NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Freedom of Information 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:	8
Responsible Executive Director:	Shane Devlin, Chief Executive
Author and Job Title:	Lucy Powell, Corporate Support Officer
Date Approved:	1 July 2022 (as part of the Core Policies approval)
Approved by:	ICB Board
Date of next review:	February 2024 (Every two years)

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 compliant with: the Freedom of Information Act 2000, and the Data Protection Act 2018 and the UK General Data Protection Regulation 2018 (the Data Protection legislation)
Has legal advice been sought?	No	Specialist advice has been taken from the Information Governance Advisors. Information Governance is represented on the Corporate Policy Review Group.
Has HR been consulted?	Yes	Specialist advice has been taken from HR. HR is represented on the

	Yes/ No/NA	Supporting information
		Corporate Policy Review Group
Have training issues been addressed?	Yes	Training is referenced in the policy. The ICB's Information Governance training includes Freedom of Information; this training is mandatory and annual. Training on ICB specific procedures as set out in the appendix will be tailored to relevant staff groups and will be at least annual.
Are there other HR related issues that need to be considered?	No	There are no HR issues raised in the policy
Has the policy been reviewed by Staff Partnership Forum?	No	The policy does not raise HR issues and has not been reviewed by the Staff Partnership Forum
Are there financial issues and have they been addressed?	No	There are no financial issues.
What engagement has there been with patients/members of the public in preparing this policy?	N/A	This policy describes a statutory responsibility and there has been no engagement with patients/members of the public beyond that undertaken by government as part of the legislative process
Are there linked policies and procedures?	Yes	Associated policies and procedures are recorded in the policy
Has the lead Executive Director approved the policy?	Yes	Shane Devlin, Chief Executive

	Yes/ No/NA	Supporting information
Which Committees have assured the policy?		Corporate Policy Review Group and Audit and Risk Committee. Both provided feedback which has been included.
Has an implementation plan been provided?	Yes	See Appendix 2
How will the policy be shared with staff, patients and the public?	Yes	The policy will be published on the ICB website and intranet and will be featured in the internal news communication. Implementation will be monitored through Information Rights reports to the Audit and Risk Committee
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 developed and approved
Have Data Protection implications have been considered?	Yes	The Policy is compliant with the Data Protection Act 2018 and the UK General Data Protection Regulation 2018 (Data Protection Legislation)

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Freedom of Information Policy

1 Introduction

The Freedom of Information (FOI) Act 2000 provides clear statutory rights granting the public access to recorded information held by Public Authorities, subject to certain exemptions as outlined in the Act. It is intended to promote a culture of openness and accountability of public sector bodies.

Within the context of the Freedom of Information Act, the term 'information' is defined as every piece of information held by NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB), whether paper or electronic. It includes but is not limited to all documents, agendas, minutes, emails and calendar entries and is inclusive of handwritten notes and draft documents.

The FOI legislation is applied to all information held by public authorities regardless of the date, for BNSSG ICB this includes information held by predecessor organisations.

BNSSG ICB also has a duty to provide and maintain a publication scheme, detailing information that it holds and how this can be accessed.

1.1 BNSSG ICB Values

This policy supports the values by outlining the process through which a statutory obligation will be fulfilled therefore demonstrating "We do the right thing". This Policy outlines the expectation that staff will "Act with integrity" by complying with the Freedom of Information Act 2000. The Policy also "Supports each other" by providing information to support staff in responding to requests.

2 Purpose and scope

This policy sets out the ICB's legal obligation to comply with the Freedom of Information Act 2000, in providing access to the public, service users, staff, journalists and anybody else who wishes to see BNSSG ICB's information. The policy is not designed to be a guide for ICB staff in complying with the Freedom of Information Act. Guidance for staff will be provided through training and the procedural documentation (Appendix 3).

This policy applies to all staff, regardless of whether they hold a corporate or clinical role and includes:

- Individuals on the ICB Board and Committees
- Employees including those seconded to BNSSG ICB

- Third parties acting on BNSSG ICB's behalf (including commissioning support and shared services)
- Agency, locum and other temporary staff engaged by BNSSG ICB
- Students, including those on work experience, trainees and apprentices.

3 Duties – legal framework for this policy

The Freedom of Information (FOI) Act 2000 provides public access to information held by public authorities. Public authorities are obliged to publish certain information about their activities and members of the public are entitled to request information from public authorities.

The Freedom of Information Act 2000 covers any recorded information that is held by a public authority.

The FOI legislation is retrospective and applies to all information held by public authorities. It does not oblige public authorities to retain information which is no longer useful to the authority.

The FOI Act is overseen by the Information Commissioner who has the ability to monitor organisational compliance, issue undertakings, serve information and enforcement notices and, if needed, initiate court proceedings to ensure compliance.

The Act does not give people access to their own personal data such as their health records. If a member of the public wants to see information that a public authority holds about them, they should make a data protection Subject Access Request. The processes for these requests are included in the ICB Individual Rights Policy.

4 Responsibilities and Accountabilities

The Chief Executive has overall responsibility for the Freedom of Information policy. The implementation and compliance with the policy is delegated to the Corporate Secretary. This responsibility includes:

- Setting out a process for dealing with Information requests
- Facilitating the provision of education and awareness for staff, ensuring that basic principles are part of the ICB's induction processes.
- Developing the approach to publication and maintenance of the publication scheme
- Bi-Annual review of policy, process and code of practice (or more frequently if appropriate, with regard to changes in legislation or guidance from the Information Commissioner)

- Management of the team responsible for the delivery of functions set out in this policy.

The Information Rights team are responsible for the delivery of the functions related to processing and responding to FOI requests. This responsibility includes:

- Acknowledging and logging request
- Sending requests to the appropriate team for a response
- Undertaking redactions and writing public interest tests as required
- Facilitating Executive Director approval processes and sending the final response to the requester
- Processes and manages the internal review process

BNSSG ICB has designated the Corporate Support Officer as the Publication Scheme Co-ordinator.

Line Managers are responsible for ensuring that staff undertake their mandatory training and are aware of requirements associated with FOI, and that time is prioritised to support timely responses to FOI enquiries.

All staff are responsible for:

- Creating and maintaining records which are accurate, appropriate and retrievable. This will include adherence to standards for referencing, titling, filing and authoring documents, both electronically and on paper. The Records Management Policy defines the expectations of staff and should be read in conjunction with the FOI Policy.
- Ensuring that requests for information are passed in a timely manner to staff who are responsible for processing FOI requests, including where a request has been sent to the wrong recipient in the ICB by the Information Rights team.
- Ensuring that disclosures are not made outside of the defined FOI process, so that inappropriate disclosures are avoided.
- Ensuring that documents that are within the classes of information of BNSSG ICB's publication scheme are provided for publication in a timely manner.
- Bringing new documents or classes of information that have not been previously published to the attention of the Corporate Support Officer in a timely manner, who will facilitate agreement on publication of information.

Staff responsibilities are set out in contracts of employment. A breach of these responsibilities could result in disciplinary action.

The Freedom of Information Act makes it an offence to alter, deface, block, erase, destroy or conceal any record held by BNSSG ICB, with the intention of preventing disclosure to all or part of the information that an applicant is entitled to. Penalties can be imposed on both BNSSG ICB and employees for non-compliance with the Freedom of Information Act.

5 Definitions/explanations of terms used

The Freedom of Information Act 2000 covers any recorded information that is held by a public authority. Recorded information includes printed documents, computer files, letters, emails, photographs and sound or video recordings.

There are special categories of personal data which require a higher level of protection. These are: race, ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic data, biometric data, health data, sex life and sexual orientation. Consideration of these characteristics has been set out in section 8.1.

6 Publication Scheme

The Freedom of Information Act Section 19 makes it a duty for every public authority to adopt and maintain a scheme relating to the publication of information by that authority, which is approved by the Information Commissioner. It is also a duty to publish information detailed in the scheme and to review the scheme regularly.

Information that BNSSG ICB publishes as part of its publication scheme and website will be the list of information available for re-use. Any published document can be re-used without charge, provided BNSSG ICB is quoted as the source and retains copyright where appropriate. This will be noted on the publication scheme.

The scheme must specify the classes of information, the manner of publication and whether the material will be provided free of charge or on payment.

The general headings of the scheme are as follows:

1. Who we are and what we do
2. What we spend and how we spend it
3. What our priorities are and how are we doing
4. How we make decisions
5. Our policies and procedures
6. Lists and registers
7. The services we offer

The publication scheme of BNSSG ICB can be found on its website.

Freedom of Information Publication Scheme - NHS BNSSG ICB

The Corporate Support Officer is responsible for ensuring the review of the scheme on at least an annual basis, seeking revised approval from the Information Commissioner's Office if classes are added or deleted from the scheme. The Publication Scheme will also state what sort of information is regarded as exempt, outlining the nature of the exemption applied.

BNSSG ICB will publish FOI request responses on its website.

7 Managing Requests for Information

The Corporate Secretary will ensure that the ICB has a full and efficient process for responding to requests received. This will include awareness for all staff of how the ICB will manage a request.

Staff receiving requests for information should pass them as soon as they are received to the Freedom of Information Team through their dedicated email address bnssg.foi@nhs.net

The ICB has 20 days after the date of receipt to respond to the request. The date of receipt is the day on which the request is delivered anywhere within the ICB. An exception to this is where te request has been emailed to an absent member of staff, with an out of office containing instructions on how to redirect the message. If this is so, the date of receipt will be the day the request arrives in the inbox of the contact.

All requests will be logged and the response process and outcome documented.

7.1 Defining a Valid FOI Request

As defined in Section 8 of the FOI Act, to meet all the requirements of a valid FOI request, a request must:

- be received in writing
- contain the name and correspondence address for the applicant
- include sufficient information to enable BNSSG ICB to identify the information requested.
- be received in a legible form
- be capable of being used for subsequent reference

The term "in writing" covers requests submitted by letter and electronic form, including those sent via social media. The request does not have to make a direct reference to the Act or be the sole or main theme of the requester's correspondence.

When determining whether or not a name is valid, where a requesters name is an obvious pseudonym or only includes a part of their real name then the request will only be valid if their real name is visible elsewhere in the body of the request. There are sections under the FOI Act where a requester's identity can be relevant such as when the ICB is considering:

- aggerating the cost of requests (Section 12)
- refusing a request as vexatious or repeated (Section 14)
- whether information is reasonably accessible to the requester by other means (Section 21)
- whether the requester is requesting their own personal data (Section 40)

The Information Commissioner advises that in most cases it is appropriate to accept the name provided at face value and there is no requirement for public authorities to routinely check identities.

However, if the requester does not supply their real name, they will be unable to make a complaint to the Information Commissioner if they are dissatisfied with the ICB response. This is because the Information Commissioner's powers only extend to valid requests for information which include the name of the applicant.

BNSSG ICB, under Section 16 of the Act, is under a duty to provide advice and assistance to members of the public making a request and will take all reasonable steps to advise anyone whose request does not fulfil the above criteria about what is required by the ICB to progress their request. The timing for response does not commence until the ICB has sufficient detail to consider its response. Any communications to clarify a request will be undertaken without unnecessary delay.

Any requester whose request has been refused will be informed of this decision within twenty working days and be informed that they may request an internal review of the decision.

7.2 Vexatious Requests

Under Section 14(1) of the Act, the ICB does not have to comply with a request if it is vexatious. Section 14(1) can only be applied to the request and not the requester. If the ICB believes a request is vexatious it must be reviewed and considered whether it is disproportionate, manifestly unjustified, inappropriate or an improper use of the FOI Act. The four broad themes the ICB will consider are:

- The burden on the public authority and its staff
- The motive of the requester
- The value or serious purpose of the request
- Any harassment or distress of and to staff

The ICB will review the detailed guidance provided by the ICO when considering whether a request is vexatious and will explain to the requester why the request is

considered vexatious and outline the recourse the applicant has if they are unhappy with this position.

7.3 Repeat Requests

Under section 14(2) of the Act, the ICB does not have to comply with a request which is identical or substantially similar to a previous request submitted by the same individual, unless a reasonable period has elapsed between the requests. The reasonable period is dependent on whether the information caught within the scope of the request has substantially changed since the information was provided previously. When responding in this manner the ICB will offer assistance to the individual by indicating why they consider the request is a 'repeat' under Section 14 of the Freedom of Information Act. They will also indicate what recourse the applicant has if they are unhappy with this position.

7.4 Time Limits for Compliance with Requests

BNSSG ICB has procedures in place to ensure that it complies with the duty to respond to requests within the statutory timeframe of twenty working days from a valid request being received. The time limit applies where the ICB refuses a request if repeated or if it exceeds the appropriate limits for costs of compliance. In most circumstances the 20 working day time limit applies where the ICB has applied an exemption.

Section 10(3) of the Act enables an authority to extend the 20 working day limit up to a 'reasonable' time where:

- It requires more time to determine whether or not the balance of the public interest lies in maintaining an exemption; **or**
- It needs further time to consider whether it would be in the public interest to confirm or deny whether the information is held

The extension will therefore only apply to requests where the ICB considers a 'qualified exemption'. The Act does not define a 'reasonable' time, however the Information Commissioners Office view is that the authority should not exceed an additional 20 working days meaning that the request should not exceed 40 working days. In any case, the ICB will provide a written response within 20 days to explain the extension and which exemptions the public interest test is being applied to.

7.5 Fees for Providing Information and Charges for Re-Use

BNSSG ICB may charge a fee for dealing with a request, in line with the National Fees regulations. Where the cost of the work to respond is estimated to be less than £450 then no fee can be charged. Where the cost is in excess of this amount, the ICB will correspond with the applicant to provide advice on how the scope of the FOI can be reduced (and therefore cost) or to agree a fee. If agreement cannot be reached on cost in such circumstances the ICB may decide not to respond to the request.

When the ICB is in receipt of a request that fulfils the criteria above, it will respond within 20 working days. Within this time the ICB must:

- identify what information it holds and whether any exemption applies in full or part to the information
- advise the applicant on any exemptions it believes apply (in full or part) to the information and inform them of their right to complain to the Information Commissioner's office
- inform the applicant of any fee to be charged
- provide any information not covered by an exemption to the applicant in any manner specified by the applicant within 20 working days of receiving the request, provided any applicable fee has been received

If a fee is proposed, then the clock measuring the 20 days can be paused, between the date the applicant is notified and the date the fee is received. If this period is in excess of 3 months, then the request can be rejected.

For re-use of information actively published, no charge will be raised.

Where information is requested for re-use that is not routinely published a reasonable charge will be applied. This will be applied on a cost recovery basis, of the costs to provide the information and up to 25% of the time costs spent on original creation. Any standard charging regimes set by the NHS in the future will apply.

7.6 Information Provided by Other Organisations

In deciding whether to disclose information provided by another organisation that is held by the ICB in response to a request, the ICB will apply the same process with regard to exemptions, and will if required involve staff from the source organisation in discussion about possible exemptions. If the response to a request is that the ICB does not hold any relevant information, then the ICB will endeavour to direct the applicant to organisations who may hold the information they seek.

7.7 Reuse of Information Provided by Other Organisations

If there is a request to re-use information provided by another organisation, the requester will be directed to the other organisation.

7.8 Redaction of Information

Redactions are made by the Information Rights Team. Decisions regarding data to be redacted will however be made with the input of colleagues who are knowledgeable about the specific data being requested.

Redaction is carried out in order to exempt specific information from a document so that it can be released without an exemption being applied. This is achieved by blocking out individual words, sentences or paragraphs or by removing whole pages or sections prior to the release of the document. If the document is deemed unreadable following redaction, then the document should be withheld.

When responding to the requester with a redacted response, the response will state which exemption the information has been redacted under.

7.9 Internal Review

Requesters may ask BNSSG ICB to conduct an Internal Review of its handling of FOI requests and/or the response received. The Internal Review process will be enacted when a requester communicates in writing that they are unhappy with a response or the way the ICB has handled the request. The communication does not need to mention internal review or complaint. The Internal Review process is outlined in appendix 4 of this policy.

BNSSG ICB will conduct Internal Reviews within 20 working days or 40 working days where a review is shown to be particularly complex. The Corporate Support Officer will review for complexity with support from appropriate staff members.

Requesters who are not satisfied with the outcome of the internal review may ask the Information Commissioners Office to review how the ICB has performed in response to the request. Should the ICB receive any notices served by the Information Commissioner it will make all endeavours to comply unless it feels the need to appeal to the Information Rights Tribunal.

8 Exemptions and Public Interest

The Freedom of Information Act sets out 23 exemptions to the general right of access to information, these are outlined in Appendix 5. Some of these are ‘absolute’, but the majority are ‘qualified’, in that if the release of information is deemed to be ‘in the public interest’ then the exemption does not apply.

The Corporate Support Officer will facilitate decision making about exemptions and undertake the public interest test by engaging staff involved in the areas the information relates to. The majority of exemptions are subject to the public interest test, where the ICB must determine if public interest in disclosure outweighs the reason for exemption. This will be decided on a case by case basis, and where necessary require applying the ‘test’ to multiple items of information in a request. Exemptions can be applied in full or part to information related to a request.

8.1 Personal Identifiable Information

BNSSG ICB will review all FOI responses for the potential to identify individuals from requested data. Where the information requested includes data defined as ‘special categories of personal data’ (see section 5), the ICB will exempt from the response figures less than 10 through Section 40 of the FOI Act. The public interest test will still apply to this exemption. ICO guidance indicates that figures less than 5 are likely to be identifiable, however there is provision for higher numbers to be subject to exemption depending on the sensitivity of the data being considered. BNSSG ICB will review the impact of disclosure to individuals, particularly concerning health data,

and will apply the exemption to numbers less than 10 where appropriate. This will be reviewed on a case by case basis. Consideration will also be taken of previous FOI responses to ensure that individuals cannot be identified from the requested information when combined with previous requests or other information available to the public.

9 Requests relating to personal data

If a request is seeking personal data either from a requester about themselves or, from a requester on behalf of another individual, then it is exempt under Freedom of Information legislation. Such requests for personal data are however covered by the individual rights provisions within data protection legislation.

This legislation gives individuals a variety of 'rights' in respect of their personal data and this includes the ability to request a copy of their personal data. This is known as the right of access or more commonly as a subject access request. It should be noted that the right of access does not provide an automatic right to information about third parties. Further information on providing personal data can be found in the Individual Rights policy.

10 Requests relating to Environmental Information

If a request is seeking information relating to Environmental Information then the request should be processed under the Environmental Information Regulations (EIR) rather than the FOI Act. The principles under which the requests would be processed are similar however there are some notable differences:

- The reasons why you can withhold information are different under the FOI Act (exemptions) from under the EIR (exceptions)
- Requests under EIR can be made verbally
- There is no equivalent to the "appropriate limit" exemption under section 12 of the FOI Act.

Where requests relate to environmental information, the ICB will process the request under the EIR legislation.

11 Contracts with other organisations

All operational contracts BNSSG ICB will have a clause detailing that information may be disclosed under the terms of the Freedom of Information Act and this Policy. For existing contracts, the clause will be inserted at the next review.

12 Our Freedom of Information Procedure

This policy sets out requirements for a number of processes to be in place, such as response to requests and managing exemptions. Detail of these processes are set out in the 'Freedom of Information Procedure" (Appendix 3). This will allow process to be changed as experience is gained and as dictated by organisational changes, without the need for a revision of this policy document. Should significant change be encountered, then it will be the responsibility of the Corporate Secretary to determine whether this policy needs to be reviewed outside of the normal schedule.

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, and also via training with all members of BNSSG ICB staff through mandatory Information Governance training completed annually. Awareness of responsibilities associated with FOI will be covered at induction.

14 Equality Impact Assessment

Equality Impact Assessment Screening has been completed and is included at Appendix 1. Screening indicates that a full assessment is not required.

15 Implementation and Monitoring Compliance and Effectiveness

An implementation plan has been prepared and is included at Appendix 2. Compliance with this policy and The Freedom of Information Act will be monitored by reporting to the Audit and Risk Committee, including information regarding the number of requests received, the percentage responded to within 20 working days, the number of exemptions applied and whether the ICB has been asked to undertake any internal reviews.

16 Countering Fraud, Bribery and Corruption

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, we have given consideration to fraud and corruption that may occur in this area and our responses to these acts during the development of this policy document.

ICB employees should be aware of the consequences of using social media platforms to post content which conflicts with information provided to the ICB, including their health and fitness to work, and secondary employment (for example, posting evidence of undertaking unapproved secondary employment whilst receiving sick pay from the ICB). If an instance such as this occurs, an employee may be subject to criminal or disciplinary proceedings, which could result in dismissal.

17 References, acknowledgements and associated documents

The following related documents may be accessed through our website:

BNSSG Information Governance Policy

BNSSG Records Management Policy

BNSSG Individual Rights Policy

BNSSG Disciplinary Policy

https://bnssgICB.nhs.uk/

Freedom of Information Act 2000

https://www.legislation.gov.uk/ukpga/2000/36/contents

Data Protection Act 2018

https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

General Data Protection Regulations (GDPR)

https://www.legislation.gov.uk/eur/2016/679/contents

Access to Health Records Act 1990

https://www.legislation.gov.uk/ukpga/1990/23/contents

18 Appendices

18.1 Equality Impact Assessment

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

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

Title of proposal: Freedom of Information Policy				Date: 17/10/23
x Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (*please state)*
EHIA type:	Screening EHIA x	Full EHIA ☐	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes ☐ No x EIA undertaken on previous policy version
Is the policy under:	Development ☐	Implementation ☐	Review x	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? All BNSSG ICB employees and members of the public				
Lead person(s) completing this assessment: Lucy Powell				
Lead person job title(s) and service area: Corporate Support Officer				

Briefly describe the proposal

Give a brief description of the context, purpose, aims and objectives of the proposal. Describe what services are currently being provided. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new

proposal or change to an existing one and the key decision that will be informed by the EHIA (e.g. whether or not to proceed with the proposal to publish an employee handbook)

This is an update to the current Individual Rights policy in line with best practice and national guidance. The aim is to ensure that all ICB employees understand the arrangements that BNSSG ICB has in place for the management of individual rights requests. This policy also outlines how members of the public and ICB staff can exercise their individual rights, including the information required by the ICB to process requests.
Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:
This policy will not directly impact Health Inequalities. However, the ICB does not undertake equality monitoring of requesters and therefore there is no data which shows whether those with protected characteristics are more/less likely to request information.
Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.
N/A The policy describes the ICB's statutory and legal responsibilities and there had been no engagement with patients/members of the public in preparing this policy beyond that undertaken by the government as part of the legislative process
Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.
The policy has been written with a view to be accessible to all individuals and can be requested in other formats as per ICB processes. The policy has been included on the ICB website, and further information about requests has been included on the Contact Us webpage. Additional information for staff is on the intranet and sent out regularly through the newsletter.

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

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

Positive Impact:				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: There is no positive impact on those holding protected characteristics. The Freedom of Information Act applies to all. The policy outlines the arrangements that BNSSG ICB has in place for the management of freedom of information requests. This policy also outlines how members of the public exercise their right to request information, and the policy outlines the how members of the public can do this.				
Negative Impact				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation

☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: It is not believed that the content of the policy would have a direct negative impact on those holding protected characteristics. The ICB has a duty to provide the policy and information requested in various formats as required to ensure equitable access to the information within the policy and equitable access to information. Unlike other rights of access, a valid Freedom of Information request must be made in writing although this can be through letter, email or social media. (you can share further details and mitigations below in 2.2)				
No Effect				
Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable' This EHIA is being undertaken as part of the review process for a current ICB policy. There have been no significant amendments made to the processes already in place.				

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

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
N/A		

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

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

To eliminating discrimination, harassment and victimisation.	Positive	X
	Negative	☐
	No effect	☐
Please describe: This policy outlines the right for members of the public to access information held by public authorities. This right supports the understanding of how the ICB works and work of the NHS. The rights outlined in the policy also encourage transparency and staff are aware that any information may be requested and disclosed.		

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	X
	Negative	☐
	No effect	☐
Please describe: The policy applies to all individuals equally. The aim is to ensure that everyone understands the arrangements that BNSSG ICB has in place for the management of Freedom of Information requests and provides clear guidance to staff who may have to process requests and members of the public who may want to request information.		

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

Action Plan

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

Action	Timeframe	Success Measure	Lead
Senior support and promotion of the policy	From ICB Board approval on the 1st February 2024	ICB Board approval and subsequent promotion at staff meetings and through staff newsletters	RH/LP
Promotion of Freedom of Information on the ICB website	Ongoing	Freedom of Information requests continue to be received through the contact us page on the webpage	LP

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

As part of the quarterly promotion of the policy and as part of the quarterly reporting to the Audit and Risk Committee

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

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

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

The policy is for all individuals including all ICB staff and members of the public. The arrangements outlined are a legal requirement. The EHIA has highlighted the importance of promotion of the policy.

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

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

Reviewer's Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)
Equality Officer Name:
Equality and Inclusion Team Signature:
Date:

Equality Delivery System 2022

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

Domain 1 – Commissioned & Provided services

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

Domain 2 – Workforce health and wellbeing

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

Domain 3 – Inclusive Leadership

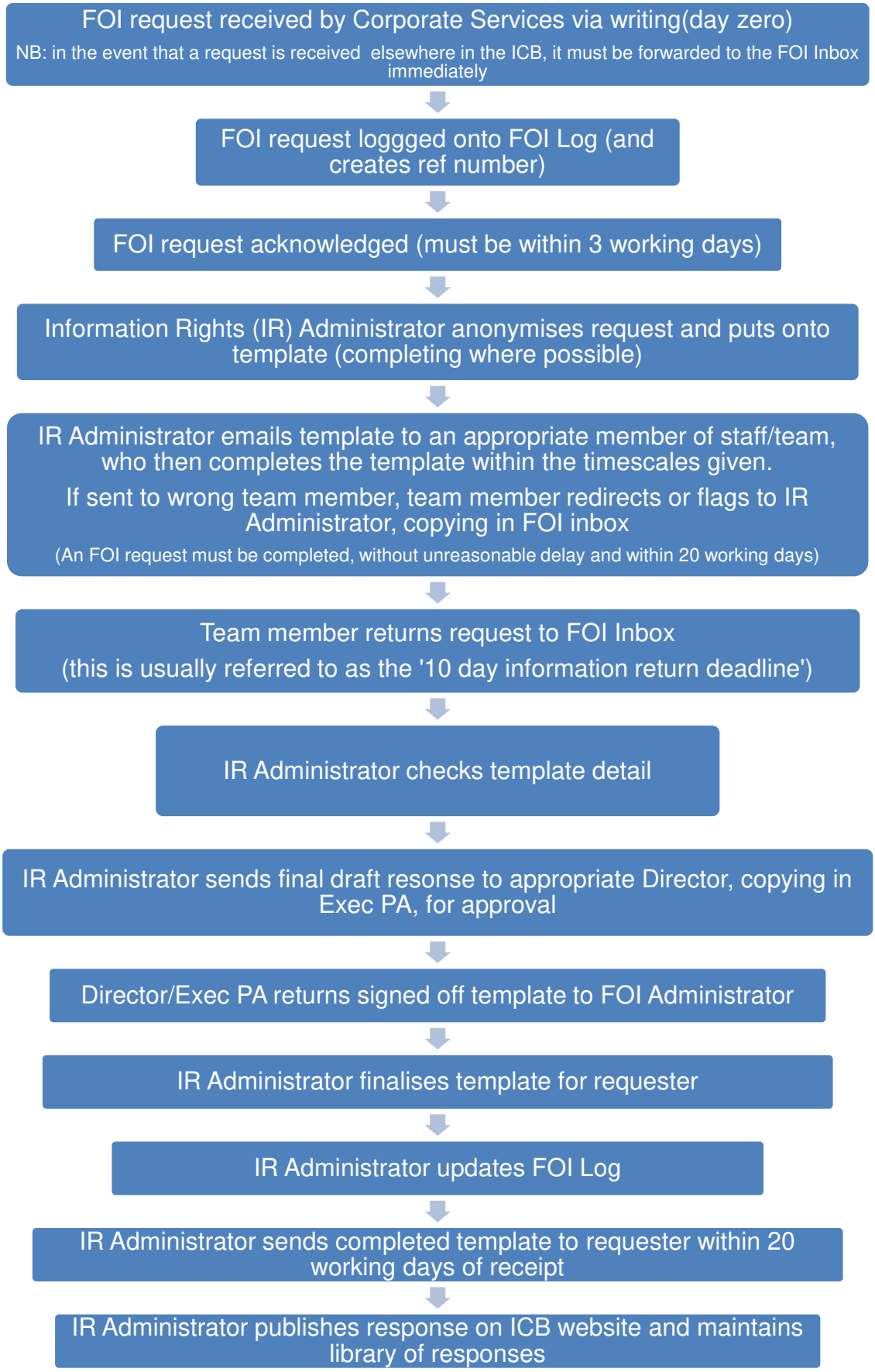
- 3A: Board members and senior leaders (Band 9 and VSM) routinely demonstrate their commitment to equality.
- 3B: Board/Committee papers (including minutes) identify equality related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and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

The policy aims to provide clear guidance to staff on the responsibilities for managing Freedom of Information requests. Having a clear policy in place with support from the appropriate teams supports all three domains. Domain 1 as Freedom of Information supports people to understand work of the NHS. Domain 2 as the policy provides clear guidance to support staff to action Freedom of Information requests. Domain 3 as the policy provides a framework for Board/Committee members and senior managers to monitor impact and risk.

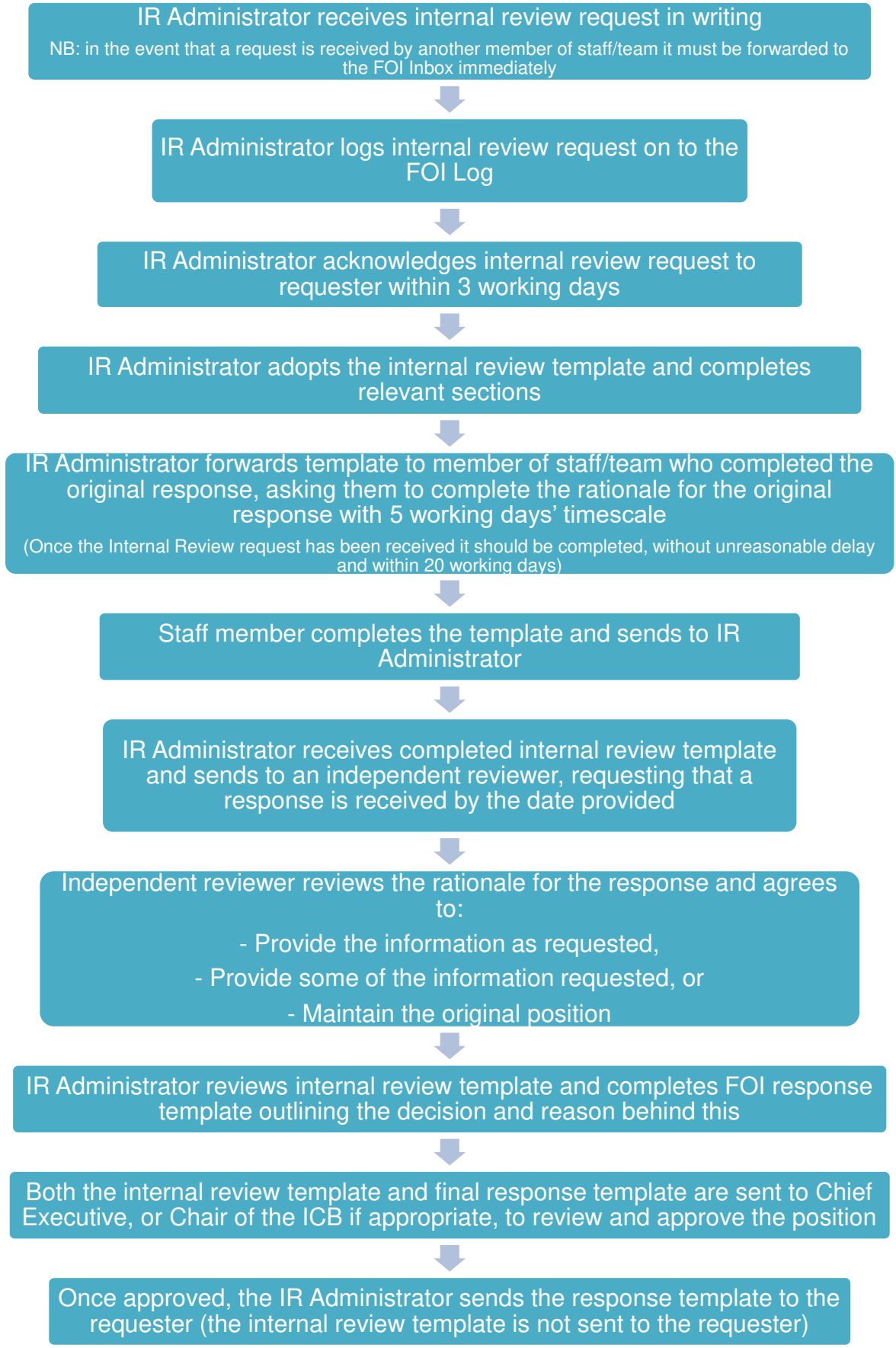
18.2 Implementation Plan

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	Chief of Staff	1st Feb 2024	1st Feb 2024	Staff time, Board members time
Executive Directors	Ensure awareness of responsibilities of ICB process to ensure compliance. This includes the requirement of Director approval processes	Email confirmation of policy implementation to Executive Directors highlighting sign off procedures for requests	Corporate Support Officer	2nd Feb 2024	2nd Feb 2024	Staff time, Executive Director time
Executive Director PAs	Ensure awareness of ICB process and Executive Director approval role in process	Email confirmation of policy implementation to Executive Directors highlighting sign off procedures for requests to be copied into PAs	Corporate Support Officer	2nd Feb 2024	2nd Feb 2024	Staff time
All staff	Ensure awareness of ICB processes and procedures	Reviewed policy to be placed on website Information about the policy and ICB process to be placed on the Hub and announced at staff meetings Information about the policy and ICB process to be communicated through internal newsletter Data Security Awareness training module to be completed by all staff	Corporate Support Officer	1st Feb 2024	Ongoing	Staff time IG training module

18.3 Freedom of Information Procedure



18.4 Internal Review Procedure



18.5 Exempt Information under Part 2 of the Act – The Exemptions

Section in the Act	EXEMPTION
Qualified Exemptions (Subject to the Public Interest test)	
(22)	Information intended for **future publication**
(24)	Information for the purpose of safeguarding **national security**.
(26)	Information that would prejudice the a) **Defence** of the British Islands or any colony, or b) The capability, effectiveness or security of any relevant forces.
(27)	**International relations**: Information that would prejudice the relations between the UK and any other State/any international organisation/or any international court and the interests of the UK abroad
(28)	**Internal Relations**: Information that would prejudice relations between any administration in the UK
(29)	Information that would prejudice the **economic** interests of the UK
(30)	**Investigations/ proceedings** - Investigations to ascertain whether a person should be charged with an offence
(31)	**Law enforcement -** Information that would be likely to prejudice the prevention or detection of crime, the apprehension or prosecution of offenders, the administration of justice etc. (see ACT)
(33)	Information in relation to the **audit of other public authorities** (Accounts, economy, efficiency and effectiveness)
(35)	Information held by a **government department** if it relates to the **formulation of government policy**.
(36)	**Prejudice to effective conduct of public affairs.**
(37)	**Communications with Her Majesty**, with other members of the Royal Family, the Royal Household, or the conferring by the Crown of any honour or dignity.
(38)	**Health and Safety -** Information, which is likely to endanger the physical/ mental health or safety of any individual or group.
(39)	**Environmental information**

(40)	**Personal** data - Patient/client identifiable information
(42)	**Legal professional privilege** - Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings
(43)	**Commercially sensitive** - Information that constitutes a trade secret, that could if released: a) Result in competitive harm to a company b) Prejudice BNSSG ICB's or any person's commercial interests or c) Impair BNSSG ICB's ability to obtain similar information in the future
Absolute Exemptions (Not subject to the Public Interest test)	
(21)	Information **accessible to applicant by other means**
(23)	Information supplied by, or relating to, **bodies dealing with security matters.** The bodies referred to are the Security Service, the Secret Intelligence Service, the Government Communications Headquarters, the special forces and others (see ACT)
(32)	**Court records** - Document for the purposes of proceedings in a particular cause or matter (e.g. post-mortem examination)
(34)	Information required for the purpose of avoiding an infringement of the **privileges of either House of Parliament**.
(35)	Information held by a **government department** if it relates to the **formulation of government policy**.
(40)	**Personal** data – If the information requested is the personal data of the requester.
(41)	**Confidential** information • Information provided to BNSSG ICB by another person not employed by it (an individual, a company or another public authority e.g. social services) • Disclosure would give raise to an actionable breach of confidence • If the information is requested, BNSSG ICB can ask the third party for permission to share it or direct the requester to the originator of the document.
(44)	Disclosure would **constitute contempt of court** or disclosure is **prohibited by an enactment**

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:	6
Responsible Executive Director:	Shane Devlin, Chief Executive
Author and Job Title:	Sarah Carr, Corporate Secretary Lucy Powell, Corporate Support Officer
Date Approved:	1 July 2022
Approved by:	Integrated Care Board (ICB) Board
Date of next review:	June 2023 (Annually)

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?	Yes	Specialist advice has been sought from the relevant Counter Fraud service. Counter Fraud is represented on the Corporate Policy Review Group.
Has HR been consulted?	Yes	Advice has been sought from HR. HR is represented on the Corporate Policy Review Group. 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. NHS England 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 NHS England 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?	Yes	Shane Devlin, Chief Executive
Which Committees have assured the policy?		Corporate Policy Review Group and Audit and Risk Committee. Both provided feedback which has been included.
Has an implementation plan been provided?	Yes	See Appendix 2
How will the policy be shared with staff		The policy will be published on the ICB website and intranet and will be featured in internal news

	Yes/ No/NA	Supporting information
		communication. Regular prompts regarding declaring gifts and hospitality 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.

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 must 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 definition also includes recognition of gifts which could also be for another person, or to benefit an organisation

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 partner 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 must 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.

The ICB is awaiting clarification of the implications of the new Economic Crime and Corporate Transparency Bill following its Royal Assent to consider whether any ICB Policies require amendment. Under this Bill, organisations will be liable where a specified fraud offence is committed by an employee or agent, for the organisations benefit, and the organisation did not have reasonable fraud prevention procedures in place. It does not need to be demonstrated that company leaders ordered or knew about the fraud.

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 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
- Management of the Corporate Governance Team to deliver its functions described in this policy.

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

Contact details can be found at Appendix 3.

Individuals
Every individual should observe the principles of good governance in the way they do business including adherence to the Nolan principles , more detail has been included at Appendix 3

Every individual is responsible for ensuring 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 must not accept gifts that may affect, or be seen to affect, their professional judgement. This overarching principle must 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 required to declare any gifts and hospitality offered.

All individuals must declare all offers of gifts and hospitality and service whether accepted or rejected within 28 days.

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, or as an enticement for the organisation or a third party, 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. which are free of charge or less than its commercial value.

6 Gifts

A ‘gift’ is defined as in Section 5 above.

As an overarching principle ICB staff must not accept gifts that may affect, or be seen to affect, their professional judgement. This overarching principle must 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 must 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 must not ask for any gifts, nor will they accept modest gifts that compromise their position or the reputation of the ICB.

Gifts over the value of £50 must 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 must 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 is defined as in Section 5 above.

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 must 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 must 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 must be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals must 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 must be refused unless (in exceptional circumstances) Executive Director approval is given. A clear reason must 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). Refer to the policy on alcohol (in development at October 2023)

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 might not usually offer i.e., business class or first class travel and accommodation or foreign travel, need approval by an Executive Director and must only be accepted in exceptional circumstances. Such offers must be declared whether it is accepted or not and a clear reason 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 must only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS;
- There must be no 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 must not be supplied;
- At the ICB's discretion, sponsors or their representatives may attend or take part in the event, but they must not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event must always be clearly identified in the interest of transparency;
- The ICB must make it clear that sponsorship does not equate to endorsement of a company or its products and this must be made visibly clear on any promotional or other materials relating to the event;
- Staff must 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. Policy for the Sponsorship of Activities by and Joint Working with the Pharmaceutical Industry - NHS BNSSG ICB

A Register of Gifts, Hospitality and Sponsorship template is at appendix 5 and will be made publicly available on the ICB website. Gifts, Hospitality and Sponsorship Register - NHS BNSSG ICB

Acceptance of commercial sponsorship must not in any way compromise commissioning decisions of the ICB or be dependent on the purchase or supply of goods or services. Sponsors must 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 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 England 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.

10 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.

10.1 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 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 ICB Audit and Risk Committee who will review any lessons to be learnt and recommendations for action. Confidentiality will be maintained in line with the relevant

HR policies that are being used. 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.

11 Countering Fraud, Bribery and Corruption

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, we have given consideration to fraud and corruption that may occur in this area and our responses to these acts during the development of this policy document.

12 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.

13 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.

14 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 ICB Audit and Risk Committee. The outcomes of any audits will be reported to the Audit and Risk Committee.

15 References, acknowledgements and associated documents

The following related documents may be accessed through our website: https://bnssgICB.nhs.uk/

- 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
- Policy on alcohol at work (in development at October 2023)

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/

16 Appendices

Appendix 1 Equality Impact Assessment

Appendix 2 Implementation Plan

Appendix 3 Principles of Good Governance and Nolan Principles

Appendix 4 Contact details for the Corporate Governance Team and Conflicts of Interest Guardian

Appendix 5 Gifts, Hospitality and Sponsorship declaration form

Appendix 6 Gifts, Hospitality and Sponsorship Register template

16.1 Equality Impact Assessment

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

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

Title of proposal: Gifts and Hospitality Policy				Date: 17/10/23
x Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (*please state)*
EHIA type:	Screening EHIA x	Full EHIA ☐	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes ☐ No x EIA undertaken on previous policy version
Is the policy under:	Development ☐	Implementation ☐	Review x	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? All BNSSG ICB employees and also ICB Board and Committee members. The individuals impacted are outlined in section 2 of the policy.				
Lead person(s) completing this assessment: Lucy Powell				
Lead person job title(s) and service area: Corporate Support Officer				

Briefly describe the proposal

Give a brief description of the context, purpose, aims and objectives of the proposal. Describe what services are currently being provided. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new

proposal or change to an existing one and the key decision that will be informed by the EHIA (e.g. whether or not to proceed with the proposal to publish an employee handbook)

This is an update to the current Gifts and Hospitality policy in line with current best practice and national guidance. The aim is to ensure that all individuals understand the arrangements that BNSSG ICB has in place for the management of offers of gifts and hospitality. This policy aims to provide clear guidance in relation to the actions required when offers of gifts and hospitality are received by individuals.
Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:
This policy will not directly impact Health Inequalities
Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.
N/A 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 NHS England as part of the legislative process
Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.

The policy has been written with a view to be accessible to all individuals set out in section 2 of the policy and to members of the public for transparency. Additional information will also be provided on the Hub and the Corporate Governance team will be available to support as required.

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

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

Positive Impact:				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: There is no positive impact on those holding protected characteristics. The policy outlines the arrangements that BNSSG ICB has in place for the management of offers of gifts and hospitality. This policy aims to provide clear guidance in relation to the actions required when offers of gifts and hospitality are received. The policy applies to all individuals set out in section 2 of the policy.				

Negative Impact				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: It is not believed that the content of the policy would have a direct negative impact on those holding protected characteristics. The ICB has a duty to provide the policy in various formats as required to ensure equitable access to the information within the policy. (you can share further details and mitigations below in 2.2)				
No Effect				
Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable' This EHIA is being undertaken as part of the review process for a current ICB policy. There have been no significant amendments made to the processes already in place.				

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

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
N/A		

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

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

To eliminating discrimination, harassment and victimisation.	Positive	☐
	Negative	☐
	No effect	X
Please describe:		

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	X
	Negative	☐
	No effect	☐
Please describe: The policy applies to all the individuals outlined in section 2 equally. The aim is to ensure that everyone understands the arrangements that BNSSG ICB has in place for the management of offers of gifts and hospitality and provides clear guidance in relation to the actions required when offers of gifts and hospitality are received.		

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

Action Plan

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

Action	Timeframe	Success Measure	Lead
Senior support and promotion of the policy	From ICB Board approval on the 1st February 2024	ICB Board approval and subsequent promotion at staff meetings and through staff newsletters	RH/LP
Individual is identified to provide independent advice and judgement	Ongoing	Independent Non-Executive Member and Chair of the Audit and Risk Committee identified	

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

As part of the quarterly promotion of the policy

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

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

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

The policy is for all individuals identified in section 2 of the policy, including all ICB staff and the arrangements outlined are a legal requirement. The EHIA has highlighted the importance of promotion of the policy

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

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

Reviewer's Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)
Equality Officer Name:
Equality and Inclusion Team Signature:

Date:

Equality Delivery System 2022

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

Domain 1 – Commissioned & Provided services

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

Domain 2 – Workforce health and wellbeing

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

Domain 3 – Inclusive Leadership

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

The policy aims to provide clear guidance to staff on the responsibilities for managing offers of gifts and hospitality. Having a clear policy in place with support from the appropriate teams and conflict of interest guardian supports Domain 2 with the ICB as a good place to work. Having a clear policy in place also supports Domain 3 as the policy provides a framework for Board/Committee members and senior managers to monitor impact and risk.

16.2 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	Chief of Staff	1st Feb 2024	1st Feb 2024	Staff time, Board members time
Executive Directors	Ensure awareness of responsibilities to ensure compliance for both Individual Executive Director responsibilities and Directorate Responsibilities	Discussion with individual directors as required	Corporate Support Officer	1st Feb 2024	Ongoing	Staff time, Executive Director time
All Staff	Ensure awareness of ICB processes and procedures	Policy to be placed on website following approval and 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 and staff meetings Annual Conflicts of Interests training module – Staff to be regularly reminded to undertake training	Corporate Support Officer /Training manager	1st Feb 2024	Following ICB Board approval Ongoing Ongoing	Staff time, Training Module

16.3 Principle 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.

16.4 Contact details for ICB Governance Lead and Conflict of Interest Guardian

Senior person responsible for Governance	
Name	Shane Devlin
Title	Chief Executive
Telephone No.	0117 900 2397
Email	shane.devlin@nhs.net
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

16.5 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 data will be managed in line with Data Protection Legislation. 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**

16.6 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

Individual Rights Policy

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	34
Responsible Executive Director:	Shane Devlin, Chief Executive
Author and Job Title:	Lucy Powell, Corporate Support Officer
Date Approved:	1 July 2022 (as part of the Core Policies approval)
Approved by:	ICB Board
Date of next review:	December 2023 (Every two years)

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 compliant with: the Data Protection Act 2018 and the UK General Data Protection Regulation 2018 (the Data Protection legislation)
Has legal advice been sought?	No	Specialist advice has been taken from Information Governance Advisors. Information Governance is represented on the Corporate Policy Review Group
Has HR been consulted?	Yes	HR have been made aware that staff have a right to request personal data held by the ICB. HR is represented on the Corporate Policy Review Group.
Have training issues been addressed?	Yes	Training is referenced in the policy. The ICB's Information Governance training includes Information Rights; this training is mandatory and annual.

	Yes/ No/NA	Supporting information
		Training on ICB specific procedures as set out in the appendix will be tailored to relevant staff groups and will be at least annual.
Are there other HR related issues that need to be considered?	Yes	Staff are able to make Subject Access Requests to request data HR hold. The HR team have developed a form for requests and this is available to staff on the Consult HR website. Staff have been informed of their rights through internal communications.
Has the policy been reviewed by Staff Partnership Forum?	No	The policy does not raise any HR issues and has not been reviewed by the SPF.
Are there financial issues and have they been addressed?	No	There are no financial issues.
What engagement has there been with patients/members of the public in preparing this policy?	N/A	This policy describes a statutory responsibility and there has been no engagement with patients/members of the public beyond that undertaken by government as part of the legislative process
Are there linked policies and procedures?	Yes	Associated policies and procedures are recorded in the policy
Has the lead Executive Director approved the policy?	Yes	Shane Devlin, Chief Executive
Which Committees have assured the policy?		Corporate Policy Review Group and Audit and Risk Committee. Both provided feedback which has been included.
Has an implementation plan been provided?	Yes	See Appendix 2

	Yes/ No/NA	Supporting information
How will the policy be shared with staff, patients and the public?		The policy will be published on the ICB website and intranet and will be featured in the internal news communication. Implementation will be monitored through Information Rights reports to the Audit and Risk Committee
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 developed and approved
Have Data Protection implications have been considered?	Yes	The Policy is compliant with the Data Protection Act 2018 and the UK General Data Protection Regulation 2018

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Individual Rights Policy

1 Introduction

Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) is under a legal duty to comply with 'individual's rights' requests under the Data Protection Legislation, in relation to personal data that it holds. It is a legal requirement that all requests for personal data held by the ICB are handled in accordance with data protection legislation.

This policy and accompanying standard operating procedure (SOP) sets out the approach that the ICB will take in responding to these requests along with useful guidance and steps to follow when requests are received anywhere within the ICB.

1.1 BNSSG ICB Values

This policy supports the values by outlining the process through which a statutory obligation will be fulfilled therefore demonstrating "We do the right thing". This Policy outlines the expectation that staff will "Act with integrity" by complying with Data Protection legislation. The Policy also "Supports each other" by providing information to support staff in responding to requests.

2 Purpose and scope

The policy sets out the ICB's legal obligation to comply with the Data Protection legislation in providing access to personal data. The Policy is not designed to be a guide for ICB staff in complying with Data Protection legislation. Guidance for staff will be provided through training and procedural documentation. (Appendix 4).

This policy applies to all staff, regardless of whether they hold a corporate or clinical role and includes:

- Individuals on the ICB Board and Committees
- Employees including those seconded to BNSSG ICB
- Third parties acting on BNSSG ICB's behalf (including commissioning support and shared services)
- Agency, locum and other temporary staff engaged by BNSSG ICB
- Students, including those on work experience, trainees and apprentices.

It is the responsibility of all those individuals set out above to respond to and help process requests under the individual rights set out in data protection legislation as soon as it is received by the ICB. Requests must be sent to the Information Rights team who will process the request: bnssg.foi@nhs.net

Any personal data in relation to an individual, no matter what format, where or how it is stored by the ICB falls into the scope of information that can be requested by individuals (i.e. data subjects) under the 'Individuals Right's' contained within the Data Protection Legislation. Individuals have the right to request a copy of their personal data which is being processed by controllers. All requests must be reviewed, without delay to see if the request can and should be complied with.

Requests received by third parties in regard to access to a data subjects personal data should be handled using the process described within the Standard Operating Procedure. Information regarding consent documentation required to open a request and further considerations have been included in Appendix 6.

3 Duties – legal framework for this policy

The UK GDPR, which was implemented though the DPA 2018, gives individuals the right of access to their personal data from any organisation which holds records on them. The right is commonly referred to as 'subject access'. The right of access is one of many rights implemented so individuals can understand how and why organisations are using their data.

An individual can make a rights request verbally or in writing and to be valid must be a request for their own personal data. An individual may ask a third party to make a request on their behalf and before processing the request, the ICB must be assured that the third party is acting on behalf of the individual.

The Information Commissioners Office (ICO) may take action against a controller or processor if they fail to comply with data protection legislation.

The ICB must provide individuals with information including (but not limited to):

- A description of the information
- The purposes the information is used for
- Our retention periods for that personal data
- The disclosures that are made or might be made

This is called 'Privacy Information' or 'Fair Processing Information'. The ICB Fair Processing Notice is available on the ICB website. This information must be regularly reviewed and where necessary updated. The ICB SIRO is responsible for approval to changes in the Privacy notice.

4 Responsibilities and Accountabilities

The Chief Executive has overall responsibility for the Information Rights Policy. The implementation and compliance with the policy is delegated to the Corporate Secretary. This responsibility includes:

- Setting out a process for dealing with Information Rights requests within the timescales stated by the legislation.
- Facilitating the provision of education and awareness for staff, ensuring that basic principles are part of the ICB's induction processes.
- Bi-Annual review of policy, process and code of practice (or more frequently if appropriate, with regard to changes in legislation or guidance from the Information Commissioner)

The Information Rights team are responsible for the delivery of the functions related to processing and responding to Information Rights requests. This responsibility includes:

- Acknowledging and logging requests
- Sending requests to the appropriate team for a response
- Reviewing all the data and undertaking redactions as required
- Logging all the redactions made
- Facilitating Executive Director approval processes and sending the final response to the requester
- Processing and managing the internal review process

All staff are responsible for:

- Creating and maintaining records which are accurate, appropriate and retrievable. This will include adherence to standards for referencing, titling, filing and authoring documents, both electronically and on paper. The Records Management Policy defines the expectations of staff and should be read in conjunction with the Information Rights policies.
- Ensuring that requests for information are passed in a timely manner to staff who process Information Rights requests.
- Ensuring that disclosures are not made outside of the defined process, so that inappropriate disclosures are avoided.

Staff responsibilities are set out in contracts of employment. A breach of these responsibilities could result in disciplinary action.

The NHS South, Central and West Commissioning Support Unit (SCW CSU) Information Governance Team is responsible for overseeing day to day information governance issues and raising awareness of information governance related to this policy within the ICB. Support and delivery of matters associated with IG will be provided by SCW CSU, and the ICB Information Governance Group chaired by the SIRO.

The ICB Data Protection Officer will provide advice and guidance in complex or disputed situations or decisions where required. The ICB Caldicott Guardian will provide advice and guidance in complex situations or decisions where the issue is clinical in nature. The ICB SIRO will approve changes to the Privacy Notice

Line Managers are responsible for ensuring that staff are aware of requirements associated with this policy including the need to pass information to the Information Rights team promptly, and prioritising work to support timely responses.

5 Definitions/explanations of terms used

Controller	A controller determines the purposes and means of processing personal data. Previously known as Data Controller but re-defined under the GDPR.
Personal Data	Any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person
Personal Confidential Data	Personal and Special Categories of Personal Data owed a duty of confidentiality (under the common law). This term describes personal data about identified or identifiable individuals, which should be kept private or secret. The definition includes deceased as well as living people and 'confidential' includes information 'given in confidence' and 'that which is owed a duty of confidence'.
Processor	A processor is responsible for processing personal data on behalf of a controller.
'Special Categories' of Personal Data	'Special Categories' of Personal Data is different from Personal Data and consists of information relating to: (a) The racial or ethnic origin of the data subject (b) Their political opinions (c) Their religious beliefs or other beliefs of a similar nature

	(d) Whether a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1998 (e) Genetic data (f) Biometric data for the purpose of uniquely identifying a natural person (g) Their physical or mental health or condition (h) Their sexual life
Healthcare Professional	ICO guidance allows for the disclosure of 3rd party data of healthcare professionals (most likely names) where they have contributed to a health record for an individual. A healthcare professional is defined as: A person associated with either a speciality or discipline and who is qualified and allowed by regulatory bodies to provide a healthcare service to a patient.
Healthcare Record	A healthcare record is defined as a record which stores information about a person's health, care and wellbeing

6 Managing requests for Information

Individuals have the right to be informed about the collection and use of their personal data. This is a key transparency requirement under UK Data Protection legislation. These rights fall into two distinct categories. Firstly, where an individual wants to know what data the ICB is processing about them and why, and/or receive a copy of that data. Secondly where an individual wants the ICB to make changes to what or how the ICB is processing their personal data, or for the ICB to pass on their personal data to another party. In these requests, the individual is not requesting a copy of the data itself.

These rights include but are not limited to the following:

- The right to be informed
- The right of access
- The right of rectification
- The right to erasure
- The right to restrict processing
- The right to data portability
- The right to object
- Rights in relation to automated decision making and profiling

An individual or their representative can exercise these rights to the ICB. These do not confer automatic agreement to the request but will be duly considered by the ICB. Acknowledgement and processing of requests will be undertaken by the Information Rights team. The rights are outlined in more detail in appendix 3.

It should be noted that there are exemptions to some of these rights and whilst the ICB must acknowledge the request, there may be legal grounds for not complying with it. Detailed guidance can be found within the Standard Operating Procedures (SOP).

6.1 Recognising an Individual Rights Request

A request can be made verbally or in writing and can be sent to anyone within the organisation. A request does not need to mention that the request is a 'right' or mention Data Protection legislation for the request to be valid. The request needs to be clearly described to be valid. If the ICB is unsure of the request, the requester will be contacted for further information. The ICB will contact the requester to ask for identification/authorisation if required. The types of identification/authorisation required are included in appendix 6. The ICB will keep a record of all requests received. This record will be updated and maintained by the Information Rights team.

The format that a request is received may differ from request to request. If an individual writes or speaks to the ICB and asks for access, changes or objections of any kind to the personal data the ICB is processing about them (whether perceived or actual) it should be considered and handled where appropriate as an Individual Rights request. Staff should contact the Information Rights Team who will process the request: bnssg.foi@nhs.net

Members of the public who would like to exercise their individual rights under Data Protection legislation can submit their requests to bnssg.foi@nhs.net

Subject access requests can be made by:

• The individual themselves
• Individuals requesting access on behalf of a child for whom they have parental responsibility
• A representative nominated by the individual to act their behalf such as solicitors or a relative, where there is valid consent by the individual granting this authority

- In certain situations a person granted an attorney or agent by the Court of Protection on behalf of an adult who is incapable of consent
- Requests from public bodies and law enforcement agencies (Police, criminal court etc)

ICB staff can submit a request for access to their personal data verbally or in writing. A staff subject access request application form is available from HR for staff to use if they wish.

6.2 Refusing a request

The ICB is committed to comply with SARs. There are, however, occasions when a SAR may be refused or timelines to response to a SAR extended.

If the ICB considers that a request is 'manifestly unfounded' or excessive or repetitive in nature the ICB can:

- request a "reasonable fee" to deal with the request; or
- refuse to deal with the request

In either case the ICB will outline the reasons why, their right to complain to the ICO and their ability to seek to enforce a right through a judicial remedy.

The ICO defines 'manifestly unfounded' as:

- The individual has no intention to exercise their right of access. For example, makes a request but offers to withdraw the request in return for a benefit;
- The request is malicious in intent and being used to harass an organisation. For example, the individual:
    - Explicitly states in communications that they intend to cause disruption;
    - Makes unsubstantiated accusations against specific employees which are clearly prompted by malice;
    - Targets a particular employee against whom they have a personal grudge;
    - Systematically sends different requests as part of a campaign, with the intention to cause disruption

A request may be considered 'manifestly excessive' when it is clearly or obviously unreasonable and the ICB Corporate Governance team will review whether the request is proportionate when balanced with the burden or costs involved in dealing with the request.

The ICB needs to be assured that they know the identity of the requester (or the person the request is made on behalf of) and if unsure, the ICB can ask for further information to verify an individual's identity, and in some cases their authority to request data on behalf of another individual. The ICB will be unable to acknowledge and process the request until the requested information is received. The ICB Information Rights team will close a request where this information has not been received within 60 days.

6.3 Time Limits for Compliance with Requests

BNSSG ICB has procedures in place to ensure it complies with the duty to respond to requests within the statutory timeframe of one calendar month. The deadline can be extended by a further two months if the request is complex or a number of requests have been received from the individual. The ICB will inform the requester of any delays within one month of receiving the request, explaining why the extension is necessary and agree a new deadline.

To manage the flow of information necessary to meet timescales ICB departments may be required to release information internally in advance of any required evidence being produced demonstrating consent. Evidence of consent which may include Lasting Power

of Attorney (LPA) documentation will be necessary before information is released by the ICB.

6.4 Charging a Fee

Individual rights requests are free of charge however the ICB may in some circumstances be able to charge a fee such as for a repetitive request. The reasonable fee will be based on the administrative costs of complying with the request. Where the ICB decides to charge a fee, the individual will be contacted within one calendar month to inform them of the cost. The request will not be processed until the fee has been received.

6.5 Verifying Identity

The ICB is responsible for ensuring it is reasonably satisfied of the identity of the requester and will take appropriate steps to ensure this. The ICB will only request information that is necessary to confirm identity and where teams within the ICB already hold identification/authentication documents, these will be reviewed rather than contacting the requester for these documents again.

For children and vulnerable adults the ICB Information Rights team will always seek confirmation of identity.

The ICB will let the individual know without undue delay that more information is needed from them to confirm their identity. The ICB does not need to comply with the request until the additional information has been received.

6.6 Retrieving Information

When a request is received the ICB will ask the requester to outline the services that they have used which may hold their information to determine which teams to contact for information. Where this information is not provided, the ICB will make reasonable efforts to conduct a search for the information. The ICB is not required to conduct searches that are unreasonable or disproportionate to the importance of providing access to the information.

6.7 Redaction of Third Party Data

Data subject to Subject Access Requests (SAR) often contains the personal data of another individual and in these cases the data must be reviewed before disclosure. Data Protection legislation states that an organisation does not need to comply with a SAR if doing so identifies another individual.

In most cases it is possible that the third party data can be redacted and therefore not included within the response. Where the data is the personal data of both the requester and the third party, the applicants rights of access must be weighed against the third parties right to privacy. The ICB Information Rights team will consider whether:

- The other individual has consented to the disclosure
- It is reasonable to comply with the request without the individuals consent

The ICB makes a record of all redactions and inclusions of third party data within SAR responses and as part of this the Information Rights team records any consent by the third party as well as any consideration taken as part of the reasonableness tests to include the third party personal data.

There is additional guidance provided by the ICO on the reasonableness of releasing the personal data of a healthcare professional without consent. Personal data of a health worker can be disclosed without consent, if it meets the 'health data test':

- A health record contains the information; and
- The third-party individual is a health professional who:
    - Compiled the record;
    - Contributed to the record; or
    - Was involved in the requester's diagnosis, care or treatment

A health record:

- Consists of data concerning health; and
- Is made by or on behalf of a health professional in connection with an individual's diagnosis, care or treatment

It is also considered reasonable to disclose information relating to third party personal data where:

- the requester has already received the information
- the requester already knows the information
- the information is generally available to the public

Where third party data is redacted from a response, this is communicated to the requester as part of the response letter.

6.8 Special Cases: Health Records

Special rules apply when providing right of access to information about an individual's physical or mental health or condition likely to cause serious harm to them or another person's physical or mental health or condition. In this case the information is likely to be exempt as its disclosure would be likely to cause such harm. In order to apply this exemption there needs to be an assessment undertaken by a clinician to decide whether the exemption applies. The requirement to consult does not apply if the individual has seen or knows the information concerned.

If the Information Rights team identify any such information, the ICB Caldicott Guardian will be consulted on and make the decision on any exemptions.

A further exemption applies where a SAR is made about an individual from a third party who has the right to make the request, such as a parent or someone appointed to manage the affairs of an individual who lacks capacity. Personal data is exempt from the

right to access where the individual has made it clear that they do not want the information to be disclosed to that third party.
From age 13, children are considered mature enough to make decisions regarding their data and therefore must provide consent if their parent or guardian applies for access to their data. It is for the ICB to decide whether a child is mature enough to make decisions regarding their data.

7 Access to Health Records Act 1990

Right of access to records of the deceased is provided under the Access to Health Records 1990. Under the terms of the Act, access is only granted if the requester is:

- A personal representative (the executor administrator of the deceased person's estate)
- Someone who has a claim arising from the death

Details of the documentation required to open an Access to Health Records request is outlined in Appendix 6.

It is accepted that the confidentiality obligations owed by health professionals continue after death. Where the individual requesting the data does not have a statutory right of access under the Act then the ICB would consider whether the disclosure is appropriate and lawful. The following needs to be considered in these cases:

- Preferences expressed by the deceased prior to death
- Any distress or detriment that a living individual may suffer following disclosure
- Any loss of privacy that might result
- The impact on the reputation of the deceased that might result
- The wishes of surviving family
- Length of time after death
- Whether the request is for full or partial disclosure of data

Each case must be considered on a case by case basis and should not be dismissed if the above conditions under the Act are not met.

8 Requests for information made on behalf of an Individual

Under Data Protection legislation, a rights request can be made on behalf of another individual with their consent, or from someone who has the right to make a request, such as a parent or someone appointed to manage the affairs for an individual who lacks capacity. In these cases, consent will be requested from the data subject alongside proof of identity and authority for the requester. Where the requester has the right to make a request without consent, there are a number of considerations taken by the ICB and documents requested. These have been outlined in appendix 6.

The ICB will ask third parties who hold an LPA for the data subject to provide a code for the Office of Public Guardian website which will allow the ICB to review the LPA online. It

has been requested that the code be received to provide added assurance that health data is being released legally. This applies to LPAs registered after 1st September 2019.

9 Training requirements

All staff are required to complete training using the NHS Data Security Awareness Level 1 modules provided by NHS Digital (Information Governance Training) or approved face to face training (if offered). Bespoke training on Individual's Rights will be provided to relevant teams and staff by the ICB Corporate Governance team with support from the SCW CSU Information Governance team where appropriate.

10 Equality Impact Assessment

Equality Impact Assessment Screening has been completed and is included at Appendix 1. Screening indicates that a full assessment is not required.

11 Implementation and Monitoring Compliance and Effectiveness

An implementation plan has been prepared and is attached at appendix 2. Compliance with this policy and associated legislation will be monitored by reporting to the Audit and Risk Committee, including information regarding the number of requests received, the percentage responded to within the legislated timeframe and the number of exemptions applied.

12 Countering Fraud, Bribery and Corruption

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, we have given consideration to fraud and corruption that may occur in this area and our responses to these acts during the development of this policy document.

13 References, acknowledgements and associated documents

The following related documents may be accessed through our website:

BNSSG Information Governance Policy

BNSSG Records Management Policy

BNSSG Freedom of Information Policy

BNSSG Disciplinary Policy

https://bnssgICB.nhs.uk/

The following are additional references associated with this policy:

Data Protection Act 2018

https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

General Data Protection Regulations (GDPR)

https://www.legislation.gov.uk/eur/2016/679/contents

Access to Health Records Act 1990

https://www.legislation.gov.uk/ukpga/1990/23/contents

Freedom of Information Act 2000

https://www.legislation.gov.uk/ukpga/2000/36/contents

In addition, consideration will also be given to all applicable Law concerning privacy confidentiality, the processing and sharing of personal data including:

- the Human Rights Act 1998,
- the Health and Social Care Act 2012 as amended by the Health and Social Care (Safety and Quality) Act 2015,
- the common law duty of confidentiality and
- the Privacy and Electronic Communications (EC Directive) Regulations
- the ICO Guidance for Individual Rights A guide to individual rights | ICO

14 Appendices

14.1 Equality Impact Assessment

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

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

Title of proposal: Individual Rights Policy				Date: 17/10/23
x Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (*please state)*
EHIA type:	Screening EHIA x	Full EHIA ☐	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes ☐ No x EIA undertaken on previous policy version
Is the policy under:	Development ☐	Implementation ☐	Review x	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? All BNSSG ICB employees and members of the public				
Lead person(s) completing this assessment: Lucy Powell				
Lead person job title(s) and service area: Corporate Support Officer				

Briefly describe the proposal

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

This is an update to the current Individual Rights policy in line with best practice and national guidance. The aim is to ensure that all ICB employees understand the arrangements that BNSSG ICB has in place for the management of individual rights requests. This policy also outlines how members of the public and ICB staff can exercise their individual rights, including the information required by the ICB to process requests.
Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to

reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:
This policy will not directly impact Health Inequalities. However, the ICB does not undertake equality monitoring of requesters and therefore there is no data which shows whether those with protected characteristics are more/less likely to request their data.
Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.
N/A The policy describes the ICB's statutory and legal responsibilities and there had been no engagement with patients/members of the public in preparing this policy beyond that undertaken by the government as part of the legislative process
Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.
The policy has been written with a view to be accessible to all individuals and can be requested in other formats as per ICB processes. The policy has been included on the ICB website, and further information about requests has been included on the Contact Us webpage. Additional information for staff is on the intranet and sent out regularly through the newsletter.

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

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

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

Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: There is no positive impact on those holding protected characteristics. The policy outlines the arrangements that BNSSG ICB has in place for the management of individual rights requests. This policy also outlines how members of the public and ICB staff can exercise their individual rights, and the policy outlines the information required by the ICB to process requests. As per legislation, individual requests can be requested in writing or verbally to anyone in the organisation. The policy also contains the provision for third parties to request and support individuals to receive their data if they are unable to do so themselves. The Policy also includes promotion of the right for individuals not to be subject to automated decision making and profiling. This protects individuals from organisations carrying out solely automated decision-making that has legal or similarly significant effects.				
Negative Impact				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: It is not believed that the content of the policy would have a direct negative impact on those holding protected characteristics. The ICB has a duty to provide the policy and information requested in various formats as required to ensure equitable access to the information within the policy and equitable access to information. (you can share further details and mitigations below in 2.2)				
No Effect				
Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable' This EHIA is being undertaken as part of the review process for a current ICB policy. There have been no significant amendments made to the processes already in place.				

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

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact

N/A		

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

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

To eliminating discrimination, harassment and victimisation.	Positive	X
	Negative	☐
	No effect	☐
Please describe: This policy outlines the individual rights which can be exercised by both staff and members of the public. The rights provide people with access to their personal data, as well as the right to correct data, erase data, restrict processing and the right to object. These rights support the understanding of how the ICB uses and processes personal data which supports individuals to have more control over and understanding of their data. The rights outlined in the policy also encourage transparency and staff are aware that any personal data may be requested and provided to the individual.		

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	X
	Negative	☐
	No effect	☐
Please describe: The policy applies to all the individuals equally. The aim is to ensure that everyone understands the arrangements that BNSSG ICB has in place for the management of individual rights requests and provides clear guidance to staff who may have to process requests and members of the public who may want to request information. The UK GDPR outlines that requests can be made verbally or in writing.		

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

Action Plan

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

Action	Timeframe	Success Measure	Lead

Senior support and promotion of the policy	From ICB Board approval on the 1st February 2024	ICB Board approval and subsequent promotion at staff meetings and through staff newsletters	RH/LP
Promotion of individual rights on the ICB website	Ongoing	Individual rights requests continue to be received through the contact us page on the webpage	LP

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

As part of the quarterly promotion of the policy and as part of the quarterly reporting to the Audit and Risk Committee

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

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

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

The policy is for all individuals including all ICB staff and members of the public. The arrangements outlined are a legal requirement. The EHIA has highlighted the importance of promotion of the policy.

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

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

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

Equality and Inclusion Team Signature:
Date:

Equality Delivery System 2022

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

Domain 1 – Commissioned & Provided services

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

Domain 2 – Workforce health and wellbeing

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

Domain 3 – Inclusive Leadership

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

The policy aims to provide clear guidance to staff on the responsibilities for managing individual rights requests. Having a clear policy in place with support from the appropriate teams supports all three domains. Domain 1 as individual rights support people to understand their health and the NHS. Domain 2 as staff are supported to make individual rights requests and the policy provides clear guidance to support staff to action individual rights requests. Domain 3 as the policy provides a framework for Board/Committee members and senior managers to monitor impact and risk.

14.2 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	Chief of Staff	1st Feb 2024	1st Feb 2024	Staff time, Board members time
Executive Directors	Ensure awareness of responsibilities of ICB process to ensure compliance. This includes the requirement of Director approval processes	Email confirmation of policy implementation to Executive Directors highlighting sign off procedures for requests	Corporate Support Officer	2nd Feb 2024	2nd Feb 2024	Staff time, Executive Director time
Executive Director PAs	Ensure awareness of ICB process and Executive Director approval role in process	Email confirmation of policy implementation to Executive Directors highlighting sign off procedures for requests to be copied into PAs	Corporate Support Officer	2nd Feb 2024	2nd Feb 2024	Staff time
All Staff	Ensure awareness of ICB processes and procedures	Reviewed policy to be placed on website Information about the policy and ICB process to be placed on the Hub and announced at staff meetings Information about the policy and ICB process to be communicated through internal newsletter Data Security Awareness training module to be completed by all staff	Corporate Support Officer	1st Feb 2024	Ongoing	Staff time IG training module

14.3 The Individual Rights in more detail

THE RIGHT TO BE INFORMED (GDPR ARTICLES 12, 13 AND 14)

The ICB must provide individuals with information including (but not limited to):

- A description of the information
- The purposes the information is used for
- Our retention periods for that personal data
- The disclosures that are made or might be made

This is called 'privacy information' or 'Fair Processing Information' and we must provide privacy information to individuals at the time we collect personal data from them. If we obtain personal data from other sources, we must provide individuals with privacy information within a reasonable period of obtaining the data and no later than one month.

How and what information should be provided
The information we provide to people must be

- concise,
- transparent,
- intelligible,
- easily accessible, and
- it must use clear and plain language

We put our Privacy Notice on our website. How we use your information - NHS BNSSG ICB

We review on an annual basis, and where necessary, update our privacy information. We must bring any new uses of an individual's personal data to their attention before we start the processing.

THE RIGHT OF ACCESS BY THE DATA SUBJECT (SUBJECT ACCESS REQUEST – GDPR ARTICLE 15)

What is the right of access?
The right of access, commonly referred to as subject access, gives individuals the right to obtain a copy of their personal data as well as other supplementary information.

What is an individual entitled to?
Individuals have the right to obtain the following from the ICB:

- confirmation that we are processing their personal data;
- a copy of their personal data; and
- other supplementary information such as
  - the purposes of processing;

- the categories of personal data concerned;
- the recipients or categories of recipient we disclose personal data to;
- retention period for storing personal data or, where this is not possible, our criteria for determining how long we will store it;
- the existence of their right to request rectification, erasure or restriction or to object to such processing;
- the right to lodge a complaint with the ICO or another supervisory authority;
- information about the source of the data, where it was not obtained directly from the individual;
- the existence of automated decision-making (including profiling); and
- the safeguards we provide if we transfer personal data to a third country or international organisation

Much of this supplementary information is provided in our privacy notice.

What about requests made on behalf of others?
Data Protection legislation does not prevent an individual making a subject access request via a third party. Often, this will be a solicitor acting on behalf of a client, but it could simply be that an individual feels comfortable allowing someone else to act for them. In these cases, we need to be satisfied that the third party making the request is entitled to act on behalf of the individual, but it is the third party's responsibility to provide evidence of this entitlement. This might be a written authority to make the request or it might be a more general power of attorney if the individual lacks mental capacity.

What about the records of deceased individuals?
The Data Protection Legislation only relates to living individuals. However requests for access to personal data relating to deceased individuals can also be made under another piece of legislation – the Access to Health Records Act (AHRA) 1990. The same rules apply regarding 'fees' etc. under Data Protection legislation; however requests under the AHRA must be completed with 40 calendar days instead of 1 calendar month. The request must still be logged and actioned without undue delay.

THE RIGHT TO RECTIFICATION (GDPR ARTICLE 16 AND 19)

Data Protection legislation includes a right for individuals to have inaccurate personal data rectified, or completed if it is incomplete although this will depend on the purposes for the processing. This may involve providing a supplementary statement to the incomplete data.

This right has close links to the accuracy principle of the GDPR (Article 5(1) (d)). However, although we may have already taken steps to ensure that the personal data was accurate when we obtained it; this right imposes a specific obligation to reconsider the accuracy upon request.

What do we need to do?
If we receive a request for rectification we should take reasonable steps to check that the data is accurate and to rectify the data if necessary. We should take into account the arguments and evidence provided by the individual.

THE RIGHT TO ERASURE (GDPR ARTICLE 17 AND 19)

Individuals have the right to have their personal data erased if:

- the personal data is no longer necessary for the purpose which we originally collected or processed it for;
- we are relying on consent as our lawful basis for holding the data, and the individual withdraws their consent;
- we are relying on legitimate interests as our basis for processing, the individual objects to the processing of their data, and there is no overriding legitimate interest to continue this processing;
- we are processing the personal data for direct marketing purposes and the individual objects to that processing;
- we have processed the personal data unlawfully (i.e. in breach of the lawfulness requirement of the 1st principle);
- we have to do it to comply with a legal obligation; or
- we have processed the personal data to offer information society services to a child

There is an emphasis on the right to have personal data erased if the request relates to data collected from children. This reflects the enhanced protection of children's information, especially in online environments, under the GDPR. For further details about the right to erasure and children's personal data please read the ICO guidance on children's privacy.

RIGHT TO RESTRICT PROCESSING (GDPR ARTICLE 18 AND 19)

Individuals have the right to request the restriction or suppression of their personal data. When processing is restricted, we are permitted to store the personal data, but not use it.

This right has close links to the right to rectification (Article 16) and the right to object (Article 21).

Individuals have the right to restrict the processing of their personal data where they have a particular reason for wanting the restriction. This may be because they have issues with the content of the information we hold or how we have processed their data. In most cases we will not be required to restrict an individual's personal data indefinitely, but we will need to have the restriction in place for a certain period of time.

THE RIGHT TO DATA PORTABILITY (GDPR ARTICLE 20)

Individuals have the right to obtain and reuse their personal data for their own purposes across different services. It allows them to move copy or transfer personal data easily from one IT environment to another in a safe and secure way, without hindrance to usability. Some organisations in the UK already offer data portability through midata and similar initiatives which allow individuals to view access and use their personal consumption and transaction data in a way that is portable and safe. It enables consumers to take advantage of applications and services which can use this data to find them a better deal or help them understand their spending habits.

THE RIGHT TO OBJECT (GDPR ARTICLE 21)

An individual has the right to object to

- processing based on legitimate interests or the performance of a task in the public interest/exercise of official authority (including profiling);
- direct marketing (including profiling); and
- processing for purposes of scientific/historical research and statistics

RIGHT NOT TO BE SUBJECT TO AUTOMATED DECISION MAKING AND PROFILING (GDPR ARTICLE 22)

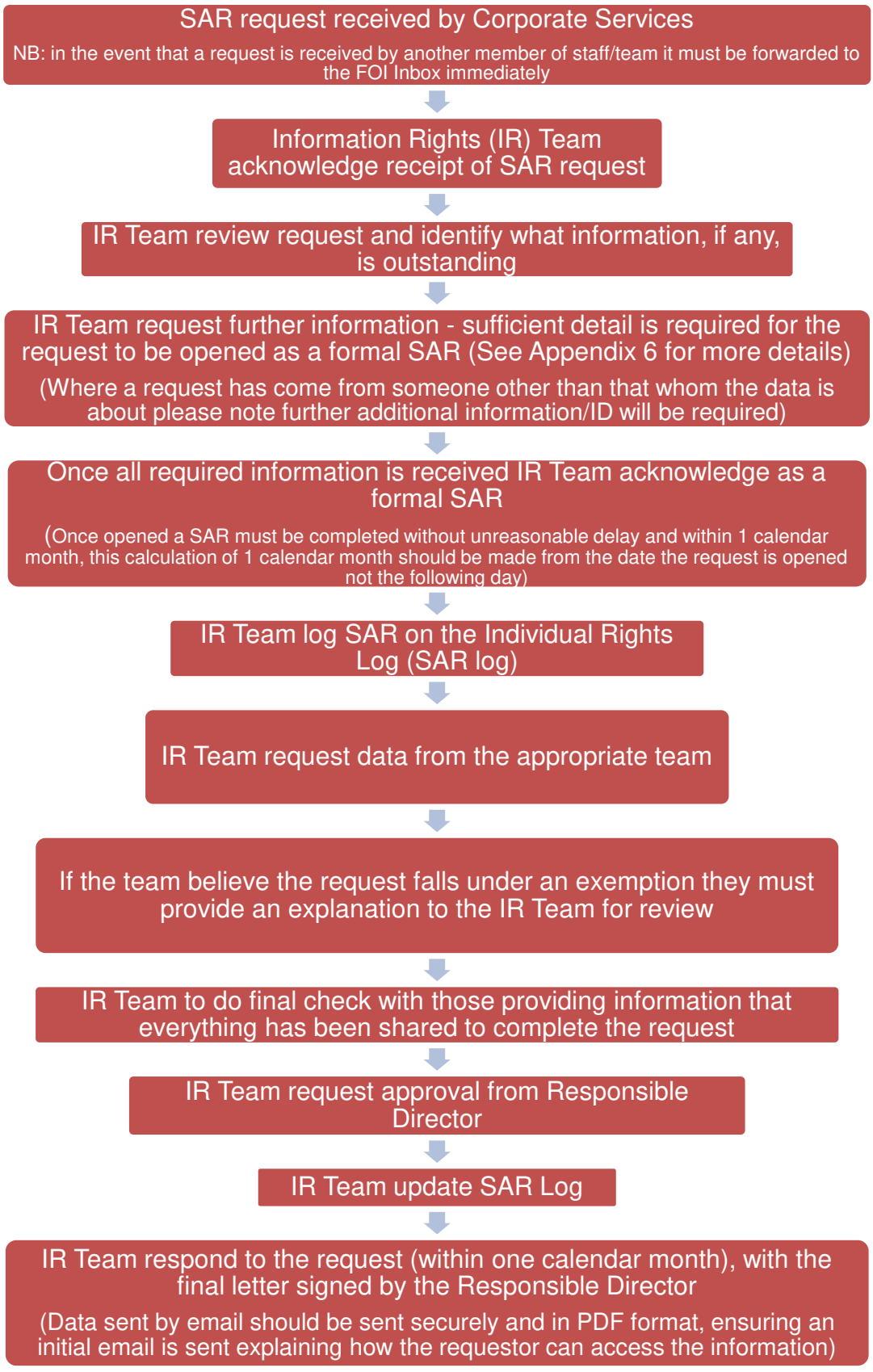
The GDPR applies to all automated individual decision-making and profiling. Article 22 of the GDPR has additional rules to protect individuals if we are carrying out solely automated decision-making that has legal or similarly significant effects on them. The processing is defined as follows:

- **Automated individual decision-making** (making a decision solely by automated means without any human involvement).

Examples include an online decision to award a loan; or a recruitment aptitude test which uses pre-programmed algorithms and criteria. Automated individual decision-making does not have to involve profiling, although it often will do.

- **Profiling** (automated processing of personal data to evaluate certain things about an individual) and includes any form of automated processing of personal data consisting of the use of personal data to evaluate certain personal aspects relating to a natural person, in particular to analyse or predict aspects concerning that natural person's performance at work, economic situation, health, personal preferences, interests, reliability, behaviour, location or movements.

14.4 Right to Access (Subject Access Request) Procedure



14.5 Right to Access (Subject Access Request) Internal Review Procedure

14.6 Consent Procedures

Under the Data Protection Act 2018, the act of obtaining consent must not be burdensome for the requester and where possible, the organisation must utilise consent documentation already received through another team rather than ask again. However, the organisation must assure themselves that the appropriate documentation has been received before opening the request.

The Information Rights team have processes in place dependent on the type of information requested and these are outlined below. In all cases, the team undertake sense checks on email addresses and home addresses and check these with any previous communications as well as against the data received to ensure that email and home addresses are consistent.

Request for own information
Where someone has requested access to their own records the following is requested:

- Name, address and postcode
- The service used which will hold the records
- Any relevant case numbers
- A copy of ID (passport, driving license or birth certificate)
- A copy of proof of address (utility or phone bill from the last 3 months)

The Information Rights team can open a request without proof of address but will not send any information via post without this.

Request for own information (Child)
Where a child requests their own information, the Information Rights team needs to consider the maturity of the child, the guidance indicates that children over the age of 13 are considered mature enough to request and receive their own records but there will be exceptions. The Information Rights team would request the following information:

- Name, address and postcode
- The service used which will hold the records
- Any relevant case numbers
- A copy of ID (passport, student card etc.)
- A copy of ID containing birth date (birth certificate etc.)

If proof of address was required in order to send the response via post then the team would work with the requester to find a suitable solution for this. These requests would also be further discussed with the team holding the records to understand whether there are any safeguarding issues or concerns.

Request for third party information from a solicitor
Where a solicitor has requested information regarding a third party the following is requested:

- Name, address and postcode
- The service used which will hold the records
- Any relevant case numbers
- Form of Authority signed by the third party

Request for third party information (of a child) from an individual
Where someone has requested information regarding a child the Information Rights team would request the following information:

- Name, address and postcode
- The service used which will hold the records
- Any relevant case numbers
- Proof of relationship to child (birth certificate)
- A copy of ID (passport, driving license or birth certificate)
- A copy of proof of address (utility or phone bill from the last 3 months)
- Dependent on the age of the child, consent from them that the individual could access their records.

These requests will also be further discussed with the team holding the records to understand whether there are any safeguarding issues or concerns.

Request for third party information from an individual
Where someone has requested the information of a third party the following is requested:

- Name, address and postcode
- The service used which will hold the records
- Any relevant case numbers
- A copy of ID (passport, driving license or birth certificate)
- A copy of proof of address (utility or phone bill from the last 3 months)
- Where the third party has mental capacity, consent from the third party must be obtained to include:
    - Name, address and postcode
    - A copy of ID (passport, driving license or birth certificate)
    - Express signed consent for the above individual to receive the records
- Where the third party lacks mental capacity the following is also requested:
    - Relationship to third party
    - Any Lasting Power of Attorney (LPA) documentation (Health and Welfare or Property and Affairs)
    - A copy of the access code to check the status of the LPA on the Office of Public Guardian website (For LPA's issued after 1st September 2019).

These requests will be further discussed with the team holding the records to understand whether there are any safeguarding concerns or concerns relating to the individual receiving the records.

It has been agreed that where a third party is requesting data, the consent documentation received will be sent to the team who hold the information so that they can be assured that the consent is in place prior to sending the data to the Information Rights team.

For all third party requests made, following review of the data should there be any indication that the data subject did not wish for part or all of their data to be shared with either anyone or the named requester specifically then the data would not be shared.

Request for records of the deceased

Requests for records of the deceased are processed under the Access to Health Records Act 1990. The Act contains set criteria under which records of the deceased can be released; access is restricted to the patient's personal representative (executor of the will or the administrator of the estate) or any person who may have a claim arising out of the patient's death. Where someone has requested this information the following is requested:

- Name, address and postcode
- The service used which will hold the records
- A copy of ID (passport, driving license or birth certificate)
- A copy of proof of address (utility or phone bill from the last 3 months)
- Where the request is made as a personal representative:
    - Sealed Grant of Probate
    - Valid Will
    - Letters of Administration
- Where there is a claim arising from the patient's death:
    - Evidence of the claim (Solicitors letter or Valid Will)
    - Evidence of relationship with the deceased

It has been agreed that where a third party is requesting data, the consent documentation received will be sent to the team who hold the information so that they can be assured that the consent is in place prior to sending the data to the Information Rights team.

For all third party requests made, following review of the data should there be any indication that the data subject did not wish for part or all of their data to be shared with either anyone or the named requester specifically then the data would not be shared.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Records Management 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:	7
Responsible Executive Director:	Shane Devlin, Chief Executive
Author and Job Title:	Sarah Carr, Corporate Secretary and Lucy Powell, Corporate Support Officer
Date Approved:	1 July 2022 (as part of the Core Policies approval)
Approved by:	ICB Board
Date of next review:	January 2024 (Every two years)

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 compliant with the Freedom of Information Act 2000 and the Data Protection Act 2018 and the UK General Data Protection Regulation 2018 (the Data Protection legislation). The policy also aligns to the Records Management Code of Practice 2023.
Has legal advice been sought?	No	Specialist advice has been taken from Information Governance Advisors. Information Governance is represented on the Corporate Policy Review Group.

	Yes/ No/NA	Supporting information
Has HR been consulted?	Yes	HR is represented on the Corporate Policy Review Group.
Have training issues been addressed?	Yes	Training is referenced in the policy. The ICB's Information Governance training includes Records Management; this training is mandatory and annual. Training on ICB specific procedures as set out in the appendix will be tailored to relevant staff groups and will be at least annual.
Are there other HR related issues that need to be considered?	No	There are no HR issues raised by the policy
Has the policy been reviewed by Staff Partnership Forum?	N/A	As there are no HR issues the policy has not been reviewed by the Staff Partnership Forum
Are there financial issues and have they been addressed?	No	There are no financial issues. Physical records archive budget is included within corporate costs
What engagement has there been with patients/members of the public in preparing this policy?	N/A	This policy describes a statutory responsibility and there has been no engagement with patients/members of the public beyond that undertaken by government as part of the legislative process
Are there linked policies and procedures?	Yes	Associated policies and procedures are recorded in the policy
Has the lead Executive Director approved the policy?	Yes	Shane Devlin, Chief Executive
Which Committees have assured the policy?		Corporate Policy Review Group and Audit and Risk Committee.

	Yes/ No/NA	Supporting information
		Both provided feedback which has been included.
Has an implementation plan been provided?	Yes	See Appendix 2
How will the policy be shared with staff, patients and the public?	Yes	The policy will be published on the ICB website and intranet and will be featured in the internal news communication.
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?	No	No DPIA required
Have Data Protection implications have been considered?	Yes	The Policy is compliant with the Data Protection Act 2018 and the UK General Data Protection Regulation 2018 (Data Protection legislation)

Table of Contents

Records Management Policy

1 Introduction

NHS Bristol, North Somerset and South Gloucestershire ICB (BNSSG ICB) is committed to a systematic and planned approach to the management of its records, throughout their life cycle from creation to through to their ultimate disposal. This approach is in line with the "Records Management Code of Practice for Health and Care Records 2023 V5" published by NHS England. The code of practice is a guide to the required standards of practice in the management of records and is relevant to all organisations who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

1.1 BNSSG ICB Values

Adoption of this approach by the organisation and its staff supports the ICB's values including the commitment to do the right thing.

2 Purpose and scope

The purpose of this policy is to provide a framework which enables BNSSG ICB to set out its records management arrangements for both its digital and paper records. This policy ensures that BNSSG ICB is able to comply with the legal and professional obligations set out for records and in particular:

- Public Records Act 1958
- UK GDPR and Data Protection Act 2018
- Access to Health Records 1990
- Freedom of Information Act 2000
- Regulation of Investigatory Powers Act 2000
- Records Management Code of Practice for Health and Care Records 2023 (v5)
- Professional Obligations (GMC, NMC)

Failure to comply with the regulations could result in reputational damage to BNSSG ICB and carries significant financial penalties in line with ICO standards.

This policy applies to all staff, regardless of whether they hold a corporate or clinical role and includes:

- Individuals on the ICB Board and Committees

- Employees including those seconded to BNSSG ICB
- Third parties acting on BNSSG ICB's behalf (including commissioning support and shared services)
- Agency, locum and other temporary staff engaged by BNSSG ICB
- Students, including those on work experience, trainees and apprentices.

3 Duties – legal framework for this policy

The Public Records Act 1958 is the principal legislation relating to public records. This Act outlines the responsibility of employees for any records that they create or use in the course of their duties. This includes records controlled by NHS organisations under contractual or other joint arrangements, or as inherited legacy records of defunct NHS organisations.

The Freedom of Information Act 2000 governs access to and management of public records. The FOI Act was designed to create transparency and provide the public with the right to access information. This right is only as effective if the organisation practices good record management processes. Records should be managed in line with the code of practice on record keeping under section 46 of the FOI Act.

UK GDPR and The Data Protection Act 2018 are the principal legislations governing how records and information relating to personal data is managed.

The Health and Social Care Act 2012 requires that health and care providers must securely maintain accurate, complete and detailed records for patients or service users and employment of staff.

4 Responsibilities and Accountabilities

The Chief Executive through the Executive Team is accountable for Records Management within BNSSG ICB and reporting any breaches.

The Chief Transformation and Digital Information Officer, who is the Senior Information Risk Officer (SIRO) for the ICB, has the lead responsibility for Records Management and for ensuring this policy is implemented and becomes an active document within BNSSG ICB.

Executive Directors are responsible for ensuring that this policy is implemented in their individual directorates. They will nominate Information Asset Owners/Information Asset Administrators who will liaise with the Corporate Secretary or their nominated deputy, regarding the management of records in the directorates.

The Corporate Secretary has operational responsibility for the Records Management Policy and is responsible for the overall development and maintenance of the

Records Management Framework and for ensuring this policy complies with legal and regulatory edicts. The Corporate Secretary is responsible for developing and supporting a culture of high quality records management practice across BNSSG ICB to deliver associated organisational benefits. The Corporate Secretary is also responsible for off site physical storage arrangements and associated contract management. Reports on off site record storage will be shared with the Information Governance Group routinely.

BNSSG ICB has a service level agreement with the Information Governance team, part of NHS South, Central and West Commissioning Support Unit, which has responsibility for ensuring that national guidelines are communicated, implemented and local guidelines and protocols on the handling and management of confidential personal data are in place. This will involve joint working with SCW IT and the servers/cloud where many records are stored.

The Corporate Support Officer provides operational management support for records management, arrangements for archiving and the maintenance of the destruction and retention schedule.

Information Asset Owners are responsible for ensuring the asset they 'own' is managed in accordance with this policy, and also for maintaining adequate records within the context, both legal and regulatory, of the business area the asset operates. In doing this they will be responsible for:

- Reviewing/adopting tracking and registration systems for appropriate records
- Ensuring that clinical records are bound and stored so that loss of documents is minimised
- Ensuring that semi-current records are archived in appropriate, secure areas
- Ensuring that there is a mechanism for identifying records which must be kept for permanent preservation.
- Ensuring a contingency or business continuity plan is in place to provide protection for records

Information Asset Administrators are responsible for assisting the Information Asset Owners in the management of the records that they 'own'.

Line Managers are responsible for ensuring that staff undertake any required training and are aware of requirements associated with Records Management processes. They are also responsible for ensuring that leavers undertake the necessary archiving and handover of records before leaving the ICB/team.

The BNSSG ICB Caldicott Guardian is responsible for approving and ensuring that national and local guidelines and protocols on the handling and management of confidential personal data are in place.

All staff are responsible for keeping a record of any significant business transaction conducted as part of their duties for BNSSG ICB. The record should be saved appropriately, a retention period assigned and access controls applied if necessary. Staff also have a responsibility to contribute to the upkeep of Information Asset Registers and Data Flow Map.

The Freedom of Information Act makes it an offence to alter, deface, block, erase, destroy or conceal any record held by BNSSG ICB, with the intention of preventing disclosure to all or part of the information that an applicant is entitled to. Penalties can be imposed on both BNSSG ICB and employees for non-compliance with the Freedom of Information Act and Data Protection Legislation.

Staff must only access records that are appropriate to their role and must not access records which would create a conflict of interest.

Staff are expected to manage records about individuals in accordance with this policy irrespective of their race, disability, gender, age, sexual orientation, religion or belief, or socio-economic status.

Individuals leaving BNSSG ICB are responsible for ensuring that the necessary arrangements have been undertaken in relation to saving key documents sensibly and ensuring that emails and attachments have been saved or deleted as required and in accordance with the retention schedule.

Where BNSSG ICB has contracts in place with other organisations it will, through the NHS Standard Contract, ensure a requirement for correct governance processes to be in place for the management and disposal of records.

5 Definitions/explanations of terms used

A record is defined as ‘Information created, received, and maintained as evidence as an asset by an organisation or person, in pursuance of legal obligations or in the transaction of business’. This Policy covers both paper and digital records.

The Data Protection Act 2018 defines a health record as a record which:

- Consists of data concerning health
- Has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates

All records provide evidence of the activities of BNSSG ICB’s functions and policies. Records have strict compliance requirements regarding their retention, access and destruction. A record can be in various formats including email, paper, digital, social media, videos and telephone messages.

Records are created to provide information about what happened, what was decided, and how to do things. Records are a valuable resource because of the

information they contain. High-quality information underpins the delivery of high-quality evidence-based healthcare. Information has most value when it is accurate, up-to-date and accessible when it is needed. An effective records management function ensures that information is properly managed and is available whenever and wherever there is a justified need for that information, and in whatever media it is required.

Records management is about controlling records within a framework made up of policies, standard operating procedures, systems, processes and behaviours. Together they ensure that reliable evidence of actions and decisions is kept and remains available for reference and use when needed, and that the organisation benefits from effective management of one of its key assets, its records.

A records retention schedule sets out the classes of records which BNSSG ICB retains and the length of time these are retained before a final disposition action is taken (i.e. destruction or transfer to an archive). It applies to information regardless of its format or the media in which it is created or might be held. All staff members should be familiar with this records retention schedule and apply retention periods to records. The BNSSG ICB retention schedule (Appendix 5) is based on and complies with the Records Management Code of Practice for Health and Social Care 2023 retention schedule.

6 Registration of Records

All information that has a clinical relevance or contains personal data should be logged/registered in accordance with the appropriate record keeping system.

Administrative records are not normally registered. If the category of record merits registration, formal protocols will be issued following decisions made by Executive Directors and/or the Caldicott Guardian/Information Governance team.

Employees are responsible for ensuring that the best practice principles of logging are adhered to:

- The file title must be unique
- The reference identity assigned to each file must be unique
- Both of the above must be relevant to and easily understood by all users
- Details should be recorded both on the file cover and in the register.

If appropriate, a tracking system must be in place. As a minimum it should include

- Patient identifier
- A description of the item e.g. the file title
- The name of the person holding the record
- The date record taken from file
- The name of the person completing the form

Under Data Protection Legislation organisations are required to complete Data Protection Impact Assessments (DPIAs) where there is a new use or change in the use of personal data and there is a potential high risk to privacy. This can include the establishment of a new records management function for those particular records. The ICB Data Protection Officer and SCW CSU IG will be able to provide further advice.

7 Record naming and maintenance

Staff should refrain from naming folders or files with their own name unless the folder or file contains records that are biographical in nature about that individual, for example, personnel records.

Version Control is the management of multiple revisions to the same document. Where records contain personal data, special category data or corporate sensitive information it is a legal requirement that such data is stored securely.

Good record keeping should prevent record duplication. Staff members should ensure team members have not previously created a record prior to initiating a new document and regularly communicate about the correct version and location of saved material.

Good record keeping requires information to be recorded at the same time an event has occurred or as soon as possible afterwards.

Staff should ensure their handwriting is legible when making entries on paper records.

Staff should ensure records are relevant including their opinions about individuals, as the individual has the right to gain access to their records via a Subject Access Request under UK Data Protection Legislation.

Electronic documents and records should be maintained in accordance with this Records Management Policy. The movement and location of paper records should be controlled to ensure that a record can be easily retrieved at any time. This will enable the original record to be traced and located if required and must be held in a shared location. Paper file storage must also be safe from unauthorised access and meet fire regulations.

Information Asset Owners should ensure they have a contingency or business continuity plan to provide protection for records which are vital to the continued functioning of the ICB.

8 Record Access

There are a range of statutory provisions that give individuals the right of access to information created or held by BNSSG ICB. Data Protection Legislation allows individuals to find out what personal data is held about them. The Freedom of Information Act 2000 gives the public the right of access to information held by public authorities. Any requests for information should be sent to the Information Rights Team via the shared inbox: bnssg.foi@nhs.net

Should a request for information be received verbally, this should be recorded in writing and sent to the Information Rights Team for processing. The Information Rights Team will undertake any redactions required prior to release.

9 Record disclosure

There are a range of statutory provisions that limit, prohibit or set conditions in respect of the disclosure of records to third parties, and similarly a range of provisions that require or permit disclosure. Only certain staff members have the authority, which is dictated by their role, to disclose records. Staff with this authority should make a record of any copies of records they have disclosed, and to whom.

Information requests received outside of business as usual should be sent to the ICB Information Rights team: bnssg.foi@nhs.net who will process the request accordingly.

10 Record retention and destruction

Records should only be destroyed in accordance with the BNSSG ICB Records Retention and Disposal Schedule. It can be a personal criminal offence to destroy requested information under either the Data Protection Act (Section 173) or the Freedom of Information Act (Section 77). BNSSG ICB needs to be able to demonstrate clearly that records destruction has taken place in accordance with proper retention procedures.

The Code of Practice on Records Management, issued under Section 46 of the Freedom of Information Act 2000, requires that records disposal 'is undertaken in accordance with clearly established policies that have been formally adopted'. The BNSSG ICB Records Retention and Disposal Schedule is a key component of the ICB's information compliance and allows a standardised approach to retention and disposal.

The recommended retention periods given on the BNSSG ICB Records Retention and Disposal Schedule apply to the official or master copy of the records. Any duplicates or local copies made for working purposes should be kept for as short a period of time as possible. Duplication should be avoided unless absolutely

necessary. It should be clear who is responsible for retaining the master version of a record and copies should be clearly marked as such to avoid confusion.

Some types of records which may be created and kept locally are the responsibility of the local department, but may be found under a different function on the retention schedule: for example where recruitment is carried out by departments, the department shall be responsible for ensuring the disposal of the records relating to unsuccessful candidate, this type of record is listed under Human Resources in the retention schedule.

Records selected for archiving in line with the ICB retention scheme and no longer in regular use by BNSSG ICB should be transferred to the ICB's archive provider institution. When files are no longer current and removed into storage, the details must be entered on the Retention and Disposal of Records Schedule, which is attached at Appendix 3 and kept by the Directorate. A copy should be sent to the Corporate Support Officer who will hold a master copy of the organisation wide schedule.

Preparation of records for storage will be undertaken using the protocol outlined in Appendix 4.

Details of the destruction of these records must be entered on the Retention and Disposal Schedule and a copy will also be kept by the Corporate Support Officer.

If a record due for destruction is known to be the subject of a request for information or potential legal action, destruction should be delayed until disclosure has taken place or, if the organisation has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information Act have been exhausted or the legal process completed.

11 Electronic Documents

It is important that staff save a copy of any key emails and/or attachments relating to their work in an appropriate folder on the network drive. This allows the ICB to retain a full record of any discussions or decisions that have taken place. An appropriate naming convention should be used, documented and communicated to relevant users of the information asset. As a guide should include – Date in YYYYMMDD format, followed by the project or work name, email topic, and if there are multiple emails with the same date, a (1), (2) etc. to show which comes first.

Individuals leaving BNSSG ICB are responsible for ensuring that the necessary arrangements have been undertaken in relation to saving key documents sensibly and ensuring that emails and attachments have been saved or deleted as required and in accordance with the retention schedule.

Staff are expected to review their mail archiving systems on a regular basis which will in turn free up inbox space. The ICB will only support the funding of additional inbox space in special circumstances. Where this is granted it should not be relied upon for archiving purposes and does not replace any requirement for staff to save key emails on the network drive. Agreement of extension to inbox space will be subject to need with assurance that archiving responsibilities have properly been fulfilled and may be affected by future IT developments such as N365.

The guidance in this document around retention also applies to electronic documents and guidance around the destruction of electronic records can be found in the SCW CSU ICT Disposal policy.

12 Public Inquiries

Public inquiries rely on records as evidence. Inquiries can require huge amounts of records in a variety of formats. When an inquiry is conducted, the Inquiry Team will outline which records they are interested in reviewing. If the ICB holds the records requested these must be provided. The ICB must consider when Public Inquiries are announced, what type of records may be required and retain these. Contact the team responsible for collating Inquiry records for advice before deleting.

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, and also via training sessions with all members of BNSSG ICB staff through mandatory Information Governance related training that is completed annually.

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 through exception reporting together with periodic reviews by Internal Audit and annually through the Data Security and Protection Toolkit.

16 Countering Fraud, Bribery and Corruption

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, we have given consideration to fraud and corruption that may occur in this area and our responses to these acts during the development of this policy document.

ICB employees should be aware of the consequences of using social media platforms to post content which conflicts with information provided to the ICB, including their health and fitness to work, and secondary employment (for example, posting evidence of undertaking unapproved secondary employment whilst receiving sick pay from the ICB). If an instance such as this occurs, an employee may be subject to criminal or disciplinary proceedings, which could result in dismissal.

17 References, acknowledgements and associated documents

The following related documents may be accessed through the ICB website:

https://bnssgICB.nhs.uk/

BNSSG Information Governance Policy

BNSSG Freedom of Information Policy

BNSSG Individual Rights Policy

Information Security Policy

ICT Disposal Policy

The following related documents may be accessed through the links provided:

NHS England Records Management Code of Practice August 2023

Records Management Code of Practice - NHS Transformation Directorate (england.nhs.uk)

UK General Data Protection Regulation (GDPR)

https://www.legislation.gov.uk/eur/2016/679/contents

Freedom of Information Act 2000

https://www.legislation.gov.uk/ukpga/2000/36/contents

Data Protection Act 2018

https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Access to Health Records Act 1990

https://www.legislation.gov.uk/ukpga/1990/23/contents

Freedom of Information Act Section 46 Code of Practice

section-46-code-of-practice-records-management-foia-and-eir.pdf (ico.org.uk)

18 Appendices

Appendix 1 Equality Impact Assessment

Appendix 2 Implementation plan

Appendix 3 Retention and Disposal of Records Log (Archived Records Log)

Appendix 4 Archive Protocol

Appendix 5 ICB retention schedule

18.1 Equality Impact Assessment

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

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

Title of proposal: Records Management Policy				Date: 19/10/23
x Policy	☐ Strategy	☐ Service	☐ Function	☐ Other (*please state)*
EHIA type:	Screening EHIA x	Full EHIA ☐	HEAT in progress/ completed ☐	Has an EHIA been previously undertaken? Yes ☐ No x EIA undertaken on previous policy version
Is the policy under:	Development ☐	Implementation ☐	Review x	
Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? All BNSSG ICB employees				
Lead person(s) completing this assessment: Lucy Powell				
Lead person job title(s) and service area: Corporate Support Officer				

Briefly describe the proposal

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

This is an update to the current Records Management policy in line with best practice and national guidance. The aim is to ensure that all employees understand the arrangements that BNSSG ICB has in place for management of records. This policy aims to provide clear guidance in relation to the actions required by employees to manage BNSSG ICB records, throughout their life cycle from creation to disposal.
Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the HEAT tool to support summarising key issues, this can help to systematically evaluate HI:
This policy will not directly impact Health Inequalities
Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.
N/A The policy describes the ICB's statutory responsibilities which support compliance with the legal and professional obligations set out for records. There has been no engagement with patients/members of the public in preparing this policy beyond that undertaken by NHS England and the Government as part of other legislative processes
Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. For more information on AIS please refer to and NHS England » Accessible Information Standard and AIS at NBT - YouTube.
The policy has been written with a view to be accessible to employees. Additional information will also be provided on the Hub and the Corporate Governance team will be available to support as required.

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

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

Positive Impact:				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation
☐ Age	☐ Pregnancy & Maternity	☐ Marriage & Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: There is no positive impact on those holding protected characteristics. The policy outlines the arrangements that BNSSG ICB has in place for the management of records. This policy aims to provide clear guidance in relation to the actions required to comply. The policy applies to all employees and good records management has a positive impact on all staff, who will be able to work more efficiently, and all members of the public, who will be able to request and receive records as needed.				
Negative Impact				
☐ Sex	☐ Race	☐ Disability	☐ Religion & Belief	☐ Sexual Orientation

☐ Age	☐ Pregnancy & Maternity	☐ Marriage and Civil Partnership	☐ Gender Reassignment	☐ Armed Forces ☐ Other health inequality (please state below)
Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here: It is not believed that the content of the policy would have a direct negative impact on those holding protected characteristics. The ICB has a duty to provide the policy in various formats as required to ensure equitable access to the information within the policy. (you can share further details and mitigations below in 2.2)				
No Effect				
Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if 'not applicable' This EHIA is being undertaken as part of the review process for a current ICB policy. There have been no significant amendments made to the processes already in place.				

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

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
N/A		

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

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

To eliminating discrimination, harassment and victimisation.	Positive	X
	Negative	☐
	No effect	☐
Please describe: This policy supports information rights processes which provide people with access to information held by the ICB as well as their personal data. These rights support the understanding of both the ICB and the NHS as well as transparency of process. These rights also support individuals to have more control over and understanding of their personal data.		

To advance equality of opportunity between people who share a protected characteristic and those who don't	Positive	X
	Negative	☐
	No effect	☐
Please describe: The policy applies to all employees. The aim is to ensure that everyone understands the arrangements that BNSSG ICB has in place for the management of records and provides clear guidance in relation to the actions required.		

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

Action Plan

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

Action	Timeframe	Success Measure	Lead
Senior support and promotion of the policy	From ICB Board approval on the 1st February 2024	ICB Board approval and subsequent promotion at staff meetings and through staff newsletters	RH/LP

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

As part of the quarterly promotion of the policy

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

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

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

The policy is for all employees and the arrangements outlined support the ICB's legal requirements. The EHIA has highlighted the importance of promotion of the policy

Select a recommended course of action:	
Outcome 1: Proceed – no potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified. E.g. proposal is not likely to have any detrimental impact on any group	x
Outcome 2: Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity and fostering good relations or breach of human rights articles. E.g. arrangements put in place to produce a BSL video to promote changes to a service	☐
Outcome 3: Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out). E.g. pilot benefits one neighbourhood due to funding restrictions	☐

Outcome 4: Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified. E.g. dress code policy discriminates against people who practice particular religions; new service that proposes to detain patient but insufficient evidence of safeguarding or human rights considerations in place	☐

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

Reviewer's Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)
Equality Officer Name:
Equality and Inclusion Team Signature:
Date:

Equality Delivery System 2022

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

Domain 1 – Commissioned & Provided services

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

Domain 2 – Workforce health and wellbeing

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

Domain 3 – Inclusive Leadership

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

The policy aims to provide clear guidance to staff on the responsibilities for managing records. Having a clear policy in place with support from the appropriate teams supports Domain 2 with the ICB as a good place to work. Having a clear policy in place also supports Domain 3 as the policy provides a framework for Board/Committee members and senior managers to monitor impact and risk.

18.2 Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target end date	Resources Required
ICB Board (including SIRO)	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	Chief of staff	1st Feb 2024	1st Feb 2024	Staff time, Board Members time
Information Asset Owners/ Information Asset Administrators	Ensure awareness of ICB processes and the responsibilities of those designated to management directorate/team records	Internal communications through the Voice Policy to be presented to the IAO/IAA Group	Corporate Support Officer	1st Feb 2024	Ongoing	Staff time
All Staff	Ensure awareness of ICB processes and procedures	Policy to be placed on website following approval and 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 and staff meetings Records Management is included in the mandatory annual Information Governance training module	Corporate Support Officer /Training manager	1st Feb 2024	Following ICB Board approval Ongoing Ongoing	Staff time, Training Module

18.3 BNSSG ICB Retention and Disposal of Physical Records Log (Archived Records Log)

There is a requirement that the below log is completed to transfer physical records for external storage. Proper completion of the log will allow for physical records in external storage to be identified and simplify the process should these records need to be recovered from storage.

Logged by	Main contact for box content	Iron Mountain Bar Code Number	Major description of contents	Minor Description of Contents	Other detail of contents *(Please ensure enough detail is entered to enable to box to be found again by anyone else)*	Contents List created and saved on S drive	Major Record Type	Record Type *(* denotes common types and is used to bring them to to top of the list)*	Period covered From	To	Date Archived	Retention Period	Date to be Destroyed

18.4 Archive Protocol for physical records

This protocol should be followed for any storage of physical records off site.

All records sent for storage must comply with NHS Retention and Disposal Schedule and the BNSSG ICB Records Management Policy

All records should be stored alphabetically, numerically, or in date order (whichever is appropriate). Do not mix different types of records in one box.

↓

Appropriate archive storage boxes with lids must be used. These can be obtained from the Corporate Team.

DO NOT overfill boxes – the lid must fit securely.

↓

Retention and Disposal Schedule must be fully completed (**Appendix 3)**

1 copy to be held by Department

1 copy to be forwarded to Corporate Team

↓

Iron Mountain transmittal sheet will be completed by Department and a bar code label attached.

1 copy to go to with box when the box is collected

1 photocopy to be retained by the Corporate Team

↓

Collection to be arranged by the Corporate Team

↓

A reminder will be issued by Corporate Team to the department to ensure destruction of documentation at an appropriate time

18.5 ICB Retention Schedule

This appendix sets out the retention period for different types of records relating to health and care.

The retention periods set out in the schedule are minimum periods. Record retention can be extended with justification. Retention periods begin when the records ceases to be operational. If the records comes back into use during its retention period then the period will reset and the retention duration will begin from the second period of use.

Health and care records should be reviewed before they are destroyed. This review should take into account:

- Serious incidents which would require records to be retained for longer periods
- Use of the record during the retention period which could extend its retention
- Potential cases for long-terms archival preservation (where records relate to rare conditions or innovative treatment decisions)

The schedule below outlines the types of records likely held by the ICB. The full retention schedule can be found as part of the NHS England Records Management Code of Practice.

Records Management Code of Practice - NHS Transformation Directorate (england.nhs.uk)

Record Type	Retention Period	Disposal Action	Notes
Care Records			
Adult health records not covered by any other section in this schedule	8 years	Review and consider transfer to archive	Check for involvements which could extend the retention. This includes medical imaging.
Adult social care records	8 years	Review and destroy if no longer required	

Children's records including midwifery, health visiting and school nursing	Up to 25th or 26th birthday	Review and destroy if no longer required	Retain until 25th birthday or 26th birthday if the patient was 17 when treatment ended. This includes medical imaging.
Electronic Patient Record Systems	Refer to notes	Review and destroy if no longer required	Where the electronic system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain demonstrating that a record has been destroyed, then the code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have this capacity, then once the records have reached the end of their retention periods they should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.
Integrated records – all organisations contribute to the same single instance of the record	Retain for period of longest speciality	Review and consider transfer to archive	The retention time will vary depending upon which type of health and care settings have contributed to the record.
Integrated records – all organisations contribute to the same records, but keep a level of separation	Retain for relevant speciality period	Review and consider transfer to archive	This is where all organisations contribute into the same record system but have their own area to contribute to and the system shows a contemporaneous view of the patient record.
Integrated records – all organisation	Retain for relevant	Review and consider	Organisations keep their own records but can grant 'view only' access to other

keep their own records, but enable them to be viewed by other organisations	speciality period	transfer to archive	organisations to help them provide health and care to patients or service users
Mental health records including psychology records	20 years, or 10 years after death	Review and consider transfer to archive	Covers records made under the Mental Health Act 1983 and 2007 amendments. This applies to records of patients and service users, regardless of whether they have capacity.
Pharmacy			
Controlled drugs – registers	2 years	Review and destroy if no longer required	See Misuse of Drugs Act 2001 for more information
Controlled drugs – order books, requisitions etc.	2 years	Review and destroy if no longer required	See Misuse of Drugs Act 2001 for more information
Pharmacy prescription records	2 years	Review and destroy if no longer required	A record of the prescription will also be held on the NHS BSA and there will be an entry on the patient records. Further guidance can be found on the Specialist Pharmacy Service website.
Event and Transaction Records			
Clinical Audit	5 years	Review and destroy if no longer required	Five years from the year in which the audit was conducted. This includes the reports and data collection sheets/exercise.
Datasets released by NHS England and its predecessors	Delete with immediate effect	Delete in line with instructions and guidance on the retention	

Including NHS Digital		and disposal of data as issued through the Data Access Request Service (DARS) process	
Destruction certificates, or electronic metadata destruction stub, or record of clinical information held on physical media	20 years	Review and destroy if no longer required	Destruction certificates created by public bodies are not covered by a retention instrument. They need to be destroyed after 20 years.
Equipment maintenance logs	11 years	Review and destroy if no longer required	
Inspection of equipment records	11 years	Review and destroy if no longer required	
Referrals – NOT ACCEPTED	2 years	Review and destroy if no longer required	Retention period begins from the DATE OF REJECTION.
Requests for care funding – NOT ACCEPTED	2 years	Review and destroy if no longer required	Retention period begins from the DATE OF REJECTION.
Research			

Research – datasets	No longer than 20 years	Review and consider transfer to place of deposit	
Research – ethics committee's and HRA approval documentation for research proposal and records to process patient information without consent	5 years	Review and consider transfer to place of deposit	This applies to trials where opinions are given to proceed with the trial, or not to proceed
Research – ethics committee's minutes (including records to process patient information without consent)	20 years	Review and consider transfer to place of deposit	Retention period begins from the year to which they relate and can be as long as 20 years. Committee minutes must be transferred to a place of deposit
Corporate Governance			
Board meetings	Up to 20 years	Review and transfer to place of deposit	A local decision can be made on how long to retain the minutes of board meetings (and associated papers linked to the board meeting), but this must not exceed 20 years, and will be required to be transferred to the local place of deposit
Board meetings (closed boards)	Up to 20 years	Review and transfer to place of deposit	Although these may still contain confidential or sensitive material, they are still a public record and must be transferred at 20 years, and any FOI exemptions noted, or indications that the duty of confidentiality applies.

Chief Executive records	Up to 20 years	Review and transfer to place of deposit	This may include emails and correspondence where they are not already included in board papers.
Committees (major) – listed in Scheme of delegation or report direct into the board (including major projects)	Up to 20 years	Review and transfer to place of deposit	
Committees (minor) – not listed in scheme of delegation*	6 years	Review and consider transfer to place of deposit	Includes minor meetings, projects and departmental business meetings. These may have local historical value and require transfer consideration.
Data Protection Impact Assessments (DPIAs)	6 years	Review and destroy if no longer required	Should be kept for the life of the activity to which it relates, plus six years after that activity ends. If the DPIA was one -off, then 6 years from completion.
Destruction certificates or record of information held on destroyed physical media	20 years	Review and destroy if no longer required	Where a record listed for potential transfer to the place of deposit has been destroyed without adequate appraisal, consideration should be given to a selection of these as an indicator of what has not been preserved.
Electronic metadata destruction stubs			Refer to destruction certificates
Incidents – serious	20 years	Review and consider transfer to place of deposit	Retention begins from the date of the Incident – not when the incident was reported.
Incidents – not serious	10 years	Review and destroy if no	Retention begins from the date of the Incident – not when the incident was reported.

		longer required	
Incidents – serious incidents requiring investigation	20 years	Review and consider transfer to place of deposit	These include independent investigations into incidents. These may have permanent retention value.
Non-clinical QA records	12 years	Review and destroy if no longer required	Retention begins from the end of the year to which the assurance relates
Patient advice and liaison service (PALS) records	10 years	Review and destroy if no longer required	Retention begins from the close of the financial year to which the records relates
Patient surveys – individual returns and analysis	1 year after return	Review and destroy if no longer required	May be required again is analysis is reviewed
Patient surveys – final report	10 years	Review and consider transfer to place of deposit	Organisations may want to keep final reports for longer than the raw data and analysis, for trend analysis over time. This period can be extended, provided there is justification and organisational approval.
Policies, strategies and operating procedures – including business plans	Life of organisation plus 6 years	Review and consider transfer to place of deposit	Retention begins from when the document is approved, until superseded. If the retention period reaches 20 years from the date of approval, then consider transfer to the place of deposit
Risk Registers	6 years	Review and destroy if no longer required	Retention period in accordance with the Limitation Act and corporate awareness of risks
Staff surveys – individual returns and analysis	1 year after return	Review and destroy if no	Forms are anonymous so do not contain Personal Identifiable Dara unless provided

		longer required	in free space boxes. May be reviewed again if analysis is reviewed.
Staff surveys – final report	10 years	Review and consider transfer to place of deposit	Organisations may want to keep final reports for longer than the raw data and analysis, for trend analysis over time. This period can be extended, provided there is justification and organisational approval.
Communications			
Intranet site	6 years	Review and consider transfer to place of deposit	
Patient information leaflets	6 years	Review and consider transfer to place of deposit	These do not need to be leaflets from every part of the organisation. A central copy can be kept for potential transfer.
Press releases and important internal communications	6 years	Review and consider transfer to place of deposit	Press released may form a significant part of the public record of an organisation which may need to be retained.
Public consultations	5 years	Review and consider transfer to place of deposit	Whilst these have a shorter retention period, there mat be a wider public interest in the outcome of the consultation (particularly where this resulted in changes to the services provided) and so may have historical value
Website	6 years	Review and consider transfer to place of deposit	Websites are complex objects, but regular crawls can be undertaken. Guidance can be found: www.nationalarchives/webarchive/guidance/
Staff Records and Occupational Health			

Occupational health records	Keep until 75th birthday or 6 years after the staff member leaves whichever is sooner	Review and destroy if no longer needed	
Occupational health report of a staff member under health surveillance	Keep until 75th birthday	Review and destroy if no longer needed	
Occupational health report of staff member under health surveillance where they have been subject to radiation doses	50 years from the date of the last entry or until 75th birthday, whichever is longer	Review and destroy if no longer needed	
Staff record	Keep until 75th birthday	Review and consider transfer to place of deposit	This includes (but is not limited to) evidence of right to work, security checks and recruitment documentation for the successful candidate including job adverts and application forms.
Staff record – summary	Keep until 75th birthday	Review and consider transfer to place of deposit	
Timesheets	2 years	Review and if no longer needed destroy	Retention begins from creation

Staff training records	See notes	Review and consider transfer to place of deposit	Records of significant training must be kept until 75th birthday or 6 years after the staff member leaves. It can be difficult to categorise staff training records as significant as this can depend upon the staff member's role. The following is recommended: clinical training records - to be retained until 75th birthday or six years after the staff member leaves, whichever is the longer statutory and mandatory training records - to be kept for ten years after training completed other training records - keep for six years after training completed
Disciplinary records	6 years	Review and if no longer needed destroy	Retention begins once the case is heard and any appeal process completed. The record may be retained for longer, but this will be a local decision based on the facts of the case. The more serious the case, the more likely it will attract a longer retention period. Likewise, a one-off incident may need to only be kept for the minimum time stated. This applies to all cases, regardless of format.
Procurement			
Contracts sealed or unsealed	Retain for 6 years after the end of the contracts	Review and if no longer needed destroy	
Contracts – financial approval files	Retain for 15 years after the end of the contracts	Review and if no longer needed destroy	

Contracts – financial approved suppliers documentation	Retain for 11 years after the end of the contracts	Review and if no longer needed destroy	
Tenders (successful)	Retain for 6 years after the end of the contracts	Review and if no longer needed destroy	
Tenders (unsuccessful)	Retain for 6 years after the end of the contracts	Review and if no longer needed destroy	
Estates			
Building plans, including records of major building works	Lifetime (or disposal) of building plus 6 years	Review and consider transfer to place of deposit	Building plans and records of works are potentially of historical interest and where possible, should be kept and transferred to the local place of deposit
Closed circuit television (CCTV)	Refer to SCW IG team for guidance	Review and destroy if no longer required	The length of retention must be determined by the purpose for which the CCTV has been used. CCTV footage must remain viewable for the length of time it is retained, and where possible, systems should have redaction or censoring functionality to be able to blank out the faces of people who are captured by the CCTV, but not subject to the access request, for example, police reviewing CCTV as part of an investigation
Equipment monitoring, and testing and maintenance where	40 years	Review and destroy if no longer required	Retention begins from the completion of the monitoring or testing. This includes records of air monitoring and health records relating to asbestos

ASBESTOS is a factor			exposure, as required by the Control of Asbestos Regulations 2012.
Equipment monitoring – general testing and maintenance work	Lifetime of installation	Review and destroy if no longer required	Retention begins from the completion of the monitoring or testing.
Inspection Reports	Lifetime of installation	Review and destroy if no longer required	Retention begins as the END of the installation period Building inspection records need to comply with the Construction (Design and Management) Regulations 2015
Leases	12 years	Review and destroy if no longer required	Retention begins at point of lease termination
Minor building works	6 Years	Review and destroy if no longer required	Retention begins at the point of WORKS COMPLETION
Photographic collections – service locations, events and activities	Up to 20 years	Review and consider transfer to place of deposit	These provide a visual historical legacy of the running and operation of an organisation. They may also provide secondary uses, such as use in public inquiries.
Surveys – building or installation (not patient surveys)	Lifetime of installation of building	Review and consider transfer to place of deposit	Retention period begins at the END of the INSTALLATION period
Finance			
Accounts	3 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate. Includes all associated documentation and records for the purpose of audit.

Benefactions	8 years	Review and consider transfer to place of deposit	These may already be in the financial accounts and may be captured in other reports, records or committee papers. Benefactions, endowments, trust fund or legacies should be offered to the local place of deposit.
Debtors records – CLEARED	2 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Debtors records – NOT CLEARED	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Donations	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Expenses	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Final annual accounts report	Up to 20 years	Review and transfer to place of deposit	These should be transferred when practically possible, after being retained locally for a minimum of 6 years. Ideally, these will be transferred with board papers for that year to keep a complete set of governance papers.
Financial transaction records	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Invoices	6 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.

Petty cash	2 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Private Finance Initiative (PFI) files	Life time of PFI	Review and consider transfer to place of deposit	Retention begins at the END of the PFI agreement. This applies to the key papers only in the PFI.
Staff salary information or files	10 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Superannuation records	10 years	Review and destroy if no longer required	Retention begins at the CLOSE of the financial year to which they relate.
Legal, Complaints and Information Rights			
Complaints – case files	10 years	Review and destroy if no longer required	Retention begins at the CLOSURE of the complaint. The complaint is not closed until all processes (including potential and actual litigation) have ended. The detailed complaint file must be kept separately from the patient file (if the complaint is raised by a patient or in relation to). Complaints files must always be separate.
Fraud – case files	6 years	Review and destroy if no longer required	Retention begins at the CLOSURE of the case. This also includes cases that are both proven and unproven.
Freedom of Information (FOI) requests, responses to the request and	3 years	Review and destroy if no longer required	Retention begins from the CLOSURE of the FOI request. Where redactions have been made, it is important to keep a copy of the response as well as the redacted response sent to the requestor. In all cases, a log

associated correspondence			must be kept of requests and the response sent.
FOI requests – where there has been an appeal	6 years	Review and destroy if no longer required	Retention begins from the CLOSURE of the appeal process.
Industrial relations – including tribunal case records	10 years	Review and consider transfer to place of deposit	Retention begins at the CLOSE of the financial year to which it relates. Some organisations may record these as part of the staff record, but in most cases, they should form a distinctive separate record (like complaints files).
Litigation records	10 years	Review and consider transfer to place of deposit	Retention begins at the CLOSURE of the case. Litigation cases of significant or major issues (or with significant, major outcomes) should be considered for transfer. Minor cases should not be considered for transfer.
Intel, patents, trademarks, copyright, IP	Lifetime of patent, or 6 years from the end of licence or action	Review and consider transfer to place of deposit	Retention begins at the END of lifetime or patent, or TERMINATION of licence or action.
Software licenses	Lifetime of software	Review and destroy if no longer required	Retention begins at the END of the lifetime of software
Subject Access Requests (SAR), response, and subsequent correspondence	3 years	Review and destroy if no longer required	Retention begins at the CLOSURE of the SAR
SAR – where there has been an appeal	6 years	Review and destroy if no longer required	Retention begins at CLOSURE of appeal

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Risk Management Framework

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	54
Responsible Executive Director:	Sarah Truelove, Deputy CEO
Author and Job Title:	Rob Hayday, Chief of Staff
Date Approved:	1/7/22
Approved by:	ICB Board
Date of next review:	December 2024

Policy Review Checklist

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

	Yes/ No/NA	Supporting information
the public in preparing this policy?		
Are there linked policies and procedures?	No	
Has the lead Executive Director approved the policy?	Yes	
Which Committees have assured the policy?	Yes	Audit and Risk Committee will review this policy in December 2023
Has an implementation plan been provided?	Yes	See section 14.1
How will the policy be shared?		Published on website
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	
Has a DPIA been considered in regards to this policy?	Yes	
Have Data Protection implications have been considered?	Yes	

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.

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

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

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

The ICB will:

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

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

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

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

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

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

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

ICB Risk Register	Operational
	Strategic
ICS Risk Register	Operational
	Strategic

3 Definitions/explanations of terms used

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Risk Appetite

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

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

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

The risk appetite is set by the ICB Board.

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

Domain	Risk Appetite	Proposed Risk Appetite Statement

Finance How will we use our resources? Value for money	Open	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of Value For Money with price not the overriding factor	
Regulatory How will we be perceived by our regulators? Compliance	Open	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	
Quality How will we delivery safe services? Quality of services Outcomes	Cautious	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes and appropriate controls are in place.	
Reputational How will we be perceived by the public and our partners?	Open	We are prepared to accept the possibility of some reputational risk as long as there is a potential for improved outcomes for our stakeholders.	
People How will we be perceived by our workforce?	Open	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and development opportunities for staff.	

5 ICB Governance Structure

The ICB has in place a constitution that describes the governance arrangements established to ensure that it meets its duties and obligations. These arrangements include the ICB Board underpinned by supporting committees. Key committees with responsibility for the management of risks are the Audit and Risk Committee, the Outcomes, Quality and Performance Committee, and Finance, Estates and Digital 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.

The ICB Board

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

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

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

The ICB Board must be informed of and where necessary, consulted on all significant risks that arise from the commissioning of services. Risks associated with commissioned services must be systematically identified, assessed and analysed in the same way as other risks to the organisation. Risks relating to commissioned

services assessed as scoring 15 or over will be escalated to the Corporate risk Register to provide a complete risk profile of the organisation to ICB Board.

The Audit and Risk Committee

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

The Outcomes, Performance and Quality Committee

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

The Finance, Estates and Digital Committee

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

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 People Committee

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

ICS Governance and the management of system risks

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

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

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

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

6 Responsibilities and Accountabilities

All staff

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

All staff must:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the ICB's business
- Comply with the ICB's policies, procedures and guidelines
- Ensure incidents, claims and complaints are reported using the appropriate procedures
- Be responsible for completing/attending mandatory, statutory and relevant education and training events

- Participate in the risk management process in a timely way, including the assessment of risk within their area of work and the notification to their line manager of any perceived risk which may not have been assessed
- Be aware of the Risk Management Framework, risk appetite and processes and comply with them.
- Engage with system partners to ensure the common understanding of ICS risk description and responsibilities for mitigating actions. One organisation cannot describe a system risk and/or its treatment without engaging stakeholders effectively.

Project Management

The ICB has adopted a Programme Management Office (PMO) approach and the management of risk is embedded in this process. Project risk management enables the systematic identification, clarification and management of risk through the lifespan of a project. Project risk management helps to both control the probability of an adverse event materialising and mitigate the impact of an adverse risk event. Where Projects are managed as a Programme then there may be a need for risk assessment at both Project and Programme level as Projects may be interdependent.

Managers

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

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

Risk Leads

Risk leads responsibilities include:

- embedding risk management processes across their directorates/teams.
- raising awareness of the Risk Management Framework across their directorates/teams

- Taking a lead role in the maintenance of risk registers and ensuring risks that meet the tolerance level of 15 or higher are escalated and managed on the Corporate Risk Register

The Chief of Staff

The Chief of Staff is responsible for:

- Developing and overseeing effective risk management systems including timetabling activities for others' contributions
- Developing a Risk Management Framework and associated policies and procedures
- Working with Executives, Risk Owners and Senior Managers to co-ordinate and implement the Risk Management Framework
- Establishing and maintaining an effective risk register process which captures ICB and ICS risks
- Raising awareness regarding the management of risk, the Risk Management Framework and the tools used by the ICB to facilitate risk management
- Support staff in the implementation of the Risk Management Framework and Policy and the tools used by the ICB to facilitate risk management
- Ensure appropriate training and development for staff is in place as required
- Convening the ICS Risk Managers Network.

ICS Risk Managers Network

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

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

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

The ICB Executive Team

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

- Demonstrating leadership, active involvement and support for risk management
- Ensuring that staff accountable to them understand and pursue risk management in their areas of responsibility
- Setting personal objectives for risk management and monitoring their achievement
- Ensuring risk are identified and managed, and mitigating actions implemented in functions for which they are accountable
- Ensuring action plans for risks relating to their respective areas 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 its committees..

The Chief Executive - Accountable Officer

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

- Continually promoting risk management and demonstrating leadership, involvement and support,
- Ensuring an appropriate committee structure is in place with regular reports to the ICB Board and Primary Care 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
- Chairing the SEG and its oversight of ICS risks

The Director with Lead for Risk Management

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

- Ensures there is an effective risk management system in place throughout the ICB
- Ensuring all risk registers are regularly reviewed and updated
- Ensuring that there is appropriate external review of the ICB's risk management systems and that any recommendations are acted on
- Has responsibility for Information Governance arrangements within the ICB and is the Senior Information Risk Owner (SIRO).

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

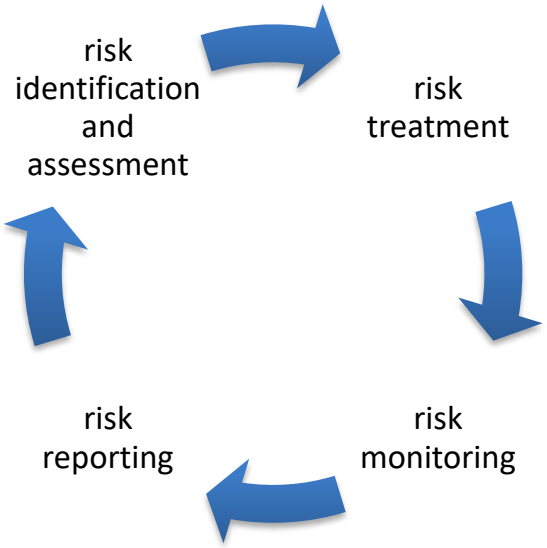
The INEM on the ICB Board with the lead role for overseeing audit, governance and risk will have the skills, knowledge and experience to assess and confirm that appropriate systems of internal control and assurance are in place for all aspects of governance including financial and risk management.

7 Risk Management Process

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

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

The risk management process structure



(HM Government 'The Orange Book')

Risk assessment incorporates risk analysis and risk evaluation

7.1 Risk Identification

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

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

Each Directorate will ensure that risks are identified within their area of business and escalated where appropriate. The description of risks will follow best practice:

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

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

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

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

7.2 Risk Analysis

Risk analysis supports a detailed consideration of the nature and level of risk. To ensure a consistent interpretation and application when defining the level of risk the ICB has adopted a risk scoring matrix and the categories of risk set out in the NPSA "A Risk matrix for Managers" (2208)

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

7.3 Risk Evaluation and Treatment

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

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

The risk assessment process will result in:

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

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

7.4 Risk Monitoring

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

7.5 Risk Reporting

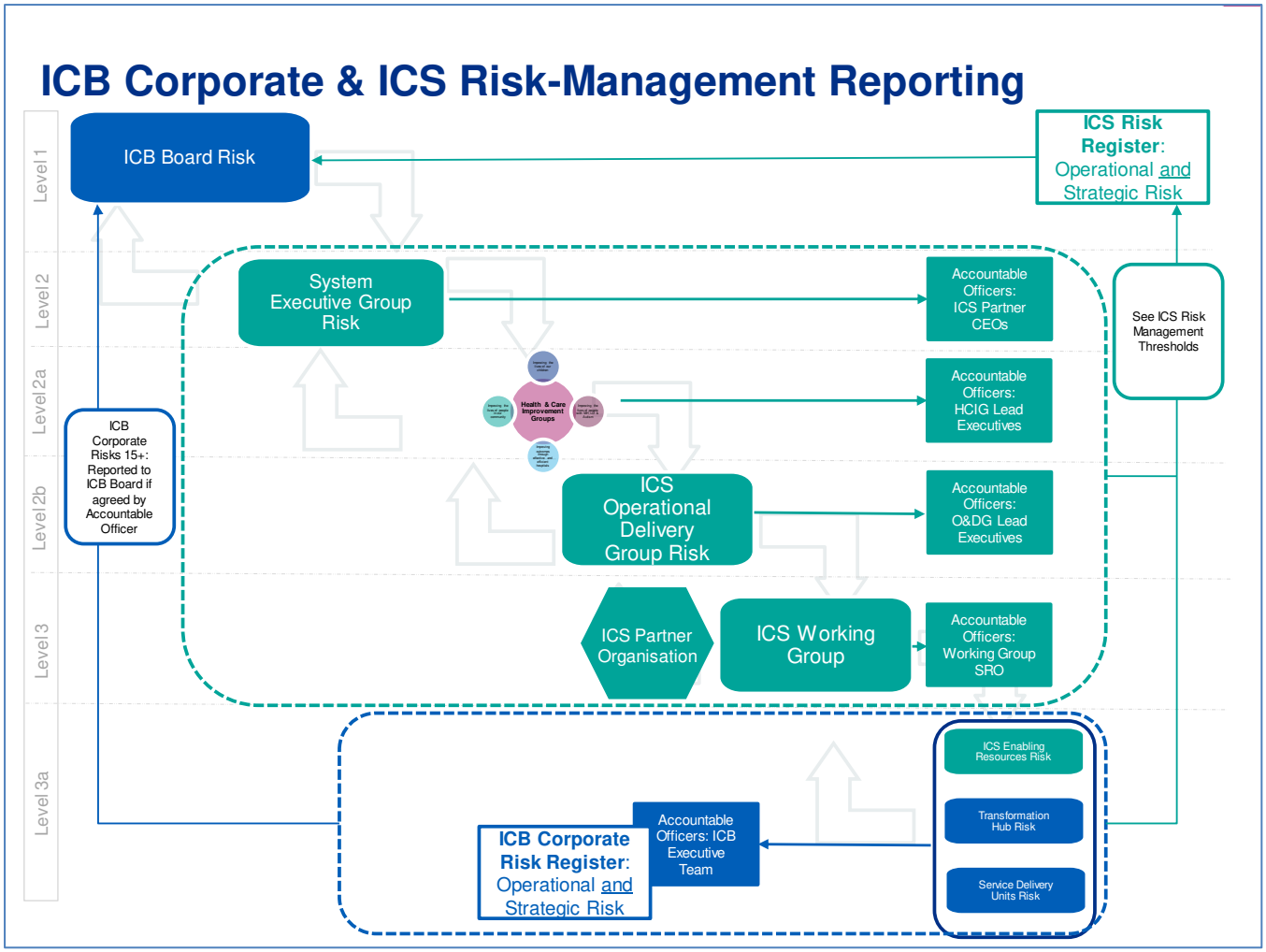
Risks are reported to the ICB Board and Committees through the Corporate Risk Register and the ICB Board Assurance Framework. Risks are also highlighted in specific reports to the ICB Board and Committees; in this case risks will also be reported on the appropriate registers.

The ICB Corporate Risk Register is underpinned by Directorate Risk Registers. Directorate, Project and Corporate Risk Registers.

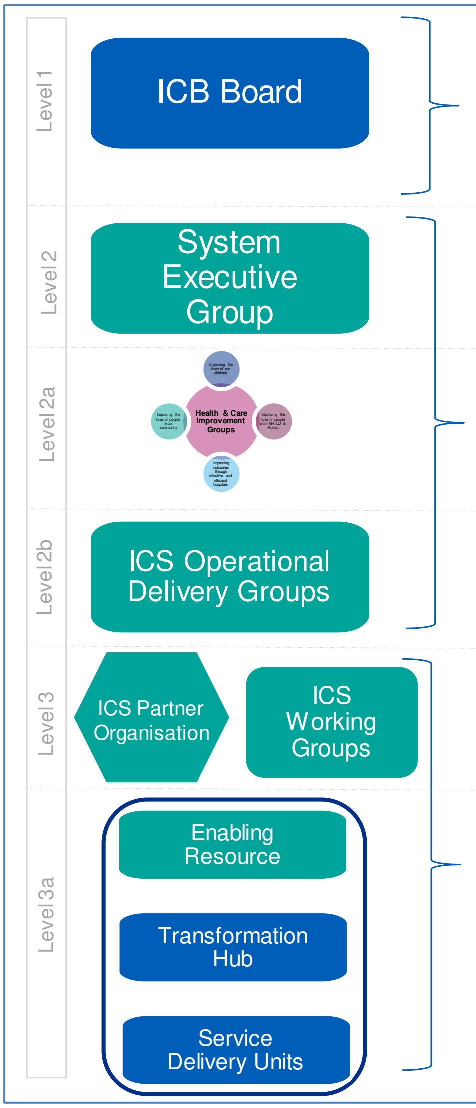
ICS risk registers will be underpinned by registers produced by Health and Care Improvement Groups and other system fora

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

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



Risks will be escalated in line with the following thresholds



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

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

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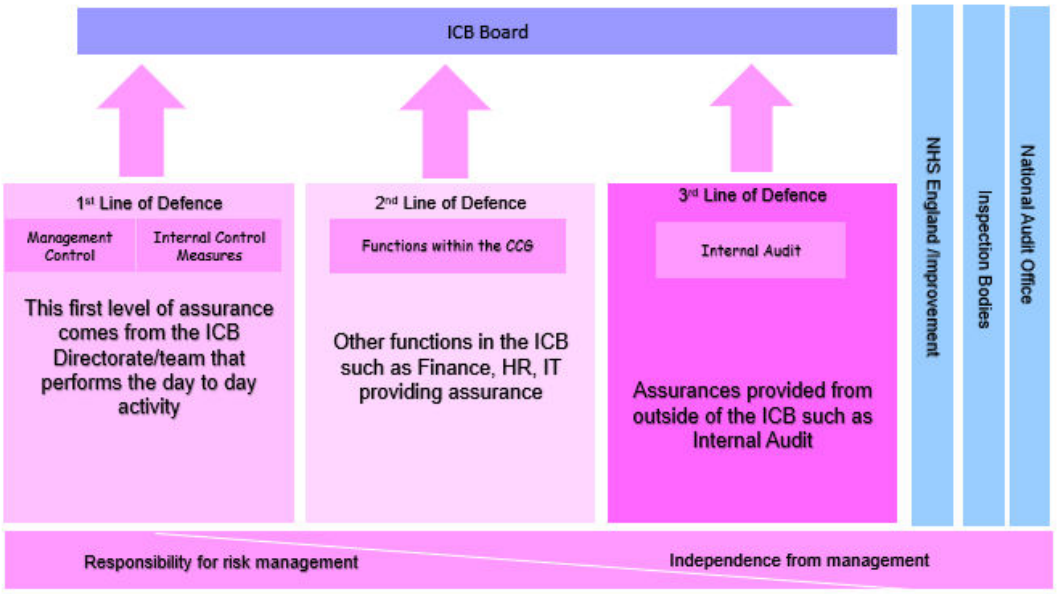
Catastrophic = 5	5	10	15	20	25
Major = 4	4	8	12	16	20
Moderate = 3	3	6	9	12	15
Minor = 2	2	4	6	8	10
Negligible = 1	1	2	3	4	5

7.6 Levels of Assurance

Assurance is the sufficient and appropriate evidence that a risk is well managed and being mitigated. Assurance may be either positive or negative and may be generated either internally or externally. Assurance provided by external bodies is considered to be stronger sources of assurance. The “three lines of defence” model (HM Government ‘The Orange Book’) describes how risk management responsibilities and assurances combine. The ICB Board is not a line of defence as it has responsibility and accountability for setting the ICB’s objectives, strategies to achieve these objectives and establishing roles, structures and process to manage risks in achieving objectives. The following diagram explains the relationship between the challenge and scrutiny function of the ICB Board and the three sources of assurance it receives.



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

8 Training requirements

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

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

9 Equality & Health Inequality Impact Assessment

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

10 Implementation and Monitoring Compliance and Effectiveness

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

11 Countering Fraud, Bribery and Corruption

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

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

12 References, acknowledgements and associated documents

ICB Constitution, Standing Orders and Scheme of Reservation and Delegation

Standing Financial Instructions

Conflicts of Interest Policy

Gifts and Hospitality Policy

Health and Safety Policy

Incident Report Policy

Serious Incident Reporting Policy

Freedom to Speak Up Policy

Management of Compliments, General Enquiries and Complaints Policy

13 Appendices

Appendix 1 Implementation Plan

13.1 Implementation Plan

Target Group	Implementation or Training objective	Method	Lead	Target start date	Target End date	Resources Required
Executive Directors	Ensure awareness of responsibilities of • ICB process to ensure compliance • Individual Executive Director responsibilities • Directorate responsibilities	Risk Management included on Exec Team agenda ongoing support in 1:1 with Chief of Staff	Chief of Staff	Jan 2024	Jan 2024	
Risk Leads	ensure risk leads aware of requirements of role including supporting directorates with risk management process and risk management training	updates through risk leads meetings	Chief of Staff	Jan 2024	Jan 2024	
All Staff	Ensure awareness of ICB processes and procedures	Once agreed by Board in February: Framework to be placed on website/Hub Information about the policy and ICB process to be communicated through internal newsletter Awareness raising with directorates at appropriate team meetings	Chief of Staff	Feb 2024	Feb 2024	

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Audit and Risk Committee Meeting

Minutes of the meeting held on 15th September 2023 at 2pm, MS Teams

DRAFT Minutes

Present		
John Cappock	Audit Committee Chair - Non-Executive Member	JCa
Jaya Chakrabarti	Non-Executive Member – People	JCh
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Alison Moon	Non-Executive Member – Primary Care	AM
Jane Norman	Audit Committee Chair - Non-Executive Member UHBW	JN
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Steve West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Lorna Harrison	Sirona Non-Executive Member, Audit and Assurance Committee Chair	LH
Rob Hayday	Chief of Staff	RH
Jon Roberts	Partner, Audit Grant Thornton	JR
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
In attendance		
Nick Atkinson	Head of Internal Audit, RSM	NA
Emma Brown	Head of Financial Services, BNSSG ICB	EB
Catherine Cookson	Associate Chief Finance Officer	CC
Jeff Farrar	Chair of BNSSG ICB	JF
Victoria Gould	Client Manager, Internal Audit RSM	VG
Jon Lund	Deputy Chief Finance Officer, BNSSG ICB	JL
Emily Mayne	Director, Value for Money, Audit Grant Thornton	EM
Lucy Powell	Corporate Support Officer, (note taker) BNSSG ICB	LP
Michael Richardson	Deputy Director of Nursing and Quality, BNSSG ICB	MR
Sarah Smith	LCFS, ASW Assurance	SS
Katie Whybray	Senior Manager, Audit Grant Thornton	KW

	Item	Action
A	**Meeting with Auditors without the Executive**	

	Item	Action
1	**Welcome and Apologies** JCa welcomed all to the meeting and the apologies above were noted. Jon Lund would be attending on behalf of Sarah Truelove. JCa reminded members of the four aims of the ICB: to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and support broader social and economic development. JCa observed it was important to consider the agenda items in terms of all aims. JCa welcomed the system focused papers such as the internal audit report on Pharmacy, Ophthalmic and Dentistry (POD). JCa highlighted the discussions at ICB Board regarding the verdict of the Lucy Letby trial and noted the role of the Audit and Risk Committee as a source of assurance around freedom to speak up. Jeff Farrar (JF) had highlighted believing the unbelievable when listening to people. Counter fraud had raised concerns about simultaneous employment which was an increasing risk as more staff worked from home. JCa highlighted the importance that the work in this area was communicated and would be raised as part of the counter fraud item.	
2	**Declarations of Interest** There were no new declarations and no existing declared interests that conflicted with agenda items. Jane Norman (JN) noted that her interests were not on the declarations register and it was agreed that this would be reviewed.	**LP**
3	**Minutes of the Previous Meeting and Action Log** The minutes of the previous meeting were agreed as a correct record. The Committee reviewed the action log: **Action 31** – NA confirmed that the timings had been discussed and work has started. The scope of the audit had been amended to include the development of the People Programme and the report was expected to be presented at the next meeting. The action was closed. **Action 38** – It was confirmed that the review had been included as part of the Board agenda setting programme. The action was closed. All other due actions were closed.	
4.1	**Internal Auditor Progress Report** NA apologised for the delay in providing the POD report. NA noted that the progress report highlighted some amendments to timings but NA was confident that the reviews would be delivered to avoid particularly pressured times. The most significant amendment was to the safeguarding review which had originally been requested as an early review. NA confirmed that several other safeguarding reviews which included the local authorities and police had been planned and therefore it was sensible to undertake the internal audit later to summarise any forthcoming actions. NA noted the importance that in the interim the Committee was sighted on the outcomes of the various reviews.	

	Item	Action
	NA highlighted the status of the management actions, noting that the majority had been updated and closed but five actions remained which were not yet closed. A long-standing safeguarding action was likely to be closed for the December meeting. Michael Richardson (MR) was welcomed to the meeting to update the Committee on the safeguarding element of the internal audit report. MR noted that the two key areas of focus were training and the development of the strategy and there had been considerable developments in these areas. A Local Government Association (LGA) review was taking place across the three local authorities, police and health partners to align safeguarding practices, efficiencies, strategies and economies of scale. This was planned alongside the safeguarding transformation programme which was a year-long programme of work with the three local authorities and safeguarding partnerships. The LGA review was expected to identify areas the transformation programme would need to target and areas where management arrangements could be further aligned. The programme was due to start in the Autumn and dedicated resource had been identified. The learning from the reviews would be shared across the system. In the meantime, the safeguarding annual report would be developed which would include clear deliverables with tangible priorities for the next two years. JCa asked where the outcomes of the review would be reported. The outputs would be reported through the Outcomes, Performance and Quality (OPQ) Committee. Ellen Donovan (ED) noted that the recommendations relating to safeguarding predated the ICB and asked whether closure of the recommendation was reliant on the outcomes of the transformation programme and system outputs. ED asked about the position of business as usual and development of the strategy. NA expected the action to be completed by October 2023. The internal auditors had asked for a detailed update and had identified that significant work had taken place around training. It was noted that the action was specific to training and the whole system approach should not affect this. MR confirmed that the safeguarding team would recommend that the training action was closed. Specific next steps would be picked up through the strategic and operational system deliverables identified for the next two years as part of the long-term plan. MR outlined the work undertaken to support the safeguarding training which included a digital solution to record the training which would negate the need for a spreadsheet going forward. Pages had been created on the training webpage to signpost colleagues to where the higher-level training could be accessed. A full communications strategy was planned for mid-October. JCa	

	Item	Action
	noted the work needed to close the action and ED asked that regular updates on the development of the strategy were presented to the OPQ Committee. NA presented the internal audit benchmarking report and explained that the report compared the audit outcomes against other health sector clients particularly on the opinions issued and the priority of the management actions identified. The ICB received 67% positive assurance against the average of 73%. NA noted the relatively small numbers benchmarked and explained that the ICB approached internal audit differently from other organisations, many of whom used the audits as tick box exercises. NA explained that the ICB asked internal audit to review areas of concern so that action plans could be developed to improve. NA suggested that there was more value for money in the BNSSG ICB approach. NA noted the importance that the auditors could see improvements and increased assurance as actions were implemented and confirmed that this was recognised within the ICB by internal audit. ED highlighted the section of the report which compared the ICB to other NHS organisations and noted that the ICBs generally had higher substantial assurance and asked how the ICBs compared in the use of internal audit. NA noted that each audit plan was different although there were some areas of mandated review. NA noted that these mandated reviews tended to provide substantial assurance as these were well reviewed processes. NA explained that BNSSG ICB had been more ambitious than other ICBs in looking at system assurance which was bold given the immaturity of the system working. NA highlighted that the focus of internal audit was on clearing actions and challenging clients to ensure internal audit were reviewing the right areas. **The Audit and Risk Committee received and discussed the Internal Audit Progress Report**	
4.2	**Internal Auditor Reports: POD Services** NA explained following delegation of POD services to the ICB, internal audit had reviewed the processes of transfer and implementation. NA noted that the services had been embedded well but work continued. It was positive that actions had been closed on the plan and these had been tracked through to completion. Assurance had been provided to the auditors as it was received by the ICB particularly the transition work and the work with the commissioning hub. **The Audit and Risk Committee received the Internal Audit report for Pharmacy, Ophthalmic and Dentistry (POD) Services**	
5.1	**Counter Fraud Interim Report** Sarah Smith (SS) led by announcing the news of the new Local Counter Fraud Specialist Ian Halkyard, and asked whether Ian could attend the next Audit and Risk Committee. This was agreed.	

	Item	Action
	SS outlined the key and emerging risks and noted that for POD services, South West Counter Fraud would handle the proactive elements with NHS England retaining the investigation and fraud risk assessment work. SS noted the importance that the Committee was sighted on any concerns and discussions continued with NHS England on the best way to manage reporting of information. SS reported that simultaneous employment had become more of a concern since home working was normalised and it was important that organisations ensured policies, contracts and employment related documents referenced any flexible ways of working and included consideration on how to easily identify fraud of this nature. This risk would be included in the Fraud Risk Assessment for the ICB and the outcome of this would be benchmarking and best practice guidance. SS thanked the internal communications team for the creation of the counter fraud page on the staff intranet which included information on how to report suspected fraud, fraud prevention and provided advice and guidance. SS highlighted that the pages were some of the best she had seen. ED asked how mature the public sector was in establishing home working policies and how long it was expected for these to be in place. SS noted the exceptional circumstances and how this has created opportunities for people to take on multiple roles. Revoking home working was not the answer but safeguards needed to be put in place to identify when this was happening. SS noted it would likely be minor tweaks to policies and confirmed that there were active discussion about simultaneous working across counter fraud organisations. JCa noted that now organisations were aware of this plus any recommendations from counter fraud, safeguards would be enabled. JCa suspected that it would be a cultural change and any circumstances such as not being able to contact a colleague regularly should raise concerns. Jon Lund (JL) noted that the ICB had cemented flexible working by relocating to a smaller office and agreed to raise this risk with Rob Hayday as the lead for the office move. SS confirmed that the actions around training had been closed as the 85% compliance rate showed that the training was being completed by staff. Action had also been taken to receive feedback regarding the training. Jaya Chakrabarti (JCh) noted the Economic Crime and Corporate Transparency Bill currently within parliament and asked how this would affect due diligence processes with public sector suppliers and how processes would be assessed. SS explained that the Bill would mean that organisation would not	**JL**

	Item	Action
	be automatically prosecuted if one of their staff committed fraud. The organisations had a responsibility to ensure that processes in place to prevent fraud were robust. SS noted that updates on the Bill would continue through the counter fraud updates. **The Audit and Risk Committee received and discussed the Counter Fraud Interim Report**	
6.1	**External Auditor Report** Emily Mayne (EM) presented the report noting that the ICB had received an amber rating across all three areas. These were financial sustainability, governance, and improving economy, efficiency and effectiveness. The recommendations indicated where improvements could be made. EM noted that nationally there had been an increase in identified weaknesses in providers and ICBs particularly within the financial sustainability domain. These related to unaligned savings cost improvement plans and medium-term financial planning between providers and ICBs. No significant weaknesses had been identified for BNSSG ICB and EM reported that the ICB was financially well controlled, and the recommendations identified had been at system level. These were around the reliance on non-recurrent spending and the significant pressures relating to agency spend. Consideration had been given to exit interview processes and retention of staff which would support reduction in agency spend. EM reported that BNSSG was one of the more mature systems which was supported by having fewer providers within the system. The ICB had a positive relationship with NHS England and the local providers. The auditors had reviewed governance in terms of how the ICB would identify any significant issues within the system providers and BNSSG ICB arrangements had been good. The previous audit had focused on the first nine months of operation and this years audit would focus on how processes had been embedded and whether the policies in place had been finalised and ratified. EM highlighted that engagement with partners around finance was good but more work was needed to strengthen the links with clinical processes. The auditors had found that performance was outcome focused and the background and analysis was good. There was an opportunity to improve the KPIs and EM provided an example of another ICB which had reviewed their demographics and tailored KPIs accordingly. EM explained that this ICB had a population similar to that of BNSSG in terms of the areas of affluence and deprivation and had determined how KPIs could drive reduction in health inequalities.	

	Item	Action
	JCa welcomed the patch on the page within the report. JCa welcomed the fair challenge within the report and highlighted the system wide work to reduce the system deficit and the work on system decision making which was being progressed through the ICB Board. ED asked for more information on the weaknesses identified within the clinical quality governance area and noted the example provided around KPI identification and asked whether the area could be shared with Executives so that good practice could be shared across regions. EM confirmed that for the clinical governance review, a registered nurse had set out questions to consider when reviewing documentation and interviews had taken place with key clinical posts within the ICB and at place level. Across the 16 bodies reviewed, development of the quality strategy and identification of the quality objectives were noted as themes for improvement and these were developed into recommendations. The recommendations were determined from detailed working papers and the general themes of improvement were around improving consistency of attendance at meetings and ensuring that deputies attended where appropriate. EM also noted the importance that minutes and actions were captured at meetings and any strategies were formally approved. EM noted that the ICBs who were leading in arrangements had developed KPIs unique to the local footprint and highlighted that BNSSG ICB could use this approach. ED agreed and explained that the ICB had reviewed information at place level and this work had been translated into a clear set of KPIs. It was noted that the ICB would soon be utilising Power BI which would support the work. JL confirmed that Sarah Truelove and Lisa Manson were leading the performance work and Power BI would provide targeted performance measures which would be embedded. JL confirmed that these measures had been reviewed thematically but the progress had been made in reviewing at a place based level. JL agreed to circulate the value for money report and ask the Executive Team to reflect on the recommendations. JW recommended that the action was broader than ICB executives and the report needed to be circulated to system Chief Executives. There was an opportunity to use the population data within the Joint Strategic Needs Assessment to support the work. JW noted the importance that the system learnt from the good work across the country and asked whether there was anything from the report the system should consider. EM confirmed that the BNSSG system was in a good position and had consistent plans. The National Audit Office (NAO) had raised concerns about the pressure from NHS England to achieve financially balanced positions as these were clearly undeliverable. EM noted the importance that a financial deficit did not automatically mean that arrangements were not robust, and the external auditors had focused on ensuring arrangements were strong rather than assessing the financial position.	**JL**

	Item	Action
	EM highlighted that the national financial position was worsening but the position in BNSSG ICB was consistent and stable. JW highlighted benchmarking and asked whether this was provided by auditors or whether this was available to the system. EM noted that NHS data was currently poor as many provider organisations had ceased data collection throughout the pandemic to focus on key clinical areas. It was confirmed that there were areas of ICB benchmarking which included life expectancy and cancer diagnosis as well as other areas of performance such as GP appointments. JW noted the importance of reflecting on benchmarking information to provide challenge to the system. JL confirmed that covid had disrupted the data flows at provider level but added that the reorganisation of commissioning organisations had also destabilised information flows. JCh asked whether any learning had been identified around workforce which was the most significant challenge in the NHS currently. EM confirmed that workforce was a challenge everywhere but noted that the NAO Code of Practice did not recognise workforce as an area of review. The auditors had instead reviewed workforce indicators such as vacancies, staff complaints, exit interviews and reconciled this with data regarding staff management. JCh asked that any available information was provided and reviewed by the ICS People Committee. AM welcomed the report noting that the links between the quality strategy and the KPI recommendations were helpful to frame the strategic questions. AM noted that the management response had been technical and AM believed that the ICB would benefit from reviewing the equality strategy and considering what was in and out of scope and whether the ambitions were achievable. **The Audit and Risk Committee received and discussed the External Audit Auditors Annual Report for period ended March 2023**	**EM/JCh**
7.1	**Conflicts of Interest Policy** Lucy Powell (LP) provided the background to the policy noting that minor changes had been made to reflect the involvement of working groups such as the Health and Care Improvement Groups and other groups which involved system partners. NHS England have confirmed that new guidance and training materials would be provided specific to ICBs. Once this was received, the policy would be updated to include the new guidance. It was confirmed that the ICB had asked NHS England to provide clarity on managing conflicts of interest in terms of system partners. It was believed that system working would be considered within the new guidance. NA noted NHS England had confirmed that previous arrangements such as the annual audit requirements which applied to CCGs no longer applied to ICBs	

	Item	Action
	however there were mixed messages when the annual reporting was received as there was an expectation that an audit had been completed. NA noted that it was sensible to wait for the guidance before updating the policy as there were likely to be significant changes. JW asked whether the Integrated Care Partnership Board had been considered as part of the policy. LP confirmed that the policy was for ICB staff only, however consideration had been given to declarations from the system partner ICB Board members. The current policy outlined the requirement for ICB Board members to follow their organisational procedures on conflicts of interest. However, it was believed that the updated guidance would provide more information on system working. It was agreed that RH would ask how the ICP Board fits into ICB conflict of interest procedures. SW noted the importance that declarations of interest were considered at meetings and conflicts identified, but noted that the processes to collate the interests could become unwieldy if not managed regularly. **The Audit and Risk Committee reviewed the Managing Conflicts of Interest policy and recommended it to the Board for approval**	**LP/RH**
8.1	**ICB Corporate Risk Register and ICS Risk Register Development** JCa confirmed that the ICB Corporate Risk Register and the development of the ICS Risk Register had been comprehensively discussed at the September ICB Board meeting. There were no further comments or questions. **The Audit and Risk Committee noted the decisions made by the ICB Board and resulting next steps**	
8.2	**HFMA Self-Assessment Checklist** JCa noted that of the 35 actions to improve the core elements of financial sustainability, 29 had been completed, 5 were in progress and 1 was outstanding. JL noted that following the change from the CCG to the ICB and the subsequent restructure of governance arrangements, the ICB was ensuring that key policies were in place and named budget holders were identified. JCa noted that the system finance leads were meeting and sharing good practice and learning. JL confirmed this and noted that the system was meeting the financial challenge together, agreeing frameworks and managing overspends. **The Audit and Risk Committee discussed and noted the progress on implementing the financial suitability improvement plan and the revised implementation dates**	
9	**Matters for Information** The Committee received the following matters for information: • Losses and Compensation Payments • Waiver of Standing Financial Instructions	

	Item	Action
	• Committee Workplan • Information Rights Report There were no comments or questions	
10	**Review of Meeting Effectiveness** ED highlighted the value for money report and asked that an update on the progress of the actions in the report be provided at the next meeting. ED asked that the update included how the executive team have updated the Board Sub-Committees on the progress. JCa agreed and noted the point made by JW about information sharing at the system Chief Executive group and suggested that Shane Devlin attend a meeting of the Non-Executive Members to provide feedback. JF asked about attendance at the Audit and Risk Committee and suggested that Executive Directors are asked to attend the Committee as appropriate. JCa agreed to discuss this as part of the agenda setting meetings with Sarah Truelove. JF agreed to discuss this further with Shane Devlin as it was important that the Executive Directors were aware and involved in the actions recommended from both the internal and external auditor reports. JW noted the importance of the value for money work and highlighted a role for system leaders in leading the wider system actions. NA noted the earlier conversation about the outstanding safeguarding action and the importance that the closure of the recommendation was captured as an action and that it was documented that the OPQ Committee would be reviewing the progress of the action between Audit and Risk Committee meetings. SS reviewed the meeting effectiveness noting: • The members had open and honest discussions, everyone was able to contribute • There had been positive conversations and the Committee recognised that there was work needed to improve • The Committee had recognised the challenges particularly in system working and the differences in organisation arrangements • The ambition of the system to be trailblazers • The Committee recognised that approaches needed to be system wide and this was positive for future system working JCa thanked SS for her comments.	**ST/JL** **JF** **RS/MR**
B	**Members meeting with the Executive without Auditors**	
	Date of Next Meeting Friday 13th December 2023: 2.00pm – 4.00pm	

Lucy Powell, Corporate Support Officer, September 2023