021.

The System has prepared a balanced financial plan at both system and organisational level. However, the plan includes utilisation of £76.2m of non-recurrent actions and resources; and further work is required to deliver a sustainable financial position for 23/24 and the medium term.

Current NHS finance policy is that if an ICB meets its financial target to breakeven for 2022/23 and 2023/24 then the cumulative bought forward CCG deficits will be written off. This balance stands at £117m. Failure to meet his target will require additional savings equivalent to £117m, over say 5 years this would equate to £23.4m (1.3% of allocation) per annum which would put delivery of ICB objectives and strategic plans at risk.

This plan assumes delivery of £39.3m of savings to deliver a balanced financial plan and ensure the underlying position of the CCG remains aligned to the Long Term Plan. This requirement is made up by:

- £10.9m 1.1% business as usual efficiency in Healthier Together NHS provider partners and Sirona
- £3.2m further savings to reduce recurrent provider deficit positions
- £13.3m Transformational Savings requiring collaboration between Healthier Together providers and CCG/ICB
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Whilst there are challenging and stretching delivery plans, there are no unidentified savings targets within the CCG plan.

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The System has identified a further £50.9m of gross financial risks to its plan, of which £15.2m relate directly to CCG budgets; offset by £19.9m of identified mitigations and £17.5m productivity challenge for Elective Recovery. This net risk of £13.5m represents less than 0.5% of allocation and is judged by the Finance teams to be manageable through additional executive management actions and use of in year financial management actions; and therefore presented as a balanced financial plan.

2. Progress since 28 April draft submission

Significant progress has been made since the 28 April draft plan, notably:

1. Rebasing of Provider Top Up funds, to align with national funding allocations, rebasing with Specialised Commissioning and pre-Covid provider deficits. This has the effect of funding on a recurrent basis the historic, structural deficits experienced in the BNSSG system including impact of PFI & LIFTCo buildings, pre-pandemic levels of agency workforce premiums, the structural deficit of Weston General Hospital
2. Rebasing of Covid funding to latest assessment of costs
3. Reinvestment of £11m recurrent MTFP savings and non-recurrent £8m contingency and £20m Covid funds, to offset residual provider deficits
4. Further granular details of all Transformation and Transaction Savings programmes
5. Further granular details on Elective Activity Plans and associated Elective Services Recovery Fund income including impact national funding incentives and rules and alignment of impact from major Community Services Transformation programmes such as Discharge to Assess, Healthier Together @ Home and Ageing Well
6. Approval of Mental Health Investment Standard and overall MH & LD Finance plan by Mental Health & LD Steering Group
7. Approval of Delegated Primary Care budgets by Primary Care Commissioning Committee
8. Application of additional recurrent and non-recurrent allocations of funds to mitigate the impact of Ambulance services pressures and excess inflationary pressures across the NHS
9. Updated Risks and Mitigations schedule
10. Detailed budgets at cost centre, Tag and MDT level

3. System Funding Envelope and Allocation

CCG Allocation

The total system allocation is £1,857,122k, which will be allocated to the CCG. This allocation was based on the H2 21/22 system funding envelope and not a return to Long Term Plan allocations.

Importantly this includes a distribution of £72.8m Provider Top Up funding, generally recycled from previous Provider Sustainability Fund allocations.

Allocations have also been subject to a revised ACRA allocation methodology, for BNSSG CCG this new methodology has resulted in the BNSSG system being ‘under-funded’ compared to the target allocation by 0.9%. Over time the national pace of change policy should increase the relative resources for BNSSG.

Allocations assume funding inflation for core services of 3.5%

Allocations assume efficiency delivered in all core services of 1.1%

	2022/23 Recurrent	Covid Allocation	SDF Funding	ERF	Health Inequalities Funding	Non-Recurrent National Reserves Allocation	2022/23 Non Recurrent	2022/23 TOTAL
CCG allocations - programme	-1,489,301,666				-3,206,000	-9,210,000	-12,416,000	-1,501,717,666
CCG allocations - running costs	-18,427,000						0	-18,427,000
CCG allocations - delegated primary care	-156,193,000						0	-156,193,000
System top-up (provider basis)	-72,835,441						0	-72,835,441
Covid funding (provider basis)	0	-39,925,000					-39,925,000	-39,925,000
SDF Funding	0		-36,379,000				-36,379,000	-36,379,000
ERF ICB (Population basis)	0			-31,645,000			-31,645,000	-31,645,000
Total Sources	-1,736,757,107	-39,925,000	-36,379,000	-31,645,000	-3,206,000	-9,210,000	-120,365,000	-1,857,122,107

Primary Care could also access additional funding for Primary Care Network ARRS funds retained nationally and funded once staff are appointed.

Total System Funding Envelope

- The total system funding envelope is assessed as £2,957,788k
- The NHS providers in the system also receive commissioning income from NHSE Direct and Specialist Commissioning; as well as Other CCGs, this is expected to be £887,289k; including additional Elective Recovery Fund income for Spec Comm and Other Direct Commissioning of £14,500k
- Providers also receive Other Income including Teaching & Research, Private Patients and Commercial income. The values are being evaluated by Providers but their current estimate is £288,476k
- The ICB is planning to commission £72,200k of activity with NHS providers outside of the ICB footprint, including £44,671k SWAST
- National funding is also available separately for the Mass Vaccination programme for Primary Care and via NBT as BNSSG Mass Vaccination host.
- PPE and Test and Trace costs continue to be funded nationally by DHSC outside of the NHS England budget

4. Key principles and Assumptions for CCG base budgets

- Opening baseline is 21/22 H2 Plan.
- All budgets changes, including savings, are assumed to be recurrent unless explicitly stated otherwise
- Acute NHS Provider contract baselines based on 19/20 M1-9 run rate expenditure; adjusted for inflation including 21/22 pay award and efficiency; plus retaining full year effect Phase 3 mitigation growth funding in line with H2 plan noting Acute activity levels remain below 19/20 levels
- System Transformation Scheme Savings removed from acute contracts in line with Medium Term Financial Plan assumptions. Non recurrent slippage in Discharge to Assess benefits assumed funded from D2A Transition Reserve.
- Provider Top Up funding allocated to 3 NHS providers in line with initial national calculation based on 19/20 run rate, adjusted to 22/23 prices and rebasing between CCG and Spec Comm allocations. Additional Top Up funded from re-investment of System Transformation Scheme Savings and 21/22 growth allocation (net of stretch efficiency target) funding
- Low Value activity (CCG to English NHS provider value < £500k per annum; previously referred to as Non Contract Activity) returned to local commissioning based on block payments calculated nationally from 3yr average uplifted to 22/23 prices, as per national schedule. Scottish and Welsh providers continue as variable payment per activity.
- Acute Independent Sector returned to local commissioning and funded at latest contract Indictive Activity Plan schedules. Base budget is 19/20 levels, adjusted for inflation and efficiency. Any growth against 19/20 baseline funded from Elective Services Recovery Fund (ESRF). £3.4m assumed in plan as per latest contract activity schedules
- Primary Care Investment as per Long Term Plan, including new DES, establishment of PCNs and new roles.
- Mental Health Investment to meet Mental Health Investment Standard (MHIS) (Mental Health budget growth in line with CCG core allocation, and Mental Health provider efficiency will be re-invested in MH services; excludes Dementia, Learning Disabilities & Autism budgets, but includes prescribing and continuing health care related to MH diagnoses).
- Growth allocated to Children's Community Services (pro-rata to NHSE community service non-demographic growth) and Dementia, Learning Disabilities & Autism budgets (pro-rata to MHIS uplift); in line with principles in the Long Term Plan; as these are key priority areas for the CCG.
- Discharge to Assess and Stroke services investments added to budgets in line with approved system wide business cases. NB. Stroke with effect from 1st Nov, plus non recurrent transition budget
- System Clinical Advice Service /111First budgets uplifted as per latest Minors programme budget plan on non recurrent basis
- High Cost Drugs growth as per local assessment

- No further growth applied to Acute Care or Adult Community Services; other than where these services will have access to Service Development Funds and Elective Recovery Fund all designed to maximise service restoration and ongoing Covid demand. Sirona will need to demonstrate returning to new contract transformation trajectory, including absorbing demographic growth, before new funding could be allocated.
- Continuing Healthcare growth, inflation & savings rates as per updated local assessment, broadly aligned to LTP and lower than demographic growth, except for higher inflation aligned to local authority fee uplifts.
- Prescribing growth & savings rates as per local assessment and lower than demographic growth, broadly aligned to previous LTP.
- Better Care Fund uplift of 5.66% fully funded as per national policy
- Running Costs in line with allocation (noting no additional allocation for Agenda for Change pay award resulting in a 2.8% efficiency requirement). CCG establishment funded, but with 7.2% vacancy factor as approved SFC March 2022.
- System Transformation Reserve established to continue funding allocations approved Summer 2021.
- All providers with NHS Standard Contracts expected to deliver 1.1% efficiency requirement.
- Other core services up to 2.4% price inflation (3.5% cost inflation offset by 1.1% efficiency requirement, implies 2% annual pay inflation)
- Placement budgets and CHC 6.0% inflation, in line with local authorities. CCG would retain responsibility for efficiency savings to offset this cost by managing package costs efficiently
- Service Development Fund allocations have been delegated to MDT budgets based on national indicative schedule, except Cancer 'hosted' fund on behalf of SWAG Cancer Alliance. The budget assumes £0.7m slippage on SDF allocations.
- Covid "In Envelope" costs funded in line with Autumn 2021 recurrent forecast assumptions. Surplus Covid funds allocated to UHBW and AWP underlying deficits. NB. Covid testing, PPE and Vaccination Programme remain 'outside system funding envelope' and outside CCG budget.
- 0.5% Contingency Reserve (£8.0m) fully utilised in 2022/23 to offset UHBW and AWP underlying deficits
- £600k CEO Reserve maintained as per previous years, although allocations will need to consider Running Cost savings requirement and vacancy factor
- Dual running costs between CCG and ICB expected to be funded nationally outside of budget
- Non Recurrent National inflation support funding has been allocated to offset excess cost inflationary pressures not otherwise funded and fund a £2m SWAST Ambulance Handover delay risk reserve

5. Provider Deficit Support

Provider deficit support allocations were calculated following extensive peer to peer challenge and review, as well as Healthier Together DoFs group commissioning an external peer review of all investments made over the last 2 financial years.

£95.2m has been allocated on a recurrent basis and £13.6m on a non-recurrent basis

Deficits can largely to attributed to 3 drivers:

i. Pre-pandemic structural deficits eg. PFI & LIFTCo premiums, Weston General, Agency Cost premiums largely defined as run rate deficit against contract income from 19/20 and structural issues emerging over last 2 years eg. pay award costs in excess of national funding.
These have been funded on a recurrent basis utilising Provider Top Up allocation, reinvestment from System Transformation Savings and 21/22 uncommitted growth allocations

ii. New unfunded service developments and unachieved savings between 19/20 and 22/23.
These have been peer reviewed and funded on a non-recurrent basis utilising CCG Contingency and uncommitted Covid funding allocation. It is notable that this relates to UHBW (£16.2m), AWP (£12.9m) and SWAST (£2.9m). Additional controls on investments are being proposed for partners with unfunded deficits. Providers will need to work with the ICB to develop recurrent solutions to these deficits including recurrent benefits from System Transformation Savings.

iii. Excess inflation forecasts above national funding allocation – largely related to general supplies and services (Energy premiums, PFI indexation, Ambulance service inflation and Care Market price inflation have largely been funded on a recurrent basis).
These have been peer reviewed and funded on a non-recurrent basis from additional national non recurrent deficit support funding. Providers will need to work with the ICB to develop recurrent solutions to these deficits including seeking to minimise or defer the impact of inflation where possible.

6. Financial Governance arrangements

Budget Reserves

Reserves	20,662,793
0.5% Contingency Reserve	0
Covid-19	156,000
Other Reserves	10,231,793
Investment Reserves	10,231,793
CEO reserve	600,000
Covid - Q1 transition	0
Discharge to Assess savings slippage	-3,750,000
ESRF risk reserve	8,426,261
High Cost drug growth	531,000
Investments Inflation Reserve	892,256
Non Demographic Adult Community Growth	0
Ockenden Review	593,000
Profiling adjustment	0
System Transformation Reserve	2,939,276
SDF	10,275,000

Virement permissions proposed

The Finance Department is delegated to adjust base budgets, on a net neutral basis, in line with recurrent contract changes and changes savings plans approved in 2022/23

The Finance Department is delegated to adjust budgets on a net neutral basis in line with Service Development Fund allocations once spend priorities approved by the relevant Heathier Together Steering Group. Spending plans over £1m per annum also require approval by CCG Strategic Finance Committee. Slippage on Service Development Funds shall be returned to Corporate Reserves (where SDF allocation is assumed to be recurrent, run rate expenditure by March may not exceed 1/12th annual recurrent allocation).

Individual MDT budget holders will be able to vire budget between contracts and cost centres within each MDT, provided the adjustments are net revenue neutral, excluding Covid.

Any un-utilised accruals or provisions, and/or prior year unforeseen costs shall be returned / charged to Corporate Reserves as soon as identified.

Virements from £600k CEO Reserve will require approval from Chief Executive

Virements from Other Reserves will require approval from Deputy Chief Executive & Chief Finance Officer

Business Cases expected 2022/23

The following business cases are funded in 22/23 budgets but commitments are subject to approval by Strategic Finance Committee during the year:

Scheme value has revenue impact of >£250k

Schemes where overall spending >£1m

Scheme requires system support for NHSE capital allocation

- System CAS/ Minors – recurrent investment case, taking into account medium-term financial plan savings targets related to Same Day Emergency Care
- Covid Medicines Delivery Unit
- Healthier Together @ Home (Virtual Wards SDF)
- Cancer SDF
- Ageing Well SDF
- Primary Care Transformation SDF
- Elective Recovery Schemes greater than £250k
- Elective Recovery Schemes with Capital value greater than £5m

Savings Deep Dives

As per previous years, Deep Dives will be expected on a rolling 3 month basis for ICB Savings programmes:

Mental Health, Dementia, Learning Disabilities and Autism

Funded Care

Prescribing

If Running Cost allocation off track CEO will prepare a Deep Dive of Running Costs savings plans.

ICB Finance Committee will also expect to receive regular briefings on actions, risks and mitigations for the in-year and recurrent delivery of Healthier Together providers internal savings plans and System Transformation Savings

Appendix 1

2022/23 System Plan Resubmission for 20.06.22

Healthier Together

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

2022/23 System plan resubmission for 20.06.22

Briefing prepared for system sign off meeting – 17 June 2022

Key Messages

- **Mental Health** – improved trajectories on the three areas where 28/4 plan was short of targets. Expect continued performance management by NHSEI regionally
  - Out of area placement bed days reduced to 576 (360 fewer than 28/4 plan) – Improved
  - Children and Young People accessing specialist support increased to 8,948 (1,948 more than 28/4 plan) – Improved
  - Women accessing specialist perinatal support increased to 1,099 (64 more than 28/4 plan) - Improved

- **Elective recovery** – improved trajectories, still short of targets. Non-compliant plans may trigger performance management by NHSEI nationally
  - >104 week waits eliminated (except for P6 patients) by March 2023 (91 fewer than 28/4 plan) - Improved
  - >78 week waits reduced to 1,243 by March 2023 (1,586 fewer than 28/4 plan) – Improved
  - >52 week waits increased to 8,132 by March 2023 (1,00 more than 28/4 plan) – Deteriorated
  - > 62 day backlog waits for Cancer treatment. NBT position remains an outlier nationally. May trigger NHSEI performance management escalation of BNSSG ICS to Tier 1 ('Mandated National Support') – No change/national outlier

- **Financial plan** – additional funding received for inflation and balanced plan proposed by BNSSG DOFs (Slide 13 shows the movement from the April submission deficit of £38.2m) - Improved and in line with National expectation
  - Unmitigated risk of ESRF clawback of £17.5m shown in the plan in line with Regional and National discussions. This is a complex area to reliably forecast due to the interplay between the system and specialist commissioning and between the NHS providers and the Independent sector. The DOFs are content to show this position.
  - Mitigations will need to be delivered through additional productivity over and above plan

- **Alignment to Quarter 1 performance** – Revised plans are better aligned to Q1 performance data - Improved
  - Trusts have rebased plans to April actuals, where possible. Weekly data shows May performance above plan

- **Bed deficit/occupancy risk** – NHSEI derived bed occupancy calculations will show an increased bed deficit vs 28/4 plan
  - Applying NHSEI methodology indicates a c331 average system bed deficit risk (c242 in the 28/4 plan) - Deteriorated
  - Mitigations will be through access to escalation beds, delivery of 'bed savings' through Home First and Trust internal productivity improvements
  - NHSEI require a further submission on bed deficit risk and mitigations on 23/6

- **Home First** – Progress on Discharge 2 Assess and Healthier Together@Home increases confidence in bed deficit mitigations
  - Discharge 2 Assess projected delivery increased by 20 to 132 bed equivalent savings by end March – Improved
  - Healthier Together@Home/Virtual Wards: detailed programme plan to be submitted to NHSEI 20/6. Highlights opportunities to achieve c150 bed equivalent savings (29 bed savings assumed in 20/6 plan), but will depend on increasing/shifting workforce. Assumes c£3.4m funding from NHSEI - Improved

Mental Health: final submission plans show improved position for CYP, OAP & Perinatal following meetings with NHSEI. Recovery plans have been updated to reflect this.

Providers	Theme	Metric	Plan agreed	Target	Does plan hit target	Planned attainment	Old planned attainment	Change
System	LD&A	Learning disability registers and annual health checks delivered by GPs	Complete	75%	Yes	75%		
System	LD&A	Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by ICSs	Complete	9	Yes	9		
System	LD&A	Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by NHS England or via a Provider Collaborative	Complete	13	Yes	13		
System	LD&A	Reliance on inpatient care for people with a learning disability and/or autism - Care for children	Complete	3	Yes	3		
AWP	MSDS	Mental Health Services Dataset - Data Quality Maturity Index Score	Complete	95%	Yes	95%		
AWP	Inpatients	Adult mental health inpatients receiving a follow up within 72hrs of discharge	Complete	80%	Yes	80%		
VITA	IAPT	Total access to IAPT services	Complete	29,937	Yes	29,937		
AWP	Diagnosis	Estimated diagnosis rate for people with dementia	Complete	66.7%	Yes	66.7%		
AWP	CYP	The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	Complete	95%	Yes	95%		
AWP	SMI	People with severe mental illness receiving a full annual physical health check and follow up interventions	Complete	5,514	Yes	6,724		
AWP	Placements	Access to Individual Placement and Support Services	Complete	714	Yes	714		
AWP	Community	Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Complete	4,177	Yes	4,200		
AWP	Psychosis	First Episode Psychosis treatment with NICE recommended package of care within two weeks of referral	Complete	60%	Yes	60%		
AWP	OAPs	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Complete	0	No	567	927	-360
AWP	CYP	The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Complete	95%	No	90%		
AWP	CYP	Access to Children and Young People's Mental Health Services	Complete	10,154	No	8948	7,000	+1948
AWP	Womens	Women Accessing Specialist Community Perinatal Mental Health Services	Complete	1,164	No	1099	1,035	+64

Overall

- NHSEI were particularly keen we improved the CYP and OAP plans, this was done while striking a balance between realism and striving to deliver the national target.
- The improved plans have been signed off by the AWP Exec team.
- Recovery plans are in place and will be shared with region too.

Mitigations

- **CYP Access**: Increased investment, ongoing recruitment, implementation of Mental Health Support Teams, expansion of crisis and eating disorder support.
- **Perinatal**: Setting up maternal mental health clinics, looking to understand best practice with a view to remodelling the current offer, as many women are currently supported by our voluntary sector. Issue with the birth rate denominator inaccurate for our area.
- **Out of Area**: "Right Care" approach to the work. Focus on flow, red to green, medically fit for discharge patients. Consideration of developing Capital Case for additional beds, as comparative data shows a low bed base.

Elective recovery – Summary of plans against target

Area	Requirement / Target	Met at System Level Yes/No	NBT	UHBW	System
Elective Admissions	104% 2019/20	No	89%	90%	90%
Day Case	104% 2019/20	No	104%	101%	103%
OP 1st	104% 2019/20	No	104%	102%	103%
OPFU	75% 2019/20 (nb. 25% reduction)	No	100%	110%	107%
Virtual OP	5% of all OP attends	**No**	**Yes**	**No**	**No**
PIFU	5%	Yes	Yes	Yes	Yes
Diagnostics – Echo	120% 2019/20	No	66%	105%	**90%**
Diagnostics – CT	120% 2019/20	No	115%	112%	114%
Diagnostics – Colon	120% 2019/20	Yes	117%	243%	172%
Diagnostics – Flexi	120% 2019/20	No	118%	82%	103%
Diagnostics – NOUS	120% 2019/20	No	94%	99%	96%
Diagnostics - MRI	120% 2019/20	No	105%	100%	102%
Cancer – Treatment Volumes	-	**Yes**	**Yes**	**Yes**	**Yes**
Cancer – Patients waiting 63+days	Feb 2020 levels	**No**	**No**	**Yes**	**No**
Cancer – FDS	75%	**No**	**No**	**Yes**	**No**
Clock Starts	-		103%	82%	91%
Clock Stops (AD)	-		100%	93%	96%
Clock Stops (NAD)	-		100%	107%	104%

Acute activity plans: summary and key changes from April

System - Change between April and June submissions

	Measure	Change
Electives	Elective day case spells	1.8%
	Elective ordinary spells	3.8%
	Consultant-led first outpatient attendances (Spec acute)	2.4%
	Consultant-led first outpatient attendances with procedures (Spec acute)	4.8%
	Consultant-led follow-up outpatient attendances (Spec acute)	2.3%
	Consultant-led follow-up outpatient attendances with procedures (Spec acute)	6.8%
	Number of episodes moved or discharged to patient initiated outpatient follow -up pathway	0.0%
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	-0.1%
	Diagnostic Tests - Colonoscopy	1.0%
	Diagnostic Tests - Computed Tomography	-0.1%
	Diagnostic Tests - Flexi Sigmoidoscopy	-0.7%
	Diagnostic Tests - Gastroscopy	0.4%
	Diagnostic Tests - Magnetic Resonance Imaging	-0.3%
	Diagnostic Tests - Non-Obstetric Ultrasound	0.4%
RTT	GP Referrals made for a First Consultant -Led Outpatient Appointment	-0.2%
	Other Referrals made for a First Consultant -Led Outpatient Appointment	-0.2%
	New RTT pathways (clock starts)	0.0%
	RTT completed admitted pathways	0.9%
	RTT completed non-admitted pathways	2.1%
UEC	Type 1&2 A&E Attendances excluding Planned Follow Ups	-0.1%
	Non-elective spells with a length of stay of zero days	1.0%
	Non-elective spells with a length of stay of 1 or more days	1.2%
	Reducing length of stay for patients in hospital for 21 days and over	0.0%
Cancer	Cancer 28 day waits (faster diagnosis standard)	-0.5%
	Cancer treatment volumes	-0.2%
	Number of patients waiting 63 or more days after referral from cancer PTL	3.2%

Waiting list change - position at March -23

		April Plan	June Plan	Change
NBT	Total	39,224	39,224	0
	52+	3660	3,660	0
	78+	878	568	-310
	104+	139	48	-91
UHBW	Total	49,649	53,649	4000
	52+	3472	4472	1000
	78+	1951	675	-1276
	104+	29	29	0
System	Total	88,873	92,873	4000
	52+	7132	8,132	1000
	78+	2829	1,243	-1586
	104+	168	77	-91

Estimated ERF cost-weighted achievement

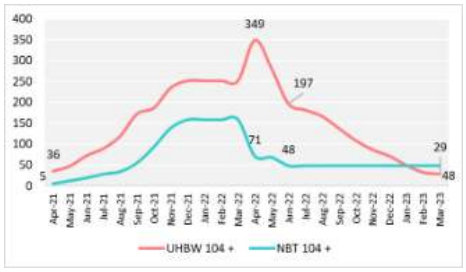
	April Plan	June Plan	Change
Total NHS	96%	98%	2.3%
Independent Sector	111%	111%	0%
ICS total	99%	101%	2.0%

Planned 22/23 activity as a percentage of 19/20 and 21/22

	UHBW		NBT		Independent Sector	
	19/20 %	21/22 %	19/20 %	21/22 %	19/20 %	21/22 %
Daycase	101%	112%	104%	116%	110%	127%
Elective	90%	123%	89%	121%	120%	115%
OP 1st	102%	118%	104%	116%	127%	123%
OP FUP	110%	117%	100%	98%	119%	86%

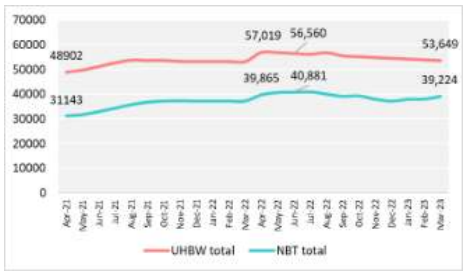
Waiting list

+104 week waits



+78 week waits

Total waiting list



+52 week waits

Waiting list change - position at March -23

		April Plan	June Plan	Change
NBT	Total	39,224	39,224	0
	52+	3660	3,660	0
	78+	878	568	-310
	104+	139	48	-91
UHBW	Total	49,649	53,649	4000
	52+	3472	4472	1000
	78+	1951	675	-1276
	104+	29	29	0
System	Total	88,873	92,873	4000
	52+	7132	8,132	1000
	78+	2829	1,243	-1586
	104+	168	77*	-91

* All P6 waiters

Finance – ESRF Risk

	UHBW	NBT	Independent Sector	Non ICB Providers (SW)	System Held	Grand Total
BNSSG ICB ESRF Allocation	£13.2	£12.8	£5.5	£0.3		**£31.6**
BNSSG ESRF Allocation	£9.9	£4.6	£0.0	£0.0		**£14.5**
TOTAL ESRF Allocation	**£23.0**	**£17.4**	**£5.5**	**£0.3**	**£0.0**	**£46.1**
TOTAL ICB Clawback	(£2.3)	(£4.3)				**(£6.7)**
TOTAL NHSE/I Clawback	(£7.2)	(£3.6)			£2.2	**(£8.6)**
TOTAL ESRF clawback	**(£9.5)**	**(£7.9)**	**£0.0**	**£0.0**	**£2.2**	**(£15.3)**
ESRF retained by the system (ICB)	£10.8	£8.5	£5.4	£0.3	£0.0	**£25.0**
ESRF retained by the system (NHSE/I)	£2.7	£1.0	£0.0	£0.0	£2.2	**£5.9**
TOTAL ESRF retained by the system	**£13.5**	**£9.5**	**£5.4**	**£0.3**	**£2.2**	**£30.8**

TOTAL commitments v Funding	(£25.9)	(£14.6)	(£5.4)	(£0.3)	£0.0	**(£46.2)**
Unmitigated Risk	**(£12.4)**	**(£5.1)**	**£0.0**	**£0.0**	**£2.2**	**(£15.3)**

- Financial Plan submission on 14th April assumed total ESRF clawback of £23.3m. Latest assessment based on revised activity plans assumes a clawback of £15.3m – a total improvement of £8.5m retained income (£6.3m relating to ICB activity, £2.2m relating to NHSE/I income activity)
- In order to deliver this improved activity position, and improve waiting list performance trajectories, a further £6.5m has been approved by System DoFs, over and above those included in the April 28th financial plan submission
- The net risk of £17.5m relating to commitments against this income therefore remains unchanged, and remains a risk to delivering a balanced financial plan in 2022/23. £2.2m assumed gain from NHSE/I income has currently not been assumed as a benefit against this risk, pending further understanding of the split of activity delivery.

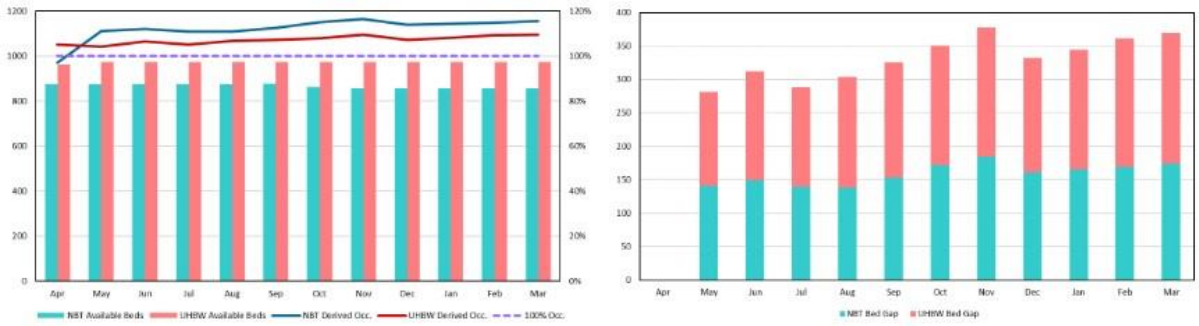
Current elective activity run rate vs. plan

	Daycase			Elective			OP 1st			OP FUP		
	NBT	UHBW	System	NBT	UHBW	System	NBT	UHBW	System	NBT	UHBW	System
Apr-22 Plan	100%	89%	93%	90%	79%	83%	103%	92%	96%	97%	102%	100%
Apr-22 Actuals	103%	84%	91%	88%	75%	80%	89%	85%	86%	96%	100%	99%
Variance	3%	-5%	-2%	-2%	-4%	-3%	-14%	-7%	-10%	-1%	-2%	-1%
May-22 Plan	107%	93%	99%	87%	83%	85%	107%	94%	99%	103%	103%	103%
May-22 Actuals	98%	91%	94%	93%	84%	88%	92%	94%	93%	96%	103%	101%
Variance	-9%	-2%	-5%	6%	1%	3%	-15%	0%	-6%	-7%	0%	-2%

Local weekly activity data %s vs. plan
NB – data does not include last week in May and likely understating % achievement

Beds

- Addition of Knightstone ward beds as ring fenced
- NBT increased G&A beds available between Oct-Apr to avoid going over 100% occupancy



			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NBT	Plan	Available beds	871	875	875	875	875	876	862	855	855	855	855	855
	Plan	Occupancy	100%	100%	100%	100%	100%	100%	100%	98%	95%	95%	94%	93%
	Derived	Occupancy		111%	112%	111%	111%	113%	115%	116%	114%	114%	115%	115%
	Derived	Beds required		972	981	970	969	986	991	996	973	978	982	986
	Derived	Bed gap		141	149	139	138	153	172	184	161	166	169	174
UHBW	Plan	Available beds	963	973	973	973	973	973	973	973	973	973	973	973
	Plan	Occupancy	98%	98%	98%	98%	98%	98%	98%	99%	98%	99%	98%	98%
	Derived	Occupancy		104%	106%	105%	107%	107%	108%	109%	107%	108%	109%	110%
	Derived	Beds required		1065	1087	1073	1090	1096	1103	1119	1095	1103	1116	1120
	Derived	Bed gap		141	163	149	165	172	179	194	171	179	192	195
System	Plan	Available beds	1834	1848	1848	1848	1848	1849	1835	1828	1828	1828	1828	1828
	Derived	Beds required		2037	2068	2044	2059	2082	2094	2114	2069	2081	2098	2106
	Derived	Bed gap		282	312	288	303	325	350	378	332	345	361	369

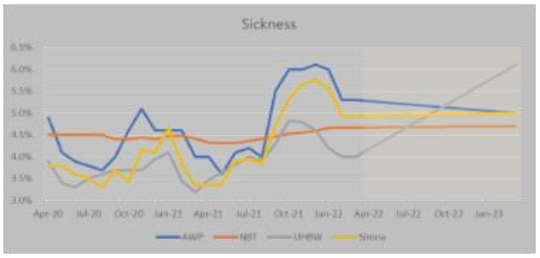
Workforce: key headlines

- Overall 3.5% growth in total workforce across 2022/23, compared to 2021/22.
  - Primary Care: c6.7%
  - Mental Health: c7.0%
  - Acute: c2.2%
  - Community: c21.7%

- 6.5% increase in Registered Nursing staff in post this equates to 180.5WTE.
  - In 2019/20, Registered Nursing staff in post grow by 6%
  - This growth reduced to 2% in 2021/22
- Reduction in Banks Staff activity by 1.1% (20.1wte) and
- Reducing our planned agency use by 18.5% (140wte)
- Planning for reduction in turnover by March 2023 when compared to March 2022. The provider target end position for 2022/23 ranges between 14-15%.
- Holding sickness absence to 3.8%

- **Additional analysis undertaken to stress test workforce plans**
- **High risk assumptions identified:**
  - **AWP: c7% growth in Staff in Post**
  - **Sirona c21.7% growth in Staff in Post**

Key risks: staff turnover and sickness rates



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Finance - Route to Balanced System Financial Plan 2022/23

	UHBW	NBT	AWP	CCG	BNSSG
Inflation	(£7.6)	(£11.3)	(£2.8)	(£7.3)	**(£29.0)**
Q1 covid costs	(£1.9)	(£0.9)		(£0.6)	**(£3.4)**
Q1 ESRF lost income	(£3.9)	(£1.9)		£0.0	**(£5.8)**
Financial Plan Submission 28/04	**(£13.3)**	**(£14.1)**	**(£2.8)**	**(£8.0)**	**(£38.2)**
Additional Inflationary Uplift (ICB)	£2.7	£2.7	£0.8	£2.8	**£9.0**
Additional ICB Growth (CHC, FNC, BCF)				£5.6	**£5.6**
National Ambulance Funding				£2.4	**£2.4**
Additional Inflationary Uplift (Other Commissioners)	£2.3	£1.5	£0.9		**£4.7**
Revised Spec Comm envelopes 310522	£0.0	(£1.4)	£0.1		**(£1.3)**
Revised Spec Comm ERF	£0.1	£0.0	£0.0		**£0.1**
Application of National Funding					
Pass-through of 0.7% inflationary uplift from/to Out of System ICBs				(£1.2)	**(£1.2)**
Pass-through of National Ambulance Funding				(£2.4)	**(£2.4)**
Off-set to revised Spec Comm Contracts	£0.0	£1.4	(£0.1)		**£1.3**
Revised Plan after National Contract changes	**(£8.2)**	**(£9.9)**	**(£1.1)**	**(£0.7)**	**(£20.0)**
Other Non-Recurrent Actions					
Non-Recurrent National Allocations (PFI)				£3.2	**£3.2**
Non-Recurrent National Allocations (Other)				£6.0	**£6.0**
Q1 Covid Costs managed down to planned level	£1.9	£0.9	£0.0	£0.6	**£3.4**
ESRF Impact (productivity Improvments / review of investments)	£3.9	£1.9	£0.0		**£5.8**
BNSSG Share of SWASFT planning gap (£21.5m)				(£2.0)	**(£2.0)**
Uncommitted Community Growth				£2.8	**£2.8**
SDF Slippage				£0.7	**£0.7**
Revised Plan after non-recurrent actions	**(£2.5)**	**(£7.1)**	**(£1.1)**	**£10.7**	**£0.0**
Allocation of non-recurrent resource					
Allocation of Non -Recurrent Funding (PFI)	£0.0	£2.7	£0.5	(£3.2)	**£0.0**
Further n/r support	£2.5	£4.3	£0.6	(£7.5)	**£0.0**
Restated 2022/23 Plan (20th June submission)	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**

- Additional recurrent funding to the ICB of £17m, of which £14.6m relates to inflationary pressures (£2.4m ambulance trust specific, passed through to SWASFT)
- Further £4.7m of funding from Other Commissioners (£3.1m Spec Comm) for additional 0.7% inflationary uplift
- Further £9.2m n/r funding from region in recognition of increased PFI inflation (£3.2m), and additional n/r support (£6m) all allocated to providers
- Q1 Covid (£3.4m) & ESRF impact (£5.8m) removed from bottom line
- £1.5m CCG surplus n/r allocated to providers to present balance plan at organisation & system level

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Finance - Underlying position and In-Year Savings requirement

Memo 1 - Bridge to Underlying

	UHBW	NBT	AWP	CCG	BNSSG
remove n/r national funding				(£3.2)	**(£3.2)**
remove n/r regional funding	(£2.0)	(£6.2)	(£1.0)		**(£9.2)**
remove n/r cost pressures				£2.0	**£2.0**
add back n/r measures	(£21.6)	(£8.3)	(£1.8)	(£3.6)	**(£35.2)**
remove n/r reserves allocation	(£16.2)		(£12.9)		**(£29.1)**
remove additional n/r support	(£0.5)	(£0.9)	(£0.1)		**(£1.5)**
n/r efficiency delivery 2022/23 (organisation)					**tbc**
n/r efficiency delivery 2022/23 (system transformation)					**tbc**
Full-Year Effect of 2022/23 plan					**tbc**
Restated Underlying position	**(£40.2)**	**(£15.3)**	**(£15.9)**	**(£4.8)**	**(£76.2)**
of which relates to unfunded inflationary costs	(£2.6)	(£7.1)	(£1.1)	(£0.1)	**(£10.9)**

Memo 2 - In-Year Savings Requirement & n/r measures required to deliver break -even plan

Core 1.1% National Efficiency Ask	(£7.8)	(£7.2)	(£3.3)	(£13.6)	**(£31.9)**
Transformational Savings	(£7.4)	(£5.9)	£0.0		**(£13.3)**
Provider Specifc Transactional Savings	(£1.2)	£0.0	(£2.0)		**(£3.2)**
Further Internal Savings Requirement	(£5.9)	(£7.1)	(£1.8)		**(£14.8)**
Sub-Total Savings Requirement	**(£22.3)**	**(£20.2)**	**(£7.1)**	**(£13.6**	**(£63.3)**
Sub-Total Savings Requirement (%)	2.2%	2.6%	2.1%	1.8%	
n/r measures required to break -even	(£21.6)	(£8.3)	(£1.8)	(£3.6)	**(£35.2)**
ESRF Productivity Challenge / Review of Investments	(£12.4)	(£5.1)			**(£17.5)**
Covid Cost Reduction					**£0.0**
Total actions embedded within break -even plan	**(£56.3)**	**(£33.6)**	**(£8.9)**	**(£17.2)**	**(£115.9)**
actions embedded within break -even plan (%)	5.4%	4.4%	2.7%	2.2%	

- Recurrent deficit on exit of 2022/23 of £76.2m
- £10.9m of originally identified £29m inflationary pressure remains part of recurrent deficit
- Position will worsen if savings only met non-recurrently (tbc)
- Recurrent route to cash out for system transformation savings still needs to be identified at provider level
- Delivery of break even plan contingent on delivery of £63.3m of savings (including Sirona 1.1% efficiency)
- £17.5m ESRF challenge expected to come from combination of reduced costs through review of investments and or additional ESRF activity/income compared to plan

Healthier Together

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Narrative delegated sign off

Narrative Section	Key narrative authors	Narrative updates since April submission	Sign off oversight
Introduction: Health Inequalities	Adwoa Webber	*No updates*	N/A
Section A: Workforce	Taylor Pryer-Freeman	*Minimal updates*	N/A
Section C: Elective Recovery, Cancer and Diagnostics	Dani Sapsford, Ben Stevens	*Minor updates*	Steve Curry (SRO)
Section D1: Urgent Care	Greg Penlington, Kate Lavington	*Minimal updates*	Jon Scott (SRO)
Section D2: Community Services	Louise Rickitt , Becca Dunn, Alissa Davies	*Significant updates*: • *Virtual Wards* • *Discharge*	Virtual Wards – Becca Dunn Discharge – Rosanna James D2 reviewed by Mary Lewis and Sirona care & Health SLT

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Narrative updates: Section D2 Community Virtual Wards

Section	Additional content added

Actions	• Healthier Together@home vision now included and programme contextualized within BNSSG "Home First" Portfolio, interdependent with Ageing Well, Discharge 2 Assess, Condition specific programs (e.g. Respiratory, Cardiovascular disease, End of Life care)
	• Recognising links with Elective Recovery – HT@H supporting the need to release acute capacity.
	• Key objectives: Delivery of 4,500 virtual ward beds by December 2023
	• Additional detail on HT@H governance i.e. primarily within the Integrated Care Steering Group, but with support from Acute Provider Collaborative, Sirona SLT and GP Provider Collaborative
	• Further detail on working processes e.g. workstream teams using a 'test and learn' approach
	• Delivery Plans detailed:
	  • Tranche 1: End of Q1 22/23 – 50 virtual ward beds in operation by July 22
	  • Tranche 2: Q2 and Q3 22/23 – 100 virtual ward beds in operation by December 22
	  • Tranche 3: Q4 22/23 – Virtual ward expansion in support of winter pressures – 150 beds by April 23
	  • Tranche 4: Q1-2 23/24: ICS interim business case and workforce allowing, move to 400 virtual ward beds
	  • Tranche 5: Q3/4: Evaluation and confirmation of Business case for long-term operating
	• Digital:
	  • Procurement for new digital solution underway and expected for completion b end of June 22/
	• Patient and public engagement embedded throughout, with 'test and learn' approach drawing on user feedback.
	• Workforce: Acute Provider Collaborative supportive of hybrid Consultant roles with mix of acute and community facing working with GP Associates also being explored for Autumn 22.

Assumptions	• OPAT recruited in full (28wte)
	• A recruitment trajectory of c.7.9% per calendar month for the specific VW model (trajectory forced to meet £8.53m in Yr2 with recruitment in Yr1)
	• Full utilisation of the Yr1 funding (£3.413m) *plus* funding to support the OPAT service additional to the VW funding – total spend Yr1 c.£5m
	  • OPAT, 40 bed equivalent
	  • VW model (Resp / HT@H / Heart Failure) 89110 bed equivalent (varying utilisation in line with monthly demand, peak in Jan 2023)
	  • VCSE, £300k
	• Full recruitment by Yr2 of the model £8.53m (£4.265m, match funded), funding £132.48wte (VW & OPAT as a single service).
	• Other General Principles: Non Pay, 5% Overhead, Estates & Contingency, 20%

Risks	• Consultant recruitment cannot be undertaken.
	  • Mitigation: support from Provider Collaborative. Discussion with current trainees on attractive role specifications.
	• Staff recruitment for @Home services in general:
	  • Mitigation: Roles being designed with workforce lead to be broader in scope and more attractive

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Narrative updates: Section D2 Community D2A

Section	Additional content added

Actions	• Outlining of all objectives including key objective of the D2A Programme; to achieve 132 acute bed day savings by March 2023
	• Summary theory of change included
	• Resources for delivery: governance through ICSG, monthly D2A Board, weekly D2A steering group and task and finish groups
	• System delivery plan
	  • Tranche 1 – 33 acute bed days saved by October 2022
	  • Tranche 2 – 132 acute bed days saved by March 2023
	• Programme workstreams:
	  1. Workforce: Sirona working to increase staff to offer greater capacity in P1 and reduce use of P2 and P3 beds
	  2. Pathway design: to test and implement new models of care across pathways via task and finish groups
	  3. Monitoring, evaluation and outcomes: focused on understanding if D2A is on track to deliver
	  4. System stakeholder engagement: Communications Lead has been recruited to develop strategic plan to ensure consistent engagement
	  5. Commissioning: Developing joint commissioning arrangements for intermediate care services

Assumptions	• Pathway proportion and length of stay: D2A modelling assumes pathway redesign will reduce length of stay in hospitals and increase the proportion of people going into D2A pathway and P1 as opposed to P2 and P3.
	• The acute bed day savings of 132 beds by March 2023 is based on the assumption that:
	  • The proportion of people going into D2A pathways will move to 70% Pathway 1, 10% Pathway 2, 10% Pathway 3 and 10% other.
	  • The average length of stay will be 10 days for Pathway 1, 21 days for Pathway 2 and 28 days for Pathway 3.
	• Recruitment: Trajectory of Sirona staff recruitment will continue to grow – 164 slots was achieved by end of May 22.

Risks	• Risk that required culture and behaviour change does not result in P2/P3 shifting to P0/P1
	  • Mitigation: system-wide action plan to support acutes with culture change
	• Risk that required length of stay in P1/2/3 is not achieved due to lack of Sirona or community capacity
	  • Mitigation: recruitment campaign ongoing e.g. Proud of Care and Workforce Capacity Fund. Options for collective recruitment to be considered.

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Virtual Wards Planning Submission

The following sections contain the same content as Section D2 (Virtual Wards) of the Operational Plan narrative:

2.1 - System Vision for Virtual Wards; **3.1** - Service Model; **3.2** - Approach to Delivery; **3.3** - Technology Enablement; **3.5** - Risks and Issues; **3.6** – Dependencies; **3.7** – Mitigation; **3.8** – Indicative Milestone Plan; **4.2** – Governance and Assurance; **5.1** - Planning Approach and Engagement with organisations/teams/staff delivering the service and **5.3** – Health Inequalities.

Section	Additional Content to D2 Virtual Ward Narrative
3.4 Winter / Surge Capacity	- Winter Capacity built into programmes expansion plans - All pathways expected to be maximised through Q4 - Response to Covid-19 variations/surges built into EPPR escalation actions – Pulse oximetry can be stepped up at short notice.
4.1 Programme Management	- Programme objectives will be monitored by the HT@Home core group which meets twice weekly. - Clinical leadership is in place through collaboration of paid leads in Sirona, NBT and UHBW. - Technology leadership is in place through Sirona lead for IM&T. - Improvement leadership is multidimensional. SRO and programme leadership in place through CCG/ICB and programme management in place through each of the provider organisations. - Financial reporting and leadership in place via the CCG/ICB finance lead for community services and partner organisations leads.
4.3 Overall Benefits Management and Evaluation	- Success criteria in place which will be monitored by SRO and sponsors. - Sitrep data being collected fortnightly by NHSEI, and will be reported at ICS level once central digital system in place (commencing July 22). - Wider programme benefits under development, linked to the outcomes of the Home First portfolio. - Further benefits expected outlined for patients and carers, staff, system, and wider population.
5.2 Planning Approach and Engagement with Patients & Carers	- Communications for new pathways to be developed following model set out for Covid Oximetry @ Home and Covid Virtual Wards. - There are 4 planned phases of insight activity: • Develop enhanced understanding of current service user experience (July 22) • Implement Regular Collection of Feedback from Potential Users of HT@Home Service (Q3 2022) • Combine Service User Experience with Subsequent Service User Activity (Q4 2022) • Gather Detailed Feedback Relating to Particular Themes (2023)
6.1 Sustainability	- A system wide business case is being developed, bringing into consideration relevant BNSSG strategies. - Workforce requirements are being married with other Home First priorities. - Match funding has been brought into the Y2 plan. - The ICSG has a direct link to the Executive Group for escalation of issues and support, and providers are updated through the ARC Provide Collaborative and Sirona SLT.

Next steps

Phase	Key milestones	Timing
	System sign off of changes to finance, activity and performance metrics	17 June
	Delegated sign off of narrative updates by SROs • C: Elective Recovery, Cancer and Diagnostics – Steve Curry	By 17 June
	System Plan Resubmission	20 June
	Healthier Together@Home/Virtual Wards programme plan submission	20 June
	Mental Health Workforce submission	23 June
	Bed deficit risk/mitigations submission	23 June

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Healthier Together
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Appendix 2

Service Development Funds

Sum of Value	Column Labels		
Row Labels	Agreed	Indicative	Grand Total
Mental Health	**10,930**		**10,930**
Adult Mental Health Community (AMH Community)	4,870		4,870
Adult Mental Health Crisis (AMH Crisis)	693		693
Adult Mental Health Liaison (Crisis/Liaison flexible funding)	314		314
CYP ARRS/Primary Care	83		83
CYP community, Crisis and Eating Disorders	1,172		1,172
CYP Ed	83		83
MHST 20/21 sites wave 3&4 (MHST20/21)	1,113		1,113
MHST 21/22 sites wave 5&6 (MHST21/22)	778		778
Perinatal	56		56
Rough Sleeping existing sites	339		339
SMI Outreach	198		198
Staff Mental Health Support	623		623
Suicide Bereavement	63		63
Young adults (18-25)	545		545
LD & Autism	**1,037**		**1,037**
Autism Diagnostic Pathway (CYP)	42		42
Autism in Schools (accelerator programme)	0		0
Care and Treatment Reviews (CeTR)	33		33
Community Capacity	686		686
Keyworkers (CYP)	243		243
LeDeR	33		33
Ageing Well	**1,262**		**1,262**
Fair Shares Allocations	1,262		1,262
111First		**872**	**872**
NHS111 Capacity Funding		872	872
Virtual Wards	**1,137**	**2,275**	**3,412**
Virtual Wards	1,137	2,275	3,412
Personalised Care	**245**		**245**
Personalised Care Fair Shares	245		245
Prevention	**114**	**341**	**455**
Tobacco - Inpatients	81	242	323
Tobacco - Maternity	33	99	132
Primary Care	**3,574**	**1,963**	**5,537**
Additional IIF funding Non-SDF (included for planning only)	558		558
Additional PCN Leadership and Management funding Non-SDF	693		693
Fellowships	164	493	657
GPIT - Infrastructure and Resilience	217		217
Improving Access - H1	312		312
Improving Access - H2	292		292
Local GP Retention	50	150	200
Online Consultation systems	250		250
Practice Resilience	134		134
Subject Access Requests - Non-SDF (included for planning only	322		322
Supporting Mentors	35	105	140
Training Hubs	200		200
Transformational Support	347	1,039	1,386
Weight Management Service Non-SDF (included for planning only)		176	176
Diagnostics Programme	**604**	**604**	**1,208**
CDC Revenue payments to support Year 1 CDCs to continue in	604	604	1,208
Maternity	**657**	**281**	**938**
Continuity of Carer	46	138	184
Local transformation & LTP - Local Maternity Systems (LMS) - c	387		387
LTP - SBL Pre-term Birth /NMM	176		176
Perinatal Pelvic Health (wave 1)	48	143	191
System Transformation	**232**		**232**
System Allocations	232		232
Cancer (SWAG)	**2,656**	**7,595**	**10,251**
Cancer Alliance Fair Shares distribution inc. core team funding	1,983	5,948	7,931
CCE	115	54	169
Cytosponge	33	98	131
Lynch Funding	102	307	409
Targeted Lung Health Checks	423	1,188	1,611
Grand Total	**22,448**	**13,931**	**36,379**

NB. Cancer SDF is held in BNSSG CCG for the South West Cancer Alliance on behalf of BNSSG, Somerset, BSW and Gloucestershire ICSs

Appendix 3

High level growth and savings assumptions as per medium term financial plan

Steering Group	Programme	Investment	Savings (Acute) *	Savings (Other)	Net Investment
		£m	£m	£m	£m
Acute	High Cost Drugs	£3.1			£3.1
Acute	One T&O		(£2.1)		(£2.1)
Acute	Outpatients		(£3.8)		(£3.8)
Children & Families	Community - Children's	£0.4			£0.4
Children & Families	Maternity	£1.6			£1.6
Funded Care	CHC	£3.8		(£3.0)	£0.8
Urgent Care	Minors Programme	£5.2			£5.2
Integrated Care	Community - Adult's	£2.8	(£2.5)		£0.3
Integrated Care	Home First / Discharge to Assess	£11.9	(£3.8)		£8.1
Integrated Care	Better Care Fund	£1.2			£1.2
Stroke	Stroke	£3.6			£3.6
MH, LD & Autism	Mental Health & LD	£6.5	(£1.3)	(£1.6)	£3.6
PCCC	Delegated Primary Care	£11.5			£11.5
PCCC	Prescribing	£5.5		(£4.4)	£1.1
Total	**TOTAL Savings Plan 2022/23**	**£57.1**	**(£13.3)**	**(£9.0)**	**£34.8**

* Excludes provider 1.1% national efficiency ask, and Additional internal savings targets

Appendix 4

Savings Plans

Provider	Core Efficiency	Transactional Savings	Transformation Savings	TOTAL Savings	ICS Provider?	NHSE Programme	NHSE Category	Risk	Maturity	Commissioning Lead	CCG Finance lead	Notes
NBT	-4,261			-4,261	Y	Acute	Evidence based interventions	Medium	Plans in progress	Provider internal plans	Chris Flook	
NBT			-5,934	-5,934	Y	Acute	Pathway transformation	Medium	Plans in progress	Various system wide transformation projects (see next tab)	Chris Flook	
UHBW	-4,213			-4,213	Y	Acute	Evidence based interventions	Medium	Plans in progress	Provider internal plans	Chris Flook	
UHBW		-1,200		-1,200	Y	Acute	Pathway transformation	Medium	Plans in progress	Provider internal plans	Chris Flook	
UHBW			-7,366	-7,366	Y	Acute	Pathway transformation	Medium	Plans in progress	Various system wide transformation projects (see next tab)	Chris Flook	
Acute Intra-System	**-8,475**	**-1,200**	**-13,300**	**-22,975**								
AWP	-1,250			-1,250	Y	Mental Health & LD	Evidence based interventions	Medium	Plans in progress	Provider internal plans	Padma Ramanan	
AWP		-2,000		-2,000	Y	Mental Health & LD	Mental Health - reducing out of area placements	Medium	Opportunity	Provider internal plans	Padma Ramanan	
MH Intra-System	**-1,250**	**-2,000**	**0**	**-3,250**								
Sirona	-1,210			-1,210		Community	Evidence based interventions	Medium	Plans in progress	Provider internal plans	Jamie Denton	
Inter-System Provider Expenditure	**-10,934**	**-3,200**	**-13,300**	**-27,434**								
CCG Block Expenditure To Outside Of System (A	-582			-582		Acute	Evidence based interventions	Medium	Plans in progress			
CCG Block Expenditure To Outside Of System (M	-57			-57		Mental Health & LD	Evidence based interventions	Medium	Plans in progress			
CCG Block Expenditure To Outside Of System	**-640**	**0**	**0**	**-640**								
Acute Care	-436			-436	N	Acute	Non-NHS Procurement	Low	Fully Developed	Jenny Falco	Chris Flook	ISTC by default via national tariff on contracts
Non-Acute Contracts	-394			-394	N	Community	Non-NHS Procurement	Medium	Plans in progress	Rachael Anthwal	Jamie Denton	default assumption is tariff uplift, will be some risk of delivery
Children's Services	-224			-224	N	Community	Non-NHS Procurement	Medium	Plans in progress	Rachael Anthwal	Padma Ramanan	default assumption is tariff uplift, will be some risk of delivery
Mental Health & Learning Disabilities	-557			-557	N	Mental Health & LD	Non-NHS Procurement	Medium	Plans in progress	Emma Moody	Padma Ramanan	default assumption is tariff uplift, will be some risk of delivery. Included in MHIS financial plan
Mental Health & Learning Disabilities		-1,579		-1,579	N	Mental Health & LD	Mental Health - reducing out of area placements	Medium	Plans in progress	Emma Moody	Padma Ramanan	default assumption is tariff uplift, will be some risk of delivery. Included in MHIS financial plan
Continuing Healthcare	-976		-2,024	-3,000	N	Continuing Care	Continuing Healthcare - cost per case review	Medium	Plans in progress	Denise Moorhouse	Padma Ramanan	default assumption is tariff uplift, will be some risk of delivery
Medicines Management	-1,499		-2,905	-4,404	N	Primary Care	Primary Care Prescribing	Medium	Plans in progress	Debbie Campbell	Netty Toth	
Primary Care	-301			-301	N	Primary Care	Non-NHS Procurement	Low	Fully Developed	Jenny Bowker / Sukeina Kassam	Jamie Denton	won't offer inflation uplift by default
Primary Care (Delegated)				0	N	Primary Care	Non-NHS Procurement	Medium	Plans in progress			
Running Costs		-375		-375	N	Running Costs	Running cost review	Medium	Plans in progress	CCG Executives	Nick Tippet	subject to Exec structure
Non-NHS Total	**-4,388**	**-1,954**	**-4,929**	**-11,271**								
Total CCG Savings	**-5,027**	**-1,954**	**-4,929**	**-11,911**								
Total CCG Savings	**-15,962**	**-5,154**	**-18,229**	**-39,345**								

22/23 Savings by Provider

	UHBW	NBT	Sub-Total Acute	Case for Change	How savings will be realised	Link to ERF income	ERF Value	Supporting Transformation	Supporting Transformation Investment - Recurrent	Supporting Transformation Investment - Non Recurrent Revenue & Capital	Transformation Finance and Leadership Support	KPIs	Acute Beds
	£'000	£'000	£'000										
Discharge to Assess (Acute)	-2.1	-1.7	-3.8	Patients known to decondition and at greater risk of harms such as infections and falls due to extended stay in hospital setting. Long term outcomes improved by support for independent living at home. c200 valuable beds per day occupied by patients no longer meeting the right to reside criteria	Reduced acute bed capacity; in short term expected to be re-utilised to support elective recovery	Yes	-3.8	ICSG: D2A programme; Healthier Together @ Home	D2A investment £12m rec	S256 Transition Risk Pool	Yes	Reducing LoS (Acute and Community); Ratio of Discharges between P0-P3	112
Frailty / Ageing Well Programme *	-1.4	-1.1	-2.5	Earlier and proactive care is more cost effective than reactive interventions, as well as meeting population need to live healthy, fulfilling lives at home	Reduced acute inpatient costs of frailty through investment in community care model and personalised & anticipatory care; in short term expected to be re-utilised to support elective recovery	Yes	-2.5	ICSG: Ageing Well ; Primary Care Transformation; Adult Community Services Transformation; Pathway specific programmes - Diabetes, Stroke. CVD: Healtier Together @	£1.3m Ageing Well SDF; £2.8m Community Services growth; share of £12m+ Primary Care	£4.4m Ageing Well 21/22 pilots; £3.4m Virtual Wards SDF; £0.5m Diabetes SDF; £1.5m OPAT	Yes	Acute admissions; Community 2hr response target	25
Mental Health *	-0.7	-0.5	-1.3	People with a mental health diagnosis currently have poorer healthy life expectancy. Lack of investment in mental health services has led to patients in inappropriate care setting, which delivers poorer outcomes and challenging for staff and other patients	Reduced use of physical health services by patients with MH diagnosis; offset by investment in MH services e.g. Eating Disorders, Ambulance Response teams, physical health checks	Yes	-1.3	MH & LD: All programmes	MHIS and MH SDF (notably Crisis, CAMHS and Tier 4 CAMHS, Comm MH)		Yes	Acute A&E attendances & admissions; Adolescent MH nursing in BRHC; MH to non-MH cost per patient ratio	0
Outpatients Transformation & Demand Management *	-2.1	-1.6	-3.8	Our citizens panel told us that 13% of outpatient attendances did not add any value to them. The model of care is not fit for purpose with increased levels of co-morbidities. Outpatient clinic care is not efficiency use of residents time and also leads to avoidable travel	Reduced avoidable outpatient capacity through better integrated care, supported self-care and digital alternatives	Yes	-3.8	ACC: Outpatients Transformation programme; ICSG: Primary Care Transformation	cE12m Primary Care Investment (ARRS)	Digital investment; Regional OP Programme SDF	Yes	OP FUP activity; A&G activity; Referral levels; PROMS	0
One T&O *	-1.2	-0.9	-2.1	Multiple providers can lead to lower productivity levels in both elective and trauma pathways. Current provider model of care leads to poor training experience for junior doctors. Profits leaked to the private sector	Remove duplication of MSK pathway capacity including medical rotas and standard theatre & clinical capacity; as well as repatriation of profitable ISTC capacity into freed up capacity	Yes	-2.1	ACC: One T&O Programme		Digital investment; ISTC capacity	Yes	IS spend net ESRF; Theatre utlisation per med staff wte and overall capacity; PROMS; Wait list size	0
Sub-Total Transformational Savings Programme	-7.5	-5.8	-13.3				-13.3						137

Appendix 5

Elective Service Recovery Fund

Memo - Summary ESRF Position 20/06/2022

	UHBW	NBT	Independent Sector	Non ICB Providers (SW)	System Held	Grand Total
TOTAL ICB Clawback	(£2.3)	(£4.3)	£0.0	£0.0	£0.0	**(£6.7)**
TOTAL NHSE/I Clawback	(£7.2)	(£3.6)	£0.0	£0.0	£2.2	**(£8.6)**
TOTAL ESRF clawback	**(£9.5)**	**(£7.9)**	**£0.0**	**£0.0**	**£2.2**	**(£15.3)**
ESRF retained by the system (ICB)	£10.8	£8.5	£5.4	£0.3	£0.0	**£25.0**
ESRF retained by the system (NHSE/I)	£2.7	£1.0	£0.0	£0.0	£2.2	**£5.9**
TOTAL ESRF retained by the system	**£13.5**	**£9.5**	**£5.4**	**£0.3**	**£2.2**	**£30.8**
TOTAL commitments v Funding	(£25.9)	(£14.6)	(£5.4)	(£0.3)	£0.0	**(£46.2)**
Unmitigated Risk	**(£12.4)**	**(£5.1)**	**£0.0**	**£0.0**	**£2.2**	**(£15.3)**

Appendix 6

Excess inflation pressures

Inflation in excess of funded levels							
	UHBW	NBT	AWP	Sirona	CCG	System	
	£k	£k	£k	£k	£k	£k	Is Estimate or Actual?
Pay	-2,919	-2,238	35	0		-5,122	Incremental drift estimate
Drugs - other	0	-128	-32	-8	-2,263	-2,432	Use ONS; excluding pass through drugs
Drugs - Pass through high cost drugs	0	-270				-270	Use ONS
Cap Charges (PFI)	0	-1,788	-322	0	0	-2,110	Actuals for PFIs, others Estimate as per plan
Energy	-3,904	-7,653	-1,097	-327	-185	-13,167	Actuals (includes Home Oxygen reimbursement for CCG)
CNST	313	513	76	0	0	902	Actuals
Other Supplies & Services	-4,428	-2,674	-1,520	-558	0	-9,180	Estimate from BWPC basket of services
Care Market					-4,429	-4,429	Actual offered rate
Primary Care Energy					-3,000	-3,000	Estimate re: Section 96
Funded Nursing Care (21/22)					-2,329	-2,329	As per notified 21/22 uplift
Community mileage rates			-150	-312	0	-462	Estimate
SWAST					-214	-214	As per SWAST model
						0	
	-10,937	-14,238	-3,011	-1,206	-12,420	-41,813	
ICB share	41%	53%	42%	100%	100%		
Other Share	59%	47%	58%	0%	0%		
Risk adjustment factor							
Pay	0%	0%	0%	0%	0%		Managed internally
Drugs - other	0%	0%	0%	0%	0%		High level estimate - show as risk
Drugs - Pass through high cost drugs	0%	0%	0%	0%	0%		High level estimate - show as risk
Cap Charges (PFI)	100%	100%	100%	100%	100%		Actuals
Energy	100%	100%	100%	100%	100%		Actuals
CNST	100%	100%	100%	100%	100%		Actuals
Other Supplies & Services	90%	90%	90%	90%	90%		Estimate
Care Market					90%		Manage individual contracts
Primary Care Energy				0%	0%		Estimate re: Section 96 - show as risk
Funded Nursing Care (21/22)					100%		As per notified 21/22 uplift; pending natinal guidance
Community mileage rates			0%	0%	0%		Unlikely to support without national policy; AfC better than prvate sector
SWAST					0%		Estimate
Risk adjusted cost pressure							
	UHBW	NBT	AWP	Sirona	CCG	System	
	£k	£k	£k	£k	£k	£k	
Pay	0	0	0	0	0	0	
Drugs	0	0	0	0	0	0	
Cap Charges (PFI)	0	-1,788	-322	0	0	-2,110	
Energy	-3,904	-7,653	-1,097	-327	-185	-13,167	
CNST	313	513	76	0	0	902	
Other Supplies & Services	-3,985	-2,406	-1,368	-503	0	-8,262	
Care Market	0	0	0	0	-3,986	-3,986	
Primary Care Energy	0	0	0	0	0	0	
Funded Nursing Care (21/22)	0	0	0	0	-2,329	-2,329	
Community mileage rates	0	0	0	0	0	0	
SWAST	0	0	0	0	0	0	
	-7,576	-11,335	-2,711	-830	-6,500	-28,952	

Appendix 7

System Source and Application of Funds

	UHBW	NBT	AWP	Sub-Total Provider	BNSSG ICB	Sub-Total Provider & ICB	System Top-Up	SYSTEM TOTAL
Recurrent ICB / System Allocations					£1,663.9	**£1,663.9**	£72.8	**£1,736.8**
Income from Outside BNSSG ICB								
Block Income From Outside Of System - ICB	£58.2	£37.3	£95.7	**£191.2**		**£191.2**		**£191.2**
Block Income From Outside Of System - NHS England	£425.0	£239.9	£31.2	**£696.1**		**£696.1**		**£696.1**
Income From Outside Of System - Other	£137.5	£81.2	£69.8	**£288.5**		**£288.5**		**£288.5**
Total Sources of Funding	**£620.8**	**£358.4**	**£196.6**	**£1,175.8**	**£1,663.9**	**£2,839.7**	**£72.8**	**£2,912.5**
Intra-System Contracts								
Recurrent Baseline Contract Value	£338.6	£330.3	£100.7	**£769.7**	(£769.7)	**£0.0**		**£0.0**
Top-Up	£29.2	£49.4	£16.6	**£95.2**	(£22.4)	**£72.8**	(£72.8)	**£0.0**
Mitigations	£22.7	£16.5	£0.0	**£39.2**	(£39.2)	**£0.0**		**£0.0**
Recurrent Savings (Transformation)	(£7.4)	(£5.9)	£0.0	**(£13.3)**	£13.3	**£0.0**		**£0.0**
Recurrent Expenditure								
Provider Expenditure - Recurrent	(£1,044.2)	(£763.9)	(£329.8)	**(£2,137.9)**		**(£2,137.9)**		**(£2,137.9)**
CCG Expenditure - Recurrent					(£666.7)	**(£666.7)**		**(£666.7)**
Running Costs Expenditure				**£0.0**	(£18.4)	**(£18.4)**		**(£18.4)**
Delegated Primary Care ringfenced spend				**£0.0**	(£156.2)	**(£156.2)**		**(£156.2)**
ICB Contingency				**£0.0**	(£8.0)	**(£8.0)**		**(£8.0)**
Total Applications	**(£661.0)**	**(£373.7)**	**(£212.5)**	**(£1,247.2)**	**(£1,667.2)**	**(£2,914.4)**	**(£72.8)**	**(£2,987.2)**
Recurrent Underlying Deficit	**(£40.2)**	**(£15.3)**	**(£15.9)**	**(£71.4)**	**(£3.3)**	**(£74.7)**	**£0.0**	**(£74.7)**
Non-Recurrent								
Non-Recurrent Regional Funding (PFI)		£2.7	£0.5	**£3.2**	£6.0	**£9.2**		**£9.2**
Non-Recurrent Health Inequalities Funding					£3.2	**£3.2**		**£3.2**
BNSSG Share of SWASFT planning gap (£21.5m)				**£0.0**	(£1.7)	**(£1.7)**		**(£1.7)**
Uncommitted Community Growth				**£0.0**	£2.8	**£2.8**		**£2.8**
Non-Recurrent Slippage on Investments	£21.6	£8.3	£1.8	**£31.6**		**£31.6**		**£31.6**
Covid allocation underspend				**£0.0**	£20.8	**£20.8**		**£20.8**
Release of ICB 0.5% contingency				**£0.0**	£8.0	**£8.0**		**£8.0**
Non-Recurrent Deficit Support	£18.7	£4.3	£13.6	**£36.6**	(£36.6)	**£0.0**		**£0.0**
SDF Slippage				**£0.0**	£0.7	**£0.7**		**£0.7**
2022/23 Financial Plan	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**(£0.0)**	**(£0.0)**	**£0.0**	**(£0.0)**

Appendix 8

Detailed MDT budgets

Row Labels	Sum of FINAL budget	ESRF
Acute Care	943,178,853	
Acute Contracts (in STP)	829,273,947	
NBT	409,565,670	8,460,000
UHBW	419,708,277	10,841,000
Independent Sector Treatment Centres	37,009,691	
Independent Sector Treatment Centres	37,009,691	
BMI	551,820	
BMI ERF	428,430	428,430
Circle - now SULIS managed by RUH	1,288,033	
Circle - now SULIS managed by RUH ERF	432,841	432,841
IS ERF	0	
IVF	705,328	
New Medical	2,853,036	
New Medical ERF	189,090	189,090
Nuffield	4,386,603	
Nuffield ERF	998,036	998,036
Other AQP	296,712	
Practice Plus Group	11,431,954	
Practice Plus Group ERF	278,412	278,412
Primary Care Gastro	2,195,586	
Primary Care Gastro ERF	428,914	428,914
Somerset Surgical	1,222,991	
Spa Medica	214,421	
Spa Medica ERF	386,042	386,042
Spire	7,945,468	
Spire ERF	775,974	775,974
Acute Contracts (outside STP)	16,696,000	
Non-Contract Activity	9,941,897	
Other Acute Expenditure	5,228,317	
Ambulance Contract	45,029,000	
Ambulance Contract	45,029,000	
SWASFT	43,029,000	
SWASFT Handover Risk Reserve	2,000,000	
Non-Acute Contracts	214,847,431	
Adult Community Contracts	121,199,781	
Community Equipment Services	4,735,679	
Community Rehabilitation & Reablement	12,367,032	
Joint Working between Health and Social Care	27,884,701	
Other Community Services	6,194,527	
Patient Transport Costs	6,088,122	
Hospices	4,331,539	

Ageing Well SDF	1,262,000
Virtual Wards SDF	3,412,000
Stroke	6,400,000
Other Community Services	6,400,000
Stroke - Non Acute	4,358,000
Stroke - Transition	2,042,000
IUC/CAS and GP Out of Hours	20,972,051
Children's Services	18,684,080
Mental Health & Learning Disabilities	212,734,464
Mental Health - AWP Block Contract	138,095,043
Mental Health - Other Services	34,149,717
MH - AWP Other Services	927,253
MH - Block Contracts	4,195,470
MH - Other Services	3,011,219
MH - Placements	18,402,757
MH - Voluntary Sector	2,941,114
MH - SDF	4,671,904
Improved Acess to Psychological Therapies	10,473,010
Child & Adolescent Mental Health Services	16,597,467
CAMHS	12,823,467
CAMHS - SDF	3,774,000
Learning Disabilities	8,188,134
LD - Placements	7,113,134
LD - SDF	1,075,000
Dementia	5,231,093
Continuing Healthcare	94,081,930
Medicines Management	142,633,338
Primary Care	19,846,611
Clinical Leads & Membership Engagement	1,958,991
Clinical Leads & Membership Engagement	1,200,991
Locality Leadership Groups	758,000
GP Forward View	8,564,213
Local Enhanced Services	2,826,148
Other Primary Care	357,388
Referral Support Service	11,227
PMS Premium Reinvestment	5,116,644
Primary Care Reserve	1,012,000
Primary Care (Delegated)	157,920,954
Other Support Costs	14,192,547
Estates Management Recharges	2,825,000
IT & Infrastructure	3,292,000
Programme Pay Costs	7,900,547
Commissioning Directorate	337,138
Fixed Term Contracts	98,987
Medical Directorate	2,941,103

Nursing & Quality Directorate	4,271,161	
Transformation Directorate	252,158	
Safeguarding	175,000	
Running Costs	18,363,000	
Running Costs Pay Costs	14,020,030	
Area Directorate	1,714,848	
Chief Executive	252,948	
Commissioning Directorate	2,805,565	
Finance, Intelligence & Corporate Services	4,232,940	
Governing Body	335,127	
Medical Directorate	792,097	
Nursing & Quality	2,028,709	
Transformation Directorate	2,720,415	
Running Costs Pay Costs	-862,618	
Running Costs Non-Pay	4,342,970	
Charges from CSU	2,750,000	
Running Costs Non-Pay	1,592,970	
Reserves	20,662,793	
0.5% Contingency Reserve	0	
Covid-19	156,000	
Other Reserves	10,231,793	
Investment Reserves	10,231,793	
CEO reserve	600,000	
Covid - Q1 transition	0	
Discharge to Assess savings slippage	-3,750,000	
ESRF risk reserve	8,426,261	8,426,261
High Cost drug growth	531,000	
Investments Inflation Reserve	892,256	
Non Demographic Adult Community Growth	0	
Ockenden Review	593,000	
Profiling adjustment	0	
System Transformation Reserve	2,939,276	
SDF	10,275,000	
Grand Total	**1,857,146,000**	31,645,000

NHS

Bristol, North Somerset and South Gloucestershire

Integrated Care Board

Shaping better health

Healthier **Together**

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

2022/23 System plan resubmission for 20.06.22

Briefing prepared for system sign off meeting – 17 June 2022

Contents

Purpose

System sign off is required on changes to finance, workforce, activity and performance metrics for the resubmission of operational plans due 20.06.22

Key Messages

- **Mental Health** – improved trajectories on the three areas where 28/4 plan was short of targets. Expect continued performance management by NHSEI regionally
  - Out of area placement bed days reduced to 576 (360 fewer than 28/4 plan) – Improved
  - Children and Young People accessing specialist support increased to 8,948 (1,948 more than 28/4 plan) – Improved
  - Women accessing specialist perinatal support increased to 1,099 (64 more than 28/4 plan) - Improved

- **Elective recovery** – improved trajectories, still short of targets. Non-compliant plans may trigger performance management by NHSEI nationally
  - >104 week waits eliminated (except for P6 patients) by March 2023 (91 fewer than 28/4 plan) - Improved
  - >78 week waits reduced to 1,243 by March 2023 (1,586 fewer than 28/4 plan) – Improved
  - >52 week waits increased to 8,132 by March 2023 (1,00 more than 28/4 plan) – Deteriorated
  - > 62 day backlog waits for Cancer treatment. NBT position remains an outlier nationally. May trigger NHSEI performance management escalation of BNSSG ICS to Tier 1 ('Mandated National Support') – No change/national outlier

- **Financial plan** – additional funding received for inflation and balanced plan proposed by BNSSG DOFs (Slide 13 shows the movement from the April submission deficit of £38.2m) - Improved and in line with National expectation
  - Unmitigated risk of ESRF clawback of £17.5m shown in the plan in line with Regional and National discussions. This is a complex area to reliably forecast due to the interplay between the system and specialist commissioning and between the NHS providers and the Independent sector. The DOFs are content to show this position.
  - Mitigations will need to be delivered through additional productivity over and above plan

- **Alignment to Quarter 1 performance** – Revised plans are better aligned to Q1 performance data - Improved
  - Trusts have rebased plans to April actuals, where possible. Weekly data shows May performance above plan

- **Bed deficit/occupancy risk** – NHSEI derived bed occupancy calculations will show an increased bed deficit vs 28/4 plan
  - Applying NHSEI methodology indicates a c331 average system bed deficit risk (c242 in the 28/4 plan) - Deteriorated
  - Mitigations will be through access to escalation beds, delivery of 'bed savings' through Home First and Trust internal productivity improvements
  - NHSEI require a further submission on bed deficit risk and mitigations on 23/6

- **Home First** – Progress on Discharge 2 Assess and Healthier Together@Home increases confidence in bed deficit mitigations
  - Discharge 2 Assess projected delivery increased by 20 to 132 bed equivalent savings by end March – Improved
  - Healthier Together@Home/Virtual Wards: detailed programme plan to be submitted to NHSEI 20/6. Highlights opportunities to achieve c150 bed equivalent savings (29 bed savings assumed in 20/6 plan), but will depend on increasing/shifting workforce. Assumes c£3.4m funding from NHSEI - Improved

Mental Health: final submission plans show improved position for CYP, OAP & Perinatal following meetings with NHSEI. Recovery plans have been updated to reflect this.

Providers	Theme	Metric	Plan agreed	Target	Does plan hit target	Planned attainment	Old planned attainment	Change
System	LD&A	Learning disability registers and annual health checks delivered by GPs	Complete	75%	Yes	75%		
System	LD&A	Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by ICSs	Complete	9	Yes	9		
System	LD&A	Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by NHS England or via a Provider Collaborative	Complete	13	Yes	13		
System	LD&A	Reliance on inpatient care for people with a learning disability and/or autism - Care for children	Complete	3	Yes	3		
AWP	MSDS	Mental Health Services Dataset - Data Quality Maturity Index Score	Complete	95%	Yes	95%		
AWP	Inpatients	Adult mental health inpatients receiving a follow up within 72hrs of discharge	Complete	80%	Yes	80%		
VITA	IAPT	Total access to IAPT services	Complete	29,937	Yes	29,937		
AWP	Diagnosis	Estimated diagnosis rate for people with dementia	Complete	66.7%	Yes	66.7%		
AWP	CYP	The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months)	Complete	95%	Yes	95%		
AWP	SMI	People with severe mental illness receiving a full annual physical health check and follow up interventions	Complete	5,514	Yes	6,724		
AWP	Placements	Access to Individual Placement and Support Services	Complete	714	Yes	714		
AWP	Community	Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Complete	4,177	Yes	4,200		
AWP	Psychosis	First Episode Psychosis treatment with NICE recommended package of care within two weeks of referral	Complete	60%	Yes	60%		
AWP	OAPs	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Complete	0	No	567	927	-360
AWP	CYP	The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Complete	95%	No	90%		
AWP	CYP	Access to Children and Young People's Mental Health Services	Complete	10,154	No	8948	7,000	+1948
AWP	Womens	Women Accessing Specialist Community Perinatal Mental Health Services	Complete	1,164	No	1099	1,035	+64

Overall

- NHSEI were particularly keen we improved the CYP and OAP plans, this was done while striking a balance between realism and striving to deliver the national target.
- The improved plans have been signed off by the AWP Exec team.
- Recovery plans are in place and will be shared with region too.

Mitigations

- **CYP Access:** Increased investment, ongoing recruitment, implementation of Mental Health Support Teams, expansion of crisis and eating disorder support.
- **Perinatal:** Setting up maternal mental health clinics, looking to understand best practice with a view to remodelling the current offer, as many women are currently supported by our voluntary sector. Issue with the birth rate denominator inaccurate for our area.
- **Out of Area:** "Right Care" approach to the work. Focus on flow, red to green, medically fit for discharge patients. Consideration of developing Capital Case for additional beds, as comparative data shows a low bed base.

Elective recovery – Summary of plans against target

Area	Requirement / Target	Met at System Level Yes/No	NBT	UHBW	System
Elective Admissions	104% 2019/20	No	89%	90%	90%
Day Case	104% 2019/20	No	104%	101%	103%
OP 1st	104% 2019/20	No	104%	102%	103%
OPFU	75% 2019/20 (nb. 25% reduction)	No	100%	110%	107%
Virtual OP	5% of all OP attends	**No**	**Yes**	**No**	**No**
PIFU	5%	Yes	Yes	Yes	Yes
Diagnostics – Echo	120% 2019/20	No	66%	105%	**90%**
Diagnostics – CT	120% 2019/20	No	115%	112%	114%
Diagnostics – Colon	120% 2019/20	Yes	117%	243%	172%
Diagnostics – Flexi	120% 2019/20	No	118%	82%	103%
Diagnostics – NOUS	120% 2019/20	No	94%	99%	96%
Diagnostics - MRI	120% 2019/20	No	105%	100%	102%
Cancer – Treatment Volumes	-	**Yes**	**Yes**	**Yes**	**Yes**
Cancer – Patients waiting 63+days	Feb 2020 levels	**No**	**No**	**Yes**	**No**
Cancer – FDS	75%	**No**	**No**	**Yes**	**No**
Clock Starts	-		103%	82%	91%
Clock Stops (AD)	-		100%	93%	96%
Clock Stops (NAD)	-		100%	107%	104%

Acute activity plans: summary and key changes from April

	System - Change between April and June submissions Measure	Change
Electives	Elective day case spells	1.8%
	Elective ordinary spells	3.8%
	Consultant-led first outpatient attendances (Spec acute)	2.4%
	Consultant-led first outpatient attendances with procedures (Spec acute)	4.8%
	Consultant-led follow-up outpatient attendances (Spec acute)	2.3%
	Consultant-led follow-up outpatient attendances with procedures (Spec acute)	6.8%
	Number of episodes moved or discharged to patient initiated outpatient follow-up pathway	0.0%
Diagnostics	Diagnostic Tests - Cardiology - Echocardiography	-0.1%
	Diagnostic Tests - Colonoscopy	1.0%
	Diagnostic Tests - Computed Tomography	-0.1%
	Diagnostic Tests - Flexi Sigmoidoscopy	-0.7%
	Diagnostic Tests - Gastroscopy	0.4%
	Diagnostic Tests - Magnetic Resonance Imaging	-0.3%
	Diagnostic Tests - Non-Obstetric Ultrasound	0.4%
RTT	GP Referrals made for a First Consultant-Led Outpatient Appointment	-0.2%
	Other Referrals made for a First Consultant-Led Outpatient Appointment	-0.2%
	New RTT pathways (clock starts)	0.0%
	RTT completed admitted pathways	0.9%
	RTT completed non-admitted pathways	2.1%
UEC	Type 1&2 A&E Attendances excluding Planned Follow Ups	-0.1%
	Non-elective spells with a length of stay of zero days	1.0%
	Non-elective spells with a length of stay of 1 or more days	1.2%
	Reducing length of stay for patients in hospital for 21 days and over	0.0%
Cancer	Cancer 28 day waits (faster diagnosis standard)	-0.5%
	Cancer treatment volumes	-0.2%
	Number of patients waiting 63 or more days after referral from cancer PTL	3.2%

Waiting list change - position at March-23

		April Plan	June Plan	Change
NBT	Total	39,224	39,224	0
	52+	3660	3,660	0
	78+	878	568	-310
	104+	139	48	-91
UHBW	Total	49,649	53,649	4000
	52+	3472	4472	1000
	78+	1951	675	-1276
	104+	29	29	0
System	Total	88,873	92,873	4000
	52+	7132	8,132	1000
	78+	2829	1,243	-1586
	104+	168	77	-91

Estimated ERF cost-weighted achievement

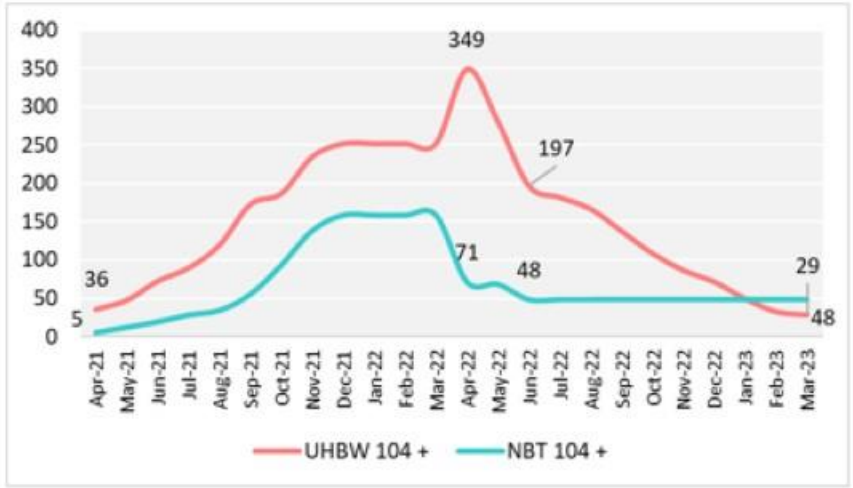
	April Plan	June Plan	Change
Total NHS	96%	98%	2.3%
Independent Sector	111%	111%	0%
ICS total	99%	101%	2.0%

Planned 22/23 activity as a percentage of 19/20 and 21/22

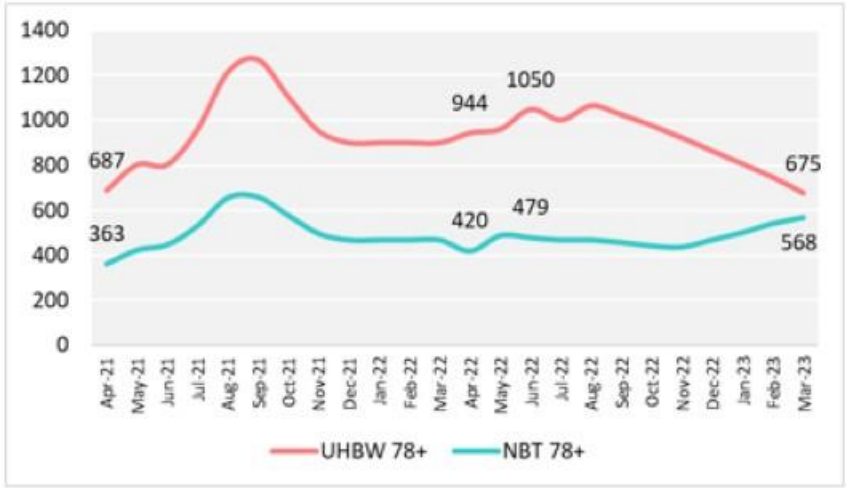
	UHBW		NBT		Independent Sector	
	19/20 %	21/22 %	19/20 %	21/22 %	19/20 %	21/22 %
Daycase	101%	112%	104%	116%	110%	127%
Elective	90%	123%	89%	121%	120%	115%
OP 1st	102%	118%	104%	116%	127%	123%
OP FUP	110%	117%	100%	98%	119%	86%

Waiting list

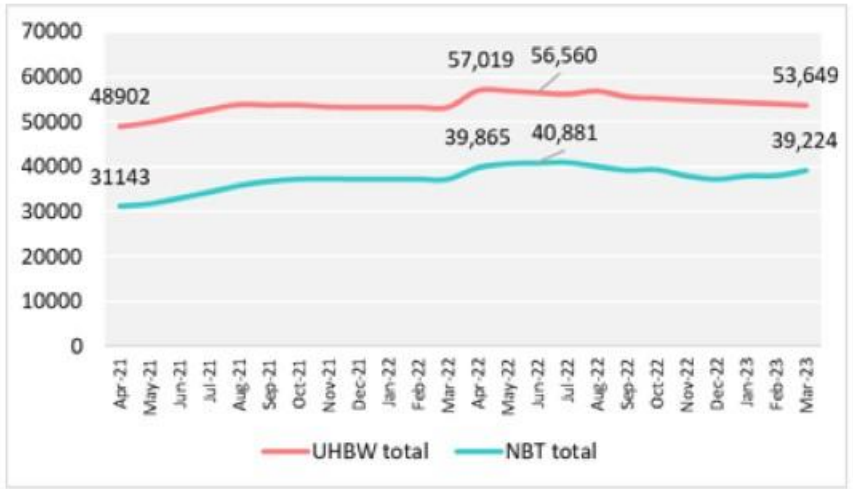
+104 week waits



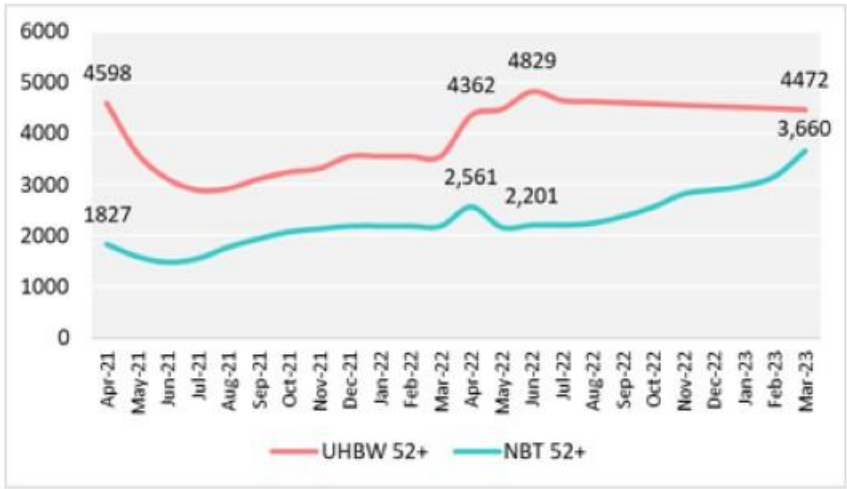
+78 week waits



Total waiting list



+52 week waits



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	78+	878	568	-310
	104+	139	48	-91
UHBW	Total	49,649	53,649	4000
	52+	3472	4472	1000
	78+	1951	675	-1276
	104+	29	29	0
System	Total	88,873	92,873	4000
	52+	7132	8,132	1000
	78+	2829	1,243	-1586
	104+	168	77*	-91

* All P6 waiters

Finance – ESRF Risk

	UHBW	NBT	Independent Sector	Non ICB Providers (SW)	System Held	Grand Total
BNSSG ICB ESRF Allocation	£13.2	£12.8	£5.5	£0.3		**£31.6**
BNSSG ESRF Allocation	£9.9	£4.6	£0.0	£0.0		**£14.5**
TOTAL ESRF Allocation	**£23.0**	**£17.4**	**£5.5**	**£0.3**	**£0.0**	**£46.1**
TOTAL ICB Clawback	(£2.3)	(£4.3)				**(£6.7)**
TOTAL NHSE/I Clawback	(£7.2)	(£3.6)			£2.2	**(£8.6)**
TOTAL ESRF clawback	**(£9.5)**	**(£7.9)**	**£0.0**	**£0.0**	**£2.2**	**(£15.3)**
ESRF retained by the system (ICB)	£10.8	£8.5	£5.4	£0.3	£0.0	**£25.0**
ESRF retained by the system (NHSE/I)	£2.7	£1.0	£0.0	£0.0	£2.2	**£5.9**
TOTAL ESRF retained by the system	**£13.5**	**£9.5**	**£5.4**	**£0.3**	**£2.2**	**£30.8**
TOTAL commitments v Funding	(£25.9)	(£14.6)	(£5.4)	(£0.3)	£0.0	**(£46.2)**
Unmitigated Risk	**(£12.4)**	**(£5.1)**	**£0.0**	**£0.0**	**£2.2**	**(£15.3)**

- Financial Plan submission on 28th April assumed total ESRF clawback of £23.8m – latest assessment based on revised activity plans assumes a clawback of £15.3m – a total improvement of £8.5m retained income (£6.3m relating to ICB activity, £2.2m relating to NHSE/I commissioned activity)
- In order to deliver this improved activity position, and improve waiting list performance trajectories, a further £6.5m of costs have been approved by System DoFs, over and above those included in the 28th April financial plan submission
- The net risk of £17.5m relating to commitments against this income therefore remains unchanged, and remains as an unmitigated risk to delivering a balanced financial plan in 2022/23. The £2.2m assumed gain from NHSE/I income has currently not been assumed as a benefit against this risk, pending further understanding of the split of activity delivery.

Current elective activity run rate vs. plan

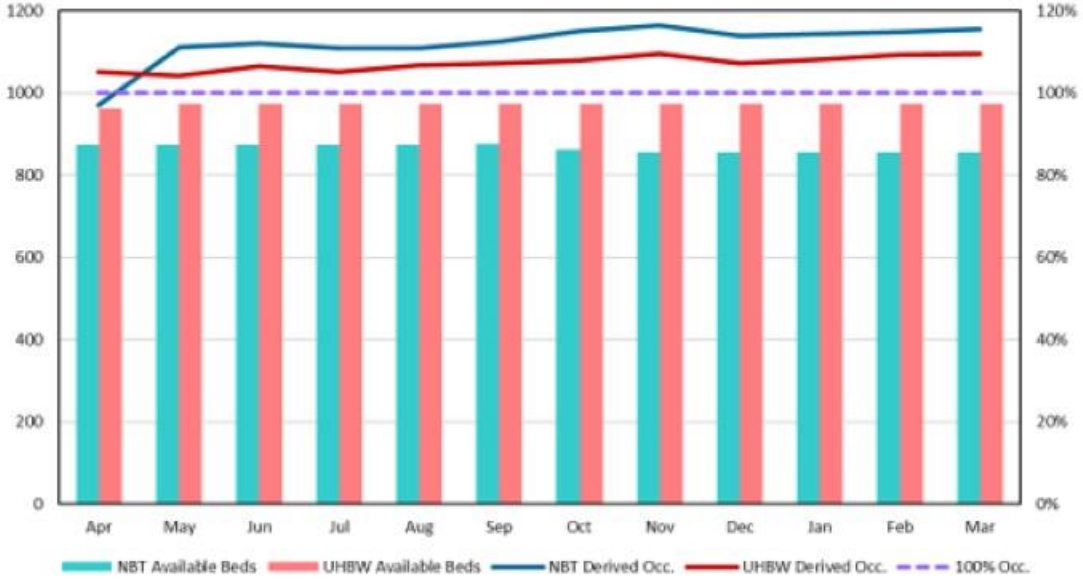
	Daycase			Elective			OP 1st			OP FUP		
	NBT	UHBW	System	NBT	UHBW	System	NBT	UHBW	System	NBT	UHBW	System
Apr-22 Plan	100%	89%	93%	90%	79%	83%	103%	92%	96%	97%	102%	100%
Apr-22 Actuals	103%	84%	91%	88%	75%	80%	89%	85%	86%	96%	100%	99%
Variance	3%	-5%	-2%	-2%	-4%	-3%	-14%	-7%	-10%	-1%	-2%	-1%
May-22 Plan	107%	93%	99%	87%	83%	85%	107%	94%	99%	103%	103%	103%
May-22 Actuals	98%	91%	94%	93%	84%	88%	92%	94%	93%	96%	103%	101%
Variance	-9%	-2%	-5%	6%	1%	3%	-15%	0%	-6%	-7%	0%	-2%

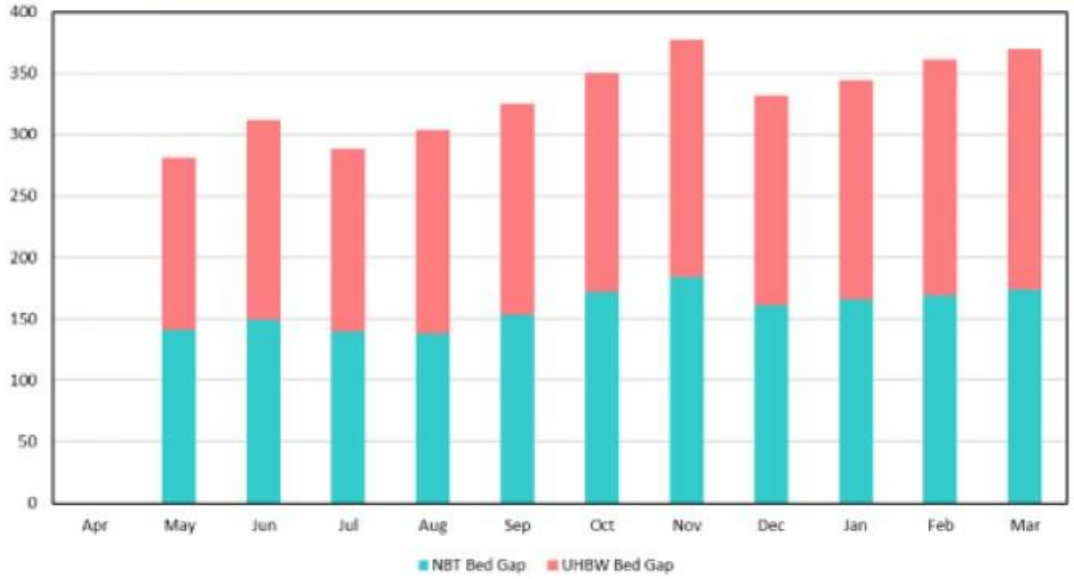
Local weekly activity data %s vs. plan

NB – data does not include last week in May and likely understating % achievement

Beds

- Addition of Knightstone ward beds as ring fenced
- NBT increased G&A beds available between Apr-Oct to avoid going over 100% occupancy





			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NBT	Plan	Available beds	871	875	875	875	875	876	862	855	855	855	855	855
	Plan	Occupancy	100%	100%	100%	100%	100%	100%	100%	98%	95%	95%	94%	93%
	Derived	Occupancy		111%	112%	111%	111%	113%	115%	116%	114%	114%	115%	115%
	Derived	Beds required		972	981	970	969	986	991	996	973	978	982	986
	Derived	Bed gap		141	149	139	138	153	172	184	161	166	169	174

UHBW	Plan	Available beds	963	973	973	973	973	973	973	973	973	973	973	973
	Plan	Occupancy	98%	98%	98%	98%	98%	98%	98%	99%	98%	99%	98%	98%
	Derived	Occupancy		104%	106%	105%	107%	107%	108%	109%	107%	108%	109%	110%
	Derived	Beds required		1065	1087	1073	1090	1096	1103	1119	1095	1103	1116	1120
	Derived	Bed gap		141	163	149	165	172	179	194	171	179	192	195

System	Plan	Available beds	1834	1848	1848	1848	1848	1849	1835	1828	1828	1828	1828	1828
	Derived	Beds required		2037	2068	2044	2059	2082	2094	2114	2069	2081	2098	2106
	Derived	Bed gap		282	312	288	303	325	350	378	332	345	361	369

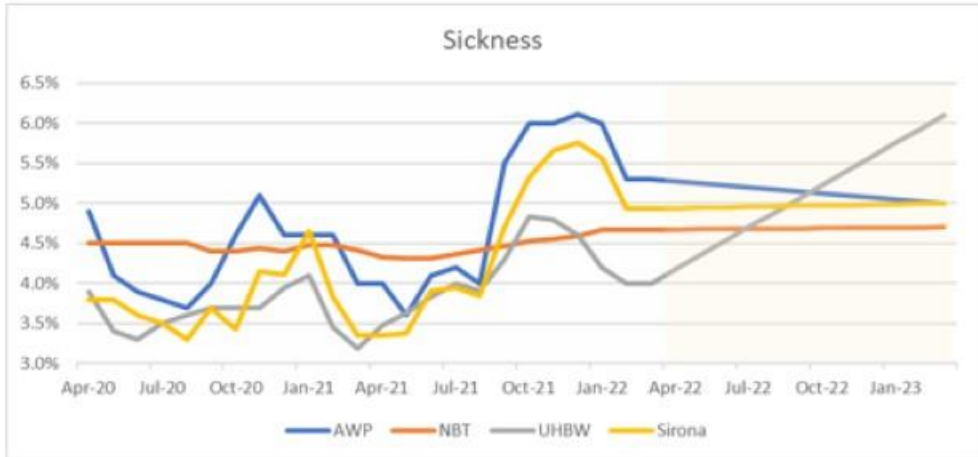
Workforce: key headlines

- Overall 3.5% growth in total workforce across 2022/23, compared to 2021/22.
  - Primary Care: c6.7%
  - Mental Health: c7.0%
  - Acute: c2.2%
  - Community: c21.7%

- 6.5% increase in Registered Nursing staff in post – this equates to 180.5WTE.
  - In 2019/20, Registered Nursing staff in post grow by 6%
  - This growth reduced to 2% in 2021/22
- Reduction in Banks Staff activity by 1.1% (20.1wte) and
- Reducing our planned agency use by 18.5% (140wte)
- Planning for reduction in turnover by March 2023 when compared to March 2022. The provider target end position for 2022/23 ranges between 14%-15%.
- Holding sickness absence to 3.8%

- **Additional analysis undertaken to stress test workforce plans**
- **High risk assumptions identified:**
  - **AWP: c7% growth in Staff in Post**
  - **Sirona c21.7% growth in Staff in Post**

Key risks: staff turnover and sickness rates



Finance - Route to Balanced System Financial Plan 2022/23

	UHBW	NBT	AWP	CCG	BNSSG
Inflation	(£7.6)	(£11.3)	(£2.8)	(£7.3)	(£29.0)
Q1 covid costs	(£1.9)	(£0.9)		(£0.6)	(£3.4)
Q1 ESRF lost income	(£3.9)	(£1.9)		£0.0	(£5.8)
Financial Plan Submission 28/04	**(£13.3)**	**(£14.1)**	**(£2.8)**	**(£8.0)**	**(£38.2)**
Additional Inflationary Uplift (ICB)	£2.7	£2.7	£0.8	£2.8	£9.0
Additional ICB Growth (CHC, FNC, BCF)				£5.6	£5.6
National Ambulance Funding				£2.4	£2.4
Additional Inflationary Uplift (Other Commissioners)	£2.3	£1.5	£0.9		£4.7
Revised Spec Comm envelopes 310522	£0.0	(£1.4)	£0.1		(£1.3)
Revised Spec Comm ERF	£0.1	£0.0	£0.0		£0.1
Application of National Funding					
Pass-through of 0.7% inflationary uplift from/to Out of System ICBs				(£1.2)	(£1.2)
Pass-through of National Ambulance Funding				(£2.4)	(£2.4)
Off-set to revised Spec Comm Contracts	£0.0	£1.4	(£0.1)		£1.3
Revised Plan after National Contract changes	**(£8.2)**	**(£9.9)**	**(£1.1)**	**(£0.7)**	**(£20.0)**
Other Non-Recurrent Actions					
Non-Recurrent National Allocations (PFI)				£3.2	£3.2
Non-Recurrent National Allocations (Other)				£6.0	£6.0
Q1 Covid Costs managed down to planned level	£1.9	£0.9	£0.0	£0.6	£3.4
ESRF Impact (productivity Improvments / review of investments)	£3.9	£1.9	£0.0		£5.8
BNSSG Share of SWASFT planning gap (£21.5m)				(£2.0)	(£2.0)
Uncommitted Community Growth				£2.8	£2.8
SDF Slippage				£0.7	£0.7
Revised Plan after non-recurrent actions	**(£2.5)**	**(£7.1)**	**(£1.1)**	**£10.7**	**£0.0**
Allocation of non-recurrent resource					
Allocation of Non-Recurrent Funding (PFI)	£0.0	£2.7	£0.5	(£3.2)	£0.0
Further n/r support	£2.5	£4.3	£0.6	(£7.5)	£0.0
Restated 2022/23 Plan (20th June submission)	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**

- Additional recurrent funding to the ICB of £17m, of which £14.6m relates to inflationary pressures (£2.4m ambulance trust specific, passed through to SWASFT)
- Further £4.7m of funding from Other Commissioners (£3.1m Spec Comm) for additional 0.7% inflationary uplift
- Further £9.2m n/r funding from region in recognition of increased PFI inflation (£3.2m), and additional n/r support (£6m) all allocated to providers
- Q1 Covid (£3.4m) & ESRF impact (£5.8m) removed from bottom line
- £1.5m CCG surplus n/r allocated to providers to present balance plan at organisation & system level

Finance - Underlying position and In-Year Savings requirement

Memo 1 - Bridge to Underlying

	UHBW	NBT	AWP	CCG	BNSSG
remove n/r national funding				(£3.2)	(£3.2)
remove n/r regional funding	(£2.0)	(£6.2)	(£1.0)		(£9.2)
remove n/r cost pressures				£2.0	£2.0
add back n/r measures	(£21.6)	(£8.3)	(£1.8)	(£3.6)	(£35.2)
remove n/r reserves allocation	(£16.2)		(£12.9)		(£29.1)
remove additional n/r support	(£0.5)	(£0.9)	(£0.1)		(£1.5)
n/r efficiency delivery 2022/23 (organisation)					tbc
n/r efficiency delivery 2022/23 (system transformation)					tbc
Full-Year Effect of 2022/23 plan					tbc
Restated Underlying position	**(£40.2)**	**(£15.3)**	**(£15.9)**	**(£4.8)**	**(£76.2)**
of which relates to unfunded inflationary costs	(£2.6)	(£7.1)	(£1.1)	(£0.1)	(£10.9)

Memo 2 - In-Year Savings Requirement & n/r measures required to deliver break-even plan

Core 1.1% National Efficiency Ask	(£7.8)	(£7.2)	(£3.3)	(£13.6)	(£31.9)
Transformational Savings	(£7.4)	(£5.9)	£0.0		(£13.3)
Provider Specifc Transactional Savings	(£1.2)	£0.0	(£2.0)		(£3.2)
Further Internal Savings Requirement	(£5.9)	(£7.1)	(£1.8)		(£14.8)
Sub-Total Savings Requirement	**(£22.3)**	**(£20.2)**	**(£7.1)**	**(£13.6)**	**(£63.3)**
Sub-Total Savings Requirement (%)	2.2%	2.6%	2.1%	1.8%	
n/r measures required to break-even	(£21.6)	(£8.3)	(£1.8)	(£3.6)	(£35.2)
ESRF Productivity Challenge / Review of Investments	(£12.4)	(£5.1)			(£17.5)
Covid Cost Reduction					£0.0
Total actions embedded within break-even plan	**(£56.3)**	**(£33.6)**	**(£8.9)**	**(£17.2)**	**(£115.9)**
actions embedded within break-even plan (%)	5.4%	4.4%	2.7%	2.2%	

- Recurrent deficit on exit of 2022/23 of £76.2m
- £10.9m of originally identified £29m inflationary pressure remains part of recurrent deficit
- Position will worsen if savings only met non-recurrently (tbc)
- Recurrent route to cash out for system transformation savings still needs to be identified at provider level
- Delivery of break-even plan contingent on delivery of £63.3m of savings (including Sirona 1.1% efficiency)
- £17.5m ESRF challenge expected to come from combination of reduced costs through review of investments and or additional ESRF activity/income compared to plan

Healthier Together

Narrative delegated sign off

Narrative Section	Key narrative authors	Narrative updates since April submission	Sign off oversight
Introduction: Health Inequalities	Adwoa Webber	*No updates*	N/A
Section A: Workforce	Taylor Pryer-Freeman	*Minimal updates*	N/A
Section C: Elective Recovery, Cancer and Diagnostics	Dani Sapsford, Ben Stevens	*Minor updates*	Steve Curry (SRO)
Section D1: Urgent Care	Greg Penlington, Kate Lavington	*Minimal updates*	Jon Scott (SRO)
Section D2: Community Services	Louise Rickitt, Becca Dunn, Alissa Davies	*Significant updates*: • *Virtual Wards* • *Discharge*	Virtual Wards – Becca Dunn Discharge – Rosanna James D2 reviewed by Mary Lewis and Sirona care & Health SLT

Narrative updates: Section D2 Community - Virtual Wards

Section	Additional content added

Actions	• Healthier Together@home vision now included and programme contextualized within BNSSG "Home First" Portfolio, interdependent with Ageing Well, Discharge 2 Assess, Condition specific programs – (e.g. Respiratory, Cardiovascular disease, End of Life care)
	• Recognising links with Elective Recovery – HT@H supporting the need to release acute capacity.
	• Key objectives: Delivery of 4,500 virtual ward beds by December 2023
	• Additional detail on HT@H governance i.e. primarily within the Integrated Care Steering Group, but with support from Acute Provider Collaborative, Sirona SLT and GP Provider Collaborative
	• Further detail on working processes e.g. workstream teams using a 'test and learn' approach
	• Delivery Plans detailed:
	  • Tranche 1: End of Q1 22/23 – 50 virtual ward beds in operation by July 22
	  • Tranche 2: Q2 and Q3 22/23 – 100 virtual ward beds in operation by December 22
	  • Tranche 3: Q4 22/23 – Virtual ward expansion in support of winter pressures – 150 beds by April 23
	  • Tranche 4: Q1-2 23/24: ICS interim business case and workforce allowing, move to 400 virtual ward beds
	  • Tranche 5: Q3/4: Evaluation and confirmation of Business case for long-term operating
	• Digital:
	  • Procurement for new digital solution underway and expected for completion b end of June 22/
	• Patient and public engagement embedded throughout, with 'test and learn' approach drawing on user feedback.
	• Workforce: Acute Provider Collaborative supportive of hybrid Consultant roles with mix of acute and community facing work. Physician Associates also being explored for Autumn 22.

Assumptions	• OPAT recruited in full (28wte)
	• A recruitment trajectory of c.7.9% per calendar month for the specific VW model (trajectory forced to meet £8.53m in Yr2 with linear recruitment in Yr1)
	• Full utilisation of the Yr1 funding (£3.413m) *plus* funding to support the OPAT service additional to the VW funding – total spend Yr1 c.£5m
	  • OPAT, 40 bed equivalent
	  • VW model (Resp / HT@H / Heart Failure) 89-110 bed equivalent (varying utilisation in line with monthly demand, peak in Jan 2023)
	  • VCSE, £300k
	• Full recruitment by Yr2 of the model - £8.53m (£4.265m, match funded), funding £132.48wte (VW & OPAT as a single service).
	• Other General Principles: Non Pay, 5%; Overhead, Estates & Contingency, 20%

Risks	• Consultant recruitment cannot be undertaken.
	  • Mitigation: support from Provider Collaborative. Discussion with current trainees on attractive role specifications.
	• Staff recruitment for @Home services in general:
	  • Mitigation: Roles being designed with workforce lead to be broader in scope and more attractive

Narrative updates: Section D2 Community – D2A

Section	Additional content added

Actions	• Outlining of all objectives including key objective of the D2A Programme; to achieve 132 acute bed day savings by March 2023
	• Summary theory of change included
	• Resources for delivery: governance through ICSG, monthly D2A Board, weekly D2A steering group and task and finish groups
	• System delivery plan
	  • Tranche 1 – 33 acute bed days saved by October 2022
	  • Tranche 2 – 132 acute bed days saved by March 2023
	• Programme workstreams:
	  1. Workforce: Sirona working to increase staff to offer greater capacity in P1 and reduce use of P2 and P3 beds
	  2. Pathway design: to test and implement new models of care across pathways via task and finish groups
	  3. Monitoring, evaluation and outcomes: focused on understanding if D2A is on track to deliver
	  4. System stakeholder engagement: Communications Lead has been recruited to develop strategic plan to ensure consistent engagement
	  5. Commissioning: Developing joint commissioning arrangements for intermediate care services

Assumptions	• Pathway proportion and length of stay: D2A modelling assumes pathway redesign will reduce length of stay in hospitals and community and proposition of people going into D2A pathway and P1 as opposed to P2 and P3.
	• The acute bed day savings of 132 beds by March 2023 is based on the assumption that:
	  • The proportion of people going into D2A pathways will move to 70% Pathway 1, 10% Pathway 2, 10% Pathway 3 and 10% other.
	  • The average length of stay will be 10 days for Pathway 1, 21 days for Pathway 2 and 28 days for Pathway 3.
	• Recruitment: Trajectory of Sirona staff recruitment will continue to grow – 164 slots was achieved by end of May 22.

Risks	• Risk that required culture and behaviour change does not result in P2/P3 shifting to P0/P1
	  • Mitigation: system-wide action plan to support acutes with culture change
	• Risk that required length of stay in P1/2/3 is not achieved due to lack of Sirona or community capacity
	  • Mitigation: recruitment campaign ongoing e.g. Proud of Care and Workforce Capacity Fund. Options for collective recruitment being considered.

Virtual Wards Planning Submission

The following sections contain the same content as Section D2 (Virtual Wards) of the Operational Plan narrative:

2.1 - System Vision for Virtual Wards; **3.1** - Service Model; **3.2** - Approach to Delivery; **3.3** - Technology Enablement; **3.5** - Risks and Issues; **3.6** – Dependencies; **3.7** – Mitigation; **3.8** – Indicative Milestone Plan; **4.2** – Governance and Assurance; **5.1** - Planning Approach and Engagement with organisations/teams/staff delivering the service and **5.3** – Health Inequalities.

Section	Additional Content to D2 Virtual Ward Narrative
3.4 Winter / Surge Capacity	- Winter Capacity built into programmes expansion plans - All pathways expected to be maximised through Q4 - Response to Covid-19 variations/surges built into EPPR escalation actions – Pulse oximetry can be stepped up at short notice.
4.1 Programme Management	- Programme objectives will be monitored by the HT@Home core group which meets twice weekly. - Clinical leadership is in place through collaboration of paid leads in Sirona, NBT and UHBW. - Technology leadership is in place through Sirona lead for IM&T. - Improvement leadership is multidimensional. SRO and programme leadership in place through CCG/ICB and programme management in place through each of the provider organisations. - Financial reporting and leadership in place via the CCG/ICB finance lead for community services and partner organisation data leads.
4.3 Overall Benefits Management and Evaluation	- Success criteria in place which will be monitored by SRO and sponsors. - Sitrep data being collected fortnightly by NHSEI, and will be reported at ICS level once central digital system in place (Impl. commencing July 22). - Wider programme benefits under development, linked to the outcomes of the Home First portfolio. - Further benefits expected outlined for patients and carers, staff , system, and wider population.
5.2 Planning Approach and Engagement with Patients & Carers	- Communications for new pathways to be developed following model set out for Covid Oximetry @ Home and Covid Virtual Wards. - There are 4 planned phases of insight activity: • Develop enhanced understanding of current service user experience (June-July 22) • Implement Regular Collection of Feedback from Potential Users of the HT@Home Service (Q3 2022) • Combine Service User Experience with Subsequent Service User Activity (Q4 2022) • Gather Detailed Feedback Relating to Particular Themes (2023)
6.1 Sustainability	- A system wide business case is being developed, bringing into consideration relevant BNSSG strategies. - Workforce requirements are being married with other Home First priorities. - Match funding has been brought into the Y2 plan. - The ICSG has a direct link to the Executive Group for escalation of issues and support, and providers are updated through Acute Provide Collaborative and Sirona SLT.

Next steps

Phase	Key milestones	Timing
	System sign off of changes to finance, activity and performance metrics	17 June
	Delegated sign off of narrative updates by SROs • C: Elective Recovery, Cancer and Diagnostics – Steve Curry	By 17 June
	System Plan Resubmission	20 June
	Healthier Together@Home/Virtual Wards programme plan submission	20 June
	Mental Health Workforce submission	23 June
	Bed deficit risk/mitigations submission	23 June

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Bristol, North Somerset and South Gloucestershire Integrated Care Board

Meeting of ICB Board

Date: 1st July 2022
Time: 09.30
Location: MS Teams

Agenda Number :	6.1	
Title:	NHS System Oversight Framework	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No

Purpose: Discussion

Key Points for Discussion:

NHS England and Improvement have published the NHS System Oversight Framework on the 28th June 2022.

To raise awareness to the ICB of the approach from NHS England/Improvement and the key guiding principle that delivery is through systems.

The NHS System Oversight Framework is intended to be monitored via routine engagement with the ICB.

The 6 key themes that form the oversight framework include a theme to establish a set of local priorities as part of the priorities.

Recommendations:	To raise awareness for the ICB Board on the NHS System Oversight Framework.
Previously Considered By and feedback :	This is National Publication and monitoring of the System will be through the Outcome, Performance and Quality Committee
Management of Declared Interest:	There are no conflicts of Interest with NHS System Oversight Framework. State whether consideration has been given to potential or actual Conflicts of Interest.
Risk and Assurance:	The NHS Oversight Framework assess the overall performance of the system and will be reported to the ICB Outcome, Performance and Quality Committee..

Financial / Resource Implications:	NHS System Oversight Framework will monitor financial performance of the system as part of the metrics.
Legal, Policy and Regulatory Requirements:	The NHS System Oversight Framework forms part of the assurance of the ICB by NHS England/Improvement.
How does this reduce Health Inequalities:	With one of the six themes within the NHS System Oversight Framework being based on local priorities will support the delivery of the outcomes of the ICB.
How does this impact on Equality & diversity	This is a National framework, and the priorities within the themes have been nationally consulted on.
Patient and Public Involvement:	This is a National framework, and the priorities within the themes have been nationally consulted on.
Communications and Engagement:	This is a National framework and has been released as part of Gateway process.
Author(s):	Lisa Manson
Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd Chief Nursing Officer/ Ellen Donovan Independent Non-Executive Director

Agenda item: 6.1
Report title: NHS System Oversight Framework

1. Background

The NHS has been developing an oversight framework over the last couple of years which has been focussed on how we improve delivery against a range of indicators and was consulted on in 2021/22. The refreshed NHS System Oversight Framework has been revised for 2022/23 and was published on the 28th June 2022 to commence on the 1st July 2022 alongside the establishment of Integrated Care Boards

2. NHS System Oversight Framework – 2022/23

The NHS System Oversight Framework is based on system led delivery and shows a commitment that NHS England will work with and through systems. The intention of the framework is to support ICBs and NHS England to work together and develop proportionate and locally tailored approaches to oversight that reflect:

a. a shared understanding of the ambitions, accountabilities and roles between NHS England, ICBs, individual trusts and local partnerships, and how performance will be monitored
b. the unique local delivery and governance arrangements specifically tailored to the needs of different communities
c. the importance of delivery against both the shared system priorities agreed between local partners and national NHS priorities

The purpose of the NHS Oversight Framework is to:

a. ensure the alignment of priorities across the NHS and with wider system partners
b. identify where ICBs and/or NHS providers may benefit from, or require, support
c. provide an objective basis for decisions about when and how NHS England will intervene.

The approach to oversight is characterised by the following key principles:

a. working with and through ICBs, wherever possible, to tackle problems
b. a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
c. matching accountability for results with improvement support, as appropriate
d. autonomy for ICBs and NHS providers as a default position
e. compassionate leadership behaviours that underpin all oversight interactions informed by Our Leadership Way

3. The Scope of the NHS System Oversight Framework

The Scope of the NHS System Oversight is based on the five national themes which are reflected in the ambitions of the NHS Long Term Plan, which are applicable to both Trusts and ICBs

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

These will be monitored at both ICB and provider level, against a revised and reduced set of metrics.

There is a sixth theme, which is local strategic priorities will allow the ICB to embed the key outcomes and strategic priorities from the strategy development.

In order to support this a memorandum of understanding is being developed between NHS England and which will reflect the governance of ICB in order to prevent duplication in the assurance and oversight arrangements.

The oversight framework will support the segmentation of the ICB, alongside the plans to address areas of challenged delivery. At this stage based on the NHS System Oversight Framework the segmentation is likely to be 2.

4. Legal implications

The NHS System Oversight Framework is part of the NHS Oversight of ICBs and NHS Foundation Trusts and Trusts.

5. Risk implications

The ICB will monitor the NHS System Oversight Framework through the Outcomes, performance and quality committee, and will raise potential changes to segmentation of the ICB and the challenges in regard to the delivery of the metrics.

6. How does this reduce health inequalities

The NHS System Oversight Framework is focussed in its oversight on Preventing ill health and reducing inequalities and with the introduction of the local priorities theme the ICBs commitment to reduce health inequalities.

7. How does this impact on Equality and Diversity?

The NHS System Oversight framework has priority theme to focus local priorities which will allow the ICB to support local priorities..

8. Consultation and Communication including Public Involvement

NHS England and Improvement undertook a consultation process in 2021/22.

Appendices

Appendix 1

NHS System Oversight Framework and Metrics

Classification: Official

Publication approval reference: PAR1378

NHS Oversight Framework

27 June 2022

Contents

1. Introduction

1. Integrated care systems (ICSs) are partnerships of health and care organisations that together plan and deliver joined up services to improve the health of people who live and work in their area. Following several years of locally-led development, the Health and Care Act 2022 has now put ICSs on a statutory footing.

2. From 1 July 2022 integrated care boards (ICBs) will be established with the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their ICS. NHS England will work with ICBs as they take on their new responsibilities, the ambition being to empower local health and care leaders to build strong and effective systems for their communities.

3. 2022/23 will be a year of transition as ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of proportionate and effective oversight of system-led care.

4. This updated NHS Oversight Framework describes NHS England's approach to NHS oversight for 2022/23. It aligns to the priorities set out in the 2022/23 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022, including the formal establishment of ICBs and the merging of NHS Improvement (comprising Monitor and the NHS Trust Development Authority) into NHS England.

5. Building on the approach outlined in the NHS System Oversight Framework 2021/22, the 2022/23 framework reinforces system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: Next steps to building strong and effective integrated care systems across England and the Integration White Paper (Joining up care for people, places and populations).

6. The approach for 2021/22 provided a single, consistent NHS monitoring framework with the flexibility to support different system delivery and governance

arrangements, as well as local partnership working. This updated framework continues that approach, but updates it to take account of:

a. the establishment of statutory ICBs with commensurate responsibilities
b. NHS England's duty to undertake an annual performance assessment of these ICBs
c. early learning from the implementation of the System Oversight Framework during 2021/22
d. revised NHS priorities as set out in 2022/23 planning documentation.

7. The framework will support ICBs and NHS England to work together and develop proportionate and locally tailored approaches to oversight that reflect:

a. a shared understanding of the ambitions, accountabilities and roles between NHS England, ICBs, individual trusts and local partnerships, and how performance will be monitored
b. the unique local delivery and governance arrangements specifically tailored to the needs of different communities
c. the importance of delivery against both the shared system priorities agreed between local partners and national NHS priorities.

8. This updated framework will take effect from 1 July 2022 and the existing oversight arrangements as set out in the System Oversight Framework 2021/22 apply until this date.

2. Purpose and principles

9. The overall purpose of and approach to NHS oversight was consulted on prior to publication of the 2021/22 System Oversight Framework. This refreshed framework aligns with these key principles.

10. The purpose of the NHS Oversight Framework is to:

a. ensure the alignment of priorities across the NHS and with wider system partners

b. identify where ICBs and/or NHS providers may benefit from, or require, support

c. provide an objective basis for decisions about when and how NHS England will intervene.

11. The approach to oversight is characterised by the following key principles:

a. working **with and through ICBs**, wherever possible, to tackle problems

b. a greater emphasis on **system performance and quality of care outcomes**, alongside the contributions of individual healthcare providers and commissioners to system goals

c. matching **accountability for results** with improvement support, as appropriate

d. **autonomy** for ICBs and NHS providers as a default position

e. **compassionate leadership behaviours** that underpin all oversight interactions informed by Our Leadership Way (an agreed set of behaviours describing what good leadership should look and feel like), the National Quality Board's (NQB's) Our shared ambition for compassionate, inclusive leadership and the NHS board level competency frameworks.

3. Role of integrated care boards

12. ICBs will become formally established on 1 July 2022 and have legal duties to arrange NHS services for their ICSs. NHS England has issued statutory guidance on the preparation of the ICB constitution,. Along with the 2022/23 priorities and operational planning guidance, this sets out the governance ICBs must have in place.

13. ICBs are responsible for ensuring their delegations to place-based partnerships are discharged effectively, and for leading the oversight of individual providers within their ICSs in line with the principles outlined in this document. ICBs will also co-ordinate NHS support interventions within their system, where appropriate, working in partnership with NHS England.

14. NHS England has statutory accountability for oversight of both ICBs and NHS providers. In general, we will discharge our duties in collaboration with ICBs, asking ICBs to oversee and seek to resolve local issues before escalation. In some exceptional circumstances, such as where enforcement action is required, we will intervene directly with providers. Should such intervention be required this will happen with the full awareness of the relevant ICB.

4. Approach to oversight

15. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs.

16. To achieve this, the NHS Oversight Framework is built around:

    a. Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and ICBs: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability (Figure 1).

    b. A set of high-level oversight metrics, at ICB and trust level, aligned to these themes (see Annex B).

    c. A sixth theme, local strategic priorities. This reflects the ICB's contribution to the wider ambitions and priorities of its ICS and recognises:

        i. that systems each face a unique set of circumstances and challenges in addressing the priorities for the NHS

        ii. that each integrated care partnership[1] will set out an integrated care strategy that its ICB must have due regard to in planning and allocating NHS resources

        iii. the continuing ambition to support greater collaboration between partners across health and care, to accelerate progress in meeting the most critical

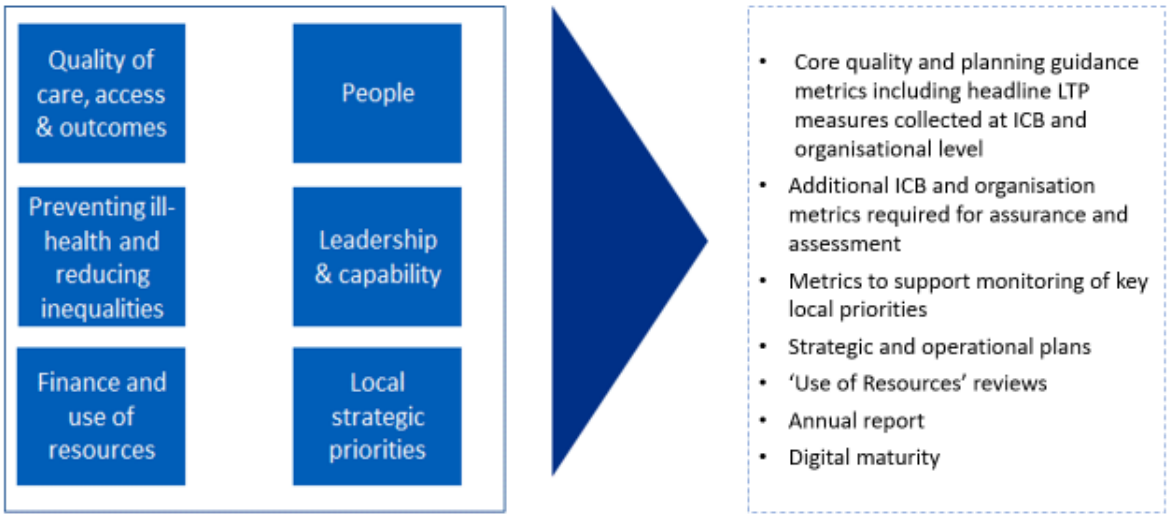
[1] Each ICB and its partner local authorities are required to establish an integrated care partnership, bringing together health, social care, public health and, potentially, representatives from the wider public space where appropriate, such as social care or housing providers.

health and care challenges and support broader social and economic development.

d. A description of how ICBs will work alongside NHS England to provide effective, proportionate oversight for quality and performance across the NHS.

e. A three-step oversight cycle that frames how NHS England teams and ICBs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

Figure 1: Scope of the NHS Oversight Framework for 2022/23



17. NHS England regional teams will lead the oversight of ICBs on delivery against the domains in the NHS Oversight Framework and, through them, gain assurance of place-based systems and individual organisations. Where necessary, regional teams will lead and co-ordinate support requirements identified for the ICB.

18. ICBs will lead the oversight of NHS providers, assessing delivery against these domains, working through provider collaboratives where appropriate. ICBs will consult with their NHS England regional team about any areas of concern identified, specific support requirements and, where necessary, issues requiring formal intervention by NHS England.

19. NHS England and ICBs will together agree the specific arrangements for each system to ensure effective and proportionate oversight, reflecting local delivery and governance arrangements. In 2021/22, NHS England regional teams and

ICSs worked together to establish individual memoranda of understanding (MoU) to reflect their oversight relationship and support ICSs in their journey towards becoming statutory bodies. An outline MoU and supporting guidance have been developed to support ICBs and NHS England regional teams to update individual MoUs to reflect the new statutory arrangements and the updated Oversight Framework.

20. MoUs will set out how NHS England and individual ICBs will work together to:

    a. discharge their respective roles and responsibilities to improve the quality of care and reduce inequalities, taking into consideration system maturity, risks and support needs

    b. improve partnership working at both local and regional level to ensure people across the system have access to high quality health and care services. This includes building an open and learning culture at local and regional level.

21. MoUs will also set out:

    a. The delivery and governance arrangements across the ICB and its partner organisations, including:

        i. The role of place-based partnerships and provider collaboratives in delivering the NHS priorities set out in the 2022/23 priorities and operational planning guidance.

        ii. Quality governance processes that enable the proactive identification, monitoring and escalation of quality issues and concerns. This should include cross-system quality governance as set out in the NQB's A shared commitment to quality and National guidance on system quality groups, which set out specific requirements for governance and intelligence sharing mechanism that ICSs are expected to have in place with system partners.

        iii. Financial governance arrangements in line with the National Health Service Act 2006, as amended by the Health and Care Act 2022, that will support the effective management of resources within the system financial envelope.

    b. The proportionate and robust oversight mechanisms and structures across the ICB and its partner organisations that:

        i. reflect the local delivery and governance arrangements

ii. are aligned to the arrangements set out in this framework, including the respective roles of the ICB and NHS England.

c. The local strategic priorities that the ICS has committed to deliver in 2022/23 as a partnership. These must align to the four fundamental purposes of an ICS.[2]

22. In some cases, bespoke oversight arrangements will be required; for example, where ICBs commission services under a delegated agreement, providers operate across multiple ICBs or a nominated ICB acts as a lead commissioner on behalf of the region. Regional teams will work with ICBs and service providers to ensure there are appropriate oversight arrangements in these situations.

23. There will be a need for flexibility in how the oversight role is carried out within the principles of this framework. In some cases, this may involve adjusting the specifics of the approach, for example:

a. as the NHS continues to rise to the challenge of restoring and transforming services following the COVID-19 pandemic, both tackling backlogs and meeting new care demands

b. where there is a need to respond quickly and proactively to unexpected issues in individual organisations, to national policy changes, the introduction of new service planning or delivery models, or new sector pressures.

[2] The four fundamental purposes of an ICS, set out in *Integrating Care: Next Steps To Building Strong and Effective Integrated Care Systems*, are: improving population health and healthcare, tackling unequal outcomes and access, enhancing productivity and value for money and helping the NHS support broader social and economic development

5. Oversight cycle

24. The oversight process follows an ongoing cycle (Figure 2) of:

    a. monitoring ICB and NHS organisation performance and capability under six themes (Figure 1)

    b. identifying the scale and nature of support needs

    c. co-ordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

Monitoring

25. As part of the oversight of ICBs and trusts, NHS England will monitor and gather insights about performance across each of the themes of the framework (Figure 1). The information collected and reviewed will include both quantitative data, including, but not limited to, the published Oversight Framework metrics (see Annex B), and qualitative information derived from oversight, quality, improvement and performance conversations with ICBs and their formal reporting documents, as well as other routine information including that from relevant third parties.

26. Depending on the type of information, the collection and review of data may be:

    a. **in year:** using monthly or quarterly collections and forums as appropriate

    b. **annual:** using annual submissions, surveys or other annually published information. In these cases, we expect that systems and regional teams will agree how they monitor progress on a timely basis linked to locally agreed plans and milestones

    c. **by exception:** where material events occur or we receive information that triggers our concern outside the regular monitoring cycle.

27. This information will be used to support ongoing monitoring at ICB and provider level of:

    a. **current performance** and service quality (based on the most recent data and insight available), including onward trajectories where available

b. the **historical performance trend** to identify patterns and changes, including evidence of improvement in reducing clinical variation.

28. A key outcome of the successful implementation of the framework will be the early identification of emerging issues and concerns, so that they can be addressed before they have a material impact or performance deteriorates further. ICBs and trusts are expected to maintain relationships with NHS England so that actual or prospective changes in performance are shared in a timely manner. Where quality risks are material to the delivery of safe and sustainable services, these should be managed and escalated in line with the National Quality Board quality risk response and escalation guidance.

29. NHS England regional teams will work with ICBs to ensure that oversight arrangements at ICB, place (including delegated commissioning arrangements) and organisation level incorporate regular review meetings as appropriate. Meetings will be informed by a shared set of information and regional teams will draw on national and other expertise as necessary (Table 1). Oversight conversations should reflect a balanced approach across the six oversight themes.

30. Ongoing oversight meetings will be complemented by focused engagement with the ICB and the relevant organisations where specific issues emerge.

Table 1: Ongoing monitoring process – review meetings

	ICB	Individual organisations/collaboratives
Scope	• Performance against national requirements including the NHS Long Term Plan deliverables at ICB level across the five national themes of the NHS Oversight Framework • Delivery against key 'local priorities' agreed with system partners • Effectiveness of current support arrangements and the extent to which these may need to be refined • Extent to which system partners are working effectively together to deliver and improve	• Oversight of and support to: – individual organisations, including those that span multiple ICSs, or have significant funding flows from outside an ICS, e.g. ambulance trusts and specialist trusts – collaboratives that span multiple places, including for the delivery of specialised services – place-based partnerships • By exception with scope determined by the specific issues identified in discussion between the NHS England regional team and ICB leadership
Roles and participation	• Led by NHS England regional team with: – ICB leadership team – senior leaders from system providers/ organisations (if not part of the ICB)	• Led by ICB with: – senior leaders from relevant providers/collaboratives – NHS England, where appropriate and by mutual agreement
Frequency of review meetings	• The default frequency for these meetings will vary according to the governance arrangements agreed between the regional team and ICB, but should be at least quarterly • Regional team will engage more frequently where there are material concerns • Annual meeting linked to ICB assessment process	• The default arrangements should be agreed between the ICB and partner organisation, and set out within the MoU

Identifying the scale and nature of support needs

31. To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support capacity as effectively as possible, regional teams have allocated all ICBs and trusts to one of four 'segments' as described in Table 2. Primary care providers and primary care networks (PCNs) will not be allocated to segments; however, the overall quality of primary care will inform ICB segmentation decisions.

32. Segmentation decisions are determined by assessing the level of support required based on a combination of objective criteria and judgement and are regularly reviewed to ensure they remain an accurate reflection of the level of support required. For individual trusts, NHS England and the relevant ICB will together discuss segmentation and any support required. NHS England will be responsible for making the final segmentation decision and taking any necessary formal enforcement action.

33. Segmentation decisions indicate the scale and nature of support needs, from no specific needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine the specific support requirements. These will be identified as set out in the section 'Identifying specific support needs'

34. The principles and approach to oversight will apply across all segments. These criteria have two components which are set out in detail in Table 3:

    a. objective, measurable eligibility criteria based on performance against the six oversight themes using appropriate oversight metrics

    b. additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

35. Where the objective, measurable eligibility criteria are met this will trigger consideration of the additional factors that will determine the overall segmentation decision.

36. Autonomy will be the default position with the expectation that ICBs and trusts will be allocated to segment 2 unless specific mandated support is required. Those ICBs and trusts allocated to segment 1 will benefit from the lightest oversight arrangements, and may be encouraged to provide peer-to-peer support and spread good practice to other systems and providers.

Table 2: Support segments: description and nature of support needs

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

Table 3: Support segments: segmentation approach

	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics and • Balanced plan, actual/forecast breakeven or better and • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	**For ICBs:** • Success in tackling variation across the system and reducing health inequalities • Whether the ICB consistently demonstrates that it has built the capability and capacity required to deliver on its statutory and wider responsibilities **For trusts:** • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICB priorities
2	This is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics or • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas or • Plan not balanced and/or a material actual/forecast deficit or • A CQC rating of 'Requires Improvement' overall and for well-led (trusts)	**For all:** • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England (e.g. delivery against the national and local transformation agenda) • A material concern with regard to the quality or safety of services being provided or a failure to escalate such risks • Evidence of capability and capacity to address the issues without additional support, e.g. where there is clarity on key issues with

	Eligibility criteria	Additional considerations
		an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances **For ICBs:** • Evidence of collaborative and inclusive system leadership across the ICB, e.g. where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope • Clarity and coherence of system ways of working and governance arrangements **For trusts:** • Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: • Longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts or • A catastrophic safety failure or • A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS or • A significant underlying deficit and/or significant actual or forecast gap to the financial plan or • CQC recommendation (trust)	

37. Where ICBs and trusts have significant support needs that may require formal intervention and mandated support, they will be placed into segment 3 or 4. They will be subject to enhanced direct oversight by NHS England (in the case of individual trusts this will happen in partnership with the ICB) and, depending on the nature of the problem(s) identified, additional reporting requirements and financial controls. Full details are set out in Annex A.

    a. Mandated support consists of a set of interventions designed to remedy the identified problems within a reasonable timeframe. There are two levels of support depending on the severity and complexity of the issues:

        i. Mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3.

        ii. Mandated intensive support that is agreed with NHS England regional teams and delivered through the nationally co-ordinated Recovery Support Programme (see Section 6: Recovery Support Programme). This level of support means automatic entry to segment 4.

    b. While the eligibility criteria for mandated support will be assessed at ICB and individual trust level, mandated support packages will always be designed and delivered within the relevant system context (e.g. place-based or provider collaboratives). Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

38. For ICBs and trusts in segments 1 and 2, overall support needs will be formally reviewed on a quarterly basis, likely as part of the routine meeting detailed in Table 1 (in the case of individual trusts this will happen in partnership with the ICB). Where ongoing monitoring suggests that the support needs may have changed, this will trigger a review of the segment allocation (see 'Identifying specific support needs' below).

39. For ICBs and trusts in segments 3 and 4, the agreed exit criteria will need to be met to exit mandated support and move to a lower segment (see Annex A).

Identifying specific support needs

40. Where an ICB or trust is triggering a specific concern, the NHS England regional team will work with the ICB to understand why the trigger has arisen and if a support need exists. The regional team will, as appropriate, involve system leaders and appropriate subject matter experts in this process – both to identify the factors behind the issues and determine whether local support is available and appropriate.

41. Regional teams will assess the seriousness, scale and complexity of the issues that the ICB, or trust where a need for support or intervention is evident, is facing. This will be done using information gathered through quality oversight, existing relationship knowledge and discussions with system members, and information from partners and evidence from formal or informal investigations. As part of this, regional teams will draw on the expertise and advice of national colleagues as required.

42. Regional teams, working with the ICB and system leaders (as appropriate), will consider the:

    a. degree of risk and potential impact
    b. degree to which the driver of the issue is understood
    c. views of leadership, governance and maturity of improvement approach
    d. inherent capability and credibility of plans to address the issue
    e. previous steps taken to support the resolution of the issue
    f. extent to which delivery against a recovery trajectory is being achieved.

43. Based on this assessment, regional teams will identify whether an ICB or trust has a specific support need and the subsequent level of support that is required. Support decisions will be taken having regard to the views of the system leadership.

44. This assessment may lead to a re-evaluation of the current allocated support needs segment, although this will not necessarily precipitate a change of segment.

45. Specific support needs will be reviewed through regular ICB oversight meetings, detailed in Table 1, or enhanced oversight arrangements, where these are required to:

a. track improvement and understand the effectiveness of the various support measures
b. ensure support is targeted where it has the greatest impact.

Co-ordinating support activity

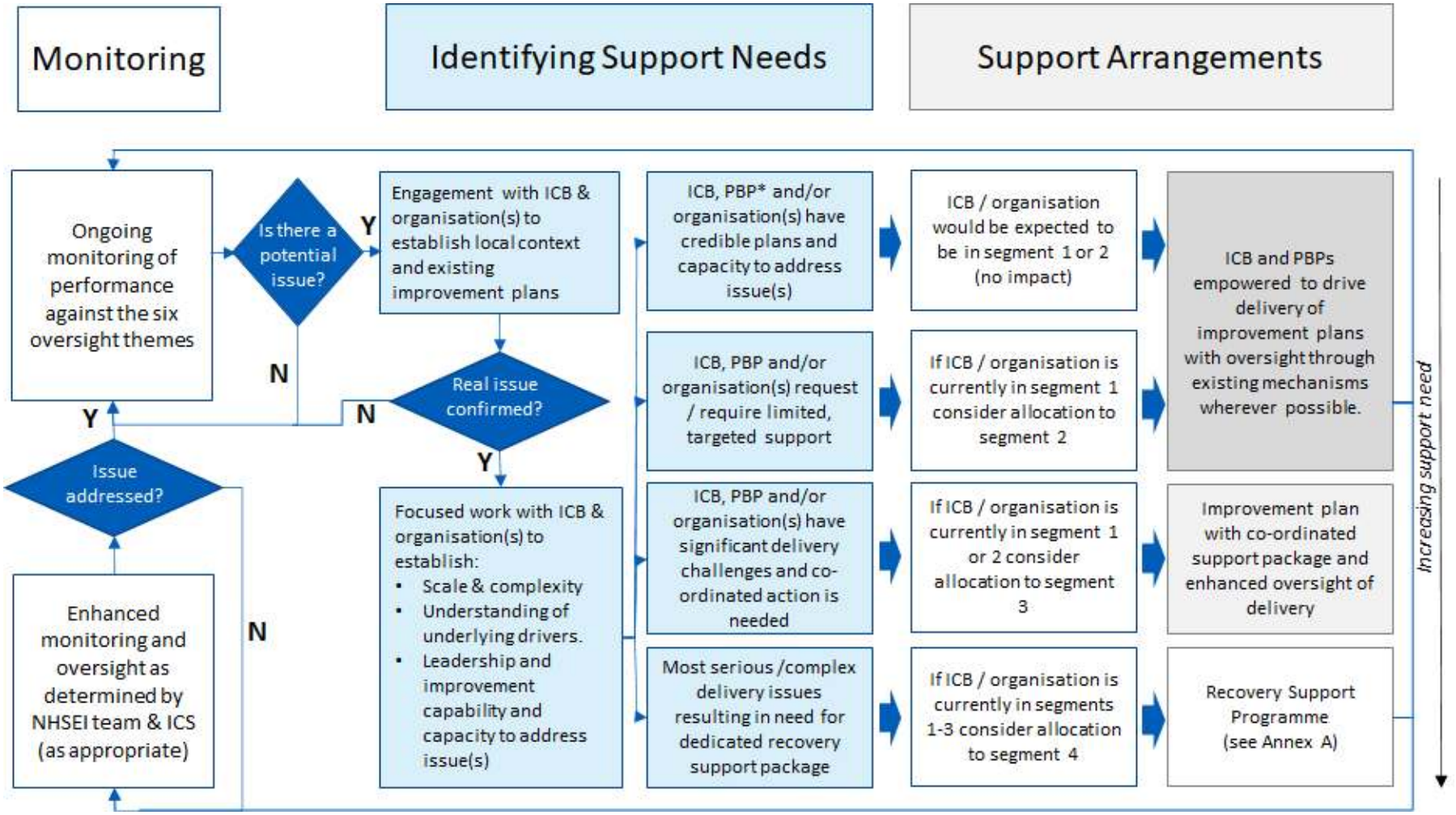
46. NHS England will work flexibly with ICBs to deploy the right support through this ongoing cycle, drawing on the expertise and advice of national colleagues as appropriate. During 2022/23 we will explore with ICBs the role peer review could play in the oversight model in future.

47. In line with the principles governing the framework, NHS England will work with and through ICB leaders, wherever possible, to tackle problems and ensure that the oversight process is both proportionate and co-ordinated across ICBs.

48. Expertise, advice and support from wider NHS England colleagues will be drawn on as appropriate, including clinical quality teams. NHS England colleagues will work to ensure that a co-ordinated support offer is provided and reflected in a co-ordinated action plan. Support requirements will be considered in parallel so that any support activities (and where necessary interventions) are mutually reinforcing and can be deployed at the right level, e.g. where concerns affect multiple organisations a system-wide approach may be needed.

49. Where the operation of the ICB itself is deemed to be a causal part of the identified issue(s), this could result in a change to the oversight approach normally associated with that system's previously assessed maturity level.

Figure 2: Oversight, diagnosis and support and intervention process



6. Recovery Support Programme

50. For ICBs and trusts allocated to segment 4, the national Recovery Support Programme (RSP) provides focused and integrated support, working in a co-ordinated way with the ICB, regional and national NHS England teams.

51. The RSP has replaced the separate quality and finance special measures programmes that were in place between 2013 and 2021 and is:

    a. available to support ICBs and trusts with increasing, complex challenges, helping to embed improvement upstream to prevent further deterioration and enable stabilisation

    b. focused at system level, while still providing tailored, intensive support to individual organisations

    c. focused on the underlying drivers of the problems that need to be addressed and those parts of the system that hold the key to improvement

    d. in the case of ICBs, nationally led by a credible, experienced system improvement director (SID) jointly appointed by the system, region and national intensive support team

    e. able to draw in support from an expert multidisciplinary team co-ordinated by the SID, or improvement director (ID) in the case of trusts

    f. time limited with clear exit criteria

    g. focused on building resilience within trusts and systems with knowledge and skills transfer providing sustainable capability within the system, such that they exit the programme with the knowledge and skills they need to achieve sustainable improvement

    h. designed to place an expectation on systems to build the capacity required to maintain improvement.

52. Where entry to segment 4 and the RSP is triggered by an individual organisation, local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

53. On entering the RSP a diagnostic stocktake, involving all relevant trust, system, regional and national partners, will:

    a. identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed

    b. recommend the criteria that must be met for the system or organisation to exit mandated intensive support (exit criteria)

    c. review the capability of the ICB's or trust's leadership.

54. At the same time as helping to address the specific issues that have triggered mandated intensive support, NHS England will also consider whether long-term solutions are needed to any structural issues affecting the ICB's or trust's ability to ensure high quality, sustainable services for the public.

55. The SID will be jointly appointed by the ICB and NHS England's national and regional intensive support teams and will normally report to the chief executive of the ICB with a reporting line to the Director of National Intensive Support to ensure sufficient independence. Specific arrangements will need to be agreed in each situation to ensure appropriate governance and independence.

56. The SID will support the ICB or relevant organisations to develop the improvement plan, which will include a target timeline for exit from the RSP and segment 4.

57. Where a trust is in the RSP, an ID, reporting to the Director of National Intensive Support, will support the trust and its system partners to develop an improvement plan which will include a target timeline for exit from the RSP and segment 4.

58. NHS England must sign off the improvement plan for both ICBs and trusts placed in segment 4.

59. The SID or ID will work with the ICB, and trust if appropriate, to co-ordinate the necessary support from the system, NHS England teams, the broader NHS or, where appropriate, an external third party. This support could include:

    - intensive support for emergency and elective care
    - intensive support to deliver the national programmes focused on reducing clinical variation across clinical pathways
    - intensive support for workforce and people practices

- financial recovery support including specialist support, eg to reduce agency use, implement cost controls
- drivers of deficit review
- governance review
- governance and leadership programme for improvement in challenged organisations and systems
- tailored delivery of a range of improvement programmes such as 'well led', 'better tomorrow' and 'making data count'.

60. NHS England will make a decision on exit from the RSP on the basis that the agreed exit criteria have been met in a sustainable way and any required transitional intensive support is in place as an ICB or trust moves to segment 3. As support is also mandated in segment 3, the improvement plan should remain in place and will continue to be reviewed at a regional level to ensure improvement is being achieved. Where the objective eligibility criteria for entry into the RSP included a recommendation from the CQC, the decision to exit segment 4 will consider the evidence underpinning the CQC recommendation.

61. In addition to the process described above, further RSP review meetings may be held between the NHS England Board and the trust and its system or the ICB. These meetings can take place:

- on entry to segment 4 and the RSP, to gain assurance that the improvement plan is robust to achieve exit in a sustainable way to the agreed timescale
- on exit to segment 3 from the RSP, to gain assurance that, with an agreed package of support, improvement can be sustained, and any lessons learnt are shared as appropriate
- where there has been a national escalation of concerns regarding a lack of progress either by regional or national executives.

62. Further details on the operation of mandated support, including how decisions are made and how support is applied, is included as Annex A.

7. ICB assessment

63. NHS England has a legal duty to annually assess the performance of each ICB in each financial year and publish a summary of its findings.

64. In conducting this performance assessment, NHS England will consult each relevant health and wellbeing board as to its views on the ICB's implementation of any joint local health and wellbeing strategy.

65. The NHS England regional team will conduct the annual assessment, drawing on national expertise as required and having regard to relevant guidance. We will, in particular, consider how successfully the ICB has:

    a. contributed to the wider local strategic priorities of the ICS

    b. performed its statutory functions, including in particular how it has discharged its legal duties under the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the Local Government and Public Involvement in Health Act 2007, in relation to:

        i. improving the quality of services

        ii. reducing inequalities

        iii. obtaining appropriate advice

        iv. the effect of decisions (The "triple aim")

        v. public involvement and consultation

        vi. financial duties

        vii. having regard to local assessments and strategies

        viii. promoting and using evidence from research.

    c. delivered on any guidance set out by NHS England or the Secretary of State regarding the functions of the ICB

66. For 2022/23 the assessment will be in narrative form and will identify areas of good and/or outstanding performance, areas for improvement and any areas that are particularly challenged.

67. As this will be the first year in which ICBs operate, NHS England will work with them during the first half of the year to develop further detailed guidance to support annual assessments for 2022/23. We expect to review and develop this approach for future years.

8. Alignment with partner organisations

68. The National Health Service Act 2006, as amended by the Health and Care Act 2022, places a duty on NHS bodies to co-operate with each other in the exercise of their functions. NHS bodies including, but not limited to, NHS England, ICBs and NHS providers must, therefore, work in close partnership to deliver their duties. The Secretary of State may also publish guidance on the duty to co-operate between NHS bodies and between NHS bodies and local authorities, which must be taken into account. A failure to collaborate may lead to formal enforcement action being considered.

69. Alongside the duty of NHS bodies to co-operate with one another, it is essential that all members within ICSs, whether NHS bodies or not, also work together across boundaries to deliver services and outcomes for their population. To achieve this, each integrated care partnership must prepare an integrated care strategy setting out how the assessed needs of its area are to be met by the exercise of functions of:

    a. the ICB
    b. NHS England or
    c. responsible local authorities.

70. The integrated care strategy will have regard for best practice and the need for a joined-up approach and increased partnership with other organisations. The NQB's A shared commitment to quality and National guidance on system quality groups emphasise the importance of prioritising quality in decision-making, having a shared understanding of quality across partner organisations, a set of agreed quality improvement priorities for the system and common quality structures in

place to support intelligence-sharing, improvement and assurance (Including system quality groups).

71. Systems will also continue to benefit from the health and wellbeing boards and local authority health overview and scrutiny committees reviewing and scrutinising their work.

72. At a regional and national level, NHS England will continue to work alongside key regulators, CQC, Health and Care Professions Council, General Medical Council and the Nursing & Midwifery Council through the Joint Strategic Oversight Group (JSOG) function to provide a dedicated space for regulators to share intelligence and develop aligned approaches to support organisations.

73. The Health and Care Act 2022 places new duties on CQC to conduct reviews of the provision of health and adult social care in each ICS and assess the functioning of the ICS, including how its ICB, local authorities and registered service providers work together. NHS England and CQC will continue to work together to ensure synergy between the ICS reviews undertaken by CQC and the ICB assessments undertaken by NHS England.

Annex A: Intervention and mandated support

Introduction

1. Mandated support applies when integrated care boards (ICBs), NHS trusts and foundation trusts ('trusts'), have serious problems and where there are concerns that the existing leadership cannot make the necessary improvements without support.

2. Mandated support consists of a set of interventions designed to remedy the problems within a reasonable timeframe. There are two levels depending on the severity and complexity of the issues:

    - Mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested. This level of support means automatic entry to segment 3 of the NHS Oversight Framework.
    - Mandated intensive support that is agreed with NHS England regional teams and delivered through the nationally co-ordinated Recovery Support Programme (RSP). This level of support means automatic entry to segment 4 of the NHS Oversight Framework.

3. While the eligibility criteria for mandated support will be assessed at ICB and trust level, mandated support packages will always be designed and delivered within the relevant system context (e.g. place-based or provider collaboratives). Where the support need is triggered by an individual organisation, this means that local system partners will be expected to play their role in addressing system-related causes or supporting system solutions to the problem(s).

4. Mandated support may involve the use of NHS England's statutory enforcement powers. A decision by NHS England to take such action must comply with the relevant statutory threshold and conditions. A trust considered to be in need of mandated support may be subject to enforcement action that requires it to carry out specific actions as part of the intervention.

5. This annex explains:

- how NHS England determines the requirement for mandated support and the level of support
- what happens to an ICB or organisation when mandated support applies
- the roles and responsibilities of other key organisations involved, specifically the Care Quality Commission (CQC)
- how an ICB or trust exits from mandated support
- what Recovery Support Programme (RSP) review meetings are.

6. This annex supersedes the previously published policy described as 'special measures' and should be read in conjunction with the 2022/23 NHS Oversight Framework.

7. While regulatory action arising from this framework at NHS foundation trusts will utilise the NHS provider licence, NHS England will, from July 1, use the legacy NHS Trust Development Authority powers it will inherit on that date to underpin any enforcement/mandated actions at NHS trusts until they receive a licence as per section 49 of the Health and Care Act 2022.

How NHS England determines the need for mandated support

8. NHS England determines which ICBs and trusts require mandated support with reference to a set of objective criteria, but also by considering other appropriate considerations. Any ICB or trust meeting the objective criteria set out below is eligible to be considered for the relevant level of mandated support but may also be excluded from this in light of other relevant considerations.

Mandated support (segment 3)

9. An ICB or trust is eligible to be considered for mandated support and entry to segment 3 if:

- performance against multiple oversight themes is in the bottom quartile nationally based on the relevant oversight metrics

  or

- there has been a dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas

  or

- it has an underlying deficit that is in the bottom quartile nationally and/or is reporting a negative variance against the delivery of the agreed financial plan and/or it is not forecasting to meet plan at year end

  or

- for trusts, there is a CQC rating of 'Requires Improvement' overall and for well-led.

10. Where there are material concerns about an ICB's and/or trust's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England (eg delivery against the national and local transformation agenda), this may also trigger consideration of mandated support. In these circumstances regional teams will also consider the extent to which the above objective eligibility criteria are met.

11. Meeting one of the objective eligibility criteria does not automatically lead to entry to segment 3. In considering whether an ICB or trust that has met the eligibility criteria would benefit from mandated support, regional teams will consider whether:

    For all:

    - there is the capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions
    - there are other exceptional mitigating circumstances.

    For ICBs:

    - there is evidence of collaborative and inclusive system leadership across the ICS, e.g. where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope
    - there is clarity and coherence in ways of working and governance arrangements across the system.

For trusts:

- whether the trust is working effectively with other system partners to address the problems.

12. NHS foundation trusts will only be placed in segment 3 where there is evidence that they are in actual/suspected breach of their NHS provider licence conditions (or equivalent for NHS trusts).

Mandated intensive support (segment 4)

13. An ICB or trust is eligible to be considered for mandated intensive support and entry to segment 4 if, in addition to the considerations for mandated support above, any of the following criteria are met:

- longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts

  or

- a significant underlying deficit and/or a significant actual or forecast gap to the agreed financial plan

  or

- a catastrophic failure in leadership or governance that risks damaging the reputation of the NHS

  or for trusts only:

- a recommendation is made by the CQC.

14. The CQC, through the Chief Inspector of Hospitals, will normally recommend to NHS England that a trust is mandated to receive intensive support when it is rated 'Inadequate' at the single trust rating level.

15. The evidence provided by the CQC will include the reasons why it is recommending the trust is mandated to receive intensive support, the specific areas of improvement where actions need to be taken and what improvements in quality need to be achieved.

16. Based on the full range of information and judgement, NHS England will decide, following national moderation, whether the trust will be placed in segment 4 and receive intensive support through the RSP.

What happens when NHS England mandates support for an ICB or trust

Mandated support (segment 3)

17. NHS England will communicate its decision to the ICB or trust, and work with it to develop and deliver a bespoke mandatory support package through the relevant regional improvement hub, drawing on system and national expertise as required.

18. The relevant NHS England regional leadership will sign off the criteria that the ICB or trust must meet to exit mandated support (exit criteria) and the ICB or trust will develop an improvement plan with a target timeline for meeting the exit criteria.

19. Typically, the following additional interventions will be put in place:

    - enhanced monitoring and oversight of the ICB or trust by the NHS England regional team
    - NHS England advisory role for senior appointments, including shortlisting and as external assessor on interview panels.

20. The interventions listed above may be supported or implemented using formal statutory enforcement action

21. Depending on the nature of the problem(s) identified and the support need, further interventions may include enhanced:

    - scrutiny/assurance of plans
    - reporting requirements
    - financial controls including lower capital approval limits.

Mandated intensive support (segment 4)

22. NHS England will communicate its decision to the ICB or trust and then make a formal public announcement.

23. Mandated intensive support will be agreed with the region and delivered through the nationally co-ordinated RSP. The RSP has been developed to provide intensive support either at organisation level (with system support) or across a whole health and social care system.

24. A diagnostic stocktake involving all relevant system partners will:

- identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed
- recommend the criteria that must be met for the ICB or trust to exit mandated intensive support (exit criteria) and an indicative exit timeline. These must be agreed by NHS England.

25. NHS England will review the capability of the ICB's or trust's leadership. This may lead, if necessary, to changes to the management of the ICB/trust to make sure the board and executive team can make the required improvements. Where changes are required, this will happen as soon as is practical and the necessary support will be provided to facilitate this.

26. At the same time as helping to address the specific issues that triggered mandated intensive support, NHS England will consider whether long-term solutions are needed to address any structural issues affecting the ICB's or trust's ability to ensure high quality, sustainable services for the public.

27. NHS England will appoint a system improvement director (SID) or an improvement director (ID) who will act on its behalf to provide assurance of the ICB's or trust's approach to improving performance. The SID or ID will support the ICB or trust to develop an improvement plan with an indicative timescale for meeting the exit criteria (typically within 12 months).

28. The ID will work with the trust and/or ICB to co-ordinate the necessary support from the system, NHS England teams, the broader NHS or, where appropriate, an external third party. This could include:

- intensive support for emergency and elective care
- intensive support to deliver the national programmes focused on reducing clinical variation across clinical pathways
- intensive support for workforce and people practices
- financial turnaround/recovery support including specialist support, eg to reduce agency use, implement cost controls
- drivers of deficit review

- governance review
- governance and leadership programme for improvement in challenged organisations and systems
- tailored delivery of a range of improvement programmes such as 'well led', 'better tomorrow' and 'making data count'.

29. Typically, the following additional interventions will be put in place:

    - regular formal progress and challenge meetings with national-level NHS England oversight
    - board vacancies filled on the direction of NHS England (trusts).

30. Depending on the nature of the problem(s) identified and the support need, further interventions may include:

    - NHS England-appointed board adviser
    - enhanced reporting requirements
    - enhanced financial controls including:
        - NHS England control of applications for Department of Health and Social Care financing (trusts)
        - peer review of expenditure controls
        - reduced capital approval limits (trusts)
        - rapid roll out of extra controls and other measures to immediately strengthen financial control, including those set out in NHS England guidance (including the 'Grip and Control' checklist).

31. The interventions listed above may be supported or implemented using formal statutory enforcement action

32. Where a trust is deemed to require mandated intensive support on the recommendation of the CQC, there will be close dialogue between the CQC, NHS England, the trust and ICB, which will include what improvements in quality would give assurance of progress being made. These improvements form the basis of joint reviews of progress during the mandated intensive support period, as well as the existing regular information exchange between the CQC and NHS England regional leads.

33. This process of information exchange and review will enable extra support or intervention to be considered as needed. These decisions need not wait until the next re-inspection.

34. NHS England will ensure that the trust addresses any urgent patient safety and quality issues identified as a priority. The CQC will continue to monitor quality at the trust. If at any time patients are at immediate serious risk of harm, the CQC can use its urgent powers to safeguard them.

35. The expectation is that the CQC will re-inspect the trust within 12 months of the start of mandated intensive support. It will judge if the quality of patient care and the trust's leadership have improved.

How ICBs and trusts exit from mandated support

36. Exit from mandated support will ordinarily occur when it can be demonstrated that exit criteria have been met in a way that is sustainable. Over time it may be necessary to review or revise these exit criteria. Any change to exit criteria must be approved by NHS England.

Mandated support (segment 3)

37. To be considered for removal from mandated support, an ICB or trust must demonstrate that the exit criteria have been met in a sustainable way. When deciding on a recommendation to exit, the NHS England regional team will also consider whether a targeted and time-limited post-exit support package is needed to ensure the improvement is sustained.

Mandated intensive support (segment 4)

38. To be considered for removal from mandated intensive support, an ICB or trust must demonstrate that the exit criteria have been met in a sustainable way. When making a decision on a recommendation to approve exit, NHS England will also consider the proposed transitional support package that will be needed when an ICB or trust enters segment 3 to ensure the improvement is sustained.

39. Where a trust is in segment 4 and so in receipt of mandated intensive support as a result of a recommendation of the CQC, NHS England will take account of any recommendation by the Chief Inspector of Hospitals before deciding the trust should exit that segment. The Chief Inspector will usually recommend this where

there is no reason on grounds of quality why a trust should remain in receipt of mandated intensive support – that is, if the quality of care is showing sufficient signs of improvement, even if it is not yet 'good', and if the trust leadership is robust enough to ensure that the trust will sustain current improvements and make further improvements. NHS England must also be confident that improvements will be sustained.

40. Where NHS England is not satisfied that the exit criteria have been met, mandated intensive support will be extended for a short period to allow the ICB or trust to make the improvements needed. This might occur, for example, where there have been changes to the leadership team and more time is needed for the new team to bring about change. In the case of an extension, the ICB or trust will prepare a revised improvement plan that lists actions to address any outstanding or new concerns.

41. NHS England will inform the ICB or trust in question of its exit decision once it has completed its formal decision-making processes. NHS England will then make a formal public announcement

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NHS oversight metrics for 2022/23

June 2022

Oversight Theme	NHS Long Term Plan / People Plan Area	Measure Name (Metric)	ICB level metric	Trust level metric
Quality of care, access and outcomes	Elective care	Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	✓	✓
	Elective care	Total elective activity undertaken compared with 2019/20 baseline	✓	✓
	Elective care	Total diagnostic activity undertaken compared with 2019/20 baseline	✓	✓
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	✓	✓
	Cancer	Proportion of patients meeting the faster cancer diagnosis standard	✓	✓
	Cancer	Total patients treated for cancer compared with the same point in 2019/20	✓	✓
	Outpatient transformation	Outpatient follow-up activity levels compared with 2019/20 baseline	✓	✓
	Urgent and emergency care	Proportion of ambulance arrivals delayed over 30 minutes	✓	✓
	Urgent and emergency care	Ambulance average response times by category		✓
	Urgent and emergency care	Proportion of patients spending more than 12 hours in an emergency department	✓	✓
	Maternity and children's health	Neonatal deaths per 1,000 total live births	✓	
	Maternity and children's health	Stillbirths per 1,000 total births	✓	
	Primary care and community services	Proportion of Urgent Community Response referrals reached within two hours	✓	
	Primary care and community services	Proportion of patients discharged from hospital to their usual place of residence	✓	✓

	Primary care and community services	Available virtual ward capacity per 100k head of population	✓	✓
	Primary care and community services	Number of general practice appointments per 10,000 weighted patients	✓	
	Primary care and community services	Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a. general practice and b. NHS111 per 100,000 population	✓	
	Primary care and community services	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	✓	
	Mental health services	Number of children and young people accessing mental health services as a % of population	✓	
	Mental health services	Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	✓	
	Mental health services	Access rate for IAPT services	✓	
	Mental health services	Access rates to community mental health services for adult and older adults with severe mental illness	✓	
	Mental health services	Inappropriate adult acute mental health placement out-of-area placement bed days		✓
	Learning disabilities and autism	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	✓	
	Learning disabilities and autism	Inpatients with a learning disability and/or autism per million head of population	✓	
	Personalised care	Rate of personalised care interventions	✓	
	Safe, high quality care	Summary Hospital-level Mortality Indicator		✓
	Safe, high quality care	National Patient Safety Alerts not completed by deadline		✓

	Safe, high quality care	Potential under-reporting of patient safety incidents		✓
	Safe, high quality care	Overall CQC rating		✓
	Safe, high quality care	Percentage of patients describing their overall experience of making a GP appointment as good	✓	
	Safe, high quality care	Acting to improve safety - safety culture theme in the NHS staff survey		✓
	Safe, high quality care	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		✓
	Safe, high quality care	Clostridium difficile infection rate		✓
	Safe, high quality care	E. coli bloodstream infection rate	✓	✓
	Safe, high quality care	Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	✓	
Preventing ill health and reducing inequalities	Reducing inequalities	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities[1]	✓	✓
	Prevention and long term conditions	Number of people receiving mechanical thrombectomy as a % of all stoke patients	✓	
	Prevention and long term conditions	Proportion of people with CVD treated for cardiac high-risk conditions	✓	
	Prevention and long term conditions	Proportion of diabetes patients that have received all eight diabetes care processes	✓	
	Prevention and long term conditions	Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	✓	

[1] NHS England has developed a national approach to support the reduction of health inequalities across the NHS, Core20PLUS5. For all relevant metrics NHS England, ICBs and providers must consider how inequalities of access and outcome are being reduced. A Healthcare Inequalities Improvement Dashboard is available via NHS Foundry to further support these considerations.

	Prevention and long term conditions	Number of referrals to NHS digital weight management services per 100k head of population	✓	
	Prevention and long term conditions	Proportion of acute or maternity inpatient settings offering smoking cessation services	✓	✓
	Prevention and long term conditions	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral	✓	✓
	Screening, vaccination and immunisation	Bowel screening coverage - % patients aged 60 - 74 screened in the last 30 months	✓	
	Screening, vaccination and immunisation	Breast screening coverage - % females aged 53 - 70 screened in the last 36 months	✓	
	Screening, vaccination and immunisation	Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	✓	
	Screening, vaccination and immunisation	Proportion of people over 65 receiving a seasonal flu vaccination	✓	✓
	Screening, vaccination and immunisation	Population vaccination coverage – MMR for two doses (5 year olds)	✓	
Leadership and capability	Leadership	Aggregate score for NHS staff survey questions that measure perception of leadership culture	✓	✓
	Leadership	CQC well-led rating		✓
Finance and Use of Resources	Finance	Financial efficiency - variance from efficiency plan	✓	✓
	Finance	Financial stability - variance from break-even	✓	✓
	Finance	Achievement of Mental Health Investment Standard	✓	
	Finance	Agency spending		✓
People	Looking after our people	Staff survey engagement theme score	✓	✓
	Looking after our people	Staff survey bullying and harassment score	✓	✓
	Looking after our people	Leaver rate	✓	✓

	Looking after our people	Sickness absence rate	✓	✓
	Belonging in the NHS	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women	✓	✓
	Belonging in the NHS	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓
	Growing for the future	FTE doctors in General Practice per 10,000 weighted patients	✓	
	Growing for the future	Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	✓	

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ICB Board: Action Log

Action Log Ref.	Meeting Date	Meeting Agenda Item Ref.	Action Point	Owner	Timescale	Action Comments	Status
1	03-May-22 [CCG GB]	8	Draft Digital Strategy public health to be involved in programme	Deborah El-Sayed	Jun-22		Open
2	07-Jun-22 [CCG GB]	8	Asylum Seeker Hotels RS to ask whether BNSSG patients can benefit from the Bath language school offer of English lessons for residents	Rosi Shepherd	Jun-22		Open
3	07-Jun-22 [CCG GB]	9	2022/23 Operational Plan Update SD to share the letter sent by Trust Chairs with the Governing Body	Shane Devlin	Jun-22		Open
4	07-Jun-22 [CCG GB]	6.2	SEND Action Plan Delivery Any comments on the SEND review consultation to be sent to Lisa Manson or Mark Hemmings	All Governing Body members	Jun-22	Any comments have been received. Recommend action closed.	Closed
5	07-Jun-22 [CCG GB]	8.1	BNSSG Quality and Performance Report Update to be provided on why inpatient falls screening was decreasing	Rosi Shepherd	Jun-22	AWP have been asked to produce an action plan for the next Quality Forum, as part of a physical health report which will come to the Quality Forum for discussion in July. This will only be escalated to QPOC if there are any concerns following this presentation. Recommend action closed.	Closed
6	09-June-22 [ICB Shadow Board]	3	Purpose and Aims of the new ICB Consider internal and external messaging on the ICB establishment – noting the audiences of our citizen and health and care staff, and the channel of the locality partnerships for key messaging.	Shane Devlin	Jul-22		Open
7	09-June-22 [ICB Shadow Board]	3	Purpose and Aims of the new ICB Create and circulate to the ICB Board descriptions of involvement of health & care professionals, VCSE and citizen voices.	Shane Devlin	**Sep-22**	ICS Development Team to support	Open

8	09-June-22 [ICB Shadow Board]	5	ICB Board Members Roles and Responsibilities Review TOR for Outcomes, Quality and Performance Committee and ensure reference to EPRR	Ellen Donovan	Jul-22	Line added to ToR: • Scrutinise robustness of arrangements, compliance with and monitor delivery of the ICB key statutory requirements relevant to outcomes, quality and performance including Emergency Preparedness, Resilience and Response Recommend action closed	Closed
9	09-June-22 [ICB Shadow Board]	5	ICB Board Members Roles and Responsibilities Meet with all non-executive directors on committee membership and priorities, plus involvement of H&C professions, VCSE and Citizens at committee level	Jeff Farrar	Jul-22		Open
10	09-June-22 [ICB Shadow Board]	5	ICB Board Members Roles and Responsibilities Confirm and send diary markers for all ICB Committees	ICB Board Secretariat	Jul-22	In progress via CCG Executive Leads support teams.	Open
11	09-June-22 [ICB Shadow Board]	7	Inaugral ICB Board Meeting and Future Meeting Schedule Consider options for future Board meetings (September onwards) to be hosted in localities – offering 15 minutes at the start of the meeting to receive feedback from locality host partners. Need to ensure venues are fully accessible and have sufficient capacity for the Board plus members of the public for the open session	ICB Board Secretariat	**Sep-22**	ICB Board Standard Agenda drafted with the option for the ICB Board to be addressed by the host Locality Partnership.	Open
12	09-June-22 [ICB Shadow Board]	7	Inaugral ICB Board Meeting and Future Meeting Schedule Consider platform for ICB Board members to network outside of meetings i.e. Board Pack or NHS Futures functions.	ICB Board Secretariat	Jul-22	MS Teams Channel is likely to be the most practicable option in the short term. For those ICB Board members that don't have an NHS.net email address, existing emails can be accredited to permit access to the MS Teams Channel if the ICB Board would like to progress this.	Open

Bristol, North Somerset and South Gloucestershire Integrated Care Board

Meeting of ICB Board

Date: 01 July 2022
Time: 09:30
Location: MS Teams

Agenda Number :	7.2	
Title:	ICB Board Standard Agenda	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No

Purpose: Decision – For Approval

Key Points for Discussion:

The ICB Board Standard Agenda sets out the recurring standing items the ICB Board will discuss. The Chair will offer opportunities to add agenda items to the ICB Board Standard Agenda under item 8: 'Any Other Business'.

ICB Board meetings and committees composed entirely of board members or which include all board members will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

Recommendations:	To receive and approve the ICB Standard Agenda
Previously Considered By and feedback:	ICB Board Chair (Designate)
Management of Declared Interest:	There are no actual or potential conflicts of interest related to the contents of this paper.
Risk and Assurance:	There are no risk or assurance implications related to the contents of this paper.
Financial / Resource Implications:	There are no finance or other resources implications related to the contents of this paper.

Legal, Policy and Regulatory Requirements:	There are no legal, policy or regulatory requirement implications related to the contents of this paper.
How does this reduce Health Inequalities:	There are no health inequalities implications related to the contents of this paper.
How does this impact on Equality & diversity	There are no equality and diversity implications related to the contents of this paper.
Patient and Public Involvement:	There are no patient and public involvement implications related to the contents of this paper. All ICB Board meetings will be open to the public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.
Communications and Engagement:	ICB Board meeting agendas will be shared with all ICB Board members, and members of the public that wish to attend, one week prior to the ICB Board meeting.
Author(s):	Ellie Wetz, ICS Development Programme Manager
Sponsoring Director / Board Member:	ICB Board Chair

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Board Meeting

Date:
Time:
Venue:

Agenda

			Sponsor
1		**Welcome and Apologies**	Chair
2		**Declarations of Interest** To consider declarations of interests and any conflicts of interest arising from this agenda	Chair
3		**Address from host Locality Partnership** *(Optional)*	
4		**Minutes of [Date] ICB Board Meeting**	Chair
5		**Actions arising from previous meetings and matters arising**	Chair
6		**Chief Executives Report**	CEO
7		**Minutes of Committees**	INEDs
8		**Any Other Business**	Chair
9		**[Date of Next Meeting]**	