Healthier Together

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Bristol, North Somerset and South Gloucestershire ICB Annual Report

1 April 2023 – 31 March 2024

Contents

PERFORMANCE REPORT

Shane Devlin

Accountable Officer

25 June 2024

Performance Overview

This performance overview provides a summary explaining what NHS Bristol, North Somerset and South Gloucestershire ICB does, the key risks faced in 2023/24 and how the ICB performed against a range of measures. We describe performance in detail in the Performance Analysis section (p15).

Chair and Chief Executive's statement

It is with great pride and optimism that we present the Annual Report for Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) for the year 2023-2024. This year marks a period of transformative progress and renewed commitment to delivering integrated, high-quality health and social care services to our diverse communities.

The past year has been one of significant achievement and collaboration. Our integrated approach has been pivotal in addressing the complex healthcare needs of our population, ensuring that services are not only effective and efficient but also equitable and inclusive. The partnerships forged between healthcare providers, local authorities, and voluntary and community organisations have laid a robust foundation for a health and social care system that truly works for everyone.

That said we have faced a number of challenges and know there is still more to do to improve waiting lists times, access to social care services and use of urgent and emergency care. Like all ICB's we have also had to reduce our running costs by 30%, which has seen us go through significant changes and adapt our ways of working.

Our initiatives this year have been guided by our core values of compassion, innovation, and excellence. We have focused on preventative care, mental health support, and digital health innovations, all while striving to reduce health inequalities across our region. The launch of new community health programs, the enhancement of our mental health services, and the expansion of telehealth options are just a few examples of our dedication to improving health outcomes.

A highlight of this year has been our concerted effort to listen to and engage with the communities we serve. Their insights and feedback have been invaluable in shaping our services to better meet their needs. This ongoing dialogue ensures that our strategies are not only responsive but also reflective of the unique challenges and opportunities within Bristol, North Somerset, and South Gloucestershire.

We have also made significant strides in workforce development, recognizing that our staff are the backbone of our success. Investments in training, wellbeing, and

support have created a resilient and motivated workforce, ready to meet the demands of a dynamic health and social care environment.

As we look ahead, we remain steadfast in our mission to deliver seamless, integrated care that enhances the health and wellbeing of every individual in Bristol, North Somerset and South Gloucestershire. The challenges we face are substantial, but with the continued dedication of our partners, staff, and community members, we are confident in our ability to navigate these and achieve our vision for a healthier future.

On behalf of BNSSG ICB, I extend my deepest gratitude to everyone who has contributed to our successes this year. Together, we are BNSSG, and we will continue to build a health and social care system that is sustainable, inclusive, and above all, centred on the needs of the people we serve.

Shane Devlin, CEO

Jeff Farrar, Chair

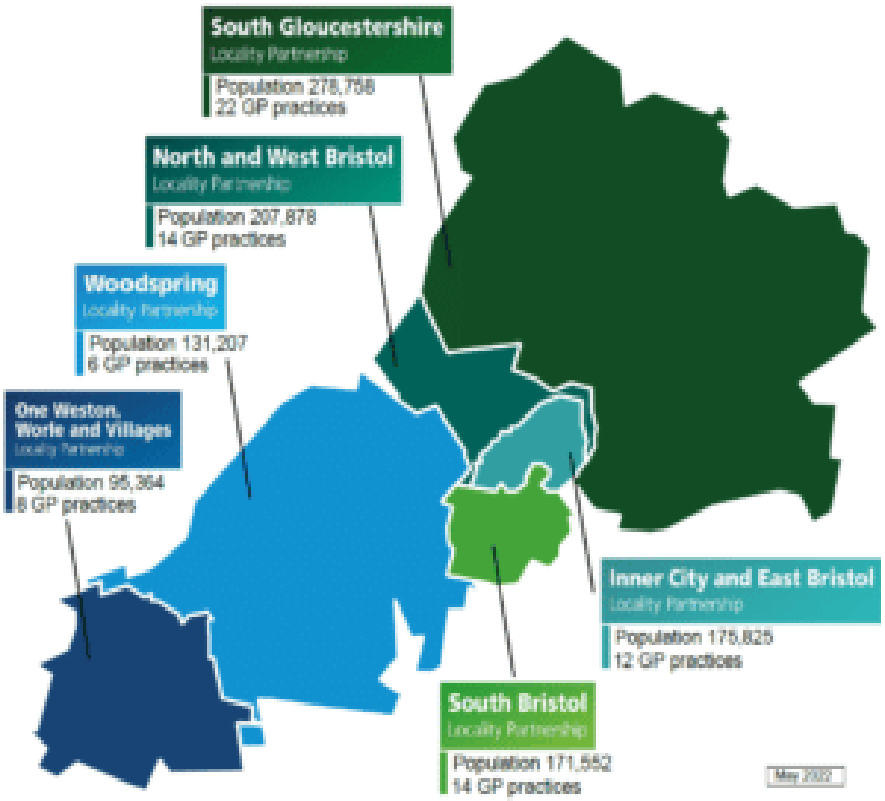
Performance Overview

About Bristol, North Somerset and South Gloucestershire Integrated Care Board

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

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

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



Population of 1 million served by:

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

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

Our priorities and plans for 2024/25 are set out in our One Year Operational Plan. Our plan reflects spending commitments required by NHS England and also includes our local commitment to continue investing in our key transformation programmes, continued investment in Urgent Care and additional planned care beds.

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

Funding has been approved for strategic investment in Anticipatory Care, Prevention and Wellbeing. This includes prioritised funding allocation to Admission Avoidance, Children's services, long-term conditions and Voluntary Community and Social Enterprises (VCSE). Furthermore, the ICB Chief Medical Officer is working with the three Directors of Public Health to develop a plan for strategic use of the funding that will support the delivery of the overarching prevention work. This includes the three BNSSG ICS strategy commitments relating to addressing BNSSG Smokefree, Healthy Weight and Alcohol and Drugs.

Our Joint Forward Plan sets out how we will deliver the national vison of high-quality healthcare for all, with equitable access, excellent experience and optimal outcomes. Our plan describes how we plan to achieve and deliver the priorities set out in our strategy over the next five years. The plan builds on the work of our local Health and Wellbeing Boards, our Locality Partnerships and our 2024/25 Operational Plan. Our Joint Forward Plan is refreshed annually to provide a five-year rolling plan. As our partnerships develop and the wider system matures our plans will increase in depth and breadth. Our plan sets out how we will work together with partners to:

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

You can view our JFP along with a summary of it here.

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

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

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

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

ICB Organisational Change

Like all ICBs in the country, BNSSG was given a huge challenge to cut running costs by 30% by the end of March 2025. In 23/24 the running cost allocation within the ICB was £18.427m, this would need to reduce to £13,876m by 2025.

To achieve these reductions and to take into account the cost of this change the ICB agreed with its Board in June 23 that the full saving requirements would need to be realised by the beginning of April 2024.

The ICB undertook the needed organisational change in two phases –

- Phase 1 focused on the functional map and Executive Team structure and took place during September and October 2023;
- Phase 2 encompassed the wider organisation and all other staff, with consultation taking place during December 2023 and January 2024; 208 responses were received to the consultation and the Staff Partnership Forum and Disability and Proud Staff networks provided a collective response.

The changes brought into being through the organisational change and consultation saw the creation of a new operating model for the ICB, new functions map and new executive team structure and directorates lead by the following Chief Officers:

- Business, Strategy and Planning – Sarah Truelove, Chief Finance Officer
- Chief Medical Office – Dr Joanna Medhurst, Chief Medical Officer

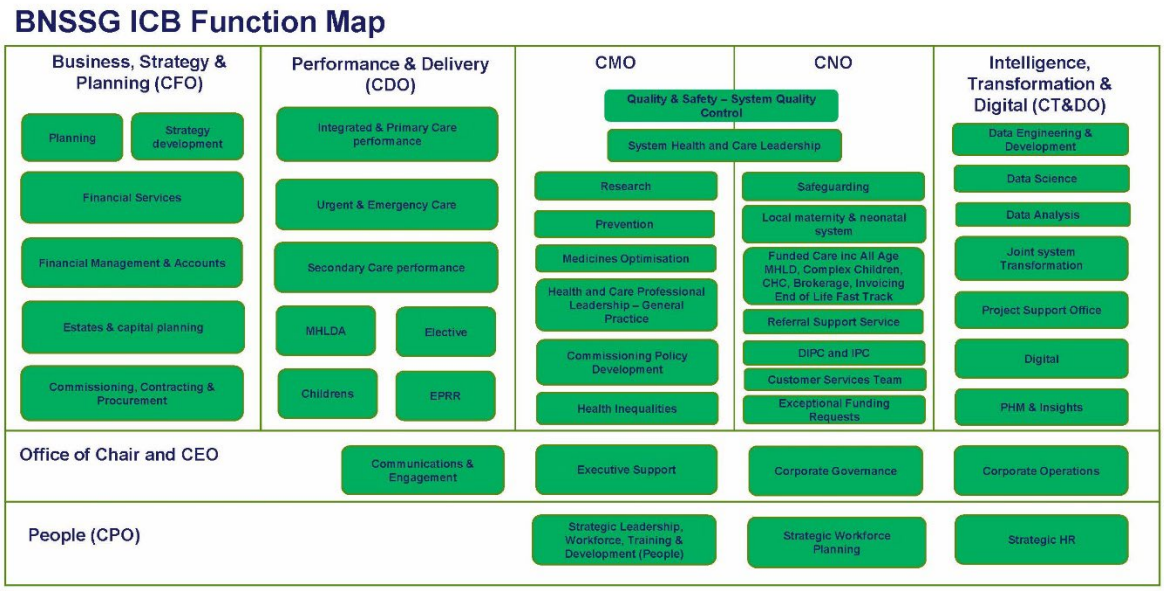
- Chief Nursing Office – Rosi Sheppard, Chief Nursing Officer
- Office of the Chair and Chief Executive – Shane Devlin, Chief Executive
- Performance and Delivery – David Jarrett, Chief Delivery Officer
- People – Jo Hicks, Chief People Officer
- Intelligence, Transformation and Digital – Deborah El-Sayed, Chief Transformation and Digital information Officer

The wider organisational restructure resulted in a total of 73.12 whole time equivalent (WTE) reductions; 16.72% of total WTE. This has resulted in a £3,531m saving, providing 65.72% towards the running cost efficiency requirements.

The remaining efficiencies, approx. £1,841m, 34,28% will be delivered through reductions in non-pay expenditure and working differently with our partners during 24/25.

Figure 2 – BNSSG ICB Operating Model

Figure 3 – BNSSG ICB Function Map



Summary of key risks to delivering objectives

Our healthcare system continued to face significant challenges during 2023/24. Key risks reported through performance reports to the Board and highlighted on the ICB internal corporate risk register included:

- Improving performance across planned and urgent care, including ambulance services and ensuring that mental health services were able to meet the demands placed on them. Access to Dental services remains a risk that was inherited from NHS England who were previously the responsible commissioner.
- The impact of Covid-19 on services, staff and the implementation of long-term plans. There was a particular focus on the impact on access and waiting times for urgent care, elective care services, diagnostics, dentistry, children and adults mental health, learning disability and autism services and ambulance services.
- Risks relating to health inequalities and the risk of increasing health inequalities for specific groups were highlighted.
- Risks relating to Healthcare Associated Infections.
- The delivery of improved population health and financial sustainability.
- Organisational restructuring within the Integrated Care Board deflecting time and resources from the need to deliver change quickly.

Mitigating actions were put in place to manage and reduce the likelihood of these risks materialising. More detail regarding performance and actions taken is provided in the Performance Analysis section of this report (p15).

Adoption of the going concern basis

The ICB has reported a small in year surplus of £8,000 against the ICB Revenue Resource Limit of £2,175,014,000.

The ICB inherited an accumulated deficit from Bristol, North Somerset and South Gloucestershire CCG caused by prior year deficits, including of predecessor bodies, against its Revenue Resource Limit of £117,059,000. However, the financial framework for ICBs states that if the ICS measured on a 'System' basis achieves breakeven or better for two successive years against the In Year Resource Limit then the requirement to repay the accumulated deficit will be withdrawn. The ICS has now met this over the last two financial years 2022/23 and 2023/24.

These accounts have been prepared on a going concern basis.

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

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

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

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

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

Summary of performance

Overview of how ICB performance is measured

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

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

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

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

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

Table 1

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

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

Key to symbols in table 2 below:


Better than last year but not achieving standard


Achieving standard


Worse than last year and not achieving standard

Table 2: 2023/24 year to date performance compared to 2022/23 year end

		BNSSG		
Indicator	**Standard**	**2022/23**	**2023/24**	**Change**
Percentage of patients admitted, transferred or discharged from A&E within 4 hours (ICB Footprint level)	76%	68.46%	73.64%	
Percentage of patients on an incomplete RTT Pathway waiting less than 18 weeks	92%	63.84%	62.78%	
Number of patients on an incomplete RTT Pathway waiting more than 52 weeks	0	4,124	2,578	
Percentage of patients waiting six weeks or more for a diagnostic test (15 key tests)	85%	79.03%	90.30%	
Maximum two-week wait for first appointment for patients referred urgently for suspected cancer	93%	51.20%	50.89%	
Percentage of patients receiving a diagnosis or ruling out of cancer, or a decision to treat within 28 days of an urgent referral for suspected cancer	75%	60.28%	65.38%	
*Maximum 31 day wait from diagnosis to first definitive treatment for all cancers (old measure)	96%	91.11%	90.62%	
***Maximum 62 day wait from urgent GP referral (two-month wait) to first definitive treatment for cancer (old measure)**	85%	54.85%	58.57%	
**31 day combined: 31-day wait from a decision to treat/earliest clinically appropriate date to first or subsequent treatment of cancer (new measure)	96% (from Q3)	Not applicable	92.64%	
****62-day combined: 62-day wait from an urgent suspected cancer or breast symptomatic referral, or urgent screening referral, or consultant upgrade to a first definitive treatment for cancer (new measure)**	85% (from Q3)	Not applicable	63.66%	
Total number of CDIFF cases	<same period previous year	254	308	
Total number of MRSA cases	0%	29	34	
Mixed Sex Accommodation breaches	0%	18	159	

***These measures were replaced with **new measures for which official reporting began in October 2023.**

Performance analysis

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

- Work to improve the quality of services
- How we have worked to improve Safeguarding
- How we have engaged with people and communities
- Work to reduce health inequalities and promote equality across the local community and workforce
- Work with local Health and Wellbeing Boards
- Sustainable development
- A summary of our financial position. This is given in detail in the Annual Accounts section of the Annual Report (p148)
- The actions to tackle fraud and bribery are described in the Governance Statement (p85)

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

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

Performance of NHS Services 2023/24

The ICB is assessed on its performance against constitutional targets which form the basis of the operational plan for 2023/24 agreed with NHS England. Key constitutional targets relate to urgent care, planned care, mental health, learning disabilities and autism and community services including urgent care response within two hours.

Planned, Elective Care and Cancer Care

Elective care, including outpatients, cancer and diagnostics services were significantly impacted by the pandemic, causing backlogs of long waiting patients across most service areas.

Since the pandemic, the elective programme in BNSSG has maintained focus on recovery and our plans have reflected national priorities in addition to a locally driven focus on productivity and efficiency, improving ways of working, progression of major strategic initiatives that will support sustainable recovery, and utilisation of digital enablers that optimise functions across our system, improve communication and support patients while they wait.

In 2023/24 a primary aim of our elective care recovery programme was to reduce the length of time people were waiting for appointments, tests and treatment; to reduce the volume of patients in the longer waiting cohorts; and address demand and capacity gaps across our elective, cancer, outpatient and diagnostic services.

This aim was addressed by:

- Holding ourselves to account for delivery of the commitments we made in our Operational Plan.
- Increasing capacity to enable us to 'do more' – through for example, workforce recruitment, training and supporting staff to develop and work at the top of their licence; increasing delivery opportunities through waiting list initiatives; utilising capacity available through our local independent sector providers; testing new ways of working; and working collaboratively across the system to improve and develop pathways that meet the needs of our population.
- Improving productivity to enable us to 'achieve more' – through for example, focussing on 'getting it right first time' (GIRFT) metrics including theatre utilisation, day case rates, scheduling and booking efficiencies; increasing throughput on lists; approaching bed utilisation flexibly. Both of out Acute Trusts have, for example, developed and implemented new short stay orthopaedic pathways in 2023/24 and there has been great success in robotic assisted gynaecology surgery.
- Developing services and improving system-wide clinical pathways and models of care. For example, in 2023/24 the system drove forward two major strategic initiatives to support recovery and sustain delivery at levels that can meet future demand. Firstly, two Community Diagnostic Centres that commenced a phased 'Go Live' from April 2024; and secondly the System Elective Centre that is currently in construction phase and will open in early 2025.
- Optimising demand management and ensuring patients are directed to the right place at the right time for the care and treatment they need.
- Supporting patients to wait well, through perioperative initiatives, citizen facing digital enablers and waiting well apps.
- Driving our system commitment to health inequalities through a number of projects and initiatives across elective and cancer services, including for example, a collaborative success focussed on understanding missed appointments in outpatient services.
- Our commitment to improvement and innovation. A great number of projects and programmes of work have been progressed in 2023/24 across the BNSSG system. Of particular note are those that have advanced communications with patients through citizen facing portals and the use of digital solutions for direct communication and messaging. There have been

pilots and new pathway development and implementation throughout 2023/24 that will further improve cancer pathways and performance. Examples, include a Teledermatology pilot and new gynaecological pathways for women experiencing post-menopausal bleeding.
- Our commitment to patient choice, which has always been transparent and actioned as standard business, but we have re-emphasised this commitment as a priority in 2023/24. We also participated in the national programme of Patient Initiated Digital Mutual Aid.

Performance against our 2023/24 Operational Plan

The nationally set ambitions for 2023/2024 were:

- To clear all patients waiting 78 weeks or more on a RTT pathway, with the exception of specifically complex cases and people who have requested to delay their treatment for longer.
- To progress clearance of all patients waiting 65 weeks or more on a RTT pathway, towards zero by the end of September 2024, with the exception of specifically complex cases and people who have requested to delay their treatment for longer.
- To increase to 85% the number of patients that receive their diagnostic test within 6 weeks of referral.
- To increase to 75% the number of patients that receive confirmation of non-cancer or a cancer diagnosis within 28 days of their GP referring them on an Urgent Suspected Cancer pathway. This is called the Faster Diagnosis Standard (FDS).
- To achieve nationally set targets for patients on a cancer pathway awaiting treatment for 63 days or more.

Recovery across many aspects of planned care and cancer care has gained momentum throughout 2023/24, despite the impacts of Industrial Action throughout the year and the additional pressures the NHS faced during winter. This has been achieved through our NHS staff providing more appointments in the evenings and weekends as well as using Independent Sector providers to support the delivery of NHS care. We have made significant progress in tackling these backlogs.

At the time of writing the latest validated data available was the end of February 2024 for some metrics and the end of March 2024 for others. This data shows:

- Data for the end of March 2024 shows that the system was performing well in the clearance of the 78 week wait cohort. There remained a small number, including some patients awaiting very complex plastic surgery procedures and a small number awaiting complex dental care.
- Data for the end of March 2024 shows that the system has made great progress in the clearance of the 65 week wait cohort, reducing the number of patients in this group by over 3/4 between April 2023 and March 2024.

- As a system, we have made significant improvements in our diagnostic performance. At the time of writing, the most recent validated data (February 2024) shows 90.3% of patients received their diagnostic test within the 6-week timeframe specified in the Standard. This exceeds the 85% target. This achievement ranks BNSSG ICB performance as second best nationally and best in the Southwest.
- The latest validated data for the Faster Diagnosis Standard (February 2024) shows that the system is exceeding the 75% target, with an achievement of 78%.
- Data for the end of March 2024 shows that both Acute Trusts have performed better than plan, achieving better than their nationally set targets for the numbers of patients waiting 63 days or more on a cancer pathway. This has been achieved through improving transition through earlier steps in the cancer pathways, increasing capacity and making more appointments available.

Next Steps

In 2024/25 we renew our commitments to delivery of our plans and meeting the NHS ambitions and Standards. We renew our commitment to our population, providing them with choice and driving down health inequalities where they exist.

We have started the development of an Elective Care strategy for BNSSG, which will anchor our commitment that BNSSG provides equitable, accessible, timely elective care of the highest standard and provides choice. That demand and capacity is balanced sustainably; that our valued workforce develops and thrives and that our system performance achieves expectations, is resilient and sustained.

Urgent Care

Urgent and emergency services in BNSSG have experienced persistently high demand over the whole second half of the year, following an unusually low level of demand in the early spring. Improvement efforts in 23/24 have focussed primarily on pathways for patients requiring hospital inpatient care, as 22/23 saw extensive delays in offloading ambulances and hence how quickly ambulances could respond to our population in the community. Significantly higher investment than previous years – over £50m – was made in new services, or expanding existing ones, to support this aim. These included services for urgent needs in the community which avoid hospital visits, and those which ensure timely discharge from our acute beds once individual's medical care has been optimised.

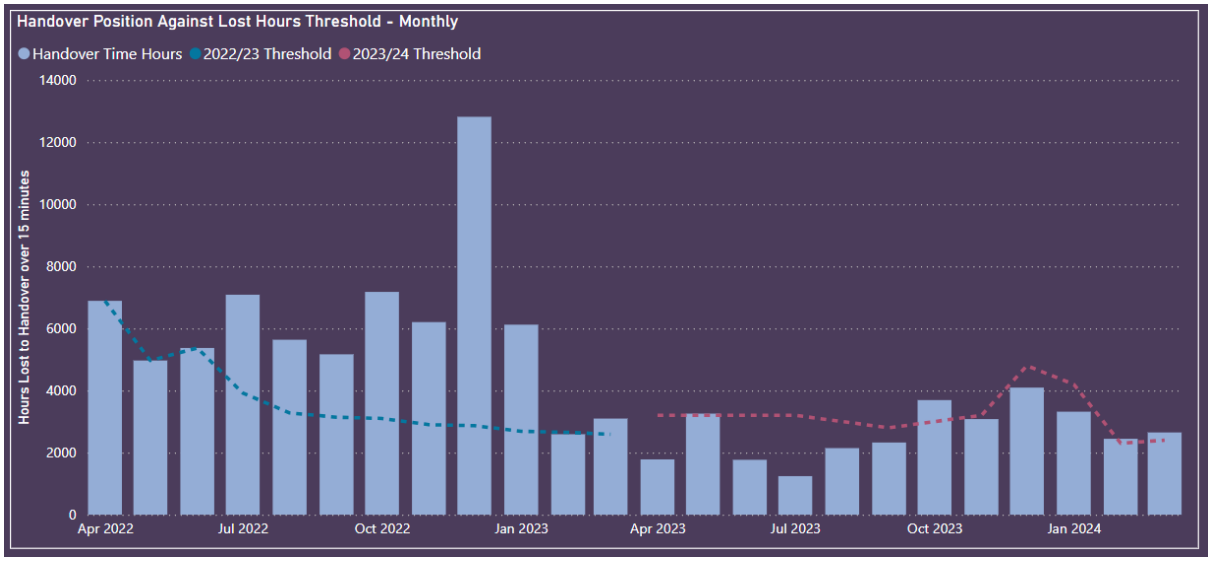
Capacity in our Urgent Community Response teams has more than doubled, meaning more individuals are seen in their own home by advanced nursing practitioners linked to community teams, rather than requiring an ambulance. The 111-based clinical assessment service also grew by over 25%, allowing more people to directly access medical support over the phone and avoid visiting hospital or requiring an ambulance. Notably, the BNSSG NHS@Home service was introduced at scale following its pilot last year, and now supports over 120 patients at any given

time This service connects community nursing teams, hospital doctors and the patient using remote monitoring technology to allow individuals to be discharged home sooner.

Same Day Emergency Care, which 'frontloads' diagnostics and clinical decision making during an individual's hospital visit to support discharge within 24 hours, also expanded significantly at all three hospitals, particularly at Weston General.

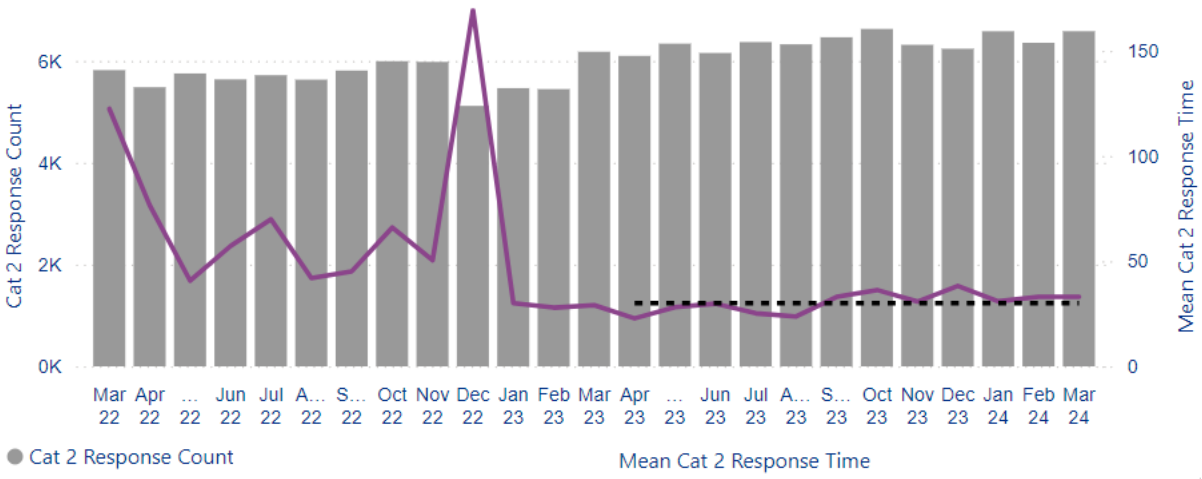
As a result of these changes, ambulance handover delays in 23/24 reduced by 56% versus the previous year. This reduction was also enabled by the introduction of new waiting areas in all three acute hospitals, and the identification of additional 'escalation' beds which can be temporarily used when the hospital is otherwise full. These changes, coupled with the high rates of demand, have however, meant that BNSSG finished the last quarter of the year at 96% hospital bed occupancy, missing our operating plan target of 94.77%.

Figure 4: BNSSG ambulance handover delays – total time lost over 15 minute standard



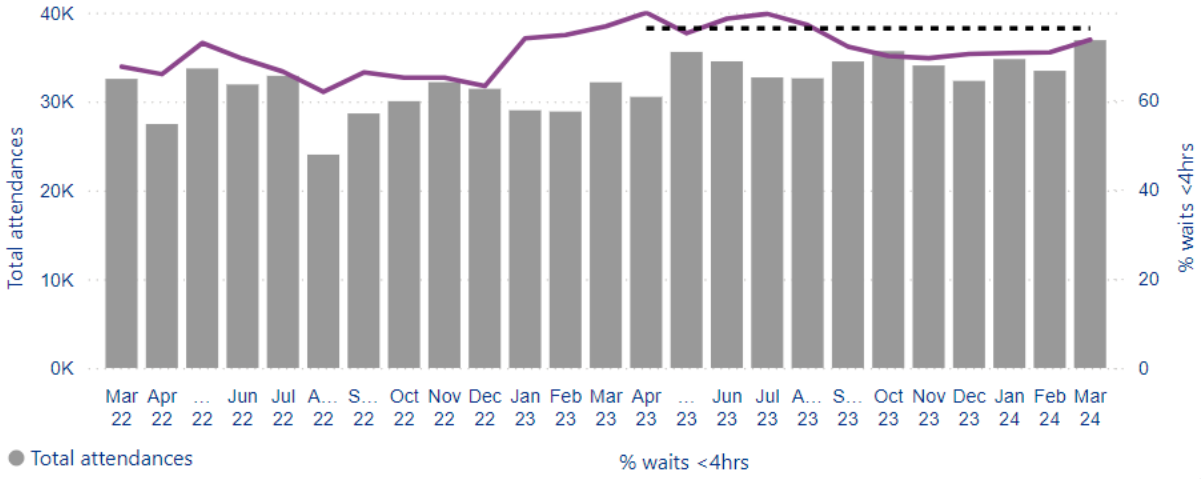
In turn, this reduction in handover delays supported improvement in our ambulance response times, with 'Category 2' responses seen in an average of 30.5 minutes, just over the national standard for 23/24 of 30 minutes.

Figure 5: Category 2 ambulance response counts and average response times in BNSSG



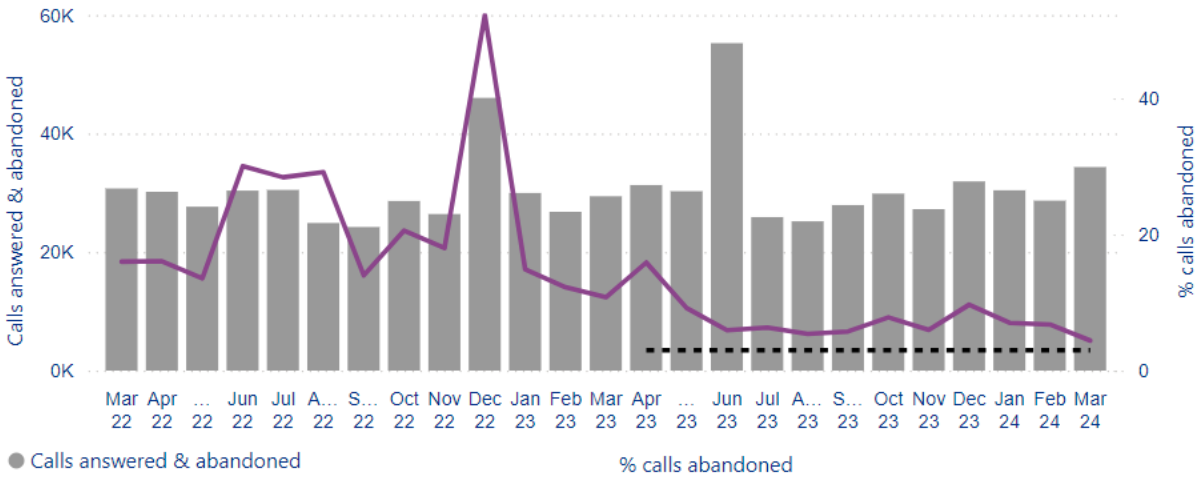
Further gains, however, are to be made with respect to emergency department 4 hour waiting times: BNSSG missed its trajectory in all months since September and is a particular area of focus for improvement in 24/25, finishing with performance of 67% in March versus the 76% standard. Performance did however improve versus 22/23 and in the context of overall activity growth of 3.2% year-on-year.

Figure 6: BNSSG all-types A&E attendances and percentage of patients waiting less than four hours



111 had its busiest ever year, receiving over 30,000 calls per month, and achieved an abandonment rate of 6.9%. This is above our 3% goal but benchmarks comparatively well, given national pressures around recruiting call handlers to the 111 services.

Figure 7: NHS 111 call demand and abandonment rates in BNSSG



Mental Health, Learning Disabilities & Autism

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

Key to symbols in table 3 below:

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

 Achieving **national target.**

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

Table 3: 2023/24 performance compared to 2022/23 (comparable periods & targets)

			BNSSG		
Indicator	**23/24 National Target**	**23/24 Local Target**	**2022/23**	**2023/24**	**Change**
Number of inappropriate adult acute out of area placement bed days (BNSSG)	---	288	325	90	
Number of inappropriate adult acute out of area placement bed days (AWP)	---	360	350	275	
Number that have accessed Talking Therapies advice and signposting or started a course of psychological therapy	23195	23195	18325	18845	
Estimated diagnosis rate for people with dementia (65+)	66.7%	66.7%	66.00%	68.26%	
Number of children and young people accessing NHS funded mental health services receiving at least one contact	13287	11514	7230	8825	
Number of women accessing specialist community Perinatal Mental Health Services	1085	1085	755	1010	
Number of adults and older adults with severe mental illnesses accessing core community mental health services	6009	7351	5860	6260	
Number of annual health checks carried out for persons aged 14 years or over on the Learning Disability Register	58.6%	58.6%	66.94%	62.28%	
Adults aged 18 and over who are autistic, have a learning disability or both and who are in inpatient care for a mental disorder (ICB beds)	6	6	12	18	
Adults aged 18 and over who are autistic, have a learning disability or both and who are in inpatient care for a mental disorder (NHSE beds)	12	12	19	19	
Children under 18 who are autistic, have a learning disability or both and who are in inpatient care for a mental disorder (NHSE beds)	9.00	<2	2	3	
Number of people accessing individual placement and support services	893	615	281	306	
People with severe mental illness receiving a full annual physical health check	75%	75%	62.23%	81.01%	

This year we have been working collaboratively with organisations in our system and people with lived experience of mental health difficulties, to deliver better mental health for all. Our vision moving forward has now been published in our *BNSSG All Age Mental Health and Wellbeing Strategy 2024-2029.*

Our performance in key areas for the year 2023/24 is as follows:

Adults and older people Community Mental Health (CMH) access:

We have achieved the national access target for people who receive two or more contacts from NHS or NHS commissioned CMH services for adults and older adults with Serious Mental Illness (SMI). Looking ahead to 24/25 we have a revised metric that measures access to transformed CMH services. Following a 3-year CMH

transformation programme we now have locally based, holistic, person-centred services that meet our communities needs and are confident we can meet our targets in the year ahead.

Serious Mental Illness (SMI) physical health improvement:

From a starting point of being one of the poorest performing systems in the South West region and country, we have, over the last three years seen an increase in performance from 12% to 81% in relation to delivering full sets of SMI physical health checks (measured at the end of March). As part of this performance improvement, over 50 of our 70+ GP practices (and 18 of 20 Primary Care Networks) have reached or exceeded the 75% national target. We still have a lot of work to do to improve our rate of follow-up to the health checks, as well as outreach to the ethnic minority communities that are over-represented amongst the SMI cohort in central Bristol. These will be our areas of focus in 2024/25.

Dementia diagnosis rate:

We have exceeded the national access target this year. Our Bristol and North Somerset services have consistently overachieved the target this year, and we have had an improved performance in South Gloucestershire. For 24/25 we have an ambitious local target that is above the national one, and we are confident we can continue our improvement journey and meet this.

Perinatal mental health (PMH) access:

While the quality of our provision has not been in question, we have not yet met the national 10% target access rate. In late January 2024, we launched the Single Point of Entry (SPE) for perinatal mental health referrals, and this has resulted in a high degree of improvement in our data that, along with the staff in our Maternal Loss and Trauma service now being able to input their data into RiO. We now almost meet the target and expect to exceed it over Q1 of 2024/25. Due to the SPE, the Specialist Perinatal Service in our mental health Trust has a full overview of the need, acuity, and demographic composition of referrals for PMH support/treatment. The service's work with partners and the expansion to two-year support is going well. The service will focus attention on therapeutic interventions (including groupwork) and on specific health inequality issues in 2024/25.

Children and young people mental health access:

Improving access for children to mental health services has improved from last year but is still far below the national target. We are working closely with our Mental Health Trust, AWP, to review the contributions from each service to the access rate and support performance improvement, where necessary. There has been a significant investment into CAMHS services to support the improvement of the access rate but there have been challenges to recruitment which have led to delays in this additional capacity. The mental health support teams (MHST) continue to develop and embed

into local schools which will support an increase in access to support. NHSE have confirmed a wave 12 of new MHST teams, which was welcome news for BNSSG with benefits starting to be seen from 2026.

Access to Talking Therapies service:

Despite good clinical outcomes that are well above the national target for people being supported by the service, and despite access rates improving in 23/24, Talking Therapies continues to miss the access target. This is an issue for services nationally as well as locally within Bristol, North Somerset and South Gloucestershire. This is predominantly due to difficulties in recruitment for Psychological Wellbeing Practitioners (replicated in the Southwest and nationally) and a lack of referrals into the service. Our provider, Vitaminds, has a dedicated Partnership Liaison Team who actively reach out across our area to promote Talking Therapies and there has been a national *Help Us Help You* campaign to improve access for people from diverse communities, for 16–18-year-olds and partnering with Age UK to reach more older people.

Inappropriate out of area placements for mental health:

We have improved the number of inappropriate out of area bed days for adults. Performance has been overachieving our local targets since September 2023 and we will continue to work with our system partners to continue this improvement to support people nearer to home and their communities.

People accessing Individual Placement Support (IPS):

Although we have not achieved our operational target in 23/24, performance has been improving and more people with SMI are accessing this vocational and employment support than last year. There is additional funding being allocated to support this programme in 24/25 and we hope to continue improving access.

23/24 Mental Health Expenditure

As in previous financial years, BNSSG ICB achieved the Mental Health Investment Standard in 23/24. In 23/24, the ICB's Mental Health programme spend was 8.76% as a proportion of the overall ICB allocation as shown in the table below. This represents Mental Health spend in inpatient and community settings, across NHS and non-NHS providers including local authorities, voluntary sector and private sector providers.

Table 4

Financial Years	2022/23 Annual MHIS Spend	2022/23 Months 4 to 12 MHIS Spend	**2023/24 Annual MHIS Spend**
	£000	£000	**£000**
Mental Health Spend	164,919	123,104	188,644

ICB Programme Allocation	1,930,275	1,476,305	2,154,499
Mental Health Spend as a proportion of ICB Programme Allocation	8.54%	8.34%	8.76%

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

Learning Disability and Autism

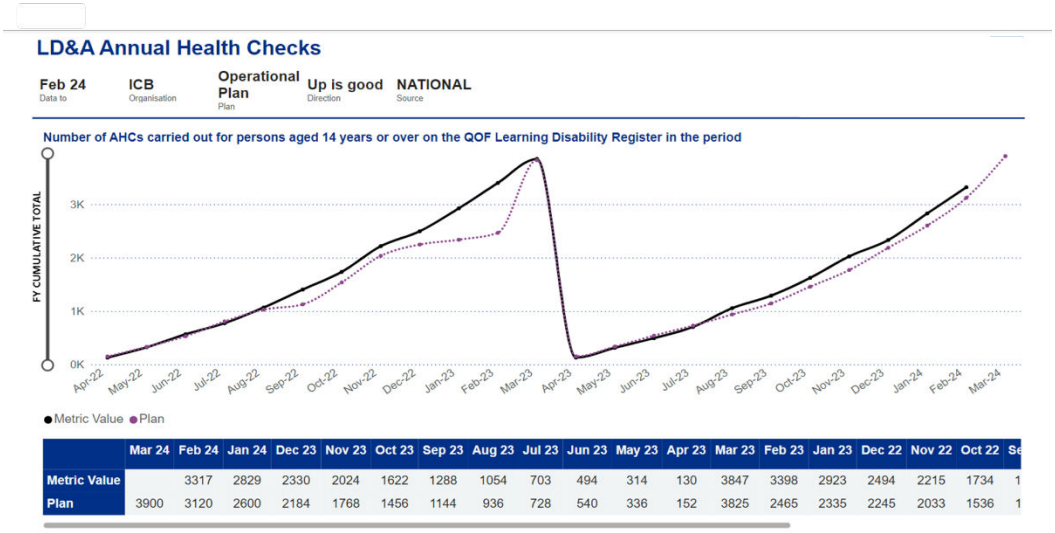
This year we have been working collaboratively with all stakeholders from across the system and we continue to work in partnership with people with learning disabilities, autistic people, and those with lived experience.

We want everyone with a learning disability and/or autism to live longer, healthier and happier lives. This means we need to ensure people are supported to have more choice, control and independence; and to always be treated with dignity and respect. We believe it is important that these improvements are embedded via a rights-based approach, focusing on citizenship and belonging.

Improving health

To support our aims of improving people's health, our current data shows that across BNSSG we have met 87% of the annual health checks national target. The 2023/24 LTP target is 75%. In 23/24 we have been delivering above our plan every month since August 2023 and expect to continue to exceed the plan and national standard at year end.

Figure 8: LD&A Annual Health Checks



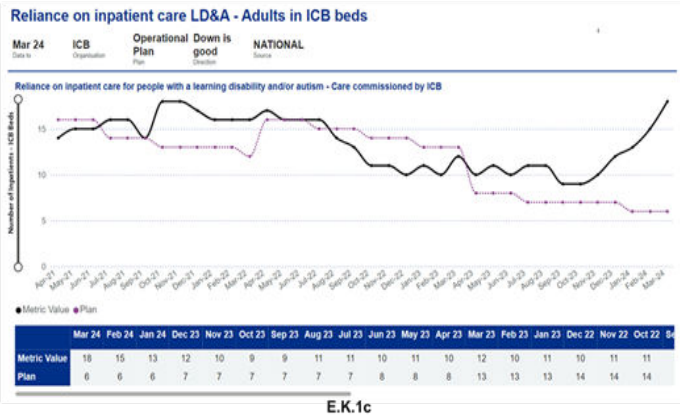
	Mar 24	Feb 24	Jan 24	Dec 23	Nov 23	Oct 23	Sep 23	Aug 23	Jul 23	Jun 23	May 23	Apr 23	Mar 23	Feb 23	Jan 23	Dec 22	Nov 22	Oct 22	Se
Metric Value		3317	2829	2330	2024	1622	1288	1054	703	494	314	130	3847	3398	2923	2494	2215	1734	1
Plan	3900	3120	2600	2184	1768	1456	1144	936	728	540	336	152	3825	2465	2335	2245	2033	1536	1

Annual Health Checks are important as people with learning disabilities and/or autism often have several co-morbidities and generally have poorer health outcomes than the general population, dying circa twenty-five years earlier, e.g. men with learning disabilities die on average 23 years sooner than men in the general population, whilst women with learning disabilities die on average 27 years sooner. Adult men from minority ethnic groups with severe, profound and multiple learning disabilities often die the youngest. Those living in the most deprived neighbourhoods, also often die earlier compared to those in the least deprived neighbourhoods. We are working on ensuring these findings are reflected in projects which aim to improve care and support and to tackle the health inequalities experienced by people with learning disabilities and/or autism.

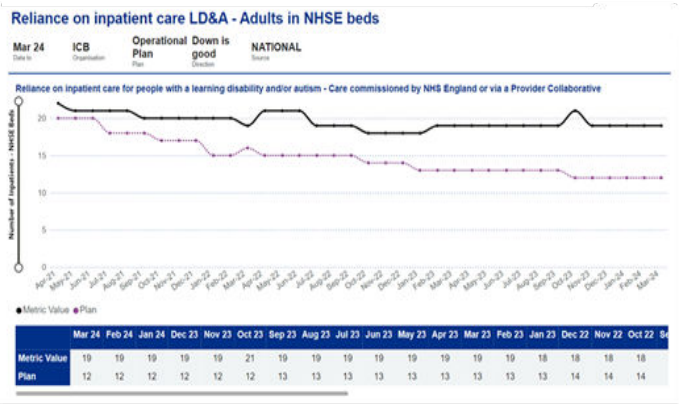
Although we continue to meet our annual health check targets month on month, further work is needed to improve our inpatient patient performance which is currently below target.

Figures 9, 10 & 11: Reliance on inpatient care LD&A – Adults in ICB beds; Adults in NHSE beds; Children in inpatient beds

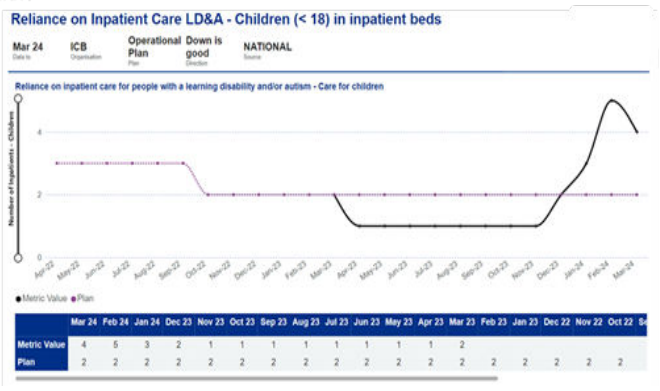
E.K.1a



E.K.1b



E.K.1c



We have a range of improvements underway as a system to support prevention and develop the right provision across the ICS which includes: new housing opportunities, the development of the North LDA treatment and assessment service and an improved Dynamic support Register (DSR) which will provide a process through which more

proactive support can be planned and put in place. Our plan is to achieve a minimum of circa 10% reduction from current position in the next year, this equates to 3 people and is reflective of the high complexity of the current cohort of people.

We continue to undertake numerous health projects with people with learning disabilities and/or autism to address the health inequalities they experience, on cancer, constipation, obesity, and aspiration pneumonia. We are in the process of developing a comprehensive programme of physical health support for people with learning disabilities and/or autism, involving partners across the system (as part of our health inequality improvement plans). Co-production policy and processes for adult social care are being developed through a working group of people with lived experience and user led groups.

Voice and influence

Ensuring people with learning disabilities and/or autism have voice and influence is a key ambition for the ICB and we aim to ensure co-production is embedded in all our programmes of work. There remains a funding commitment to this process in order to build systems and forums for people with learning disabilities and/or autism to be equal partners in our different workstreams. We are keen to implement a pure co-production culture and are developing a robust and inclusive model across the system (coordinated across health and care partners). This includes a policy design working group, through which we have established a core group of experts-by-experience, to test end-to-end learning disability and autism pathway journey through services.

Sir Stephen Bubb, Director of Chairty Futures and former Chief Executive of the UK Chairty leaders representative body; Association of Chief Executive of Voluntary Organisations (ACEVO) worked with stakeholders to make recommendations for the development of a national commissioning framework. What is now known as the Bubb review, the report makes a series of recommendations for the NHS, local government, regulators and the government, to support people with learning disabilities and/or autism move out of hospitals and into the community. We have a number of programmes in flight which seeks to implement the ten Bubb review recommendations and amongst others aim to:

- Ensure tour provider market has the capacity and resilience to provide highly individualised quality care (in line with Long Term Plan commitments and the Building the Right Support national service model - in collaboration with NHS Lead Provider Collaborative).
- Support people to stay living locally when behaviour becomes exceptionally challenging; to return from out of area placements; contribute to placement development (i.e., employment, community inclusion) and quality improvement.
- Take a discovery approach to better understanding the challenges and opportunities affecting some of our most vulnerable people.

Learning Disabilities Mortality Review (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme is a national programme designed to review the quality and improve the experience of services for people with learning disabilities and/or autism using health services. A review is undertaken when the death of a person with a learning disability and/or autism is notified, whether they die in hospital or in the community. This involves looking at GP, hospital, and community patient notes for the last couple of years of the person's life, against an enquiry review template designed by NHS England. During a review any family member, the GP and staff who knew the person well, will be interviewed to get a portrait of the person and the care they received. The reviewer reports on their findings and makes recommendations.

Over the course of 2023/24, we received 75 new notifications and closed 41 cases. We are working on increasing our resource capacity to ensure a sustainable, stable reviewer workforce that is dedicated to completing LeDeR reviews. In the interim, we have secured additional capacity to help address the increases in demand. Notifications for deaths of ethnic minority people is not optimal and we are working with ethnic minority communities to improve awareness of GP's LD registers and plan to work with our GP Collaborative Board to understand the demographic of GP's LD registers.

The LeDeR report identified the five most common causes of death for adults with a learning disability nationally as being:

- Circulatory system (16.7%)
- Cancers (14.6%)
- Respiratory system (14.6%)
- Nervous system (13.6%)
- Congenital malformations and chromosomal abnormalities (13.3%)

In BNSSG, the most common cause of death is aspiration pneumonia and pneumonia, and we are planning a deep dive focussing on our Acute Trusts Structured Judgement Reviews (SJRs).

Community Services

Across Bristol, North Somerset, and South Gloucestershire, Adult and Children's community services are provided by Sirona care and health.

There is an improving workforce position within Community Nursing however demand is exceeding capacity, despite the impact of internal change programmes.

Planned rehabilitation referrals are currently 34.8% above target. Recruitment remains a challenge. Demand and capacity work is being undertaken to support improvements in this area.

The Discharge to Assess transformation programme has resulted in marked shifts in workflow and required Sirona to be agile to meet the changing needs of the system.

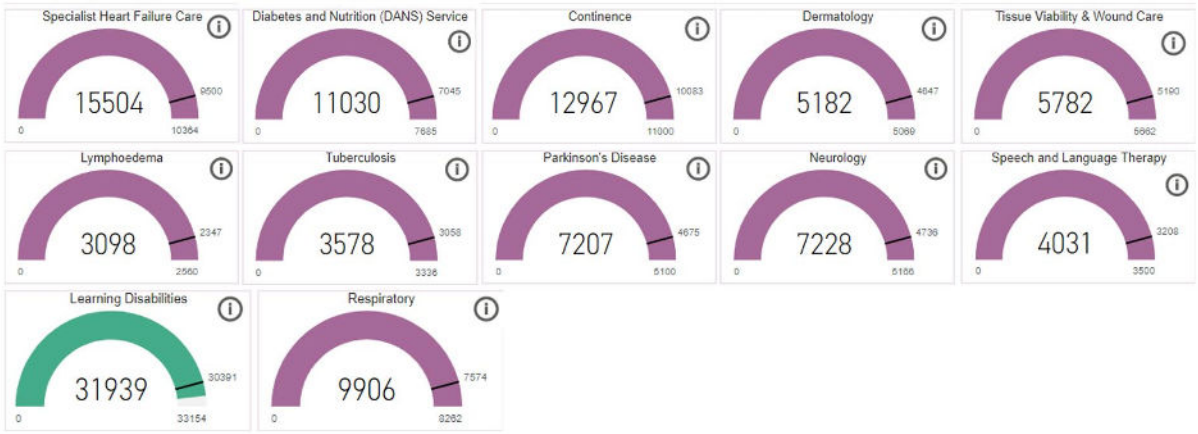
Pathway 1 (support to recover at home) demand has remained static however Pathway 2 (rehabilitation in a bedded setting) has remained significantly above target with a higher than planned length of stay. Pathway 3 (assessment bed where home is not an option at the point of discharge) demand is also static but below target. Sirona are integral to the transformation programme and are proactively working to drive efficiencies and quality through the Discharge to Assess pathways.

Within Specialist Services, all 12 services with a contact target have delivered higher than target year to date. Over-delivery in these areas has been attributed to a combination of response to increased demand and improvements in recording non-face-to-face patient contacts.

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

Figure 12 - Non RTT 18-week performance

Figure 13 - Contacts Against target (specialist services)



Funded Care Services (Children's Continuing Care, individually funded Mental Health, Learning disability and Autism, Adult CHC,) including Referral Support services and Exceptional Funding Requests

The team has expanded in 23/24 and have welcomed the Referral Support Service and the Exceptional Fund Request team under the umbrella of Funded Care.

The individually funded care teams assess and work with some of the most vulnerable children, young people and adults in our population; those with complex physical, psychological and social needs for which cannot be met by universally commissioned services.

In 23/24 the team have seen increased demand on them, and it is apparent that many more individuals live in the community with a higher level of need requiring a multi-agency team to ensure they are able to live well in the community.

Despite the increased demand and the impact of organisational change, many achievements have been made and the team remain committed to a culture of continuous quality improvements to deliver efficiencies and best outcomes for the population.

- A complete review of the Fast Track case load has enabled the team to make sure individuals are in receipt of the right care in the right place. This has resulted in the caseload size now being in line with similar ICB's.
- Building on the improved performance of the CHC team, the team are working to sustain the improved position and the accolade of most improved in the

South West. Part of that is delivering the service in the most efficient way. Using the Calderdale framework, a review of the pathway has been started to review who undertakes tasks at each part of the pathway. The aim is to move non-clinical tasks away from registered nursing to create clinical capacity to undertake assessments and reviews.

- The team have contributed to the development of a system dynamic support register for Children and Young pope at risk of hospital admission.

Primary Care

2023/24 has continued to be a challenge for our 76 GP practices, 20 Primary Care Networks (PCNs) and 24/7 GP Out of Hours service in terms of patient access and experience, workload and demand, workforce and estates. This includes an ongoing increase in same-day demand and patients presenting with higher acuity.

This year also saw us expand to delegated responsibility for pharmacy, optometry and dental (POD) services who are also not immune from these challenges.

General Practice

In May 2023, along with the Department of Health and Social Care (DHSC), NHSE published a two-year delivery plan for recovering access to primary care.

This was incredibly helpful to guide us to address the inequality in access we know there is in general practice across BNSSG.
We developed a system level access improvement plan based on patient survey results and a triangulation of all patient feedback in relation to the key areas to inform our actions. Our plan was used as an example of best practice in the South West.

All of our 20 PCNs developed capacity and access improvement plans, supported by data packs on current access and population health information. They have and continue to work hard to deliver the access recovery plan and continuous improvement for the populations they serve.

We delivered 4% more appointments than last year, nearly 6 million appointments, meeting the National ambition. This included:

- 40% of appointments same day, for those who are clinically appropriate
- 85% of appointments within 14 days, above the National average
- 65% of appointments Face to face
- 30% of appointments Telephone Consultations

We increased our workforce by 3%. We met the national target for additional roles and we did well at increasing non-clinical roles. However, the challenge continues to

recruit and retain our GPs and nurses. Work started on our primary care workforce strategy in alignment with the long term workforce plan that was published this year.

The Training Hub continues to be vital in supporting recruitment and retention initiatives in general practice. 82% of Newly Qualified GPs completed the 2-year Fellowship Programme. Our recent evaluation suggests 100% of Newly Qualified GP Fellows intend to continue working in general practice, and 98% intend to continue working in substantive roles. 100% of GPNs (at the 6 and 12 month points of the Fellowship Programme) intend to continue working in primary care.

There has been significant work on implementing digital solutions to support the management of workload. While all patients can still access their GP Practice through the usual routes, we have continued to support the move to a digitally enabled operating model. We're making significant progress here, with digital telephone systems to enable call waiting and call back, electronic patient records, supporting technology enabled care and more.

- 67% of our practices use advanced telephony
- 72 practices signed up to online patient access to records
- 100% of practices offering an Online Consultation option
- 60% uptake of the NHS App

To support the access work our primary and secondary care interface is crucial, we have established a monthly group to look at culture, planned and urgent care to do this.

The work to improve access supports our practices to deliver their core contract requirements but they are also supported to provide supplementary services. This is an important part of the care our population receives, and we needed to review our provision of services commissioned via these agreements. This has required a significant amount of work this year to engage and review this specification with stakeholders.

Community Pharmacy

The success of our Community Pharmacist Consultation Service for patients requiring simple advice, treatment and urgent repeat prescriptions has continued reaching 7000 referrals per month, exceeding our goal.

January 2024 saw this transition into the Pharmacy First service which adds to the existing consultation service and enables community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways.

In addition, we have worked to successfully recruit three pharmacies to pilot the Independent Prescribing Pathfinder Programme to establish a framework for the future commissioning of NHS community pharmacy clinical services that incorporate independent prescribing for patients in primary care.

Dentistry

Work has commenced to develop our dental strategy with two successful workshops taking place in 23/24 with a wide range of stakeholders. The aims of the strategy have been agreed as:

- Reducing health inequalities, by increasing access to NHS dental provision
- Developing the workforce, retaining staff and attracting more applicants
- Reducing the burden of dental disease through oral health promotion and integration with other services

Further engagement is now underway with stakeholders.

We are striving to improve access to NHS dentists and the units of dental activity. Significant work resulted in the successful opening of a practice in the St Pauls are of Bristol and we continue to support the stabilisation pilot into 2024/2025 which enables people who do not have a dental home, but do have high oral health needs to be referred to a dental practice for a course of treatment to stabilise their oral health.

A proposal was developed and agreed to commit non recurrent investment for one year's training for all dental practice staff for the General Dental Council recommended hours to support recruitment and retention.

A pilot has also been developed and agreed to support increasing access to dental services for children in care. Work is underway to implement the National Dental Recovery plan in BNSSG and the minimum UDA of £28 has been implemented across providers and providers have been invited to opt in for the new patient premium.

Notwithstanding this access to dental services remains a significantly challenging area for our population and we anticipate this taking several years to recover, supported by national contract reform.

Community Optical Services

Our optometry practices are conveniently located across BNSSG. This enables the system to utilise both the clinical skills and specialist equipment that they possess to alleviate unnecessary pressures from overburdened secondary care services as well as GP practices who are often the first port of call for these patients.

The eye accelerator programme is moving forward after overcoming barriers and agreeing next steps towards an integrated digital system. This is a significant step from the current position of the Eye Hospital being on one digital platform and 2/3 of opticians are on a community platform. Adoption of an accepted integrated system will allow the developed and agreed referral pilot between community practices and

the local Trust for macular referrals to be implemented. Learnings from this pathway will help to refine an overall approach to direct referral options.

It is important to share that the success of the work outlined above this year has been due to the continued collaborative working between the ICB, General Practice Collaborative Board, Avon Local Medical Committee, One Care and BrisDoc. The lessons learned here have enabled us to develop the same relationships with Community Pharmacy Avon, Local Optical and Dental Committees in continued challenging times.

Safeguarding Children and Young People and Vulnerable Adults

Following a thorough business case to increase the resource in the ICB Safeguarding Team, additional funds were assigned to support a new structure to deliver the ICB statutory safeguarding duties in December 2022. The financial year of 2023-24 has been spent recruiting into many of these statutory roles, inducting staff, and reviewing what the ICB Safeguarding Team can offer to the system and to Primary Care. The relationships with system partners have strengthened during this time, providing clarity on what the new structure can offer in terms of system support and place based relationship management by a team of all-age Deputy Designated Nurses for the three local authority areas.

BNSSG ICB is a statutory partner in all three Local Authority areas by various configurations for the Safeguarding Children Partnership/Adult Boards/Community Safety Partnership arrangements. In line with the statutory guidance, and adherence to the NHSE Safeguarding Accountability and Assurance Framework (SAAF) the ICB has Designated Doctors for Safeguarding Children and Children in Care, Named GP's all age safeguarding, Designated Nurses/Professionals for Safeguarding Children in Care (CIC), Children and Adults at risk. The ICB contributes to Annual Reports written by the Safeguarding Partnerships and Boards operating within the BNSSG footprint for 2023/24 and these will be published during Autumn 2024 on the following five websites.

Welcome to the Keeping Bristol Safe Partnership website. (bristolsafeguarding.org)

Adult Safeguarding Board | Adult Safeguarding Board (nssab.co.uk)

Category: Adults | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)

Childrens Safeguarding Board | Childrens Safeguarding Board (nsscp.co.uk)

Category: Children | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)

During Quarter 1 and 2 of 2023/24, the ICB Safeguarding Team collaborated with Exec sponsors from South Gloucestershire Council and Avon and Somerset

Constabulary to support the Local Government Association (LGA) to conduct a review of the Safeguarding Partnership arrangements. The outcome of this piece of work has been the agreement of a Systemwide Safeguarding Transformation Programme which is intended to be supported by either an independent full time Programme Manager or resources in kind from across the system, which will bring challenge and rigour to the system. This programme of work is also linked to the requirements under 'Working Together to Safeguard Children 2023' which enforces that each safeguarding statutory partner is required to identify a Lead Safeguarding Partner (LSP) and a Delegated Safeguarding Partner (DSP). Further implementations relating to this revised statutory guidance will be prioritised during 2024/25.

The ICB Safeguarding Team during this financial year has continued to contribute to partnership arrangements, including, leading some sub-groups across the system, and delivering the statutory safeguarding duties, including safeguarding statutory reviews. During this reporting period, there has been a surge in statutory safeguarding reviews with specific peaks in Quarter 2 for Safeguarding Adult Reviews and Quarter 4 for Rapid Reviews. The team has refreshed how these processes are monitored and created process maps and trackers to aid clarity on which stage each review is at, as well as traction on the implementation of recommendations.

Following the safeguarding extract in last year's Annual Report 2022-23, a 'Leading Culture Change in Safeguarding Course' was commissioned by the ICB for system partners, using NHSE Safeguarding Programme monies to support strategic leaders in how changes could be made in this sector. This course was delivered by the University of Worcester and received excellent feedback. Attendees found the 2 day training course engaging, found the networking opportunity and protected time with safeguarding peers a valuable exercise and thought provoking in how and what could be changed to improve safeguarding both in practice and in strategy.

During this financial year, the ICB Safeguarding Team have also delivered a development session to the ICB Board; providing information on what the ICB safeguarding statutory duties are, some of the system learning points from statutory safeguarding reviews for both children and adults and encouraging a conversation in relation to professional curiosity at system executive level. The session was met with positive and challenging feedback, with an invitation to attend on an annual basis with updates.

Dedicated time has also been spent this financial year in designing and developing the ICB Safeguarding Team offer to Safeguarding Link GPs within GP Practices. Named Professionals for Primary Care were recruited into these posts, and together with the support of Named GPs a comprehensive training offer has been made. Further work is planned for 2024-25 to host some events in person, offer regular 'lunch and learn' sessions to provide Safeguarding Link GPs with updates on

national policy changes, learning points from statutory reviews and other appropriate messages.

During Quarter 3 2023-24 the ICB Safeguarding team launched a new mechanism for monitoring the safeguarding training compliance of all ICB staff for all levels 1-5 using the e-learning platform Consult OD. This required the team to agree a training matrix to determine levels of training by role. Since the launch, the ICB Safeguarding Team have delivered a number of 'Think Family' Level 3 training to ICB staff to support them with their compliance. Having a mechanism to provide oversight of training competence enables the ICB Safeguarding team to understand and target safeguarding training interventions so that the subject of safeguarding children and adults is part of the organisation's core business.

The ICB Safeguarding Team has provided the Outcomes, Performance and Quality Committee with a number of safeguarding reports illustrating the delivery of statutory duties, achievements undertaken by the team or system and risks known and understood by the ICB Safeguarding Team. There is also a direct reporting line into the Chief Nursing Officer as Executive Lead for Safeguarding in the organisation who regularly meets with the Designated Nurses/Professionals and Head of Safeguarding in terms of accountability of delivery against the statutory duties.

The ICB hosts an All-Age Safeguarding Health Professionals Network and a Strategic Health Safeguarding System Group. Safeguarding assurances have been sought from health partner organisations via quarterly reports and their own safeguarding annual reports. Further work is planned for 2024-5 to use a Quality Management System approach to seek safeguarding assurance from health partners in the system.

As per SAFF guidance ICB workstreams have included the list below but is not exhaustive.

- CP-IS
- FGM
- Prevent
- Working Together
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Liberty Protection Safeguards/Mental Capacity Act

Confirmatory Statement that BNSSG ICB has followed the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework.

"*All previous functions and duties of BNSSG CCG have now passed to the BNNSG Integrated Care Board (ICB) including commissioning responsibilities and contracts. Safeguarding duties have transitioned with BNSSG executive leads. BNSSG's core*

principles of Safeguarding children, young people and adults at risk in the NHS, including protecting the paramountcy of children, are sustained by adherence to the Safeguarding accountability and assurance framework "(SAAF) NHSE 2022

Children in Care

To reflect statutory guidance, Children in Care should receive an initial health assessment to evaluate the child's physical health and any requirement for access to specialist behavioural, mental, and emotional health assessment within 20 working days of becoming a child in care. The performance against this metric has been challenging for some time owing to timeliness of notifications from the local authority, capacity, and availability of community paediatricians within Sirona Care and Health to undertake the assessment and a proportion of appointments where children were not brought. System partners continue to work together to improve performance against this statutory timeframe. A working group was also set up during this financial year to closely monitor this position which has been reported to be useful by all system partners and is led by the ICB Performance and Delivery Team.

In addition to the above, system partners have been working together this financial year to agree an enhanced pathway for unaccompanied asylum seeking children to reduce duplication in terms of assessment and provide a more holistic approach for the child. System partners are aiming to agree the new pathway in Quarter 1 2024-25.

Improve Quality

The ICB has a duty to ensure that safe, high quality, and effective health services for the people of Bristol, North Somerset and South Gloucestershire are in place as per section 14z34 of the National Health Service Act 2006 (as amended by the Health Care Act 2022). In 2023/24 the ICB commenced the standardisation of this oversight and monitoring by developing a Quality Management System, based on the principles of Quality Monitoring, Quality Oversight, Quality Assurrance and Quality Improvement. Our Outcomes, Performance and Quality Committee ensures comprehensive oversight and monitoring of the quality of services, providing assurance to the ICB Board. Highlighted below are some of the key indicators of quality and performance against these across our system.

Infection Control Management

Between 1 April 2023 and 31 March 2024 there were 308 cases of *Clostridioides difficile* Infection (CDI) assigned to the ICB. The threshold set by NHS England is 284 cases and the number of cases reported show an increase in cases in comparison with the previous year (240 cases in 22/23). New infection continued to be the main categorisation. Despite the overall increase there have been periods of reduction in hospital associated cases where significant amounts of focused work have been undertaken. A systemwide CDI case review has been developed enabling the full patient pathway prior to the development of CDI to be understood and enable

the identification of themes, trends and associated learning. This will be expanded in 2024/25 to include other healthcare associated infections.

During the same period (1 April 2023 and 31 March 2024), there were 580 cases of E. coli bacteraemia assigned to the ICB. The threshold set by NHS England is 505 and the number of cases reported showed an increase in cases in comparison with the previous years (459 cases 2022/23 and 516 2021/22). The majority of the cases continued to be Community Onset. There were 180 assigned cases of Klebsiella bacteraemia against an ICB threshold of 147. A systemwide Urinary Tract Infection working group had been established to bring together work across the system that can assist in the reduction of gram negative bacteraemia's including antibiotic stewardship for urinary tract infections, catheter care and hydration.

34 cases of Methicillin Resistant Staphylococcus aureus (MRSA) were assigned to the ICB meaning that we did not meet the standard. Commonalities from hospital associated MRSA cases were, patient's having multiple admissions or continuous inpatient stay, longstanding invasive devices, compliance issues with aseptic non touch technique on insertion, management of cannula/peripheral line (and accurate documentation), incomplete admission screening for MRSA (high risk), catheter specimen urine not being taken with MRSA admission screen, incomplete catheter bag change documentation, cannulas removal after a certain time period/not required.

216 cases of Methicillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia cases compared to 182 cases reported in 2022/23. The ICB is collaborating with a regional improvement group to address this increase and improve things for 2024/25.

59 assigned cases of Pseudomonas Aeruginosa bacteraemia against an ICB threshold of 60. This was the only infection likely to meet the threshold target.

During 23/24 the Antimicrobial Stewardship group focused on course length in primary care and the IV to oral switch of antibiotics in secondary care. Both UHBW and NBT met the IV to oral switch CQUIN target. In primary care the appropriate course length of amoxicillin was the focus and in January 2024 BNSSG ICB had the highest national rate of 5 days prescribing. Primary care is also meeting both the nationally set prescribing measures, for most of the year being one of only 10 ICBs to do so and the only ICB in the South West to meet this measure.

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

During 2023/24, system partners shared plans and the learning from successful strategies to support staff Flu and Covid vaccination take up. Staff vaccination rates for our NHS system partners and Health and Social Care staff are given below.

Table 5: Staff vaccination rates for BNSSG system partners

Organisation	Front Line Healthcare workers influenza vaccination uptake rate up to end Feb 2024.	Front Line Healthcare workers with Direct Patient Care vaccinated with influenza vaccine up to end of Feb 24
North Bristol Trust	48.0%	51.3%
Sirona Healthcare	66.6%	74.2%
University Hospital Bristol and Weston Foundation Trust	42.2%	48.2%
Health and Social Care Staff	20%*	N/A

**Capacity Tracker data*

Local providers have been meeting across the system to share learning and good practice. This year co-administration of both covid and flu vaccines was encouraged for eligible staff, with providers offering vaccination at a range of clinic times and days to try to be as accessible as possible. An updated cross system film featuring staff from organisations across Bristol, North Somerset and South Gloucestershire was shared with partners to encourage staff to come forward for vaccination. Also following staff insights, a 'be in control, get vaccinated' campaign was issued to ease staff worries and dispel any myths. Working in collaboration with local authorities, supportive communications was also issued to home care staff and GP Practices.

BNSSG ICB overall showed an uptake of 52.5% as per the end of February 2023 (ImmForm) for the 2 and 3 year old flu vaccination cohort. This was higher than the South West and national average for 2 and 3 year old vaccination uptake. However, within BNSSG variation had been noted across PCNs and at individual practice level in particular with the areas of low uptake being identified as areas of socio-economic deprivation, therefore project work was undertaken in 23/24 to help reduce these inequalities. The learnings from the pilot work in children centres and community clinics in areas of low uptake undertaken in 2022/23, suggested it would be good to explore clinics in a nursery setting in 2023/24. So this was a focus area and a pilot set up. The pilot work included 5 nursery vaccination clinics across the BNSSG area, with 39 children vaccinated in a nursery setting.

The School Aged Immunisation Service (SAIS) clinic also supported this 2 and 3 year old workstream via the provision of opportunistic vaccinations to younger siblings at catch up clinics and vaccinated 49 children, with a high proportion of

these being for the injectable vaccine. Targeted communications were also key to supporting this work. Positive feedback was received from both children, their families and nursery staff in relation to these vaccination offers.

We also offered vaccination via community clinics, however, this had very low interest, indicating that the approach of Community Vaccination Clinics for 2-3 year olds may not the best way to encourage higher vaccination uptake, this is in contrast to the nursery pilot which had good uptake. This reinforces the learning from our Weston Campaign that we need to make vaccination as easy as possible for parents – go where they/children already are, rather than standing up dedicated events.

By the end of February 24, 52.5% of 2 year olds and 52.0% of 3 year olds had been vaccinated, higher than the South West average.

In our area 81.8% of the 65 years and above age group were vaccinated with the flu vaccine in 2023/24, which is positive and 46% of those classified as ‘at risk’ aged under 65 years. This season, we worked closely with health charities and support groups to support vaccination messaging to those in clinical at-risk groups. Further work in this area will continue in 24/25 to support access to vaccination and gain further insights. As per last year we were able to offer vaccination to patients in community clinics in areas of low uptake as well as via the GP practice, community pharmacy and midwives to support access to vaccination.

A comprehensive evaluation of the learning from the vaccination work streams will be used when planning for the 2024/25 season, with focused working groups with system wide involvement.

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

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

ICB quality surveillance

We have established a Bristol, North Somerset and South Gloucestershire Serious Incident Learning monthly panel with stakeholder and partner organisation

representation. This is a robust environment where our system can understand and share learning from themes/trends following Patient Safety Incident Investigations and quality improvement deep dives. Our System Quality Group (SQG) provides a strategic forum at which partners from across health, social care, public health and wider within the ICS can join up to consider:

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

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

Patient Experience

The ICB recognised that the voice of local people and communities was imperative and continued to engage with them to co-design and co-create new services. One of the main challenges faced was how to use data intelligently to lead to real improvements in patient experience. By continuous analysis of patient experience information and learning encountered along the way, themes and trends can be ascertained to help improve the patient experience.

The Customer Services Team continued to gather feedback from patients through compliments and complaints, advice and liaison enquiries, MP enquiries, feedback from healthcare professionals, patient surveys and Healthwatch reports. The Customer Services Team will also be developing and improving how they gather patient feedback in 2024/25.

The ICB uses social media, including X (formally Twitter) and Facebook, and monitor responses posted on the NHS Choices and Care Opinions websites. A customer satisfaction survey was sent to all patients raising a complaint, and this data was regularly reviewed with colleagues across the ICB.

During the first quarter of 2023/24 the ICB received 502 contacts, 373 General Enquiries, 86 formal complaints, 13 Compliments and 30 MP/Councillor enquiries. In Q1 1 complaint to the Parliamentary and Health Service Ombudsman was outstanding form 2022/23

During quarter two of 2023/24 the ICB received 770 contacts, 483 General Enquiries, 232 formal complaints, 10 compliments and 37 MP/Councillor. 2 complaints were reported to the Parliamentary and Health Service Ombudsman.

During quarter three of 2023/24 the ICB received 932 contacts, 628 General Enquiries, 230 formal complaints, 25 compliments and 49 MP/Councillor. 1 complaint

was outstanding from quarter three reported to the Parliamentary and Health Service Ombudsman.

During quarter four of 2023/24 the ICB received 952 contacts, 603 General Enquiries, 275 formal complaints, 19 compliments and 56 MP/Councillor there were no further complaints reported to the Parliamentary and Health Service Ombudsman and 0 outstanding from quarter three.

Patient experience was used to improve how the ICB operated across the health system. Feedback and analysis of trends or themes were shared with the Quality Committee and Governing Body, to ensure that learnings were shared, and patient experience improved.

- The Customer Services Team continued to provide training for ICB staff regarding patient feedback, how this is used and why it is important to the ICB as service commissioners. This was also explored at the corporate induction for all ICB new starters.
- Customer Services implemented regular meetings with key service providers within the ICB, to discuss feedback from patients and to facilitate a swifter and smoother process for people contacting the Customer Services Team.
- Customer Services are now working alongside the South West HUB delivering all POD services and also Primary Care complaints since the delegation of these services back to the ICB in 2023.
- Customer services evolved the Clinical Review Team who met weekly to discuss complex cases, processes and strategy with a view of giving the best possible patient experience.
- There were regular meetings with external providers to improve services and to facilitate a swifter and smoother process for patients and improve collaborative working.
- Learning and intelligence collected was used to inform and update policies and related documentation, to provide a fair and transparent service for patients.
- There is now a monthly learning panel which the Quality Team, Customer Services and other trusts/providers attend to go through monthly learning which incorporates thematic reviews.

Working with our people and communities

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

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

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

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

Turning an understanding of our population into action

Understanding our population is essential to help us focus on, and prioritise, the issues of greatest importance to our people: their health and care needs, and what helps to keep them happy, healthy and well.

We developed our Joint Forward Plan by building on the work of the Health and Wellbeing Boards, and the 2023/2024 Operational Plan.

The Joint Forward Plan is structured around the four responsibilities of the Health and Care Improvement Groups (HCIGs), as listed below:

- Improve population health and wellbeing
- Deliver quality services
- Improve efficiency and sustainability
- Engage with the public and partners

The HCIGs will work together to deliver the priorities set out in the Joint Forward Plan. This will involve:

- Co-designing with patients, carers, and other providers
- Developing and implementing interventions and changes
- Monitoring and evaluating progress

As we move towards making specific changes, we will continue to collaborate, engage and consult to co-design with input from all partners, the public, our clinicians, practitioners and the VCSE and to ensure our plans meet their needs.

Partner engagement

In readiness to prepare, review and take action to update our Joint Forward Plan we delivered a number of engagement and consultation sessions with all our Health Care Improvement system groups, including our Operational System Delivery groups that sit and support our Health Care Improvement Groups. We also worked collaboratively, actively engaging and consulting through the review of our JFP with individual organisation trust boards, system partners and Health and Wellbeing Boards. The outcome of the engagement with all partners led to securing positive feedback and further input and contribution ahead of publicising the 24/25 JFP. It is noteworthy that in preparing for the review the Local Health and Wellbeing Boards and Integrated Care Partnership Boards were engaged and consulted on the draft Joint Forward Plan, with specific development sessions held for Bristol and South Gloucestershire during the month of May, this included engagement with the voluntary sector partners and Healthwatch, supported by the strategy team. For further information, in addition to the consultation sessions arranged the engagement sessions mentioned above were held at Sirona care & health's Board, acute trusts (via planning colleagues), primary care (via Integrated Care Board colleagues), Mental Health, Learning Disability and Autism, Children and Community Health and Care Improvement Groups, Health and Care Professional Leadership Group, System Medicines Optimisation Board and Integrated Care Board staff during the month of May 2023. There has been a significant amount of consultation, engagement, feedback and collaboration across the system, reflecting that this is a system-level plan. Further work is required in future iterations to ensure the plans are fully integrated, delivering the strategy as the core ambition for the system.

VCSE Alliance

The VCSE sector is a crucial part of the ICS and delivery of the strategy. The BNSSG ICB is supporting several developments that are seeking to make proactive strategic and operational changes to the engagement and inclusion of diverse VCSE organisations in the ICS. These include:

- Investment and collaboration on the establishment of a new BNSSG VCSE Alliance. Building on VCSE engagement infrastructure at locality and local authority levels, the Alliance aims to:
    - Encourage and enable the VCSE sector to work in a coordinated way to inform policy, strategy and decision making.
    - Provide the NHS, health, and social care colleagues with a single route of contact, engagement, and links to community.
    - Better position the VCSE sector to contribute to the design and delivery of integrated care.
- Co-design of a new model/framework for investment and collaboration with the diverse VCSE sector.

- Supporting VCSE leadership and participation in ICS developments.
- Generating income that builds on VCSE strengths and opportunities to invest in the VCSE and ICS.

This engaging programme is including many VCSE organisations that are focused on specific communities (for example, disabled people), different challenges (for example, mental health) or working in priority neighbourhoods. Diverse VCSE organisations are commonly staffed by people with experience, which bring specific ideas, perspectives and expertise to these developments.

Public engagement

We plan to run a second Have Your Say campaign in 24/25 to build on the extensive engagement to date. This will help us to share progress updates on key areas of work, but most importantly listen to our local communities and understand what matters most to them.

Working closely with our partners, we have undertaken several areas of community engagement and co-production, some recent examples are outlined below.

Neurodiversity Transformation Programme and working with the Parent Carer Forums: Like many areas across the country, we have seen a significant increase in demand for autism and attention deficit hyperactivity disorder assessments. To help ensure children and families can be supported appropriately, work is underway on a transformation programme.

The ICS is working closely with the Chairs of our three Parent Carer Forums in Bristol, North Somerset and South Gloucestershire to ensure proposals are co-produced and to strengthen our mechanisms for engaging and involving the wider parent and carer community in this programme.

Our Parent Carer Forum Chairs, were recently shortlisted for a co-production with parents and carers award, recognising the important contribution they provide to developing an inclusive culture and positive outcomes for people with special educational needs and disabilities.

Securing a new NHS dental provider for the St Pauls community: Working with NHS partners and local stakeholders, we have been able to secure a new provider of NHS dental services in the St Pauls area.

Following the announcement that Bupa would be withdrawing NHS dental provision at the St Pauls practice in June 2023, we regularly met with the local Dental Action Group to provide updates and to help understand the community perspective. Following a successful procurement exercise, SGA services Ltd were appointed as the new provider. The Dental Action Group supported this work, particularly helping us to target communications to local residents regarding the new practice opening.

Let's talk about MMR: Collaborating with the Bristol Somali community and local health partners, the BNSSG Vaccination Programme led the development of a short

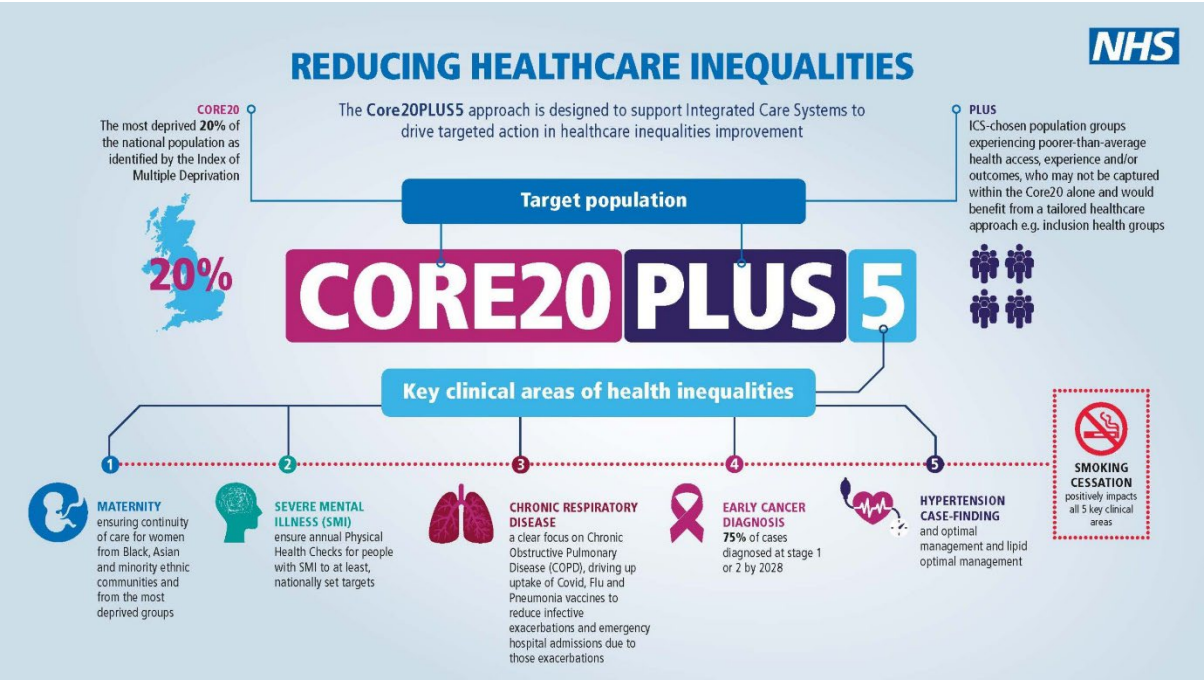
film aimed at young people aged 17 to 30 of Somali heritage to consider the MMR vaccine. Let's Talk about MMR was funded by Bristol City Council and produced by community interest group Caafi Health and the Bristol Somali community, working with a local film maker from Inner City Bristol.

The film has been viewed nearly two thousand times and has been used as part of community engagement events and targeted social media activity to help us reach audiences. It has also been shared and used widely by health systems and local authority public health teams across the UK, with NHS England using for a national social media campaign.

Working with people and communities to address health inequalities

We know that gaps in care and support disproportionately affect those with the greatest needs and poorest outcomes. There is real potential to address health inequalities by ensuring that our marginalised or disadvantaged communities are reached appropriately, listened to, and involved in developing action and making changes. Our ICS has a commitment to tackling health inequalities and improving the health and wellbeing of our underserved communities, including our CORE20PLUS5 approach to reduce health inequalities. Our strategic development plan includes working with people and communities as a key enabler to our focus on extending preventative work, and emphasises the need for insight from, and understanding of, these communities as key to achieving our commitment to the reduction of health inequalities.

Figure 14: Core20 Plus5 approach



To further develop this we are working to develop a key set of principles across our partnership to enable shared recruitment and payment of lived experience reps.

BNSSG Vaccination Programmes

In April 2023, the successful approach of the BNSSG Vaccination Programme was recognised by NHS England, with our Programme named as one of 11 national demonstrator sites for vaccination. In this capacity, the remit of the Vaccination Programme expanded to include other immunisations alongside Covid-19 and flu. The National NHS Vaccination Strategy launched in December 2023 and will shape the future delivery of NHS vaccination and immunisation services. It was informed by the work of our Vaccination Programme along with the other demonstrator sites.

The National Vaccination Strategy builds on learnings from the Covid-19 vaccination programme, aiming to increase uptake of other immunisations and reduce vaccine-preventable diseases. It calls for every ICB in England to develop vaccination services that are tailored and convenient for their local population, supplement existing vaccination offers with targeted outreach, and work in a joined-up, integrated way across the system. In BNSSG, we are already applying many of the principles contained within the Strategy, which included three BNSSG case studies to illustrate the approach systems should consider: MMR Community Conversations run in partnership with community and health organisations, catch-up vaccinations for refugee and asylum seekers led by Sirona care & health, and our outbreak vaccination response to Mpox.

Our Vaccination Programme continued its work to co-ordinate delivery and increase uptake of seasonal Covid-19 and flu vaccinations during the Winter and Spring campaigns in 23/24. In addition to offering community vaccination clinics in underserved areas, our central vaccination team provided flexible support to some primary care networks (PCNs). This ranged from vaccinating housebound populations to running Covid-19 clinics in partnership with PCNs to support with capacity. During the last two months of the Autumn/Winter Covid-19 campaign (Feb-Mar 2024) when PCNs stopped offering Covid-19 vaccinations, the Vaccination Programme ran community clinics that GPs could refer people to for Covid-19 vaccination.

During 23/24, the Vaccination Programme widened its remit to include childhood immunisations, with a particular focus on increasing measles, mumps and rubella (MMR) vaccination uptake in children and young adults, in response to emerging measles cases national, regionally and locally. In summer 2023, Bristol City Council’s Public Health Team raised concerns about low levels of MMR vaccination among young people aged 17-30, with particularly low uptake in some minority ethnic communities. In response, our Vaccination Programme approached NHS England to request funding to undertake flexible, targeted work with the 15 GP surgeries across BNSSG that had the highest number of young people with no, or incomplete, MMR vaccine records. We received £70,000 funding for the project and NHS England went on to award the same amount to every health system in the South West.

Our MMR vaccination work has included supporting [Student Health Services] GP practice by working with the University of Bristol to run MMR vaccination clinics for students which have been very well-received. At one surgery, we identified issues with MMR vaccine coding and have gone on to support several GP surgeries in updating their records. We went on to raise this issue with NHS England. We also worked in partnership with a surgery in Inner City Bristol to invite unvaccinated young people to a dedicated MMR clinic.

Our approach to vaccination continues to be through collaborative partnership working with the local voluntary sector, our communities, Local Authorities, Public Health Community Development Team, general practice, community pharmacies, hospitals and the school aged immunisation service. We provide a more intense offer where need is higher, to improve outcomes and inequalities. We remain committed to building around strengths and assets in our local communities, co-producing solutions, offering community grants to local organisations to raise awareness of all aged vaccines.

Insight continued to inform and develop the vaccination delivery model across BNSSG and at a hyper local level; holding community conversations in partnership in areas where there is the greatest disparities in vaccine confidence and uptake. Our communications has continued to build on this insight, offering audio translations of vaccination information for some languages such as Somali and Arabic where it is common for people not to be able to read their spoken language. We also produced dedicated information about MMR for communities, translated into six languages.

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

<u>Autism Pathway User Experience Project</u>

Since the Covid-19 pandemic, referrals to the Autism Assessment Service in BNSSG increased significantly. During 2023, BNSSG and Gloucestershire ICBs worked collaboratively on a project to improve the experience of parents and carers while waiting for an autism assessment for their child. The project sought to develop a consistent, reliable suite of support information and pre-referral tools for parents and carers across the two ICS.

The BNSSG ICB Insights team led a three-phase discovery and User Experience (UX) project to inform the design of a pre-referral child behaviour questionnaire, and ongoing support from online guidance and resources.

Through early engagement with local autism support charities and the Parent/Carer Forums in each ICS, the Insights team scoped the key challenges faced by parents and carers throughout the pre-referral and referral process. In partnership with these organisations, we recruited parents and carers with children at different stages of the autism pathway (those considering a referral, waiting for and having received the

outcome of their child's assessment), as well as of different genders, ages and from different ethnic groups. The parent and carers themselves had varying degrees of digital literacy and involvement with support networks.

We also engaged with education professionals from primary and secondary schools of a range of sizes and with varying proportions of pupils with special educational needs.

Through 1:1 conversations and group discussion, these parents and carers and education professionals:

- **Provided feedback on early concepts of a set of digital tools to support parents and carers seeking information about autism and, whilst waiting for an assessment**. This helped us to position the child behaviour questionnaire more clearly as a supporting, not diagnostic, tool. This included using text, rather than scores, to indicate the degree to which a specific behaviour may be affecting a child and changing the structured table format to present the results. It also highlighted the value of the resources not only for parents and carers at the start of the referral process, but also for those who have received a diagnosis for their child, as well as for education professionals to recommend and draw on. It was therefore important that the resources were available without completing the questionnaire.

- **Directly informed the content and language used in these tools ensuring they were appropriate and beneficial to parents and carers.** This allowed us to tailor the language used, which included providing more examples and definitions to the child behaviour questions to help parents and carers answer appropriately. By completing the questionnaire and reading the related guidance it was felt that parents and carers would feel more informed and confident when going on to submit referral forms.

- **Tested the presentation and navigation of the webpages to ensure they were intuitive for parents and carers to use.** This led to changes to the layout of the advice and guidance pages.

Children and Young People

During 2023-24, we have been working together with system organisations, parent carers and children and young people with a common aim of providing effective and high-quality services. We have made progress against our operational plan targets and continue to deliver on the aims set out within the joint forward plan.

Improvements are being made with our health contribution to system arrangements for safeguarding children, including consistent health input to multi-agency safeguarding hubs across BNSSG, focus on the timeliness of initial and review health assessments for children in care and consistency of adoption processes and improved timescales. Alongside this, significant improvements for Special

Educational Needs & Disability (SEND) has meant there is only is only one remaining SEND Accelerated Progress Plan (APP) in place across BNSSG.

A key challenge in BNSSG is the increasing need for autism assessments which significantly outweighs capacity. Progress has been made with the discovery phase of the system neurodiversity programme that aims to address this issue and the broader challenge of meeting the needs of neurodiverse children, young people and their families. Alongside this transformation programme, additional capacity for autism assessments has been mobilised and a plan has been developed to implement an interim autism support and assessment model, that aims to maximise current resources and ensure families are able to access support that is readily available to them, in the short term whilst the longer-term, sustainable transformation programme is underway.

The recommissioning of the Autism Intensive Service (AIS) has seen significantly improved outcomes for young people in BNSSG. AIS intervention has shown improved relationships with families, peers and supporters; increased engagement in positive activities; re-engagement in education; improved emotional literacy, behavioural self-regulation and thoughts about future life directions. In addition, parents experienced a range of positive outcomes all contributing to a feeling that their daily quality of life had improved. There were no exclusions or Tier 4 admissions for any of the young people working engaged with the Autism Intensive Service during the intervention period.

Around 70 children with a learning disability and/or autism now have a designated keyworker across BNSSG. The purpose of a keyworker is to ensure the child or young person and their family have the support they need to prevent inpatient admissions to a child and adolescent mental health service (CAMHS). Inpatient numbers in BNSSG remain very low with inpatient admissions being avoided.

The children's elective recovery programme has continued to support flow and provide additional capacity resulting in a significant reduction in waiting time for elective care, with the majority of paediatric specialities eliminating 78 week waits by the end of 23/24. This focus is maintained in the 2024/25 Joint Forward Plan, paying particular attention to cardiac surgery, dental and cleft that are facing specific risks and challenge.

Maternity and Neonatal

We have made great progress across our maternity and neonatal services during 23/24. Both Acute Maternity Trusts have had CQC inspections this year- North Bristol Trust (NBT) CQC Inspection in October 23 and University Hospital Bristol & Weston (UHBW) December 23. Both maintained their 'Good' overall rating. This is particularly pertinent as 75% of Maternity Services have been downgraded. NBT's Safety rating was also upgraded from 'Requires Improvement' to 'Good', one of only five maternity services in England to have achieved this improvement.

Other key areas of work and achievement during 23/24 across maternity and neonatal services have included:

Saving Babies Lives Version 3

- Both UHBW and NBT have achieved compliance with Saving Babies Lives Version 3 (launched in June 2023)
- For this first year compliance was set at 70%, both Trusts have achieved over 80%
- Work will be continuing in 24/25 to increase this compliance

Maternity Incentive Scheme (MIS) Year 5

- Both UHBW and NBT have achieved full compliance of all 10 safety actions in MIS Year 5
- The National Picture is 92/120 trusts compliant nationally, with only 6/13 in the South West Region
- MIS Year 6 (published in April 25) and an implementation tool (similar to that of Saving Babies Lives) has been launched so that the Local Maternity and Neonatal System (LMNS) can track evidence being submitted contemporaneously.

Badgernet implementation

- Both UHBW and NBT Maternity went live with Badgernet a new electronic patient record (EPR) on September 26th 2023.
- The implementation phase has been very successful with staff transitioning well to the new way of working.
- The digital programme board continues to meet on a monthly basis with deployment of centralised monitoring the next phase.
- Discussions at a Trust level as to what programme support will be available once the implementation phase ends in April this year.

Race and Health Observatory Learning and Action Network

- One of only 9 systems across England to be chosen
- Aim to reduce health inequalities and improve outcomes for Black and Asian mothers and babies
- 15 month project with BNSSG focusing on pre-term births and the disparity with antenatal interventions between our white and ethnic minority population.
- The LMNS are in the process of publishing our local Maternity & Neonatology Equity and Equality Action Plan which sets out key priorities in reducing inequalities for 24/25

Bristol, North Somerset and South Gloucestershire Locality Partnerships

BNSSG's six Locality Partnerships come together as equal partners across the public and voluntary & community sector around the needs of their local communities. They employ population health intelligence insights to identify and tackle local priorities, aiming to join up services, simplify pathways and support a shift to earlier support and intervention.

Examples of work:

Each Locality Partnership is running a programme of cardiovascular disease (CVD) prevention, targeted to areas or communities who experience higher health inequalities. Heart disease is the single biggest condition where lives can be saved, and crucially, is impacted by modifiable factors, including access to health and care services and the social and economic conditions in which people live[1].

The programmes run health events in non-clinical community settings, for example, shopping centres and barber shops, aiming to reach residents who may not access traditional health care settings. The events provide opportunistic screening for hypertension alongside raising awareness of the lifestyle risks contributing to CVD and supporting individuals to make lifestyle changes by referral to a range of community wellbeing interventions. In tandem, health champions are identified and trained from trusted groups to work within their communities. The groups targeted vary depending on population need. For example, Population Health Management data shows geographic inequalities in the Lawrence Hill and Stokes Croft wards alongside inequalities experienced by groups including the Afro-Caribbean population, the South Asian population and drug users. In South Gloucestershire, data has directed events to the Kingswood and Hanham areas, and the Gypsy and Roma Traveller communities.

The Locality Partnerships have implemented community wellbeing workers, responding to differing community need. For example, In South Bristol, these are Community Connectors, working in defined postcodes in urban areas; in South Gloucestershire, these are Village Agents, working in rural locations; and in Weston, Worle and Villages they are Community Health and Wellbeing Workers. All live in the communities they serve and work to reduce isolation and loneliness in their populations, promote prevention opportunities and connect with local services and initiatives.

Examples of further Locality Partnership initiatives include:

South Gloucestershire Locality Partnership's Chronic Pain and Wellbeing Service runs across two Primary Care Networks, supporting those experiencing chronic pain. Individuals are identified through their GP practice and access holistic 1:1 support via specialist staff from Developing Health and Independence (DHI), working through

[1] Women & Heart Disease – BHF, para 2

a Pain Manual developed for the Service. The programme has strong links with a range of Community Wellbeing activities alongside clinical pain services, and individuals are encouraged to join specialist pain peer support groups.

Woodspring Locality Partnership have been focussed on reducing self-harm in children and young people. Led by Avon Wildlife Trust, and in partnership with Off The Record, Portishead Wellbeing Partnership and the CAMHS intensive outreach team, the Locality Partnership has developed a Green Social Prescribing project in one of our local forested areas. The programme consists of a six-session course for the children participating with three parallel sessions for parents. An experiential day is included in the programme to connect with and build relationships with specific partners. The learning and insights from this project will feed into the co-design of future Green Social Prescribing initiatives for children and young people in Woodspring. It will also inform educational workshops for parents and guardians to help them manage anxiety in children and young people in their care.

North and West Bristol Locality Partnership has been working to improve support and access to services for people with Chronic Obstructive Pulmonary Disease (COPD), particularly in the outer wards where the prevalence of respiratory illness is significantly higher than the national average. We are working with partners and are piloting a new access point for pulmonary rehab which addresses some of the known transport barriers. As part of the project, GPs and the Voluntary sector have worked together to support those most unwell over the Winter, and bring energy awareness and support to people living in cold homes to those who are eligible.

Reducing Health Inequality and Inequalities

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

Resources for health inequalities

In addition to the ‘business as usual’ budgets that BNSSG ICB allocates to fulfil its responsibilities, in 2023/24 we set up a health inequalities budget that was allocated to its Chief Medical Officer. The funding was used as follows:

- Three years of funding to the six Locality Partnerships – each of them decided how to use it to reduce health inequalities in their area in response to their communities’ needs.

- Support the increase in health and care needs of people within our communities and who are migrants. The funding is being used to support a range of services and statutory requirements.

Core20Plus5

- Blood pressure - We co-ordinated work and support for general practice and community pharmacies to find people with high blood pressure who might not know they have high blood pressure. This work focussed on people living in the 20% most deprived areas. We also supported general practices working in our most deprived areas to focus their effort and work on blood pressure on improving care for people who have the highest risk of having a heart attack or stroke. This work resulted in more people in these areas achieving lower blood pressure.

- Health checks for people with severe mental illness – we have worked with Nilaari, a Black led charity providing mental health support especially to adults from Black Asian and Minoritised Communities, and two inner city Bristol general practices to improve those practices engagement with that community and therefore improve support for their physical health issues. We exceeded the national target of 75% by achieving 81% and spent the year understanding how to break the figure down by ethnicity which we have now almost achieved. Whilst doing the work in 2023/24 we recognised that the rate of follow up from the health check, i.e. results being given, actions being taken, etc. still needs improving.

- Cancer – General practice worked to support cancer screening uptake including 43 practices developing a bespoke offer for cervical screening based on the needs of their population. The Homeless Health Service ran training events for support workers on trauma informed care and cancer screening, whilst also offering outreach services for cervical screening in settings such as the Spring of Hope Women's Centre. Primary, secondary care and the ICB worked together to create videos to explain the Urgent Suspected Cancer Referral Pathway in several languages including BSL. The ICB also worked in partnership with Sirona, the community services provider, to appoint a new Learning Disabilities Screening Practitioner who supports practices, develops resources and offers training to carers and people with learning disabilities to support them to access screening.

Policies and practices

Part of the ICB's response to the health inequalities section of the BNSSG Integrated Care Partnership's strategy has been to look at its process for progressing transformation projects. We have implemented a process where all transformation projects must complete an assessment of the effect that the work will have on health inequalities before the project can move to the next phase.

Collecting, analysing and publishing information on health inequalities

In November 2023 NHS England advised, through the 'NHSE Statement', that all ICBs (and other relevant NHS organisations) should collect, analyse and publish certain information on health inequalities within or alongside their annual report.

As this is a new requirement, BNSSG ICB has been identifying what already exists and identifying gaps which we will make a plan for filling. Of the 22 metrics listed for ICBs to report from NHS England's statement on health inequalities, we have been able to produce analysis on 12 of the metrics. The remaining metrics require either further analytical development (3), or access to data that is not currently routinely available (7). This is described in the table below.

Table 6: NHS England Statement – BNSSG ICB data availability in 2023-24

Domain	Indicator	Status
Elective recovery	Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks	Data provided
	Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances	Data Provided
	Elective activity vs pre-pandemic levels for under 18s and over 18s	Data provided
Urgent and emergency care	Emergency admissions for under 18s	Data provided
Respiratory	Uptake of COVID and flu by socio-demographic group	Data provided
Mental health	Overall number of severe mental illness (SMI) physical health checks	Not yet available to BNSSG ICB
	Rates of total Mental Health Act detentions	Needs Development
	Rates of restrictive interventions	Data Provided
	NHS Talking Therapies (formerly IAPT) recovery	Data Provided
	Children and young people's mental health access	Needs Development

Domain	Indicator	Status
Cancer	Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	Data provided
Cardiovascular disease	Stroke rate of non-elective admissions (per 100,000 age-sex standardised	
	Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)	
	CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold, by data	Not yet available to BNSSG ICB
	CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	Not yet available to BNSSG ICB
	CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy	Not yet available to BNSSG ICB
Diabetes	Variation between % of people with Type 1 and Type 2 diabetes received all 8 care processes	Not yet available to BNSSG ICB
	Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile	Not yet available to BNSSG ICB
Smoking cessation	Proportion of adult acute inpatient settings offering smoking cessation services	Not needed
	Proportion of maternity inpatient settings offering smoking cessation services	Not needed

Domain	Indicator	Status
Oral health	3.7.ii Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted	Data provided
Learning disabilities and autistic people	Learning Disability Annual Health Checks	Not yet available to BNSSG ICB
	Adult mental health inpatient rates for people with a learning disability and autistic people	Not yet available to BNSSG ICB
Maternity and neonatal	Preterm births under 37 weeks	Data provided

The summary findings from the data we have been able to collect show that:

- There is a clear relationship between deprivation and vaccine update, with flu vaccination rates significantly higher in the least deprived quintile. There is also significant variance in uptake across ethnic groups.
- BNSSGs percentage of cancers diagnosed at stage 1 or 2, when case mix adjusted, is similar to the national average.
- The most deprived quintile, and Black and Asian ethnic groups attend the most outpatient appointments, with virtual outpatient activity showing the highest rates in the more deprived quintiles of the population, whilst being notably lower in the Asian ethnic group.
- Elective inpatient activity is highest in the most deprived quintile, and there does not appear to be any statistically significant variance by ethnic group.
- A&E activity and non-elective admission rates are significantly higher in the most deprived quintile of the population than the least deprived.
- Non-elective admission rates for strokes and myocardial infarctions are significantly higher in the most deprived quintile of the pop.ulation than the least deprived
- Talking therapies rates are significantly lower in the most deprived quintile of the population than any other quintile, and lower in Asian and Black ethnic groups.
- Restrictive interventions are significantly higher in the most deprived quintile, and highest in the Black ethnic group.

During 2024-25, the ICB will work with the Health and Care Improvement Groups to share the metrics and conclusions that are relevant to their areas of work. They will

be expected to use the information to inform their workplans and projects to make improvements where appropriate.

Medicines Optimisation

Medicines are the most common therapeutic intervention and the second highest area of NHS spending. To improve health outcomes and ensure the most efficient use of NHS resources medicines optimisation is vital.

Within Bristol, North Somerset and South Gloucestershire Integrated Care System, the Medicines Optimisation vision is to implement a person-centred, collaborative approach to get the best value from medicines, investing in medicines to improve patient outcomes, reduce avoidable harm and improve medicines safety, align, and simplify processes including the transfer of information, reduce wastage of medicines and avoid patients taking unnecessary medicines. This will be achieved through safe and evidence-based prescribing, increasing patient empowerment through shared decision making whilst ensuring a sustainable pharmacy workforce to support this. Driving value through an evidence informed approach. In addition, medicines feature in the sustainability/ Green Plan for our system in which we are supporting the headline ambition to reduce the impact of medicines and medical devices on the environment.

Our Medicine Optimisation plan continues to set out our ambitions to improve patient's outcome, aligning measurement and monitoring of medicines optimisation within health and care services across primary, secondary and community care, working collaboratively. The plan had input from several stakeholders including acute, community, primary care staff and representation from system groups. The success of this plan will be driven by strong clinical leadership, a focus on benefits to patient outcomes underpinned by evidence and data, and recognition of the benefits of working together.

In 23/24, the Medicines Optimisation programme has continued to drive evidence based, safe prescribing ensuring the best value for medicines. This has been supported by a range of medicines optimisation projects in primary care including a review prescribing in type 2 diabetes patients, optimising inhaler management in COPD and antimicrobial stewardship. Other system wide projects have included supporting prescribers to choose the most cost-effective medicines such as Direct Oral Anticoagulants (DOACs) and best value biologics.

The Medicine Optimisation programme of work embeds drivers and principles within system priorities and works to reduce health inequalities, such as ensuring equitable access to medicines. Further work is planned to understand why treatment uptake and outcomes are lower in some areas than others and to do some targeted work on this.

Ensuring safe use of medicines continues to be a key priority and areas of achievement in 23/24 have been embedding the ICB Medicines Safety Dashboard to support Primary Care practices to identify significant medication risks which could lead to medication related harm and potential hospital admissions. System-wide working groups continue to facilitate safer prescribing in areas such as anticoagulation, diabetes, prescribed drugs of dependence as well as sodium valproate following the National Patient Safety Alert.

An increase in the number of various national medicine shortages has required greater focus and processes are in place to support local prescribers with advice and mitigations where possible.

In a continued effort to support healthcare professionals to tackle inappropriate polypharmacy and overprescribing, a range of training materials was completed in 23/24 and work was undertaken with Primary Care Network (PCN) pharmacists to prioritise patients for structured medication reviews, this will be evaluated in 24/25.

Ensuring the appropriate use of antibiotics continues to be high priority for the system and BNSSG are one of 10 ICBs that have achieved national targets and are amongst the lowest prescribers of antibiotics in children and benchmark in the top 5% based on evidence to reduce length of antibiotic courses in certain areas.

Great progress was also made in supporting patients to access care in the right place for them, by expanding the range of services that are available from community pharmacies, such as successfully completing the community pharmacy ear pilot, with over 3000 referrals for otitis externa, freeing up appointments in other parts of the system. BNSSG is one of the top users of the Clinical Pharmacist Consultation Scheme (now part of Pharmacy First) within the country and due to local services in place to provide medication under Patient Group Directives (PGDs) for some minor conditions, is well placed to deliver the national Pharmacy First scheme in 24/25. This also includes providing contraception and blood pressure checks. BNSSG are also part of the national community pharmacy independent prescribing pathfinder to test community pharmacists prescribing for minor ailments.

Regarding spend on medicines, the team with system partners and finance undergo a horizon scanning each year to pre-empt the financial impact of either new drugs to the market approved through NICE or growth in use of existing medicines. Along with a plan for any possible savings/ efficiencies that can be made. This is done for both primary care prescribed drugs and the more specialist prescribed medicines (high cost medicines, including some devices).

In 2023/24, the prediction for additional growth on primary care prescribing budgets was focussed around new NICE TAs, including license extension of existing medicines in diabetes and heart failure. With continued growth forecast in other areas such as treatment for ADHD and Menopause. In 23/24 growth has been almost as predicted and the savings plan has been achieved.

Research 2023/24

ICBs have a legal duty to facilitate and promote research relevant to the health service and the use of evidence obtained from research.

BNSSG ICB supported 56 high quality research studies to open recruitment in our community health and care partner organisations. These projects encompass a breadth of health conditions and topics across many health and care settings, including general practice, local authority, community care, hospice, care homes and voluntary, community and social enterprise (VCSE).

We also have our own portfolio of externally funded research grants (26) bringing £34m into our health economy. We are proud that this is the most of any ICB and is 2nd highest amongst all NHS organisations in England. The research funding is awarded to BNSSG ICB to deliver as the lead organisation in collaboration with multiple universities and health & care organisations, as well as VCSE partners.

A highlight of our activity is the diverse Research Engagement Network (REN). Working with VCSE and Patient & Public contributors, the ICB is supporting community led initiatives to increase participation in research of under-represented communities. This includes Health Ambassadors who raise awareness of our researchers and advocate for our communities, as well as schemes to improve research design and delivery so that under-heard voices are shaping our research projects and driving up standards of research delivery. The network has monthly meetings with over 140 members sharing best practice and providing space for peer support and collaborations.

DH&SC recognise and encourage research activity amongst NHS organisations through awards of Research Capability Funding (RCF). RCF is used to support local research infrastructure and drive development of new research.

In April 2023 BNSSG ICB was awarded RCF of £1.5m and we have used those funds to support more than 50 individuals across health, care and local university organisations who are developing research in areas of priority for BNSSG. We have submitted 66 applications for research grant funding (38 Outline & 28 Full) and initiated a further 19 research development projects that will lead on to grant applications in the near future.

To support our use of evidence, the ICB has partnered with University of Bristol and UWE to establish a health system embedded Impact Accelerator Unit. The Impact Accelerator Unit is dedicated to accelerating the use of evidence in our health and care services and we have been actively supporting the evidence from 13 of our research projects to be embedded into services and positively impact on the health of our population.

ICB Workforce Inequality

Within 23/24 we have continued to focus on improving diversity and inclusion within the ICB and building an inclusive and equitable culture. We have and continue to be an active participant in the most recent cohort of the NHS Diversity in Healthcare Programme with attendance from senior leaders across alongside our organisational EDI lead.

In line with the NHS EDI Improvement plan high impact actions, our executive team all have specific and measurable EDI objectives to ensure that we create a culture that values and sustains a diverse workforce. There has been a continued focus on inclusive recruitment practices; alongside system partners the ICB undertook a full audit and gap analysis of our recruitment practices closely aligned to the recommendations within the Roger Kline paper 'No More Tick Boxes'. The ICB Freedom to Speak up policy and processes were reviewed and re-launched to support the elimination of conditions in which bullying, discrimination, harassment and physical violence occur at work.

We have continued to engage with our staff networks. This has included regular meetings of our inclusion council, joint policy and system reviews and events. Examples include the Parent and Carers network supporting review of the maternity policy, the Disability Staff Network supporting review of the sickness policy and cloudbooking system and the Proud network holding Allyship training sessions and attending Bristol Pride.

We continue to iterate and improve our centralised reasonable adjustment process with support from our Disability Support Network to enable an inclusive culture across the ICB. Alongside this we have worked with our IT support colleagues to ensure appropriate support is provided for those with technological reasonable adjustments in place. We maintain a robust wellbeing offer, including mental health first aiders, mental health support and have, additionally, this year held a number of training sessions to support resilience and the impacts of organisational change.

Work to review Workforce Race Equality Standard (WRES), Disability Equality Standard (WDES) and Gender Pay Gap data to identify opportunities to improve the working life experience of our staff continues. The Equality Delivery System (EDS) 22 reporting was also undertaken, working collaboratively with system colleagues. We are committed to monitoring and acting on evidence. This year the ICB also received the bronze award from the Defence Employer Recognition Scheme and will continue to progress this work.

ICS Workforce Inequality

The ICS partners worked collaboratively throughout the year. There was a key focus on inclusive recruitment with a system wide inclusive recruitment audit undertaken and an inclusive recruitment toolkit developed and launched. System wide inclusive

recruitment workshops were undertaken with a focus on international and refugee recruitment.

BNSSG has worked with the Princes' Trust to support young people from disadvantaged backgrounds into employment within the NHS and wider health and care system, to date over 50 young people have received offers of employment. Additionally, we commissioned Careers Matters to deliver a specific project to enable people with experience of care to enter our workforce and thrive. This year we have also provided over 500 work experience placements to young people and have redesigned our work experience process to ensure equitable opportunity; this has resulted in over 50% of applications for next year's programmes received from young people within ethnically marginalised communities.

There has been a system focus on retention with a key focus on health and wellbeing. The system set itself a target to reduce turnover and this has been achieved with a reduction from 15.9% in March 2023 to 13.1% in March 2024.

BNSSG has worked together as a system to ensure all NHS Employers are signed up to the Defence Employer Recognition scheme, this has been achieved with all system providers awarded Silver recognition.

The EDS 22 reporting was a positive, collaborative process including peer review with a focus on Maternity services, Communication and PALS within domain one. A system wide report has been developed and published. We have also undertaken a 'Deep Dive' of our EDI WRES and WDES data at a system level and continue to progress work to improve the experience of staff across the system.

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

The ICB is a key partner in each of the three Health and Wellbeing Boards (HWBs) of Bristol, North Somerset and South Gloucestershire, with a member of the ICB Executive Team on each Board and serving as Deputy Chair. We have worked with our three Directors of Public Health to produce this section that describes the engagement and consultation undertaken with our three HWBs.

In 2023/24, the ICB worked closely with the three HWBs to develop the ICS Strategy and Joint Forward Plan. The Strategy sets out our vision, opportunities and commitments, which align closely with the Joint Local Health and Wellbeing Strategies of the three HWBs in Bristol, North Somerset and South Gloucestershire. This reflects the shared goals of Local Authorities, the NHS and our partners in all three HWBs.

In 2023/24, the ICB has also continued to work closely with partners in the three HWBs, to deliver integrated care through Locality Partnerships. Each of the six Locality Partnerships in Bristol, North Somerset and South Gloucestershire is aligned

to one Local Authority area, and the ICB Locality Delivery Directors are members of the Health and Wellbeing Board for that area.

South Gloucestershire Health and Wellbeing Board

The South Gloucestershire Health & Wellbeing Board (HWB) has held three formal meetings during 2023/24. Colleagues from the ICB have supported or participated in HWB discussions which included highlights such as the Better Care Fund end of year template 22-23 and planning for 23-25; refreshed JSNA and CYP Needs Assessment; Special Educational Needs and Disabilities Strategy; adoption of the Financial Security Framework; and recommissioning of sexual and reproductive services across BNSSG. The meeting papers can be viewed on the South Gloucestershire Council Health and Wellbeing Board site.

The current JHWS runs until 2025. The overarching and strategic objectives are set out in the diagram below and the ICS Strategy is closely aligned to these objectives and themes.

Figure 15: South Gloucestershire Health and Wellbeing Board strategic objectives

Each of the priorities has an associated action plan and nominated lead(s) from across the HWB membership. In 2023/24, we have completed deep dives into the overarching aim of reducing inequalities and taking a place and community-based approach; strategic objective 4, to maximise the potential of our built and natural environment to enable healthy. At each meeting the Board has reflected work undertaken by partners over the previous 12 months and discussed how it can add value by working in partnership to deliver actions in the year ahead lifestyles and prevent disease; and strategic objective 1, to improve educational attainment of CYP and promote their wellbeing and aspirations.

The HWB and Locality Partnership also held four joint development sessions in 2023-24 to build relationships, develop joint priorities and inform development of the ICS Strategy and Joint Forward Plan development.

A new strategy will be developed over the course of the next year which will reflect national and local developments in the health and care landscape including the BNSSG ICS Strategy.

Bristol Health and Wellbeing Board

The Bristol Health & Wellbeing Board (HWB) has held six formal meetings and six development sessions during 2023/24. Colleagues from the NHS, community providers and ICB are members of the Board and are active contributors to the work programme. Work of the Board has included suicide prevention, fuel poverty, cost of living, immunisations, stroke services, dental services and oral health and domestic abuse and sexual violence.

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

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

Figure 16: Bristol Health and Wellbeing Board priorities

The Health and Wellbeing Board has a Plan on a page which sets out and monitors progress against its statutory functions and key priorities. Priorities are informed by the Bristol JSNA and the ICS needs analysis 'Our Future Health'. Many of these priorities are also reflected in the ICS Strategy including: mental health, especially in adolescence, smoking and substance abuse, healthy weight, and trauma.

A number of programmes linked to the work of the board are delivered locally including work led by Feeding Bristol to extend the work of their Children's kitchen, which works in the most deprived 20% of areas of Bristol to encourage healthy eating, improve access to quality food and share how to cook it. They were successful in obtaining funding from the ICB to further extend their food leaders programme which offers digital food leader's courses to those who work in early education; The Thriving Communities, Thriving at Work and Thrive at Night programmes which promote mental health and wellbeing and work with the homes board on healthy homes standards

The North Somerset Health and Wellbeing Board

The North Somerset Health & Wellbeing Board (HWB) has held four formal meetings during 2023/24. Colleagues from the ICB have supported or participated in HWB discussions on a range of topics.

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

The North Somerset Health and Wellbeing Board's vision is for people to be enabled to optimise their health and wellbeing and to lead long, happy and productive lives in thriving communities, building on their strengths in a way that reduces inequalities in health. The vision will be achieved by:

- Preventing health problems before they arise
- Intervening early in relation to existing health and wellbeing problems
- Supporting communities to be connected, healthy and resilient.

Achieving this vision will improve health and wellbeing from the early years through to older age, providing opportunities to increase the number of people being supported and empowered to be healthy and well. This vision will also enhance the extent to which our local communities identify, own and implement tailored solutions to thrive, and, through targeted action, narrow gaps in health and wellbeing outcomes between groups.

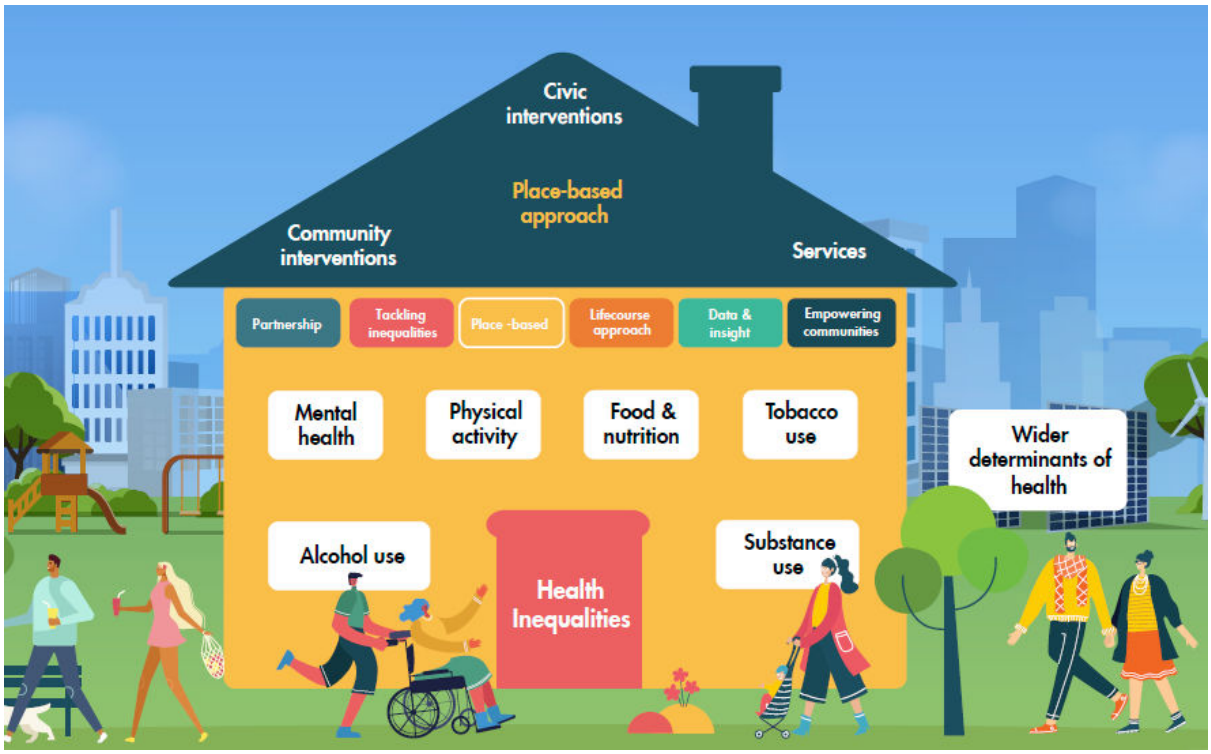
The North Somerset Health and Wellbeing Board Strategy focuses on activities that will have the greatest impact on health and wellbeing. Underpinning this work are the following principles for how the vision will be achieved:

1. Strong and effective partnerships

2. Tackling health inequalities
3. A place-based approach
4. Life course approach
5. Informed by data, insight and ongoing learning
6. Enabling and empowering communities.

Below is a picture describing North Somerset Health and Wellbeing Board's approach and priority areas to be addressed through action plans.

Figure 17: North Somerset Health and Wellbeing Board priorities



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

Environmental Matters

The Bristol, North Somerset and South Gloucestershire ICB Green Plan can be found at Healthier Together Integrated Care System Green Plan 2022-2025 - NHS BNSSG ICB. We remain committed to delivering our Green Plan.

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

“We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 2030; improving the quality of the natural environment; driving efficiency of resource use”

Our Deputy Chief Executive, Sarah Truelove, is the nominated ICB executive lead for sustainability and is a member of the Bristol, North Somerset and South Gloucestershire ICS Green Plan Steering Group which is expanding to cover the breadth of partner organisations in the system which is so crucial to driving change.

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

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

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

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

The determinants and impacts of health and climate change are interconnected, and climate change impacts exacerbate health inequalities. People living in most deprived areas are often most detrimentally impacted by climate change and air pollution. Through focusing on these three outcomes, we intend to reduce health inequalities.

Working in partnership, we have agreed how we will commit resources to co-ordinate and lead delivery across the system.

Governance groups and workstreams have been established with a system-wide dashboard reporting progress. We are embedding sustainability in decision making,

with a sustainability impact assessment and carbon calculator now part of the ICB gateway process.

The ICB allocation of resources has recognised the need for capital to be ring fenced for decarbonisation and that this will help unlock grant funding. There has been initial assessment of carbon impacts in the supply chain in acute hospital trusts and mental health trusts; but there has been limited progress on training and integrating sustainability into procurement processes.

Estates decarbonisation plans have been developed for the hospital trusts and energy surveys for GP surgeries. Transport progress has been made with moving to low and zero emissions vehicles in fleets. The Sirona care & health fleet has achieved net zero. Promotion of active travel has progressed with bicycle and electric vehicle purchase schemes and travel discounts. The introduction of the Clean Air Zone has been supported and we have seen improvements in air quality, particularly around our inner-city hospitals which will provide significant health benefits.

Waste plans have focussed on new waste contracts for acute Trusts, which will enable our zero waste to landfill target to be achieved and will support increasing recycling. A system-wide costed delivery plan has been produced, showing responsibilities, actions and timescales to realise our Green Plan targets going forward.

There are health benefits from mitigating climate change. We will design our services and estates in ways that support achieving cleaner air, healthier diets and increasing physical activity.

Embedding sustainability into decision-making and how we operate as a system is core to meeting the aims and objectives of our ICS, delivering a sustainable health and care system and the long-term health of our population. In developing our ICS, we aim to deliver a truly sustainable health and care system that will bring multiple mutually reinforcing benefits.

Governance

Quarterly meetings have been held by the executive-led ICS Green Plan Steering Group that reports directly into the System Executive Group.

The Green Plan Implementation Group meets monthly to monitor progress of workstreams that are working across the acute trusts and with representation from other organisations including AWP and Sirona care & health. The group also maintain a dashboard reporting into the Green Plan Steering Group.

General Practice and a Sustainability and Health Group also report directly into the Green Plan Steering Group. They enable wider representation from across the system including primary care, local authorities, SWAST and Sirona care & health to provide input and coordination for cross cutting areas such as climate change adaptation.

Within these groups, other system-wide workstreams have been established to support delivery of the green plan, including:

- Net Zero Carbon
- Sustainable Procurement
- Travel, Transport and Air Quality
- Biodiversity
- Healthier With Nature
- Sustainable Waste
- Communications and Engagement
- Medicines Optimisation.

Financial review 2023/24

The financial year 2023/24 was the first full year of the Integrated Care Board, which came into being 1 July 2022. The year was notable for:

- Consolidation and recovery of core services following the adverse impact of Covid-19 pandemic
    - In financial terms this mainly led to:
        - £39m investment in Home First / Urgent & Emergency Services, which, alongside £13m joint investment with Adult Social Care in Discharge to Assess in 22/23, is expected to leverage £26m of cash-releasing savings.
        - Operation of Elective Services Recovery Fund with a 'payment by Results' style reimbursement scheme to incentivise additional activity to clear waiting list backlogs.
        - Investment in primary care access.

- Further progress towards financial sustainability, including managing the unwinding of additional funding provided by Government during the pandemic period and returning to pre-pandemic levels of productivity. The ICB continues to operate in a system by default financial framework.
    - In financial terms this mainly led to:
        - Enhanced focus and challenge on delivery of Savings Plans.
        - Establishing metrics and measures of productivity.
        - Creation and operation of system-wide financial performance escalation framework (System Forecast Outturn Change protocol), with an emphasis of early warning & response and peer-to-peer support.

- Continued progress towards NHS Long Term Plan priorities such as improvements in Mental Health, Learning Disabilities and Autism, Maternity, Long Term Conditions and Cancer services.
    - In financial terms this led to:
        - Managing a number of targeted 'Service Development Funds' allocated on a non recurrent basis by NHS England.
        - Commissioning new models of care, often with new providers, including VCSE or through Locality Partnerships.

- Delegation of commissioning responsibilities for Pharmacy, Optometry and Dental Services.
    - In financial terms this led to:
        - Responsibility for new allocation of £85,682k.

        - 100s of small independent providers, managed through national contracts, collaborative working with NHSE Regional Commissiong Hub, managing contracts with patient fee contributions.

- The impact of high inflation on pay, including industrial action with all major NHS staff groups; and prices of goods and services, including the care market.
    - In financial terms this led to:
        - Complex commercial environment to negotiate price uplifts, ensuring safe and sustainable services are secured, sometimes in excess of national funding allocations.
        - Multiple re-assessments and funding allocations for NHS staff pay settlements throughout the year.
        - Multiple change to Elective Services Recovery Fund activity target, as well as costing and allocating new funding, in response to the impact of Industrial Action of elective care capacity.

- Making progress on the 4 key aims of the ICBs, whilst responding to the Government's announcement of a 30% reduction in Running Costs Allocation.
    - In financial terms this meant:
        - Developing new allocation methodologies and management information to ensure focus on population health and reducing health inequalities.
        - Costing new funded establishments in line with revised Running Cost Allocation.

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

Table 7:

2023/24 March 2024 - Month 12	2023/24 Budget	Expenditure	Variance
	£m	£m	£m
BNSSG ICB Surplus/(Deficit)	**2,175.014**	**2,175.006**	**0.008**
Provider Surplus/Defict			
AWP	-	0.006	**0.006**
NBT	-	0.019	**0.019**
UHBW	-	0.041	**0.041**
Provider Surplus/(Deficit)	-	**0.066**	**0.066**
ICS Position	**2,175.014**	**2,175.072**	**0.074**

Table 8:

Duty	RAG	Position
Maintain expenditure within the revenue resource limit	G	The ICB is reporting a small surplus of £0.008m against an allocation of £2,175.014m
Ensure running costs are within the running cost resource limit.	G	The ICB has a running cost budget per the allocation of £20.515m. At year end there is a small underspend of £0.002m.
Maintain capital expenditure within the delegated limit	G	The 2023/24 capital programme is £6.677m; £1.961m ICB allocation, £1.800m system CDEL prioritised capital and reforecast £2.916m IFRS16 office lease. The ICB's underspends on non IFRS16 allocations have been utilised by the acute providers.
Maintain expenditure within the allocated cash limit	G	At year end the ICB had drawn down all of the £2,192.846m cash allocation

Whilst the ICB is audited as a statutory public body and has prepared and reported its accounts on this basis, NHS England's performance management regime works on an Integrated Care System (ICS) basis, taking into account the financial position of the ICB, and its constituent NHS partner bodies. It should be noted that whilst the ICB commissioning responsibilities are for its population, the providers within the ICS have significant inflows of income for patient care activity, notably for specialised services on a regional and occasionally national footprint, along with teaching and research activities. Avon and Wiltshire Mental Health Partnership also derives c45%

of income and assets related to the Bath, Swindon and Wiltshire ICB population footprint. Approximately one third of ICS funding comes from outside ICB allocation.

This financial performance was in line with the Operational Plan for the year approved by the Board in April 2023; and the formal re-forecast to NHSE for H2 in response to the impact of Industrial Action in the NHS, approved by the Board in November 2023.

- Within this overall Programme Revenue performance there were underspends against Delegated Primary Care Pharmacy, Ophthalmology and Dental (POD) allocations, and some Service Development Fund (SDF) allocations; offset by overspends on Core allocation and Delegated Primary Care.
    - The key adverse variances were in Acute Hospital Care (£3.159m) driven by growth in high cost drugs expenditure and increased diagnostics activity outside the scope of Elective Service Recovery Fund and Community Diagnostics Centre programme; Primary Care Medicines (£1.219m) caused primarily by price increases; and most significantly in Funded Care (£13.800m) caused by a combination of increasing demand and acuity, most notably for patients with learning disabilities; post-pandemic demand recovery, such as for nursing home care; and increasing cost of care in the care market.
    - The key favourable variances were delegated Pharmacy, Optometry and Dental services (of which £4.500m was managed release of earmarked reserve and allocation contingency and £4.651m was contract under delivery) and release of budget reserves (£7.600m) created from new allocations associated with inflation and pay awards.

- The ICB has also met the requirements of the Mental Health Investment Standard (MHIS) to invest equal to or greater share of new resources in Mental Health services each year.
- The ICB achieved the Better Payment Practise Code (BPCC) target of paying greater than 95% of invoices within 30 days.
- The ICB underspent it's Capital budget. The £1.872m underspend was a result primarily of delay to Central Weston scheme which will now be funded from the 24/25 allocation. This underspend was successfully re-allocated to system providers, so the money was not lost to BNSSG population.

The consequence of this performance is the formal write off of inherited CCG accumulated deficit of £117m, achievement of NHSE System Oversight Framework performance targets, sustainable position to build on in 24/25, and importantly maintaining local control, confidence and integrity of our finances.

The Table below summarises where the ICB spent it revenue resources by programme area on behalf of the local population, and the performance against planned budgets:

Table 9

2023/24 March 2024 - Month 12	2023/24 Budget	Expenditure	Variance
	£m	£m	£m
Acute	1,101.063	1,104.222	**(3.159)**
Mental Health	232.030	232.968	**(0.938)**
Community	212.711	211.768	**0.943**
Delegated Primary Care incl POD	269.542	260.391	**9.151**
Medicines Management	155.598	156.816	**(1.219)**
Other Primary Care	39.527	39.139	**0.388**
Funded Care	114.147	127.948	**(13.800)**
Community Childrens	21.279	20.696	**0.583**
Support Costs	7.386	6.929	**0.457**
Reserves	1.216	(6.384)	**7.600**
Running Costs	20.515	20.513	**0.002**
BNSSG ICB Surplus/(Deficit)	**2,175.014**	**2,175.006**	**0.008**

In delivering the outturn position savings of £26.561m were achieved, of which £14.971 were commissioning efficiencies passed through to providers and £11.590m were delivered by ICB Savings Programmes:

Table 10

2023/24 Month 12	Planned net saving £ms	Actual net saving £ms	Variance £ms
ICB savings plan			
Running Costs/Support costs	0.534	0.534	-
Funded Care	3.000	3.380	0.380
Primary Care	0.750	0.750	0.000
Medicine Optimisation	2.691	6.926	4.235
Total ICB savings plan	**6.975**	**11.590**	**4.615**
Commissioning efficiencies			
NHS Providers inside system	9.827	9.827	-
NHS Providers outside of system	0.719	0.719	-
Non NHS provider	3.705	3.705	-
Profiling reconciliation to NHSE return	0.809	0.720	(0.089)
Total savings	**22.035**	**26.561**	**4.526**

In addition, ICS Providers also delivered £43.436m of savings, to meet the NHS national efficiency requirement and to contribute to reducing their underlying deficits.

The total system capital envelope was £102.997m and the outturn position was £105.613m, as shown below:

Table 11

	System Total	ICB	AWP	NBT	UHBW
Allocation of Operational Capital to organisations	102,997	2,261	6,014	35,430	59,292
Intra-system brokerage	-	(99)	(83)		182
Allocation after brokerage	**102,997**	**2,162**	**5,931**	**35,430**	**59,474**
Charge against allocation	105,613	2,162	5,931	37,424	60,096
	105,613	**2,162**	**5,931**	**37,424**	**60,096**
Variance to allocation	**(2,616)**	**-**	**-**	**(1,994)**	**(622)**

The overspend was agreed in advance with NHS England South West Regional team to utilise underspend against allocations within our ICS's across the region. This is not anticipated to require repayment via a reduction in future years Capital allocation.

This analysis excludes Provider Capital expenditure funded from external sources, such as Charitable Donations & Grants or DHCS Public Dividend Capital funding for National Capital Programmes.

Financial outlook

The ICS has made a strong start and has met its financial duties in each of the two years of its existence on a statutory basis. Most significantly this will result in the write-off of £117m of accumulated deficits from predecessor CCGs and a chance to move forward with a clean slate.

The ICS is recognised for having strong system working arrangements, and this has enabled internal system regulation and peer-to-peer support, and a platform to move align funding with the needs of the whole population.

However, the financial context for the NHS and all public sector is extremely challenging. Whilst the system has achieved breakeven, this has relied on non-recurrent and often non-repeatable actions. The underlying annual financial deficit bought forward into 24/25 is estimated to be £145.9m, this has arisen since 19/20 and been caused by increased spending beyond funded levels, excess inflation costs and the consequence of unachieved savings.

The ICS works together to develop and maintain a rolling 5 year medium term financial plan, this aims to deliver recurrent breakeven by March 2027, with outline savings plans identified and non-recurrent solutions to achieve in year breakeven each year.

24/25 is acknowledged as being the most challenging year, where both Revenue and Capital funding growth are constrained compared to the preceding period and the key focus is translating the benefits of investment and transformation into cash releasing savings.

Delivery of this plan will mean the ICS can avoid enhanced regulator scrutiny & intervention, crucially retain control of its own investment decisions, and will be eligible to receive additional capital funding.

The ICS submitted an Interim Plan in March 2024 which forecast a deficit of £30m, however at the time of writing further mitigations are being developed which it is anticipated will ensure a balanced plan for the year. This will be underpinned by a Savings Programme of c£100m which is approximately double those delivered in the current year, with the full year benefit of previous years investment and rising productivity following the subsidence of the pandemic impact and last year’s Industrial Action also being key enablers.

The plan enables Strategic Investments of £5m in Proactive care; £3.2m in Reducing Health Inequalities, £1m in NHS Prevention and £7m in Data & Digital. The Capital Programme allocates a growing share of Capital to Primary & Community Services infrastructure and allocates £3m for progress towards Net Zero targets. The strong financial delivery of the last few years enable these investments in strategically important priorities aligned to ICP Strategy and 4 aims of the ICB, and will support long term financial sustainability by better meeting the needs of the population

through earlier intervention, supporting people living with multiple long term conditions, and preventing escalation to reactive, crisis driven care.

ACCOUNTABILITY REPORT

Shane Devlin

Accountable Officer

25 June 2024

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

The Corporate Governance Report includes:

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

We provide information about the ICB Board and Committees, explain there were no Personal Data Incidents between 1 April 2023 and 31 March 2024. We also include the ICB Modern Slavery Statement.

ICB Board Members Report

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

- The Chair
- Chief Executive
- Chief Finance Officer/Deputy CEO
- Chief Medical Officer
- Chief Nursing Officer

- Five Non-executive Directors
- Nine Partner members

The nine partner members bring the perspectives from:

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

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

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

From 1 April 2023 to 31 March 2024 voting Board members were:

Name	Title	Tenure 2023/24	Attendance
Jeff Farrar	Chair of BNSSG Integrated Care Board	1 April – present	Eleven of Eleven
John Cappock	Non-Executive Director, Chair of Audit and Risk Committee	1 April – present	Nine of Eleven
Jaya Chakrabarti	Non-Executive Director, Chair of People Committee	1 April – present	Nine of Eleven
Shane Devlin	Chief Executive Officer, BNSSG ICB	1 April – present	Eleven of Eleven
Ellen Donovan	Non-Executive Director Chair Quality and Performance Committee and Chair of Remuneration Committee	1 April – present	Ten of Eleven
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	1 April – present	Eleven of Eleven

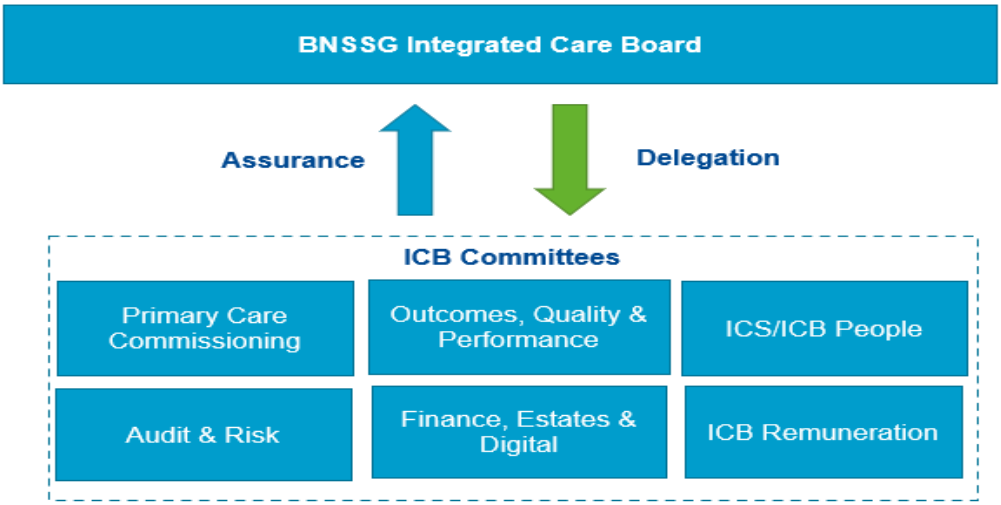
Jon Hayes	Chair of the GP Collaborative Board	1 April – present	Seven of Eleven
Maria Kane	Chief Executive Officer, North Bristol Trust	1 April – present	Nine of Eleven
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	1 Jan – present	Two of Two
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	1 April – present	Nine of Eleven
Alison Moon	Non-Executive Director, Chair Primary Care Committee	1 April – present	Ten of Eleven
Stephen Peacock	Chief Executive, Bristol City Council	1 April – present	Eight of Eleven (One open session)
Dave Perry	Chief Executive, South Gloucestershire Council	1 April – present	Five of Eleven
Sue Porto	Chief Executive Officer, Sirona care & health	1 July - present	Eight of Eight
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	1 April – July 2023	Four of Four
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	1 April – present	Ten of Eleven
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	1 April – present	Ten of Eleven
Jo Walker	Chief Executive Officer, North Somerset Council	1 April – present	Ten of Eleven
Stuart Walker	Interim Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	1 Jan – present	None of Two
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	1 April – Dec 2023	One of Nine

Steve West	Non-Executive Director – Finance, Estates and Digital	1 April – present	Ten of Eleven
Eugine Yafele	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	1 April – Dec 2023	Seven of Nine

Participants regularly attending the ICB Board in 2023/24 included:

Name	Title
Colin Bradbury	Director of Strategy, Partnerships and population BNSSG ICB (1st April to November 2023)
Mark Cooke	Director of Strategy and Transformation, NHS England (February 2024 to present)
Deborah El-Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB
Aishah Farooq	Associate Non-Executive Director
Chris Head	VCSE Alliance Representative (February 2024 to present)
Jo Hicks	Chief People Officer, BNSSG ICB
Ruth Hughes	Chief Executive Officer, One Care (July 2023 to present)
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB
Lisa Manson	Director of Performance and Delivery, BNSSG ICB (1st April to September 2023)
Ruth Taylor	Chief Executive Officer, One Care (1st April to June 2023)
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire
Sue Doheny	NHS England SW Chief Nurse (1st April to December 2023)

Our ICB Board has six committees that report to it. Their terms of reference can be found here Governance Handbook - NHS BNSSG ICB. We provide more information about our committees, their membership and attendance details, including the Audit and Risk Committee, in the Governance Statement (p85).



Personal data related incidents

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

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

In the period covered by this report, 1 April 2023 to 31 of March 2024, no incidents were reported to the ICO.

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

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

Shane Devlin

Accountable Officer

25 June 2024

Governance Statement

Introduction and context

NHS Bristol, North Somerset and South Gloucestershire ICB is a body corporate established by NHS England on 1st July 2022 under the National Health Service Act 2006 (as amended).

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

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

Between 1 April 2023 and 31 March 2024, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

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

The ICB Board composition and attendance is described at (p79). The ICB Constitution sets out how appointments are made to the Board and the process for the joint nomination, assessment, selection and appointment of ICB partner members and role descriptions are on our website. Governance Handbook - NHS BNSSG ICB

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

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

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

Audit and Risk Committee

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

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

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

Name	Title	Attendance
John Cappock	Non-Executive Director, ICB Chair of Audit and Risk Committee	Five of five
Jaya Chakrabarti	Non-Executive Director, ICB Board	Five of five
Ellen Donovan	Non-Executive Director ICB Board	Three of five
Lorna Harrison	Non-Executive Director, Sirona	Three of five
Alison Moon	Non-Executive Director, ICB Board	Five of five
Jane Norman	Non-Executive Director, UHBW	Two of five
Jo Walker	Chief Executive Officer, North Somerset Council	Three of five
Steve West	Non-Executive Director ICB Board	Four of five

Remuneration Committee

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

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

Name	Title	Attendance
Ellen Donovan	Non-Executive Director ICB Chair of Remuneration Committee	Five of six

Jaya Chakrabarti	Non-Executive Director, ICB Board	Six of six
Jeff Farrar	Chair ICB Board	Four of six
Alison Moon	Non-Executive Director, ICB Board	Four of six
Steve West	Non-Executive Director ICB Board	Four of six

Outcomes, Performance and Quality Committee

Our Outcomes, Performance and Quality Committee and oversees and seeks assurance on the effective delivery of the ICB Operational Plan and that cohesive and comprehensive structures are in place for effective planning, management and improvement of outcomes, quality and performance. The committee's Terms of Reference provide more detail about its responsibilities Governance Handbook - NHS BNSSG ICB . The membership and attendance at meetings are detailed in the table below. Details of performance matters can be found in the Performance Report (p3).

Name	Title	Attendance
Ellen Donovan	Non-Executive Director ICB; Chair of Outcomes, Performance and Quality Committee; Chair of Remuneration Committee	Seven of seven
Sue Balcombe	Non-Executive Director, UHBW	Three of seven
Hugh Evans	Executive Director, Adult & Communities, Bristol City Council	Three of seven
Sue Geary	Healthwatch	Two of seven
Jon Hayes	GP Collaborative Board Chair	Three of seven
Lisa Manson	Director of Performance and Delivery, ICB *(attendance until September 2023)*	Three of four
Paul May	Non-Executive Director Sirona	Three of seven
Jo Medhurst	Chief Medical Officer, ICB	Five of seven
Rosi Shepherd	Chief Nursing Officer, ICB	Six of seven
Sarah Weld	Director of Public Health, South Gloucestershire Council	Six of seven
Jeff Farrar	Chair, BNSSG ICB	Six of seven
Alison Moon	Non-Executive Director, ICB *(attendance from September 2023)*	Three of three

David Jarrett	Chief Delivery Officer, ICB *(attendance from December 2023)*	Two of Two

Finance, Estates and Digital Committee

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

Name	Title	Attendance
Steve West	Non-Executive Director ICB Chair of Finance, Estates and Digital Committee	Eleven of twelve
John Cappock	Non-Executive Director, ICB Board	Nine of twelve
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, ICB	Eleven of twelve
Richard Gaunt	Non-Executive Director NBT	Three of twelve
Christina Gray	Director of Public Health, Bristol City Council	Nine of twelve
Jo Medhurst	Chief Medical Officer, ICB	Five of twelve
Nina Philippidis	Section 151 Officer South Gloucestershire Council *(attendance until Feb 2024)*	Eight of twelve
Amy Webb	Section 151 Officer, North Somerset Council *(attendance from March 2024)*	One of twelve
Brian Stables	Non-Executive Director, AWP	Four of twelve
Martin Sykes	Non-Executive Director, UHBW	Four of twelve
Rosi Shepherd	Chief Nursing Officer, ICB	One of twelve
Sarah Truelove	Chief Financial Officer, ICB	Ten of twelve

Primary Care Committee

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

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

Membership and attendance at meetings are detailed below.

Name	Title	Attendance
Alison Moon	Non-Executive Director ICB Chair of Primary Care Committee	Eight of eight
Amanda Cheesley	Chair, Sirona	Seven of eight
Ellen Donovan	Non-Executive Director ICB Board *(Attendance from September 2023)*	Three of five
David Jarrett	Director of Primary and Integrated Care, ICB	Seven of eight
Jo Medhurst	Chief Medical Officer, ICB	Five of eight
Sarah Purdy	Non-Executive Director, NBT	Seven of eight
Rosi Shepherd	Chief Nursing Officer, ICB	Four of eight
Sarah Truelove	Chief Finance Officer, ICB	Two of eight

People Committee

The People Committee is made up of the ICS People Committee and the ICB People Committee. The ICB People Committee oversees the development of the ICS People Strategy and Plan, monitoring its implementation across the system. The committee challenges and scrutinises workforce risks, ensuring mitigating actions are identified and implemented. The committee seeks assurance on the ICB's Equalities and Diversity Strategy and Equality Delivery Strategies. The ICB People Committee element ensures that the ICB has in place a robust People Strategy and monitors its implementation. The membership and attendance at meetings are detailed below.

ICS People Committee

Name	Title	Attendance
Jaya Chakrabarti	Non-Executive Director, ICB Board	Six of six
Ellen Donovan	Non-Executive Director ICB Board	One of one
Alison Moon	Non-Executive Director, ICB Board	One of one
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	One of six
Emma Wood	Chief People Officer for UHBW: SRO for Learning, Leadership and Wellbeing	One of six

Helen Holland	Chair of Bristol Health and Wellbeing Board	Two of six
Jo Hicks	Chief People Officer, BNSSG ICB	Six of six
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	Two of six
Kelvin Blake	Non-Executive Director, NBT	Six of six
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	Four of six
Bernard Galton	People Committee Chair, Non-Executive Director, UHBW	Three of six
Judith Gray	Chief People Officer, NBT: SRO (workforce, planning strategy, supply & demand)	One of six
Jeff Farrar	Chair of BNSSG ICB	Two of six
Anil Patil	Non-Executive Director, Sirona	One of six
Sarah Truelove	Deputy CEO and Chief Finance Officer, BNSSG ICB	One of six
Bryony Campbell	Executive Director, Transformation & Strategy, OneCare	One of six

ICB People Committee

Name	**Title**	**Attendance**
Jaya Chakrabarti	Non-Executive Director, ICB	Four of four
Ellen Donovan	Non-Executive Director, ICB	Two of four (shared attendance with Alison Moon)
Alison Moon	Non-Executive Director, ICB	Two of four (shared attendance with Ellen Donovan)
Jeff Farrar	Chair BNSSG ICB	One of four
Shane Devlin	Chief Executive BNSSG ICB	One of four
Jo Hicks	Chief People Officer BNSSG ICB	Four of four
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer BNSSG ICB	One of four

Joanne Medhurst	Chief Medical Officer BNSSG ICB	None
Rosi Shepherd	Chief Nurse Officer BNSSG ICB	Two of four
Deborah El-Sayed	Chief Transformation and Digital Information Officer BNSSG ICB	One of four
Dave Jarrett	Chief Delivery Officer BNSSG ICB	Three of four
Jaya Chakrabarti	Non-Executive Director, ICB	Four of four

ICB Decision Making Framework

The ICB Board agreed the adoption of a Decision Making Framework which sits within the governance arrangements. The aim is for decisions of the ICB to be timely, responsive and proportionate. The Decision Making Framework aligns to the Scheme of Reservation and Delegation and Standing Financial Instructions, distributing decision making in accordance with the delegated authorities set out in these documents. A visual representation of our Decision Making Framework can be views on page 96.

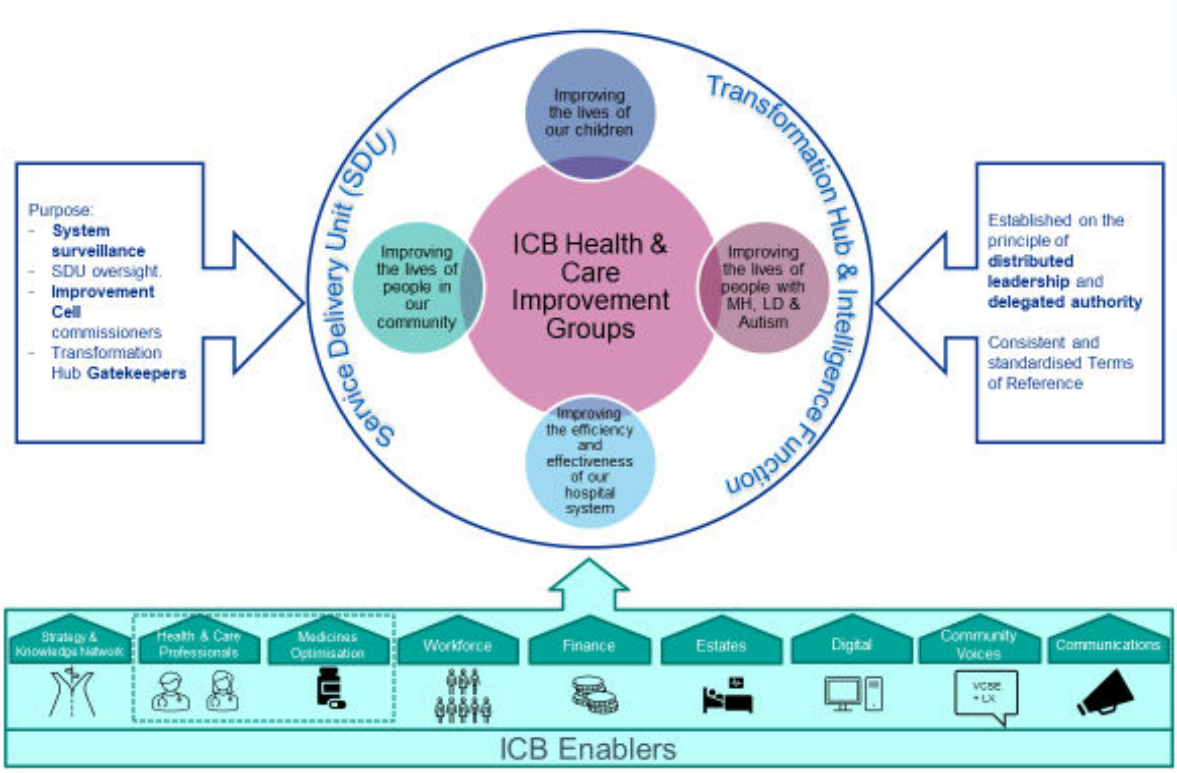
The decision making framework introduces new system groups with specified delegated authority through the relevant Executive Director:

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

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

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

continuous improvement. The ICB Health and Care Improvement Groups report directly to the ICB Board.



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

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

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

*ICB Executive delegated authority as set out in SORD

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

The ICB has adopted risk management arrangements focused on the management of risk within the ICB and developed an ICS Risk management framework. Our internal ICB risk management arrangements can be found in the ICB Governance Handbook Governance Handbook - NHS BNSSG ICB . This defines the structures for the management and ownership of risk within the ICB. The Audit and Risk Committee seeks assurances on the ICB governance arrangements including financial governance and risk management. The ICB committees are responsible for the oversight and scrutiny of risks within their remit. The Board receives monthly updates from each committee which include the escalation of concerns where committees are not sufficiently assured. The risk management framework includes a series of risk appetite statements. Further information on the development of the ICS risk appetite statements which were adopted by the ICB is given below. The ICB Corporate Risk Register identifies risks to the achievement of the ICB objectives, highlights gaps in controls and assurances and details the mitigations to be implemented. Risks are identified through data analysis, external and internal audit reports and other regulatory reporting mechanisms, incident reporting, complaints and litigation, and staff concerns/whistle blowing. Risks are evaluated and assessed using a risk scoring matrix set out in the Risk Management Framework and are reported through Directorate and Corporate Risk

Registers. Risk is embedded in the reporting arrangements to the Board as part of the standard paper template. Equality Impact Assessments are used to assist with the identification and mitigation of risks. Equality Impact Assessments also form part of the standard template for papers to the ICB Board and committees.

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

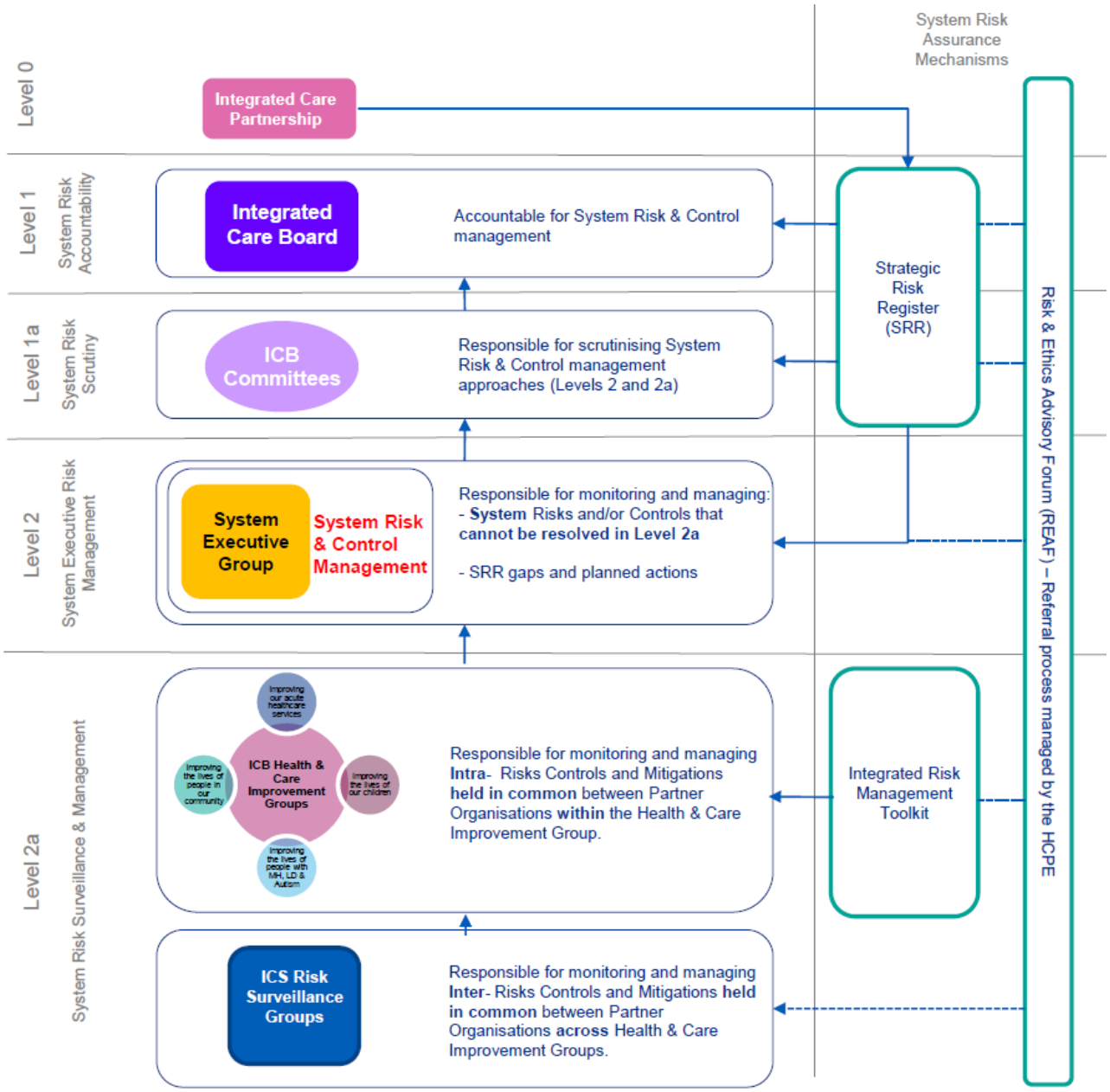
Our work with patients and members of the public ensures that our local people are involved throughout our planning and commissioning processes and these present the opportunity for public stakeholders to highlight relevant risks and engage in discussions around how to mitigate them.

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

ICS System risk management

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

The ICS Risk Management Framework developed describes the principles for identifying system risks, escalation protocols for system risks and supporting arrangements for health and care partners to use to better understand and manage actions to control and mitigate system risks. The levels of system risk surveillance, management, scrutiny and accountability (below diagram) mirror the ICB Decision Making Framework (p96).



To provide assurance to the ICB Board on principal strategic risks to the achievement of the core aims of the ICB a Strategic Risk Register has being developed during 2023/24 by the System Executive Group and was agreed by the ICB Board in September 2023. This will support the ICB Board and committees to review and scrutinise system risks, the mitigations and controls in place to manage them and map assurances. The ICB led a programme of work to develop a set of shared system risk appetite statements which were agreed by the ICB Board in September 2023. These have been communicated across organisations within the system to ensure there is common understanding and shared risk appetite.

Capacity to Handle Risk

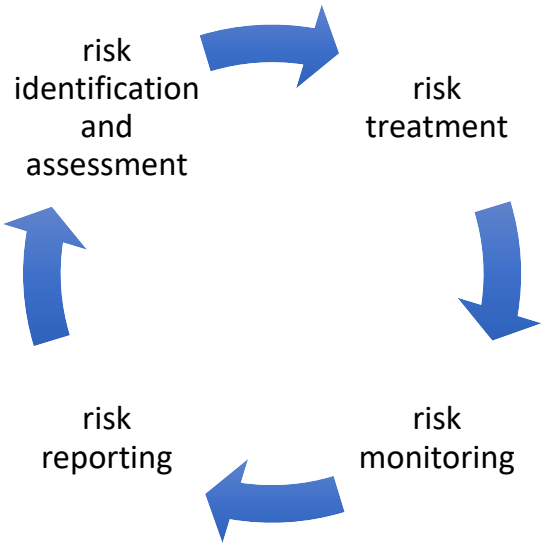
The ICB's policy is to identify, minimise, control and, where possible, eliminate risks that could have an adverse impact on patients, staff and the organisation. As Accountable Officer I carry ultimate responsibility for all risks within the ICB. Our Risk Management Framework and the ICS Risk Management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

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

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

Risk Assessment

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



Risks are identified and assessed using a risk-scoring matrix, risks are analysed, the actions required to mitigate them are identified and implemented and the impact of these mitigations is monitored. Risks are reported through Board reports and via the committees through the Corporate Risk Register. Major risks to governance, risk management and internal control in 2023/24 are detailed at page 105 ‘Control Issues’.

Other sources of assurance

Internal Control Framework

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

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

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

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

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

• Audit and assurance reports

• Minutes of committees of the ICB and other key groups

• Strategic planning

• Reports on patient safety and quality of clinical care

• Performance management

• Financial management

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

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

Deputy Chief Executive/Chief Finance Officer:

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

Chief Nursing Officer:

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

Chief Medical Officer:

- Innovation and research
- Caldicott Guardian

Chief Transformation and Digital Information Officer:

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

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

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

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

Conflicts of interest management

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

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

Data Quality

The information used by the ICB Board and its Committees enables the ICB to carry out its responsibilities and discharge its statutory functions. Information is strategic operational, financial, or relates to outcomes, performance, quality and patient experience. The Board and its Committees are engaged in a continuous cycle of improvement with regard to the quality of the information received. The reports received underwent regular review and improvement. The Board found the quality of data to be acceptable. No risks relating to the quality of data were highlighted between 1 April 2023 and 31 March 2024.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

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

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

Business Critical Models

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

Third party assurances

The ICB purchases services from the South Central and West Commissioning Support Unit which include HR, procurement, IT, and information governance support. Independent assurances on these services are provided through service auditor

reports. Day to day assurance of the above services is achieved through regular performance meetings attended by senior members of staff from both organisations.

ISAE3402 Assurance Letters of Comfort are received and shared with the Chief Financial Officer, and the Internal Auditors. The internal auditor reviews are reported in the Head of Internal Auditor Opinion on page 196, and noted as follows;

- Finance and Accounting provided through NHS Shared Business Services. This was an unqualified report.
- Dental payment process system, Electronic Staff Record (ESR) system, Prescription payments process system provided through NHS Business Services Authority. The three systems received unqualified reports with no exceptions noted.
- Calculating Quality Reporting Systems (CQRS) services provided by South Central and West Commissioning. This was an unqualified report with one exception which was not deemed to be significant to impact the Head of Internal Audit Opinion.
- Primary Care Support England (PCSE) Services provided by Capita. The report was qualified in respect a control objective with NHS England providing a letter of comfort stating that the NHSE continue to work with Capita to assure control measures are applied consistently and that improvement actions introduced. The findings have not impacted on the Head of Internal Audit Opinion.

Control Issues

The following control issues were reported to NHS England in the January 2024 Governance Statement return. More detail about performance is provided in the Performance section of the Annual Report (p15).

Access to services/capacity

Access to services and optimising capacity has been a focus in 23/24 and achieved through a range of initiatives including, although not limited to, improvements in scheduling/booking and productivity across theatres and diagnostic modalities, optimising core capacity, delivering additional capacity through WLI's and utilising the independent sector through both insourcing and outsourcing arrangements. The system has engaged in DMAS and PIDMAS, although successful transfers via these routes have been relatively few. The system is currently reviewing the Elective Care Access

Policy through a health inequalities lens and reinforcing the restatement of Patient Choice issued earlier in the year.

Accident and Emergency

4hr A&E performance in BNSSG for type 1 services has been in the top 10 nationally for most of Q2 and Q3 but since September the performance has deteriorated meaning BNSSG is below its operational plan trajectory. This deterioration has coincided with increased ambulance handover delays and Category 2 response times and is driven chiefly by complex discharge flow and occasional IPC issues affecting the admitted pathway, and some surges in demand affecting both the admitted and non-admitted pathways.

The system has invested circa £40m recurrently 23/24 in schemes which will improve admitted patient flow, including discharge to assess capacity and transformation, new transfer of care hubs, increased SDEC provision, expansion of virtual wards and 2-hour urgent community response, and Healthy Weston 2. For non-admitted patients, there has been an expansion of the ED footprint and capacity at the BRHC, additional GP appointments funded for respiratory conditions over winter, and increased funding for the 111 clinical assessment service, though this has struggled to increase materially due to staffing issues. These investments are monitored via the HCIGs and are subject to an evaluation in Q4 this year.

Mental Health and Dementia

The system has seen an increase in demand for MH services, this is against a backdrop of services that are still recovering from the impacts of COVID. Workforce issues remain a key challenge for the system (including industrial action over the last year). We continue to experience staffing level pressures generally and particularly in relation to Talking Therapies, IPS. Following ICB re-organisation, we are now taking a robust focus on access targets in perinatal (MH), Talking Therapies and SMI physical health checks. Power BI data has been refined to provide the system with more reliable and responsive data for performance management. Over the winter months the system experienced an increase in escalation and flow issues, the increase in S140 escalations for December are being reviewed to ensure learning and offer of support to the system to maintain system flow.

Planned Care

Performance against the targets for the length of time people waited for planned treatment and care has shown improvements although national targets were not met. Mitigations have included improvements in scheduling/booking and productivity across theatres and diagnostic modalities, targeting specific waiting lists and those waiting over 104 weeks and over 78 weeks. Additional capacity has been identified and waiting list validation continues with clinical prioritisation. Patient communication is supporting a reduction in the number of missed appointments. We continue to work with Independent Sector providers to source additional capacity.

Ambulance services

Operational performance for ambulance services has improved significantly on 22/23 but has at times been impacted by system flow issues driven chiefly by complex discharge flow, infection, prevention and control issues, and some surges in demand. May, October and December saw high levels of handover delays at acute hospitals caused by system flow issues for admitted patients. As a result, Category 2 performance has been under the 30-minute interim national standard from April to August but exceeded this since September peaking at 38 minutes in December.

In response to known issues with system flow, the ICB maintained £4.9m additional resourcing investment in SWAST to enable more ambulances and paramedics to respond to demand and mitigate some of the effect of handover delays.

Furthermore, a fortnightly Handovers group has met all year to agree process mitigations at the SWAST-ED interface at all three acute sites to release crews as quickly as possible, including expanding direct paramedic access to non-ED pathways, introducing 'reverse queue' capacity for patients with a DTA to temporarily improve ED flow, and expanding cohorting areas available for queueing patients awaiting ED treatment.

More broadly, the system has invested circa £40m recurrently 23/24 in schemes which will improve system flow, including discharge to assess capacity and transformation, new transfer of care hubs, increased SDEC provision, expansion of virtual wards and 2-hour urgent community response, and Healthy Weston 2. These investments are monitored via the HCIGs and are subject to an evaluation in Q4 this year.

Cancer

Cancer performance and delivery has been impacted by industrial action (IA). While the system has seen improvements recently in the Faster Diagnosis Standard (FDS) (latest data Nov 23 was 67.3%), the impact of IA continues to be seen in the 62+ day ongoing PTL. Three tumor sites drive the performance challenges across all cancer targets (Skin, Gynae, Urology) and account for two thirds of the backlog position. Improvement plans are in place for each area and include pathway redesign for both skin (telederm) and Gynae (PMB pathways). Cancer performance is tracked monthly for the FDS through the system Elective Recovery Operational Delivery Group and weekly for the backlog position by the system elective team and Trust cancer managers.

Both BNSSG Trusts are currently in Tier 1 for cancer.

Finance, Governance and Control - Procurement

Following a legal challenge to a procurement undertaken for non-emergency patient transport the ICB is working to prepare the case for defence. A review of all the procurements led by BNSSG that have been challenged has been undertaken and the learning identified has been shared with the Finance, Estates and Digital Committee and the ICB Board. Action has been taken to strengthen procurement processes and a procurement Standard Operating Procedure (SoP) has been drafted along with updating our procurement policy. The Procurement Policy and Procurement SoP also reflects the new legislation and the implementation of the Provider Selection Regime.

Regulators (inc patient safety)

BNSSG ICB has a well embedded System Quality Group with good attendance from system partners. This is the route through which formal quality escalations are managed with oversight, triangulation and risk management taking place in a partnership setting which spans providers, regulators, and Local Authorities along with Healthwatch. It is also a forum for the sharing of learning and best practice receiving presentations on a range of subjects as well as undertaking workshops to explore share issues in more depth such as the quality response to winter planning and the development of a system model of dynamic risk assessment.

The NHSE National Quality Board guidance and framework is embedded into the SQG governance and escalation framework and has been used to work intensively as system partners where significant risk has been identified in relation to patient care and/or significant safeguarding issues. The SQG has stood up both Rapid Reviews and Quality Improvement Groups to assess and mitigate risk that has emerged both within individual

providers or joint system issues. This has provided a forum for strong partnership working both in BNSSG ICS and across ICSs. All the QIGs to date have resulted in improved joint ownership of complex risks as well as the resolution of individual provider quality concerns.

The ICB also has relationship meetings with both ICB and NHSE to ensure effective triangulation of quality concerns, sharing of learning from other systems and the co-ordination of support offers to individual providers.

Work underway with Local Authority system partners regarding joint reviews of community placements and the quality assurance of community providers.

Full engagement of the ICB with the system safeguarding arrangements including at safeguarding partnership meetings, sub groups and development sessions with the associated development of system priorities and the delivery of related work programmes.

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

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

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

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

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

The ICB's Scheme of Reservation and Delegation and Standing Financial Instructions underpin the use of economic, efficient and effective resources. These are supported by

budgetary controls and other policies and procedures. The Internal Audit Reports relating to the main accounting process have provided assurance regarding these arrangements. Regular contract management processes are established with providers to link service quality, performance and financial management.

Financial planning and in-year performance monitoring

The finance regime has continued as a system finance framework, in line with the ICB regime.

The goal of the system for 2023/24 was to ensure breakeven for each organisation and a commitment to shared system working and management of financial & operational risk. This being the second year that the System has achieved this means that the historic debt carried forward from the predecessor CCGs will be written off in line with the financial framework set by NHS England. The performance monitoring actions for the period 1 April 2023 to 31 March 2024 include:

- The Audit and Risk Committee and Finance Estates and Digital Committee receiving regular briefings
- Routine reviews and updates of the Business, Strategy and Planning Directorate Risk Register
- Periodic reviews of the ICB's financial governance arrangements
- Provision of greater levels of information on the provider sector financial position including deep dive reviews at the Finance, Estates and Digital Committee meetings

Alongside this, where practicable and proportionate, existing financial control mechanisms have been maintained.

Clear and appropriate controls are in place for the planning and monitoring of financial activity including the development and monitoring of savings programmes through a robust programme management approach.

A detailed internal budgeting process and reconciliation to the Medium-Term Financial Plan has been established to support delivery of the financial plan.

Regular financial monitoring and reporting arrangements exist, and these are accompanied by actions to address emerging financial risks, and development and delivery of recovery plans.

During 2023/24 a standard operating procedure was developed for when financial risk is identified in year. This was approved by the ICB Board in December and sets out a clear process for organisations to follow when financial risk emerges in year.

There is robust challenge by the Finance, Estates and Digital Committee on the ICB's financial performance, including contract monitoring and the delivery of savings programmes, along with further review by the ICB Board.

Central management costs

Central management costs are contained within the ICB Running Cost Allowance. The ICB running costs from the 1 April 2023 to 31 March 2024 were £20.515m. Early in 2023/24 the ICB was notified that the running cost allowance would reduce in 2024/25 with a further reduction in 2025/26. The organisation has responded to this challenge of a 30% reduction through an organisational development approach with wide engagement with staff and stakeholders. The Board have been kept updated throughout the period and following formal staff consultation a new structure was approved in February 2024 which will be in place from 1 May 2024.

Delegation of functions

Where the ICB has delegated functions internally feedback is received through bottom-up information such as performance reports, the evaluation and assessment of processes, the review of the corporate risk register, evidence from internal audit reports highlighting failures in internal controls and or the poor management of risk and also from feedback from whistle-blowers through its Freedom to Speak Up arrangements (p138).

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

Counter fraud arrangements

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

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

The Chief Finance Officer is responsible for overseeing and providing strategic management and support for all counter fraud, bribery and corruption work within the organisation, and is assisted by the Chair of the Audit and Risk Committee who is the Counter Fraud Champion. The LCFS works in consultation with the Chief Finance Officer to identify and report cases of actual or suspected fraud and ensure that learning identified from any subsequent investigation is implemented.

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

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2023 to 31 March 2024 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

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

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

Area of Audit	Level of Assurance Given
Key Financial Controls Review	Reasonable Assurance
Funded Care	Partial Assurance
Safeguarding	Partial Assurance
People Programme Plan	Reasonable Assurance
Financial Sustainability and Reporting	Reasonable Assurance
Risk Management	Partial Assurance
Project Gateway – system benefit realisation	Partial Assurance
DSP Toolkit	Moderate/Medium Assurance

The audit work focused on funded care identified that challenges regarding resource capacity have limited progress on key funded care workstreams which could improve efficiency, reporting and monitoring activity within funded care. The Safeguarding audit identified that although there had been good progress in enhancing the team and re-design of the governance process the progress with the System Safeguarding Transformation programme has not been timely since the LGA review findings and collaboration and buy in with system partners does not appear to be as effective as required. The Risk Management Audit found that more work was required to embed a robust and mature culture of risk management throughout the organisation and its governance structure. The issues raised in all of these audits are being addressed and they will be followed up and reported to the Audit and Risk Committee.

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

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

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

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

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

Conclusion

With the exception of the control issues identified and reported in the 2023/24 Month 9 return to NHS England, no significant control issues have been identified during the year.

Shane Devlin

Accountable Officer

25 June 2024

Remuneration and Staff Report

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

Remuneration Report

Remuneration Committee

The ICB has established a Remuneration Committee which makes decisions about the remuneration and allowances for Very Senior Managers (VSM) and persons in senior positions within the ICB. More information about our Remuneration Committee, including the membership can be found at the Governance Statement in this report (p86).

Entities are required to disclose:

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

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

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

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

Table 12 Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	13%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	0%

The highest paid director in 2023-24 is Shane Devlin, ICB Chief Executive. In the 9 months to March 2023, the highest paid director was also Shane Devlin, ICB Chief Executive.

Shane Devlin did not receive performance pay in 2023-24 or in the 9 months to March 2023.

Pay ratio information

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

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

The remuneration of the highest paid director / member in NHS Bristol, North Somerset and South Gloucestershire ICB at 31 March 2024 was £197,500.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table 13.

Table 13 Pay Ratio Information 2023-24

	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£34,581	£43,742	£54,151
Salary component of total remuneration (£)	£34,581	£43,742	£54,151
Pay ratio information	5.71:1	4.52:1	3.65:1

Remuneration ranged from £13,861 to £192,436 during the year ended 31 March 2024. As at March 2024, remuneration ranged from £12,230 to £197,500. The increase in the remuneration of the highest paid director / member is due to a pay rise in June 2023.

Table 14 Pay Ratio Information 9 months to 31 March 2023

2022/23	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£29,180	£41,659	£54,619
Salary component of total remuneration (£)	£29,180	£41,659	£54,619
Pay ratio information	6.0:1	4.2:1	3.2:1

ICB prior year is for 9 months only (1 July 2022 to 31 March 2023). Remuneration ranged from £12,230 to £374,000 during the period ended 31 March 2023. As at March 2023, remuneration ranged from £12,230 to £175,000.

During the reporting period 2023/24, no one received remuneration in excess of the highest-paid director/member. During the 9-month reporting period 2022/23, one employee received remuneration in excess of the highest-paid director/member.

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

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

Policy on the remuneration of senior managers

The policy on the remuneration of VSM, including members of the ICB Board is set using NHS England guidance. National remuneration guidance for VSM pay was applied for 2023-24.

Remuneration of Very Senior Managers

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

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

Table 15 Senior manager remuneration (including salary and pension entitlements)

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

Name and Title	Note	2023-24					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Shane Devlin, Chief Executive Officer	1	190-195	-	-	-	45-47.5	235-240
Sarah Truelove, Chief Financial Officer and Deputy Chief Executive	2	165-170	-	-	-	-	165-170
Colin Bradbury, Director of Strategy, Partnerships and Population (to Dec 23)	4, 11	125-130	-	-	-	-	125-130
Deborah El-Sayed, Chief Transformation and Digital Information Officer	5, 11	135-140	-	-	-	-	135-140
Joanne Hicks, Chief People Officer	6	135-140	-	-	-	22.5-25	155-160
David Jarrett, Chief Delivery Officer	7, 11	130-135	-	-	-	-	130-135
Lisa Manson, Director of Performance and Delivery (end date 30/09/23)	8, 11	70-75	-	-	-	-	70-75
Joanne Medhurst, Chief Medical Officer	9, 11	155-160	-	-	-	-	155-160
Rosalind Shepherd, Chief Nursing Officer	10, 11	130-135	-	-	-	30-32.5	165-170

Name and Title	Note	2023-24					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Non-Executives							
Jeffrey Farrar, Chair	12	65-70	-	-	-	-	65-70
John Cappock, Non-Executive Member, Chair of Audit and Risk Committee	13	15-20	-	-	-	-	15-20
Jaya Chakrabarti, Non-Executive Member, Chair of People Committee	13, 14	15-20	-	-	-	-	15-20
Ellen Donovan, Non-Executive Member Chair Quality and Performance Committee	13, 14	15-20	-	-	-	-	15-20
Alison Moon, Non-Executive Member, Chair Primary Care Committee	13	15-20	-	-	-	-	15-20
Steve West, Non-Executive Member – Finance, Estates and Digital	13, 14	15-20	-	-	-	-	15-20
Non-remunerated Senior Managers							
Dominic Hardisty, Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	15	-	-	-	-	-	-
Jonathan Hayes, Chair of the GP Collaborative Board	15	-	-	-	-	-	-
Maria Kane, Chief Executive Officer, North Bristol Trust	15	-	-	-	-	-	-

Name and Title	Note	2023-24					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
John Martin Interim Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust (from Jan 24)	15	-	-	-	-	-	-
Stephen Peacock, Chief Executive, Bristol City Council	15	-	-	-	-	-	-
Dave Perry, Chief Executive, South Gloucestershire Council	15	-	-	-	-	-	-
Sue Porto (from June 23) Chief Executive, Sirona care & Health	15	-	-	-	-	-	-
Julie Sharma, Interim Chief Executive Officer, Sirona Care & Health (to Jul 23)	15	-	-	-	-	-	-
Jo Walker, Chief Executive Officer, North Somerset Council	15	-	-	-	-	-	-
Stuart Walker Interim Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust (from Jan 24)	15	-	-	-	-	-	-
Will Warrender, Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust (to Dec 23)	15	-	-	-	-	-	-
Eugine Yafele, Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust (to Dec 23)	15	-	-	-	-	-	-

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

Table 16 Senior manager remuneration (including salary and pension entitlements)

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

Name and Title	Note	2022/23 (for the reporting period 1 July 2022 to 31 March 2023)					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Shane Devlin, Chief Executive Officer	1	130-135	-	-	-	30-32.5	160-165
Sarah Truelove, Chief Financial Officer and Deputy Chief Executive	2	115-120	-	-	-	-	115-120
Julie Bacon, Interim Chief People Officer	3	95-100	-	-	-	-	95-100
Colin Bradbury, Director of Strategy, Partnerships and Population	4, 11	85-90	-	-	-	32.5-35	120-125
Deborah El-Sayed, Director of Transformation and Chief Digital Information Officer	5, 11	100-105	-	-	-	45-47.5	145-150
Joanne Hicks, Chief People Officer (start date 27/02/2023)	6	10-15	-	-	-	2.5-5	10-15
David Jarrett, Director of Primary and Integrated Care	7, 11	90-95	-	-	-	40-42.5	130-135
Lisa Manson, Director of Performance and Delivery	8, 11	100-105	-	-	-	25-27.5	130-135
Joanne Medhurst, Chief Medical Officer (start date 01/08/2023)	9, 11	95-100	-	-	-	45-47.5	145-150
Rosalind Shepherd, Chief Nursing Officer	10, 11	95-100	-	-	-	130-132.5	230-235

Name and Title	Note	2022/23 (for the reporting period 1 July 2022 to 31 March 2023)					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Non-Executives							
Jeffrey Farrar, Chair	12	45-50	-	-	-	-	45-50
John Cappock, Non-Executive Member, Chair of Audit and Risk Committee	13	10-15	-	-	-	-	10-15
Jaya Chakrabarti, Non-Executive Member, Chair of People Committee	13, 14	10-15	-	-	-	-	10-15
Ellen Donovan, Non-Executive Member Chair Quality and Performance Committee	13, 14	10-15	-	-	-	-	10-15
Alison Moon, Non-Executive Member, Chair Primary Care Committee	13	10-15	-	-	-	-	10-15
Steve West, Non-Executive Member – Finance, Estates and Digital	13, 14	10-15	-	-	-	-	10-15
Non-remunerated Senior Managers							
Dominic Hardisty, Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	15	-	-	-	-	-	-
Jonathan Hayes, Chair of the GP Collaborative Board	15	-	-	-	-	-	-
Maria Kane, Chief Executive Officer, North Bristol Trust	15	-	-	-	-	-	-

Name and Title	Note	2022/23 (for the reporting period 1 July 2022 to 31 March 2023)					
		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Stephen Peacock, Chief Executive, Bristol City Council (Feb 23 onwards)	15	-	-	-	-	-	-
Mike Jackson, Chief Executive, Bristol City Council (Jul- Oct 22)	15	-	-	-	-	-	-
Dave Perry, Chief Executive, South Gloucestershire Council	15	-	-	-	-	-	-
Julie Sharma, Interim Chief Executive Officer, Sirona Care & Health	15	-	-	-	-	-	-
Jo Walker, Chief Executive Officer, North Somerset Council	15	-	-	-	-	-	-
Will Warrender, Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	15	-	-	-	-	-	-
Eugine Yafele, Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	15	-	-	-	-	-	-

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

Notes:

No senior manager waived his/her remuneration.

1 The full year equivalent salary for Shane Devlin in 2022/23 was £175,000 - £180,000. Shane Devlin received non-taxable relocation expenses during the period July 22 to March 23 as part of his remuneration package.

2 The full year equivalent salary for Sarah Truelove in 2022/23 was £155,000 - £160,000.

3 The full year equivalent salary for Julie Bacon in 2022/23 was £125,000 - £130,000. Julie Bacon was the Interim Chief People Officer. She left the ICB on 31st March 2023.

4 The full year equivalent salary for Colin Bradbury in 2022/23 was £115,000 - £120,000. Colin Bradbury has been on secondment from the ICB since 11/12/23. However, none of his salary or pension costs have been recharged, Therefore, the full cost for the year has been included in the 2023/24 calculations.

5 The full year equivalent salary for Deborah El-Sayed in 2022/23 was £135,000 - £140,000.

6 The full year equivalent salary for Joanne Hicks in 2022/23 was £125,000 - £130,000. Jo Hicks joined the ICB as Chief People Officer on 27th February 2023.

7 The full year equivalent salary for David Jarrett in 2022/23 was £120,000 - £125,000.

8 The full year equivalent salary for Lisa Manson in 2022/23 was £135,000 - £140,000. Lisa Manson left the ICB on 30 September 2023.

9 The full year equivalent salary for Joanne Medhurst in 2022/23 was £130,000 - £135,000. Joanne Medhurst joined the ICB as Chief Medical Officer on 1 August 2022.

10 The full year equivalent salary for Rosalind Shepherd in 2022/23 was £130,000 - £135,000.

11 Staff affected by the Public Service Pensions Remedy. Their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

12 The full year equivalent salary for Jeffrey Farrar in 2022/23 was £65,000 - £70,000.

13 The full year equivalent salary for John Cappock, Jaya Chakrabarti, Ellen Donovan, Alison Moon and Steve West in 2022/23 was £15,000 - £20,000.

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

15 These are non-remunerated posts.

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

Following that agreement, Peter agreed a shorter notice period with a termination date of 31 August 2022, which meant he was only entitled to 23 years redundancy totalling £122,667. The ICB has agreed to pay this as a top up to his pension, to which Peter will contribute £1,632. These transactions were accrued for in the 2022-23 accounts and paid in 2023-24.

Peter continued to receive his salary in July and August 2022, which totalled £20,711 including pay uplift arrears. During the period 1 July 22 to 31 March 23, his total pension related benefits increased by £7,006.

17 No performance payments were made in 2023-24 or in the period July 2022 to March 2023.

18 All Pensions Related Benefits: The real increase in the value of pension benefits accrued during the year excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20 less the contributions made by the individual. As the period ended 31 March 2023 was a part year, the value of pension benefits accrued during the 9 months were calculated as:

- The real increase in pension multiplied by 20 (for the 12 months from 1 April 2022 to 31 March 2023);
- Less the contributions made by the individual over the same 12-month period;
- Apportioned pro-rata between the periods 1 April 2022 to 30 June 2022 and 1 July 2022 to 31 March 2023 on the basis of calendar days.

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

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

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

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

Table 17 Pension benefits at 31 March 2024

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

Name and Title	Notes	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Shane Devlin (note 1) Chief Executive Officer	1	2.5-5	-	5-10	-	45	35	111	-
Colin Bradbury Director of Strategy, Partnerships and Population	2	-	30-32.5	30-35	85-90	591	106	774	-
Deborah El-Sayed Chief Transformation and Digital Information Officer	2	-	32.5-35	40-45	115-120	783	128	1,008	-
Jo Hicks Chief People Officer		0-2.5	-	0-5	-	3	12	33	-
David Jarrett Chief Delivery Officer	2	-	32.5-35	40-45	115-120	696	176	960	-
Lisa Manson Director of Performance and Delivery	2	-	12.5-15	50-55	140-145	975	46	1,176	-
Joanne Medhurst Chief Medical Officer	2	-	35-37.5	40-45	110-115	816	128	1,048	-
Rosalind Shepherd Chief Nursing Officer	2	2.5-5	0-2.5	65-70	190-195	1,422	156	1,745	-

Table 18 Pension benefits at 31 March 2023

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

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

Notes:

1 Shane Devlin was previously a member of the Northern Ireland NHS Pension scheme. Shane applied to transfer his Northern Ireland NHS pension to the NHS Pension Scheme in April 2023. The transaction has still not been completed. Therefore, the figure in the table above may be a considerable under reporting of the true CETV.

2 Staff affected by the Public Service Pensions Remedy. Their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

3 The ICB has no pension liabilities for Sarah Truelove, Deputy Chief Executive and Chief Finance Officer, Julie Bacon, Interim Chief People Officer (for the period to March 2023) and Jeffrey Farrar, ICB Chair. None of these employees are contributing to the NHS Pension Scheme.

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

5 Real increase in pension at pension age is calculated based on the increase between 1 April and 31 March, as adjusted for inflation. For the period ended 31 March 2023, this was calculated pro-rata for 9 months.

6 Real increase in pension lump sum at pension age is calculated based on the increase between 1 April and 31 March, as adjusted for inflation. For the period ended 31 March 2023, this was calculated pro-rata for 9 months.

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

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement of for loss of office

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

No senior managers were made redundant during 2023-24.

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

Following that agreement, Peter agreed a shorter notice period with a termination date of 31 August 2023, which meant he was only entitled to 23 years redundancy totalling £122,667. The ICB agreed to pay this as a top up to his pension, to which Peter

contributed £1,632. These transactions were accrued for in the accounts for the period ended 31 March 2023.

Peter continued to receive his salary in July and August 2022, which totalled £20,711 including pay uplift arrears. During the period 1 July 22 to 31 March 23, his total pension related benefits increased by £7,006.

No payments for compensation on early retirement were received by any senior managers in 2023-24 or in 2022-23.

Payments to past directors

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

No payments were made to past directors during 2023-24.

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

Staff Report

Number of senior managers, Staff numbers and costs

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

There was an average of number 94 Senior Managers in 2023-24 (116 between 1 July 2022 and 31 March 2023).

Table 19 Senior Manager Numbers 2023-24

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	3	8	-	-	-	5	3	8
Band 9	5	3	8	-	-	-	5	3	8
Band 8D	3	2	5	1	-	1	4	2	6
Band 8C	21	14	35	-	1	1	21	15	36
Band 8B	21	11	32	3	1	4	24	12	36
Total	**55**	**33**	**88**	**4**	**2**	**6**	**59**	**35**	**94**

Table 20 Senior Manager Numbers 1 July 2022 to 31 March 2023

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

Staff numbers and costs

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

The total staff costs for the 2023-24 were £28,421,674 (£25,641,750 for the period 1 July 2022 to 31 March 2023). The breakdown by cost, contract type and category is set out in the table below.

Table 21 Staff costs 2023-24

	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Employee Benefits	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	9,885	533	10,418	10,511	952	11,463	20,396	1,485	21,881
Social security costs	1,191	-	1,191	1,054	-	1,054	2,245	-	2,245
Employer contributions to the NHS Pension Scheme	2,739	-	2,739	1,313	-	1,313	4,052	-	4,052
Apprenticeship Levy	97	-	97	-	-	-	97	-	97
Termination benefits	-	-	-	147	-	147	147	-	147
Gross employee benefits expenditure	**13,912**	**533**	**14,445**	**13,025**	**952**	**13,977**	**26,937**	**1,485**	**28,422**

Table 22 Staff costs 1 July 2022 to 31 March 2023

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

Included in the above is £1.165m for the period 1 July 2022 to 31 March 2023 relating to the agenda for change non-consolidated pay offer. This was not received in 2023-24.

The total average number of staff was 444 in 2023-24 (519 in the period 1 July 2022 to 31 March 2023). The breakdown by staff category, contract type and sex is set out in the table below.

Table 23 Staff Numbers 2023-24

	Permanent			Other			Total		
Staff Category (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Administrative and Clerical	188	65	253	5	3	8	193	68	261
Medical and Dental	3	1	4	1	-	1	4	1	5
Add Professional. Scientific and Technical	18	7	25	-	-	-	18	7	25
Nursing and Midwifery	54	5	59	-	-	-	54	5	59
Allied Health Professionals	-	-	-	-	-	-	-	-	-
Estates and ancillary	-	-	-	-	-	-	-	-	-
Senior Managers	55	33	88	4	2	6	59	35	94
Total	**318**	**111**	**429**	**10**	**5**	**15**	**328**	**116**	**444**

Table 24 Staff Numbers 1 July 2022 to 31 March 2023

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

Staff composition

There were 510 staff (headcount) in 2023-24 (607 between 1 July 2022 and 31 March 2023). The breakdown by sex, seniority and contract type is set out in the table below.

Table 25 Staff composition 2023-24

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Members of the governing body	3	3	6	-	-	-	3	3	6
Directors	5	3	8	-	-	-	5	3	8
Band 9	5	3	8	-	-	-	5	3	8
Band 8D	3	2	5	1	1	2	4	3	7
Band 8C	22	14	36	-	1	1	22	15	37
Band 8B	24	12	36	4	1	5	28	13	41
Other employees	**304**	**83**	**387**	**12**	**4**	**16**	**316**	**87**	**403**
Total	**366**	**120**	**486**	**17**	**7**	**24**	**383**	**127**	**510**

Table 26 Staff composition 1 July 2022 to 31 March 2023

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

Sickness absence data

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

and manage stress, are provided with support and guidance on making reasonable adjustments in the workplace and how to increase wellbeing amongst staff. All sickness absence is managed in line with the Managing Sickness Absence Policy.

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

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

The ICB had an average number of full-time equivalent members of staff (FTE) of 449 over the period 1st January 2023 to 31st December 2024. The full time equivalent possible working days available was 163,733. The data in the table below has been calculated by NHS Digital. ESR does not hold details of normal number of days worked by each employee. Average annual sick days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE and multiplying by 225 (the typical number of working days per year).

Table 27 Full Time Equivalent (FTE) Members of Staff

	Number of FTE staff (average)	Sum of FTE Days Sick	Sum of FTE Days Available	FTE sickness absence %	Average Annual Sick Days per FTE
NHS Bristol, North Somerset and South Gloucestershire ICB	**449**	**5,162**	**163,733**	**3.15%**	**7.1**

Source: NHS Digital – Sickness Absence Publications – based on data from the ESR Warehouse.

Staff turnover percentages

Bristol, North Somerset and South Gloucestershire ICB staff turnover is reported via the Electronic Staff Record (ESR). During the period 1st April 2023 to 31st March 2024, 45 members of staff joined the ICB, and 77 staff members left. Staff turnover measures the number of staff who leave an organisation during a period of time. The ICB staff turnover for the period 1st April 2023 to 31st March 2024 of 15.8% is based on a headcount of 77 leavers.

Whilst the turnover rate measures the outflow of people from an organisation and is expressed in terms of the number of people who leave over a period of time, the stability rate calculates the proportion of the workforce who remain employed for a specified period and measures how effectively the organisation is retaining staff. The ICB's stability index reports that 86% of employees were retained during the period 1st April 2023 and 31st March 2024.

Staff engagement percentages

Staff engagement is an important source of information about our staff and in the Autumn of 2023 the ICB participated in the Annual NHS Staff Survey. There were 363 responses, which equated to a response rate of 77% and demonstrated good staff engagement. The ICB response rate was slightly higher with the national average of 71% for our national benchmarking group. The full Staff Survey can be found at NHS Staff Survey Results 2023. In relation to the theme of 'Staff Engagement' the ICB has achieved a score of 6.6 which is slightly higher than the national average for our national benchmarking group. The results have been shared across the ICB and key themes incorporated within our ICB People Plan and Organisational Development Plan.

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

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

Staff policies

The ICB has an integrated approach to delivering workforce equality. Equalities issues are incorporated in policies covering all aspects of employee management ranging from recruitment to performance to discipline.

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

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

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

The ICB have been through a period of significant change and transition and throughout this reporting period, during this time we have reviewed our Organisational Change policy, Grievance Policy and Appeals policy and in doing so it was our priority to actively engage staff in their development through our Staff Partnership Forum and Staff Networks.

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

The ICB has a timetable for policy reviews and will continue to be updated in the with the review cycle. All HR policies will be reviewed in partnership with staff and Trade Union representatives through the Staff Partnership Forum, which continues to meet regularly and provides a constructive space for collaboration between staff representatives, and management.

Freedom to Speak Up

The ICB has in place policies to support staff when raising concerns, including the Freedom to Speak Up Policy, Fraud and Bribery Policy, and Bullying and Harassment Policy. Freedom to Speak Up was introduced by Sir Robert Francis following a 2015 review into NHS 'whistleblowing' processes. It incorporates whistleblowing and extends

beyond that to develop cultures where concerns are identified and addressed at an early stage before people feel the need to ‘blow the whistle’.

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

Trade Union Facility Time Reporting Requirements

The total number of employees who were relevant union officials during the period 1st April 2023 to 31st March 2024 was:

Table 28

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

Expenditure on consultancy

Consultancy expenditure was £289,000 in 2023-24 (£624,000 for the financial period 1 July 2022 to 31 March 2023), and this can be analysed as follows:

Table 29 Consultancy Expenditure

Consultancy Category	2023-24 £'000	1 July 2022 to 31 March 2023 £'000
Finance	41	45
Human Resources, Training and Education	18	-
Marketing and Communications	1	-
Organisation and Change Management	56	6
Programmes and Project Management	27	-
Property and Construction	-	2
Strategy	53	435
Technical	93	136
Total	**289**	**624**

Off-payroll engagements

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

Table 30 Length of all highly paid off-payroll engagements

For all off-payroll engagements at 31 March 2024 for more than £245* per day:

	Number
Number of existing engagements as of 31 March	5
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	2

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

The ICB confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the

individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 31: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2023 to 31 March 2024, for more than £245[1] per day:

	Number
Number of temporary off-payroll workers engaged	30
Of which, the number that have existed:	
No. not subject to off-payroll legislation[2]	25
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	5
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	-
the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

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

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

Table 32: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2023 to 31 March 2024:

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

Exit packages

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

Table 33: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	2	14,554	**2**	**14,554**	-	-
£10,000 - £25,000	-	-	3	64,470	**3**	**64,470**	-	-
£25,001 - £50,000	-	-	5	170,865	**5**	**170,865**	-	-
£50,001 - £100,000	2	146,988	4	290,232	**6**	**437,220**	-	-
£100,001 - £150,000	1	128,000	2	266,458	**3**	**394,458**	-	-
£150,001 – £200,000	-	-	2	355,880	**2**	**355,880**	-	-
>£200,000	-	-	-	-	**-**	**-**	-	-
TOTALS	**3**	**274,988**	18	**1,162,459**	**21**	**1,437,447**	**-**	**-**
				Agrees to table 34 below				

Redundancy and other departure cost have been paid in accordance with the provisions of The NHS Terms and Conditions of Service (Agenda for Change). Exit costs in this note are the full costs of departures agreed in the year. Where Bristol, North Somerset and South Gloucestershire ICB has agreed early retirements, the additional costs were met by the ICB and not by the Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not include in the table.

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

Table 34: Analysis of Other Departures

	Agreements	**Total Value of agreements**
	Number	**£000s**
Voluntary redundancies including early retirement contractual costs	18	1,162
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
TOTAL	**18**	**1,162**

A – agrees to total in table 33

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary. The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

NHS Bristol, North Somerset and South Gloucestershire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at page 146. An audit certificate and report is also included in this Annual Report at page 217.

ANNUAL ACCOUNTS

Shane Devlin

Accountable Officer

25 June 2024

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The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	Year ended 31 March 24 £'000	9 months to 31 March 23 £'000
Income from sale of goods and services	3	(36,118)	(7,975)
Other operating income	3	-	-
Total operating income		**(36,118)**	**(7,975)**
Staff costs	4	28,422	25,642
Purchase of goods and services	5	2,177,432	1,459,838
Depreciation and impairment charges	5	281	441
Provision expense	5	(3,397)	5,562
Other operating expenditure	5	8,355	6,473
Total operating expenditure		**2,211,093**	**1,497,956**
Net Operating Expenditure		**2,174,975**	**1,489,981**
Finance expense	7	31	1
Comprehensive Net Expenditure for the year		**2,175,006**	**1,489,982**

The notes on pages 152 to 195 form part of this statement.

Statement of Financial Position as at 31 March

	Note	2023-24 £'000	2022-23 £'000
Non-current assets			
Property, plant and equipment	9	448	384
Right-of-use Assets	10	2,576	104
Intangible assets	11	-	-
Total non-current assets		**3,024**	**488**
Current assets			
Trade and other receivables	12	40,607	13,617
Cash and cash equivalents	13	174	81
Total current assets		**40,781**	**13,698**
Total assets		**43,805**	**14,186**
Current liabilities			
Trade and other payables	14	(141,065)	(126,757)
Lease liabilities	10	(150)	(104)
Provisions	15	(8,280)	(13,301)
Total current liabilities		**(149,495)**	**(140,162)**
Non-current liabilities			
Lease liabilities	10	(2,445)	-
Total non-current liabilities		**(2,445)**	**-**
Total Assets less Total Liabilities		**(108,136)**	**(125,976)**
Financed by Taxpayers' Equity			
General fund		(108,136)	(125,976)
Total taxpayers' equity		**(108,136)**	**(125,976)**

The notes on pages 152 to 195 form part of this statement.

The financial statements on pages 148 to 195 were approved by the Audit and Risk Committee on 25/06/2024 with delegated authority from the Board and signed on its behalf

Chief Accountable Officer
Shane Devlin

Statement of Changes In Taxpayers Equity for the year ended 31 March 2024

	Note	General fund reserves
		£'000
Balance at 1 April 2023		**(125,976)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net recognised expenditure for the year		(2,175,006)
Net funding		2,192,846
Balance at 31 March 2024		**(108,136)**

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

The notes on pages 152 to 195 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2024

	Note	Year ended 31 March 24 £'000	9 months to 31 March 23 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(2,175,006)	(1,489,982)
Depreciation and amortisation	5	281	441
Transfer from other public bodies under absorption	8	-	(84,078)
(Increase)/decrease in trade & other receivables	12	(26,990)	(13,617)
Increase/(decrease) in trade & other payables	14	14,342	126,723
Provisions utilised	15	(1,624)	(491)
Increase/(decrease) in provisions	15	(3,397)	5,562
Net Cash Inflow (Outflow) from Operating Activities		**(2,192,394)**	**(1,455,442)**
Cash Flows from Investing Activities			
Interest received		31	1
(Payments) for property, plant and equipment	9	(210)	(239)
Net Cash Inflow (Outflow) from Investing Activities		(179)	(238)
Net Cash Inflow (Outflow) before Financing		**(2,192,573)**	**(1,455,680)**
Cash Flows from Financing Activities			
Net Funding Received		2,192,846	1,455,972
Repayment of lease liabilities	10	(180)	(313)
Net Cash Inflow (Outflow) from Financing Activities		**2,192,666**	**1,455,659**
Net Increase (Decrease) in Cash & Cash Equivalents at 31 March		**93**	**(21)**
Cash & Cash Equivalents at the Beginning of the Financial Period		81	102
Cash & Cash Equivalents at the End of the Financial Year	13	**174**	**81**

The notes on pages 152 to 195 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to Integrated Care Boards as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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

1.2 Accounting Convention

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

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

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

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

1.4 Better Care Fund Budgets

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

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.5.1 Critical Judgements in Applying Accounting Policies

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

1.5.2 Key Sources of Estimation Uncertainty

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

1.6 Operating Segments

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

1.7 Revenue

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

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

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

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

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

1.8.2 Retirement Benefit Costs

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

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

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

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

1.9 Purchase of Goods, Services and Other Expenses

The purchase of goods, services and other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.10.2 **Measurement**

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

1.10.3 **Subsequent Expenditure**

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

1.11 Intangible Assets

1.11.1 Recognition

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

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

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

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

1.11.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

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

1.12 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.13 **Leases**

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

1.13.1 **The Integrated Care Board as Lessee**

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

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

The HM Treasury incremental borrowing rate of 4.72% is applied for leases commencing, transitioning or being remeasured in the 2024 calendar year under IFRS 16 (3.51% in the calendar year 2023).

Lease payments included in the measurement of the lease liability comprise

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

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

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

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

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

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

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

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the

definition of a lease in all aspects apart from containing consideration. For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the Financial Reporting Manual (FreM).

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

1.14 **Cash & Cash Equivalents**

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

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

1.15 **Provisions**

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

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

- short-term rate of 4.26% (2022-23: 3.27%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- medium-term rate of 4.03% (2022-23: 3.20%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- long-term rate of 4.72% (2022-23: 3.51%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- very long-term rate of 4.40% (2022-23: 3.00%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.16 **Clinical Negligence Costs**

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

1.17 **Non-clinical Risk Pooling**

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

1.18 **Continuing healthcare risk pooling**

Claims that have arisen since April 2013 with a retrospective element dating back to a maximum of 1 April 2013, have been assessed and, if appropriate, paid from the current year budget. Therefore, in each accounting period there may be some costs relating to previous years but the budget has funding for this (based on historical spend being built into the baseline) which obviates the need for a provision. It is also very difficult to estimate the level of retrospective liabilities as cases are not known until a claim is made and an estimate cannot be made with any certainty.

1.19 **Financial Assets**

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

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

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

1.19.1 **Financial Assets at Amortised cost**

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

1.19.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

The ICB has not elected to measure any assets at fair value.

1.19.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The ICB has not elected to measure any financial assets / financial liabilities at fair value.

1.19.4 **Impairment**

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

The Integrated Care Board adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance

is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 months expected credit losses (stage 1).

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

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

1.20 **Financial Liabilities**

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

1.20.1 **Financial Guarantee Contract Liabilities**

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

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

1.20.2 **Financial Liabilities at Fair Value Through Profit and Loss**

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

1.20.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 **Value Added Tax (VAT)**

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

1.22 **Foreign Currencies**

The Integrated Care Board's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2024. Resulting exchange gains and losses for either of these are recognised in the Integrated Care Board's surplus/deficit in the period in which they arise.

1.23 **Losses & Special Payments**

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

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

1.24 **Gifts**

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

1.25 **Grants Payable**

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

1.26 **Contingent liabilities**

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

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

1.27 **New and revised IFRS Standards in issue but not yet effective**

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

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

2 Financial Performance

2.1 Financial Performance for the year ended 31 March 2024

The financial year 2023/24 was the first full year of the Integrated Care Board, which came into being 1st July 2022. The year was notable for:

Consolidation and recovery of core services following the adverse impact of Covid-19 pandemic

In financial terms this mainly led to:

- £39m investment in Home First / Urgent & Emergency Services, which, together with £13m joint investment with Adult Social Care in Discharge to Assess in 22/23, is expected to leverage £26m of cash-releasing savings
- Operation of Elective Services Recovery Fund with a 'payment by Results' style reimbursement scheme to incentivise additional activity to clear waiting list backlogs
- Investment in primary care access

Further progress towards financial sustainability

The ICB continues to operate in a system by default financial framework. In financial terms this has meant:

- Enhanced focus and challenge on delivery of Savings Plans
- Establishing metrics and measures of productivity
- Creation and operation of a system-wide financial performance escalation framework (System Forecast Outturn Change protocol), with an emphasis of early warning & response and peer-to-peer support from within the system

Continued progress towards NHS Long Term Plan priorities

The ICB has delivered improvements in Mental Health, Learning Disabilities and Autism, Maternity, Long Term Conditions and Cancer services. In financial terms this led to:

- Managing a number of targeted 'Service Development Funds' allocated on a non-recurrent basis by NHS England
- Commissioning new models of care, often with new providers, including VCSE or through Locality Partnerships

Taking on the delegation of commissioning responsibilities from NHS England for Pharmacy, Optometry and Dental Services

In financial terms this led to:

- Responsibility for new allocation of £85,682k
- 100s of small independent providers, managed through national contract terms, collaborative working with NHSE Regional Commissiong Hub, managing contracts which include patient fees as a contribution to their care

The impact of high inflation on pay, including managing the impact of industrial action with all major NHS staff groups; and prices of goods and services, including the care market

In financial terms this led to:

- Complex commercial environment to negotiate price uplifts, while ensuring safe and sustainable services are secured, sometimes with cost in excess of national funding allocations
- Multiple re-assessments and funding allocations for NHS staff pay settlements throughout the year
- Multiple changes to Elective Services Recovery Fund activity target, as well as costing and allocating new funding, in response to the impact of Industrial Action on elective care capacity

Making progress on the 4 key aims of the ICBs, whilst responding to the Government's announcement of a 30% reduction in Running Costs Allocation

In financial terms this meant:

- Developing new allocation methodologies and management information to ensure focus on population health and reducing health inequalities
- Costing new funded establishments to support 'Shaping our Future' the programme which we ran to design a new organisational structure to fit within the revised Running Cost Allocation

2.2 Financial Performance targets for the period ended 31 March 2024

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

Full year 2023/2024	Target £'000	Performance £'000	Variance £'000	Achieved
Expenditure not to exceed income	2,214,320	2,213,940	380	Yes
Capital resource use does not exceed the amount specified in Directions	3,189	2,817	372	Yes
Revenue resource use does not exceed the amount specified in Directions	2,175,014	2,175,006	8	Yes
Revenue administration resource use does not exceed the amount specified in Directions	20,515	20,513	2	Yes

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

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

There were no capital or revenue resources on specified matters in 2023/24 and 2022/23.

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

3.1 Operating Income

	Year ended 31 March 24 Total £'000	9 months to 31 March 23 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies - *note 1*	7,992	6,013
Prescription fees and charges	9,951	-
Dental fees and charges	12,826	-
Other contract income	5,349	1,962
Total income from sale of goods and services	**36,118**	**7,975**
Total Operating Income	**36,118**	**7,975**

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

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

Notes

1. £7.8m of this revenue figure relates to income for Research and Development from the Department of Health and Social Care (2022-23 £5.9m).
2. Pharmacy, Ophthalmic and Dental (POD) services were delegated to ICBs in 2023-24, giving rise to prescription and dental fee income.

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

	Year ended 31 March 24			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	204	-	-	2,275
Non NHS	7,788	9,951	12,826	3,074
Total	**7,992**	**9,951**	**12,826**	**5,349**

	Year ended 31 March 24			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	7,992	9,951	12,826	5,349
Over time	-	-	-	-
Total	**7,992**	**9,951**	**12,826**	**5,349**

	9 months to 31 March 23			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	155	-	-	1,940
Non NHS	5,858	-	-	22
Total	**6,013**	**-**	**-**	**1,962**

	9 months to 31 March 23			
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	6,013	-	-	1,962
Over time	-	-	-	-
Total	**6,013**	**-**	**-**	**1,962**

Pharmacy, Ophthalmic and Dental (POD) services were delegated to ICBs in 2023-24, giving rise to prescription and dental fee income.

4. Employee benefits and staff numbers

4.1 Employee benefits

	Year ended 31 March 24		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee benefits			
Salaries and wages	20,396	1,485	21,881
Social security costs	2,245	-	2,245
Employer contributions to NHS Pension scheme	4,052	-	4,052
Apprenticeship levy	97	-	97
Termination benefits	147	-	147
Gross employee benefits expenditure	**26,937**	**1,485**	**28,422**

	9 months to 31 March 23		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee benefits			
Salaries and wages	16,693	3,872	20,565
Social security costs	1,948	-	1,948
Employer contributions to NHS Pension scheme	3,049	-	3,049
Apprenticeship levy	80	-	80
Termination benefits	-	-	-
Gross employee benefits expenditure	**21,770**	**3,872**	**25,642**

There were no capitalised staff costs in 2023-24 or in the nine months ended 31 March 2023.

4.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
2023-24	429	15	444
2022-23	465	54	519

There were no whole-time equivalent people engaged on capital projects in 2023-24 or in the nine months ended 31 March 2023.

4.3 Staff annual leave accrual balances

	Permanent Staff £'000
Employee accrued benefits liability at 31 March 2024	198
Employee accrued benefits liability at 31 March 2023	125

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

4.4 Exit packages agreed in the financial year

	Year ended 31 March 24					
	Compulsory redundancies		Other agreed departures		Total	
	No.	£	No.	£	No.	£
Less than £10,000	-	-	2	14,554	2	14,554
£10,001 to £25,000	-	-	3	64,470	3	64,470
£25,001 to £50,000	-	-	5	170,865	5	170,865
£50,001 to £100,000	2	146,988	4	290,232	6	437,220
£100,001 to £150,000	1	128,000	2	266,458	3	394,458
£150,001 to £200,000	-	-	2	355,880	2	355,880
Over £200,001	-	-	-	-	-	-
Total	**3**	**274,988**	**18**	**1,162,459**	**21**	**1,437,447**

	9 months to 31 March 23					
	Compulsory redundancies		Other agreed departures		Total	
	No.	£	No.	£	No.	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	122,667	-	-	1	122,667
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**122,667**	**-**	**-**	**1**	**122,667**

The other agreed departures in 2023-24 all related to voluntary redundancies (2022-23 Nil). There were no departures where special payments were made in 2023-24 (2022-23 Nil).

No payments were made relating to non-contractual payments in lieu of notice.

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

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

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

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

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary. (2022-23 Nil).

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

4.5 Pension costs

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

Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP Practices and other bodies allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

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

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

4.5.1 Accounting valuation

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

The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In

undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming that the employer contribution rate will increase to 23.7% from 1 April 2024 (previously 20.6%).

The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The ICB offers the National Employment Savings Scheme (NEST) as an additional defined contribution workplace pension scheme to relevant employees. The ICB recognises contributions payable under this scheme as an expense during the year that it was incurred.

5. Operating Expenditure

	Year ended 31 March 24 Total	9 months to 31 March 23 Total
Purchase of goods and services	**£'000**	**£'000**
Services from other ICBs and NHS England	8,635	5,658
Services from foundation trusts	584,949	389,635
Services from other NHS trusts	627,726	442,344
Services from other WGA bodies	1,787	1,078
Purchase of healthcare from non-NHS bodies	505,230	358,863
Purchase of social care	8,681	4,173
General dental & personal dental services – *note 1*	41,745	-
Prescribing costs	149,512	110,575
Pharmaceutical services – *note 1*	29,183	-
General ophthalmic services – *note 1*	8,027	-
GPMS/APMS and PCTMS	193,923	138,440
Supplies and services – clinical	4,255	3,293
Supplies and services – general - *note 2*	239	(174)
Consultancy services	824	624
Establishment	5,843	1,050
Transport	34	9
Premises	4,878	2,321
Audit fees - *notes 3,4*	252	198
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees - *note 5*	1,061	1,052
Legal fees	355	129
Education, training and conferences	293	570
Total Purchase of goods and services	**2,177,432**	**1,459,838**
Depreciation and provisions expense		
Depreciation	281	377
Amortisation	-	64
Provisions expense	(3,397)	5,562
Total Depreciation provisions expense	**(3,116)**	**6,003**
Other Operating Expenditure		
Chair and Non-Executive Members	164	124
Grants to Other bodies - *note 5*	150	188
Research and development (excluding staff costs)	8,041	6,079
Expected credit loss on receivables	-	70
Other expenditure	-	12
Total Other Operating Expenditure	**8,355**	**6,473**
Total Operating Expenditure	**2,182,671**	**1,472,314**

5. Operating Expenditure (continued)

Notes

1. There is no comparator for General dental & personal dental services, Pharmaceutical services and General ophthalmic services as these relate to services that were delegated to the ICB in 2023-24.

2. Negative expenditure reported on this line in 2023-23 was caused by the movement on the annual leave accrual between 30 June 2022 and 31 March 2023.

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

4. External audit fees, excluding VAT, £210,000. This comprises £180,000 core services, £15,000 for the 2023-24 MHIS audit and a further £15,000 for the 2021-22 MHIS audit which was charged in this financial year but not accrued in 2022-23. In 2022-23, the cost excluding VAT was £190,000 for the 9 month ICB audit and an estimated £15,000 for MHIS audit.

5. Internal Audit services are provided by an external provider RSM Risk Assurance Services LLP and fees totalled £71,760 net of VAT (2022-23 £46,800 net of VAT). This is included in Other professional fees.

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

6.1 Better Payment Practice Code

Measure of compliance	Year ended March 24 No.	Year ended March 24 £'000	9 months to March 23 No.	9 months to March 23 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the period	31,150	772,437	21,330	505,337
Total Non-NHS Trade Invoices paid within target	30,716	745,444	20,946	496,651
Percentage of Non-NHS Trade invoices paid within target	**99%**	**97%**	**98%**	**98%**
NHS Payables				
Total NHS Trade invoices paid in the period	1,010	1,226,793	824	853,412
Total NHS Trade invoices paid within target	985	1,226,067	816	853,379
Percentage of NHS Trade Invoices paid within target	**98%**	**100%**	**99%**	**100%**

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

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

7. Finance Costs

	Year ended 31 March 24 Total £'000	9 months to 31 March 23 Total £'000
Interest on lease liabilities	31	1
Total finance costs	**31**	**1**

8. Net Gain (Loss) on Transfer by Modified Absorption

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

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption so prior year transactions (which have been accounted for under merger accounting) were not restated in the accounts for the 9 months ended 31 March 2023. Absorption accounting requires that entities account for their transactions in the period which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

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

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

The balances that fed into the cashflow statement for the period ended 31 March 2023 are starred * = £84,078k Payables transferred at 30 June 2022 included £95,917k Current trade payables and £416k lease liability.

9. Property, plant and equipment

	2023-24 £'000	2022-23 £'000
Cost or Valuation opening balance	1,022	-
Transfer from other public bodies under absorption	-	749
Additions purchased	177	273
Disposals	(369)	-
Cost or Valuation closing balance	**830**	**1,022**
Depreciation opening balance	638	-
Transfer from other public bodies under absorption	-	573
Disposals	(369)	-
Charged during the year	113	65
Depreciation closing balance	**382**	**638**
Net Book Value closing balance	**448**	**384**
Purchased	448	384
Total at 31 March	**448**	**384**
Asset financing:		
Owned	448	384
Total at 31 March	**448**	**384**

All property, plant and equipment held by the ICB at 31 March 2024 and 31 March 2023 relate to Information Technology assets.

9.1 Economic lives

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

10. Leases

10.1 Right-of-use assets

	2023-24 Buildings £'000	2022-23 Buildings £'000
Cost opening balance	520	-
Transfer from other public bodies under absorption	-	520
Additions purchased	2,640	-
Cost closing balance	**3,160**	**520**
Depreciation opening balance	416	-
Transfer from other public bodies under absorption	-	104
Charged during the period	168	312
Depreciation closing balance	**584**	**416**
Net Book Value closing balance	**2,576**	**104**

10.2 Lease liabilities

	2023-24 £'000	2022-23 £'000
Lease liabilities opening balance	(104)	-
Transfer from other public bodies under absorption	-	(416)
Adjusted lease liabilities opening balance	**(104)**	**(416)**
Additions	(2,640)	-
Interest expense relating to lease liabilities	(31)	(1)
Repayment of lease liabilities (capital and interest)	180	313
Lease liabilities closing balance	**(2,595)**	**(104)**

All Right of Use Assets are leased from NHS Property Services.

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2023-24 Obligations Leased from NHS Property Services £'000	2022-23 Obligations Leased from NHS Property Services £'000
Within one year	(268)	(104)
Between one and five	(1,602)	-
After five years	(1,333)	-
Total	**(3,203)**	**(104)**
Effect of discounting	608	-
Included in:		
Current lease liabilities	(150)	(104)
Non-current lease liabilities	(2,445)	-
Total	**(2,595)**	**(104)**

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	SoCNE Year ended 31 March 24 £'000	SoCNE 9 months to 31 March 23 £'000
Depreciation expense on right-of-use asset	168	312
Interest expense on lease liabilities	31	1

10.5 Amounts recognised in cashflow

	SOCF 2023-24 £'000	SOCF 2022-23 £'000
Total cash outflow on leases under IFRS 16	180	313

11 Intangible non-current assets

	2023-24 £'000	2022-23 £'000
Cost or valuation opening balance	170	-
Transfer from other public bodies under absorption	-	170
Cost or valuation closing balance	**170**	**170**
Amortisation opening balance	170	-
Transfer from other public bodies under absorption	-	106
Charged during the period	-	64
Amortisation closing balance	**170**	**170**
Net Book Value closing balance	**-**	**-**

All intangible assets held by the ICB at 31 March 2023 relates to computer software.

11.1 Cost of valuation of fully amortised assets

	2023-24 £'000	2022-23 £'000
Computer software: purchased	170	170

11.2 Economic Lives

	Minimum Life (Years)	Maximum Life (Years)
Computer software: purchased	2	5

12 Trade and other receivables

	2023-24 Current £'000	2022-23 Current £'000
NHS receivables: Revenue	4,760	4,002
NHS prepayments	744	706
NHS accrued income	1,020	-
Non-NHS and Other WGA receivables: Revenue	20,382	5,934
Non-NHS and Other WGA prepayments	1,267	2,086
Non-NHS and Other WGA accrued income	769	576
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	11,473	-
Expected credit loss allowance-receivables	(73)	(73)
VAT	263	383
Other receivables and accruals	2	3
Total Current trade & other receivables	**40,607**	**13,617**

POD services were delegated to ICBs in 2023-24, giving rise to a non-NHS receivable of £11,473k.

The ICB had no non-current trade receivables at 31 March 2024 or at 31 March 2023.

The ICB had no prepaid pensions contributions at 31 March 2024 or at 31 March 2023.

12.1 Receivables past their due date but not impaired

	2023-24		2022-23	
	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	394	18,834	-	376
By three to six months	21	168	-	-
By more than six months	7	11	74	712
Total	**422**	**19,013**	**74**	**1,088**

12.2 Loss allowance on asset classes

	Trade and other receivables: Non DHSC Group Bodies	
	2023-24	2022-23
	£'000	£'000
Allowance for credit losses opening balance	(73)	-
Lifetime expected credit losses on trade and other receivables-Stage 2	-	(73)
Allowance for credit losses closing balance	**(73)**	**(73)**

12.3 Provision matrix on lifetime credit loss

	31 March 2024		
	%	£'000	£'000
Non NHS Debt	**Lifetime expected credit loss rate**	**Gross Carrying amount**	**Lifetime expected credit loss**
Current	-	247	-
1-30 days	0.5	13,182	67
31-60 days	2	2	-
61-90 days	10	33	3
90-365 days	10	9	1
Greater than 365 days	100	2	2
Total expected credit loss		**13,475**	**73**

	31 March 2023		
	%	£'000	£'000
Non NHS Debt	**Lifetime expected credit loss rate**	**Gross Carrying amount**	**Lifetime expected credit loss**
Current	-	326	-
1-30 days	-	-	-
31-60 days	2	6	-
61-90 days	10	-	-
90-365 days	10	710	71
Greater than 365 days	100	2	2
Total expected credit loss		**1,044**	**73**

The Integrated Care Board did not hold any collateral against receivables outstanding at 31 March 2024 or at 31 March 2023.

13. Cash and cash equivalents

	2023-24 Total £'000	2022-23 Total £'000
Opening balance	81	-
Transfer from other public bodies under absorption	-	102
Adjusted opening balance	**81**	**102**
Net change in period	93	(21)
Closing balance	**174**	**81**
Made up of:		
Cash with the Government Banking Service	173	80
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**174**	**81**

14. Trade and other payables

	2023-24 Total £'000	2022-23 Total £'000
NHS payables: Revenue	2,494	4,829
NHS accruals	5,256	398
Non-NHS and Other WGA payables: Revenue	49,568	57,048
Non-NHS and Other WGA payables: Capital	-	34
Non-NHS and Other WGA accruals	80,654	59,591
Non-NHS and Other WGA deferred income	38	158
Social security costs	299	343
Tax	325	326
Other payables and accruals	2,431	4,030
Total Current Trade & Other Payables	**141,065**	**126,757**

The ICB had no non-current trade and other payables at 31 March 2024 or at 31 March 2023.

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

Other payables include £1,757,444 outstanding pension contributions at 31 March 2024 (£2,330,667 as at 31 March 2023).

15 Provisions

	2023-24 Total £'000	2022-23 Total £'000
Current		
Redundancy	747	-
Restructuring	-	300
Legal claims	4,761	4,761
Other	2,772	8,240
Total	**8,280**	**13,301**

The ICB had no non-current provisions at 31 March 2024 or at 31 March 2023.

	2023-24				
	Redundancy	Restructuring	Legal Claims	Other	Total
	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2023	**-**	**300**	**4,761**	**8,240**	**13,301**
Arising during the period	747	1,484	-	-	**2,231**
Utilised during the period	-	(1,624)	-	-	**(1,624)**
Reversed unused	-	(160)	-	(5,468)	**(5,628)**
Change in discount rate	-	-	-	-	**-**
Balance at 31 March 2024	**747**	**-**	**4,761**	**2,772**	**8,280**
Expected timing of cash flows:					
Within one year	747	-	4,761	2,772	8,280
Between one and five years	-	-	-	-	-
After five years	-	-	-	-	-
Balance at 31 March 2024	**747**	**-**	**4,761**	**2,772**	**8,280**

The Legal provisions relate to outstanding contract challenges with providers.

The Other provision relates to:
- £2,150k for General Practitioner service charge payments disputed with NHS Property Services
- £622k for dilapidations associated with the Head Office and a GP practice.

	2022-23			
	Restructuring	Legal Claims	Other	Total
	£'000	£'000	£'000	£'000
Balance at 1 July 2022	**-**	**-**	**-**	**-**
Transfer from other public bodies under absorption	419	4,948	2,863	8,230
Adjusted balance at 1 July 2022	**419**	**4,948**	**2,863**	**8,230**
Arising during the period	300	180	5,376	**5,856**
Utilised during the period	(125)	(366)	-	**(491)**
Reversed unused	(294)	-	-	**(294)**
Change in discount rate				
Balance at 31 March 2023	**300**	**4,762**	**8,239**	**13,301**
Expected timing of cash flows:				
Within one year	300	4,762	8,239	13,301
Between one and five years	-	-	-	-
After five years	-	-	-	-
Balance at 31 March 2023	**300**	**4,762**	**8,239**	**13,301**

The Legal provisions in 2022-23 related to outstanding contract challenges with providers.

The Other provision in 2022-23 related to:
- £4,407k for General Practitioner service charge payments disputed with NHS Property Services
- £756k for dilapidations associated with the Head Office and a GP practice.
- £3,077k to provide a proportion of the non-consolidated pay offer to staff at the Community Provider as currently they do not fall within the scope of the national offer.

16. Financial instruments

16.1 Financial risk management

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

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

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

16.1.1 Currency risk

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

16.1.2 Interest rate risk

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

16.1.3 Credit risk

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

16.1.4 Liquidity risk

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

16.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

16.2 Financial assets

	Financial Assets measured at amortised cost	
	2023-24 Total £'000	2022-23 Total £'000
Trade and other receivables with NHSE bodies	2,747	2,952
Trade and other receivables with other DHSC group bodies	3,054	1,734
Trade and other receivables with external bodies	32,605	5,829
Cash and cash equivalents	174	81
Total closing balance	**38,580**	**10,596**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
	2023-24 Total £'000	2022-23 Total £'000
Trade and other payables with NHSE bodies	(1,462)	(1,314)
Trade and other payables with other DHSC group bodies	(6,532)	(3,983)
Trade and other payables with external bodies	(135,005)	(120,738)
Other financial liabilities	-	-
Total closing balance	**(142,999)**	**(126,035)**

16.4 Maturity of Financial liabilities

	2023-24		
	Payable to DHSC	Payable to Other bodies	Total
	£'000	£'000	£'000
In one year or less	7,994	135,005	**142,999**
Total at 31 March 2024	**7,994**	**135,005**	**142,999**

	2022-23		
	Payable to DHSC	Payable to Other bodies	Total
	£'000	£'000	£'000
In one year or less	5,297	120,738	**126,035**
Total at 31 March 2023	**5,297**	**120,738**	**126,035**

17. Operating segments

	Year ended 31 March 24	9 months to 31 March 23
	Commissioning Healthcare	Commissioning Healthcare
	£'000	£'000
Gross expenditure	2,211,124	1,497,957
Income	(36,118)	(7,975)
Net expenditure	2,175,006	1,489,982
Total assets	43,805	14,186
Total liabilities	(151,941)	(140,162)
Net assets	(108,136)	(125,976)

17.1 Reconciliation between Operating Segments and SoCNE

	Year ended 31 March 24 £'000	9 months to 31 March 23 £'000
Total net expenditure reported for operating segments	2,175,006	1,489,982
Total net expenditure per the Statement of Comprehensive Net Expenditure	2,175,006	1,489,982

17.2 Reconciliation between Operating Segments and SoFP

	2023-24 £'000	2022-23 £'000
Total assets reported for operating segments	43,805	14,186
Total assets per Statement of Financial Position	43,805	14,186

	2023-24 £'000	2022-23 £'000
Total liabilities reported for operating segments	(151,941)	(140,162)
Total liabilities per Statement of Financial Position	(151,941)	(140,162)

18. Related party transactions

18.1 Details of related party transactions with other organisations

The Department of Health and Social Care is the parent department and is regarded as a related party. During the year to 31 March 2024 the Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts - significant parties University Hospitals Bristol and Weston NHS FT & South Western Ambulance FT;
- NHS Trusts - significant parties North Bristol NHS Trust and Avon & Wiltshire Mental Health Partnership Trust
- NHS Litigation Authority; and,
- NHS Business Services Authority.

The Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies during the period to 31 March 2024. The transactions with Bristol City Council, North Somerset Council and South Gloucestershire Council have a net spend of £117.8m and the main services this relates to are: Better Care Fund and Other (£46.9m); Funded Nursing Care (£27.5m); and all groups of Complex Care clients (£43.4m).

Local Authority	Year ended 31 March 24 £m	9 months to 31 March 23 £m	Movement £m
Bristol City Council	40.2	31.8	8.4
North Somerset Council	25.1	39.4	(14.3)
South Gloucestershire Council	52.5	19.8	32.7
Total	**117.8**	**91.0**	**26.8**

18.2 Details of related party transactions with individuals

During the year, there were two declarations of interest between parties:

- A £146.3m interest between a Board member of Avon & Wiltshire Mental Health Partnership Trust and a Board member of the Integrated Care Board (£103.5m in the 9 months to 31 March 2023).
- A £0.5m interest between British Red Cross and a Board member of the Integrated Care Board (£0.5m in the 9 months to 31 March 2023).

19. Partnership arrangements

The Integrated Care Board has partnership arrangements with Bristol City Council, North Somerset Council and South Gloucestershire Council for the delivery of the Better Care Fund for the provision of community and mental health services together with continuing and social care. The arrangements are made in accordance with S75 of the NHS Act 2006 and any surplus or deficits are the responsibility of the respective partners. Each of the partner bodies is responsible for managing the individual schemes for which they have lead responsibility.

The funding and expenditure for each BCF are:

Bristol City Council	**Year ended 31 March 24 £'000**	**9 months to 31 March 23 £'000**
Funding provided to partnership budgets	38,928	27,632
Additional NHS contribution	1,332	981
ASC discharge funding	3,584	3,428
ICB funding to council for protection of adult social care	(20,239)	(14,366)
Expenditure from partnership arrangement	**23,605**	**17,675**

North Somerset Council	**Year ended 31 March 24 £'000**	**9 months to 31 March 23 £'000**
Funding provided to partnership budgets	18,475	13,114
Additional NHS contribution	1,400	1,031
ASC discharge funding	1,735	2,362
ICB funding to council for protection of adult social care	(8,096)	(5,747)
Expenditure from partnership arrangement	**13,514**	**10,760**

South Gloucestershire Council	**Year ended 31 March 24 £'000**	**9 months to 31 March 23 £'000**
Funding provided to partnership budgets	18,937	13,442
Additional NHS contribution	1,529	565
ASC discharge funding	1,868	2,526
ICB funding to council for protection of adult social care	(6,849)	(4,862)
Expenditure from partnership arrangement	**15,485**	**11,671**

20. Losses and special payments

The ICB incurred no losses and made no special payments in 2023-24.

In 2022-23 the ICB made a fruitless payment of £215,000 relating to a compensation payment. This was fully covered by the release of a provision created in 2021-22.

21. Contingences

Contingent Liabilities

	2023-24 £'000	2022-23 £'000
Continuing Healthcare	121	799

The contingent liability relates to continuing healthcare claims back to 2018. The uncertainty relates to the eligibility of outstanding historic claims. Whilst possible, it has been deemed unlikely these amounts will be reimbursed.

The ICB has a procurement challenge which is going through a legal process where the potential obligation is not known or quantifiable.

22. Events after the reporting period

No events occurred after the reporting date that require adjustment or disclosure in these financial statements.

NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB

Annual internal audit report 2023/24

Draft

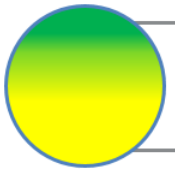
25 June 2024

THE ANNUAL INTERNAL AUDIT OPINION

This report provides an annual internal audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance reporting.

The opinion

For the 12 months ended 31 March 2024, the head of internal audit opinion for NHS Bristol, North Somerset and South Gloucestershire ICB is as follows:



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

Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

It remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be a substitute for management responsibility around the design and effective operation of these systems.

Scope and limitations of our work

The formation of our draft opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- internal audit has not reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance; and
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention.

FACTORS AND FINDINGS WHICH HAVE INFORMED OUR OPINION

We have completed 11 assignments throughout 2023/24. Of which, four were advisory and without an assurance opinion, four partial and three provided a reasonable level of assurance in the areas detailed below. Three audits remain in draft at the time of reporting.

Partial Assurance

Risk Management / Assurance Framework (6.23/24)

We would have expected to see a more embedded approach to risk management across the ICB and more regular reporting of risk registers through the governance structure throughout the year but appreciate this has been a work in progress. Through consideration of work across our other clients, we note that common areas of difficulty included having clear guidelines on what constitutes an ICS risk; and ensuring that a consistent approach is taken through the governance structure to ensure that the ICB's sub-committees are exposed more to and review relevant ICB and system risks. The ICB has defined what constitutes an ICS risk, but greater work is required on embedding a more robust and mature culture of risk management throughout the organisation and its governance structure. However, we would question whether based on the current level of resource that the ICB has the capacity to implement and embed an effective risk management framework for the ICB as well as overseeing the equivalent for the ICS.

Safeguarding (7.23/24)

The ICB has demonstrated progress in identifying and creating solutions for areas of weakness in its safeguarding arrangements. This has included the enhancements made to the Safeguarding team structure through recruitment, re-design of the safeguarding internal governance structure, and the ongoing meeting mapping exercise of statutory and non-statutory meetings. The improvements to date have been recognised by NHSE and evidence provided during this review has highlighted ongoing work is being undertaken to address systemwide weaknesses following external reviews. However, progress with the System Safeguarding Transformation Programme has not been timely since the LGA review findings, and collaboration and buy in with system partners does not appear to be as effective as required to move this forward. The Safeguarding team can demonstrate regular reporting on the ICB's safeguarding activities through the ICB's governance structure (attended by system partners) however, we identified weaknesses whereby we could not evidence discussions or scrutiny of safeguarding reports through meeting minutes, and there appeared to be a lack of progress and engagement from system partners to take the System Safeguarding Transformation Programme forward.

Funded Care (8.23/24)

Our audit focused on financial and performance governance and found that the Funded Care team were monitoring the current adverse financial position of the services, with clarity on where funded care activities require improvement. The Funded Care team demonstrated actions taken to implement positive change, through implementing CareTrack and enlisting additional support from the ICB Finance team. However, challenges regarding resource capacity, have limited progress on key funded care workstreams, such as work around data accuracy, automation of month end processes and development of insight data to inform funded care eligibility growth, which could improve efficiency, reporting and monitoring activity within funded care.

Project Gateway – System Benefits Realisation (Part 2) (10.23/24) DRAFT

The ICB is enhancing project management by reviewing active project prioritisation, developing tools for alignment with key priorities, and introducing a Programme Board for major changes. We could see progress had been made following the Project Gateway Part 1 review, with the project prioritisation tool fully developed and communications circulated on the Project Gateway Process to ICB staff through directorate and HCIG meetings. However, the current framework has inconsistencies in application, especially for legacy projects, lacks formal guidance on the gateway process, and holds uncertainty around the central capture and management of non-gateway projects, (including cost, resource, priority alignment, and benefits monitoring). Lastly, whilst we could see the ICB submitted an update on major change projects through the System Executive Group (SEG), there was insufficient evidence to show regular project reporting through the ICB/ICS governance structure.

Reasonable Assurance

People Programme Plan (3.23/24)

We found that the ICB needed to improve how it captures the use of impact data in reports going forward, to present through the governance structure, to provide a transparent and accurate reflection of progress and issues across the long term delivery of the People Programme. High level metrics were sometimes reflected in reports; granular level data analysis and impact data were not included to support the position statements. This was a consistent finding across the ICB's reporting arrangements. The ICB had taken steps to ensure its People Programme was aligned to the NHSE people functions / outcomes, and was regularly reporting on the progress and developments of its people functions that underpin the wider ICS People Programme. Reporting took place through the ICS governance structure, and could demonstrate how the system aimed to achieve its workforce priorities through specific project activities.

Financial Sustainability and Reporting (4.23/24)

We concluded that the ICB appeared to have a mature and embedded system of financial management with good, established engagement of system partners. There is a governance structure in place through which progress against the ICS financial plan is reported, escalated, and challenged on a monthly basis. The ICB has policies, procedures and terms of reference in place that outline the governance requirements in relation to financial planning and that direct staff to carry out their duties in a manner that aligns with the ICB's financial sustainability strategy. Providers submit financial data to the ICB and NHSE via a template developed by NHSE. BNSSG consolidates provider PFRs in order to report a system-wide position to the FED and ICB Board, as well as to all system provider governance forums. The key data in the PFRs is reviewed and discussed at Deputy Director of Finance meetings, where reporting to FED / Board is agreed. However, no outcomes or actions were captured for these meetings. We have agreed with management an action to consider an approach to documenting decisions and actions that result from these meetings, given the ICB's role of monitoring and challenging system-wide financial reporting at an operational level.

Financial Controls – Payroll (5.23/24)

Our annual financial controls concluded that the ICB has an adequate framework of control in place for oversight of its outsourced payroll function and the completion of control account reconciliations during the month-end process, with processes in place to ensure the payroll prepared by NBT each month reconciles to supporting documentation, with any anomalies addressed during monthly payroll touchpoint meetings. We have highlighted improvements to be made in the retention of evidence relating to the review of control account reconciliations, including those completed by SBS and the ICB itself.

Advisory

Pharmacy – Ophthalmic and Dentistry (POD) Services (1.23/24)

We concluded that the framework appeared to be well designed, and we found that the ICB is informed and aware of its statutory responsibilities for the newly onboarded services. Capacity and oversight frameworks had been developed to support the ICB in discharging its duties to deliver effective POD services on behalf of NHS England. However, we did identify an opportunity to strengthen the control in place to ensure that actions raised as part of the live and ongoing Transition Plan assigned to the ICB are appropriately tracked and monitored.

Project Gateway – System Benefits Realisation (Part 1) (2.23/24)

In line with benchmarking and good practice as seen across our client base, our review identified areas of potential improvement in the project gateway framework. Whilst acknowledging that the framework was yet to be fully embedded at the time our audit, we noted inconsistencies of practice which included different documentation and templates being used at similar stages for different projects. Implementation of the areas of improvement identified will act to strengthen the existing frameworks in place and ensure that there are robust controls and oversight over the development, prioritisation and management of future projects.

Governance at Place (9.23/24) DRAFT

The ICB demonstrated appropriate discussions were taking place regularly around developing place-based service delivery and governance through local and system-wide governance arrangements. This included System partner attendance to meetings and clear considerations around place-based fund allocations. Formal recording through meeting papers and minutes evidenced the ICB and ICS's journey from developing place-based working for CMH services however, we identified newly agreed governance arrangements (from November 2023) had only commenced in December 2023 and were still in the process of being embedded, with some local Terms of Reference (ToR) yet to be formally approved. Whilst we could see place-based service delivery and governance had first been established when the ICB were still a CCG (to 'go-live' from 1 April 2022), we found the initial approach for devolving funds had been reviewed and reset (November 2022). The revision resulted in reduced funding devolved to Locality Partnerships, to establish locality Mental Health and Wellbeing Integrated Network Teams (MINTs). As the new place-based governance arrangements have not yet been embedded, the ICB could not demonstrate what impact the new arrangements have had on place-based service delivery.

DSP Toolkit (11.23/24) DRAFT

Our assessment was undertaken using the NHS England DSP Toolkit Independent Assessment Guide and Independent Assessment Framework 2023 / 2024. The assessment contains two ratings:

- our confidence level in the veracity of your self-assessment / DSP Toolkit submission. This is determined by comparing our independent assessment findings against your latest DSP Toolkit submission - **Medium**; and
- our overall risk assurance rating as regards your organisation's data security and data protection control environment. This has been derived from an evaluation of the impact and likelihood of each in-scope assertion and an assessment of risk at the standard level - **Moderate**.

The confidence level together with the risk assurance rating provides valuable insight into the technical and operational data security and data protection control environment and relative strengths and weaknesses of those controls. We agreed a total of two high, 18 medium and one low priority actions with management.

A summary of internal audit work undertaken, and the resulting conclusions, is provided at Appendix B.

Action tracking

We have also tracked progress in implementation of previous years' management actions raised as part of our internal audit work. At the point of reporting, there are **two** **Medium** actions (in the area of Financial Controls) in progress whereby an extension to the original action deadline has been requested; and a further **one** **Medium** action (in the area of Appraisals) where the action deadline has been extended.

THE BASIS OF OUR INTERNAL AUDIT OPINION

As well as those headlines previously discussed, the following areas have helped to inform our opinion. A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

Acceptance of internal audit management actions

Management have agreed actions to address all of the findings reported by the internal audit service during.

Implementation of internal audit management actions

Throughout the year internal audit has tracked the implementation of previously agreed management actions and reports the position to each Audit, Governance and Risk Committee. **Reasonable progress** has been made in implementing management actions, as discussed above.

Working with other assurance providers

In forming our opinion, we have not placed any direct reliance on other assurance providers other than through consideration of the service auditor reports received. We have liaised with the Local Counter Fraud Specialist and External Audit as appropriate during the course of the year. The service auditor reports considered are as follows.

Service auditor reports

Service Auditor Report - NHS Shared Business Service ISAE 3402

In forming our opinion, we reviewed the Service Auditor Report from the internal auditors of NHS Shared Business Services who provide financial transactional services to the ICB. An unqualified opinion from PwC was assigned that “the control objectives stated were achieved and operated effectively throughout the period 1 April 2023 to 31 March 2024”. Although there were two exceptions noted around documenting of client requests to remove invoice holds and maintenance of email communication sent to the client with the results of reconciliations.

NHS Business Services Authority: Prescription Payments Process - Type II ISAE 3402

We reviewed the Service Auditor Report from the internal auditors for the NHS Business Services Authority for Prescriptions Payments Process for the period 1 April 2023 to 31 March 2024. No exceptions were noted.

NHS Business Service Authority: Dental Payment Process – Type II ISAE 3402

We reviewed the Service Auditor Report from the internal auditors for the NHS Business Services Authority for Dental Payments Process for the period 1 April 2023 to 31 March 2024. No exceptions were noted.

Primary Care Support England - Capita Type II ISAE 3402

Capita provide a range of payment and pensions administration services under the PCSE contract. Within the scope of our work, a qualified opinion was issued in relation to one control objectives during the period 1 April 2023 to 31 March 2024. This was in relation to the objective 'Controls provide reasonable assurance that logical access by internal Capita staff and GPs to NHAIS and PCSE Online is restricted to authorised individuals.'

ESR –Type II ISAE 300

In forming our opinion, we also reviewed the Service Auditor Report from the internal auditors of the Electronic Staff Record Programme for the period 1 April 2023 to 31 March 2024. No exceptions were noted.

NHS England South, Central and West Commissioning Support Unit Report - Internal Controls (Type II) Calculating Quality Reporting Service (CQRS) National

We reviewed the Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering CQRS (calculating quality reporting systems) services covering the period 1 April 2023 to 31 March 2024. One exception was identified around inactive infrastructure service accounts which we do not deem to be significant to the Head of IA Opinion.

Working with other assurance providers

In forming our opinion we have not placed any direct reliance on other assurance providers.

OUR PERFORMANCE

Wider value adding delivery

Area of work	How has this added value?
Healthcare Benchmarking	We prepared benchmarking papers around Financial Sustainability 2022/23 to enable the ICB to review its position against the NHS England Average and other similar ICBs. We completed a benchmarking exercise for our individual clients based on all of the internal audit assurance reports we have issued to our healthcare clients during the audit year 2022/23 This paper provided the ICB with a useful snapshot of the organisation's performance against others in the sector.
Client Briefings	As part of our client service commitment, we continue to issue news briefings to each Audit, Governance and Risk Committee meeting.
Audit Committee	We contributed to the discussions at each audit committee on various items on the agenda in order to ensure that the ICB benefits from wider input in further developing its governance arrangements.
Employment Matters	We have prepared regular Employment Matters publications which provide a variety of topical information on matters relating to employment including legal, tax, and global mobility issues.
Client invitations	We continue to hold regular events throughout the year that are relevant for our NHS Clients and we have invited the ICB to attend all such events, Examples include the following: • RSM ran a survey seeking views around the current apprenticeship landscape. Results were collated and we invited the ICB to attend a webinar to share results and discuss common themes. • We have also extended invites for bitesize introductions to the NHS VAT dashboard and a Public Procurement Webinar held by RSM in conjunction with CIPFA. These were held in January 2023.
Webinars	We have invited the ICB to various webinars including to our series of procurement and contract management network webinars offering expert advice on EU and UK public sector procurement legislation and practice. These monthly webinars include an update on current developments in public procurement as well as a more detailed discussion on a selected topical area.

Conflicts of interest

RSM has not undertaken any work or activity during 2023/24 that would lead us to declare any conflict of interest.

Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS).

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our risk assurance service line commissioned an external independent review of our internal audit services in 2021 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF), and the Internal Audit Code of Practice, as published by the Global Institute of Internal Auditors (IIA) and the Chartered IIA, on which PSIAS is based.

The external review concluded that RSM 'generally conforms* to the requirements of the IIA Standards' and that 'RSM IA also generally conforms with the other Professional Standards and the IIA Code of Ethics. There were no instances of non-conformance with any of the Professional Standards.'

* The rating of 'generally conforms' is the highest rating that can be achieved, in line with the IIA's EQA assessment model.

Quality assurance and continual improvement

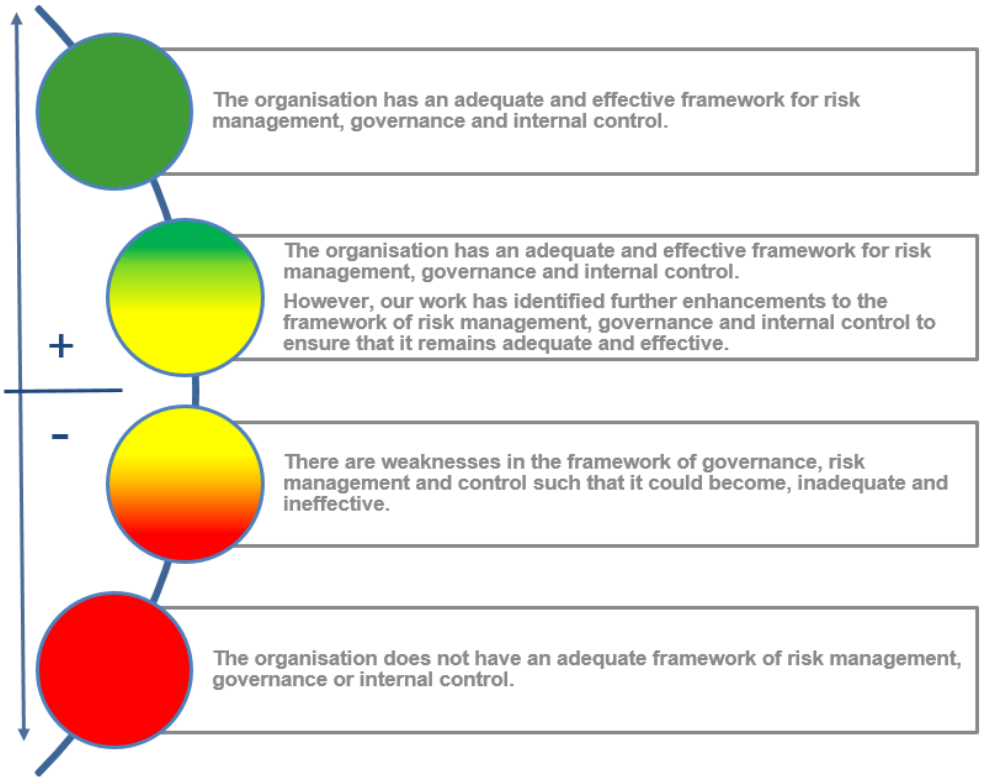
To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

Resulting from the programme in 2023/24 there are no areas which we believe warrant flagging to your attention as impacting on the quality of the service we provide to you.

In addition to this, any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments is also taken into consideration to continually improve the service we provide and inform any training requirements.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.

Annual opinions	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • limitations in the individual audit assignments; • the adequacy and effectiveness of the risk management and / or governance control framework; • the impact of weakness identified; • the level of risk exposure; and • the response to management actions raised and timeliness of actions taken.

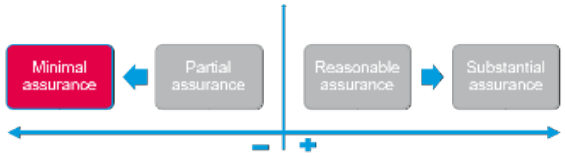
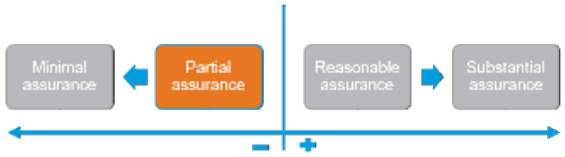
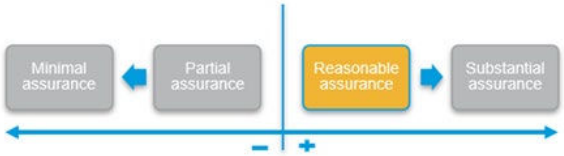
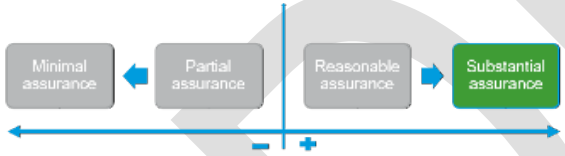
APPENDIX B: SUMMARY OF INTERNAL AUDIT WORK COMPLETED 2023/24

All of the assurance levels and outcomes provided above should be considered in the context of the scope, and the limitation of scope, set out in the individual assignment report.

Assignment	Executive lead	Assurance level	Actions agreed			
			Adv	L	M	H
Pharmacy, Ophthalmic and Dentistry (POD) Services (1.23/24)	David Jarrett – Director of Integrated Primary Care	Advisory [●]	0	0	1	0
Project Gateway – System Benefits Realisation (Part 1) (2.23/24)	Deborah El-Sayed – Director of Transformation	Advisory [●]	8	-	-	-
People Programme Plan (3.23/24)	Jo Hicks – Chief People Officer	Reasonable Assurance [●]	-	1	4	0
Financial Sustainability and Reporting (4.23/24)	Sarah Truelove – Chief Finance Officer	Reasonable Assurance [●]	-	0	2	0
Financial Controls / Payroll (5.23/24)	Sarah Truelove – Chief Finance Officer	Reasonable Assurance [●]	-	0	2	0
Risk Management / Assurance Framework (6.23/24)	Shane Devlin – CEO	Partial Assurance [●]	-	0	7	0
Safeguarding (7.23/24)	Rosi Shepherd – Chief Nursing Officer	Partial Assurance [●]	-	2	4	0
Funded Care (8.23/24)	Rosi Shepherd – Chief Nursing Officer	Partial Assurance [●]	-	2	6	1
Governance at Place (9.23/24) DRAFT	David Jarrett – Director of Integrated Primary Care	Advisory [●]	8	-	-	-
Project Gateway – System Benefits Realisation (Part 2) (10.23/24) DRAFT	Deborah El-Sayed – Director of Transformation	Partial Assurance [●]	-	0	4	2
DSP Toolkit (11.23/24) DRAFT	Deborah El-Sayed – Director of Transformation	Moderate / Medium	-	1	18	2

APPENDIX C: OPINION CLASSIFICATION

We use the following levels of opinion classification within our internal audit reports, reflecting the level of assurance the board can take:

	Taking account of the issues identified, the board can take minimal assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

YOUR INTERNAL AUDIT TEAM

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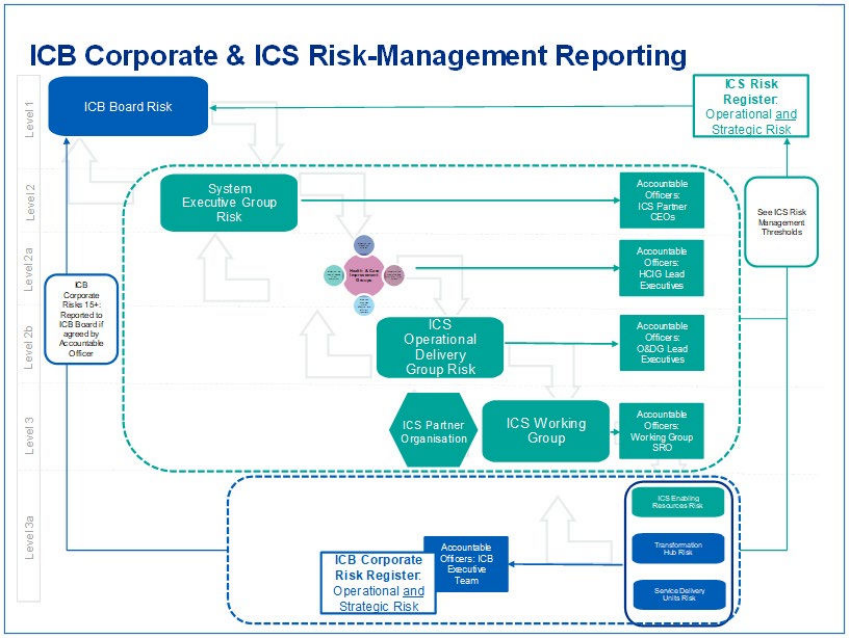
EXECUTIVE SUMMARY – RISK MANAGEMENT / ASSURANCE FRAMEWORK

Assignment	Opinion issued	Actions agreed		
		L	M	H
Risk Management / Assurance Framework (6.23/24)	**Partial Assurance**	**0**	**7**	**0**

Background

This audit was completed to review the BNSSG Integrated Care Board (ICB) and Integrated Care System (ICS) risk management and board assurance activities to ensure that risks to the achievement of both ICB and wider system objectives and priorities have been identified and are being effectively managed, with assurance on how they are being managed flowing through the ICB and ICS governance structures.

The ICB's approach to both organisation and system risk management reporting is set out in the flow chart below, as presented to the ICB Board in December 2023:



Conclusion

We acknowledge that the development of system risk has been an ongoing concern for management with a change in personnel and restricted resource impacting progress. It is through this prism that we have considered and fed in benchmarking and good practice from across our ICB-client base throughout our audit and have agreed actions with management to drive this forward and apply workable improvements in the highlighted areas. Fundamentally, we would have expected to see a more embedded approach to risk management across the ICB and more regular reporting of risk registers through the governance structure throughout the year, but appreciate this has been a work in progress.

Through consideration of work across our other clients, we note that common areas of difficulty included having clear guidelines on what constitutes an ICS risk; and ensuring that a consistent approach is taken through the governance structure to ensure that the ICB's sub-committees are exposed more to, and review relevant ICB and system risks.

The ICB has defined what constitutes an ICS risk but greater work is required on embedding a more robust and mature culture of risk management throughout the organisation and its governance structure. However, we would question whether based on the current level of resource that the ICB has the capacity to implement and embed an effective risk management framework for the ICB as well as overseeing the equivalent for the ICS.

Key findings

We identified the following findings:

We noted that the significant majority of risks from the ICB, ICS and directorate risk registers examined, were not mapped to a principal ICB or ICS objective. This is an element of standard practice observed across our client base and allows for clearer mapping and prioritisation of risks and threats to achievement of principal objectives.

Most NHS Organisations, including more advanced ICBs, around risk management have clear linking of risks to strategic aims / objectives through a Board Assurance Framework, or similar. We acknowledge that the ICB does not have a Board Assurance Framework in place, and work was nearing completion at the time of our audit on a standard reporting template. We have highlighted elements of good practice seen across our client base that the ICB may wish to consider adding to the template, based on availability of resource.

The ICB may wish to consider as part of its development of a standard risk reporting template to the Audit and Risk Committee is the inclusion of sections outlining:

- identified gaps in control or assurance for the highest scoring risks, which are required to be addressed to achieve the desired risk score. Further actions to close these gaps with responsible owners and due dates could then be added for greater assurance; and
- current assurance mechanisms in place over the effectiveness of the existing operating controls in place.

Further good practice to the above we have observed at our ICB clients is a similar report is then drafted to cover system risks with accompanying separate risk registers for system risks and ICB risks (which we acknowledge the ICB already has) to provide as much assurance / opportunity for scrutiny as possible to the Audit and Risk Committee / Board.

Examination of both the ICS and ICB risk registers confirmed that each risk had a section to include detail on associated mitigating existing controls. However, in our opinion, greater clarity and streamlining could be completed to ensure that only the key and most important controls are listed for each risk, to provide readers with a clearer snapshot of what those controls are. In turn, this would allow better scrutiny over the suitability of the existing controls to mitigate the risks to desirable levels.

We identified one instance whereby a risk had a current risk score of 15 on the Primary and Integrated Care Risk Register (Risk PCC49) but had not been escalated to the ICB Risk Register. Whilst this was justified and explained by management, there is the opportunity for the control framework to be strengthened to ensure that risk registers presented to the Audit and Risk Committee and Board are as up to date as possible.

We examined the minutes of the Audit and Risk Committee meetings held between February 2023 and February 2024. We noted that updates on risk management and the ICB risk register had taken place throughout this period, with the exception of the meeting held in February 2024. Updates on work on the ICS risk register had been discussed at the September and December 2023 meetings only - which we acknowledge is newly introduced. Standard practice seen across our client base is for risk management and discussion of the risk

register(s) to be a standing agenda item at all Audit and Risk Committee meetings to ensure there is adequate scrutiny of risk management arrangements.

An ICS Partner Risk Managers Network was in the process of being established at the time of our audit, although no Terms of Reference or meeting minutes / actions / notes were available to review. As per the Risk Management paper presented to the December 2023 ICB Board the Network will aim to:

- share collective responsibility for the identification, controls and mitigations of ICS risks and the maintenance of an ICS risk register;
- share insights and learning; and
- moderate and standardise ICS risk assessments.

Notwithstanding the above, we also identified the following instances of effective control design and good practice:

With the exception of the areas highlighted above, examination of the ICB's Risk Management Framework Policy / document confirmed that:

- its contents were in line with standard practice seen across our client base;
- it was publicly available on its website; and
- it was in date and had been ratified by the Audit and Risk Committee in December 2023.

We confirmed that the ICB had defined its risk appetite, which had been ratified by the ICB Board in September 2023, in line with guidance from the Good Governance Institute across five domains:

- finance;
- regulatory;
- quality;
- reputational; and
- people.

Examination of the ICB and ICS risk registers confirmed that:

- each risk was well described and followed the if... then... resulting in... methodology adequately setting out the cause, risk event and impact should risks crystallise;
- risks were scored based on the likelihood and consequence of the risk occurring; and
- a matrix was in place which identifying the scoring range, which was interpreted into a RAG rating.

Insight and good practice from across our ICB client base:

- Formally agreed shared resourcing from across the system partners, collaborating for joined up system risk management activities.
- System risk matrix to plot all strategic risks from ICS partners to ensure no outliers. This could be done as part of the ICS Partners Risk Management Network.
- Having a single risk register – clearly aligning but separating ICB from ICS risks.
- The ICS risk register is shared with system partners quarterly and organisations are encouraged to map their risk registers to the system risks - this shows the influence both ways and helps to provide wider assurance from within the system.

ACTION PLAN

Management Action 1	Standard ICB and ICS risk reporting templates will be used to collect and collate relevant risk management data and information from risk owners and risk registers, which will be reported to Audit Committee moving forward.	**Responsible Owner** Chief of Staff / Head of Strategy and Planning	**Date** 31 July 2024	**Priority** **Medium**
Management Action 2	The need for individual risk owners to review their risks on revised templates to ensure that these are either mapped to principal objectives or clearly marked as not applicable / relevant, will be communicated.	**Responsible Owner** Chief of Staff / Head of Strategy and Planning	**Date** 31 July 2024	**Priority** **Medium**
Management Action 3	Presentation of ICB and ICS risk registers will be added as a standing agenda item for future ICB Audit and Risk Committee meetings.	**Responsible Owner** Head of Strategy and Planning	**Date** 31 July 2024	**Priority** **Medium**
Management Action 4	Dedicated reviews / deep dives of specific risks required by the Audit and Risk Committee will be scheduled with the risk owner attending committee meetings to allow for examination of and addressing of any gaps in control or assurance required to achieve the desired risk score. This will allow the Committee to decide further actions required to close these gaps with responsible owners and due dates assigned.	**Responsible Owner** Head of Strategy and Planning	**Date** September 2024	**Priority** **Medium**

Management Action 5	It will be communicated to risk owners that risks for which they are responsible, must be reviewed to ensure that only key controls for mitigation (and assurances in place over those controls) are listed against each risk. The controls will be clear, specific and demonstrate how the risk is being managed. This will be an ongoing process to ensure continuous review of risks and that risk registers remain relevant and useful.	**Responsible Owner** Chief of Staff / Head of Strategy and Planning	**Date** 30 July 2024	**Priority** **Medium**
Management Action 6	A reconciliation exercise will be completed between the ICB Risk Register and directorate risk registers prior to finalisation of future Board and Audit Committee papers by Directorate Leads. The Chief of Staff will communicate this responsibility to Directorate Leads.	**Responsible Owner** Chief of Staff / Head of Strategy and Planning	**Date** 31 July 2024	**Priority** **Medium**
Management Action 7	Terms of Reference will be created for the ICS Partner Risk Managers Network. This will explicitly set out the roles and responsibilities for the identification and escalation of system risks.	**Responsible Owner** Chief of Staff / Head of Strategy and Planning	**Date** 30 September 2024	**Priority** **Medium**

Independent auditor's report to the members of the Board of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Bristol, North Somerset and South Gloucestershire ICB (the 'ICB') for the period ended 31 March 2024, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the accounts, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2024 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2023-24 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2023-24 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023-24; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or

is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24).
- We enquired of management and the Audit and Risk Committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit & Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of control and completeness of expenditure. We determined that the principal risks were in relation to:

- high risk journals including consideration of closing entries, self-authorised journals, entries posted after the year end, journals posted by senior officers, manual journals and journals that have a material impact on the reported outturn
- Completeness of secondary healthcare expenditure and specifically expenditure not covered by contracts and contract variations
- Management's assumptions and judgements made in its significant accounting estimates in respect of expenditure accruals

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on unusual journal entries using criteria based on our knowledge of the entity and the risk factors identified;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing and expenditure accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including [add details of risks]. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2024.

We have nothing to report in respect of the above matter except on 25 June we identified.

- A significant weakness in the ICB's governance arrangements. This was in relation to the impact that
    - The ICB does not consistently have appropriate arrangements in place when awarding grants to external bodies and in ensuring that they are spent on the purposes intended. We recommended that the ICB:
        - use the appropriate national NHS template agreement
        - monitor expenditure against grants requiring recipients ro provide supporting evidence
        - maintain a grant register
        - ensure senior officer and appropriate Committee oversight and that this is documented

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS Bristol, North Somerset and South Gloucestershire ICB in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Beth Bowers

Beth Bowers, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

28 June 2024