Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

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Annual Report

1 July 2022 – 31 March 2023

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Sue Harriman

Accountable Officer

22 June 2023

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Chief Executive Officer report

I feel incredibly proud to have led the new Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board since its establishment on Friday 1 July 2022.

We marked the inception of this new organisation with our first Board meeting in public, which allowed us to toast the start of a new chapter and formally set out our vision for a more collaborative, joined-up future for health and care in Bath and North East Somerset, Swindon and Wiltshire.

Our ICB Board is made up of 18 members, each of whom represents a different part of the health and care community. Having these people working in unison, and not in isolation, to achieve common goals, such as improving overall population health, reducing inequalities and enhancing productivity, felt notably different from what had come before.

The membership of our ICB Board can be viewed in full on our website.

Another new organisation – Bath and North East Somerset, Swindon and Wiltshire Integrated Care Partnership – was also created on the same day as the ICB. Its role is to develop an integrated care strategy for how local organisations will work in partnership for the greater good, and to champion innovation and new approaches, while driving forward improvements.

Cllr Richard Clewer, Leader of Wiltshire Council, was announced as the ICP's Chair in August 2022. His appointment is a reflection of the partnership itself, in that it is an organisation wider than the NHS, and one which draws representation from across the entire local health and care landscape.

We are currently in the final stages of developing a joint forward plan, which will set out in practical terms how partners will work together to best deliver and implement the goals, vision and future ways of working that are outlined in the strategy, which was published on 31 March.

Many of the ICB's executive posts were filled before 1 July, but I am pleased that all roles were appointed to within the first few weeks. It means a lot to me that our executive team reflects the diverse population we serve, and I know having a mix of highly skilled and experienced colleagues from different backgrounds makes a real difference.

One of the Board's key focuses during its first nine months was the development of a target operating model, which is a framework for how different parts of an organisation can work together to get things done.

Our target operating model reflects our role as a standalone organisation, as well as our position as a key partner in the wider integrated care system (ICS). As such, the model provides a framework of how we can simultaneously deliver the requirements of the strategy for the integrated care system, such as creating collaboration, connection and meaningful change, while also continuing to deploy our own internal statutory accountabilities.

The model also supports us in safely delivering the financial savings that we, along with all other ICBs, are required to make over the next two years. We know that working differently, and in a way that ensures we remain within our means, can be challenging, especially at a time

when services are still getting used to life post-pandemic. But our organisation is resilient, and I have every faith our colleagues can adapt to what is required.

I am passionate about engaging our colleagues, and while it was a privilege to see so many at our first all-colleague event in September, it is important that dialogue with our people happens on a regular basis. We hold weekly colleague Q&A sessions, and these have proved invaluable in recent months, especially as the organisation finds its feet and prepares for some internal changes.

We also host a monthly colleague briefing, which is a useful way of providing teams with the latest news and information. What is good about these briefings is that colleagues are encouraged to take on the role of presenter. This creates a real sense of community, and I always enjoy hearing colleagues talk so passionately about their work.

External engagement is every bit as important as internal, especially as patients and the public play such an important role in our design and planning processes.

We are fully committed to holding meaningful conversations with people, and have a brand-new communications and engagement strategy to enable us to do this. It sets out our commitment to local communities, and outlines how people can input directly into services. I feel the local NHS should be bespoke and designed around the needs of its communities.

The Our Health, Our Future Citizens Panel is another way in which we engage with local people, by directly asking for their views on health and care issues. In line with our value of inclusivity, this online panel is made up of a representative sample of our region's population. More than 1,200 panel members take part in regular surveys and focus groups.

Full reports of every survey are made available on our website.

Although 2022/23 was our inaugural year, we have wasted no time in driving forward improvements and completing long-term projects.

The new Devizes Health Centre, which opened in February, is one of the country's very first net zero health facilities. I find it hugely symbolic to have a facility on our patch that is conscious of its environmental impact, especially as the whole NHS works moves towards becoming entirely net zero.

The centre is also a real and tangible illustration of joined-up working between different providers, with the site acting as a hub for local primary care services and also a base for community teams and mental health specialists.

Our response to the Covid-19 pandemic, especially the rollout of the vaccine, has been one of our most visible successes as a system. Not only were we able to provide our wider population with more than 2.6 million vaccinations, our clinicians ensured that no communities or groups were left behind.

Dedicated vaccination clinics for people less likely to come forward for the vaccine, such as school and college students, people who live on the region's canals, local Eastern-European residents and those from the Muslim community, took place across all parts of Bath and North East Somerset, Swindon and Wiltshire.

Reducing health inequalities, and ensuring everyone has equal access to care and services, is a must, and I was overjoyed at how our teams went above and beyond to arrange relaxed

vaccination clinics for adults with learning disabilities.

As a region, we also ranked second in the country for vaccine uptake during the autumn booster programme, which is a feat I am very proud to share.

Collaborating with our partners proved invaluable during the winter, and demonstrated the successes of a truly integrated care system. By working together, we were able to open temporary hospital wards, free up valuable ward space by caring for Covid-19 patients in their own home through Oximetry @Home and provide support, cover and extra resources during episodes of industrial action.

We have also taken great strides with partners to shorten the length of time people have to wait for hospital treatment, which has been a particular focus for all health and care systems since the pandemic.

I am confident that many of our recent improvements, such as reducing the number of people waiting more than 62 days for cancer care by a quarter, will continue after 1 April, especially with the introduction of many new mobile testing facilities.

I have always found that looking ahead is just as important as taking stock, and as we say goodbye to this year, I am moved to think about what is next for Bath and North East Somerset, Swindon and Wiltshire.

Not only are we supporting the construction of an integrated front door at the Great Western Hospital in Swindon, which will involve building a much larger emergency department and converting existing space into an improved children's emergency department, we are also fortunate to be leading a £20 million project on behalf of all ICBs in the north of the South West region that will improve mental health services for people with learning disabilities and autism.

With many other large-scale projects in the pipeline, coupled with our ongoing commitment to help the region fully recover from the pandemic and ensure our services are resilient to future challenges, the next 12 months are shaping up to be just as busy as those that have come before, but also every bit as rewarding, if not more.

Sue Harriman,
Chief Executive Officer – March 2023

Our executive team

The ICB is led by an executive team of health and care professionals, all of whom have a wide-ranging knowledge of the NHS in Bath and North East Somerset, Swindon and Wiltshire, as well as its local partner organisations.

Led by Sue Harriman, Chief Executive Officer, the executive team is responsible for leading the ICB, and supporting colleagues across all areas of the organisation to deliver effective health and care services to local people.

The full executive team for 2022/23 can be seen below:

- Sue Harriman, Chief Executive Officer
- Richard Smale, Director of Strategy and Transformation

- Gill May, Chief Nurse
- Dr Amanda Webb, Chief Medical Officer
- Jasvinder Sohal, Chief People Officer
- Gary Heneage, Chief Finance Officer
- Rachael Backler, Director of Planning and Performance
- Dr Jane Moore, Director of Equalities, Innovation and Digital Enterprise
- Laura Ambler, Director of Place (Bath and North East Somerset)
- Gordon Muvuti, Director of Place (Swindon)
- Fiona Slevin-Brown, Director of Place (Wiltshire)

What we do as an integrated care board

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board is a statutory body which brings together NHS organisations, along with local authorities and other partners, to work to improve population health and establish shared strategic priorities.

The ICB oversees how money is spent and makes sure that health services work well and are of high quality. It also ensures there is effective collaboration between hospital providers, primary care, local councils, hospices, voluntary community, and social enterprise (VCSE) organisations and Healthwatch partners across all areas of Bath and North East Somerset, Swindon and Wiltshire.

As an ICB, we have strategic responsibility for overseeing healthcare strategies for the local health and care system, and have also inherited many of the day-to-day functions that were previously carried out by the region's former clinical commissioning group.

A key focus of the ICB is to use its many resources and powers to influence effective collaboration among partners, so that complex challenges specific to our region can be addressed.

These challenges include:

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help people with preventable conditions
- Supporting people with long-term conditions or mental health issues
- Caring for the complex multiple needs of older people
- Getting the best from collective resources so people can access care quickly

We are also part of the BSW Together ICS, which was established on 1 July 2022 and is one of 42 other similar systems in England.

As an ICS, BSW Together has four key purposes:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes
- Enhance experience, access, productivity and value-for-money
- Support broader social and economic development

More information on the ICB is detailed in its constitution, which is available to read online.

BSW Together vision and values

The BSW system vision – working together to empower people to lead their best life – is shared by all health and care partners working in Bath and North East Somerset, Swindon and Wiltshire.

This mutually-held ethos underpins the work we do on a day-to-day basis, while also inspiring and shaping the work of tomorrow.

Our vision is supported by three core principles:

- Collective voice – working together as one whole system
- Healthy communities – empowering people to lead on their health with their families, their communities and health professionals
- Stories and strengths – holding people's strengths, stories and experiences, and what matters to them, at the heart of our system

Additionally, our organisation's core values, which were developed with the help of our colleagues, can be found at the heart of all we do for local people and communities.

These values are represented by the following five characteristics:

- Caring
- Innovative
- Inclusive
- Accountable
- Collaborative

BSW Together outlines its commitment to all health and care colleagues, and how it will support their ambition to empower local people to live their best life, in its People Strategy, which can be read online.

Our population and their health

We serve a population of approximately 940,000 people, with our residents spread out across a large and varied area that includes the densely populated town of Swindon in the north, Salisbury plains to the south and the historic city of Bath to the west.

While the collective geography of Bath and North East Somerset, Swindon and Wiltshire is relatively less deprived than other parts of England, this is not the case for all communities.

People in these more deprived areas do not live as long as those in other areas, and they are more likely to experience a combination of physical and mental health issues.

The three main causes of mortality in BSW are cancer, cardiovascular disease and respiratory disease, with people in the more deprived areas more likely to have a poorer outcome if diagnosed with one or more of these conditions.

We know the main contributing factors for these diseases are smoking, being overweight, not getting enough physical activity and regularly consuming a high volume of alcohol.

As an integrated care system, our attention is focused on supporting those in high-risk groups to make better lifestyle choices, while also using our powers to make healthier decisions as easy and as accessible as possible.

Corporate objectives

The ICB identified its vision as:

Working and listening effectively together to improve health and wellbeing

The ICB's strategic objectives for the next five years are:

- Focus on prevention and early intervention
- Fairer health outcomes,
- Excellent health and care services

Key risks and issues

During 2022/23, the risk categories that had the highest number of high-scoring risks were:

- Capacity and capability
- Public, patient and staff safety, including clinical harm
- Quality and patient experience

The highest scoring risks were:

- **Capacity for winter 2022/23**

  This risk was closely associated with the system's ability to maintain flow, hospital discharge and meet non-criteria to reside targets. Seasonal planning identified that, across the health and care system, there was potentially insufficient capacity to safely manage seasonal surges in demand and deliver the schemes that would maintain system flow. Demand and flow issues often create additional pressures to capacity, which can result in poor patient experience and prolonged periods of escalation.

  Mitigations and controls included:

  - Specific surge and resilience plans
  - Oversight and coordination through the Urgent Care and Flow Board
  - Tactical urgent care meetings
  - Local risk management processes for staffing and community hub approaches
  - Recruitment initiatives, both local and international
  - Regular reporting, both internally and to NHS England

- **Industrial action**

  Unions of health and care workers voted to undertake industrial action in the dispute over pay and working conditions. Industrial action, including action short of strike, posed a potentially significant risk to the system's capacity.

Mitigations and controls included:

- Review of providers' business continuity arrangements
- An industrial action plan for the coordination of a system response
- A dedicated workforce cell to discuss and coordinate organisational activities
- Sharing information with the Local Health Resilience Partnership

- **Workforce and resilience**

  At a time of high demand, staff vacancies across the health and care system remained high, with providers regularly relying on a temporary workforce. The workforce and resilience risk was heightened by the continual challenge to recruit and retain staff and the ongoing impact of Covid-19.

  Mitigations and controls included:

  - Local health and wellbeing support in organisations
  - Local recruitment initiatives, including talent pipeline, career opportunities and international recruitment
  - Retention initiatives, including training and development
  - Using the HR Delivery Group to focus on recruitment, retention and supply initiatives
  - Development of system-wide surge plans

- Elective care

  There was a risk that elective care capacity would not recover as planned or to the extent which was required. As a result there was a risk that the system would not meet NHS England's expectations of having zero 104-week-breaches by July 2022 or eliminating 78-week-waits by March 2023.

  Mitigations included:

  - All three acute providers participated in the new NHS England-led digital mutual aid process and supporting contract
  - RUH-focused recovery plan for gastroenterology and general surgery 78-week-waits
  - Increased theatre productivity
  - Completion of actions for high volume low complexity

- Hospital handover delays and ambulance call stack delays

  This risk related to ambulance not being able to be dispatched and patients left waiting in 999 call stacks. Additionally, there was a risk that crews unable to offload patients at emergency departments within 15 minutes of arrival could lead to a delay in responding to other incidents. These issues also posed a risk to the health and wellbeing of ambulance staff.

Mitigations included:

- Development of appropriate policies and procedures
- Oversight of South Western Ambulance Service NHS Foundation Trust performance at ambulance governance meetings
- BSW Urgent Care and Flow Board and Quality and Outcomes Committee oversight
- Pilot of the Swindon Care Coordination model, and the subsequent roll-out across the wider system
- South Western Ambulance Service NHS Foundation Trust transformation plan
- Expansion of same-day emergency care services and paramedic access to advice lines

- **Financial sustainability**

  The ICB has submitted a joint system plan with its three acute providers for 2022/23. There is a requirement for the system to breakeven against this plan, and there was a risk that this was achieved. The failure of one party to deliver on their plan may require other partners to provide mutual aid.

  Mitigations included:

  - System financial plan signed off by the Boards of each organisation
  - Monthly system financial meetings, which were attended by NHS England, to discuss and review the position, along with associated risks and mitigations
  - Partnership agreements in place
  - Regular reporting to each organisation's finance committee
  - Provider membership of ICB Board

Statement of going concern

At the time of preparing the financial statements, the Board was required to assess whether the ICB was a going concern, which related to whether the organisation could continue to operate for the foreseeable future. It would require a parliamentary intervention for the ICB to cease to operate and, in the event of such an intervention, there is existing legislation whereby the functions undertaken by the ICB would be transferred to an existing public sector entity or one that is newly created.

The Secretary of State for Health and Social Care has directed that where parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

In April 2022, the new Health and Care Act received Royal Assent in Parliament and, as such, it was announced that CCGs would dissolve and be replaced by new organisations known as integrated care boards.

This transition took place on Friday 1 July 2022, and with it the assets, liabilities and duties transferred from BSW CCG to the new Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board.

Performance analysis

Overview of performance

Between July 2022 and March 2023, the ICB focused on delivering the following NHS priorities:

- Managing the ongoing impact of the Covid-19 pandemic, including the vaccination programme
- Supporting patients and services that have been impacted by continued high demand
- Recovering elective care services to support the reduction of waiting lists, including a focus on reducing the number of people who have waited a long time for their required treatment

This focus reflects a wider national change in how NHS England has asked organisations to deliver the national access standards, including the NHS constitutional measures, as a result of the Covid-19 pandemic.

For example, for elective care, the NHS has been focused on reducing waiting lists and the number of people waiting more 78 weeks for treatment, rather than 18-week access times. This is because the NHS response to the pandemic changed the way many services operated, with some having to close in 2020, which reduced access to planned services, in both a hospital and community setting.

For elective care over this period, waiting lists continued to increase, with a return to more usual referral levels, and a continued reduction in usual activity due to Covid-19 infection prevention and control measures, workforce absences, patient availability and the knock-on impact of urgent and emergency care demand.

The reduction of long waiters was targeted nationally in 2022/23, with systems asked to ensure no patient was waiting longer than 104 weeks for treatment by the end of July 2022. This was achieved locally. However, some patients specifically requested a delay to their treatment.

The next target was the removal of 78-week waiters by March 2023. At the time of writing, 43 BSW patients were still waiting longer than this for treatment, with external factors, such as industrial action by junior doctors, contributing to the delay.

Demand for urgent and emergency care remained high in 2022/23, with NHS 111, ambulance services and emergency departments experiencing significant pressure. NHS England asked all systems to plan for a difficult winter, and BSW set up a winter room and daily metrics to ensure that challenges could be identified and responded to as early as possible. The experience of patients was impacted. Longer waits for ambulances and ambulance handover delays peaked in December 2022.

In June, a rise in Covid-19 cases among both patients and health and care staff resulted in access to care becoming limited.

Primary care continued to deliver the Covid-19 vaccine throughout 2022/23, with staff also working hard to return face-to-face activity and non-urgent patient support, such as clinical reviews, back to pre-pandemic levels.

BSW took a system-wide approach to developing initiatives and solutions to recover the delivery of services. The elective care programme and the urgent and emergency care

programme were two examples of initiatives that brought system-wide partners together.

We also worked with providers to ensure that patient safety was not compromised during times of increased pressure, and that longer waiting patients were managed in a way that maintained safety and clinical effectiveness.

NHS oversight framework

The NHS oversight framework for 2022/23 described NHS England's approach to oversight of integrated care boards and trusts. Oversight focused on the delivery of the priorities set out in NHS planning guidance, the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual systems.

The purpose of the NHS oversight framework is to:

- Ensure the alignment of priorities across the NHS and with wider system partners
- Identify where ICBs and NHS providers may benefit from, or require, support
- Provide an objective basis for decisions about when and how NHS England will intervene

A set of oversight metrics has been published, which are applicable to integrated care boards, NHS trusts and foundation trusts, to support implementation of the framework.

These will be used to indicate potential issues and prompt further investigation of support needs, while aligning with the five national themes of the NHS oversight framework:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- People
- Finance and use of resources
- Leadership and capability.

A sixth theme – local strategic priorities – is under development, and this will reflect the ICB's contribution to the wider ambitions and priorities of its integrated care system.

The ICB has worked with partner organisations to agree the delivery and governance arrangements, and these are summarised in a memorandum of understanding between the ICB and NHS England South West.

In August 2022, the first quarterly cycle of oversight was started. This provided an initial segmentation of the level and nature of support required throughout 2022/23, and enabled the system and NHS England to target support as effectively as possible.

The ICB worked with partner organisations to review performance against the oversight themes. The system's three acute trusts were reviewed individually, and other partners, including community providers and primary care, were reviewed as part of BSW overall.

In addition to the oversight metrics, there was a review of system leadership and behaviours, improvement capability and capacity. Partners with a lead commissioning relationship outside BSW, such as Avon and Wiltshire Mental Health Partnership NHS Trust and South Western Ambulance Service NHS Foundation Trust, were reviewed in those systems.

NHS England and the ICB discussed the proposed segmentation and any support required.

NHS England was responsible for making the final segmentation decision and taking any necessary formal enforcement action. A description of the segments is in the table below.

Support segments: Description and nature of support needs

Segment description			Scale and nature of support needs
	ICB	**Trust**	
1	Consistently high performing across the six oversight themes. Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed.	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and 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, including Getting It Right First Time, 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, which draws on system and national expertise as required.
4	Very serious and complex issues manifesting as critical quality or finance concerns that require	In actual or suspected breach of the NHS provider licence, or equivalent for NHS trusts, with very serious, complex issues	Mandated intensive support delivered through the Recovery Support Programme.

	intensive support.	manifesting as critical quality or finance concerns that require intensive support.	

For the four quarters of 2022/23, the ICB received confirmation that the organisation, along with Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, Salisbury NHS Foundation Trust, were placed in segment two.

Our partners commissioned by other systems – Avon and Wiltshire Mental Health Partnership NHS Trust and South West Ambulance Service NHS Foundation Trust – are in segment three.

There have been specific areas of concern noted for each organisation, and the ICB monitors these areas through its overall oversight arrangements.

Performance reporting and management

With the establishment of the ICB on 1 July, there has been a review of how reporting is carried out under the new regulatory framework, the updated 2022/23 NHS oversight metrics, the 2022/23 plan deliverables and other emerging priorities.

The ICB performance reporting has been focused on key metrics from the NHS oversight framework, and aligned with local key quality metrics. This allowed the organisation to monitor its performance against the core NHS priorities, as well as making sure that assurance of safe high-quality services was provided.

Where possible, the ICB used nationally-defined, reported and validated metrics.

Key areas covered include:

- **Urgent care**: NHS 111, A&E, ambulance handovers and hospital discharge
- **Safe, high-quality care**: patient safety, patient experience, infection prevention and control
- **Primary care**: access time, method of appointment and healthcare professional
- **Mental health and learning disabilities**: access and treatment in psychological therapies, inpatients with learning disabilities, annual health checks
- **Planned care**: waiting lists, cancer treatment, diagnostic, elective care and outpatient appointments
- **Covid-19**: system status, prevalence and vaccinations

BSW ICS workforce reporting has been developing throughout 2022/23 to include vacancies, staff experience and retention. This included work with partners to develop new system workforce data sets.

The BSW Performance and Quality reports are a key part of the ICB assurance process and are shared with the following meetings:

- ICB Executive Performance and Risk Meeting
- Quality and Outcomes Committee (formerly the Quality Assurance Committee)
- The ICB Board

There are a range of more detailed and subject specific reporting that goes to other key meetings, including:

- Urgent Care and Flow Programme
- Elective Care Programme
- Strategic Workforce Group
- Finance and Investment Committee

Delivery of national standards

One of the key pledges in the NHS Constitution is the right of everyone to access the care they need. There are a number of national standards that enable us to measure and compare access performance.

In recent years, additional national measures have been made available for wider and improved understanding of access and waiting that are not in the constitution. Some of these are included within this report, such as ambulance response times and access to mental health services.

Performance delivery of the national standards is supported by the quality team who work with providers to ensure patient safety is not compromised during times of increased pressure in emergency departments, and that waiting lists are managed in a way that maximises patient safety and clinical effectiveness.

This work has taken on more importance since the pandemic, with longer waits for all types of planned care, as well as delays in receiving emergency care.

Access to urgent and emergency care

The A&E four-hour target measures the time a patient spends in an emergency department from arrival to transfer, admission or discharge. These waiting times are often used as a barometer for overall performance of the NHS and social care system. This is because A&E waiting times can be affected by changing activity and pressures in other areas, such as the ambulance service, primary care, community-based care and social services.

For example, patients cannot be admitted quickly from A&E if wards are full as a result of delays in transferring patients to other NHS services or discharging with social care support.

While the target A&E is for 95 per cent of patients to wait no more than four hours, recent performance has been lower than this at both a local and national level.

The clinically-led review of urgent and emergency care standards has recommended moving to a bundle of measures, which track activity across the urgent and emergency care pathway, rather than focusing only on the A&E four-hour standard. It is hoped this approach will help patients and the public understand what to expect at each stage of care, as well as implement overall improvements.

*Provider data for A&E four-hour standard includes: Bath and North East Somerset – Royal United Hospitals NHS Foundation Trust (RUH), Swindon – Great Western Hospitals NHS Foundation Trust (GWH), Wiltshire – Salisbury Foundation Trust (SFT)

National Standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Percentage of patients admitted, transferred or discharged from A&E within four hours* (All)	Mar-23	95%	71.5%	72.5%	71.2%	A	R
Ambulance Response Times (minutes) Cat 1 Mean	Mar-23	7	n/a	11	10	n/a	G
Ambulance Response Times (minutes) Cat 1 90th percentile	Mar-23	15	n/a	18	18	n/a	A
Ambulance Response Times (minutes) Cat 2 Mean	Mar-23	18	n/a	53	53	n/a	A
Ambulance Response Times (minutes) Cat 2 90th percentile	Mar-23	40	n/a	114	118	n/a	A
Ambulance Response Times (minutes) Cat 3 90th percentile	Mar-23	120	n/a	380	459	n/a	R
Ambulance Response Times (minutes) Cat 4 90th percentile	Mar-23	180	n/a	445	417	n/a	G
NHS111 Answered in 60 seconds	Mar-23	95%	43%	53%	61%	G	G
NHS111 % Calls clinically triaged	Mar-23	75%	93%	90%	83%	G	G

Key for benchmarking ratings	Green	Amber	Red
vs Eng. (England) **or SW** (South West): Compares BSW and ICB to England or South West result and target	Better than Eng. or SW and/or target	Similar or within acceptable variance to Eng. or SW and/or target	Worse than Eng. or SW and target; outside amber tolerance

In 2022/23, the urgent care performance trends from 2021/22 continued, with the system not able to meet the national A&E four-hour target, which was reflective of what was happening elsewhere in the country.

In the summer of 2021, A&E attendances had increased in both volume and complexity, with hospitals becoming full and ambulance services being stretched. This level of demand continued through 2022/23.

Ambulance response times for people with the most serious conditions were measured as a mean response time and at the 90th percentile, which measures delivery on the every-call-counts principle of the current standards. Performance was outside of the national targets in all of 2022/23.

The ongoing pressure in hospitals resulted in high levels of delayed ambulance handovers, which ultimately reduced the availability of ambulances for new calls. The BSW Care Co-ordination Hub pilot, which ran from December 2022, had been successful in supporting less urgent calls in the 999 queue to be helped elsewhere.

The number of calls to NHS 111 continued at high levels throughout 2022/23, with a continuation of Covid-19-related concerns and a continued focus on Think 111.

Although the number of calls answered within 60 seconds improved across the year, performance was still below target. However, local activity was better than that recorded for England and the South West.

The level of clinical triage was above target, though below England and the South West.

Access to planned care

The 18-week referral to treatment target has been the key measure of the NHS Constitution for planned care.

In recognition of the continuing growth in waiting lists and long waiters, ICBs were asked to focus on reducing the longer waiters.

National Standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Referral To Treatment Overall Waiting List % growth in year	Mar-23	n/a	15%	16%	21%	n/a	n/a
Patients waiting 18 weeks or less from referral to hospital treatment	Mar-23	92%	59%	60%	61%	G	G
Patients waiting over 52 weeks for treatment	Mar-23	0	359,798	35,751	3,937	n/a	n/a

Patients waiting over 78 weeks for treatment	Mar-23	0	10,737	1,963	43	n/a	n/a
Patients waiting six weeks or more for Diagnostics	Mar-23	1%	25%	28%	38%	R	R
Patients seen within two weeks of a referral for suspected Cancer	Q4 2022/23	93%	84%	74%	83%	R	G
People with urgent GP referral being told of cancer diagnosis outcome within 28 days of referral (FDS)	Mar-23	75%	74.2%	74.7%	74.0%	A	A
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q4 2022/23	85%	59%	60%	68%	G	G

Key for benchmarking ratings	Green	Amber	Red
vs Eng. (England) **or SW** (South West): Compares BSW and ICB to England or South West result and target	Better than Eng. or SW and/or target	Similar or within acceptable variance to Eng. or SW and/or target	Worse than Eng. or SW and target; outside amber tolerance

The BSW-wide patient waiting list has continued to grow from 78,163 patients in March 2022 to 94,819 patients as of March 2023.

The ICB and its providers have been working together to deliver the Elective Recovery Programme, which aims to reduce waiting times for patients, especially those who are classed as a long waiter.

Tools were put in place to identify and track the patients at risk of waiting longer than 78 weeks and 104 weeks until their treatment is completed.

Key actions included looking for opportunities for transfers and mutual aid, as well as setting up five system groups that focused on each of the high-risk specialties. At the end of March 2023, there were 30 patients waiting more than 78 weeks at Acute providers in BSW. BSW remains on target to treat all patients, excluding those requesting a delay, by the end of June (revised NHS expectation).

At the end of March there were 43 BSW patients waiting over 78 weeks at all providers, including those out of area.

Diagnostic waiting times have continued to be a challenge during 2022/23. At its peak in December 2022, 47 per cent of patients were waiting longer than the six-week standard. This reduced to 38 per cent by March 2023. This figure is higher than March 2022, when 34 per cent of patients were waiting longer than the six-week standard.

The Community Diagnostics Centre programme has been in development to provide additional diagnostics capacity across the system, and this is due to start next year.

Cancer access waiting times for 2022/23 have continued to miss the national standards, but local performance remains strong against national and regional averages. The ICB is now working with the local cancer alliances to put recovery plans in place for the areas most in need.

Access to mental health

In recent years, national standards have been developed to enable the ICB to measure waiting times for many mental health services. This allows for understanding the progress made in delivering timely access to mental health services.

The ICB worked with local partners on the BSW THRIVE workstream to develop services, while also keeping a focus on local outcomes.

National Standard	Period	Target	England	South West	BSW	BSW vs Eng	BSW vs SW
Talking Therapies - entering treatment (rolling 3 months)	Mar-23	5,076	320,254	26,725	2,740	n/a	n/a
Talking Therapies Recovery Rate (month actual)	Mar-23	50%	51%	49%	35%	R	R
Talking Therapies <6 wks Referral to Treatment (Completed) in month actual	Mar-23	75%	90%	89%	85%	G	G
Talking Therapies <18 wks Referral to Treatment (Completed) in month actual	Mar-23	95%	98%	100%	99%	G	G
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral (Qtr) *	Mar-23	60%	71%	68%	70%	G	G

Access to Children and Young People's Mental Health Services (1 contact) rolling 12months*	Mar-23	12,500	721,506	46,315	7,775	n/a	n/a
Children and Young People Eating Disorders seen within four weeks for non-urgent cases. *	Mar-23	95%	*79%*	*83%*	*75%*	n/a	n/a
Estimated diagnosis rate for people with dementia (Diagnoses as % of prevalence)	Mar-23	66.7%	63.0%	58.1%	57.8%	R	A
Learning Disability Annual Health Checks (full year)	Mar-23	75%	-	-	71.0%	n/a	n/a
Learning Disability Inpatients (all age)	Mar-23	25	-	-	37	n/a	n/a

* There was a cyber incident in August 2022, in which a number of mental health providers, including the provider of BSW Children and Young People's services, lost data for several months. National reporting is estimating the results for three of the metrics shown during this period. Local data has been used for EIP March 23 as national estimate is not available.

Key for benchmarking ratings	Green	Amber	Red
vs Eng. (England) **or SW** (South West): Compares BSW and ICB to England or South West result and target	Better than Eng. or SW and/or target	Similar or within acceptable variance to Eng. or SW and/or target	Worse than Eng. or SW and target; outside amber tolerance

Community talking therapies for adults has a national target for growth in service access, which is based on an estimated population need.

The number of people who entered treatment in 2022/23 was below the expected target. A national workforce modelling tool is being used to identify the staff gap which will need to be addressed if BSW is to achieve next year's access and recovery standards.

The recovery rate is below target. Patients who may have reached out during the pandemic, but now do not need to engage with the service, are being discharged without completing treatment, which explains why recorded recovery rate is below normal levels.

The National Institute for Health and Care Excellence (NICE) recommended that care for people with a first episode of psychosis should be given in a mental health ward. Overall, the ICB had good performance in this area, with some fluctuation due to the low numbers of people needing the service.

Access to children and young people's mental health services measures access against an expected prevalence of need. The ICB developed a range of services to sit alongside its traditional Child and Adolescent Mental Health Service (CAMHS), such as an online support service, and group and one-to-one sessions run by local providers.

The ICB has made progress this year in improving national data recording across the smaller providers. As a result of the main provider recovering from a national cyber attack, NHS England is estimating the BSW results.

Performance data for the access standard for eating disorder services for children and young people is also not available due to the cyber incident. The data shown is an NHS England estimate.

The ICB is not meeting the national standard for dementia diagnosis rates but is performing similar to others in the South West. A recovery plan is in development.

Mental health

Financial years	**2021/22 (000s)**	**2022/23 (000s)**
Mental health spend	£124,907	£133,893
ICB programme allocation	£1,708,445	£1,759,936
Mental health spend as a proportion of ICB programme allocation	7.3 per cent	7.6 per cent

In 2021/2022, the ICB reported an outturn of £124,907k against the Mental Health Investment Standard (MHIS), which equated to 7.3 per cent of the ICB's programme allocation.

In 2022/2023, the ICB is reporting £133,893k against the MHIS, which is 7.6 per cent of the ICB's programme allocation.

The growth in spend reflects BSW's commitment to achieving the investment standard and shows the additional investment made in mental health services across the footprint.

Children and young people safeguarding

The ICB's Chief Nurse and its ICB safeguarding team attend all three safeguarding partnerships, including the Violence Reduction Unit (VRU) in Bath and North East Somerset and the Swindon and Wiltshire Community Safeguarding Partnership.

The team also works closely with other NHS providers, the police and local authorities to support continuous education and updates in this evolving workstream. This includes female genital mutilation, forced marriage and violence against women and girls, PREVENT and multiagency public protection arrangements.

Safeguarding should be the golden thread that runs through NHS commissioning organisations and all NHS-funded care. The ICB has complied with the NHS England Safeguarding Accountability and Assurance Framework 2022.

The ICB also ensured that organisations commissioned to provide healthcare services had systems in place to effectively safeguard children, children looked after, young people and adults at risk in line with section 11 of the Children Act 2004 and Care Act 2014.

This included making sure policies and procedures were current, clear and accessible, that recruitment was safe, training and supervision was available and governance systems were in place through the named leads for safeguarding within provider organisations and supported to do this by designated safeguarding professionals and the named GPs for safeguarding.

Community Safety Partnerships (CSPs) and VRUs have an explicit role in evidence-based strategic action on serious violence and these partnership meetings are the driver for delivering the serious violence duty (SVD) and safeguarding statutory duties.

Domestic abuse prevention is an important aspect of the SVD and each of the local authorities in BSW has a domestic abuse partnership which feeds into the CSPs. There is expertise within the safeguarding team around domestic abuse with participation in the domestic abuse partnerships.

The designated nurses for children looked after continue to meet quarterly with the three local authorities' participation officers to look for opportunities to gain the views of CLA and care experienced young people. The nurses have received invitations to the local authorities' children in care councils and care experienced groups to hear this feedback directly.

The Swindon care experienced group shared their experiences around loneliness and the impact this had on their emotional wellbeing. The pandemic had increased their feelings of loneliness and many of them were finding it difficult to re-engage with activities since restrictions were lifted.

Children under the age of one

Research has long established the increased risk to children under the age of one from abuse and neglect.

Local case reviews across Bath and North East Somerset, Swindon and Wiltshire have also identified this risk.

Nationally, the Child Safeguarding Practice Review Panel has published a number of reviews into sudden, unexpected death in infancy, and these have identified learning which can support improved safeguarding of children under the age of one.

Across the three individual partnerships, work has taken place to respond to the learning from these reviews. The ICB led the development of a steering group across the three partnerships, which has been used to coordinate activity and system improvements in safeguarding unborn babies and children under the age of one.

National learning

A national review was initiated following the murders of Star Hobson and Arthur Labinjo-Jones in 2020, both of whom experienced sustained abuse and neglect from their caregivers. All ICBs and safeguarding partnerships were asked to review their safeguarding systems and provide assurance of how agencies act to safeguard young children and whether their tragic deaths were representative of wider national issues.

As a result of the above reviews, all three localities looked at the functioning of their multiagency safeguarding hubs (MASH) and their partnerships' understanding of their role.

In Wiltshire, a MASH strategic board was established to ensure that there was multi-agency oversight. In Bath and North East Somerset, the designated nurse supported the joint targeted area inspection learning and led on the Solihull JTAI evaluation and review.

The Swindon Safeguarding Partnership reviewed the strength of its MASH arrangements, as well as focusing on the health agency contribution, through its strategic MASH subgroup.

In September 2021, the Norfolk Safeguarding Adults Board published a safeguarding adults review into the deaths of three young adults with learning disabilities at Cawston Park Hospital.

The review made 13 recommendations for critical system and strategic change. NHS England commenced an immediate requirement for all CCGs to implement reviews of all patients with a learning disability or autism living in inpatient care settings. The ICB lead commissioner coordinated the review of BSW residents in similar placements and a subsequent action plan is being developed.

Environmental matters

Climate change threatens the foundations of good health, with direct and immediate consequences for individuals, infrastructure and public services. Addressing climate change is important in helping the ICB to meet its system-wide goals of developing healthier communities, improving health outcomes and addressing the wider social determinants of health that lead to inequalities.

In this respect, the ICB is not only concerned with reducing its carbon footprint but also protecting the environment and ensuring that it is working with partners across the system to meet the necessary green commitments.

BSW Green Plan (2022-25)

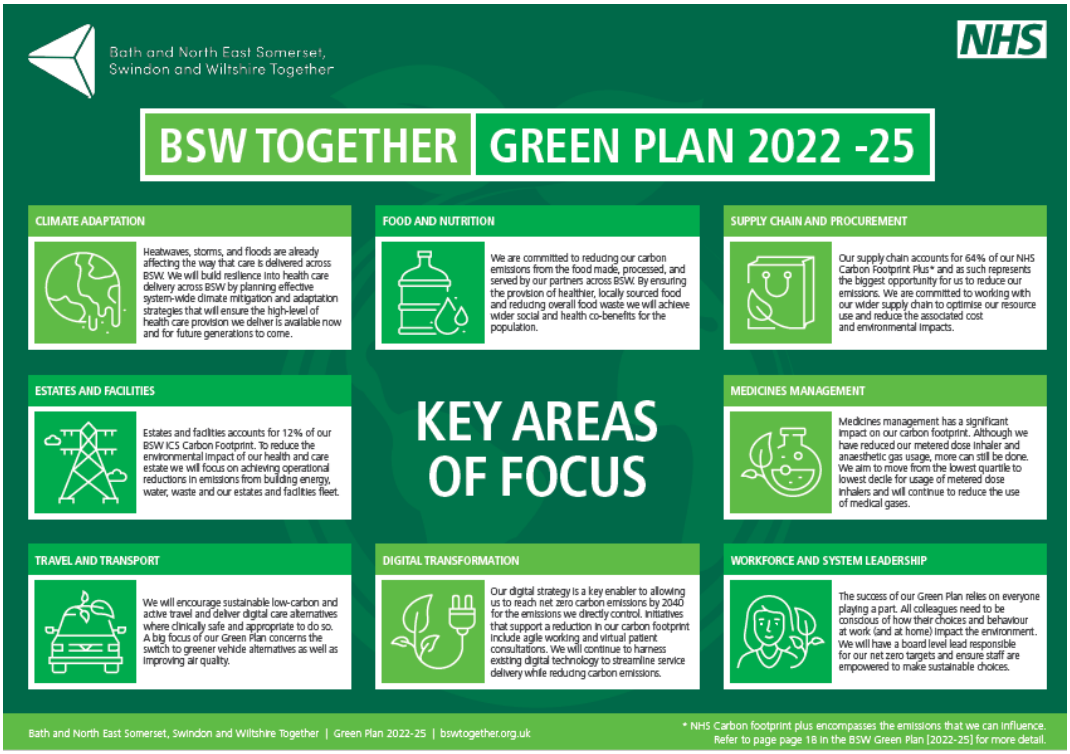
In October 2020, the Greener NHS National Programme published its new strategy, Delivering a Net Zero National Health Service. The report set out trajectories and actions for the entire NHS to reach net zero for the emissions it controls directly by 2040, and 2045 for those it can influence.

Working collaboratively with partners, the ICB has developed a system-wide Green Plan to detail its vision for reducing emissions in line with national trajectories and how it can create a sustainable healthcare system for the population.

The BSW NHS Carbon Footprint for 2019/20 was 80,490 tonnes of CO2 equivalents (tCO2e), which were the emissions that could be directly controlled.

The BSW Green Plan (2022-25) was published in 2022 and describes the system's ambitions, along with its objectives and how they will be met.

The plan supports the strategic priorities of the integrated care system by improving the health and wellbeing of the population, so people can age well and the health inequalities caused by poor environments can be reduced.



Progress in 2022/23

The Greener BSW Programme Delivery Group (PDG) was established in September 2022, and brought together a wide range of partners to collaboratively drive forward change.

The PDG focused on the delivery of the Green Plan commitments, along with priority actions, across several key areas.

Delivery of these commitments was supported through a work plan, which outlined key actions for the system to undertake. Some of these actions, which will be delivered in the near future, include:

- Board-level lead identified at organisational and ICS level
- Integrated Care Board to undertake sustainability training
- Partners to switch to 100 per cent renewable suppliers
- NHS trusts to sign up to clean air hospital framework
- All BSW partners will include 10 per cent social value weighting in all procurement tenders
- All NHS trusts to reduce use of desflurane in surgical procedures to less than five per cent
- Climate change included as a key strategic risk on corporate risk registers and business continuity plans

Additional actions are outlined in the BSW Green Plan (2022-25).

Sustainable activity

The introduction of new ways of working has provided the opportunity for the ICB to rationalise its premises. As a result, the former offices of Wiltshire Clinical Commissioning Group at Southgate House in Devizes closed in January 2023.

During the office closure, every effort was made to reuse and recycle assets so to avoid unnecessary wastage. Desks, filing cabinets, bookcases, chairs, tables, fridges and whiteboards were donated to our system health partners. Several GP practices have also benefitted from the reallocation of these items.

An estimated three cubic metres of stationery was collected by Wiltshire Scrap Store for use by local schools, charities and individuals. Perishable supplies, such as coffee, tea and sugar, were donated to a homeless charity in Devizes.

ICB mileage

The table below provides an overview of the number of miles claimed by ICB staff between April 2022 and January 2023.

The miles are categorised by fuel type and indicate carbon emissions and total expense:

Category	April 2022 – January 2023	
Petrol	Miles	42,709
	tCO^2e	14.02
Diesel	Miles	22,522
	tCO^2e	7.60
Zero Emission	Miles	1,453
	tCO^2e	0.14
Total cost	£	36,595

Sustainable transport

The ICB can improve local air quality and improve the health of local communities by promoting active travel to staff, partners, patients and the wider public. The ICB has encouraged all staff to consider sustainable transport and offered a range of schemes to encourage this, including a cycle to work scheme and an electric car lease scheme.

Between April 2022 and February 2023, four bikes and six electric cars have been accessed by staff.

Paper usage

The move to a paperless NHS is supported through new ways of working, and ICB staff have

utilised digital technology to reduce the use of paper at office sites, while continuing to recycle paper.

During this financial year, the ICB purchased 96 boxes of A4 paper at a cost of £3,474. Paper of A3 size is no longer purchased.

Water consumption

Water consumption for the current financial year is expected to be similar to what was recorded during 2021/22. The total water consumption for the first three quarters of 2022/23 can be seen below:

- Quarter one: 371m³
- Quarter two: 371m³
- Quarter three: 370m³

Based on the information available at the time of writing, it is expected that the total water consumption for this year will be 1,484 m³. In 2021//22, total water consumption was 1,480 m³.

Improving quality

Each integrated care board must exercise its functions in a way that delivers continuous improvements and enhanced patient outcomes.

Quality is a shared goal that requires system commitment and action. For the ICB, system-wide quality is based on these principles:

- Collaboration, trust, and transparency
- Transformation
- Equity and equality

This means the ICB has systems and processes in place to ensure that care is safe, effective, well-led, sustainably resourced and equitable.

Through responsive, caring and personalised delivery, the care experience of patients will be positive.

The quality of service delivery will be based on the following principles:

- Set clear quality standards and expected outcomes when commissioning health and care services
- Have clear governance and accountability arrangements for collective monitoring of quality and safeguarding
- A shared commitment to delivering seamless pathways of care where the fundamental standards of quality are delivered, including managing quality and safety risks and addressing inequalities and variation
- Develop a culture which is open, transparent and supportive of continuous improvement
- Work with local communities to shape the design and delivery of services

Delivery of quality care across the system is underpinned by:

- Key quality metrics that focus on safety, effectiveness and experience, combined with performance data, intelligence and professional insight
- Focusing on population health and system quality priorities across pathways and settings with particular emphasis on reducing inequalities in access, experience and outcomes
- Identification of risks and issues to patient safety and quality, and the strength of the mitigation at both an organisation and system level
- Recognition of collaborative and inclusive patient safety leadership, with shared vision and values, driven by continual promotion of learning which is aligned to an inclusive culture
- Consistent and up-to-date guidelines and evidence, which are designed to protect the whole community and delivered in a way that enables continuous improvements based on best evidence
- Recognising and supporting the capability to deliver safe and effective services, while ensuring the right number of people, who have the right mindset, skills and tools to be able to fulfil their roles
- Actively promoting co-production with people using services

The ICB role in quality surveillance and assurance has continued to progress, and collaboration has continued with provider organisations. The established BSW System Quality Group has had a key role in supporting this approach.

Patient Safety and Patient Safety Incident Response Framework (PSIRF)

The ICB has a responsibility to ensure the services it commissions are safe. Colleagues have always strived to ensure that individuals are not harmed when receiving healthcare, but it is acknowledged that a serious incident or patient safety incident may occasionally occur.

In September 2022, the Patient Safety and Patient Safety Incident Response Framework (PSIRF) was published.

This was the start of a transitional period, in which organisations would move away from the Serious Incident Framework (2015).

The PSIRF sets out how the NHS should develop and maintain effective systems and processes for responding to patient safety incidents, for the purpose of learning and improving patient safety.

There are four key principles to PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learn from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening system function and improvement

The PSIRF replaced the Serious Incident Framework and removed the serious incident classification and threshold. This has meant that organisations must develop a full understanding of their patient safety profile and embed patient safety incident responses within a wider system of improvement.

The involvement of patients, carers and families who have been impacted by a patient safety incident will be front and centre of learning. Assurance of patient safety will be formed through understanding an organisation's safety and learning culture, and this will be a significant step towards systematic patient safety management.

The ICB has a significant role to play in facilitating the transition to PSIRF. As such, a patient safety community of practice has been established, and will include engagement from providers.

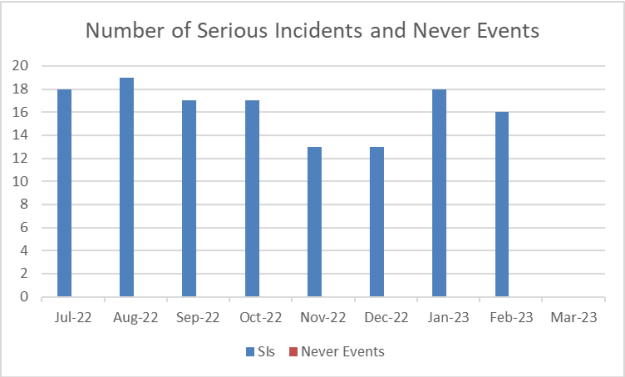
In the first nine months of the ICB's existence, staff have gained assurance of patient safety through collation, analysis and triangulation of data, and by utilising observation visits using the 15 Steps Challenge methodology.

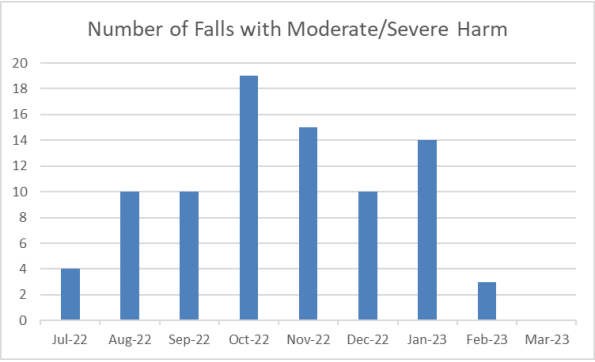
This has allowed the ICB to gain assurance, recognise areas of development and drive improvement through collaboration with partners. It is clearly recognised that local healthcare services have been under significant pressure in the time since the ICB's inception, and patient safety and experience metrics for urgent care and flow have been a key focus. These are shown in the graphs below.

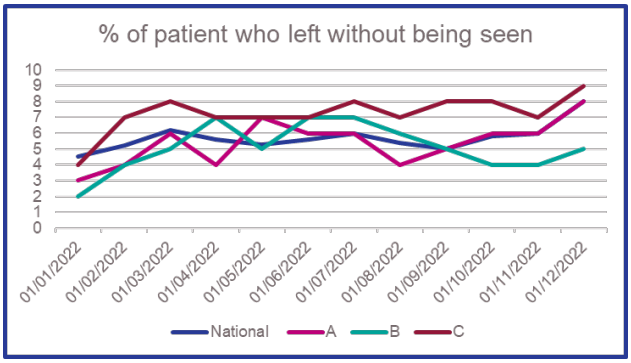
Equality and quality impact assessments (EQIAs) have been fundamental to support the safe and effective delivery of new initiatives to help support improved patient flow and to reduce harm from people being in an acute hospital for a longer-than-expected period of stay.

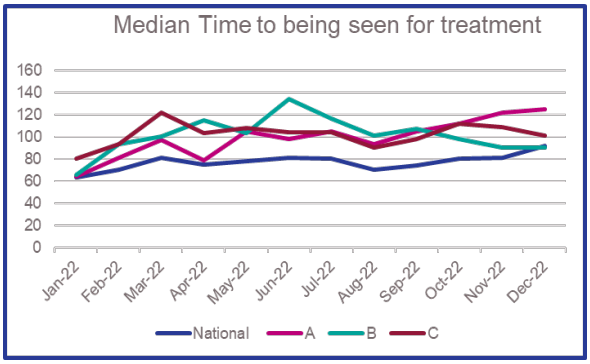
The new initiatives have included:

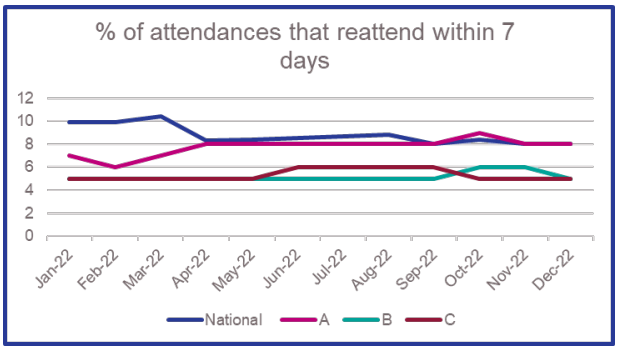
- Increasing bed capacity in alternative environments, such as South Newton Hospital in Salisbury and Ward Four at St. Martin's Hospital in Bath
- Delivery of virtual wards
- Implementation of a BSW-wide care coordination centre











Thematic reviews

As a result of emerging themes from patient safety data and information such as serious incident reporting, patient experience and effectiveness, the BSW Patient Safety and Quality team, along with system partners, have undertaken a deep-dive analysis of stroke, autism and attention deficit hyperactivity disorder (ADHD) pathways.

Stroke

Prevalence of stroke survivors is slightly higher in BSW (1.97 per cent) than it is across England (1.81 per cent).

Pre-hospital admission data from South Western Ambulance Service NHS Foundation Trust showed an increase of 13.24 per cent in activity for stroke in 2020/21, compared to the two previous years.

It is recognised that the provision of care for people who have suffered a stroke has been impacted by increasing pressures on health and social care services, timely ambulance conveyances, busy emergency departments, workforce challenges and consistency of services across seven days and 24 hours, including early supported discharge schemes.

However, the ICB has recognised there are further improvements that can be taken forward, which go over and above those already in place to reduce the number of patients classed as non-criteria to reside. These include:

- Integrated community-based care transformation provides opportunities for new stroke service models to be designed and brought in line with the national service model
- Consideration for digital solutions
- Greater connections with integrated stroke delivery networks, and greater collaboration across the system
- Opportunities for support from the rollout of the BSW Academy and Care Coordination Centre
- Supporting workforce development and ensuring people are signposted to the right services at the right time, while enabling the ambulance service to convey the right people to emergency departments

The ICB will be re-establishing a BSW stroke network in 2023/24 to oversee improvements in

the stroke pathway.

The system has recognised there is a risk that people who have a stroke will not be able to access the required services within the expected timeframes. The role of a BSW stroke network will continue to review this level of risk, and the associated mitigations and support.

National data collected through the Sentinel Stroke National Audit Programme (SSNAP) has enabled organisations within BSW to identify current system delivery performance and monitor improvements.

Autism and attention deficit hyperactivity disorder (ADHD)

Waiting times for specialist assessments of conditions including autism and ADHD are recognised challenges within the NHS and have been identified in the NHS Long Term Plan (2020).

These challenges are recognised across Bath and North East Somerset, Swindon, and Wiltshire.

The following key points were highlighted in the report:

- The number of people referred for an autism assessment, both nationally and locally, is increasing, as is the number of people who have been diagnosed with ADHD
- The pathways for ADHD and autism assessments and management in BSW are generally compliant with National Institute for Health and Care Excellence (NICE) guidance
- Research has found that autistic people are more likely to have mental health needs
- Feedback collated by local Healthwatch groups shows that autistic people in BSW feel there is a lack of support around people's understanding of an autism diagnosis
- A group has been established across BSW and Bristol, North Somerset and South Gloucestershire with Avon and Wiltshire Mental Health Partnership NHS Trust to develop plans for recovery of the ADHD waiting list
- The ICS is developing a training plan to ensure sufficient capacity is in place to deliver the Oliver McGowan Mandatory Training
- Pilot schemes have highlighted areas of benefit within both adult and children and young people pathways, in terms of pre-diagnostic support in the adult autism pathway, and an approach to enhancing the skill mix and assessment pathway for children and young people to reflect a needs-led approach

Clinical effectiveness

NICE guidance

The ICB has a responsibility to ensure that care and treatment is provided is in line with the latest evidence. The National Institute for Health and Care Excellence (NICE) publishes a variety of reports and is a resource that organisations should use when planning and providing services.

It is also a key resource for patients and their families, as it informs them of treatments and best practice. It is an expected that all health and care organisations have a process for evaluating and implementing NICE guidance.

Research continually produces new evidence that can improve care and lives. However, this evidence does not always find its way into routine practice. NICE guidance and quality standards play a key role in reducing the gap between recommended and actual practice, but successful implementation is dependent on both national and local action.

During the pandemic, many processes were changed to focus on frontline services. Now, organisations are reviewing processes for NICE guidelines and evidencing their compliance.

Mortality

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die.

All acute trusts in BSW have received a rating of as expected with regard to the SHMI methodology. Better coding practice has improved the monitoring of mortality.

Infection prevention and control

The ICB maintains responsibility of ensuring that systems and processes are in place to support the management, prevention and control of healthcare-associated infections (HCAI).

It is the ICB's role to ensure appropriate governance structures are in place for infection prevention and control, and to monitor providers' contributions towards sustained improvement.

The ICB and its provider organisations work together to support quality improvement initiatives, which are aimed at delivering safer services and improved adoption of national policies.

The ICB sets, agrees, monitors and reviews surveillance data against nationally-set thresholds for specific organisms and other locally-agreed indicators. The surveillance data, in combination with learning identified from post-infection reviews or root cause analysis of health care associated infection incidents, is used to inform key improvement areas and address potential risks.

Epidemiology data from the UK Health Security Agency Field Epidemiology Services (UKHSA FES) is also used by the ICB and providers in collaboration with local public health teams to scan for future risks.

During this reporting period, BSW infection prevention and control specialists continued to work collaboratively to support the health and care system. This was achieved by ensuring that updates to national guidance were implemented and understood as a system, by reviewing risk assessments and updating as appropriate and by ensuring patient safety remained a priority for all.

The BSW infection prevention and control peer network continued to work collaboratively throughout 2022/23. Three key workstreams were identified following deep dives and a collective system review of learning. The three workstreams supported the overarching aim of reducing local incidences of E-coli blood stream infections. There was also an unintended reduction in Clostridioides difficile across the system, due to an improved focus on judicial use of antibiotics.

Utilising quality improvement methodologies with support from wider system colleagues will allow the BSW system to begin implementing changes that will help to reduce healthcare-associated infections and support colleagues in taking a preventative approach to ensuring communities are not harmed by an avoidable healthcare-associated infection.

A more detailed Annual Infection Prevention and Control Report for 2022/23 will be available on the ICB website in 2023.

Commissioning for Quality and Innovation (CQUIN)

The use of CQUIN to support quality improvement was reinstated for 2022/23. There had been a change in the eligibility criteria for 2022/23, and the organisations that completed CQUIN were:

- Great Western Hospitals NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Royal United Hospitals Bath NHS Foundation Trust
- Wiltshire Health and Care
- HCRG Care Group (formerly Virgin Care Services)
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South Western Ambulance Service NHS Foundation Trust

A final year report will be shared with BSW Quality Assurance and Outcomes Committee in July 2023.

Patient experience

The ICB welcomes all comments and feedback about its role in commissioning services and aims to provide a feedback process that is fair and impartial, widely publicised and accessible to all.

The ICB Patient Advice and Liaison Service (PALS) is currently managed by South, Central and West Patient Advice and Complaints Teams (SCW PACT).

All feedback received is valued and acted on, with all concerns and complaints viewed as a rich source of information.

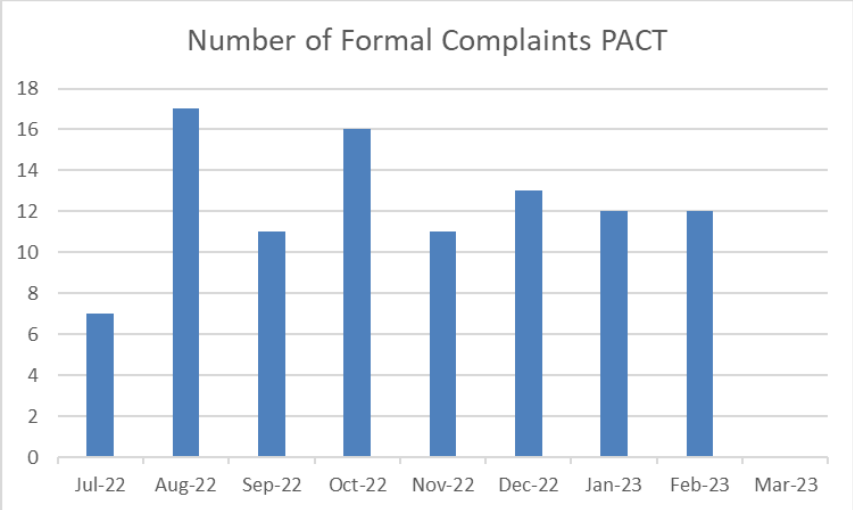
When complaints or concerns are raised, the ICB collaborates proactively with providers to ensure that service improvements are implemented. The ICB report the trends and themes across the healthcare system within the Quality Assurance and Performance Committee. As the integrated care system develops and matures, this information will be used to inform priorities and a collaborative approach towards continuous healthcare improvement.

Responses to concerns and complaints have been administered in line with the Local Authority Social Services and National Health Service (England) Complaints Regulations 2009.

The ICB, through the contracting arrangements with SCW PACT, ensures that any concern or complaint raised by an individual is dealt with compassionately, effectively and in a timely manner in line with the organisational policy.

Between 1 July 2022 and 28 February 2023, SCW PACT received a total of 99 formal complaints. Service users can choose to provide feedback to the provider organisation, the ICB or NHS England.

The table below shows the number of formal complaints received on a monthly basis by SCW PACT.



Complaints or concerns raised with SCW PACT regarding commissioned providers are generally signposted to these organisations.

During the period 1 July 2022 and 28 February 2023, of the 99 formal complaints received, 23 related to either commissioning or ICB-provided services.

Of these complaints, 14 were upheld and a further 16 were partially upheld.

The services with the highest number of complaints were:

- Continuing healthcare (17)
- Commissioning (6)

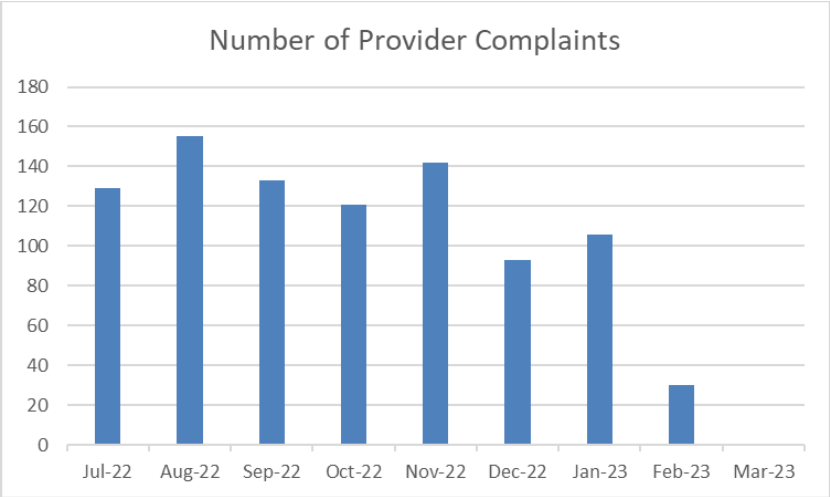
Between 1 July 2022 and 28 February 2023, SCW PACT received 791 PALS enquiries. The main themes of the enquiries were:

- Covid-19 vaccinations for people who are house bound
- Service pathways for ADHD
- Referral for Covid Medicine Delivery Unit (CDMU)

In addition to using complaints and comments to support its role in commissioning services, the ICB receives compliments and positive feedback that help to demonstrate where things have gone well.

Between 1 July 2022 and 28 February 2023, SCW PACT received 12 compliments. Seven were for SCW PACT and five were for provider organisations.

The ICB monitors the number of formal complaints received by the provider services within BSW. The table below shows the number of complaints received by acute hospitals and community providers between 1 July 2022 and 28 February 2023.



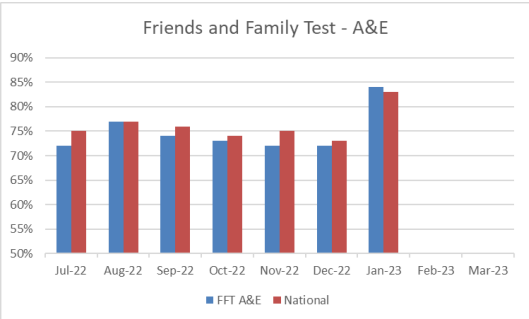
The main themes for complaints from the providers were:

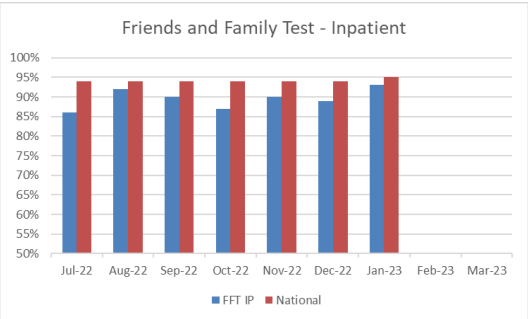
- Clinical care and concerns
- Waiting times for appointments
- Communication

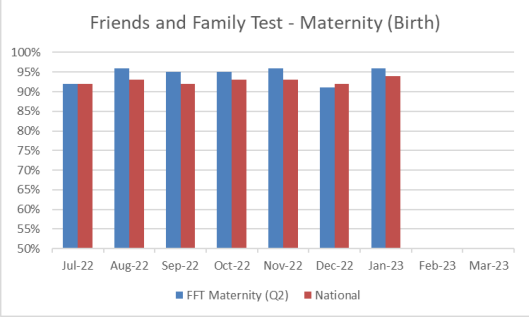
The Family and Friends Test (FFT) is also used by providers within BSW to obtain patient feedback. However, the response rates for FFT are lower than before the pandemic, and providers within BSW are looking at alternative ways to make FFT more accessible.

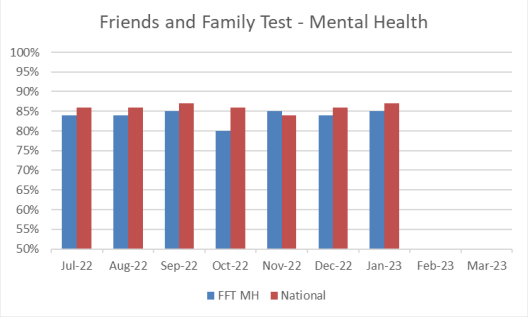
The tables below provide a summary of FFT response across BSW providers.

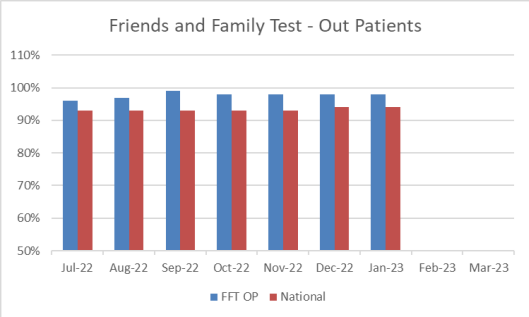
This shows the percentage of respondents who would recommend their service to friends or family.











The ICB is committed to responding to patient needs and encouraging a culture that seeks and uses people's experiences of care to improve the commissioning of services.

The ICB policy and contact details for submitting feedback can be found on the ICB website.

The ICB also has a role in making sure people who wish to submit a complaint regarding a provider are aware of the relevant process.

Details of advocacy services can also be found online.

Engaging people and communities

The involvement and engagement of people and communities is essential to the work carried out by the ICB, as well as that of the wider integrated care system.

In fact, the constitution of the ICB sets out the legal obligation to involve local people in the commissioning and planning of new services, as well as the decision-making process around changes to those already in place, from the earliest possible stage.

Patients and the public possess a wealth of knowledge and experience, and their insights can help to deliver services that accurately reflect the needs of the region. Almost one million people live across Bath and North East Somerset, Swindon and Wiltshire, and at some point or another, each and every one will have had reason to use the NHS.

Over the last nine months, public involvement has remained a cornerstone of the ICB, and has also continued to be one of the main enablers in helping to meet and achieve system priorities.

The priorities for 2022/23, as well as examples of how patient and public involvement has supported, or is continuing to support, delivery, can be seen below:

- Recovery following the pandemic, and reduce waiting times for care

  The ICB has recently established a group called Connecting With Our Communities. This initiative, which is made up of colleagues from a number of partner organisations, aims to support and guide meaningful community engagement during the development, initiation and delivery of transformation and service improvement work, including the many projects in place that are helping the system recover from the Covid-19 pandemic. As well as this, the group will become a place in which members can bring shared learning and best practice to the table. It will also be a group that colleagues that can contact when looking for advice and guidance on how to effectively engage and involve patients and the public.

Although still in its infancy, the Connecting With Our Communities group will help to amplify all engagement work, and ensure that those colleagues speaking with patients and members of the public have the correct knowledge and skills to do so in a truly effective way.

- Reduce health inequalities, particularly among groups most affected by Covid-19

  During the pandemic, it was shown that people with a learning disability were likely to become seriously unwell and suffer complications if they became infected with Covid-19. As was the case with the wider population, the effects of Covid-19 for people with learning disabilities could be greatly reduced through vaccination. Because of this, colleagues within the ICB worked closely with community groups and charities to promote dedicated vaccination clinics for people with learning disabilities.

  These clinics were held at the Steam Museum in Swindon and allowed people who would otherwise not have otherwise come forward for the vaccine to do so, and to also receive important information on future vaccinations.

  The clinics were advertised via easy read posters that were displayed on websites and across social media. Using established links with third sector organisations, the ICB asked these colleagues to share the poster and vaccine clinic walkthrough video directly with people with learning disabilities, as well as their carers.

  The project has allowed the ICB to focus on understanding the barriers that prevent people with learning disabilities from accessing healthcare, and the work has now paved the way for further engagement and involvement with this community, particularly around improving the uptakes of annual health checks, as these can be extremely useful in tackling health inequality.

- Support the mental health of our population

  In November 2022, the ICB took part in the annual Carers Rights Day celebrations in Swindon. The Associate Director of Patient Safety and Quality attended the in-person event, and was one of a number of panellists who spoke about the various support available to carers during the current cost-of-living crisis.

  It is known that carers play a huge role in supporting those who are older, vulnerable or living with long-term conditions, and that their work saves the local NHS a considerable amount of money each year. However, what is less known is that carers can often overlook their own health and wellbeing, particularly their mental health, as they prioritise looking after their friend or relative.

  By taking part in this event, the ICB was able to gauge the feeling among carers and signpost them to services that can make their day-to-day life that bit easier. One such initiative that was advertised on the day was the carers passport, which is a card recognised by all acute hospitals in the region, and entitles the carer to a range of benefits, such as free drinks, parking concessions and discounted meals.

  In fact, the production of the carers passport has been a collaborative project, and was driven forward by the BSW Carers Partnership Group, which is made up of health and care professionals and local carers. The group invited carers to a meeting in which they were asked what could make a visit to hospital as a carer easier. Feedback from the meeting was acted upon, and the carers passport at each of the region’s acute hospitals

was adapted accordingly.

- Focus on prevention and early intervention

  The Optum project took place in Wiltshire, and allowed the locality team to use patient and public engagement as a way of preventing avoidable health issues among a given group of people, while also promoting local health and care services. Locally-gathered population health data, which was sourced through collaboration with local authority partners, showed there to be approximately 100 people in the Trowbridge area who, although not currently housebound, were at risk of becoming so.

  The intention of the project was to speak directly with these people and intervene to protect not only their mobility and independence, but their overall health and wellbeing.

  Patients took part in telephone interviews, during which they were asked a range of questions to help identify any gaps in their current care plans, as well as any existing or developing needs that could be met through being referred to a local health or care service.

  Much of the feedback received during the telephone interviews highlighted a growing rate of isolation and loneliness among patients and, as the Optum project involved partners from all areas of the wider integrated care system, many people were given help from social prescribers to attend local charities, clubs and interest groups.

  Patients who took part in the project will now be revisited at regular intervals to see how the various interventions have benefited their overall health and wellbeing, and if the measures have been able to prevent, or at least delay, the person becoming housebound.

Supporting regular engagement

The ICB is fully committed to holding meaningful conversations with local people, on the right issues at the right time. The organisation has a brand-new communications and engagement strategy, which sets out a commitment to ensuring local communities have the opportunity to input into how services are developed and provided.

Currently, the ICB has two virtual patient and public engagement forums, which meet on a regular basis. Both forums, which are chaired by the ICB's Lay Member for Patient and Public Involvement, have a strong and diverse membership, with attendants made up of interested members of the public, carers, people working in nearby voluntary organisations and representatives from local Healthwatch groups.

As well finding out the latest news and information, those coming along play an important role in holding the ICB to account for how it involves local people in the design and commissioning of local health services.

More information on the patient and public engagement forums can be found on the ICB website.

The Our Health, Our Future Citizens Panel is another engagement resource that the ICB has access to, and one that it is hoping to use utilise more in the future. In line with the ICB's value of inclusivity, the online panel is made up of a representative sample of the population from

across the region. So far, more than 1,200 members have been recruited to the panel.

When fully established, the citizen's panel will be a resource of enormous value, as it will allow the ICB to tap into the thoughts and feelings of local communities, which in turn will enable the organisation to become better at providing services that are reflective of the region.

Reducing health inequality

During 2022/23, the ICB has continued its commitment to reduce the inequalities experienced by patients when accessing health services, as well as in their health outcomes, which is outlined in the Health and Social Care Act 2012.

Key to this for the ICB has been to embed the notion of reducing inequalities into the planning and development of all programmes at both a system-wide and place level.

During 2022/23, the ICB used the £2.4 million health inequalities funding to enable the development of inequalities activities at both place and system level, with the majority of the funding being allocated to place.

Each locality developed costed plans for local spend, and these focused on building capacity to drive the inequalities programme, as well as funding projects directly at an integrated care alliance level.

The use of the funding at system level was collectively agreed by NHS organisations and programme leads, with the ICB priorities as follows:

- Data and intelligence
- Organisational development
- Prevention
- Community engagement

A full implementation plan and breakdown of costs, as well as expected outcomes, is to be presented to the ICB Board.

As part of its commitment to reducing inequalities, the ICB, along with system partners, has focused on delivering the Core20PLUS5 ambitions, which aim to achieve equity of access, excellent experience and optimal outcomes for all.

Outcomes from this work are aligned to the five NHS priorities.

For 2023/24, the health inequalities budget of £2.1 million has been confirmed on a recurrent basis, and forms part of the baseline for system allocations over the next two years. Funding priorities, as well as allocation of this budget, has been managed through a task and finish group, made up of senior NHS directors and directors of public health. In line with funding guidance, the focus will be on the delivery through the NHS Five Priorities and the Core20PLUS5.

In May 2022, the BSW Inequalities Strategy was approved. This provided a framework of how the system would reduce health inequalities.

This overarching strategy was updated in March 2023 to include updated NHS guidance, such

as Core20PLUS5 for children and young people. The aim of the strategy is to systematically raise awareness of inequalities across the ICS, bring together guidance on healthcare and the NHS Five Priorities for reducing inequalities, while also integrating the work needed at a place level to address the wider determinants of health.

At the core of the BSW Inequalities Strategy is the use of the Core20PLUS5 approach to ensure that all programmes target populations suffering from the greatest inequalities in health.

The Implementation plan for awareness raising has been completed and is being rolled out. The following achievements took place during 2022/23:

- A dedicated inequalities online hub has been launched through the BSW Academy to collate resources and training on health inequalities
- BSW inequalities workshops took place to support colleagues and partners, including those in primary care, with their work on health inequalities
- A comprehensive health inequalities training module has been co-created for NHS and public health analysts to understand and interpret health inequalities data and intelligence
- An inequalities communication plan will be established to effectively map stakeholders and to ensure inequalities are truly embedded in thinking across BSW

With inequalities such a key focus, the ICB has improved the way in which it uses and shares data and intelligence on inequalities. The aim of this has been to enable the use of good quality data, which can be separated into specific demographics, such as deprivation and ethnicity, to provide the best evidence-base for decision-making.

Highlights for 2022/23 include:

- Reporting designed and published that operationally supports improvements in ethnicity coding completeness
- Processes, technicalities and governance arrangements are being investigated to flow ethnicity data back from primary care and other organisations to the three acute providers. This process will support further improvements in coding completeness
- Development of system-level Core20PLUS5 dashboards, alongside a suite of other data tools that identify the inequality groups within populations, while enabling providers and programmes to understand and take action to reduce inequality gaps

Alongside the 20 per cent most deprived population, the BSW PLUS (inclusion) populations are defined at a place level for Bath and North East Somerset, Swindon, and Wiltshire separately.

This decision was taken to capture the unique populations of each locality and ensure that health inequalities are not exacerbated by reflecting an average of a much larger group. Each PLUS group was chosen based on the local Joint Strategic Needs Assessments (JSNA) for each area.

The PLUS populations for BSW are:

- Bath and North East Somerset: Ethnic minority communities, homeless and people living with severe mental illness
- Swindon: Ethnic minority communities
- Wiltshire: Manual workers, traveller communities and those in rural areas

A senior responsible officer (SRO) is in place within the inequalities programme to provide leadership and accountability. An executive director with a remit for inequalities within the ICB is also in place. An integrated inequalities group meets every six weeks to gain a comprehensive insight into the local population's diverse health needs and assets. It provides the opportunity to coordinate activity and offer wider collaboration to reduce inequalities through working in partnership.

This includes representation from public health, local authority partners, clinical leads, acute hospitals, providers and commissioners.

Equality and diversity

The Equality Delivery System (EDS 2022) for BSW was completed during 2022/23. Results are due to be published later in the year, and will be available on the ICB website.

Domain one – patients and services – has been compiled at a system level, and reports on the current maternity services across BSW.

Domain two – staff health and wellbeing – and domain three – inclusive leadership – has been completed on behalf of the ICB. The EDS was scored as developing activity and the resulting equality action plan, which will address the outcomes from the review, will be signed off by the ICB Board.

Following the completion of the 2021/22 Annual Equality and Inclusion Assurance Summary Report: Clinical Commissioning Group to Integrated Care Board, the following tactically flexible objectives were published:

- Approve and mandate the use of a standardised Equality and Quality Impact Assessment (EQIA) format to ensure that quality, equality, and the nine protected characteristics are considered in all ICB and ICS business
- Develop and deliver on targeted system and place equality priorities, with formal Board reporting and action evidence of the Core20PLUS5 to:
    - Reduce health inequalities
    - Make reasonable adjustments
    - Remove barriers to accessing care and support within BSW
- Improve the accuracy of health and social care demographics and coding to ensure that population data and associated health needs are precisely collated and responded to

These objectives reflect that the ICB is a new statutory body, and therefore will grow with the ongoing integrated system development opportunities. The 2023 Annual Equality Report will provide a progress position and further objective review as the organisation settles along with an accompanying system EDS report.

Within the ICB, equality impact assessments are recommended for any major organisational changes is due to take place.

For 2023, templates for Equality and Quality Impact Assessment are due to be refreshed and made mandatory for all ICB business. Equality impact assessments were carried out for the consultations that took place relating to the transfers from the former CCG to the new ICB.

The ICB's provider organisations are also required to demonstrate independent compliance

with:

- Equality and inclusion
- Legal, mandatory and non-mandatory requirements
- The publication of an annual equality and inclusion report, complete with objectives

Our providers also provide reports which include equality and inclusion issues, as well as barriers for patients from different groups with protected characteristics.

The ICB Quality and Outcomes Committee was established as a formal committee of the Board, in line with the organisation's constitution.

The terms of reference ensure that the committee, along with its individual members, consider the equality and diversity implications of their decision-making. The committee has decision-making responsibility and seeks assurance that quality/equality impact assessments have been undertaken and shared.

Examples of consideration of equalities and patient engagement include:

- Access to vaccinations for people with learning disabilities
- Mental health charities working with the ICB to help those in need
- Making adjustments and adaptations to the new Devizes Health Centre

Health and wellbeing strategy

The ICB has continued to build on the work of the former CCG by working in partnership on joint health and wellbeing strategies with the system's three local authorities. This involved ICB representatives attending local authority strategy steering group meetings and having the opportunity to review and comment on evolving drafts.

In Wiltshire, the ICB worked with local authority colleagues to co-develop the new Wiltshire Joint Local Health and Wellbeing Strategy, which aligns to both ICB and locality priorities.

Across each local authority, joint delivery plans will ensure progress and success. The ICB monitors these plans to ensure there is alignment with the integrated care strategy and joint forward plan. The joint delivery plans will be developed and published over the coming months.

While the joint health and wellbeing strategy for each of the three local authorities differs slightly, shared areas of focus have included responding to the considerable pressures within the health and care system, focusing on tackling inequalities within the local population and promoting prevention and wellbeing.

As mentioned, the ICB has also focused on working with partners to develop the integrated care strategy. This was approved by the integrated care partnership in March, and sets out the vision and aims of the integrated care system over the next five years.

At the heart of this strategy will be a commitment from BSW partners to focus on prevention and early intervention, fairer health and wellbeing outcomes, and excellent health and care services.

The joint forward plan, which the system is referring to as its implementation plan, will set out how all partners will deliver the ambitions of the strategy. At the time of writing, local authorities

and other partners have been consulted on the first draft.

Financial review

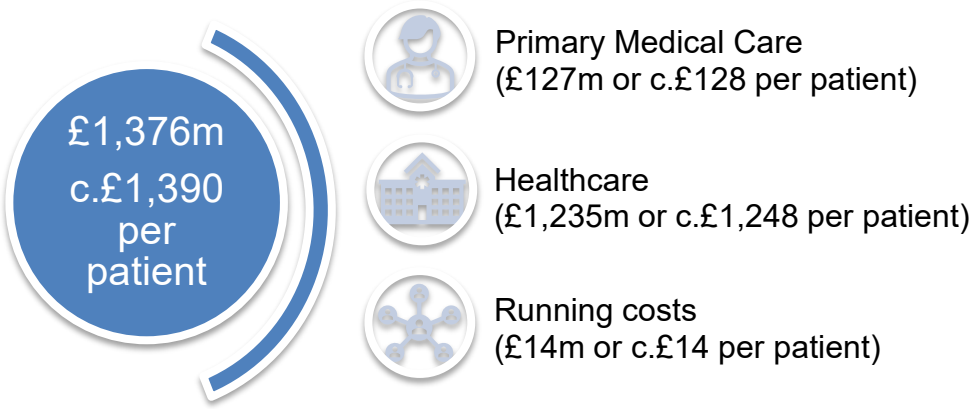
The ICB received an annual funding allocation from NHS England to provide health services for its resident population. Funding was allocated by NHS England based on local healthcare needs and health inequalities.

The ICB used this funding to pay for the services set out within locally-agreed plans.

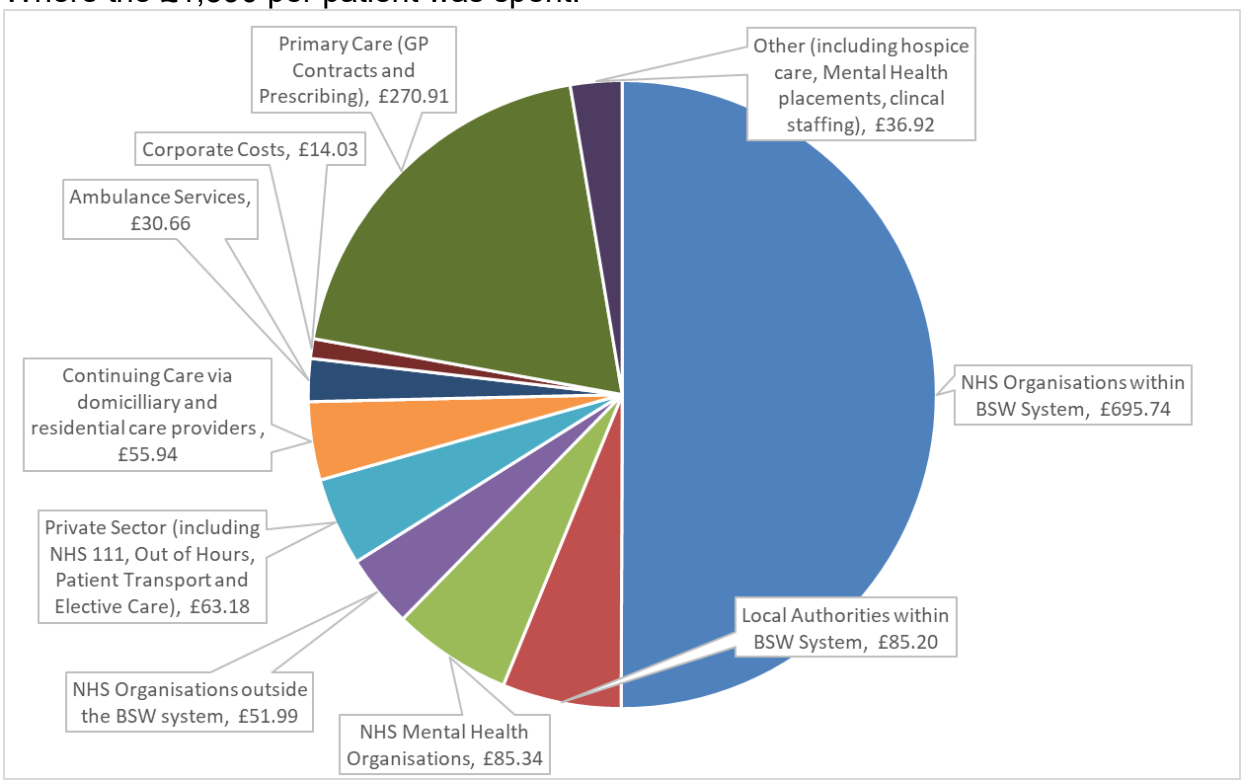
Further details on the ICB's financial performance are included within the financial statements section of the Annual Report.

The ICB has published details of all payments of more than £25,000 on its website.

Funding received during the period can be seen below:



Where the £1,390 per patient was spent:



Promoting and using research

The ICB worked in partnership with the National Institute for Health and Care Research's Clinical Research Network to support a BSW Research Hub. This has since been made accessible to all health and care researchers within BSW. The hub meets monthly, and representatives attend similar forums in neighbouring systems to share research findings and practice.

The ICB has developed greater support in its approach to system research where there is strategic opportunity. This has led to a partnership with NHS England, which has resulted in a lead healthcare scientist being recruited and healthcare scientist forum being established.

The ICB is actively working to establish a lead research role to help take initiatives forward and support research opportunities within the system.

Innovative use of technology

The ICB led the way in creating a system-wide Microsoft Office 365 team, which has supported collaboration through the use of the SharePoint and Power Business Intelligence applications.

This platform was launched in the autumn, and access was made available to all NHS organisations and local partners. The SharePoint site hosts a raft of Power BI reporting tools that focus on population health management and health inequalities.

The ICB has championed the use of cloud technology and has worked to ensure all existing technology can be made compatible. Cloud-based technology has the potential to increase the efficiency of the ICB's data warehouse, which will improve data gathering and decision-making, particularly in terms of health inequalities.

In addition, the cloud technology has enabled the ICB to have a truly agile approach to the use of its estate, while also contributing to lowing running costs.

Anchor institution

The ICB has contributed to the ICS becoming an anchor system, which supports economic and social development through the following programmes:

- **Work experience and access to employment**

  As part of the BSW Academy, there has been a virtual work experience programme to enhance access to skills and employment opportunities across health and care.

  The access to employment has been in partnership with the Department for Work and Pensions, local colleges and schools. Inclusive employment routes have also focused on supporting people with learning disabilities.

  The recruitment and retention directorate of the BSW Academy ran three system-wide recruitment events for support worker roles in March 2023. The events were supported by local organisations, which ensured maximum inclusivity and community involvement.

- **Access to skill development programmes**

  The ICB is focused on offering apprenticeships and T levels for additional employment and skills opportunities, especially entry level roles.

  Funding has been secured from the Department of Education for a Multiply Programme Lead in Wiltshire, which will help adults improve numeracy.

  The BSW Academy principles state that training and procurement of training should be sourced through local communities. As evidence, a co-production module has been developed and delivered with partners from the voluntary, community and social enterprise sector.

- **Increasing the diversity of research participation**

  The ICB was successful in its bid for funding from the NHS England Research Network Development Programme.

  As a result, the ICB will lead a programme of work that focuses on recruiting those who belong to travelling community and manual workers for whom English is a second language.

  The outputs of this work will support further research participation and community involvement.

ACCOUNTABILITY REPORT

Sue Harriman

Accountable Officer

22 June 2023

Accountability Report

The Accountability Report describes how the ICB met key accountability requirements and embodied best practice to comply with corporate governance norms and regulations.

It comprises three sections:

- The Corporate Governance Report sets out how the ICB has governed the organisation during the period 1 July 2022 to 31 March 2023, including membership and organisation of governance structures and how each supported the achievement of objectives

- The Remuneration and Staff Report describes the remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on 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 purpose of this report is to explain the composition and organisation of the ICB's governance structures, and how each supports the achievement of objectives.

Members Report

The ICB's constitution outlines how it will deliver its statutory duties, who its Board members are and how decisions will be made. The ICB's Governance Handbook further explains how the organisation works, and includes the terms of reference of all the committees of the Board. The ICB's Constitution, Governance Handbook, and other key corporate documents can be found on the ICB's website.

Member profiles

The ICB is a statutory body which brings together NHS organisations with local authorities, as well as other partners, to work to improve population health and establish shared strategic priorities.

Profiles of the ICB Board members can be found on the ICB website.

Composition of the ICB Board

The Board is in place to ensure the ICB has the appropriate arrangements to discharge its functions effectively, efficiently and economically.

An ongoing role of the Board is to review the governance arrangements and ensure principles of good governance are adhered to.

The ICB's constitution, as determined by the Health and Care Act 2022, requires partner members to sit on the Board.

Each member of the Board has a responsibility to ensure the ICB performs its duties in accordance with the terms of the constitution, with each member bringing a unique perspective that is informed by their individual expertise and experience.

BSW covers the boundaries of three local authorities, each of which are partner members of the Board. Also included are representatives from the voluntary, community and social enterprise sector.

The membership of the Board between 1 July 2022 and 31 March 2023 was as follows:

Position on the ICB Board	Name
Chair	Stephanie Elsy
Chief Executive Officer	Sue Harriman
Chief Finance Officer	Gary Heneage
Chief Nurse	Gill May
Chief Medical Officer	Dr Amanda Webb
Non-Executive Director for Audit and Governance	Dr Claire Feehily
Non-Executive Director for Patient and Public Engagement (PPE)	Julian Kirby
Non-Executive Director for Remuneration and People	Suzannah Power
Non-Executive Director for Finance	Paul Miller
Non-Executive Director for Quality	Professor Rory Shaw
NHS Trusts & NHS Foundation Trusts Partner Member – acute sector	Stacey Hunter
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector	Dominic Hardisty
Community Provider Partner Member *(until 17 March 2023)*	Douglas Blair
Local Authority Partner Member BaNES	Will Godfrey
Local Authority Partner Member Swindon	Susie Kemp
Local Authority Partner Member Wiltshire	Terrence Herbert
Partner Member Voluntary Community and Social Enterprise (VCSE)	Pam Webb
Partner Member Primary Care	Dr Francis Campbell

To ensure governance arrangements remained appropriate for the ICB, a governance review was undertaken during September and October 2022. The purpose of this was to reflect on whether the structures put in place from 1 July 2022 took account of the new ICB responsibilities and whether the executive and assurance functions were clearly defined.

The recommended changes to governance structures and committee membership were agreed by the Board, and adopted and implemented on 1 November 2022.

As part of this review, the Board agreed to streamline committees, and stood down the Primary Care Commissioning Committee and the Commissioning Assurance Committee.

This is reflected within the committee membership tables included in this Annual Report.

Committees, including Audit Committee

The Board is supported in its work by the mandated Audit and Risk Committee and Remuneration Committee.

The terms of reference for these mandatory committees are included in the ICB's Governance Handbook, which is available to view on the ICB website.

The members of the Audit and Risk Committee for the period 1 July 2022 to 31 March 2023 were as follows:

BSW ICB Non-Executive Director (Audit and Governance)	Dr Claire Feehily
BSW ICB Non-Executive Director (Remuneration and People)	Suzannah Power
BSW ICB Non-Executive Director (Public and Community Engagement)	Julian Kirby
Local Authority Partner Member of the Board from November 2022	Susie Kemp
Community Provider Partner Member of the ICB Board – from November 2022	Douglas Blair
BSW ICB Non-Executive Director (Quality) until October 2022	Professor Rory Shaw
BSW ICB Non-Executive Director (Finance) until October 2022	Paul Miller
ICB Chief Nurse a voting member until October 2022	Gill May

Executive Director of Planning and Performance a voting member until October 2022	Rachael Backler

There is more information about the governance arrangements, including details and membership of all other ICB committees, in the governance statement below.

The Remuneration Report includes details of the membership of the Remuneration Committee.

Register of interests

The ICB recognised that effective handling of conflicts of interest is crucial to ensuring that patients, tax payers, healthcare providers and Parliament are confident that all commissioning decisions were robust, fair, transparent and offered value for money.

In managing conflicts of interest, the ICB followed Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2022), which set out the minimum requirements of what must been done in terms of managing conflicts of interest.

The ICB's Standards of Business Conduct Policy complied with national guidance and set out the expectations regarding standards of business conduct for the ICB, including the management of conflicts of interest.

The policy ensured that conflicts of interest were managed in a way that could not undermine the probity and accountability of the organisation. The policy also provided guidance to all staff and Board members on the receipt of gifts and hospitality.

The ICB regularly reviewed its register of Board member interests. This is published on the ICB website.

Personal data-related incidents

Between July 2022 and March 2023, there were 32 identified breaches of data security.

Fifteen of these have been attributed to acts or omissions by ICB colleagues. Other organisations were accountable for the remaining incidents.

All fifteen ICB attributable incidents/near misses related to ICB colleagues inadvertently or accidentally sharing information with an incorrect recipient. Seven of the recipients were internal recipients or trusted partners.

All breaches were dealt with internally and, where appropriate, colleagues were directed to guidance and training materials. The ICB has not had any data security incidents deemed to be Serious Untoward Incidents during this period, and there were no breaches of a level that required reporting to the Information Commissioner's Office (ICO).

The ICB received a letter from the ICO on 9 November 2022 regarding an applicant's

complaint into how BSW CCG handled four related Freedom of Information requests and a subsequent Internal Review. The ICB provided the requested information and response to the ICO on 18 November 2022 and the ICO closed the case on 29 November 2022 with no action required from the ICB.

Modern Slavery Act

The ICB supports the government's objectives to eradicate modern slavery and human trafficking.

The Slavery and Human Trafficking Statement for the period ending 31 March 2023 is published on the ICB website.

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 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 has been required to comply with the requirements of the government's 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's Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- Prepare the accounts on a going concern basis
- Confirm 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 ICB shall have an Accountable Officer and that officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of BSW 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 ICB and enable them to ensure that the accounts

comply with the requirements of the Accounts Direction, and for safeguarding the ICB's 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 the ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

The ICB is a corporate body, which was established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended). The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Between 1 July 2022 and 31 March 2023, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended), and has delivered a breakeven position.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, while 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 ICB's Accountable Officer appointment letter.

I am responsible for ensuring that the 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 Members Report summarises the composition of the Board from 1 July 2022 to 31

March 2023.

The main function of the Board is to ensure the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with the generally accepted principles of good governance.

The constitution sets out the governance and decision-making arrangements of the ICB. The Board ensures the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically, in accordance with the principles of good governance.

Reporting to the Board, the following committees enable it to discharge its responsibilities, and to oversee and manage the ICB's performance, quality and risk effectively:

Mandatory committees

- Audit and Risk Committee (see the Members' Report for the committee's membership)
- Remuneration Committee (see the Remuneration Report for details of the membership of the committee)

Non-mandatory committees

- Finance and Investment Committee
- Quality and Outcomes Committee
- People Committee
- Public and Community Engagement Committee
- Local Commissioning Group Bath and North East Somerset
- Local Commissioning Group Swindon
- Local Commissioning Group Wiltshire

The Board has worked diligently to carry out its responsibilities as a statutory body. The agendas and papers for those meetings held in public are available on the ICB's website in advance of the meeting, and act as a public record of the decisions taken and performance to date.

The ICB and its Board understand their public involvement duty, and responsibility to listen to and engage with its stakeholders and population when planning, developing and commissioning services for patients.

Audit and Risk Committee

The Audit and Risk Committee supports the Board and Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

The Audit and Risk Committee is accountable to the Board and provides an

independent and objective view of the ICB's compliance with its statutory responsibilities.

Its terms of reference are included in the ICB's Governance Handbook.

In summary, the Audit and Risk Committee is responsible for:

- Reviewing the establishment and maintenance of an effective system of integrated governance, continuous improvement processes, risk management and internal control, across the whole of the ICB's activities
- Ensuring there is an effective internal audit function that meets the Public Sector Internal Audit Standards, and provides appropriate independent assurance to the committee, the Accountable Officer and the Board
- Reviewing and monitoring the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work
- Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation
- Ensuring the ICB has adequate arrangements in place for countering fraud, and reviewing the outcomes of work in this area
- Monitoring the integrity of the financial statements of the organisation
- Reviewing the effectiveness of the arrangements in place for allowing staff to raise concerns in confidence about possible improprieties in financial, clinical or safety matters, as well as ensuring that any such concerns are investigated proportionately and independently

The Audit and Risk Committee regularly reviews the ICB's Freedom to Speak Up policy, which is published on the intranet.

The Non-Executive Director for Quality is the ICB's Freedom to Speak Up Guardian, whose profile, along with contact details, are also published on the intranet.

The committee met six times during the reporting period.

Highlights of work undertaken during the period included:

- Review of the Annual Report and Accounts for 2022-23
- Internal audit reviews including primary care workforce, IT network implementation, improving NHS financial sustainability and conflicts of interest
- Review of the ICB corporate registers

The committee also received reports from counter fraud and security management, and updates from the external auditors.

Remuneration Committee

The Remuneration Committee supports the ICB to exercise its functions in relation to the NHS Act 2006 by setting and adopting the ICB pay policy and frameworks, and

considering and approving executive remuneration and terms of employment.

Its terms of reference are included in the ICB's Governance Handbook.

The Remuneration Committee met four times during the reporting period.

Finance and Investment Committee

The Finance and Investment Committee provides assurance to the ICB Board in relation to the financial management and sustainability of the ICB as a body corporate, the financial sustainability and achievement of agreed financial and productivity goals of NHS providers that operate in the ICB's area, and the effectiveness of the ICB's efforts, with partners in the wider health and care economy in the area, to achieve financial sustainability of health and care services.

The committee's terms of reference are published in the ICB's Governance Handbook.

In summary, the committee monitors the ICB's financial performance, supports the Board in ensuring financial management achieves value for money, efficiency and effectiveness in the use of resources, provides assurance that plans are effectively managed and outcomes are being delivered, reviews financial risks and sets the framework for the ICB's conduct of procurement, ensures estate, capital and digital plans support collaboration and increase productivity, and receives assurance of its implementation.

The Committee also seeks assurance on the arrangements for discharging the ICB's responsibilities in relation to the themes in the NHS Oversight Framework.

The Finance and Investment Committee met ten times during the reporting period and considered the financial performance, risks and position reports, the system wide recovery programme, and the financial plan for 2023/24.

Quality and Outcomes Committee

The Quality and Outcomes Committee (QOC) is responsible for providing assurance to the Board that the ICB is discharging its statutory duty and functions with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services. The committee also provides assurance that the ICB has the right quality governance processes in place and that it is working effectively with providers of health services in its area to ensure the effectiveness, safety and good user experience of services.

The committee's terms of reference are published in the ICB's Governance Handbook.

The QOC met six times during the reporting period, and considered the BSW Learning Disability Mortality Review (LeDeR) Annual Report, performance and quality reports, Special Educational Needs and/or Disabilities (SEND) Annual Report, Children Looked After Annual Report, and ICB clinical and operational policies.

People Committee

The People Committee provides assurance to the Board on matters relating to the BSW health and care workforce, ICB staff and the BSW Academy, in line with the system's people strategies and plans, as well as the NHS People Functions.

The committee's responsibilities include the review and approval of all necessary frameworks, policies, and procedures for the employment of ICB staff, and development of people and organisational strategies for supporting and engaging the ICB workforce.

The committee's terms of reference are published in the ICB's Governance Handbook.

The People Committee met three times during this reporting period, and considered the work undertaken against the BSW Ten People Function Outcomes, progress against the Workforce Race Equality Standard, Workforce Disabilities Equality Standard and Gender Pay Gap report actions, and the BSW Strategic Workforce Priorities.

Public and Community Engagement Committee

The Public and Community Engagement Committee provides assurance to the Board that the ICB is discharging its statutory duties and functions regarding public involvement and engagement.

The committee provides assurance that the ICB and its system partners have effective public and community engagement processes, at both system and place level.

The committee's terms of reference are published in the ICB's Governance Handbook.

The Public and Community Engagement Committee met three times during the reporting period and considered the statutory guidance regarding Working in Partnership with People and Communities, the Ten Community Engagement Principles, the Equality Delivery System Report for 2022 and the Voluntary, Community and Social Enterprise Engagement Methodology.

Locality commissioning groups

The ICB Board has established three locality commissioning groups, which met in common with groups established by the three local authorities within BSW that have similar remits.

The committees' terms of reference are published in the ICB's Governance Handbook.

In summary, the groups have responsibility for commissioning activities in the Bath and North East Somerset, Swindon and Wiltshire localities, including collaborative and joint commissioning arrangements, as permitted with the local authorities.

For the avoidance of doubt, primary care commissioning is not included within this remit and remains the responsibility of the Primary Care Commissioning Committee (before November 2022) and the Primary Care Executive Group (after November 2022).

The groups regularly considered performance and quality reports regarding commissioned services and pooled budgets, including the Better Care Fund.

Integrated Care Partnership

The Integrated Care Partnership is a statutory committee formed by the ICB, and brings together the NHS, local government, the VCSE sector, and other partners to focus on prevention, wider social and economic factors that affect people's health and reducing health inequalities.

The ICP will develop the integrated care strategy for local health and care services, and be an advocate for innovation, new approaches and improvement to the way services are provided and run.

Ambulance Joint Commissioning Committee

A collaborative commissioning model is in place for the commissioning of ambulance services across the South West.

The Ambulance Joint Commissioning Committee has been established to jointly commission emergency ambulance services across the South West, and to manage the commissioning contract with the provider of emergency ambulance services.

The ICBs covered by these joint commissioning arrangements are:

- Bath and North East Somerset, Swindon and Wiltshire
- Bristol, North Somerset and South Gloucestershire
- Devon
- Dorset
- Gloucestershire
- Cornwall and Isles of Scilly
- Somerset.

As set out in the ICB's constitution, the Board has statutory responsibility for ensuring the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically, to achieve the four core purposes of the ICB, and to comply with the requirements of the National Health Service Act 2006 (as amended), and other supporting pieces of legislation applying to ICBs.

The Board is also responsible for approving the ICB's Annual Reports and Accounts, and ensuring good governance occurs and leading a culture of good governance throughout the ICB and wider system.

The ICB's Scheme of Reservations and Delegations sets out the Board's delegations of decision-making powers, authorities to Board committees and to individuals.

The Board met regularly throughout the reporting period to discharge its respective functions.

The business covered included:

- The delegation of pharmacy, ophthalmic and dental Services
- The development of the BSW Integrated Care Strategy
- The approval of the BSW Green Plan
- The NHS England Operating Framework and 2022-23 Memorandum of Understanding

Orange – as non-voter								
Total number of meetings 1 July 2022 to 31 March 2023:		5	6	4	3	6	10	3
Position on the ICB Board	**Name**	ICB Board *(Meetings held in public)*	Audit and Risk Committee	Remuneration Committee	People Committee	Quality and Outcomes Committee	Finance and Investment Committee	Public and Community Engagement Committee
ICB Chair	Stephanie Elsy	5		4	1		7	
Chief Executive / Accountable Officer	Sue Harriman	5	5	3			6	
Chief Finance Officer	Gary Heneage	5	5				10	
Chief Nurse	Gill May	5	3 as voter 2			6		2
Chief Medical Officer	Dr Amanda Webb	4				4		
BSW ICB NED for Public and Community Engagement	Julian Kirby	5	6	4	1 From 1/11/22	6		3
BSW ICB NED for Audit and Governance	Dr Claire Feehily	5	6					
BSW ICB NED for Finance	Paul Miller	5	0 1/7/22 to 31/10/22	4	2 From 1/11/22	2 From 1/11/22	10	
BSW ICB NED for Quality	Professor Rory Shaw	4	2 1/7/22 to 31/10/22	3		6	7	1 1/7/22 to 31/10/22
BSW ICB NED for Remuneration and People	Suzannah Power	4	3	4	3		5 From 1/11/22	
Local Authority Partner Member – BaNES	Will Godfrey	3				1 From 1/11/22		
Local Authority Partner Member – Swindon	Susie Kemp	2	2 *From 1/11/22*					
Local Authority Partner Member – Wiltshire	Terence Herbert	3			3			

Orange – as non-voter								
Total number of meetings 1 July 2022 to 31 March 2023:		5	6	4	3	6	10	3
Position on the ICB Board	**Name**	ICB Board *(Meetings held in public)*	Audit and Risk Committee	Remuneration Committee	People Committee	Quality and Outcomes Committee	Finance and Investment Committee	Public and Community Engagement Committee
NHS Trusts and NHS Foundation Trusts Partner Member – mental health sector	Dominic Hardisty	3			1 1/7/22 to 31/10/22		4 From 1/11/22	
Primary Medical Services Partner Member	Dr Francis Campbell	4				3 From 1/11/22		1 From 1/11/22
Voluntary, Community and Social Enterprise Partner Member	Pam Webb	5			2			2
NHS Trusts and NHS Foundation Trusts Partner Member	Stacey Hunter	3				3 From 1/11/22		
Community Provider Partner Member	Douglas Blair	5	1 From 1/11/22					1 From 1/11/22

UK Corporate Governance Code

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

Discharge of statutory functions

The 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.

Risk management arrangements and effectiveness

The ICB has a duty to assure itself that it has properly identified the risks it faces, and

that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

The Risk Management Framework recognises that the ICB's risk management requirements, as a corporate body, are complex because the ICB has system functions, and its performance and achievement of strategic and operational objectives is closely connected with NHS partner organisations' performance.

System risks may also be risks that are relevant to, or affect, the ICB.

The ICB's new Risk Management Framework, which was adopted by the Board in January 2023, is structured in two parts:

- Part one sets out the ICB's approach to risk, including risk appetite, the Board Assurance Framework (BAF), Corporate Risk Register (CRR) and Local Risk Registers (LRR) as key components of the ICB's risk management framework
- Part two describes the ICB's risk management process, and colleagues' roles and responsibilities relating to risk management. Appendices contain explanation of commonly used terms, guidance, and templates to facilitate proactive risk management throughout the ICB. Further information and contact points re risk management are signposted throughout.

The Board is ultimately responsible for ensuring that an effective risk-aware culture is in place and that risk is effectively managed, recorded and reported. This includes the process of risk escalation through the Board's assurance committees. This is an essential mechanism to ensure that senior managers, executives and Board members are aware of emerging risks and that prompt mitigating action is taken.

Not all risks can be eliminated. Nor can strategic and business risks necessarily be avoided. Risk may be embraced and explored so that new and innovative schemes and projects can develop.

Considered risk is to be encouraged, together with experimentation and innovation, but within authorised limits aligned to the ICB's risk appetite. The priority is to reduce, and where possible, eliminate risks that impact on patient safety, and to reduce the ICB's financial, operational and reputational risks to tolerable levels.

Risk appetite helps the ICB establish a threshold of impacts it is willing and able to absorb in pursuit of its objectives. Risk appetite provides a framework which enables the ICB to make informed management decisions.

Ultimately, it is for the ICB to decide which risks it is prepared to accept. The Board will agree the ICB's risk appetite and he Board will also agree the ICB's strategic objectives. In addition, it will identify the risks to achieving objective, and agree its appetite for each risk identified to the achievement of the ICB's strategic objectives.

Capacity to handle risk

Risk refers to uncertainty, the possibility of incurring misfortune or loss, or missing opportunities. This is measured in terms of the likelihood of something happening and the impact of the possible consequences on the ICB's ability to fulfil its aims and

objectives, and its statutory functions and duties.

Risk management is the effective identification, analysis and response to risks in order to maximise the likelihood of successfully discharging the ICB's functions and achieving the ICB's aims and objectives, while minimising the impact of any risk materialising.

The ICB's Board is responsible for the performance of the ICB and, as such, needs to be simultaneously entrepreneurial in driving the organisation forward while keeping it under prudent control. It needs to strike a balance between controls, assurance and strategy, risk-taking and delivery.

The Board determines the ICB's strategic objectives, strategic approach to risk, risk appetite, and identifies risks to the ICB's achievement of its strategic objectives.

It approves the ICB's framework for risk management and reviews the Corporate Risk Register. The Board also receives and responds to risk assurance reports and issues raised by the Audit and Risk Committee in regard to risk, internal control and assurance.

The Audit and Risk Committee scrutinises the ICB's risk management arrangements and processes, and their effectiveness via regular reviews of the Corporate Risk Register and Board Assurance Framework. It also provides assurance to the Board on the effectiveness and adequacy of the ICB's processes for managing risks.

The Board's assurance committees – Finance and Investment, People, Quality and Outcomes, Community Engagement – will regularly review risks with a score of 15 and above that fall within their particular remit.

The purpose and focus of such review is to assure committees that risks are managed well, and committees may scrutinise the effectiveness of the risk management activities in place. Committees will not actively manage risks.

The Executive Performance and Risk Meeting ensures that the ICB has adequate arrangements in place for risk management and provides assurance on this to the Audit & Risk Committee and the Board. It acts to effectively manage and co-ordinate risk management activity and establishes a strategic approach to risk management across the ICB and ensures that the approach is proactive.

The Executive Performance and Risk Meeting regularly presents the Corporate Risk Register to the Audit and Risk Committee, and updates the committee on risk profiles, risk trends, and effectiveness of controls and mitigating actions.

The Audit and Risk Committee will seek assurances that risks that relate to the achievement of the ICB's operational objectives, plans and targets are managed well, and may request deep dives into principal risks.

The Chief Executive Officer is ultimately accountable for all risks relating to the operations of the organisation and leads on the strategic approach to risk, establishment and maintenance of risk management structures and processes in the ICB.

The Chief Executive Officer also ensures that the Board Assurance Framework is

developed, reviewed and reported to appropriate committees and the Board, and that business continuity and disaster recovery plans are established and regularly tested and that risk transfer mechanisms are in place.

Executive directors own their directorate risk registers, and ensure that they are maintained, up-to-date and carry out monthly reviews.

They regularly engage with the Head of Risk and Information Governance to consider local risks for escalation to the Corporate Risk Register and promote a consistent approach to the identification and management of risk.

ICB colleagues apply and implement the risk management process and actively identify risk, discuss and report it to line managers, team leads, heads of departments and directors.

A risk management audit for the ICB was undertaken by KPMG in March 2023 and reported its finding to the Audit and Risk Committee. The Audit and Risk Committee of the ICB is responsible for commissioning internal audits to provide assurance to the Board on the robustness and effectiveness of risk management within the ICB.

The Head of Risk and Information Governance works regularly with directorates and teams to enable the successful implementation and application of the ICB's risk management framework.

Training sessions for ICB colleagues have taken place throughout February and March 2023 and training needs analyses will support targeted provision of further relevant training. All ICB colleagues can access, via the Risk Management intranet pages, the Risk Management Framework, advice, guidance, information and training slides, in order to carry out their respective responsibilities with regard to risk management.

The ICB is committed to maintaining a sound system of internal control, including risk management. By doing this, the organisation aims to ensure that it can maintain a safe environment for patients, minimise financial loss to the organisation and demonstrate to the public that it is a safe, effective and efficient organisation.

Risk assessment

Risk assessment and management are an intrinsic part of the ICB's operation.

The Corporate Risk Register is a live document, not a static record, and should be viewed as a communication tool and action plan that gives details of current controls, assurances and auditable actions for risk treatment.

Actions should always be specific, measurable, achievable, relevant and timebound (SMART).

It is a record that aims to illustrate the operational risk profile of the ICB by reflecting the extent to which operational objectives are threatened by the uncertainty that risk presents.

The Corporate Risk Register is subject to regular reviews and scrutiny by several

committees including:

- ICB Board
- Audit and Risk Committee
- Executive Performance and Risk Meeting

Each risk includes:

- Category of risk
- Description of the risk, including event, cause and consequences
- Date entered
- Existing controls
- Responsible executive director
- Risk Manager
- Assurance Committee
- Assurances and gaps in assurance
- Current risk score (likelihood and impact)
- Target risk score
- Risk treatment
- Mitigations, mitigation owner and target dates for mitigations
- Mitigations RAG
- Date of latest review

The ICB has a Quality and Equality Impact Assessment (QEIA) process in place which provides the framework to ensure compliance with statutory obligations and to identify any risks to the organisation.

Impacts are also assessed through the cover sheets for all reports that are presented to the Board, as well as other committees, to ensure it is integral to planning and implementation. The ICB has an active framework for patient and public engagement and attends local health and wellbeing boards. A network of patient participation groups and regular events seek the views of patients and the public.

The purpose of the Board Assurance Framework (BAF) is to set out the risks to achieving the ICB's strategic objectives and the controls that management are to put in place to minimise the likelihood or effect of those risks materialising.

The BAF should be built on and around the ICB's agreed risk appetite and risk tolerance for each strategic objective, on agreement regarding what is sufficient in terms of controls, and on agreement regarding what is sufficient in terms of the assurances that the controls are operating effectively.

The BAF is currently in development and will be considered regularly by the Board. The Board will make decisions as to the addition and removal of risks from the BAF.

The BAF will allow the ICB to determine where to make the most efficient use of resources and to address identified issues to improve the quality and safety of care. It is the role of the Board to focus on those risks and events which may compromise the achievement of strategic objectives and to support an organisational culture that allows the organisation to anticipate and respond appropriately to adverse events.

The BAF has a different format and lists the:

- Strategic objective
- Key risks to achieving strategic objectives
- Executive lead
- Controls and mitigations
- Assurance Committee
- Assurances and evidence
- Gaps in controls and assurances
- Planned actions
- Current risk score (likelihood and impact)
- Target risk score
- Inherent risk score

All identified operational risks, scoring 15 or above, are recorded on the ICB's Corporate Risk Register. Where risks cannot be managed within the specific area of responsibility, these are escalated to the next level of governance to be managed appropriately.

The Corporate Risk Register is reviewed monthly by the Executive Performance & Risk Meeting and quarterly by the Audit & Risk Committee and Board.

The ICB actively deters risks through the adoption of robust counter fraud and security management methodology. The ICB has a contract with counter fraud specialists TIAA to provide counter fraud management and the ICB rated itself as green against the national standards for counter fraud and security management in 2022/23.

The Audit and Risk Committee critically reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the ICB's activities, which supports the achievement of the organisation's objectives.

The highest scoring risks identified during the reporting period related to:

- Capacity for winter 2022/23, particularly across urgent and emergency care
- Financial sustainability
- Hospital handover delays and ambulance call stack delays
- Industrial action
- System-wide workforce and resilience

There was also a risk that elective care capacity would not recover as planned

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.

Annual audit of conflicts of interest management

There is no requirement to report on the internal audit of conflicts of interest, via returns to NHS England, following the formal establishment of ICSs in July 2022.

While the Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own conflicts of interest policy, which is referenced in the ICB's governance handbook, NHS England's engagement with local stakeholders suggests nationally-commissioned basic training would be of value to avoid unnecessary duplication across systems.

NHS England will provide updated national e-learning modules on managing conflicts of interest in the context of the new ICB arrangements and explore the development of additional guidance on conflicts of interest in consultation with ICB Chairs.

Internal audit carried out an audit on managing conflicts of interest in January 2023, which was presented to the Audit and Risk Committee at its February meeting. The audit reviewed the design and operation of controls in place for managing conflicts.

The report resulted in an overall rating of significant assurance with minor improvement opportunities. Recommendations were made to consider a robust escalation process for non-compliance with conflicts of interest training.

The ICB has taken the recommendations forward.

Data quality

The Board, in addition to its committees and sub-committees, receives information provided by the business intelligence team that is sourced from national mandatory returns and NHS Digital information.

This data is subject to data quality checks from providers prior to submission, from NHS Digital as part of the national collation process and from the ICB as part of its data management processes. Information is also sourced directly from local providers, and this is validated by the ICB business intelligence team, as well as against national information and guidance, wherever available.

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.

High importance is placed on ensuring there are robust information governance systems and processes to help protect patient, ICB colleague and corporate information. The ICB operated an information governance management framework in line with the Data Security and Protection Toolkit (DSPT), which is reviewed on an annual basis.

There is a suite of GDPR compliant information governance policies, and an Information Governance Handbook provides further information to ICB colleagues to ensure they are aware of their information governance roles and responsibilities.

The ICB had a trained Senior Information Risk Officer (SIRO), a trained Caldicott Guardian and a trained Data Protection Officer (DPO).

The ICB also benefited from trained Information Asset Owners (IAO) and Information Asset Administrators (IAA) across the organisation, and all ICB colleagues have been required to complete the national data security awareness training on an annual basis. The ICB actively promotes information governance through detailed intranet pages and briefings to ICB colleagues, and this has been particularly important during 2022/23, when colleagues have worked from home.

A reporting and investigation framework is utilised for information governance incidents and near misses, and is supported by information governance expertise provided by South Central and West Commissioning Support Unit. The ICB demonstrates a strong risk reporting culture.

ICB colleagues understand the importance of privacy by design and have increased the number of data protection impact assessments (DPIA) undertaken, often leading on these for the ICS and facilitating the legal sharing of information between organisations to promote patient care.

Business critical models

The ICB has an appropriate and proportionate approach to providing quality assurance of business-critical models.

This is in line with the recommendations of the 2013 Macpherson Report.

Third party assurances

As a commissioning organisation, the ICB routinely contracts with third party providers to deliver healthcare services. These services are contracted using NHS standard contracts using national terms and conditions.

The ICB places reliance on these contracts to make sure that services remain effective, as well as on regular performance monitoring reports and meetings with providers.

The ICB also uses third party providers to deliver some of its back-office processes:

- It is nationally mandated for the ICB to use NHS Shared Business Services for the provision of back-office financial services. These services are provided under a contract between NHS England and NHS Shared Business services. The ICB places reliance on NHS England to manage this contract and report back on any control issues identified
- The ICB sub-contracts the provision of several of its corporate services to the South Central and West Commissioning Support Unit. The ICB reviews the performance of this service level agreement each month
- The ICB has pooled budget arrangements with its three local authorities for the provision of healthcare services. These arrangements are formalised through Section 75 agreements and performance is reviewed in-year by all partners

Control issues

The ICB's performance against national standards has continued to be impacted by the aftermath of the Covid-19 pandemic.

Further details on performance and recovery plans are set out within the Performance Report.

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

The ICB has systems and processes in place for managing its resources effectively, efficiently and economically. The Board has an overarching responsibility for ensuring that appropriate arrangements are in place, and has delegated responsibility to the Finance and Investment Committee, Audit and Risk Committee and the Quality and Outcomes Committee.

The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control is in place. An annual internal audit programme is agreed by the Audit and Risk Committee to provide assurance.

The Audit and Risk Committee met regularly throughout 2022/23 to review and monitor the ICB's financial reporting and internal control principles, and to ensure the ICB's activities were managed in accordance with legislation and NHS regulation. Both internal and external auditors attend the committee.

The Finance and Investment Committee met throughout the year to approve the financial plans, monitor financial performance, savings plans and overall use of resources. The committee also approves business cases and has oversight over procurement activities.

The Quality and Outcomes Committee has monitored effectiveness of contracts and outcomes.

The Chief Finance Officer meets regularly with the ICB finance team to review monthly reporting. Regular meetings are also held between the ICB and the finance leads of system partner organisations.

As part of the annual audit, the ICB's external auditors are required to satisfy

themselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

The findings are reported to both the Audit and Risk Committee and the ICB Board.

The ICB's performance against its targets for the period are set out within the notes of the financial statements.

Delegation of functions

The ICB has not delegated any of its statutory functions.

The ICB has had a service level agreement in place with the CSU for the provision of a range of services, including procurement, human resources, health and safety support, Freedom of Information requests and information governance.

Counter fraud arrangements

The ICB has a contract in place with a third party for the provision of counter fraud services and security management services.

The arrangements include:

- An accredited counter fraud specialist and a security management specialist contracted to undertake counter fraud and security management work proportionate to identified risks and to embed counter fraud measures in line with the NHS Counter Fraud Authority (NHSCFA) Strategy for 2020-2023
- Security management work is completed in line with NHS England's Violence Prevention and Reduction Standard to support a safe and secure working environment for NHS staff
- The ICB Audit and Risk Committee receives a regular progress report and an annual report against each component of the NHSCFA requirements and the Government Functional Standard 013. The counter fraud specialist and security management specialist have regularly attended audit committee meetings. There is executive support and direction for a proportionate proactive work plan to address identified risks
- A member of the Board is proactively and demonstrably responsible for tackling fraud, bribery and corruption
- Appropriate action is taken regarding any NHSCFA quality assurance recommendations and progress is overseen by the Audit and Risk Committee
- The ICB undertakes an annual assessment against its compliance with the standards and NHS requirements for counter fraud by submitting a Counter Fraud Functional Standard Return to the NHSCFA at the end of the year. The ICB's rating for the 2022/23 return is green overall

Proactive reviews of systems, processes and controls by both internal audit and the counter fraud specialist contribute to the identification of the risk of fraud, and recommendations are made to mitigate against the identified risks. The counter fraud specialist has completed a bespoke fraud risk assessment for the ICB the current year

Head of Internal Audit opinion

Following the completion of the planned audit work for the period 1 July 2022 to 31 March 2023, 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:

Overall opinion

Our overall opinion for the period 1 April 2022 to 31 March 2023 is that significant assurance with minor improvements can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Commentary

The commentary below provides the context for our opinion and, together with the opinion, should be read in its entirety. Our opinion covered the period 1 April 2022 to 31 March 2023 inclusive, and is based on the audits completed in that period.

Our plan looks at core governance areas, including areas such as governance, risk management, financial controls and data quality, as well as conflicts of interest and delegated commissioning.

In addition to these areas, we perform risk-based reviews in areas the Audit and Risk Committee has directed us towards.

We identified robust controls over governance, financial controls, conflicts of interest and delegated commissioning, as evidenced by our significant assurance with minor improvement required opinions in these areas.

Two core reviews were given a partial assurance with improvements required opinion, relating to data quality and risk management. For both reviews, we were guided to areas of concern or where there were changes since the inception of the ICB. The above does not prevent us from issuing significant assurance with minor improvements overall, as the organisation is implementing the management actions raised as a result of our work to address the issues identified and these assurance ratings were in line with management forecast assurance rating.

Further detail on all of the partial assurance with improvements required reports can be found below.

The three reviews graded as partial assurance with improvements required relate to:

- Primary Care workforce planning: We raised one high priority management action in 2022/23 relating to the lack of an overarching workforce strategy within primary care. Following this, management have agreed an action plan to put in place a strategy. Management accepted the actions, with responsible individuals

and deadlines agreed. This action was completed in-year

- Risk Management: We raised one high priority finding in respect to embedding new processes around risk escalation. This was a new process for the ICB, and one which was a known area to improve. Management accepted the actions, with responsible individuals and deadlines agreed. This is due to be delivered within 2023/24
- Data Quality: We raised one high priority action in respect to ensuring there was clarity over data quality requirements for providers and enhancing inequalities data. Management accepted the actions, with responsible individuals and deadlines agreed. This is due to be delivered within 2023-24

The design and operation of the Assurance Framework and associated processes

The Assurance Framework reflects the ICB's key objectives and risks, and is regularly reviewed.

The Executive reviews the Assurance Framework on a monthly basis and the Audit Risk and Assurance Committee provides reviews on whether the ICB's risk management procedures are operating effectively. New processes for the ICB are embedding, but actions plans are in place to support the organisation going forward.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

Three partial assurance reports – primary care workforce planning, risk management and data quality – have been issued. There have been zero no assurance opinions issued in respect of our 2022/23 assignments.

Management accepted the actions, with responsible individuals and deadlines agreed.

This does not prevent us from issuing significant assurance with minor improvements overall as the organisation is implementing the management actions raised as a result of our work to address the issues identified.

The status of these actions is reported by management to the Audit and Risk Committee.

The organisation has directed us towards areas where there have been concerns in terms of operation or performance in-year.

KPMG LLP
Chartered Accountants
London
31 March 2023

During the period, internal audit issued the following audit reports:

Area of audit	**Level of assurance given**
Integrated care system due diligence	Significant assurance with minor improvement opportunities
Primary care workforce	Partial assurance with improvements Required
Procurement – Lessons learnt	N/A – lessons learnt review
IT Network implementation review	Significant assurance with minor improvement opportunities
Net-zero design authority – data assurance	N/A – advisory review
Improving NHS Financial Sustainability (HFMA Checklist)	N/A – advisory review
Conflicts of interest	Significant assurance with minor improvement opportunities
Risk management	Partial assurance with improvements Required
Delegated commissioning	Significant assurance with minor improvement opportunities
Data quality	Partial assurance with improvements Required

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 assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Board
- Audit and Risk Committee
- Internal audit
- Other explicit review or assurance mechanisms

The governance review of arrangements undertaken partly through this reporting period also included the review of supporting corporate policies and the Scheme of Reservation and Delegation (SoRD).

Recommended changes were endorsed by the Audit and Risk Committee and approved by the Board, before implementation.

Conclusion

No significant internal control issues have been identified. The ICB does however continue to underperform against national performance targets.

Remuneration and staff report

This section sets out the ICB's remuneration policy for directors and senior managers, and how it has been implemented.

Remuneration report

Remuneration Committee

The committee is accountable to the Board and sets the remuneration, fees and other allowances, including pension schemes, for employees and other individuals who provide services to the ICB.

During the reporting period, its members were:

BSW ICB Non-Executive Director (Remuneration and People) – Chair	Suzannah Power
BSW ICB Non-Executive Director (Public and Community Engagement)	Julian Kirby
BSW ICB Non-Executive Director (Finance)	Paul Miller
BSW ICB Non-Executive Director (Quality)	Professor Rory Shaw
BSW ICB Chair	Stephanie Elsy

Policy on the remuneration of senior managers

The ICB executives are employed with terms and conditions including duration, notice periods and termination payments in accordance with existing Agenda for Change and very senior manager (VSM) arrangements, as well as the ICB Executive Pay Framework, which was released in February 2022.

Remuneration is designed to fairly reward each individual based on their contribution to the ICB's success, and takes into account the need to recruit, retain and motivate skilled and experienced professionals.

Remuneration must take into account considerations of equal pay, value for money in the use of public resources and the ICB's obligation to remain within its financial allocations.

Senior manager remuneration for executive directors is set through a process that is based on a consistent framework – the ICB Executive Pay Framework – and independent decision-making based on the framework and previous experience. This ensures a fair and transparent process through bodies that are independent of the senior managers whose pay is being set.

No individual is involved in deciding his or her own remuneration.

NHS England published the ICB Executive Pay Framework in February 2022, which detailed the minimum and maximum operational salary ranges for all Board members. All appointment and salary data is to be reported annually moving forward to allow any equity issues to be identified.

Executive director pay is set in accordance with the ICB Executive Pay Framework (February 2022).

For CCG directors who remained employed by the ICB during part or all of the reporting period, remuneration was in line with the Clinical Commissioning Groups: Remuneration Guidance for Chief Officers and Chief Finance Officers Guidance, existing VSM pay scales, and terms and conditions.

Amendments to VSM and Board member salaries are reviewed annually by the Remuneration Committee, which then provides assurance to the Board. This is normally following the national guidance on VSM salaries as advised by the review pay bodies. Salaries exclude on-call payments. Executive and senior manager performance is monitored through the ICB's formal appraisal process, which is based on organisational and individual objectives.

When considering and setting the remuneration of appointed members of the Board, other than those executive directors who are ex-officio members of the Board, the Remuneration Committee and the Board take into account available guidance, and comparative data from other ICBs and NHS organisations.

Appointed members' remuneration takes into account an individual's salary in their general practitioner role, if relevant, along with any loss of seniority pay due to the time commitment to the ICB.

The ICB's constitution determines the composition of the Board, the ways in which members are appointed or elected and terms of office.

Remuneration of very senior managers

The ICB has taken robust steps to ensure the remuneration of all very senior managers is reasonable and appropriate for the roles being undertaken, as well as the conditions of the labour market and in line with the ICB Executive Pay Framework.

For any salary above £150,000, the ICB Remuneration Committee is to note and endorse the proposals and, where necessary, seek approval from NHS England and HM Treasury, in line with NHS England guidance.

One executive director has been appointed on a salary above the operational maximum, and a request for approval has been submitted to NHS England and HM Treasury.

Senior manager remuneration (including salary and pension entitlements) 2022/23 (AUDITED)

Name	Title	Note	Salary (bands of £5,000) *4, 5 , 8*	Expense payments (taxable) to nearest £100 *3*	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other (bands of £5,000) *7*	Compensation for loss of office *9*	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
			£'000s	£s	£'000s	£'000s	£'000s	-	£'000s	£'000s
Sue Harriman	Chief Executive		145 - 150	-	-	-	0 - 5	-	62.5 - 65	210 - 215
Amanda Webb	ICB Medical Director		115 - 120	100	-	-	-	-	35 - 37.5	155 - 160
Gary Heneage	Chief Finance Officer		115 - 120	-	-	-	-	-	32.5 - 35	145 - 150
Jane Moore	ICB Director of Equalities & Innovation		100 - 105	-	-	-	-	-	107.5 - 110	210 - 215
Gillian May	Director of Nursing & Quality	3, 6	105 - 110	200	-	-	-	-	112.5 - 115	215 - 220
Rachael Backler	Director of Planning and Performance	1	90 - 95	-	-	-	5 - 10	-	30 - 32.5	130 - 135
Fiona Slevin-Brown	Director of Place - Wiltshire		100 - 105	100	-	-	5 - 10	-	62.5 - 65	170 - 175
Laura Ambler	Director of Place - Bath and North East Somerset	1	70 - 75	-	-	-	-	-	5 - 7.5	80 - 85
Corinne Edwards	Chief Operating Officer, BaNES Locality	1, 5	55 - 60	-	-	-	-	160 - 165	-	215 - 220
Richard Smale	Executive Director of Strategy & Transformation		90 - 95	100	-	-	-	-	60 - 62.5	155 - 160
Alison Kingscott	Executive Director of Workforce	1, 4	40 - 45	-	-	-	-	65 - 70	-	105 - 110
Francis Campbell	Locality Healthcare Professional (Swindon)		25 - 30	-	-	-	-	-	0 - 2.5	25 - 30
Richard Collinge	Chief of Staff	1	75 - 80	-	-	-	-	-	7.5 - 10	80 - 85
Jasvinder Sohal	Chief People Officer	1,	90 - 95	-	-	-	-	-	20 - 22.5	110 - 115
Suzannah Power	Lay Member Primary Care Commissioning and Deputy Chair		10 - 15	-	-	-	-	-	-	10 - 15
Gordon Muvuti	Director of Place - Swindon		95 - 100	-	-	-	-	-	-	95 - 100
David Coyle	Interim Chief Operating Officer	1, 11	45 - 50	-	-	-	-	-	-	45 - 50
Stephanie Elsy	BSW Independent Chair	6	45 - 50	100	-	-	-	-	-	45 - 50
Julian Kirby	Non-Executive Director for Public and Community Engagement	6	10 - 15	-	-	-	-	-	-	10 - 15
Dr Claire Feehily	Non-Executive Director for Audit	6	10 - 15	-	-	-	-	-	-	10 - 15
Paul Miller	Non-Executive Director for Finance	6	10 - 15	100	-	-	-	-	-	10 - 15
Professor Rory Shaw	Non-Executive Director for Quality & Performance	6	10 - 15	-	-	-	-	-	-	10 - 15

Notes

1. Where senior managers were in post for part of the financial year, salaries and figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.

2. The salary figures shown for senior managers above exclude recharges made to the BSW Sustainability & Transformation Partnership, but include recharges out to other NHS organisations.

3. Taxable benefits refer to where senior managers are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with the Agenda for Change guidance on mileage payments.

4. Alison Kingscott left the ICB during January 2023. The banded figure quoted for Salary includes any redudancy payment made in the financial period.

5. Corinne Edwards left the ICB in September 2022. The banded figure quoted for Salary includes any redudancy payment made in the financial period.

6. Lay Members are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits.

7. Other relates to those senior managers in receipt of a relocation allowance. The banded figures disclosed relate to the amounts claimed under those arrangements.

8. Salary includes any salary sacrifice arrangements under the ICBs lease car scheme.

9. Compensation for Loss of office relates to those persons in receipt of redundancy payments.

10. The highest paid director/member on an annualised basis was Sue Harriman, who was contracted at 1 WTE. The annualised banded salary (excluding pension benefits) for this role was £185k-£190k.

11. David Coyle left the ICB in October 2022.

Pensions Disclosure - 2022-23 (AUDITED)

Name ❶	Title	Real increase in pension at retirement age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at retirement age at 31 March 2023 (Bands of £5,000)	Lump sum at retirement age related to accrued pension at 31 March 2023 (bands of £5,000) ❷	Cash equivalent transfer value at 1 April 2022	Real increase in Cash equivalent transfer value	Cash equivalent transfer value at 31 March 2023 ❸	Employers contribution to stakeholder pension
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Sue Harriman	Chief Executive	2.5 - 5	2.5 - 5	55 - 60	85 - 90	912	61	1,049	0
Amanda Webb	ICB Medical Director	2.5 - 5	0 - 2.5	15 - 20	30 - 35	205	15	253	0
Gary Heneage	Chief Finance Officer	0 - 2.5	0	20 - 25	0	209	18	262	0
Jane Moore	ICB Director of Equalities & Innovation	5 - 7.5	0	75 - 80	0	1,115	106	1,309	0
Gillian May ❹	Director of Nursing & Quality	5 - 7.5	10 - 12.5	65 - 70	200 - 205	0	14	39	0
Rachael Backler	Director of Planning and Performance	0 - 2.5	0	15 - 20	0	117	9	155	0
Fiona Slevin-Brown	Director of Place - Wiltshire	2.5 - 5	5 - 7.5	55 - 60	110 - 115	899	64	1,031	0
Laura Ambler	Director of Place - Bath and North East Somerset	0 - 2.5	0	0 - 5	0	0	0	14	0
Corinne Edwards	Chief Operating Officer, BaNES Locality	0 - 2.5	0	45 - 50	90 - 95	835	2	887	0
Alison Kingscott	Executive Director of Workforce	0	0	40 - 45	100 - 105	865	5	910	0
Francis Campbell	Locality Healthcare Professional (Swindon)	0 - 2.5	0	10 - 15	25 - 30	162	1	173	0
Richard Collinge	Chief of Staff	0 - 2.5	0	0 - 5	0	0	3	18	0
Jasvinder Sohal	Chief People Officer	0 - 2.5	0	5 - 10	0	39	8	70	0
Richard Smale	Executive Director of Strategy & Transformation	2.5 - 5	2.5 - 5	50 - 55	95 - 100	806	61	930	0

Notes

❶ *Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.*

❷ *There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.*

❸ *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 members 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.*

The 2021/22 values for accrued pension, lump sum and CETV have been calculated by NHS Pensions with no allowance for a potential adjustment arising from a legal case known as the McCloud judgement. This case concerned potential age discrimination over the way in which UK public sector pension schemes introduced a Career Average Related Earning benefit design in 2015 for all members excluding the oldest members who remained on a final salary design.

The CETV values included in the table above have been prepared by NHS Pensions as at 31st March 2023. The figures have not been pro-rated to reflect the CCG to ICB transition as at 30th June 2022.

❹ *The Cash equivalent transfer values disclosed for Gill May relates to the 2015 Scheme only. The member is over the Normal Retirement Age in the existing schemes and therefore no CETV figures have been provided by NHS Pensions.*

❺ *CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.*

Cash equivalent transfer values

A cash equivalent transfer value 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 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

No such payments were made in the financial period.

Payments to past directors

No such payments were made in the financial period.

Fair pay disclosure (AUDITED)

Percentage change in remuneration of highest paid director

As the ICB is a new entity from 1st July 2022, there are no prior period comparators for the highest paid direct or employee remuneration. Therefore, this disclosure has not been included in this report.

Pay ratio information

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

Total remuneration is further broken down to show the relationship between the highest paid director's salary, including the total remuneration, against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded, annualised remuneration of the highest paid director in the ICB in the financial period 2022/23 was £195,000 - £200,000, and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

1 July to 31 March 2023	25th percentile	Median	75th percentile
Total remuneration (£)	£28,946	£43,850	£58,748
Salary component of total remuneration (£)	£28,946	£43,842	£58,737
Pay ratio information	6.8 : 1	4.5 : 1	3.4 : 1

During the reporting period 1 July 2022 to 31 March 2023, zero employees received remuneration in excess of the highest-paid director. Remuneration ranged from £21,925 to £165,811.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments.

It does not include employer pension contributions or the cash equivalent transfer value of pensions.

Staff report

Number of senior managers

The ICB has categorised members of the Board, and the senior leadership team, as being senior managers, and their salaries are included on page 75.

As of 31 March 2023, the number of senior managers by Agenda for Change bands and very senior managers (VSM) were:

Agenda for Change band	Number of senior managers
Very senior managers (VSM) ICB	12
Band 9	1

The Board of the ICB has an independent chair, one lay member and four non-executive directors who have non Agenda for Change remuneration arrangements.

Staff numbers and costs (AUDITED)

As of 31 March 2023, the ICB had 514 employees, excluding bank colleagues. The workforce was made up of employees from a wide range of professional groups.

Staff costs	2022-23		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	16.1	0.6	16.7
Social security costs	1.8	-	1.8
Employer contributions to the NHS Pension Scheme	2.9	-	2.9
Apprenticeship Levy	0.1	-	0.1
Termination benefits	0.2	-	0.2
Employee benefits expenditure	**21.1**	**0.6**	**21.7**

The average number of people employed by the ICB during the reporting period on a whole-time equivalent (WTE) basis was 429.41.

Permanent WTE average was 386.83 and other equated to 42.58 WTE.

Permanently employed	Other
386.83	42.58

Analysed as:	Perm	Other
Scientific, therapeutic and technical staff	27.97	0.88
Admin and estates staff	299.01	34.44
Medical and dental staff	1.59	4.90
Nursing, midwifery and health visiting	58.26	2.36
Other healthcare	0	0

Staff composition

The table below shows the gender breakdown as of 31 March 2023:

	Female headcount	Male headcount	Total
ICB Board Members	11	8	19
All other ICB staff	399	96	495
Total	410	104	514

Sickness absence data

Overall, the rolling staff sickness absence figure for the nine month period was 2.18 per cent. The overall rolling sickness absence figure is as a result of 1.33 per cent short term sickness absence and 0.85% long term sickness absence.

All sickness absence is managed in line with the ICB Sickness Management policy and colleagues are supported by their manager,

The Health and Safety Executive Stress Risk Assessment is also undertaken with colleagues, if appropriate. Sickness absence data is reported on a quarterly basis and action is taken to address any areas of concern.

As an organisation, the ICB recognises that organisational and systemic change is a

growing feature, and this can cause feelings of uncertainty and unrest.

A particular focus over the coming year will be to support mental wellbeing.

Staff turnover percentages

The overall average staff turnover percentage for the ICB for the nine-month reporting period based on the full-time equivalent was 9.56 per cent.

The table below shows the turnover figures for each month during the reporting period. The highest turnover for the nine-month period was recorded in October 2022.

	2022 / 07	2022 / 08	2022 / 09	2022 / 10	2022 / 11	2022 / 12	2023 / 01	2023 / 02	2023 / 03
Turnover Rate (FTE)	1.02%	0.67%	1.29%	1.50%	1.07%	0.67%	0.69%	0.65%	1.35%

Staff engagement percentages

The ICB participated in the national NHS Staff Survey between 3 October 2022 and 25 November 2022, and all eligible ICB colleagues were invited to take part.

A total of 514 colleagues were eligible to participate, and 367 colleagues completed the survey, which is more than 71 per cent of the organisation. The questions were aligned to the NHS People Promise, which sets out the things that would most improve working experiences. The survey consisted of a number of multiple-choice questions and two opportunities to provide free text responses.

The survey focused on seven main areas:

- Your job
- Your team
- People in your organisation
- Your managers
- Your health
- Wellbeing and safety at work
- Your personal development
- Your organisation.

Benchmarking against other ICBs and NHS organisations has also been undertaken and the output of this will be analysed during quarter one.

Sixty-seven per cent of colleagues either agreed or strongly agreed that the organisation takes positive action on health and wellbeing, and 79 per cent of colleagues strongly agreed or agreed that their immediate line manager took a positive interest in their health and wellbeing.

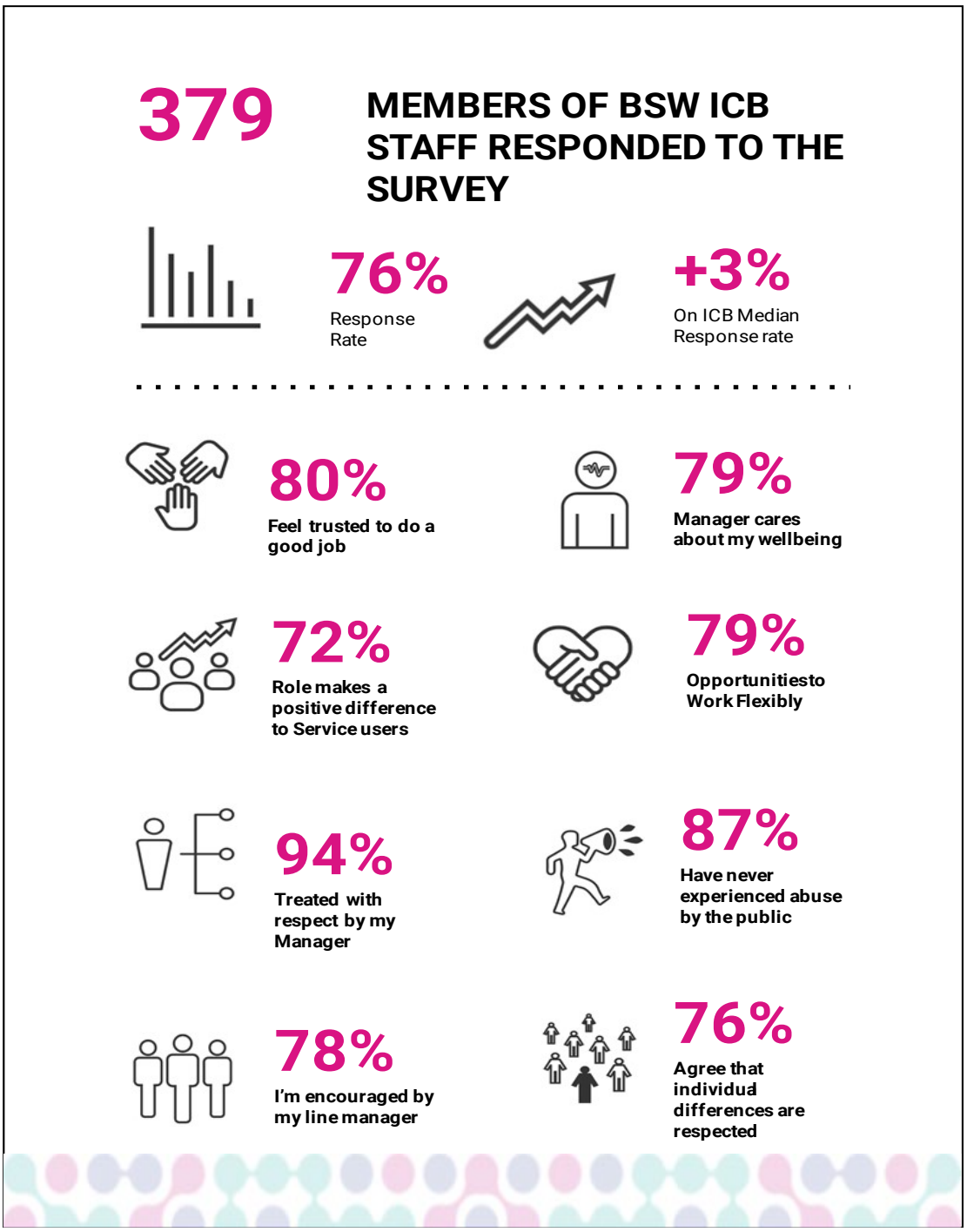
Seventy-nine per cent of colleagues also agreed or strongly agreed that there were opportunities for flexible working patterns. The ICB continues to work in an agile way and there is the option for colleagues to work from any of the BSW offices, should they wish.

Seventy-two per cent of colleagues also agreed or strongly agreed that they receive the respect they deserve from colleagues at work, and 88 per cent of colleagues agreed or strongly agreed they feel trusted to do their job. Ten per cent disagreed or strongly disagreed with this statement that they receive the respect they deserve from colleagues at work.

Eighty-seven per cent of colleagues reported never experiencing harassment, bullying or abuse from patients or the public, but 13 per cent had.

Ninety-four per cent of colleagues reported never experiencing harassment, bullying or abuse at work from managers but six per cent had. The ICB has a zero-tolerance approach to bullying, harassment and abuse. If bullying, harassment or abuse is reported, action is taken immediately to address it. Fifty-seven percent of colleagues who experienced bullying, harassment or abuse stated that they did not report it.

Further action will be taken to ensure that all colleagues know how to report any incidences of bullying, harassment or abuse. Further actions to address this will be built into the organisation-wide action plan.



Staff policies

The ICB has a suite of HR policies that were transferred to the ICB from the CCG on 1 July 2022. The policies are in the process of being formally reviewed, with the review deadline set as June 2023. All HR policies will be reviewed by subject matter experts and the People Committee, and will then be embedded within the organisation.

All policies currently in operation are legally compliant and in line with Agenda for Change terms and conditions. The ICB does not have separate policies for disabled

colleagues or colleagues with other protected characteristics, as the ICB has an integrated approach to delivering workforce equality. All the HR policies pay due regard to the Equality Act 2010, and this is reflected in the policies and through training on specific HR policies.

The ICB's aim is to operate in a way that does 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, such as by making any reasonable adjustments that may be required on a case-by-case basis.

When applying any of the ICB's HR policies, the organisation will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity and provide good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act 2010:

- Age
- Disability
- Gender
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sexual orientation

Diversity and inclusivity continue to be monitored through the equality impact assessments that have been carried out on all HR policies.

The ICB is disability-confident, which means it is committed to carrying out inclusive and accessible recruitment, communicating vacancies, offering an interview to disabled people, providing reasonable adjustments and supporting existing employees to ensure no individuals are disadvantaged.

Any employees who become disabled during their employment with the ICB will be supported by their line manager, HR, occupational health and the Staff Support service. Where possible, reasonable adjustments will be made and training, if appropriate, provided to the individual's line manager and team members to ensure they are able to support the employee in the best way possible.

The ICB will also work with Access to Work, if appropriate, to ensure the best possible support is provided. The ICB has a good relationship with Access to Work through supporting previous employees.

The ICB also has an inclusion charter – Everyone Counts – that was co-produced and details how it is committed to welcoming and embracing equality and diversity, and actively tackling discrimination in all its forms.

The ICB publishes its employee profile by each of the nine protected characteristics, which helps to identify and address areas of under-representation in a systematic manner. On a six-monthly basis, the executive management team receive a report

on the workforce profile.

The ICB has submitted and published its Gender Pay Gap Report. This report details the differences between the average and median hourly rate of pay for male and female employees, and includes an action plan to continue to narrow the gender pay gap.

The ICB had a mean gender pay gap of 31 per cent and a median pay gap of 27 per cent as of 31 March 2022.

The ICB is committed, and aided through the national NHS Staff Survey and Gender Pay Gap data, to continue to improve diversity, remove barriers and increase inclusiveness of the workforce.

Colleague Partnership Forum

The ICB had a Colleague Partnership Forum (CPF) made up of colleague representatives from across the organisation. The CPF aimed to provide regular and effective means of joint discussion between senior management and colleague representatives on issues of mutual interest or concern. It fostered maximum involvement of all partners in effective communication, engagement and consultation on working practice and employments.

The CPF was disbanded in November 2022 and the ICB is in the process of establishing a new forum which will include representatives of each of the BSW directorates. The new forum will be supported to deliver through a clear terms of reference, and its purpose is to work with senior managers to build a sense of collective ownership and belonging for a thriving organisation.

The ICB is an active member of the Social Partnership Forum.

Trade union facility time reporting requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires the ICB to publish the following information:

The total number of relevant union officials employed by the ICB	0
Percentage of time spent on union facility time	0
Percentage of pay bill spend on union facility time	0
Paid trade union activities	0

Facility time is paid time-off for union representatives to carry out trade union activities. The reporting requirements apply to all departments and a defined list of arm’s length bodies within Statutory Instrument 328.

Other employee matters

The ICB has continued to embrace agile working following the Ways of Working Programme, and works in partnership with staff to design new ways of working and estates redesign. The ICB continues to provide greater flexibility to colleagues with the choice of working from home or a BSW office base. This is embedding well to become part of the culture of the organisation.

The ICB continues to be focused on colleague health and wellbeing. The wellbeing group works to promote wellbeing activities and its resources focus on a range of matters, including menopause, display screen equipment assessments, wellbeing checklists, stress risk assessments and flexible working.

During the last six months, a new manager checklist was introduced to support managers with new starters, and a pregnancy and maternity support group has also been established to support colleagues.

There has been a session open to all colleagues about leading in a hybrid world to support ways of working. The ICB has trained mental health first aiders who can act as a point of contact for anyone experiencing a mental health issue or emotional distress.

The ICB has also renewed its subscription with Carers UK, which provides a range of resources for carers to help manage work and their caring responsibilities.

During the autumn and winter, the ICB focused on supporting colleagues' financial wellbeing. One aspect of this involved the ICB commissioning a virtual session with the Money and Pensions Service called Building Financial Wellbeing.

All colleagues were invited to attend the session and it covered a range of topics, including budget planning, financial resilience, dealing with debt, pensions and talking about money.

An ICB People Strategy will be developed in the coming months, in partnership with staff and wider partners, to set out the people ambitions for the coming years. This will focus on actions to help deliver the NHS People Plan, and will ensure the ICB has an optimised operating model, a talented and well equipped workforce, and an open culture which enables colleagues to thrive and deliver for service users.

This will be closely aligned to a refreshed Equality, Diversity and Inclusion (EDI) Strategy.

It is recognised that the equality, diversity and inclusion agenda is substantial, and the ICB is committed to improving in these areas. The ICB is a member of the BSW ICS Equality, Diversity and Inclusion Network, which allows staff to draw on best practice and work collaboratively across the system.

The ICB also has an EDI Specialist, who has provided expertise during the HR policy review and gender pay gap.

Expenditure on consultancy

The ICB spent £375,000 consultancy in the reporting period.

Off-payroll engagements

Table one: Length of all highly paid off-payroll engagements

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

	Number
Number of existing engagements as of 31st March 2023	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a senior civil servant.

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

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

	Number
No. of temporary off-payroll workers engaged between 1st July 2022 to 31st March 2023	0
Of which:	
No. not subject to off-payroll legislation(2)	0
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	0
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

(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 3: Off-payroll engagements / senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	0
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.	0

Exit packages, including special (non-contractual) payments and Analysis of Other Departures **(AUDITED)**

Please see page 108, Table 3.3 in the Statutory Accounts.

Parliamentary Accountability and Audit Report

BSW 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.

An audit certificate and report are also included in this Annual Report.

Financial statements and Audit Report

Audit opinion

Overview

This section provides an overview of how the ICB worked, what it did, the risks it was exposed to, and how it performed during the reporting period 1 July 2022 to 31 March 2023.

NHS organisations produce an annual report and financial accounts at the end of every financial year. In this report, the ICB described how it fulfilled its duties as laid out in the National Health Service Act 2006 (as amended) for the reporting period.

Independent auditor's report to the members of the Board of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (the 'ICB') for the period ended 31 March 2023, 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 financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice

Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).

We enquired of management and the Audit 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 committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to high risk journals including consideration of closing entries, entries posted after year end, manual journals and journals that have a material impact on reported outturn along with a number of other risk factors. We considered whether there was any potential management bias in accounting estimates or any significant transactions with related parties which could give rise to an indication of management override. Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- journal entry testing, with a focus on unusual journal entries using criteria based on our knowledge of the entity and the risk factors identified.
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual.
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

The team communicated with management and the Audit Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual.

Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the ICB operates
- understanding of the legal and regulatory requirements specific to the ICB including:
  − the provisions of the applicable legislation
  − NHS England's rules and related guidance
  − the applicable statutory provisions.

In assessing the potential risks of material misstatement, we obtained an understanding of:

- The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**
- A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Julie Masci

Julie Masci, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

29 June 2023

Independent auditor's report to the members of the Board of NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

In our auditor's report issued on 29 June 2023, we explained that we could not formally conclude the audit and issue an audit certificate for NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (the 'ICB') for the period ended 31 March 2023, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the period ended 31 March 2023 issued on 29 June 2023 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

No matters have come to our attention since 29 June 2023 that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

The Accountable Officer of the ICB 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 – Audit certificate

We certify that we have completed the audit of NHS Bath and North East Somerset, Swindon and Wiltshire for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

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.

Julie Masci

Julie Masci, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
Bristol

8 September 2023

ANNUAL ACCOUNTS

Sue Harriman

Accountable Officer

22 June 2023

Entity name:	NHS Bath and North East Somerset, Swindon and Wiltshire ICB
This period:	2022-23
This period ended:	31 March 2023
This period commencing:	01-July-2022

The figures presented within these accounts have been prepared in millions (£m) rather than thousands (£k). Where appropriate, disclosure notes may include figures in thousands.

CONTENTS **Page Number**

The Primary Statements:

Note **Notes to the Accounts**

Statement of Comprehensive Net Expenditure for the 9 month period ended 31 March 2023

	Note	£m
Income from sale of goods and services	2	(5.5)
Total operating income		**(5.5)**
Staff costs	3	21.7
Purchase of goods and services	4	1,362.1
Depreciation and impairment charges	4	0.9
Provision expense	4	2.0
Other operating expenditure	4	4.4
Total operating expenditure		**1,391.1**
Net operating expenditure		**1,385.6**
Finance expense	6	0.6
Net expenditure for the Year		**1,386.2**
Comprehensive expenditure for the year		**1,386.2**

The notes on pages 110 to 114 form part of this statement.

The ICB has delivered an £18k surplus position against its allocation for the period. See Note 21 for further information.

Statement of Financial Position as at 31 March 2023

	Note	2022-23 £m	1.7.2022 £m
Non-current assets:			
Property, plant and equipment	7	0.2	1.0
Right-of-use assets	8	1.6	1.2
Intangible assets	9	0.1	0.2
Total non-current assets		**1.9**	**2.3**
Current assets:			
Trade and other receivables	10	10.8	11.9
Cash and cash equivalents	6	0.0	9.3
Total current assets		**10.8**	**21.2**
Total current assets		**10.8**	**21.2**
Total assets		**12.7**	**23.5**
Current liabilities			
Trade and other payables	12	(120.3)	(105.8)
Lease liabilities	8	(0.3)	(0.2)
Borrowings	12	(2.1)	-
Provisions	13	(9.0)	(8.6)
Total current liabilities		**(131.7)**	**(114.7)**
Non-Current Assets less Net Current Liabilities		**(119.0)**	**(91.1)**
Non-current liabilities			
Lease liabilities	8	(1.3)	(0.9)
Total non-current liabilities		**(1.3)**	**(0.9)**
Assets less Liabilities		**(120.3)**	**(92.1)**
Financed by Taxpayers' Equity			
General fund		(120.3)	(92.1)
Total taxpayers' equity:		**(120.3)**	**(92.1)**

The notes on pages 105 to 129 form part of this statement.

The financial statements on pages 101 to 129 were approved by the Integrated Care Board on 22nd June 2023 and signed on its behalf by:

Chief Executive Officer
Sue Harriman

Chief Financial Officer
Gary Heneage

Statement of Changes In Taxpayers Equity for the 9 month period ended 31 March 2023

	General fund £m
Changes in taxpayers' equity	
Balance at 01 July 2022	-
Changes in NHS Integrated Care Board taxpayers' equity for the period	
Net operating expenditure for the financial year	(1,386.2)
Transfers by absorption (from) other bodies	(92.3)
Net Recognised NHS Integrated Care Board Expenditure for the period	**(1,478.5)**
Net funding	1,358.2
Balance at 31 March 2023	**(120.3)**

Statement of Cash Flows for the 9 month period ended 31 March 2023

	Note	£m
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	17	(1,386.2)
Depreciation and amortisation	4	0.9
Movement due to transfer by Modified Absorption	6	(84.6)
Other gains & losses	6	0.5
(Increase) in trade & other receivables	10	(10.8)
Increase in trade & other payables	12	120.3
Provisions utilised	13	(1.9)
Increase in provisions	13	2.0
Net Cash (Outflow) from Operating Activities		**(1,359.8)**
Cash Flows from Investing Activities		
(Payments) for property, plant and equipment	7	(0.2)
(Payments) for intangible assets	9	(0.1)
Net Cash (Outflow) from Investing Activities		**(0.3)**
Net Cash (Outflow) before Financing		**(1,360.0)**
Cash Flows from Financing Activities		
Grant in aid Funding Received		1,358.2
Repayment of lease liabilities	8	(0.3)
Net Cash Inflow from Financing Activities		**1,357.9**
Net (Decrease) in Cash & Cash Equivalents	11	**(2.1)**
Cash & Cash Equivalents at the Beginning of the Financial Period		-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**(2.1)**

The notes on pages 113 to 123 form part of this statement.

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

The Health and Care Act received Royal Assent on 28 April 2022. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished clinical commissioning groups (CCG). ICBs took on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities transferred to NHS Bath and North East Somerset, Swindon and Wiltshire ICB.

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.

Where an Integrated Care Board ceases to exist, it considers whether or not 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 statement of financial position has therefore been drawn up at 31 March 2023 on a going concern basis.

The amounts disclosed for NHS BSW ICB cover a nine month period of 1st July 2022 to 31st March 2023. Therefore, any comparative figures included in these accounts may not be entirely comparable as the financial periods covered are different lengths.

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. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

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

1.4 **Joint arrangements**

Arrangements over which the integrated care board has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the integrated care board is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 **Aligned/Pooled Budgets**

The ICB has entered into separate joint arrangements with Swindon Borough Council, Wiltshire Council and Bath and North East Somerset Council in accordance with Section 75 of the NHS Act 2006. Under each arrangement all funds are hosted by the local authorities.

The ICB accounts for its share of assets, liabilities, income and expenditure in accordance with the respective Section 75 agreements.

The ICB determines which party has control over the services being delivered in accordance with IFRS 11.

Note 21 provides further details on the individual arrangements.

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 ICB.

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• As per paragraph 121 of the Standard the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for NHS BSW ICB is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

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 NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the ICB of participating in a scheme is taken as equal to the contributions payable to the 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 is charged to expenditure at the time the ICB 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.

Employees not eligible to join the NHS Pension Schemes are eligible to join an alternative defined contribution scheme (see Note 3.4.3). costs of the scheme are recognised in the period in which service is received.

The NHS Pension scheme is subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

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

1.1 **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**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

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.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

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 clinical commissioning group'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 ICB;
- 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.

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.

1.11.3 **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 ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB 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 ICB 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.

1.12 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 **The ICB as Lessee**

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

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

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

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 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 impairments' 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 the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

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

1.13 **Inventories**

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

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 clinical commissioning group's cash management.

1.15 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group 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.

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

• A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

A restructuring provision is recognised when the clinical commissioning group 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 ICB 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 ICB.

1.17 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB 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 **Contingent liabilities and contingent assets**

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 clinical commissioning group, 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.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

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

1.19 **Financial Assets at Amortised cost**

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

1.20 **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 clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group 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 month 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 clinical commissioning group 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 clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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

1.21 **Financial Liabilities**

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

1.21.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 **Value Added Tax**

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

1.23 **Foreign Currencies**

The clinical commissioning group'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. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.24 **Losses & Special Payments**

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

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

1.25 **Critical accounting judgements and key sources of estimation uncertainty**

The ICB has made no critical accounting judgements and has not identified any areas of estimation uncertainty.

1.26 **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.

1.27 **New and revised IFRS Standards in issue but not yet effective**

● 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.
● 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.

2 Other Operating Revenue for the 9 month period ended 31st March 2023

	£m
Income from sale of goods and services (contracts)	
Education, training and research	1.2
Non-patient care services to other bodies	3.9
Other Contract income	0.4
Total Income from sale of goods and services	**5.5**
Other operating income	0.0
Total Other operating income	**0.0**
Total Operating Income	**5.5**

The income recognised in the reporting period relates to various training, operational and clinical schemes operated and managed by the ICB. £1.2m of the above funds were receivable from Health Education England in the period.

2.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Other Contract income
	£m	£m	£m
Source of Revenue			
NHS	0.0	1.9	0.0
Non NHS	1.2	2.1	0.3
Total	**1.2**	**4.0**	**0.3**

	Education, training and research	Non-patient care services to other bodies	Other Contract income
	£m	£m	£m
Timing of Revenue			
Point in time	0.0	0.0	0.0
Over time	1.2	3.9	0.4
Total	**1.2**	**3.9**	**0.4**

3. Employee benefits and staff numbers for the 9 month period ended 31st March 2023

3.1 Employee benefits

	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	16.1	0.6	16.7
Social security costs	1.8	-	1.8
Employer Contributions to NHS Pension scheme	2.9	-	2.9
Apprenticeship Levy	0.1	-	0.1
Termination benefits	0.2	-	0.2
Gross employee benefits expenditure	**21.1**	**0.6**	**21.7**

3.2 Average number of people employed for the 9 month period ended 31st March 2023

	Permanently employed Number	Other Number	Total Number
Total	386.8	42.6	**429.4**

3.3 Exit packages for the 9 month period ended 31st March 2023

	Other agreed departures		Total	
	Number	£m	Number	£m
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	1	0.1	1	0.1
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	1	0.2	1	0.2
Over £200,001	-	-	-	-
Total	**2**	**0.3**	**2**	**0.3**

	Departures where special payments have been made	
	Number	£m
Less than £10,000	-	-
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	-	-
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**-**	**-**

Analysis of Other Agreed Departures *

	Other agreed Number	£m
Redundancies including early retirement contractual costs	2	0.2
Contractual payments in lieu of notice	1	0.0
Total	**3**	**0.3**

The ICB had two exit payments payable to individuals in 2022-23.

* 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 year. 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 terms stipulated in contract of employments.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

3.4 Pension costs

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

The ICB has an alternative pension scheme as a result of "auto enrolment" under the Pensions Act 2008. See 3.4.3.

3.4.1 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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.

3.4.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

For the period, employer's contributions of £2.9m were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. During the period, NHS England funded NHS Pension contributions totalling £0.9m (6.3%) on behalf of the ICB. Both the funding and cost of this are shown within the ICBs accounts.

3.4.3 Defined Contribution Pensions

The ICB contributed to an alternative pension scheme during the period as a result of "auto enrolment" under the Pensions Act 2008. This pension is offered to staff who are not eligible to join the NHS Pension scheme. These staff are enrolled in a defined contribution pension scheme called "NEST". In the period, employee contributions were 5% and employer contributions 3%.

4. Operating expenses
for the 9 month period ended 31st March 2023

	£m
Purchase of goods and services	
Services from other ICBs and NHS England	2.5
Services from foundation trusts	724.1
Services from other NHS trusts	86.9
Services from Other WGA bodies	44.7
Purchase of healthcare from non-NHS bodies	221.5
Purchase of social care	16.0
Prescribing costs	116.2
GPMS/APMS and PCTMS	132.5
Supplies and services – clinical	2.7
Supplies and services – general	3.8
Consultancy services	0.4
Establishment	3.7
Transport	3.7
Premises	1.4
Audit fees	0.2
Other non statutory audit expenditure	
· Internal audit services	0.1
Legal fees	0.7
Education, training and conferences	1.0
Total Purchase of goods and services	**1,362.1**
Depreciation and impairment charges	
Depreciation	0.7
Amortisation	0.2
Total Depreciation and impairment charges	**0.9**
Provision expense	
Provisions	2.0
Total Provision expense	**2.0**
Other Operating Expenditure	
Chair and Non Executive Members	0.1
Grants to Other bodies	0.9
Expected credit loss on receivables	3.3
Other expenditure	0.1
Total Other Operating Expenditure	**4.4**
Total operating expenditure	**1,369.4**

The external audit fee for the period excluding VAT was £175,000. The external auditor carried out a separate audit of the Mental Health Investment Standard (MHIS) and were reimbursed £30,000.
The external auditor's liability for external audit work carried out for the financial period is limited to £1,000,000.

5.1 Better Payment Practice Code
for the 9 month period ended 31st March 2023

Measure of compliance

	Number	£m
Non-NHS Payables		
Total Non-NHS Trade Invoices paid in the Year	27,358	443.9
Total Non-NHS Trade Invoices paid within target	26,938	436.0
Percentage of Non-NHS Trade invoices paid within target	**98.46%**	**98.22%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,047	815.9
Total NHS Trade Invoices Paid within target	1,030	814.7
Percentage of NHS Trade Invoices paid within target	**98.38%**	**99.85%**

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

The ICB had no Late Payment of Commercial Debts (Interest) to report in 2022-23.

6.1 Other gains and losses
for the 9 month period ended 31st March 2023

	£m
Loss on disposal of property, plant and equipment assets other than by sale	0.5
Total	**0.5**

6.2 Net (loss) on transfer by absorption
for the 9 month period ended 31st March 2023

On the 1st July 2022 NHS Bath and North East Somerset, Swindon and Wiltshire ICB took over the assets and liabilities of NHS Bath and North East Somerset, Swindon and Wiltshire CCG.

Transfers as part of a reorganisation fall to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period 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.

A further transfer of £0.2m was made during the period from NHS England, relating to provisions held for historic Continuing Care claims (pre 2013).

The table below identifies the Statement of Financial Position as at 30th June 2022 for NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group and the consolidated position transferred to NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board.

	£m
Transfer of property plant and equipment	1.0
Transfer of Right of Use assets	1.2
Transfer of intangibles	0.2
Transfer of cash and cash equivalents	9.3
Transfer of receivables	11.9
Transfer of payables	(105.8)
Transfer of provisions	(8.6)
Transfer of Right Of Use liabilities	(1.2)
Transfers in from CCG (sub-total)	**(92.1)**
Transfer in from NHS England, PUPOC provision	(0.2)
Net loss on transfers by absorption	**(92.3)**

7 Property, plant and equipment

	Plant & machinery £m	Information technology £m	Furniture & fittings £m	Total £m
Cost or valuation at 01 July 2022	-	-	-	-
Additions purchased	0.2	-	0.0	0.2
Disposals other than by sale	(0.3)	(0.5)	(0.0)	(0.8)
Transfer (to)/from other public sector body	0.1	1.3	0.0	1.5
Cost/Valuation at 31 March 2023	**0.0**	**0.8**	**0.1**	**0.9**
Depreciation 01 July 2022	-	-	-	-
Disposals other than by sale	(0.0)	(0.2)	(0.0)	(0.2)
Charged during the period	0.0	0.5	0.0	0.5
Transfer (to)/from other public sector body	0.0	0.4	0.0	0.4
Depreciation at 31 March 2023	**0.0**	**0.6**	**0.0**	**0.7**
Net Book Value at 31 March 2023	**0.0**	**0.2**	**0.0**	**0.2**
Purchased	0.0	0.2	0.0	0.2
Total at 31 March 2023	**0.0**	**0.2**	**0.0**	**0.2**
Asset financing:				
Owned	0.0	0.2	0.0	0.2
Total at 31 March 2023	**0.0**	**0.2**	**0.0**	**0.2**

The ICB had no Revaluation Reserve for Property, Plant and Equipment.

7.1 Economic lives	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	5	10
Information technology	5	8
Furniture & fittings	5	6

8 Leases

8.1 Right-of-use assets

	Buildings excluding dwellings £m
Cost or valuation at 01 July 2022	-
Additions	0.7
Transfer from other public sector body	1.2
Cost/Valuation at 31 March 2023	**1.9**
Depreciation 01 July 2022	-
Charged during the period	0.2
Transfer (to) from other public sector body	0.1
Depreciation at 31 March 2023	**0.2**
Net Book Value at 31 March 2023	**1.6**

8.2 Lease liabilities

	£m
Lease liabilities at 01 July 2022	-
Additions purchased	(0.7)
Repayment of lease liabilities (including interest)	0.3
Transfer (from) other public sector body	(1.2)
Lease liabilities at 31 March 2023	**(1.6)**

8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	£m
Within one year	(0.3)
Between one and five years	(1.1)
After five years	(0.2)
Balance at 31 March 2023	**(1.6)**
Effect of discounting	0.0
Included in:	
Current lease liabilities	(0.3)
Non-current lease liabilities	(1.3)
Balance at 31 March 2023	**(1.6)**

8.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2022-23 £m
Depreciation expense on right-of-use assets	0.3

8.5 Amounts recognised in Statement of Cash Flows

	2022-23 £m
Total cash outflow on leases under IFRS 16	0.3

8.6 Revaluation

There were no revaluations of lease assets or liabilities in the period.
The ICB was not party to any sale and lease-back transactions in the period.
The leases recognised relate to the ICBs office sites.

9 Intangible non-current assets

	Computer Software: Purchased £m
Cost or valuation at 01 July 2022	-
Additions purchased	0.1
Transfer (to)/from other public sector body	0.2
Cost / Valuation At 31 March 2023	**0.3**
Amortisation 01 July 2022	-
Disposals other than by sale	-
Charged during the period	0.2
Amortisation At 31 March 2023	**0.2**
Net Book Value at 31 March 2023	**0.1**
Purchased	0.1
Total at 31 March 2023	**0.1**

9.1 Economic lives

	Minimum Life (years)
Computer software: purchased	5

10.1 Trade and other receivables	Current 31.3.2023 £m	Current 1.7.2022 £m
NHS receivables: Revenue	1.1	0.5
NHS prepayments	-	0.8
NHS accrued income	-	0.2
Non-NHS and Other WGA receivables: Revenue	7.6	3.7
Non-NHS and Other WGA prepayments	2.4	4.1
Non-NHS and Other WGA accrued income	2.9	3.0
Expected credit loss allowance-receivables	(4.0)	(0.7)
VAT	0.8	0.1
Total Trade & other receivables	**10.8**	**11.9**
Total current and non current	**10.8**	**11.9**

10.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £m	2022-23 Non DHSC Group Bodies £m
By up to three months	0.9	-
By three to six months	-	-
By more than six months	0.1	-
Total	**1.0**	**-**

10.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £m	Total £m
Balance at 1 July 2022	-	-
Lifetime expected credit losses on trade and other receivables	(3.3)	(3.3)
Transfer by Absorption from other entity	(0.7)	(0.7)
Total	**(4.0)**	**(4.0)**

11 Cash and cash equivalents

	2022-23 £m
Balance at 01 July 2022	-
Net change in period	(2.1)
Balance at 31 March 2023	**(2.1)**
Made up of:	
Cash and cash equivalents	**-**
Bank overdraft: Government Banking Service	(2.1)
Total bank overdrafts	**(2.1)**
Balance at 31 March 2023	**(2.1)**

Please refer to Note 12.2 for further information regarding the "Bank overdraft: Government Banking Service" balance.

12.1 Trade and other payables	Current 31.3.2023 £m	Current 1.7.2022 £m
NHS payables: Revenue	3.8	5.9
NHS accruals	2.9	4.8
NHS deferred income	0.3	-
Non-NHS and Other WGA payables: Revenue	13.1	9.0
Non-NHS and Other WGA accruals	92.1	79.7
Non-NHS and Other WGA deferred income	0.6	0.3
Social security costs	0.3	0.3
Tax	0.2	0.2
Other payables and accruals	7.0	5.5
Total Trade & Other Payables	**120.3**	**105.8**
Total current and non-current	**120.3**	**105.8**

There are no liabilities due in future years under arrangements to buy out the liability for early retirement.
References to "WGA" relate to balances included in the Governments Whole of Government Accounts exercise.
Other payables include £0.4m outstanding pension contributions at 31 March 2023

12.2 Borrowings	Current 31.3.2023 £m	Current 1.7.2022 £m
Bank overdrafts:		
Government banking service	2.1	-
Total overdrafts	**2.1**	**-**

The Government Banking Service bank overdraft relates to a BACS payment run which was transacted on 31st March 2023. The total amount paid was £3m. The funds associated with this transaction will clear the ICBs bank account on 6th April 2023.

In line with NHS England's accounting guidance, the ICB has presented the overdrawn cash position as a technical overdraft.

13 Provisions

	Current 2022-23 £m
Restructuring	0.5
Continuing care	5.4
Other	3.1
Total	**9.0**
Total current and non-current	**9.0**

	Restructuring £m	Continuing Care £m	Other £m	Total £m
Balance at 01 July 2022	**-**	**-**	**-**	**-**
Arising during the period	0.1	1.5	2.9	**4.6**
Utilised during the period	(0.3)	(0.0)	(1.6)	**(1.9)**
Reversed unused	(0.6)	(0.1)	(1.9)	**(2.6)**
Transfer (to) from other public sector body under absorption	1.3	4.0	3.6	**8.9**
Balance at 31 March 2023	**0.5**	**5.4**	**3.1**	**9.0**
Expected timing of cash flows:				
Within one year	0.5	5.4	3.1	**9.0**
Balance at 31 March 2023	**0.5**	**5.4**	**3.1**	**9.0**

Restructuring provision recognised to reflect costs associated with organisational change.

Continuing Care - This category relates to three separate provisions:

- £4.1m Those existing Continuing Healthcare retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) that have not yet been agreed by the CHC panel and those identified funded nursing care cases which may demonstrate eligibility based upon the outcome of the nationally set application and review process.
- £0.4m Related to VAT.
- £0.3m Related to those outstanding PuPOC cases formerly the responsibility of NHS England.

During 2022-23 NHS England transferred the closing provision relating to NHS Continuing Healthcare claims for periods of care before the establishment of Clinical Commissioning Groups to the ICB, totalling £0.2m. NHS England is responsible for meeting any Income Tax payments relating to these claims.

Other provisions reflect contract indemnities and provisions for legal claims.

Where appropriate a provision for legal claims may be calculated from the number of claims currently lodged with the NHS Resolution, and the probabilities provided by them. There are currently no claims logged with NHS Resolution, hence no provision is included in the accounts.

There is a requirement for NHS bodies to note the value of provisions carried in the books of NHS Resolution in regard to ELS (Existing Liabilities Scheme) and CNST (Clinical Negligence Scheme for Trusts) claims as at 31 March 2023.

The provision for ELS claims is £0, and for CNST claims is £0.

14 Contingencies

	2022-23 £m
Contingent liabilities	
Continuing Healthcare	8.0
Net value of contingent liabilities	**8.0**

15 Commitments

15.1 Capital commitments
The ICB had none in 2022-23.

15.2 Other financial commitments

The ICB has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2022-23
	£m
In not more than one year	122.5
In more than one year but not more than five years	11.9
In more than five years	1.5
Total	**135.9**

The commitments relate to healthcare service arrangements entered into with third-party non-NHS providers.

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 ICB 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 ICB 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 ICB in undertaking its activities.

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

16.1.1 Currency risk
NHS Bath and North East Somerset, Swindon and Wiltshire ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations and therefore has low exposure to currency rate fluctuations.

16.1.2 Interest rate risk
When required the ICB receives capital resource from NHS England for fund capital expenditure and has no powers to borrow. The ICB draws down cash to cover expenditure as the need arises, and does not need to borrow to finance its business. The ICB therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the ICBs revenue comes from parliamentary funding, the ICB 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

NHS Bath and North East Somerset, Swindon and Wiltshire ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arise, and is not, therefore, exposed to significant liquidity risks.

16.1.5 Financial Instruments

As the cash requirements of the ICB 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 the ICB's expected purchase and usage requirements and the ICB is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £m	Total 2022-23 £m
Trade and other receivables with NHSE bodies	0.7	0.7
Trade and other receivables with other DHSC group bodies	3.9	3.9
Trade and other receivables with external bodies	7.1	7.1
Total at 31 March 2023	**11.7**	**11.7**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £m	Total 2022-23 £m
Loans with external bodies	2.1	2.1
Trade and other payables with NHSE bodies	1.5	1.5
Trade and other payables with other DHSC group bodies	8.3	8.3
Trade and other payables with external bodies	110.6	110.6
Total at 31 March 2023	**122.5**	**122.5**

17 Operating segments

	Gross expenditure £m	Income £m	Net expenditure £m	Total assets £m	Total liabilities £m	Net assets £m
BSW Commissioning	1,391.7	(5.5)	**1,386.2**	12.7	(133.0)	**(120.3)**
Total	**1,391.7**	**(5.5)**	**1,386.2**	**12.7**	**(133.0)**	**(120.3)**

The ICB considers it has one commissioning segment - BSW wide commissioning.

The Net expenditure disclosed within this note has been reported in line the internal monitoring and management of ICB expenditure.

18 Joint arrangements

The ICB has entered into arrangements with three local authorities during the period. The detail of these are reported below.

		Better Care Fund			
BaNES Locality arrangement	**Total**	**Better Care Fund**	**Community Equipment**	**Adult Services (Learning Disabilities)**	**Children's Services**
	£m	**£m**	**£m**	**£m**	**£m**
Contribution					
Bath & North East Somerset Council	41.8	22.3	0.2	17.4	2.0
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	38.1	31.9	0.4	5.5	0.3
Income from client contributions	-	-	-	-	-
Grant Funding	-	-	-	-	-
Total Funding	**79.9**	**54.2**	**0.5**	**22.9**	**2.3**
Expenditure					
Bath & North East Somerset Council	49.5	22.3	0.2	21.2	5.9
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	40.0	31.9	0.4	6.8	0.9
Total Expenditure	**89.6**	**54.2**	**0.6**	**27.9**	**6.9**
Net overspend/(underspend) as detailed below					
Bath & North East Somerset Council	7.7	-	0.0	3.7	4.0
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	2.0	-	0.0	1.3	0.6
Total Overspend/(Underspend)	**9.7**	**-**	**0.1**	**5.0**	**4.6**

The Memorandum Accounts for Children and Young People with Multiple and Complex Needs and all the other accounts were approved by the Chief Financial Officer of Bath & North East Somerset Local Authority.

These statements confirm that the Memorandum Accounts accurately disclose the income received and expenditure incurred in accordance with the Partnership Agreement, as amended by subsequent agreed variations, entered into under section 75 of the NHS Act of 2006.

The net contribution by the ICB to the Joint Arrangement was £38.1m of which £2m was a net overspend.

18 Joint arrangements cont'd

Swindon Locality arrangement	Total	Better Care Fund	Better Care Fund Community Equipment	Other Adult Services	Children's Services	Public Health
	£m	£m	£m	£m	£m	£m
Contribution						
Swindon Borough Council	99.6	24.8	-	35.6	31.2	7.9
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	59.3	29.2	0.5	27.7	2.0	-
Income from client contributions	-	-	-	-	-	-
Grant Funding	-	-	-	-	-	-
Total Funding	**158.8**	**54.0**	**0.5**	**63.3**	**33.1**	**7.9**
Expenditure						
Swindon Borough Council	106.9	21.9	-	37.2	39.9	7.9
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	63.4	29.0	0.5	32.0	1.9	-
Total Expenditure	**170.3**	**50.8**	**0.5**	**69.2**	**41.8**	**7.9**
Net overspend/(underspend) as detailed below						
Swindon Borough Council	7.3	(3.0)	-	1.6	8.7	-
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	4.1	(0.2)	-	4.4	(0.0)	-
Total Overspend/(Underspend)	**11.4**	**(3.2)**	**-**	**6.0**	**8.7**	**-**

The Integrated Care Board has aligned budget arrangements with Swindon Borough Council pursuant to Section 75 of the National Health Service Act 2006. The budgets are hosted by Swindon Borough Council.

Any over/underspend on health services sit with the Integrated Care Board and over/underspends on social care services sit with the Local Authority. Over/underspends on community equipment are shared according to fixed percentages.

The net contribution by the ICB to the Joint Arrangement was £59.3m of which £4.1m was a net overspend.

18 Joint arrangements cont'd

		Better Care Fund	
Wiltshire Locality arrangement	**Total**	**Better Care Fund**	**Community Equipment**
	£m	**£m**	**£m**
Contribution			
Wiltshire Council	18.7	17.4	1.3
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	33.7	30.5	3.2
Income from client contributions	-	-	-
Grant Funding	4.7	4.7	-
Total Funding	**57.1**	**52.6**	**4.5**
Expenditure			
Wiltshire Council	16.8	15.6	1.2
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	34.4	30.5	3.9
Total Expenditure	**51.2**	**46.1**	**5.1**
Net overspend/(underspend) as detailed below			
Wiltshire Council	(6.6)	(6.5)	(0.1)
NHS Bath and North East Somerset, Swindon & Wiltshire ICB	0.7	-	0.7
Total Overspend/(Underspend)	**(5.9)**	**(6.5)**	**0.6**

The Integrated Care Board has aligned budget arrangements with Wiltshire Council pursuant to Section 75 of the National Health Service Act 2006. The budgets are hosted by Wiltshire Council.

Overspends and underspends on the Better Care Fund are managed by the Local Commissioning Board in accordance with the S75 agreement. If all remedial options to correct an overspend are exhausted, that the overspend will be recovered from the parties to the Fund in proportion to their respective financial contributions. Underspends are divided equally between the partners, unless a different arrangement is agreed by the Local Commissioning Board. The community equipment budgets are not pooled, and any overspend or underspend is attributed to the party that was responsible.

The final contribution by the ICB to the Joint Arrangement was £33.7m, of which £0.7m was a net overspend.

19 Related party transactions

Details of related party transactions with individuals are as follows:

The ICB has made payments under General Medical Contracts with GP practices for which members of the Board are partners of. These payments are to an organisation and not individuals. The ICB has also reimbursed practices for Locum and related costs. The figures below reflect financial transactions between the ICB and GP practices and not between Board members and the ICB. Details of payments made to GPs for their services to the ICB are included in the Remuneration report. The amounts disclosed below relate to the period 1st July 2022 to 31st March 2023.

	Payments to Related Party £m	Receipts from Related Party £m	Amounts owed to Related Party £m	Amounts due from Related Party £m
Dr Amanda Webb - ICB Medical Director - Transactions for Westrop Medical Practice	7.9	-	1.5	(0.2)
Dr Francis Campbell - ICB Partner Member - Primary Care - Transactions for Elm Tree Surgery	1.0	-	0.1	(0.0)

Partner members of the board (not remunerated):

Stacey Hunter - ICB Partner Member - Acute Sector - Salisbury NHS FT
Dominic Hardisty - ICB Partner Member - Mental Health Sector - Avon and Wiltshire Mental Health Partnership
Will Godfrey - ICB Partner Member - Local Authority - BaNES Council
Susie Kemp - ICB Partner Member - Local Authority - Swindon Council
Terence Herbert - ICB Partner Member - Local Authority - Wiltshire Council
Douglas Blair - ICB Partner Member - Community - Wiltshire Health and Care
Pam Webb - ICB Partner Member VCSE - Voluntary Action Swindon

The Department of Health is regarded as a related party. During the period the Integrated Care Board has had a significant number of material transactions with entities for which the Department of Health is regarded as the parent Department.
Great Western Hospitals NHSFT
Royal United Hospitals Bath NHSFT
Salisbury NHSFT
South Western Ambulance NHSFT
Oxford University Hospitals NHSFT
Gloucestershire Hospitals NHSFT
Avon and Wiltshire Partnership NHS Trust
North Bristol NHS Trust
NHS England
South Central and West CSU
NHS Property Services

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Swindon Borough Council, Wiltshire Council and Bath and North East Somerset Council. As part of BSW STP in 2022-23, the ICB has been both the host and recipient for funding which has been allocated to the STP.
The ICB has therefore only included Related Party Notes for Board Members and Directors.

The ICB has detailed in this note all declarations of interest for Board Members, however, only related party transactions have been disclosed where they meet the criteria of having (i) control or joint control over the reporting entity, (ii) have significant influence over the reporting entity or (iii) are a member of the key management personnel.

20 Events after the end of the reporting period

The accounts were authorised for issue by the Chief Financial Officer on 22nd June 2023

21 Financial performance targets for the 9 month period

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	2022-23 Target £m	2022-23 Performance £m
Expenditure not to exceed income	1,392.7	1,392.6
Capital resource use does not exceed the amount specified in Directions	1.0	1.0
Revenue resource use does not exceed the amount specified in Directions	1,386.2	1,386.2
Revenue administration resource use does not exceed the amount specified in Directions	15.8	13.9

22 Losses and special payments

22.1 Losses

The ICB had no losses in the period.

22.2 Special payments
for the 9 month period ended 31st March 2023

	Total Number of Cases Number	Total Value of Cases £m
Ex Gratia Payments	2	0.0
Total	**2**	**0.0**

The ICB made two special payments totalling £29k which related to care packages and were determined as a consequence of Court of Protection or Ombudsman proceedings.