NHS Dorset

Annual Report and Accounts

1 July 2022 to 31 March 2023

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Introduction

Introduction

Statement from the Chair and Chief Executive

The last year has brought a lot of change for NHS services in Dorset with the formation of NHS Dorset Integrated Care Board in July 2022, recovery of services following the pandemic and working through one of the most challenging winters on record. This could not have been achieved without the hard work, commitment, and teamwork of all staff and the valuable contribution they bring.

Some of our achievements over the last year include:

- Meeting all the statutory requirements to set up the Integrated Care Board
- Developed an Integrated Care Partnership Strategy informed by the views and experiences of people who live and work in Dorset
- Excellent results in our first staff survey as an Integrated Care Board
- Shortlisted for and successfully won national awards, including nominations in five categories in the HSJ Awards and the “Think Big” team winning three awards at the 2022 Patient Experience Network National Awards for its work on the outpatient assessment clinics at Beales and South Walks House

As we continue the recovery of services, we acknowledge this will still take time to return fully to where we were before Covid-19. We have continued to focus on the recovery of planned care services and tackling long waiting lists. We have made progress in some areas including access to cancer diagnosis and treatment, but we know there is still work to do.

Throughout 2022/23 we have seen an increase in demand for urgent and emergency care services. Working with partners we have been addressing these demands in a number of ways, most importantly looking at solutions from the views of people and communities using the services.

Building on the progress we have already made as an Integrated Care System we have been working together to improve outcomes and tackle inequalities. We recognise the importance of strengthening diversity and creating a culture of inclusion. We need to address the challenges related to high demand for care and support and focus more on promoting wellbeing to prevent people from getting ill.

We recognise that different people have different experiences when using health and care services. This includes differences in access to services, how comfortable you feel when using the services, and the impact those services have on your health and wellbeing. These differences contribute to health inequalities that are unfair and avoidable, and we are working with our communities to address these.

We have a clear vision to take forward – working together to achieve the best possible improvements in the health and wellbeing of our communities. We can only achieve this by listening to people and communities, and working together.

Our aim is to support everyone to live their best life by being more responsive and making sure the decisions we make are driven by the needs of our communities. To do this we need to understand how people live their lives and work together with communities and our partners to design the services people need.

As well as planning health services for our local communities, NHS services employ around 50,000, which is 15 per cent of the total workforce in Dorset and accounts for 11 per cent of Dorset's economy. We spend millions of pounds each year on goods and services, including food, and we have a major impact on our local environment. As such, we are an anchor institution and have an important role to play in both the social and economic development of our communities. We aim to create a lasting, positive social impact and legacy for the communities we serve.

We would like to take this opportunity to thank all our staff and those that work in the wider health and care sector for their dedication, commitment and enthusiasm. We also want to thank our communities for their support and working in partnership with us on our journey to create vibrant places where everyone can thrive.

Jenni Douglas-Todd
Chair

Patricia Miller OBE
Chief Executive Officer

Performance Report

Performance Report

Review of 1 July 2022 to 31 March 2023: statement from the Accountable Officer on performance

The following section provides the view of our Accountable Officer, and a summary of our performance.

Key Positives

The period since the formation of NHS Dorset in July 2022 has continued to be one of challenge for the NHS as a whole and our communities in Dorset. The impact of the Covid-19 pandemic continues to be felt and the rising cost of living has put pressure on our communities. Despite these pressures we are proud of the work of all our partners to continue to deliver and develop services, and there has been much positive operational performance including:

- developing new discharge pathways and implementation of our Discharge to Assess beds enabling additional capacity which has improved flow within the hospitals
- delivering our planned reduction in the number of people waiting more than 104 weeks and 78 weeks from referral to starting treatment
- continuing to be the second-best performing South West system for the number of patients waiting for diagnostics.

In addition, the report below details many examples of innovative work and positive outcomes in a range of work programmes across Dorset including the system's performance against the national standards, elective care, diagnostic services, cancer treatment, primary and community care services, urgent and emergency care, maternity services, medicines, children and young people, learning disabilities and autism, mental health, and safeguarding.

We are also proud of the research, strategic partnerships and innovation work that is underway and the progress in delivering against the NHS Dorset Green Plan.
NHS Dorset and our NHS partners are committed to providing high quality and safe care. We have continued to work hard over the reporting period to improve quality and safety, and the report details how we are achieving this.

Three further areas where we have much positive news to report is in our work to support broader social and economic development, engagement with our people and communities, and in our work to tackle health inequalities. This work is central to our delivery of the Integrated Care System purposes and is detailed in the report.

Finally, we were proud that, despite the financial challenges, NHS Dorset achieved a breakeven position across the whole of the financial period 2022/23, meaning that its expenditure was fully funded by its income. The report provides further details on the

financial performance for the reporting period, with further information available in the Annual Accounts.

Principle Risks

Many of the risks we face are common across the country, and our report details both these national risks and those that are more specific to NHS Dorset. During the reporting period the demand for urgent and emergency care services, the higher acuity of patients and an increased number of patients in hospital beds awaiting discharge continued to put pressure on our health and care providers.

The financial position has been challenging for the NHS, and we are proud to have delivered a breakeven position for this period despite these challenges. The position remains challenging for the year ahead and we will continue to work hard with partners to deliver a breakeven position and to deliver the Integrated Care System purpose of enhancing value for money.

We also have risks relating to the recruitment, retention and sustainability of our workforce. This is a risk reflected nationally in the NHS. Our Integrated Care System People Plan and NHS Dorset People Plan will help us to address these risks over the coming year and help us work towards building a sustainable workforce model.

Future Plans

The sections below on our performance during the reporting period provide details of future plans for many of the elective care, diagnostic and cancer services that we commission in Dorset. This work is underpinned by our ambition to deliver on the Integrated Care System purposes of improved outcomes in population health and healthcare, tackling inequalities, enhancing value for money and helping the NHS deliver broader social and economic development.

Over the coming year we will be continuing the work we have commenced in 2022/23 in developing our relationships with our partners and working together to deliver the best possible outcomes for our communities.

We will be working with our Integrated Care Partnership colleagues to deliver the Integrated Care Strategy.

We will be submitting the Joint Five Year Forward Plan in June 2023, and will then be working with our NHS partners on delivering the objectives which have been agreed by NHS partners to deliver the best health and care outcomes for our communities.

We will continue to work with our local authority partners and their Health and Wellbeing Boards to deliver the objectives of the Joint Health and Wellbeing Strategy.

Performance Overview

This section of the report provides an overview of NHS Dorset Integrated Care Board (ICB), its main objectives, strategy, performance and main risks for the period 1 July 2022 to 31 March 2023 following the transition from Dorset Clinical Commissioning Group.

Overview

About us

The introduction of the Health and Care Act 2022 led to the establishment of the Integrated Care Board (ICB) on 1 July 2022, a statutory organisation responsible for meeting the healthcare needs of people and communities in Dorset. The organisation moved from being a GP-led membership organisation to a unitary Board.

The Integrated Care Board for Dorset is called 'NHS Dorset' and is responsible for leading the Dorset Integrated Care System (ICS) on behalf of the system partners.

The organisation took on the functions of the Dorset Clinical Commissioning Group (CCG) and additional responsibilities were also introduced, delegated from NHS England.

We are responsible for planning, buying and monitoring (also known as commissioning) health services from healthcare providers, such as hospitals and GP practices for our local Dorset population to ensure the highest quality healthcare. We also have a performance monitoring role of these services, which includes responding to any concerns from our patients on services offered.

NHS Dorset will work with others to deliver the four national Integrated Care System strategic objectives. These objectives are to:

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

Improve Outcomes

Tackle Inequalities

Enhance Productivity

Social & Economic Development

Prior to the establishment of NHS Dorset, system leaders had agreed three values as guiding principles for how we work. These values are:

- Ambition - working together to achieve the best possible outcomes for local communities.
- Community-driven - moving to a more person centric focus, improving wellbeing, and better use of resources.
- Partnership - ensuring all organisations and individuals are population and community driven, moving away from organisationally driven behaviours.

These are underpinned by the principles of trust, honesty, respect, candour and kindness.

The Integrated Care System encompasses the following Dorset NHS organisations and local authorities:

- Bournemouth, Christchurch and Poole Council
- Dorset Council
- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- NHS Dorset Integrated Care Board
- Public Health Dorset
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust.

However, the Integrated Care System is broader than this, working in partnership with the primary care, people and communities and the voluntary, community and social enterprise sector (VCSE).

Our Constitution

Our NHS Dorset Constitution is a formal document which sets out the governing principles, rules and procedures for our organisation which will ensure integrity, honesty and accountability. It also commits the organisation to taking decisions in an open and transparent way and places the interests of patients and public at its heart. The current version of our Constitution (1 July 2022) can be found on our website. Sitting alongside our Constitution is our Governance Handbook which sets out key supporting documents.

The population we serve

We have a registered Dorset GP population of approximately 822,000 people. The area we serve also has a high transient population with university students during term time and an increase in visitors during holiday periods. Overall, the local population shows a steady increase with much of the growth happening among older people.

People in Dorset generally live healthier and longer lives compared to the average for England, but this is not evenly spread across our population – the data reveals unacceptable inequalities between different groups. One of the four strategic objectives of the Integrated Care System is to tackle inequalities in outcome and access. We want everyone in Dorset to receive the same high quality of care, regardless of where they live, what health condition they have, or any other personal characteristic.

Increased longevity brings new challenges to health and care systems, because as we grow older more of us develop long-term conditions such as diabetes and dementia. In line with the Integrated Care System's strategic objectives, we are working to improve outcomes in population health and healthcare.

Covid-19 has been one of the biggest challenges for our health and care systems for generations. Beyond the immediate impacts of the disease and system pressure are the wider long-term impacts on health and wellbeing, and the risk of further widening existing health inequalities. The impact of Covid-19 is much broader than health and, as part of the Covid-19 recovery, the Integrated Care System is working towards delivering the strategic objective of helping the NHS deliver broader social and economic development.

We also know that people who act as carers are at high risk of experiencing worse health outcomes, having their employment or education disrupted and becoming socially isolated, which in turn impacts on their role as a carer.

Our providers

We commission (buy) services from a range of providers including:

- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Salisbury NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- general practices
- third sector – which are non-governmental and non-profit-making organisations or associations, including charities and voluntary agencies
- independent sector care homes and hospitals.

How we work

NHS Dorset has developed an Operating Model setting out how we will work to deliver our priorities and objectives. It helps our teams and partners understand how we work and make decisions and provides assurance to the ICB Board on how we discharge our functions.

To reflect the functions of NHS Dorset, the internal structure has been re-aligned to comprise eight directorates led by a Chief Officer:

- Patricia Miller, Chief Executive Officer
- Rob Morgan, Chief Finance Officer
- Debbie Simmons, Chief Nursing Officer
- Paul Johnson, Chief Medical Officer
- Neil Bacon, Chief Strategy and Transformation Officer
- David Freeman, Chief Commissioning Officer
- Dean Spencer, Chief Operating Officer
- Dawn Harvey, Chief People Officer
- Stephen Slough, Chief Digital Information Officer.

Integrated Care Partnership

NHS Dorset and the local authorities in our area, Dorset Council and Bournemouth, Christchurch and Poole Council, have established the Integrated Care Partnership in accordance with section 116ZA of the Local Government and Public Involvement in Health Act 2007. In additional to local councils and local NHS organisations, membership of the Integrated Care Partnership includes representatives from the police and fire services, the voluntary and community sector, primary care, public health, Healthwatch Dorset, the Wessex Academic Health Science Network, and public engagement groups. This period, since its formation, the Integrated Care Partnership has been focusing on creating its strategy and considering the next steps in implementing its vision and priorities.

The Integrated Care Partnership works with a shared purpose towards the four national Integrated Care System strategic objectives detailed above. To support this, the Integrated Care Partnership has written a strategy outlining how it will achieve its vision to work together to deliver the best possible improvements in health and wellbeing. The Integrated Care Partnership aims to achieve its vision by focusing on three key priorities: prevention and early help, thriving communities and working better together. The strategy is based on conversations with a wide range of people including leaders in our health and care organisations, people working on the frontline, and people living and working in Dorset.

The full strategy and more information about the work of the Integrated Care Partnership is available to read on the Our Dorset website.

Performance Synopsis

The key performance highlights for NHS Dorset from 1 July 2022 to 31 March 2023 are:

- transitioning from the Clinical Commissioning Group to the Integrated Care Board including supporting staff through the transfer and ensuring we continued to deliver our responsibilities
- continued recovery of our services including:
    - continued work of the Dorset Health Villages to reduce waiting lists at Beales in Poole and South Walks House, Dorchester
    - implementing new discharge processes, including full roll-out of a discharge to assess approach for all acute to community transfers, mobilisation of new discharge to assess bedded and reablement capacity, working in partnership with our local authorities, and focused work with operational teams across health and social care to reduce hand-off and delays in discharge planning processes
- delivering a breakeven financial plan.

However, there have been a number of significant challenges including:

- the balance between system resilience, elective recovery and people recovery. We continue to operate within a backdrop of high and complex

demand, and limited workforce supply, which impacts on retention as well as staff health and well-being
- a financially demanding period
- increased demand for personal health commissioning
- maintaining and improving clinical targets.

The NHS System Oversight Framework 2022/23 describes NHS England's approach to NHS oversight for 2022/23. Its metrics align to the five national themes of the System Oversight Framework of quality of care, access and outcomes, preventing ill health and reducing inequalities, people, finance and use of resources, and leadership and capability. The annual performance review between NHS Dorset and NHS England for 2022/23 is currently being undertaken.

Key Issues and Risks

A Board Assurance Framework enables the Board and delegated Committees to focus on the strategic risks of the organisation and the residual risk which remains once all possible mitigations are in place. We agreed to retain the Clinical Commissioning Group's Board Assurance Framework as we transitioned to an Integrated Care Board. This version currently remains in place, however the Board Assurance Framework will be refreshed in the new financial year to reflect the strategic objectives set out in the Joint Five Year Forward Plan and the related strategic risks to delivery of these objectives. Further information on strategic risk is provided in the Annual Governance Statement below.

The Board Assurance Framework is supported by the Corporate Risk Register which documents the operational risks reported within the organisation. The Corporate Risk Register is regularly reported to the ICB Board and Risk and Audit Committee. In addition, the Quality and Safety Committee reviews the full Corporate Risk Register, with the other Board Committees reviewing the risks relevant to their areas of work. Further information on operational risk is provided in the Annual Governance Statement below.

We are committed to minimising risks to which we are exposed, strategically, corporately and operationally. The overriding aim is to reduce the potential for loss of services due to adverse events, financial challenges or performance and quality management of commissioned services that could ultimately be of detriment to the Dorset population.

During the period 1 July 2022 to 31 March 2023, key operational risks identified were as follows:-

Risk: Financial Challenge – if we do not meet our financial duties and/or the Dorset Integrated Care System does not manage expenditure within its financial envelope, then the impact on the future financial position will affect the delivery of services including elective recovery and will hinder transformation.

How we have addressed this: the Integrated Care Board and the Integrated Care System partners reported a breakeven position in 2022/23. The risk, therefore, was

mitigated. The breakeven position for 2022/23 was made possible largely through non-recurrent actions and therefore actions to improve the recurrent position must be found in 2023/24 if the underlying position is to be improved. Final plans for 2023/24 show an underlying deficit both for NHS Dorset and Integrated Care System which must be managed through transformation. For 2023/24, we have set a budget which will result in breakeven if delivered. Success, however, is dependent upon delivery of efficiency schemes and inflationary pressures being mitigated.

Risk: Overspend on Personal Health Commissioning - the budget, while based on outturn, provides a net increase of 4.1% across adult Continuing Healthcare. However, this increase alone does not support the increased levels of spend through uplifts on local authority frameworks to reflect cost of care exercises for which Personal Health Commissioning is a party, subsequent impacts of uplifts for non-framework providers due to framework increases, increasing numbers of individuals eligible for Section 117 aftercare services and increasing numbers of individuals eligible for Continuing Healthcare.

How we have addressed this: this risk was realised for 2022/23 and we reported a considerable overspend on Personal Health Commissioning. Whilst this was a financial risk, we reported a breakeven position at the end of the reporting period due to non-recurrent savings elsewhere in the system (see above). Work is now taking place to address the predicted deficit for 2023/24, with limited savings identified. While there are cost efficiencies that can be made through the programmes of work planned within the service, there is a need for wider engagement to address commissioning gaps, whilst also commissioning services differently to address the ongoing issue of the rising cost of care and patient growth in the Personal Health Commissioning cohorts.

Risk: Ambulance Response Times - Dorset has seen increased levels of hours lost due to ambulance handover delays, with a growing number of ambulances queueing outside Emergency Departments. Consequently, this has meant there are fewer vehicles available on the roads to respond to Category 2 incidents within the national Ambulance Response Programme Standards. Patients could experience harm as a result of the extended operational response times.

How we have addressed this: recognising the significant challenges throughout 2022/23 and that achieving the Ambulance Response Programme Standards is not currently attainable, the 2023/24 Priorities and Operational Planning Guidance has set out an interim ambition to improve Category 2 ambulance response times to an average of 30 minutes. To achieve this, the South West NHS providers have been asked to reduce handover delays to an average of 40 minutes to support the delivery of the Category 2 response times. Within Dorset, this is being achieved through system wide on-going work to reduce handover delays, ensuring 999 continue to use alternative pathways such as Urgent Care Response. Partnership work is on-going to manage this process and promoting the use of the Single Point of Access for paramedics on scene for rapid referral to other services. Ensuring the Directory of Services reflects the services that are available for 999 to utilise will also support the Category 2 segmentation process as it develops, ensuring patients are navigated to the correct resource and not added to another clinical queue.

Risk: High Demand for Acute Mental Health Inpatient Beds – the current flow and high demand for acute mental health in-patient beds, has significant implications on the wider health economy with the likelihood of patients becoming stranded in acute general hospitals or being left in community settings despite having acute mental health needs. This in turn increases the risk to patient safety. Such demand creates challenges across the general acute sector where individuals may end up waiting for a suitable bed to become available. This pressure is compounded by challenges within community mental health services where workforce pressures are limiting overall capacity.

How we have addressed this: utilising inpatient beds in a private provider in Southampton continues, to supplement local bed capacity to maximise opportunities for achieving continuing care with local teams. Additional bed capacity forms part of the agreed new hospitals programme for Dorset, which is due to come online in 2024/25. On-going development of integrated community mental health services is anticipated to address some of the on-going, underlying demand.

Risk: Capacity in the Continuous Positive Airways Pressure (CPAP) treatment pathway - during Covid-19, there were significant pressures on the treatment service due to workforce issues and an international shortage of Continuous Positive Airways Pressure (CPAP) devices. This resulted in patients waiting significantly longer for treatment. In addition to this backlog of patients waiting for treatment, the current treatment provider has closed the routine CPAP treatment pathway. This means there is now no capacity for newly diagnosed routine patients to be referred for treatment. Lastly, the current treatment service provider has served notice to NHS Dorset to cease their service on 31 July 2023. In addition to being added to our Corporate Risk Register, this issue is being closely managed and monitored from a quality and service perspective by our team and has oversight from the Deputy Chief Medical Officer.

How we have addressed this: NHS Dorset approved funding to provide an interim routine treatment pathway for all patients currently waiting at the out of area provider. This service commenced in March 2023 and will treat all patients on the routine waiting list. The interim service is working in conjunction with the current provider to facilitate a seamless pathway for patients. Clinical validation of the complete routine waiting list has taken place and patients have been escalated for treatment on the urgent pathway where clinically indicated. We have approved funding to provide an interim urgent treatment pathway to support Dorset patients which runs in addition to the urgent treatment pathway at the current provider and commenced in December 2022. We are working with Dorset system partners and have agreed an in-county Dorset Sleep Service to commence on 1 August 2023. This service will provide treatment for routine and urgent patients alongside the existing Dorset diagnostic services and will take over from the out of area service at its cessation on 31 July. Communication with patients will be paramount and is a significant aspect of the mobilisation plan. An outcome patients can expect is that all Dorset patients with suspected obstructive sleep apnoea will be diagnosed and treated in Dorset, with the service delivering the quality and standards patients expect and is nationally required of a comprehensive sleep service.

Risk: Assurance from Providers on Attracting, Recruiting, and Retaining a Sustainable Workforce – a sustainable workforce is required to deliver models of care in line with the people plans. Dorset continues to experience high demand for health services and significant delays in medically fit patients being discharged from hospital, which is due to pressures in social care, a shortfall in care home beds and domiciliary care provision. This risk reflects the need to improve system understanding of, and consistent engagement with, local authorities on social care workforce matters. This will enable a greater understanding of the role and support that local authorities provide to social care and domiciliary care providers, either directly or through partners in care.

How we have addressed this: by collectively engaging in this work, we are in a better position to prioritise and expedite the right work and actions, and identify where that work is best done i.e. individual provider, provider collaborative, or across the Integrated Care System. In April 2023, a review of the risk was undertaken and a decision was made to reduce the risk score from high to moderate. The newly revised score reflects the maturity of the people performance reporting and the development of workforce data and insight which is presented to the People and Culture Committee on a quarterly basis. As a result, the risk was removed from our Corporate Risk Register and moved to the local People Directorate Risk Register.

Performance Analysis

The following section provides information on our achievements from 1 July 2022 to 31 March 2023 and how we have worked to meet our statutory duties.

NHS Constitution standards and operational targets

Our performance against the NHS Constitution standards and key operational targets are set out in the following section. The red/amber/green rating assessment is used to indicate the performance for the period ending 31 March 2023. As noted last year, performance against the constitutional standards should be read with caution as the focus has been on coping with stages of reset and recovery following the suspension of routine activity in 2020/21.

We are proud of the continued response of the Dorset system and the way we have worked together to maintain essential services during the continued pressures on the system including industrial actions. We have prioritised the most clinically urgent patients and those with unacceptably long waits, continued to recover services, supported our staff and for some, have undergone or are undergoing organisational change, and worked with partners to develop our Integrated Care Partnership Strategy and Joint Five Year Forward Plan.

Throughout 2022-23 we have seen an increase in demand for urgent and emergency care services, higher acuity of patients, and increased number of patients not meeting the clinical criteria to reside, which has impacted on the performance across the system. We have developed new discharge pathways and implemented our Discharge to Assess beds enabling additional capacity which has improved flow within the hospitals.

During the period, we have continued to focus on the recovery of elective services, tackling long waiting lists, access to cancer diagnosis and treatment and improvements in diagnostics, theatre usage and outpatients. This has seen us deliver our planned reduction in the number of people waiting more than 104 weeks and 78 weeks from referral to starting treatment. However, our position at the end of March 2023 for all long waiting times was worse than planned due to the impact of industrial action.

We have continued to be the second-best performing South West performing system for the number of patients waiting for diagnostics with only 15% waiting more than six weeks.

Dorset is taking a population health management approach in addressing elective care health inequalities as well as undertaking a number of initiatives to ensure services are restored inclusively. These initiatives include:-

- Implementing a process for tracking new elective patients with a learning disability flag in University Hospitals Dorset and Dorset County Hospital with the aim to ensure first outpatient appointments are held within 18 weeks. We have also sought feedback from the learning disability network on

communication received and experience of outpatient appointments to improve the experience of patients.

- Development and launch of an elective care health inequalities dashboard, on the Dorset Insight and Intelligence Service platform, including key metrics for the reporting requirements for providers and the system as a whole, and additional reports disaggregating service access and activity by the index of multiple deprivation, ethnicity and minority groups.
- Wessex Alliance has supported Trusts to track recovery equitably, by a weekly refreshed dashboard summarising waiting times by deprivation and ethnicity. All Trusts review all patients on the patient tracking list weekly, with focus on those waiting over 62 days, including clinical revalidation and prioritisation.

During 2023/24 our focus will be on the equity of outcomes for patients in an elective care pathway and will include a new approach to waiting list management that also focuses on non-clinical factors to move towards equity of patient outcome. We will consider how we can develop proactive identification of patients for planned care who would otherwise only seek health support at late stages of a condition and often as an emergency admission.

Further details on the programmes of work undertaken to recover elective services can be seen below.

Table 1: NHS Constitution standards performance as at 31 March 2023

ICB based indicators	Operational standard	2022/23	2021/22	2020/21
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	92%	54.89%	60.50%	
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 104 weeks from referral - 0 by June 2022	0	0	484	14
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 78 weeks from referral - 0 by March 2023	0	116	1241	
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 52 weeks from referral - 0 by March 2025		5231	4309	8897
Clock stops at 89% or better of 19/20 equivalent	89%	99.70%	88.60%	84.00%
Advice and Guidance rate as per 100 first Outpatients Attendances	16	14.6	7.7	9.9

Patient Initiated Follow Ups as percentage of Total Outpatient Attendances	5%	7.30%	1.40%	1.10%
Outpatient virtual activity	25%	20.80%	22.90%	28.90%
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	1% (Regional ambition 25%)	14.80%	16.20%	
Maximum two-week wait for first outpatient appointment for patients referred urgently for suspected cancer by a GP	93%	55.20%	64.30%	81%
Maximum 31-day wait from diagnosis to first definitive treatments for all cancers	96%	96.10%	97.70%	93%
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	85%	66.70%	72.90%	60%
60% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral	60%	84.00%	91.30%	100%
75% of people with common mental health conditions referred to the improved access to psychological therapies (IAPT) programme will be treated within six weeks of referral	75%	96.00%	97%	98%
66.7% of dementia diagnosis of the estimated number of people with dementia	66.70%	56.00%	55.70%	56%
A&E waits – percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission of discharge: Dorset County Hospital NHS FT	95%	73.90%	65.70%	81.00%
No Criteria to Reside: Percentage of beds occupied		27.70%		
NHS 111 service: South Western Ambulance Service NHS FT: calls answered in 60 seconds	95%	86.6%	48.20%	88.0%
NHS 999 service: South Western Ambulance Service NHS FT: Category 1 mean response duration	7 mins	8.5 mins	12.3 mins	7.3 mins

Elective Care Programme

The Elective Care Programme focuses on elective recovery, including reducing health inequalities, creating capacity to meet and exceed the national planning guidance and the ambitions of the long-term plan. It does this by focusing on pathway redesign, maximising productivity and protecting elective capacity. This work is overseen by the Elective Care Oversight Group; a multi-disciplinary system group made up of commissioners, and local providers including GPs.

Elective Performance

Dorset has reduced the number of patients waiting 104 weeks to zero. The system continues to work hard to reduce the number of patients waiting more than 78 weeks. As at the end March 2023, the Dorset system had 116 patients waiting over 78 weeks against a projected position of 123.

While operational challenges have meant not achieving 104% activity across the board, Dorset has seen some of the highest volumes of activity in the region for day case and first outpatient appointment (Dorset County Hospital NHS Foundation Trust) and inpatients (University Hospitals Dorset NHS Foundation Trust). Diagnostic recovery in Dorset has also been particularly strong in the South West region across both Trusts for computerised tomography and endoscopy, colonoscopy and gastroscopy.

Good progress was made in Dorset during the period with NHS providers supporting each other's mutual aid requests. Good relationships continued with independent sector providers, often creating capacity for complex patients.

Elective Clinical Programmes

Throughout the reporting period NHS Dorset has supported several programmes across Dorset to improve access to elective care, diagnostics and cancer treatments.

Elective Prevention Schemes

- **Cardiovascular Disease (CVD):** we have supported a number of initiatives under the newly formed Dorset Cardiology Oversight Group.
    - NHS health checks: these restarted in 2022/23 and review is ongoing, the ambition is for a mixed model with GP service supported by LiveWell Dorset.
    - Community pharmacy blood pressure checks: as of January 2023, 104 pharmacies have signed up for the service resulting in 12,209 patients having 12,384 checks.
    - CVD Prevent: presentations were given to all primary care networks on CVD Prevent audit and the improvement tool with a focus on hypertension and health inequalities.

- Development of Secondary Prevention Clinics: these provide health checks for patients following heart attacks and stents to check their cholesterol and reduce the risk of a secondary event.
- Running pilots on Atrial Fibrillation (AF) and Familial Hypercholesteremia: primary care has been working with Wessex Academic Health Science Network (AHSN) support to identify patients with these high-risk conditions to reduce heart attacks and strokes.

- **Musculoskeletal (MSK):** digital funding secured from NHS England enabled the development of three shared decision aids supporting patients with good information to make an informed decision on surgery. One of these is a training resource for health and social care practitioners to support their use of shared decision making during their interaction with patients.

- **Chronic Respiratory disease:** we have supported several initiatives under the newly formed Dorset Respiratory Oversight Group:

  - the Pulmonary Rehabilitation five-year transformational plan has commenced and additional capacity is being targeted at areas of health inequality and high demand.
  - The Dorset Respiratory Oversight Group Chair has given educational sessions on asthma guidelines for all networks, including Short-Acting Beta Agonists (SABA) overuse which is higher in areas of health inequality.
  - Chronic Obstructive Pulmonary Disease (COPD) educational sessions planned for early 2023 for networks, again a condition which is widespread in areas of health inequality.
  - Additional respiratory equipment has been provided to some Primary Care Networks (PCNs) for use in the local community, targeting vulnerable populations.
  - Provided funding for the training for staff in primary care to undertake Association for Respiratory Technology and Physiology (ARTP) accredited spirometry training and registration.
  - Supported the development of the regional Respiratory Champions programme with 14 champions from Dorset networks taking part in the programme.

- **Restored diagnosis, monitoring and management of hypertension, atrial fibrillation, high cholesterol and diabetes, including:**

  - Investment locally to support long term condition management including using population health management and risk stratification to support delivery of Quality on Outcome Framework and Investment and Impact Fund priorities for 2022/23.
  - Evaluated digital proof of concept with BP@Home service and improved offers to support Chronic Obstructive Pulmonary Disease and diabetes, with a focus on prevention and self-management.

Elective Care Outpatients

- Increasing Advice and Guidance - we have enabled patients and primary care clinicians to access speedier specialist advice and avoid potentially unnecessary hospital appointment. An increased number of services offering Advice and Guidance, better join up of data systems and clearer service descriptions have resulted in around 1,200 additional requests per month.
- Patient Initiated Follow-ups (PIFU) - PIFU enables some patients to have control over whether they need to come back for a follow up based their symptoms. We have increased the number of specialities where this is available from 14 to 26 with 9% of patients being moved or discharged onto PIFU Pathways (as of February 2023). We have also used PIFU as a tool to help address the overdue follow up backlog, using retrospective reviews of patients, enabling faster access for those that need to be seen for a follow up.
- Virtual Consultations - these enable patients and clinicians use telephone or online secure video conferencing for their appointment. Around 21% of all consultations with hospital services are carried out in this way. Dorset has participated in the regional procurement and implementation of the virtual consultation software 'Attend Anywhere' for a further two years.
- NHS Dorset has supported local Trusts in developing Outpatient Assessment Centres which bring health to the high street:
- "Think Big" at the Beales shopping centre has seen growth in activity and increasing number of specialties, with further improvements to facilities and access to additional diagnostics. There has been demonstrable positive impact on waiting list reductions across a range of services including Ophthalmology, Breast Screening, Colorectal & General Surgery.
- South Walks House in the centre of Dorchester has contributed to a reduction in the orthopaedic outpatient waiting list by 60%. The pilot evidenced success that supported a successful bid for capital investment enabling the refurbishment of site into a permanent facility. This will include dedicated outpatient, diagnostics and high volume, low complexity (HVLC) procedures within the high street setting, and will be expanded to incorporate other specialist outpatient services with the aim in delivering increased activity from quarter 3 2023.
- Digital – Dorset has also seen a several digital initiatives progress in 2022/23 including:
    - Implementation of a patient portal which supports patient communication and the management of appointments.
    - Digital dictation and speech recognition.
    - Patient self-check-in kiosks within the hospitals.

Inpatients and day cases

- A business case to ringfence orthopaedic beds at Dorset County Hospital was developed and approved and is being implemented.

- Getting It Right First Time (GIRFT) High Volume Low Complexity (HVLC) is a national programme that supports health systems to work at pace to:

    - agree standardised pathways
    - adopt best practice
    - pool capacity and resources
    - achieve top 10% performance in clinical outcomes and equity of access to care for their population.

  This, in turn, allows capacity to be freed up for other surgical priorities. There are six specialties that are priorities for this programme. Further development of clinical networks has taken place in these specialties with system wide clinical leads appointed. Further progress has been made in developing a shared vision for specialties, putting patients at the centre and sharing best practice. Progress was recognised in the visit to Dorset by the national GIRFT team in December 2022. Current performance improvements against some of the GIRFT HVLC metrics include:

    - Current performance: Both Trusts do well for British Association of Day Surgery (BADS) rates with University Hospitals Dorset at 81% and Dorset County Hospital at 85% (against an 85% target). As a system Dorset is now third best nationally with rates of 82%. At specialty level improvements have been seen in Ear, Nose and Throat, ophthalmology and general surgery.
    - Orthopaedic hip and knee replacement length of stay: Dorset County Hospital has improved to 2.5 days in quarter 2 of 2022/23, from 3.2 days in quarter 4 of 2021/22. This is against a target of 2.7 days length of stay.
    - Ear, Nose and Throat (ENT) Tonsillectomy Readmission Rates – Dorset is the best nationally for adult readmissions for tonsillectomy.
    - HVLC theatre utilisation saw improvement throughout the first half of 2022/23 however, several areas of pressure impacted on our ability to sustain this performance. This is a key area of work and an enabler for continuing to reduce long waits for patients in 2023/24.

Diagnostics

Overview

The Diagnostic Board for Dorset consists of both monitoring local recovery plans for DM01 performance and oversight of programmes being undertaken including the national Community Diagnostics Programme (CDC) plans for Dorset. The Board includes radiology, physiological measurement, endoscopy, pathology and other associated diagnostic services. It links into outpatient services and cancer pathway development as well as workforce planning. The main programmes currently underway are:

- Community Diagnostic Programme
- One Dorset Radiology
- Pathology reconfiguration
- Endoscopy expansion
- Cancer pathway development.

DM01 is the recovery aim to bring the percentage of waiting lists under six weeks towards the national ambition. The target is 95% of patients seen within six weeks by March 2025 across several diagnostic modalities relating to imaging, physiological measurement and endoscopy.

Progress made during 2022/23

Over the last 12 months we have made progress within the following areas:

- Approval of the Poole hub, endoscopy equipment and South Walks House CDC business cases.
- Expression of interest submitted for endoscopy expansion strategy. An endoscopy business case for expansion in the Poole hub has been submitted and endoscopy funding for Dorchester work has been laid out. A project manager has been appointed to take this work forwards through 2023/24.
- A Physiological Science Lead is in post for Dorset.
- A Physiological Sciences stocktake is underway.
- A PhD student is being recruited with Bournemouth University to undertake research into how Community Participatory Research can support Community Diagnostic Hubs (CDHs) to develop inclusive services in partnership with local communities to reduce health inequalities.
- Work on the pathology hub build has started, with the estates reconfiguration at Dorset County Hospital finished, and work at University Hospitals Dorset continuing.
- A digital slide scanner in place on all three sites, with commissioning and training in progress
- IT integration at Dorset County Hospital for Artificial Intelligence for Targeted Lung Health Checks programme CT reporting complete and testing in progress.

Performance

- Endoscopy DM01 performance has improved from 32.3% waiting longer than 6 weeks in Feb 2022 to 25.4% in Feb 2023. This is due to the mobile service at University Hospitals Dorset and additional lists being put on in both acute Trusts.
- Imaging DM01 performance (CT, MRI, ultrasound and Dexa) has improved from 11.8% waiting over 6 weeks in Feb 2022 to 1.4% in Feb 2023.

There are some workforce and recruitment challenges in achieving DM01 performance in areas such as echocardiology and audiology. Plans are being developed to overcome these and improve performance throughout 2023/24.

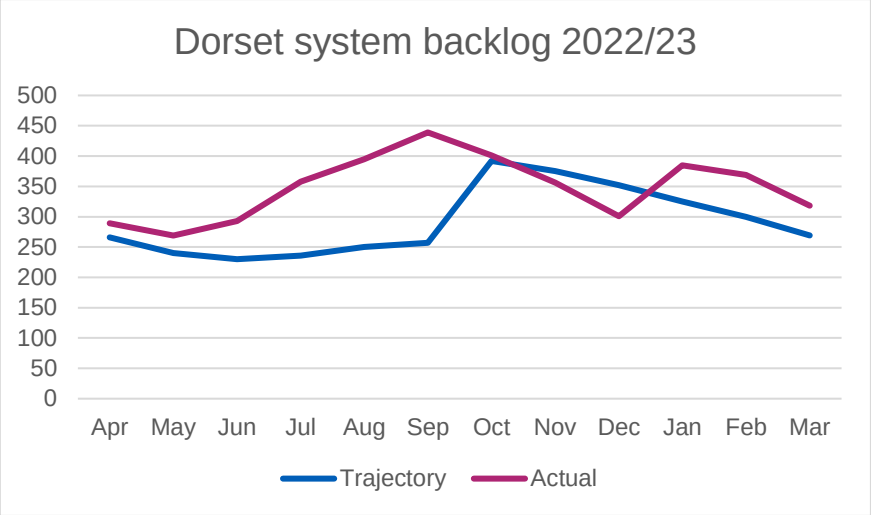
Dorset Cancer Partnership

Reducing the number of people waiting for longer than 62 days

One of the key actions is to return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020) and meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments. Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog (lower gastrointestinal (GI), prostate and skin).

Many weekend clinics and additional hours were delivered by clinical teams to manage demand across 2022/23, Dorset system working was improved particularly with breast and head and neck services and there was a continued high level of effort by services to retain staff and recruit to vacant posts. Work was undertaken within services to improve operational productivity and recruit staff including gynaecology, head and neck, and breast at Dorset County Hospital and skin at University Hospitals Dorset. Wessex Cancer Alliance provided funding which enabled waiting list initiatives in quarter 3. There was also an extra focus on validation supported by cancer navigators, administrators and Multi-Disciplinary Team (MDT) facilitators moving patients through the pathways. The chart below shows the monthly Dorset system backlog (patients waiting over 62 days for treatment).

The positive impact of the specific focus on backlog reduction in quarter 3 can be seen, however national industrial action has negatively impacted the backlog position in quarter 4. Waiting list initiatives are planned for quarter 1 2023/24 to improve the position, whilst the impact of sustainable pathway improvement schemes are realised. The position for the 27 March 2023 is a backlog of 318 against a target of 269 (Feb 2020 level). To put this into context, the volume of 2 week wait referrals into cancer services has increased between 2019/20 and 2022/23 by 50%.



The table below shows a breakdown of recovery metrics for lower GI, prostate and skin.

Table 2: Breakdown of recovery metrics for lower GI, prostate and skin

Over 62 days	Over 62 days change Feb 2020 – Mar 2023	Referral change 2019/20 – 2022/23	Treatment activity
Lower GI	17 to 50	+3312 (53%)	+139 (29%)
Urology	12 to 29	+1268 (33%)	+243 (27%)
Skin	26 to 17	+2197 (26%)	+314 (26%)

The priority actions to ensure there is enough diagnostic capacity in these tumour sites have been delivered as follows:

- Lower GI –Dorset implemented the NHS England guidance to change the lower GI 2 week wait referral pathway so that a Faecal Immunochemical Test (FIT) result is made available by primary care at time of referral for most patients, this went live in early January 2023; and at the same time a new pathway was introduced which has enabled Dorset County Hospital and University Hospitals Dorset to transfer patients from a 2 week wait pathway if referred with a negative FIT and absence of red flag symptoms. Work continues to monitor the impact and to support primary care with regular webinars, communications and data.

- Urology – University Hospitals Dorset implemented local anaesthetic (LA) precision point template biopsies in 2022/23 and has sufficient capacity to meet demand by March 2023. This is a significant time saving and also releases theatre capacity. Dorset County Hospital has made progress towards implementation and has secured a chair and space to carry out LA biopsies

with a plan to go live in early 2023/24. The prostate 2 week wait referral criteria was also updated to include revised prostate-specific antigen (PSA) ranges based on patient age which is expected to appropriately reduce the volume of referrals.

- Skin – High flow diagnostic clinics were carried out throughout the period at the new Community Diagnostic Centre location 'Beales'. This enabled an increase in productivity at University Hospitals Dorset. University Hospitals Dorset also made improvements to their service protocols to improve efficiency and recruited two additional consultants; these actions have enabled the service to recover performance and the backlog is lower than it was in February 2020. Dorset County Hospital has delivered an efficient skin service and met demand. A dermatology triage clinic was launched, this model could support the 2 week wait pathway and will be evaluated in 2023/24. Progress was made by Dorset County Hospital in developing the IT functionality to transfer images from the e-referral system to the Dorset Patient Record and this is planned to go live in May (dependent on approval from NHS Digital) enabling the introduction of tele-dermatology at Dorset County Hospital. Conversations were progressed with system partners and Skin Analytics regarding a community-based pilot.

- Dorset consistently met the 31-day treatment standard in 2022/23 up to December 2022 however this showed a reduction below standard in January 2023 which is unusual for Dorset and reflects the additional focus on validation work in quarter 3 which brought forward some additional patients into January for treatment, and the impact of winter pressures combined with national industrial action. Waiting list initiatives are planned for quarter 1 2023/24 to recover this position.

Improving performance against all cancer standards

Another key action is to improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard.

The Dorset system developed a comprehensive cancer performance recovery plan in early 2022 with support from Wessex Cancer Alliance. This was co-produced with clinicians and operational colleagues within the tumour site services and the process fostered a positive sense of ownership, engagement and system working. The Dorset Cancer Partnership recruited a new Programme Lead post for Cancer Pathway Improvement and Performance with support and funding from Wessex Cancer Alliance to take forwards this recovery plan. The Dorset system partners have worked together well to coordinate and manage risks and issues as a system, with strong clinical leadership from the Dorset system cancer Site Specific Groups and support from Wessex Cancer Alliance. System relationships were progressed particularly between head and neck and breast services.

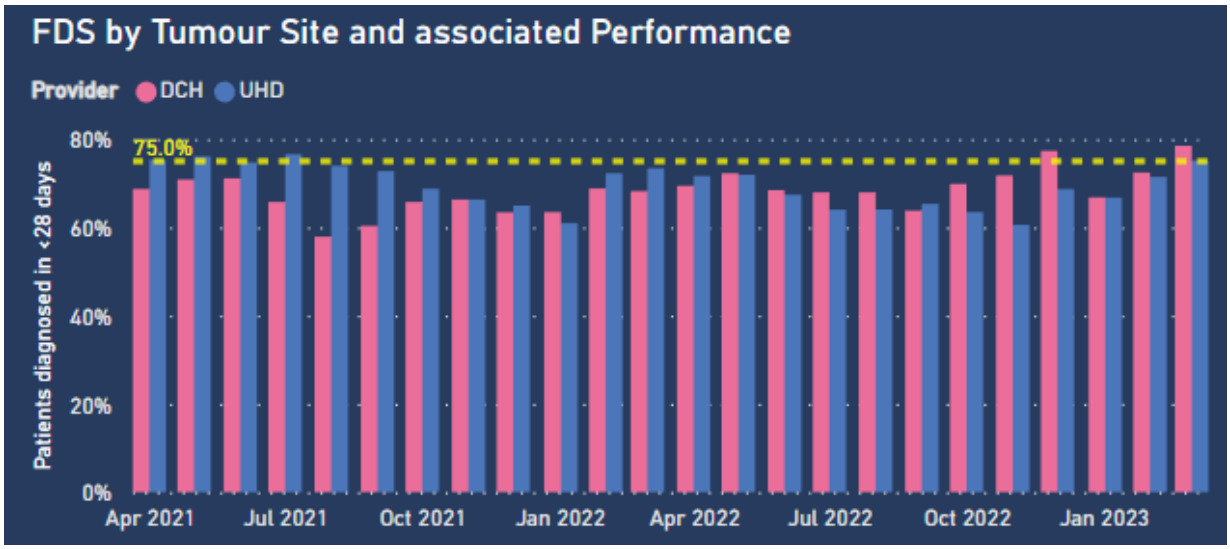
Progress was made with cancer pathway demand and capacity work carried out and pathway analysis in some services to support pathway improvement. Trusts delivered improvements to efficiency and productivity and used new Pathway Navigator and Physician Associate roles to support the faster diagnosis standard. Waiting list initiatives were also delivered to manage demand. Specific recovery plan actions were delivered including improvements to pathology turnaround time for Skin samples at University Hospitals Dorset, upgrade of the endoscopy software (HICSS), implementation of Endoscope-I at Dorset County Hospital to increase head and neck diagnostic capacity and recruitment of consultant radiographer for breast services at Dorset County Hospital.

Risk stratified follow up went live at University Hospitals Dorset and continued to be delivered at Dorset County Hospital with positive feedback from system users. This is expected to release Clinical Nurse Specialist capacity. Tumour sites live at University Hospitals Dorset are breast, colorectal and prostate, with endometrial due to go live at the beginning of April 2023. Breast, colorectal, endometrial, and prostate are live at Dorset County Hospital.

Work continued to support primary care throughout the period to deliver the NHS England Directed Enhanced Service (DES) to improve early diagnosis, referral quality and use of FIT, including a commissioned local improvement scheme supporting a network of Primary Care Network cancer clinical and non-clinical champions. Close partnership working with the Community Diagnostic Centre took place to ensure plans incorporated cancer diagnostic requirements, however this has not gone live due to NHS England funding not yet being released to enable recruitment. Dorset responded quickly to the GP Direct Access guidance and has developed a new pathway for patients with postmenopausal bleeding who are taking systemic Hormone Replacement Therapy (HRT). This is planned to go live by quarter 2 2023/24 dependent on NHS England CDC funding and is expected to appropriately reduce 2 week wait gynaecology referral demand.

From December 2022/23 both Trusts began seeing improvements to the Faster Diagnosis Standard performance with Dorset County Hospital achieving this in December 2022 followed by a reduction due to industrial pressures. Both Trusts are on an improving trajectory. This will continue to be supported into 2023/24 with waiting list initiatives in quarter 1 (dependent on funding from Wessex Cancer Alliance) whilst the remainder of the cancer recovery and sustainability plan is implemented, and benefits realised.

The 62 days from referral to treatment standard remains challenged and this is due to Faster Diagnostic Standard (FDS) performance. Most patients breaching 62 days are still within the diagnostic part of the pathway. This is further evidenced by Dorset consistently meeting the 31-day treatment standard. As FDS performance continues to improve, 62-day performance is expected to follow.



Non-specific symptom pathways

It was planned to extend coverage of non-specific symptom pathways, with at least 75% population coverage by March 2023.

The Wessex Cancer Alliance commissioned Rapid Investigation Service (RIS) has been available for all referrers in Dorset since 2020/21. Work was undertaken as part of the Primary Care work programme to support referrals to the RIS through communications and webinars, this was also enabled by the inclusion of this requirement in the Primary Care Network Directed Enhanced Service. Referral volume to the RIS service remains low despite the service being available. An evaluation found high patient satisfaction. The service will be evaluated in 2023/24 to inform the commissioning of the service by NHS Dorset from April 2024 onwards.

Prevention and Early Detection Programme

The Dorset Cancer Prevention and Early Detection Programme continued to make good progress throughout the period against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower. The progress we have made includes:

- Supported Primary Care Networks to deliver the NHS England Directed Enhanced Service, Quality and Outcomes Framework (QOF) and Impact and Incentive Scheme for cancer.
- Commissioned local improvement scheme to support Primary Care Networks (PCNs) to improve early diagnosis of cancer and to support PCNs to maintain cancer clinical and non-clinical champions.
- Worked to increase screening uptake in low uptake groups including:
    - Trialled a new video-text messaging initiative to improve cervical screening
    - Commissioned People First Dorset to review and recommend easy read screening resources.

    - Commissioned Dorset HealthCare to provide a learning disability screening uptake specialist nurse to support people with learning disabilities to access screening.
    - Worked with services that support people with Serious Mental Illness to develop approaches to supporting screening uptake.

- Commissioned and supported delivery of homeless support services in Bournemouth and Weymouth and Portland to improve symptom awareness, screening uptake, and to support people to access cancer related appointments.
- Worked with primary care to develop new pathways and supported Primary Care Networks to access these.
- Supported primary care to improve uptake of FIT and produced data through the Dorset Insight and Intelligence Service to monitor uptake against the Impact and Investment Fund (IIF).
- Targeted Lung Health Checks was launched in Portland, one of the most deprived areas in Dorset with a high number of smokers, in December 2022. This will be expanded to North Bournemouth and the remainder of Weymouth in 2023/24.
- Quit Genius smoking cessation service (digital with telephone support) continued in 2023/24 with one practice in Bournemouth with the highest smoking rate; this pilot ended in January 2023. Early evaluation shows a higher quit smoking rate compared with traditional smoking cessation services, and the pilot aimed to achieve 50% uptake from people from ethnic minorities which was achieved.
- The Wessex Cancer Alliance led Lynch Syndrome testing project identified clinical champions in Dorset County Hospital and University Hospitals Dorset and funded a joint nursing post.
- Wessex Cancer Alliance worked with the Hepatitis C Operational Delivery Network to ensure the services had sufficient capacity to provide surveillance for at risk groups. Work remains to be carried out to identify those at risk and invite them to surveillance.
- Dorset secured funds from the NHS England Innovation in Health Inequalities programme and Wessex Cancer Alliance to commission C the Signs clinical decision support tool in Primary Care Networks across Dorset as a pilot.

Primary and community care services

General practice and wider primary care providers play a key role within the health and care system, especially in relation to improving health outcomes and reducing inequalities. The focus for the community services programme is to transform and build community services' capacity to deliver more care at home and improve hospital discharge.

The highlights from our primary and community care work programme are outlined below.

Workforce

- Additional Roles Reimbursement Scheme (ARRS): work continues with Primary Care Networks to support network workforce planning, recruitment, retention and development of a range of additional roles. As at March 2023 there are 273 whole time equivalent additional roles across Dorset.
- All 18 Primary Care Networks completed their national workforce planning returns in the Autumn of 2022.
- During February/March 2023, stocktake meetings have been held with 16 Primary Care Networks to further understand their recruitment intentions for the next financial year and consider any support needed.
- Situation report (sitrep) monitoring continues and a GP Resilience Forum has been operating weekly as part of winter planning.
- NHS reservists programme: a national programme has launched to encourage people to sign up to become an NHS reservist and a Dorset-wide group continues to meet, with organisations considering expressions of interest and best of skillsets.
- A digital survey of locum GPs has been carried out, and focus groups are being arranged to gather further insight.
- A Digital locum pilot has been live since December 2022 and training has been booked with those Primary Care Networks that registered an interest. The GP Alliance has undertaken a cultural audit to understand and improve recruitment, retention and health and wellbeing and key messages are being shared.

Access to primary care

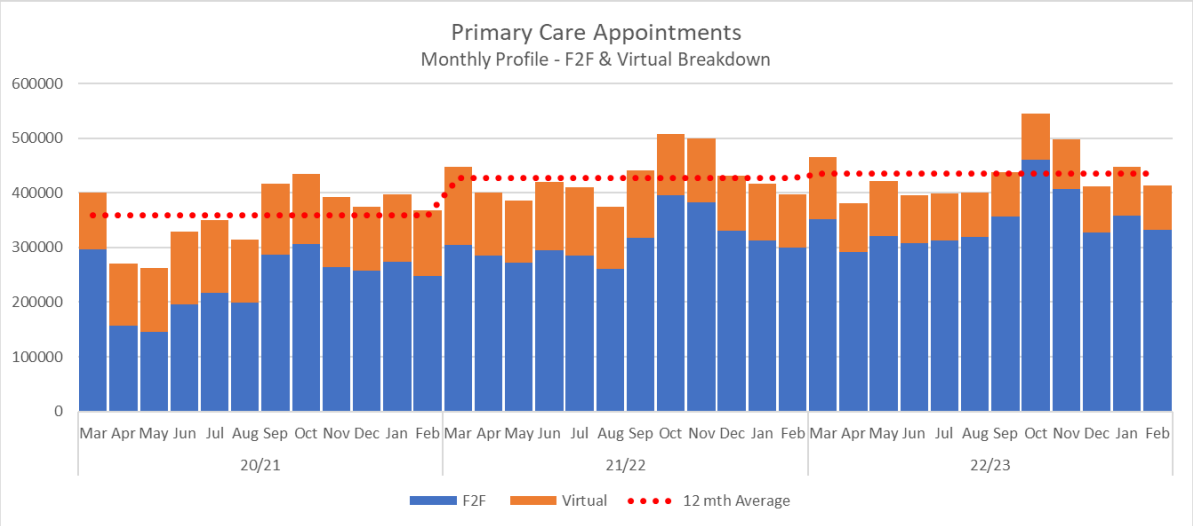
- Appointment activity continues to rise year on year, with February 2023 representing a 4.1% increase compared to February 2022. Face-to-face appointments continue to deliver 80% of the appointment volume, compared to the national average of 69.4%. If previous years' activity is to be expected, then a spike in activity will occur during March 2023. Between February and March 2021 there was an uplift in activity by 21%, and in 2022 there was an uplift of 17%. Therefore, it is forecasted that appointment activity may rise to above 490,000 for March 2023 (see below).

Table 3: Primary care appointments

Indicator	Primary care appointments (comparable 12-month periods – March to February)			
	2019/20	2020/21	2021/22	2022/23
Total recorded appointments	4,541,987	4,310,041	5,131,095	5,217,689
Annual change		-5.1%	19.0%	1.7%
Face to face appointments	3,820,005	2,845,634	3,742,382	4,146,275
Annual change		-25.5%	31.5%	10.8%
Virtual appointments	721,982	1,464,407	1,388,713	1,071,414
Annual change		102.8%	-5.2%	-29.60%

- Pre-pandemic levels of activity have now been surpassed. The average volume of recorded appointments (based on 12-month period) can be seen in the figure below the dotted red line, showing increase over both the last year and period pre-pandemic:

Primary care appointments: monthly profile face to face and virtual



- A review of the operational use of SystmOne and recording of appointment activity, including an assessment of practice/ Primary Care Network variation, data completeness and quality was undertaken providing very high validity to Dorset Intelligence & Insight Service (DiiS) activity data. A project is underway to collate all general practice data into a DiiS portal for both internal and external (approved) users. This is currently in a manual form which is utilised for general practice profiling at the General Practice Assurance Group (GPAG).

Access improvement planning

- All Primary Care Networks have now completed a winter access improvement plan to support patient access and general practice recovery.
- Enhanced Access plans provide extended access in evenings and Saturdays across all Primary Care Networks. Patients were asked for their views on this to inform what services should be provided.
- All 18 Primary Care Network plans were supported and subsequentially implemented from the 1 October 2022. In the first week of implementation over 50,000 appointments were delivered across Dorset for Enhanced Access.
- The Dorset Intelligence & Insight Service platform for Enhanced Access is currently being developed. The platform will provide data assurance and remove the need for any manual reporting.

Post COVID-19 assessment service (PCAS)

- A post COVID-19 assessment service is available again in 2022/23 to support patients who have signs and symptoms of long Covid. Dorset HealthCare provide the service.
- Up to 100 Dorset residents a month are being referred to the service to manage the condition, which includes multidisciplinary rehabilitation and therapy services.

Pulse oximetry at home

GP practices across Dorset have continued to support patients with Covid-19, particularly those who are most vulnerable, to detect early deterioration and silent hypoxia. The remote monitoring supports patients remaining at home isolating whilst having regular input from a clinician.

Ageing well

- An at scale urgent community response service is running across Dorset 12 hours a day 7 days a week.
- Primary Care Networks are delivering local ageing well plans, building on established models of care, to support urgent community response, anticipatory care, and enhanced health in care homes.
- We are engaging with Age Care Technologies to develop and pilot an

Anticipatory Care Programme. The purpose is to demonstrate methods to help older people living at home report concerns about their wellbeing, independence, social connection and social connection, staying healthy and connecting them to sources of support.

Palliative care

NHS Dorset has agreed the strategy and work is now underway to deliver this. The vision of the strategy is 'Achieving excellent, proactive, responsive, personalised and equitable palliative and end of life care for the people of Dorset and those important to them'.

The focus areas under development are:

- Community support workers with a focus on end-of-life care. This is being tested as a proof of concept in Purbeck.
- Development of a model for 24/7 telephone access for people at end of life across Dorset, their carers and professionals.
- Early identification in Primary Care with anticipatory care conversations.

General practice resilience

- Active support of practices with acute resilience issues has enabled practices to remain open ensuring the provision of high-quality care.
- A number of practices continue to require high levels of intensive support following the pandemic and we are working with the General Practice Alliance to support practices and Primary Care Networks to develop sustainable models of general practice.
- The development of the General Practice Assurance Group and Resilience Forum has enabled decision making to further support general practice resilience and identify areas of performance management.

Internal audit of delegated responsibilities

NHS England delegated functions rated 'substantial' by internal audit for three consecutive years. During this reporting period we have been focusing on our governance and decision making, improving access and preparing for further delegated authority from NHS England.

Integrated care system development

As part of the implementation of the Health and Social Care Act 2022, we have been working to ensure safe delegation and transfer of commissioning responsibility for Pharmacy, Optometry and Dentistry services to the Dorset Integrated Care Board from 1 April 2023. We are working with NHS England to ensure Dorset residents begin to benefit from this change, strengthening the role of our Clinical and professional leaders so that services can be fully integrated into our care system and place-based partnerships. There are a number of challenges we face especially around dental access and ensuring community pharmacies continue to serve each local community. Local decision making will help to ensure we can meet local needs

through the provision of community pharmacy services as well as plans to improve oral and eye health.

Quality improvement initiatives

- 100% of GP practices and Primary Care Networks have signed up to the 2023/24 clinical commissioning local improvement plans (CCLIP).
- Quality areas that general practices will be focusing on include:
    - Palliative and End of Life Care
    - Prescribing Safety and Quality in Type 2 Diabetes
    - Dorset GP Alliance - development and engagement.

Better Care Fund

The Better Care Fund supports joining up health and social care, and provides us with opportunities to improve health and wellbeing, improve quality of care, as well as enhancing efficiency and productivity. During this reporting period we have continued with current plans across both the Dorset and Bournemouth, Christchurch and Poole Councils. However, we have also had additional funding in the latter part of the reporting period to further support hospital discharges. This funding has been used to address some of the increased demand and capacity challenges that we are facing as a system, as well as enable us to further develop out future model for intermediate care services.

Planning discussions for next year's Better Care Fund have also considered how we further strengthen and expand our integrated services and how children and young people may also be included.

In addition, we are planning for the re-procurement of the integrated community equipment service and have agreed a service specification and timetable to ensure that a new contract is in place for 1 April 2023.

Diabetes and Audiology

NHS Dorset remains committed to improving the lives of Diabetic patients through the continuation of the Diabetes Transformation Programme in Dorset. Our priority for 2022/2023 has been to support Diabetic Services in Dorset with recovery following Covid-19, restoring the identification, monitoring and provision of management support for people with all types of Diabetes.

Highlights from the Diabetes Transformation Programme over the reporting period include:

- Live Well Taking Control have supported people in Dorset who have been identified as Pre-Diabetic to reduce their risk of further developing Diabetes through their Healthier You Programme. This includes support with exercise,

diet, coaching, peer support and Diabetes education. GP practices have referred 2,932 people onto the programme from July 2022 to March 2023.

- Investment has been made into the Dorset Intelligence and Insight Service (DiiS) for Diabetes data, which is helping to support services across both primary and secondary care to better understand the needs of the Dorset population. This in turn allows us to develop services which improve outcomes for people with Diabetes and tackle health inequalities in Dorset. Tools have been developed in the DiiS which provide clinicians with the ability to identify patients at risk of developing diabetes, allowing them to offer early intervention and prevention through referrals into Live Well Taking Control.
- A team of five Clinical Champions have been established to support the Diabetes Transformation Programme in delivering deep dives across Primary Care Networks in Dorset. This includes a lead GP Clinical Champion and four Diabetic Nurse Specialists who work across the Dorset Integrated Care System. This has further improved outcomes for Diabetic patients by increasing the completion of National Institute for Health and Care Excellence (NICE) treatment targets and '8 Care Processes'. Out of the eight Primary Care Networks who have had a deep dive, there was a 9% increase in the proportion of people with diabetes completing all 8 Care Processes compared to 5.7% of Primary Care Networks that have yet to participate.
- Collaborative working across both primary and secondary care has been supported through the continuation of the Diabetes Transformation Board which includes representation from NHS Dorset, Dorset HealthCare, Dorset County Hospital, University Hospitals Dorset, Primary Care, Public Health Dorset, Diabetes UK and NHS England. Further Project Groups have been developed to support the Restoration of Routine Care, Structured Education, Diabetic Footcare and Diabetes Prevention.
- Educational webinars are being provided to support professionals delivering Diabetes services in Dorset. This provides a platform for professionals to share learning and support best practice, further helping to improve patient experience and access to healthcare.
- NHS Dorset have updated commissioning guidance for prescribable continuous glucose monitoring. From December 2022 prescribable continuous glucose monitoring (CGM) devices have been recommended by Diabetes specialist healthcare professionals for those people with type 1 Diabetes. From 1 April 2023, Diabetes specialist healthcare professionals will be able to recommend these devices to limited groups of people with insulin treated type 2 Diabetes.

For audiology services, we continue to bring service teams together to align our offer across Dorset as an all-age service offer as part of a plan to bring services into a single provider. Our focus has been on:

- Improved referral pathways and waiting list management
- Embedding consistent clinical pathways

- Better use of community sites to improve access
- Developing and embedding a new clinical record system that can also support monitoring of impact.

Urgent and Emergency Care Programme

Our Urgent and Emergency Care Programme is responsible for setting the strategy and delivery plans for the urgent and emergency care (UEC) pathway, reducing fragmentation, increasing integration and reducing health inequalities. It is also responsible for the System Control Centre (SCC) and Emergency Preparedness Resilience and Response (EPRR) functions.

The system has faced significant challenges throughout 2022/23, with our acute Trusts declaring Business Continuity or Critical Incidents in times of extreme demand and pressure.

We have seen an increase in demand for urgent and emergency care services, higher acuity of patients, increased number of patients not meeting the clinical criteria to reside and continued to manage the impact of Covid-19, flu, Respiratory Syncytial Virus and the industrial action from 999 Ambulance and the Royal College of Nursing.

During 2022/23 we have progressed the following areas:

- Supported the implementation of the Dorset 999 Emergency Ambulance transformation deliver plan including:
    - Securing additional ambulance resource to support more timely transfers for lower acuity incidents and GP admissions into hospital, supporting access to Same Day Emergency Care (SDEC) pathway.
    - Enabling referrals from the 999 emergency operations centre (EOC) into the Urgent Community Response (UCR) service.
    - Continuing to undertake our assurance role including programme and performance management support for ambulance handovers in order to reduce the number of delays.
- Successful re-procurement of the Non-Emergency Patient Transport Service (NEPTS), with a planned go live date of 1 July 2023.
- Implemented a 7-day working System Control Centre (SCC) to support managing the demand within the system to help patients get access to care and treatment as quickly as possible.
- In July 2023, NHS Dorset became a Category One responder which saw us take on more duties for the management of emergencies, such as:
    - Assess the risk of emergencies occurring.
    - Putting in place emergency plans.
    - Putting in place business continuity management arrangements.

    - Maintaining plans to inform and advise the public in the event of an emergency.
    - Sharing information with other local responders to enhance co-ordination
    - Co-operating with other local responders to enhance coordination and efficiency.

- We have implemented the changes required for us to take on these additional roles and responsibilities:

    - Implementation of the Discharge and Flow Targeted Improvement programme.
    - Commencement of the Urgent Care Out-of-Hospital Project, with engagement from system clinicians.

- Implementation of a new High Intensity User Service.
- Enhanced System Communications to urge the public to use services appropriate to their needs.
- Continued to work across our teams to provide assurance to the system regarding Urgent and Emergency Care services.
- Improved access along the Urgent and Emergency Care pathway working in collaboration with our Integrated Care System partners, Dorset population and key stakeholders.
- On-going design of an out-of-hospital infrastructure including Urgent Treatment Centre configuration that will reduce fragmentation along Urgent and Emergency Care pathways and increase integration, ensuring that patients have their urgent need met by the optimum number of interactions.
- Continued to embed the Integrated Care Partnership strategy, Operating Plan and Urgent and Emergency Care Recovery Plan into the Urgent and Emergency Care programmes of work, developing a Urgent and Emergency Care Portfolio, focusing on reducing health inequalities, at programme and project level, through better use of data.

Maternity

Our Dorset local Maternity and Neonatal System (LMNS) are committed to assuring safe and quality services for the Dorset system with full and ongoing oversight of quality and safety, and where it informs service transformation. Work continues to ensure delivery of all the actions arising from the Ockenden Report and focus on the East Kent review remains a priority. The LMNS are responsible for the delivery of the national maternity transformation programme recommendations, including the priorities of the Better Births review, the Long-Term Plan and Neonatal Critical Care Review.

We continue to make progress in the following areas:

Improving outcomes in population health and healthcare, including helping the NHS support broader social and economic development

- Ockenden Insight visits completed at the Dorset Trusts to assess progress against the seven immediate and essential actions including workforce and planning guidance.
- Pan Dorset learning from Serious Incidents and an agreed buddy with Somerset LMNS for wider shared learning.
- Shared learning via the LMNS and Operational Delivery Network Neonatal Network and actions identified where there are issues or instances where Dorset women do not give birth in the right hospital.
- As one of 14 early implementor sites, work has progressed to improve the prevention, identification and treatment of pelvic floor dysfunction.
- Mobilising the new maternal mental health service delivering on the Long-Term Plan ambition.
- Embedding the expanded maternity voices representatives' model.

Specifically tackling inequalities in outcomes, experience, and access

- Finalised equity and equality needs assessment, gap analysis and co-produced action plan
- Maternity Matters Website translation tool now in use at both acute Trusts following a review of themes from patient safety investigations.

Specifically enhancing productivity and value for money

- Ongoing work to deliver benefits following implementation of a Pan Dorset maternity digital system (BadgerNet) to enable personalised care plans (women's access to handheld records) and interoperable maternity records
- Leadership model.

Medicines Optimisation

Supporting Medicines Commissioning and Prescribing

Pharmacy leaders in Dorset work collaboratively to drive improvement in medicines optimisation, safety, cost effectiveness and efficiency through an integrated Medicines Optimisation Committee and shared formulary.

The formulary is maintained and updated through robust decision-making processes involving doctors, specialists, pharmacists and pharmacy technicians. This includes ensuring NHS Dorset meets its statutory responsibilities for making medicines with a positive National Institute for Health and Care Excellence technology appraisal (NICE TA) available to commissioned services within the statutory 90 days of publishing, or 30 days where a technology appraisal has been identified for rapid access. Nineteen NICE TAs received positive appraisal since July 2022 and were added to the formulary for providers to implement.

Increasing Access to Care

The GP community pharmacist consultation service (GP CPCS) is a nationally commissioned advanced service. Roll-out of the service in Dorset has been in partnership with NHS England Improvement South West and the Local Pharmaceutical Committee and was a key part of the winter access plan. This included securing a digital platform to aid referral from March 2022. Training and implementation support is ongoing for both community pharmacies and GP practices. Since implementation began, over forty GP practices are now referring patients to community pharmacies which means they are able to free up GP time and access for more complex cases.

Dorset has challenges in the pharmacist and pharmacy technician workforce and a pharmacy faculty is supporting the initial education and training, looking at ways to work with partners to train more pharmacy technicians in Dorset and attract and retain pharmacists in the county. This includes making placements available for students and trainees in community pharmacy, general practice, hospitals, the community and within our medicines team.

Improving collaboration for population health

Our Medicines and Communication teams have transformed our communications and messaging to professionals working with medicines across Dorset via www.nhsdorset.nhs.uk/medicines. This includes the use of trusted newsletter formats to enroll subscribers and increase our reach, using automation and tailoring messages to sector professionals.

The Medicines team has worked with Population Health and Business Intelligence teams to apply data on differences in medicines use and the impact on communities. This enables identification of unmet need and potential inequalities, which supports planning to address these.

Through adoption of a national medicines procurement initiative, we have seen more than 2,000 extra people treated with oral anticoagulants to reduce risk of stroke, without incurring additional costs.

The Medicines team worked with Primary Care Networks to ensure that structured medication reviews were targeted at people who were most at risk of medicines harm. These evidence-based reviews with clinical pharmacists put each person at the centre of decision-making around their medicines and aim to reduce medicines-related harm and unplanned admissions. More than 27,000 structured medication reviews have been completed in general practice in 2022-23 to an eligible population of 61,000.

This collaborative effort to target those most at risk has contributed to reducing the number of people prescribed combinations of medicines that increase the risk of gastric bleeding by half in Dorset.

Children and Young People

Special Educational Needs and Disabilities (SEND)

The Health and Care Act (2022) transferred all relevant statutory duties from Clinical Commissioning Groups to Integrated Care Boards (ICBs). As part of this ICBs must continue to deliver the commissioner duties set out in Part 3 of the Children and Families Act 2014 and the SEND Code of Practice (2015) statutory guidance. This includes jointly commissioning services for children and young people with Special educational needs and disability (SEND), with local authorities.

Our Children and Young People Team have worked in partnership across the system, to ensure that services commissioned for SEND meet the statutory requirements, as set out in the Children and Families Act (2014), Code of Practice (2015) and are relevant to the identified health needs of the local area and population to deliver an effective, high quality integrated pathway. We have committed to our statement of intent during the period July 2022 to March 2023 by:

- Commissioning services in partnership with our local councils for children and young people aged 0-25 years old with SEND.
- Working with the local councils and NHS health provider organisations to contribute to the Local Offer to include information about health care services.
- Working in partnership with Parent Carer Forums, support groups representing young people with SEND, Healthwatch, the voluntary sector and community groups.
- Ensuring there is health care provision as specified in the Education, Health, and Care Plan (EHCP) as part of our commissioning role.

Co-production has been our golden thread and has resulted in the publication of a Dorset Partnership Agreement with Dorset Council (DC) and Dorset Parent Carer Council (DPCC). We have also worked with Bournemouth, Christchurch and Poole Council (BCP), Parent Carers Together (PCT) and wider community groups to develop Co-Production Charters for parent carers and children and young people as well as wider resources and workforce development opportunities.

Joint Commissioning for SEND

A Joint Commissioning Plan with Bournemouth, Christchurch and Poole Council (BCP) has been developed. This is outcome focused and acknowledges the need for us to build on joint commissioning opportunities. The priorities for 2022/23 included Emotional Health and Wellbeing, Speech and Language and Autism Spectrum Condition, all of which will carry forward in to 2023/24.

We have continued to work with BCP to address the areas of improvement as part of the Written Statement of Action agreed following the SEND inspection 2021 with clear areas of improvement including, culture, workforce sustainability and ensuring a graduated response to meet need.

We have also continued to work with Dorset Council. Their SEND Strategy has six clear priority areas for attention. Each priority has associated supporting actions, these actions, in the first instance, are focused on the first year of delivery. The six strategic priorities are:

1. Early Identification and Support
2. Inclusion
3. SEND Pathway
4. SEND Sufficiency and Provision
5. Transitions and Preparation for Adulthood
6. Managing Money and Resources

Children and Young People (CYP) Transformation Programme

Our work to deliver on the national CYP Transformation Programme and the ambitions in the Long Term- Plan, has been progressed as part of a developing local landscape as an Integrated Care Board and our role as part of the Integrated Care Partnership.

Encompassing a system-based approach, our areas of focus have been to:

- Ensure that we have a clear understanding of the needs and priorities of children and young people in Dorset and develop integrated care approaches that is based upon their voice and involvement.
- Deliver the outcomes within the national bundle of care for children and young people with Asthma.
- Develop the provision of community-based Acute Respiratory Infection Hubs with a focus on treating children to reduce hospital admissions.
- Reduce variation in access and care for children with diabetes, in particular, around access to technology and supporting young people to manage their diabetes as they move into adulthood.
- Development of a whole systems approach to healthy weight for children.
- Understanding the local population needs and developments to be considered for children with Epilepsy.
- Improved access to provision and support for children with bladder and bowel management needs.
- Ensure that the urgent care needs of children and young people are part of local system remodelling and design to access care in the right place.
- Recognise opportunities to support both the physical and mental health needs of children and young people as part of a holistic and integrated model of support.
- Support the system wide recovery of elective care services for children.
- Understand where transition for children and young people works well, where there is need for improvement and develop recommended approaches to ensure that the experience is positive for all.

All Age Neurodevelopmental Review

Working with the mental health and learning disability team the all-age autism neurodevelopmental review has continued to make progress towards developing a care pathway that will result in service improvements delivered by the system. Guided by the co-design process, undertaken with stakeholders in 2021, there has been detailed work to turn ideas into action. Highlights include the launch of a pilot autism training programme for health and social care staff and development of a neurodevelopmental website information hub for individuals, families and professionals.

We have also worked closely with our system partners to take forward the options which emerged from co-design workshops. In 2023/24 work is planned to explore the professional skill-mix that could make up the future assessment and diagnosis model of care in Dorset.

Paediatrics in Primary Care (PiPC)

Paediatrics in Primary Care continue to achieve many of the ambitions of the Dorset Integrated Care System. We have provided support to the system in embedding secondary care outreach clinics across the Primary Care Networks, working in partnership with primary care practitioners to develop relationships and share knowledge and skills across the pathways of care.

Our Children and Young People team has also maintained, and continues to test and trial, paediatric multi- agency team meetings across several Primary Care Networks. We have also continued to support the development of 'Healthier Together', a key enabler towards integration between primary and secondary care.

Speech, Language and Communication Needs

The speech, language and communication transformation programme has continued to progress towards a speech, language and communication pathway. Key areas of work within this transformation programme have included:

- increasing investment in commissioning arrangements
- commissioning an online resource for all, containing national and local speech language and communication need information, training and education resources
- ongoing development of the system level transformation plan
- ongoing development of the speech and language service transformation plan.

Universal Family and Care Leaver Covenant

NHS Dorset has been selected as a 'pathfinder' ICB, developing a programme to enable care-experienced young people to access employment and training opportunities across Dorset in a supported way. This is being planned through co-design. Workforce awareness and training will also be in place, preparing the work

environment to be informed and understanding of the additional challenges being care-experienced may pose. The aim is to enable an inclusive employment experience – responding to the needs of the employee, working towards reducing inequity of opportunity and improving life outcomes for this cohort.

Learning Disability and Autism

Priorities for learning disability and autism are outlined within the NHS Long Term Plan and the key headlines are to:

- Improve community-based support so that people can lead lives of their choosing in homes not hospitals, further reducing our reliance on specialist hospitals, and strengthening our focus on children and young people.
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs.
- Ensure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access, experience and outcomes from care and treatment.
- Reduce health inequalities, improving uptake of annual health checks, reducing overmedication through the Stopping The Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR).
- Continue to champion the insight and strengths of people with lived experience and their families in all our work and become a model employer of people with a learning disability and of autistic people.
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.

We have continued to work with our system partners to progress and deliver our plan to improve the care and treatment of people with a learning disability and/or autism. Key highlights include:

- Oversight and ongoing facilitation of Care and Treatment Reviews (CTR) for individuals at risk of hospital admission or placed in specialist hospital settings. These reviews focus on ensuring care is personalised and delivered to a high standard with the overarching aim of enabling individuals to be cared for in community-based settings closer to their home setting. The table below is for the period 1 April 2022 to 23 March 2023.

Table 4: Care (education) and treatment reviews

	2022/23	2021/22	2020/21	2019/22
Total number of CTRs where admissions avoided	26	35	37	28
Total number of CTRs with adult admissions avoided	17	15	16	7
Total number of CETRs where children and young people's admission avoided	9	20	21	21
Number of adults admitted	23 (1 admitted twice and 1 admitted 3 times)	18 (1 admitted three times and 2 admitted twice)	10	8
Number of children and young people admitted	13 (2 young people admitted twice)	8	6	8
Number of discharges	28 (3 discharged twice)	29 (1 discharged four times, 1 discharged three times, 4 discharged twice)	12	14 adults 10 children

- Developing and testing new approaches for the Dynamic Support Register aimed at identifying individuals at high risk of hospital admission and/or placement breakdown enabling pro-active intervention to take place.
- Through the use of NHS England capital grants, developing bespoke accommodation for named individuals enabling discharge from long term hospital placements.
- Concluding the Safe and Wellbeing Reviews undertaken to assure that all Dorset residents placed in specialist inpatient settings are safe and well and receiving high quality of care.
- Developing co-produced toolkits to support primary care when undertaking annual health checks for people with a learning disability. This, along with a real time business intelligence dashboard, has supported efforts to increase the rate of uptake despite the ongoing impact of the Covid-19 pandemic. The Dorset system achieved an uptake rate of 82.3% as at 31 March 2023 (an increase from 72% in 2021-22). This represents the highest uptake of learning disability annual health checks for the local system.
- Continuing to progress a co-produced review of local pathways of care for individuals of all ages who are neurodiverse.
- Launching the Keyworker Project to scope a service design to support children and young people up to 25 years who are heading towards a mental health crisis.

We continue to support the priorities against the Learning Disability and Autism Long Term Plan.

The learning disability annual health check uptake for 2022/23 has exceeded the Long Term Plan target of 75% of the learning disability register uptake. This is a first for Dorset.

There has been a move to a model of hybrid care (education) and treatment reviews following the lifting of Covid-19 restrictions.

Mental Health

Table 5: NHS Constitution standards performance as at 31 March 2023

Financial Years	2021/22 £	2022/23 £
Mental Health Spend	119,910,603	128,986,862
ICB Programme Allocation	1,153,877,000	1,327,477,000
Mental Health Spend as a proportion of ICB Programme Allocation	10%	10%

The mental health and wellbeing of local communities has been a key area of focus for NHS Dorset with noticeable increases in demand for support across a range of services observed since the Covid-19 pandemic. Lower life expectancy associated with severe mental illness is also a key health inequality that we are striving to address. Service improvement and mental health transformation programmes have continued to progress.

Co-production with our statutory and non-statutory partners, communities and people with lived experience remains at the heart of all this work. Key developments over the last 12 months include:

- Development of an integrated primary and community model of care for the management of adult mental health needs. This has seen strong partnership work across the system involving our statutory mental health service provider, primary care, local authorities, local voluntary and community sector and people with lived experience come together to re-imagine how services can be provided in a way that puts the individual at the heart of their own wellbeing and recovery plans. This has culminated in an opportunity to test out a new way of working at a local neighbourhood / primary care network level that seeks to remove historical barriers between services.
- Aligned to this we have expanded the number of primary mental health workers based in GP practices, enabling people to access more timely support at the time of need.
- We have continued to improve the uptake of physical health checks for those with a serious mental illness by building on previous years' developments with

the addition of dedicated outreach to engage with individuals who traditionally are less likely to engage with the programme. This continues to be a key workstream to support a reduction in heath inequalities.

- Following additional new investment, local perinatal mental health support has been expanded. This broadens the scope of support offered to include children up to the age of two years and partners. It has also seen the introduction of a new maternal mental health service element based within local maternity units.
- A new model of care for Dementia has continued to bed in with improvements continuing to be made in the memory assessment process but equally important within the post diagnostic support available to individuals and their families. This was one of the key features people asked for as part of the Dementia Services Review with a key element being the introduction of Dementia Co-ordinators which have been well received.
- Improving the level of support our children and young people's mental health services can provide is a key priority for NHS Dorset. Work has been completed to re-model local children's eating disorders provision so that it is able to respond in a timely way to rising demand. Implementation of the expanded service continues to progress.
- A dedicated crisis alternative for students and young people aged 18-25 years was also co-produced with local university students and the University Retreat formally opened in March 2023. This provides a bespoke mental health space for students from Bournemouth University (BU), Arts University Bournemouth (AUB) and AECC University College to use whenever they need support. It is a safe and welcoming space for any student struggling with mental health and potentially approaching crisis point.

Children and Young People (CYP) Safeguarding

We have continued to fulfil our statutory responsibilities providing clinical, professional and strategic leadership in safeguarding, promoting the health needs of children in care and care leavers, and reducing child mortality. We have worked in collaboration with our key local partnerships including the Pan-Dorset Safeguarding Children Partnership, the Dorset and Bournemouth, Christchurch and Poole (BCP) Safeguarding Adults Board, the Community Safety Partnerships in the Dorset and BCP local authority areas, the Corporate Parenting Boards of the Dorset and BCP local authorities, and the Pan-Dorset and Somerset Child Death Overview Panel.

Safeguarding children - we continue to work in collaboration with partners through the Pan-Dorset Safeguarding Children Partnership. The partnership has prioritised tackling child exploitation, reducing the harm from sexual abuse, recognising and responding to the impact of domestic abuse on children, and supporting children to maintain positive mental health and emotional wellbeing. We learned about the importance of identifying harm that occurs within families from Child Safeguarding Practice Reviews carried out during the reporting period.

Children in Care and Care Leavers - the number of children and young people in care has remained consistent at just under 1,000 children aged 0-18. This is an increase of approximately 6% from the previous year. We are leading a project to improve the process for delivering Initial Health Assessments (IHAs) which are used to develop personal health plans for children and young people who come into care. An additional clinic providing IHAs was implemented to accommodate an increase in the number of unaccompanied asylum-seeking children coming into Dorset to ensure their health needs were identified at an early opportunity. Priorities for the year ahead include improving the way the NHS supports the 900 care-experienced young people aged 18-25 in Dorset, improving the process for adoption notification and record reviews, criminal exploitation screening for children in care, and the launch of a new pregnancy pathway for children in care.

Safeguarding adults - dominant themes in safeguarding referrals made by NHS professionals were concerns about neglect, self-neglect and omissions of care. Self-neglect was identified as the primary theme in two of the six Safeguarding Adults Reviews undertaken. We have continued to embed the principle of 'making safeguarding personal' into healthcare delivered to adults, supported by an audit commissioned by the Safeguarding Adults Board. Work continues in developing a local model and process for the delivery of the anticipated Liberty Protection Safeguards.

Community safeguarding - we are preparing for the introduction of the new Serious Violence Duty through our existing collaborative, working with partners through the local Community Safety Partnerships. We reviewed and updated a domestic abuse toolkit for General Practice and undertook an audit to ensure that the toolkit was embedded in practice.

Safeguarding in Primary Care - our named GPs have continued to support the identification and implementation of learning from safeguarding reviews whilst also working collaboratively with partners to facilitate quality and process improvement. The completion and analysis of the Primary Care safeguarding audit has also been undertaken to help identify areas of support and help guide future strategy. The named GPs have also provided safeguarding lead training and provide practice support and assurance visits to each practice in Dorset.

Child mortality - we work with partners to understand and reduce the cause of child mortality through the work of the Pan Dorset and Somerset Child Death Overview Panel (CDOP). As well as undertaking reviews and learning events, the panel supplies thematic information and learning to the National Child Mortality Database. This database is utilised by Government and national partners to develop national strategies for improving the life expectancy of children in the UK. The CDOP annual report is published here.

Research and Strategic Partnerships

Our vision for research is for every person in Dorset to have the opportunity to take part in research by harnessing the collective assets, skills and expertise across the Dorset Integrated Care System, working in a collaborative and co-ordinated way. Our

aim is to deliver outstanding research fully aligned to the needs of the people of Dorset and to clinical services, and to continue delivering excellent research within our institutions, focusing on condition-led research and trials.

To ensure that Dorset's current research activity supports and delivers outcomes for the people of Dorset, we have focused on the following five key holistic areas of research:

- Tackling health inequalities
- Empowering patients and communities
- The wider determinants of health
- Public health
- Technological solutions to workforce shortages.

In 2022/23 we have focused on delivery on four main areas:

- The people of Dorset – delivering research required to support Dorset's people, in a space close to their homes and communities.
- Our workforce – creating research opportunities for all our staff, empowering our staff to use and embed research into practice.
- Working in partnership – fostering a research ecosystem with partners where diverse and transformative people and ideas can thrive.
- Management of research – creating an efficient approach to managing research in Dorset across all our health and care organisations, including improving the understanding of research in line with the government's Future of UK Clinical Research Delivery paper.

In 2022 NHS Dorset along with Bournemouth University, University Hospitals Dorset and Dorset County Hospital joined Wessex Heath Partners. Wessex Heath Partners also brings together Bournemouth University, the Universities of Portsmouth and Southampton, the two Integrated Care Systems covering Dorset and Hampshire and the Isle of Wight, most of the NHS providers in the two Integrated Care Systems and the Wessex Academic Health Science Network. As Wessex Heath Partners develops it is envisaged that other partners will join.

The commitment from health and care systems in Dorset and Hampshire and the Isle of Wight to build stronger partnerships with local universities will allow Wessex Heath Partners to continue to develop, with the ambition of becoming an Academic Health Science Centre.

This will improve health and care services by translating early scientific research and innovation into benefits in healthcare at local and regional level, linking with local authorities and industry. The bridge between Wessex Health Partners and the Wessex Academic Health Science Network remains key to realising research (Discovery) and the innovation and adoption (Develop and Deploy) to improve or transform the delivery models for health and social care in Dorset.

Highlights during the reporting period include:

- A clear statement of common purpose: *A Partnership that learns together and accelerates improvements to health and social care through innovation, research, and training for the benefits of patients and wider society.*
- A preliminary mapping of significant research assets across Wessex Health Partners.
- A survey of the Discover, Develop, Deploy pathway from the perspective of researchers, innovators, and adopters in Wessex.

Supporting the people of Dorset to undertake research in a space close to their homes and communities has been the cornerstone for direction of travel in 2022/23. Dorset's population is unique, it has one of the oldest average life expectancies of 84.6 years, with 28.6% of its residents aged 65+ years, compared to the national average of 18.3%. This, along with a higher proportion of population aged 50-64 years, has a significant impact on the health and care system and wider economy. Understanding this remains key to understanding the wider determinants of health.

We will increase access to research for the population of Dorset through increased awareness of research as well as enabling participation in research studies. We want to take research to communities and under-served groups through community hubs.

We also aim to establish research hubs closer to home. The aspiration was for development of four research hubs within our Health Villages, to be co-located with community diagnostic centres and community wellbeing hubs. Initial locations now established over 2022/23 include:

- Beales, Dolphin Shopping Centre – Poole
- South Walks House – Dorchester
- AECC University College – Boscombe
- Lindon Unit – Weymouth (due to be operational in May 2023).

In addition, we will continue to work with the third sector charity the HealthBus Trust to providing a roaming research hub to reach communities such as the homeless. To reinforce this activity, we have invested £500,000 working with Wessex National Institute for Health and Care Research to purchase two additional Research Buses to extend our reach across Dorset. This are due to be delivered in Summer 2023.

These living labs, both fixed and mobile, will give agility and reach across the community of Dorset.

We are working to create the appropriate large-scale physical infrastructure to aid research as an extension of the living labs, as a future international exemplar research and development space. This will act as a magnet for attracting leading edge industry research companies to locate in Dorset creating wealth and employment. Engagement work commenced and students at Arts University

Bournemouth began to explore the design concepts. This has included working with stakeholders to inform this work and bench marking against other models worldwide.

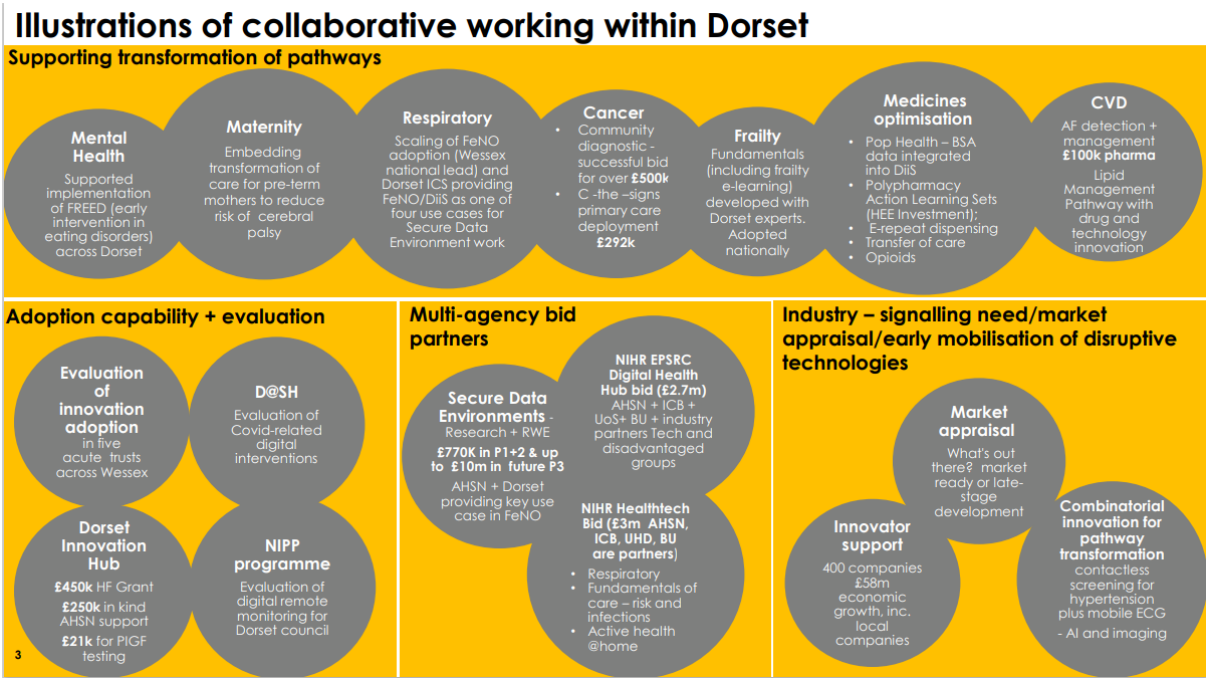
We are also aiming to expand the Patient Research Ambassadors programme across Dorset. Dorset County Hospital established volunteer Patient Research Ambassadors in 2018, their role includes raising awareness of research and informing the design of research at the hospital. We are now seeking to expand this model to provide engagement and involvement across Dorset. The creation of the Dorset-wide Voluntary and Community Sector Assembly (VCS Assembly) in 2022 has allowed us to appoint Research Ambassadors to engage with NHS Dorset in the early stage of research design.

NHS Dorset is actively working to build upon the opportunity that the Integrated Care System can offer: a change of culture but with a unique selling point to focus on people and community, with prevention and partnership at the heart of our change initiative in research. Our aim is to continue aligning research as a key component of system working, and to remain curious.

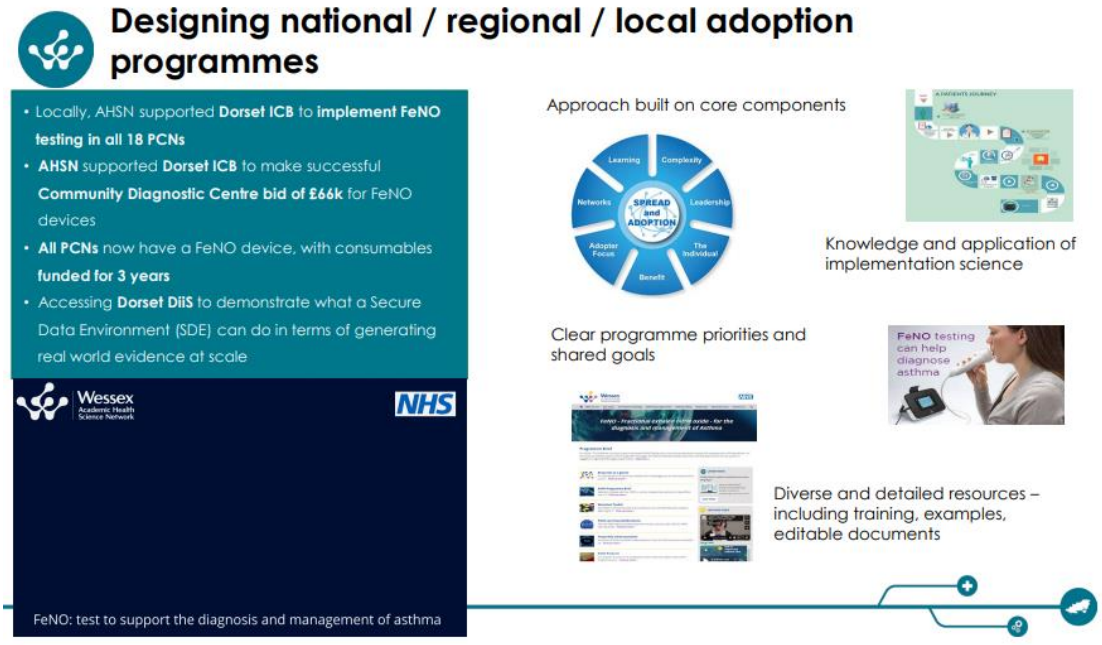
Innovation

NHS Dorset in 2022/23 has continued to strengthen its partnership with Wessex Academic Health Science Network, using this as our primary platform to connect with the wider life science networks, industry and academia to bring innovation to our community and enable innovation in the community.

In 2023 Wessex Academic Health Science Network appointed an Associate Director for Dorset. The focus is now to align the four Integrated Care System purposes and the Dorset Integrated Care Partnership Strategy and objectives, with Wessex Academic Health Science Network in a supporting role. Supporting the transformation of pathways has been cemented in the Wessex Academic Health Science Network Operational Plans for 2023/24. Illustrated below is what has been achieved in 2022/23. We will now re-evaluate and realign our portfolio of programmes to support the strategic objectives.



In the previous 36 months up to March 2023 over 450 innovations have been supported across the wider Wessex Healthcare Sector, with the creations of 256 jobs directly helping NHS Dorset support broader social and economic development. One such innovation has been the design, and adoption of a regional programme to support Dorset's population with the implementation of Fractional Exhaled Nitric Oxide (FeNO) Devices.



The Dorset Innovation Hub is one of four Health Foundation Adoption of Innovation Hubs and is currently hosted by University Hospitals Dorset. The Dorset Innovation Hub is a partnership of all Dorset health and care organisations (see below) that

provide expertise to spread and adopt innovation across Dorset. Further information on the work of the DIH is available at: [Innovation – Our Dorset ICS Innovation]

Funded for two and a half years to establish and embed a sustainable innovation impact and culture in Dorset, the Dorset Innovation Hub works within system partners' objectives and work programmes to embed a culture of innovation and sustainable adoption of prioritised evidence-based innovation within Dorset. This includes collaborative working with the Wessex Academic Health Science Network and National Institute for Health and Care Research Applied Research Collaborative Wessex and their wider programmes. The Dorset Innovation Hub framework includes:

- A simplified prioritised Dorset Integrated Care System partners model and approach including health learning system through innovative cultural approach, co-designing with communities, benefits realisation, training and development, community of practice, case studies and communications.
- Integration into the Dorset Integrated Care System, enabling innovation to connect with the detail of Dorset system priorities and supporting communities across Dorset to live their best lives.
- Governance from the Dorset Innovation Hub programme group, made up of voting members of Integrated Care System partner organisations that span Dorset including health and care, councils, and academia.
- An Innovation core team providing facilitative innovation advice and support, working with the project sponsor and clinical teams, and to support work towards the strategy including education programme, governance, provide practical support including learning from experience.
- Established prioritised yearly work programmes agreed by the Dorset Innovation Hub programme group and in line with NHS Dorset priorities. The work programme has been developed to ensure our work is focused on

improving people's care, outcomes or experience. The plan covers both national and local priorities.

- The Dorset Innovation Hub works with partner organisations to 'develop the impact'. Utilising established NHS Dorset governance processes, we work as a system team with staff from partner organisations to facilitate innovation within organisations. Our partners work with us to take forward priority innovation projects and embed innovation in their organisations. Developing the impact, enables ownership by partner organisations, with a focus on national and local priorities whilst developing the culture, capability, capacity and adoption, implementation, and sustainability of prioritised innovation.

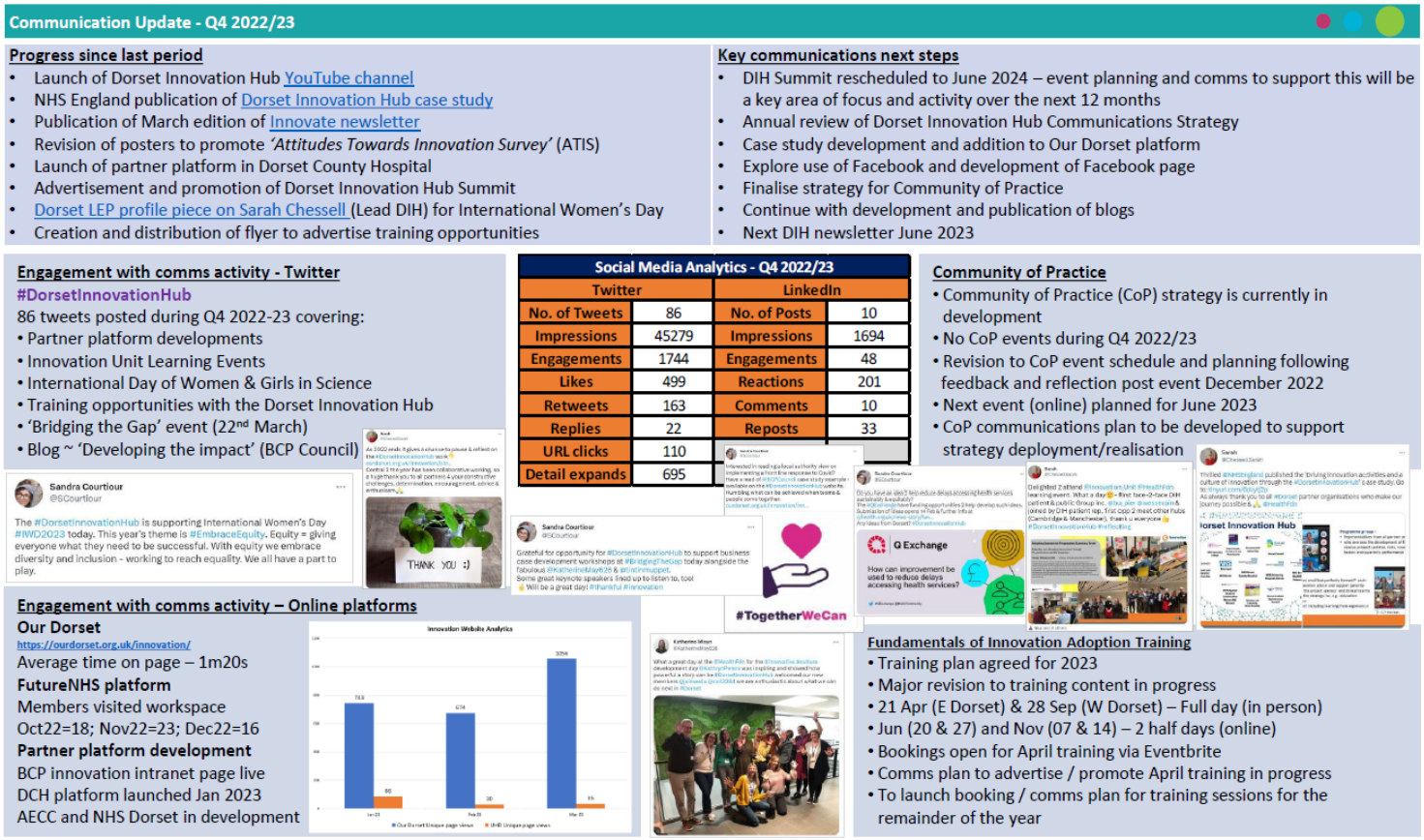
Learning and achievements

Highlights of our achievements and learning points over 2022/23 are listed below. For updates on all our activities please go to Innovation – Our Dorset ICS Innovation.

- **Innovation Unit** – proactive work with the Innovation Unit team including implementation support (programme group, core team and malnutrition in ageing people project) and peer coaching with the three other hubs.
- **Learning events** - active participation and development for members of the Dorset Innovation Hub in the Health Foundation learning events run by the Innovation Unit, including Culture Change and Storytelling for Adopting Innovation, and Adapting and Adopting Innovation through Co-production and Participation.
- **Education programme** - was developed, revised and established including Lunch and Learn sessions, one hour awareness training and an all day 'Fundamentals of Innovation Adoption'.
- **Community of Practice** – was established, including a ''Learning from the Covid Pandemic' event held in December 2022 which received case study presentations from partners on an Automation Roadmap, Implementing a Front Line Response to Covid: a Local Authority View, and Covid Care@Home.
- **Benefits realisation toolkit and process –** was developed and established including training to the core team. The framework is accessible for use across training and project support including a project initiation document and key performance indicators.
- **Patient and Public Involvement (PPI) –** we appointed and trained Patient and Public Involvement representatives who participate in the Malnutrition in Ageing people project and the Evaluation Working Group.
- **MedTech Funding Mandate (MTFM)** – a process was established including a standard operating procedure, benefits realisation template, finance mechanisms and reporting activity. We established sustainability processes and a process to assess against NICE guidance. We are undertaking clinical audit and the first case study published for placental growth factor test (PLFG).

In addition, we were delighted to have the opportunity to:

- Present the collaborative work of the Dorset Innovation Hub to NHS England's Innovation, Research and Life Sciences team when they visited the Wessex Academic Health Science Network in May 2022.
- Be finalists in the Academic Health Science Network Innovate Awards in the 'Innovate Health System of the Year Award' category in September 2022.



Environmental matters

Under the Health and Care Act 2022, the NHS must exercise its functions in line with both the Climate Change Act 2008 and the Environment Act 2021, setting out national targets for carbon, biodiversity, air and water pollution. The 'Delivering a net zero NHS' report provides the NHS with a national-level framework for action on climate change and sustainability. This sets out net zero targets that exceed the UK national targets. Every NHS organisation has an essential role to play in meeting this ambition.

In Dorset, we and our partner organisations have been working together to consider and plan how we can meet this NHS ambition together. Each NHS organisation in Dorset has a Green Plan. Together, we have produced an NHS Dorset Green Plan.

This annual report reflects our shared mission and the work we have started with our NHS partners in Dorset towards the national ambitions for sustainability in health and care.

NHS Dorset Green Plan

As NHS organisations in Dorset, our ambition is set out in our shared mission:

> To offer excellent health care for our patients and the wider community in ways which matter to the people we serve, and to do so in a manner that respects the needs of this generation and future generations. The size of this challenge will require all NHS organisations to acknowledge and take ownership of this mission, working together with partners and the community

across Dorset's Integrated Care System. Our ambition is to agree a clear and sustainable direction for Dorset.

To deliver this shared mission our shared priorities, delivered locally and together are:

- Shift to 100% renewable energy for all electricity supplies.
- Align with greener NHS estates delivery plan.
- Apply a minimum 10% social value weighting to all contracts.
- Switch to 100% recycled paper.
- Address single use plastics.
- Share learning on driving sustainable procurement.
- To reduce the use of desflurane.
- To prescribe lower carbon inhalers.
- To increase virtual outpatients and primary care appointments.
- Develop plans to support active travel.
- To embed carbon reduction principles in the way all care is delivered.

Our shared challenges with these priorities are:

- Achieving the NHS carbon footprint plus on plan.
- Collaboration as one Integrated Care System.
- Championing and driving culture changes across the system.
- Ensuring local ownership to deliver on agreed actions.
- Reducing the emissions caused by staff and patients.

The NHS Dorset Green Plan sets out in more detail what we have all achieved to date, within Trusts and across partners.

Our progress in 2022/23:

- NHS partners in Dorset have launched Dorset NHS Liftshare. Any NHS employee in the catchment is able to access the scheme; register the journeys they wish to make and find other staff members that would like to share the journey. Staff have the choice to travel only with members of their own site or anyone in the wider NHS community. The service is easy to use, and shared journeys can be acknowledged just by touching smart phones together. This service is helping staff to save money, reduce congestion, and reduce green-house gas emissions and other pollutants, helping to improve air quality.

- All NHS partners in Dorset have launched EcoEarn. This staff engagement platform helps to promote net zero carbon reduction activities and other sustainability and wellbeing behaviours. It is a digital platform easily accessible through a bespoke app and website. EcoEarn has the facility to track the environmental difference made and can provide individual, team, Trust-wide and Dorset-wide impact data. The system supports wider sustainability and wellbeing initiatives also, rewarding users for lift-sharing and for undertaking health and wellbeing activities such as taking physical exercise and logging it with Strava.
- As part of Dorset's Integrated Care System, we regularly meet with partners to collaborate on sustainability and are seeking to work more closely on a range of challenges including climate change mitigation and adaptation. Our ambition is to produce a Green Plan for the Dorset Integrated Care System during 2023/24.
- NHS Dorset has appointed a Deputy Director to lead on the Sustainability agenda as part of a portfolio including Health Inequalities and Population Health Management. This post reports to the organisation's Chief Medical Officer who provides Board level leadership. The sustainability agenda will be overseen by the Dorset Health Inequalities Group.

We have returned to a hybrid working model and continue to look at ways we can keep travel to a minimum. Where staff do need to travel, we will be promoting and encouraging sustainable ways of travelling and continue to hold meetings virtually where appropriate to reduce travel.

Paper

As most staff worked from home during the pandemic the use of digital technology was increased, and this consequently lessened the need for paper at all levels. This reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve information security. As staff begin to spend more time back in the office there has been an increase in usage but still below levels in 2019/20.

Paper use

Table 6: Paper Usage

	2019/20	2020/21	2021/22	2022/23
A4 reams	595	0	250	335
Boxes	119	0	50	67

Confidential wastepaper

Table 7: Confidential wastepaper (calculated by volume)

	2019/20	2020/21	2021/22	2022/23
Confidential waste (coving both sites)	260 bins @ 140 litres 36,400 litres (21.84 tonnes)	110 bins @ 140 litres 15,400 litres (9.24 tonnes)	36 bins @ 140 litres 5,040 litres (3.02 tonnes)	32 bins @ 140 litres 25 bins @240 litres 10,480 litres (6.28 tonnes)
Cost @ £12 per 140 litre bin Cost @ £17 per 240 litre bin	£3,120	£1,320	£432	£384 £425

Single use plastics

NHS Dorset does not purchase any single use plastics.

Water, gas and electricity usage

The utilities relate to our two offices, our headquarters in Dorchester and a site office in Poole for the period 1 July 2022 to 31 March 2023. The Poole office has no gas supplied.

We also assist our partners in providing office space at both sites to relieve the impact of works being undertaken on the transformation on the hospitals' sites.

Part of our Vespasian House site is currently being used as an Outpatient Assessment Centre.

Table 8: Water, gas and electricity

	2019/20	2020/21	2021/22	2022/23
	m^3	m^3	m^3	m^3
Water *	2,034	2,122	1,911	1,615
	kWh	kWh	kWh	kWh
Gas	205,453	178,193	292,734	230,181
Electricity	350,850	327,475	295,656	254,402

Improving the Quality of Services

This section describes our commitment to quality improvement and shows how we discharge our duty to improve quality under Section 14R of the Health and Social Care Act 2012.

Improve quality

One of our key functions is to secure continuous improvement in the quality of the services commissioned. The safety of the services and the quality of care experienced by patients are paramount and this is evidenced through improved outcomes. The usual assurance process relating to the quality-of-care provision is implemented through the contract monitoring framework, quality assurance schedule and quality reviews. Post pandemic and the establishment of Integrated Care Boards has identified that new ways of working have to be considered for services commissioned in Dorset. Focus for the year ahead is on defining our quality schedules working in collaboration with all system partners to achieve shared quality goals and improved patient outcomes.

Part of our overview of quality of services in Dorset, alongside our contract monitoring, is collaborative working with agencies such as the Care Quality Commission (CQC) inspectorates to understand our local context and areas of focus for future quality improvement. This collaboration is for all services in Dorset regulated by the CQC.

Infection prevention and control

We continue to strengthen a collaborative approach to infection prevention and control (IPC) across all Dorset partners. We continue to collaborate as a system for the achievement of IPC deliverables such as audit and system learning.

Local leadership in infection prevention and control continues to be key in successful IPC outcomes. We continue to provide a support mechanism for our system partners focusing on the reduction in IPC measures. We continue to focus on quality improvement for other infections, which may have been a concern for Dorset, through developing training in topics such as hydration in the prevention of infection and learning from data surveillance.

In the year ahead we will continue to strengthen our relationships and collaboration and build on the developments and opportunities in relation to IPC and quality improvement.

Primary Care

We continue to offer support to Primary Care Services, focusing on quality improvement and support when a level of risk is identified through quality assurance processes. With particular attention on areas such as service resilience and quality improvement in topics such as infection prevention and control remain key. The support offer is a collaborative approach between the commissioning teams at NHS

Dorset as well as the Local Medical Committees (LMC) and the newly formed Dorset GP Alliance.

Independent care sector

We continue to offer support to independent care providers, including care homes, domiciliary agencies and learning disability residential homes in partnership with the local authority quality and service improvement teams. Focusing on quality improvement alongside support when a level of risk is identified.

We work closely with system partners and continue to focus on enabling quality improvements as part of the Enhanced Care in Care Homes work, in areas such as the management of resident deterioration and the use of tools and developments to support end of life care and dementia assessment, by providing information on tools and training available to independent providers.

National programme for learning from lives and deaths – people with a learning disability and autistic people

We continue to implement the Learning from Lives and Deaths: People with a Learning Disability and Autistic People Policy (formerly known as the Learning from Deaths Review Programme (LeDeR)).

Reviewers have dedicated time to complete reviews including continued engagement with system partners to review learning, and to gain assurance that changes in practice are implemented as a result. Examples of this success has been around dysphasia support and its access.

The Dorset LeDeR team continue to meet the six-month key performance indicator of completing reviews within six months of the notification of death.

Personal Health Commissioning (PHC)

The service is meeting all NHS England standards for Continuing Healthcare. The market remains extremely fragile with an increase in costs of care and complex patient referrals presenting an ongoing challenge.

A joint funding policy for adults has been implemented and significant work has been undertaken on Section 117 and the implementation of the pooled arrangements, supporting hub model and associated system workplan. Bournemouth, Christchurch and Poole Council is due to join NHS Dorset and Dorset Council in this arrangement from April 2023.

The service will continue to aim to meet standards and to provide a high level of patient care while ensuring that it explores all opportunities to realise greater efficiencies in its operating model and in the commissioning of services to support patient care.

Complaints

As part of our commitment to continually improve the quality of local health services we recognise that all feedback, either as a complaint or praise, is a valuable source of information to assist in managing performance and highlighting any areas where we can make improvements.

We have also worked closely with the Parliamentary Health Service Ombudsman (PHSO) for a pilot phase of their NHS Complaints Standards programme. This programme ultimately aims to assist all NHS healthcare providers to standardise their practices to ensure consistency and delivery of exemplar complaint handling. The anticipated roll-out of the PHSO programme by the end of 2022 has been deferred to April 2023.

During the period 1 July 2022 to 31 March 2023, 60 complaints were received. Of these 30 related to NHS Dorset and 30 to providers of services. The trends of complaints received relating to NHS Dorset only, are demonstrated in Table 8 below.

Table 9: Complaints received by NHS Dorset

Complaints Received by NHS Dorset	**2022/23 Quarter 1** ***as Dorset Clinical Commissioning Group***	**2022/23 Quarter 2 – 4** ***as NHS Dorset***
Personal Health Commissioning	5	20
Individual Patient Treatment	0	0
General	7	10

Personal Health Commissioning works continuously to reduce the numbers of complaints and to improve our response to them. Staff have attended targeted training to support them in handling difficult situations with compassion. Monthly complaint review meetings are undertaken and learning identified from these. Service improvements are delivered through our change management pathway.

Friends and Family Test

Friends and Family Test (FFT) gives patients the opportunity to submit feedback to providers of NHS funded care or treatment using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment. Data on all these services is published on a monthly basis.

Table 10: Friends and Family Data to February 2023

	Provider	Percentage likely to recommend
A&E responses	Dorset County Hospital	91%
	University Hospitals Dorset	83%
Inpatients	Dorset County Hospital	93%
	University Hospitals Dorset	94%
Outpatients	Dorset County Hospitals	94%
	University Hospitals Dorset	95%
Community providers	Dorset HealthCare University	93%
Maternity	Dorset County Hospital	93%
	University Hospitals Dorset	89%
Mental health	Dorset HealthCare University	88%

Engaging people and communities

NHS Dorset is strongly committed to working with people and communities. We want to empower them, and to listen, to help us to improve health and care services for the better, together.

In July 2022 NHS England published new statutory guidance on working with people and communities. NHS Dorset was represented on the national co-production group and our Chief Executive Officer (CEO) was one of four Integrated Care Board CEOs to endorse the guidance stating:

> *"I am very privileged to confirm my support for a new approach to involving communities. If we are going to fulfil the ambition of integrated care systems around reducing inequalities, we need to understand the lived experience of our communities and design solutions with them that enable them to live their best lives and thrive. Our citizens should be at the centre of every decision we take."* Patricia Miller, CEO, NHS Dorset

This section describes an overview of our commitment to working in partnership with people and communities and shows how we meet our duty to involve under Section 14Z45 of the Health and Social Care Act 2006 (as amended by the Health and Care Act 2022)

Further detail is provided in our Working in Partnership with People and Communities Annual Report 2022-23.

NHS Dorset believes that working with people and communities helps us to:

- Better understand people's needs, beliefs, behaviours, culture, experiences and aspirations.
- Reduce health inequalities, reaching out to identify people's unique and diverse needs.
- Improve services and safety and help people to live healthier lives.
- Meet our duty to involve and work in line with national guidance.

We work closely with our partners and have put processes in place to help us work better together with people and communities. Dorset has a well-established engagement leads network, with representatives the NHS, local councils, Healthwatch Dorset, the Voluntary and Community Sector (VCS), Public Health, Wessex Academic Health Science Network and Community Resilience.

This network meets monthly to collaborate, avoid duplication and share good practice. The Terms of Reference have recently been updated to recognise the importance of working together with people and communities to meet Integrated Care Partnership and Joint Forward Plan priorities.

An Integrated Care System Engagement and Communications Steering Group will guide the network and also provide assurance to the NHS Dorset's People and

Culture Committee and the Board. Strong links are also being planned for the emerging Places in Dorset and we already support the Primary Care Networks at Neighbourhood level.

The Integrated Care Partnership's membership includes representatives from Healthwatch and the VCS Assembly, who also attend the NHS Dorset Board, as well as the Integrated Care System Public Engagement Group Chair (PEG) and the Digital PEG.

NHS Dorset is committed to working in line with the ten principles for working with people and communities as included within the national guidance, our NHS constitution and strategic approach to working with people and communities.

To enable this we:

- Have clear engagement guidance for staff, in line with national guidance and duty to involve.
- Have a dedicated public engagement team, Head of Engagement and Deputy Director, reporting to our People and Culture Committee and the Board.
- Provide advice, guidance, and support on public engagement to teams across NHS Dorset.
- Maintain a detailed engagement planner to manage and track engagement activities.
- Carry out stakeholder analysis and equality impact assessments to help inform our plans, who we reach out to and how we do so.
- Promote opportunities for involvement and co-production and let people know how their views have informed service provision ("you said – we did").
- Work closely with the Dorset Public Engagement Group (PEG) and Digital PEG who advise and challenge our approaches to public engagement and use of digital technology.
- Work closely with engagement teams from the NHS, local councils, Healthwatch and the VCS.
- Consider together research, insight or feedback from local people and communities.
- Continue to strengthen our relationships with a wide variety of people, groups and communities across Dorset's geography, demography and diversity.
- Support local Patient Participation Groups to inform and improve services and network.
- Work collaboratively with regional and national NHS England teams.
- Provide training to help staff understand the benefits of working together and to develop their engagement and co-production skills.
- Have a governance structure in place as described above.

Some highlights from the reporting period include:

- **Community Conversations** – we have been talking to people about what it is like to live their lives, exploring what helps them with their health and wellbeing. We trained 40 people from across the NHS, local councils and the VCS to have these conversations and we have been reaching out across our communities, our geography and our diversity. These conversations, along with a detailed system wide insight review. informed the Integrated Care Partnership Strategy and the Joint Forward Plan. We are continuing these conversations, providing further training, looking at different ways of capturing feedback and measuring outcomes and impact. www.ourdorset.org.uk/100
- **Working with Healthwatch** – we continue to work closely together, having monthly meetings about working with people and communities. We have commissioned Healthwatch to gather feedback on urgent and emergency care and local dental services to inform service provision.
- **Dorset VCS Assembly** – we have supported the VCS in its co-design of an Assembly which will bring together the voices of the VCS, engaging with thousands of groups and community members, building on existing networks, strengthening partnerships and supporting people to contribute their skills and time.
- **Co-designing Wellbeing Hubs Across Dorset** - we are working closely with Community Action Network to co-design wellbeing hubs across Dorset. The aim is to provide a safe and welcoming space where people can come and receive support for whatever 'life-related' issues they are experiencing which have led, or may lead, to anxiety, depression, or other psychological wellbeing challenges. This work is community led and will provide key services such as housing, finance, and benefits advice in response to local need.
- **Children and young people's mental health services** - making sure young people have access to the best mental health services is a priority for us. Following extensive view seeking we are now hosting modelling workshops to redesign the services and will let people know how their views are informing changes. Children and Young People's Mental Health Services – Your Mind, Your Say – NHS Dorset
- **Keyworker Project** - this project is helping children and young people with a learning disability and/or autism, and their families, to get the right help at the right time, before they reach crisis. Project models, informed by people with lived experience have been reviewed by local people at engagement events across the county and online. Further engagement and co-production will ensure the service is developed to best support the people who will need it. Keyworking project – NHS Dorset
- **Urgent care** – we are working with Dorset HealthCare University NHS Foundation Trust, the Voluntary and Community Sector and local people to develop a new community-based urgent care service will the objectives of

improving quality of care, outcomes and experience, reducing attendance at emergency departments and avoiding unplanned admissions.

- **Dorset Health Village –** students from the Arts University Bournemouth have worked in partnership with staff, patients, local residents, public health and the VCS to co-design a pop-up healthcare facility on the high street that provides diagnostics and clinical assessments. The students helped us to look through the eyes of the curious and create a calm, welcoming and friendly environment, supporting people to stay health and inspiring a healthy lifestyle.
- **Using the Health Equality Assessment Toolkit (HEAT)** – we are starting to use the HEAT tool to help us consider the nine protected characteristics but also socioeconomic groups, geography, deprivation, inclusion health and vulnerable groups, for example people who are experiencing homelessness, Gypsy, Roma and Travellers, vulnerable migrants, people who leave prison. This has been used by Dorset's local maternity and neonatal system and is informing an equality and equity strategy to make sure parents and babies are treated fairly across Dorset.
- **Mental Health Integrated Community Care Health Inequalities Group** - this group has a diverse membership with a wide range of lived experience and knowledge and is chaired by the manager of Healthwatch Dorset. The group is helping to ensure that seldom reached voices are heard and views are integrated within new care pathways. Mental Health Integrated Community Care Project – NHS Dorset
- **Providing Clear and Accessible Information** - we want to make sure that everyone in Dorset can understand what we are doing, and why. One of the first steps to meet that goal is to make sure the language we use is accessible to everyone. With this in mind, we have recently set up a health literacy task and finish group to review any and all content that NHS Dorset creates.

Working with people and communities strategy

Reducing health inequality and supporting broader social and economic development

Building on our understanding of the impact of health inequalities and the role of social and economic factors on population health and wellbeing, we have undertaken some important initiatives to begin to address equity of service delivery. A system wide Health Inequalities Group (HIG) brings together key partners to agree and oversee focused action on health inequalities. An elective care health inequalities group has led developments to pilot new approaches to waiting times for patients with specific characteristics. Using the Dorset Intelligence and Insight Service (DiiS), we have led the design and development of data analytics to gain greater insight as to how we engage with under-served groups and address unwarranted variations in referrals, treatment, and patient outcomes. Training in population health management and health inequalities has been rolled out across all NHS partners. The acute Trusts undertake monthly reporting to identify where variations in treatment times occur and are supporting work to better understand why some cohorts of patients are much more likely not to attend planned appointments.

To deliver our role in addressing social and economic factors we have started to think about how we use the opportunities available to us as an employer, through how we use our buildings and land, how we buy goods and services, and how we work with partners to address some of the wider factors which impact on health and wellbeing and which contribute to our ambition to enable people to live their best lives. Examples of this are spread throughout this report, and include:

- Working with our Academic, Local Authority and Industry partners to develop an Innovation Hub which will act as a magnet for attracting leading edge industry research companies to locate in Dorset creating wealth and employment. This builds on our success to date through which in the previous 36 months up to March 2023 over 450 innovations have been supported across the wider Wessex Healthcare Sector, with the creations of 256 jobs directly helping NHS Dorset.
- Our Health Villages on High Streets, designed with Dorset Arts students, taking diagnostic and clinical assessment services closer to people, and contributing to thriving communities.
- Developing Wellbeing Hubs - with our voluntary and community sector (VCS) providing housing, finance, benefits and other advice to address the social and economic life-issues which impact on mental health and wellbeing.
- Working with our voluntary and community sector to support co-production of a VCS Assembly, strengthening how our vibrant voluntary and community sector work together and making it easier for the VCS to work with statutory organisations across Dorset to help to grow strong communities.
- Ensuring that the good quality work we offer is open to all, for example, through our pro-equity approach, commitment to the workforce race and disability equality standards, apprenticeships, learning and leadership opportunities, and through our ambition to become a model employer of people with a learning disability and of autistic people.

- As an anchor institution, working with our partners providing employment opportunities as well as the Department for Work and Pensions, local colleges and our local employability training provider, we have successfully delivered a new and innovative vocational scholarship programme which provides new routes to careers in health and care. The scholarship programme provides person centred pre-employment support, enabling people to reach their potential, develop their skills and confidence, and become job ready. Focusing on those who are unemployed or leaving education, to date 104 people have been supported on a scholarship programme of which 81 have gone on to secure employment as a result.
- Ensuring community voice is at the heart of everything we do. Our Dorset engagement leads network co-ordinates engagement across organisations and supports initiatives such as our Community Conversations programme which supported the development of our Dorset Integrated Care Partnership strategy and the Joint Forward Plan.
- Publication of the NHS Dorset Green Plan, setting out how we will achieve the NHS carbon footprint plus including considering the impact of our energy use, our estates, travel and transport use, and procurement decisions.
- NHS Dorset support to GP practices through Minor Improvement Grant funding, to enhance their practice buildings to improve the delivery of patient care, to a value of £440,000 in 2022/23. The projects ranged from building works to provide additional space, to improvements in infection control measures and physical access into the building. Local businesses were utilised by practices for this work across Dorset, bringing work into the local economy.
- The Children and Young People, Learning Disabilities and Autism and Mental Health Teams working with colleagues to deliver health checks for people who have serious mental illness and people who have learning disabilities. These programmes of health checks have improved life chances and access to health care.
- A new Community Front Room opened on Bournemouth University Campus to support students experiencing mental health crisis. This has prevention at its heart and supports a reduction in students needing to attend an Emergency Department or call an ambulance when they are in crisis. This preventive work helps ensure that poor mental health does not persist and worsen.

The next steps are to:

- Develop a health inequalities strategy focused on addressing the most significant inequalities, for example in the prevention of cardiovascular disease, and which considers how we can take action on all of the things which influence how healthy we are.
- Work with clinical colleagues to develop an approach that embeds equity for patients.

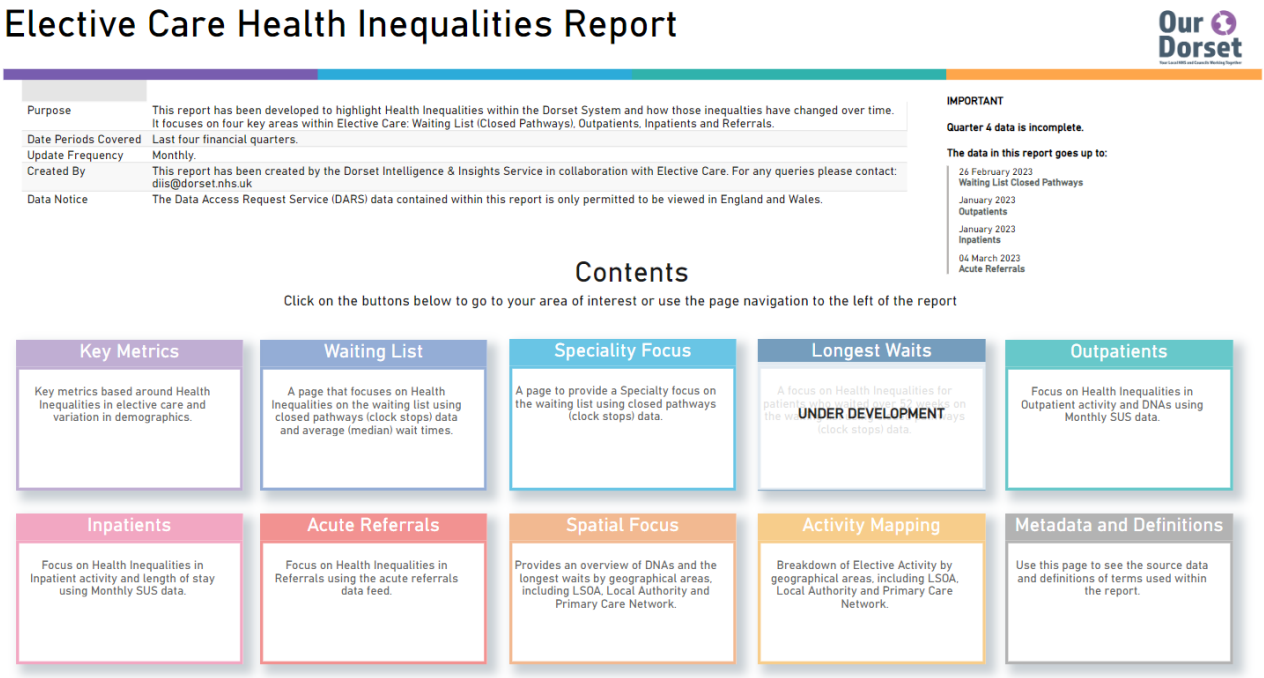
- Work in partnership with communities, voluntary organisations, and system partners to understand, enable and empower local partnerships to address inequalities and the provision of local services using a population health management approach.
- Work in partnership with Public Health to develop a joint approach to tackle wider determinants of inequalities.
- Consider health inequalities as a key principle of the developing clinical strategy.

<u>Dorset Intelligence and Insight Service (DiiS)</u>

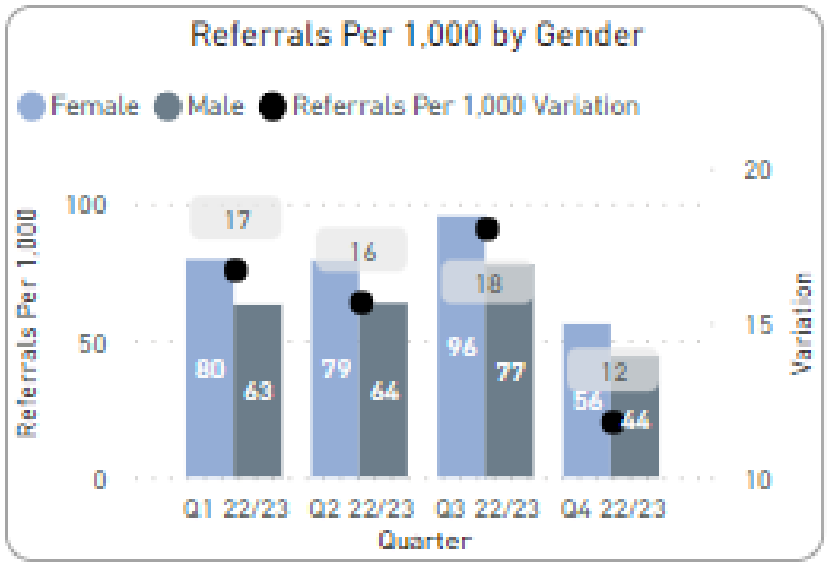
The development of our DiiS system enables us to interrogate data to inform the development of our approach to health inequalities and prioritise areas where we can have the greatest impact:

Using the DiiS we are able to slice and segment data regarding our population by gender, age, ethnicity, deprivation and socio-economic markers. This enables clinicians to understand the contextual circumstances behind a patient's pathway and identify vulnerable populations, previously overlooked with patients who have primarily been associated with their health condition alone.

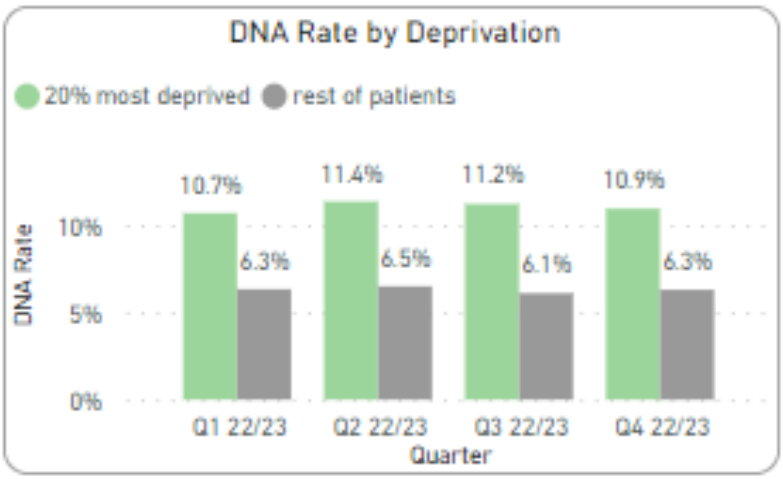
An example of what has been developed using this approach is in one of the latest reports looking at Health Inequalities in Elective Care:

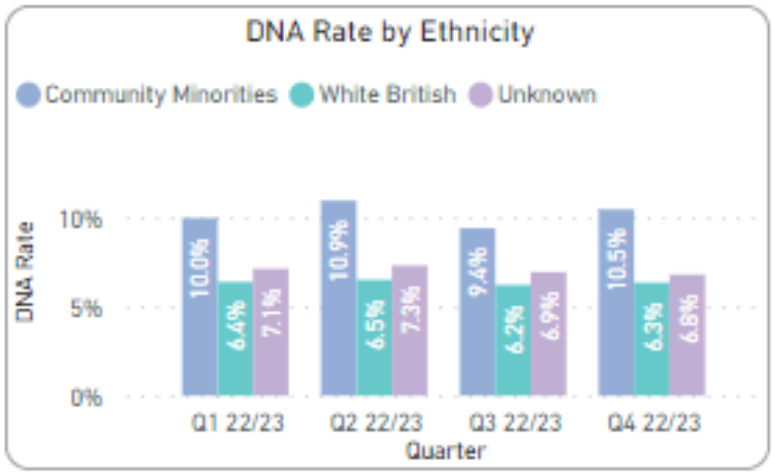


This report enables users to see elective data overlayed with deprivation, age, gender and ethnicity and therefore identify potential inequalities. For instance, acute referrals are higher in females than males:



Whilst rates of those not attending appointments are higher in people living in more deprived areas, and from a community minority background:





Such insights are just the beginnings of the ability to interpret and interrogate data using the health inequalities lens and enable the beginning of conversations of how services can identify new strategies and approaches to removing health inequalities.

The DiiS service has been developed internally to the NHS, using a combination of locally employed permanent and fixed term contract staff. The majority of these staff live in Dorset or just outside of the county. Where more specialised consultancy services were required, local consultants or a local Microsoft partner was used.

We are working with our Integrated Care System partners to share and develop resources. We have created the roles of DiiS Link Officers for partner organisations to work alongside the DiiS team to develop analytical and technical solutions. These relationships have extended to include a graduate from Bournemouth University, shared with Public Health Dorset, to deliver cross- Integrated Care System data science services. Our ambition is to broaden this relationship going forwards.

Videos and training materials for both the Population Health Management programmes and the Data and Analytics Centre of Excellence, both locally lead initiatives, have been produced using local independent providers. In addition, the Wessex Cancer Alliance contracted the DiiS services to provide their Wessex-wide (Dorset & Hampshire and the Isle of Wight) analytics.

Health and wellbeing strategy

We engaged with and supported the Joint Strategic Needs Assessment facilitated by Public Health Dorset, which supports the Health & Wellbeing Boards of Dorset Council and Bournemouth, Christchurch and Poole Council (BCP) in their work.

The overarching reports on the Public Health Dorset website provide a summary of the Joint Strategic Needs Assessment and the current and future strategic health and wellbeing issues for the two local councils:

- BCP JSNA Summary Narrative 2022
- Dorset JSNA Summary Narrative 2022

The assessment was triangulated with engagement work with stakeholders and formed the basis for the development of the Joint Health and Wellbeing Strategy. The findings from the Joint Strategic Needs Assessment supported the development of the first Integrated Care Partnership Strategy as detailed above. Both the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy have fed into the Joint Five Year Forward Plan, which will be submitted to NHS England in June 2023.

Following the formation of the Integrated Care Board, it was agreed by partners that the Joint Health and Wellbeing Strategy would not be updated until the Integrated Care Strategy was in place. The priorities from the Integrated Care Strategy would then shape the priorities of the Joint Health and Wellbeing Strategy. Our focus has therefore been on agreeing and planning the future direction for joint working on health and wellbeing. Over the coming year we will be working alongside our partners to implement the updated Joint Health and Wellbeing Strategy.

Workshops with the local Health and Wellbeing Boards will be held to discuss the health and wellbeing priorities for Dorset and to agree the next steps for implementation of the Joint Health and Wellbeing Strategy. Review meetings are planned between our Chief Executive Officer and each of the Health and Wellbeing Chairs to consult with them on our implementation of health and wellbeing work in Dorset to date, to receive their feedback on the proposed joint health and wellbeing priorities and to confirm that they are in agreement with the direction for the future.

We are members of the Health and Wellbeing Boards which are run by local authorities to develop and monitor the major health and wellbeing priorities for the area. There are two Health and Wellbeing Boards in Dorset – one run by Dorset Council, and one run by Bournemouth Christchurch and Poole Council. These Boards are made up of representatives from a number of organisations such as the NHS including GPs, the voluntary sector and local authorities. They set the direction for health and wellbeing across the system and work together to ensure that people receive the best possible care.

The Director of Public Health has been heavily involved in developing priorities and ensuring these are built into the public health work programmes to ensure these align to the Joint Health and Wellbeing Strategy.

Financial review

NHS Dorset achieved a break-even position across the whole of the financial year 2022/23, meaning that its expenditure was fully funded by its income.

Due to the inception of NHS Dorset on 1 July 2022, the financial year ending 2022/23 relates to a 9-month period for NHS Dorset from 1 July 2022 to 31 March 2023. Dorset NHS Integrated Care System was issued a fixed financial envelope with a requirement to effectively plan and deliver services within this allocation for the population of Dorset.

The Dorset NHS Integrated Care System comprises:

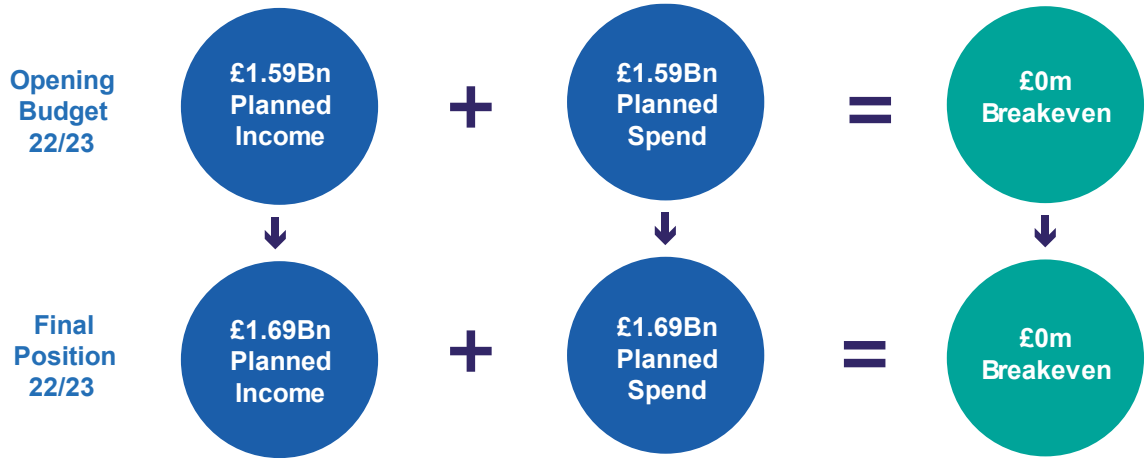
- NHS Dorset Integrated Care Board
- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust.

These five NHS bodies received an initial allocation of £1.59bn for 2022/23 and were required to collectively plan within this envelope. NHS bodies in the Dorset Integrated Care System planned and achieved a break-even financial performance across the year, with a collective underspend of £0.4m against the final allocation. In addition, NHS Integrated Care System partners have successfully planned and delivered capital investment projects totalling £182.1m, in line with allocations from NHS England.

The Integrated Care System also encompasses Local Authority partners, Dorset Council and Bournemouth and Poole Council, plus other partners such as those in the voluntary sector.

The allocations made available for the financial periods ending 31 March 2023 are outlined in the figure below. During the reporting period, additional non-recurrent funding was made available beyond planned income values in including funding for Elective Recovery plus additional targeted funding for specific projects and programmes from NHS England. This is referenced in the final income of £1.69bn when compared to the planned income of £1.59bn.

Financial Performance against plan



NHS Dorset ICB Financial Performance

NHS Dorset has met all of its statutory and administrative financial duties in its first statutory reporting period ending 31 March 2023, which are to remain within its revenue, capital and running costs allocations, and to ensure cash at year end is no more than the mandated threshold.

The full results are set out within NHS Dorset's Annual Accounts and notes to the accounts at the end of this document, however the key duties and performance of Dorset ICB is shown below:

Duty	What this means	Dorset ICB Achievement
Expenditure does not exceed sums allotted to the ICB plus other income received.	To keep the amount spent on commissioning and delivering services to or below the amount allocated.	✔ Achieved Dorset ICB planned for, and delivered, a breakeven balance for the financial year
Capital resource use does not exceed the amount specified in our Capital Expenditure Limit.	To not spend more on buying property, plant and equipment than allocated.	✔ Achieved Capital investment was delivered within the limit for both Dorset ICB and the wider NHS Dorset ICS.
Revenue administration resource use does not exceed the amount allocated of £11.2m.	To ensure that ICB efficiently discharges its responsibilities and keeps the spend to or below the amount allocated.	✔ Achieved This was spent on ICB staff and associated costs, details of which were published in an organogram on our website in January 2023.
Invest in Mental Health Services in line with the Mental Health Investment Standard.	ICBs are required to invest in Mental Health Services by an amount greater than general allocation growth each year.	✔ Achieved For 2022/23, the target investment in mental health was £119.1m. The ICB achieved £119.9m which is an £5.4m increase from 2021/22 investment levels.

Cash Limits received from NHS England are not exceeded in any one year.	To keep the cash in the bank within acceptable limits.	✔ Achieved The ICB managed its cash resource and achieved a cash balance below the mandated threshold of 1.25% of the cash drawdown in March 2023.

However there have been a number of challenges for us in 2022/23, which have been managed within the overall breakeven position. These included:

- Increasing pressure on Personal Health Commissioning (PHC) expenditure due to pressures in the care market, leading to overspends against plan of £16.6m.
- An emerging pressure on drugs expenditure, particularly No Cheaper Stock Obtainable drugs due to inflation and supply issues, leading to additional expenditure in the reporting period.
- Retained focus on No Criteria to Reside and elective recovery, which have remained key priorities for the Integrated Care System in 2022/23.

Better Payment Practice Code

NHS Dorset is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry (CBI) Better Payment Practice Code. The target is to pay non-NHS and NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

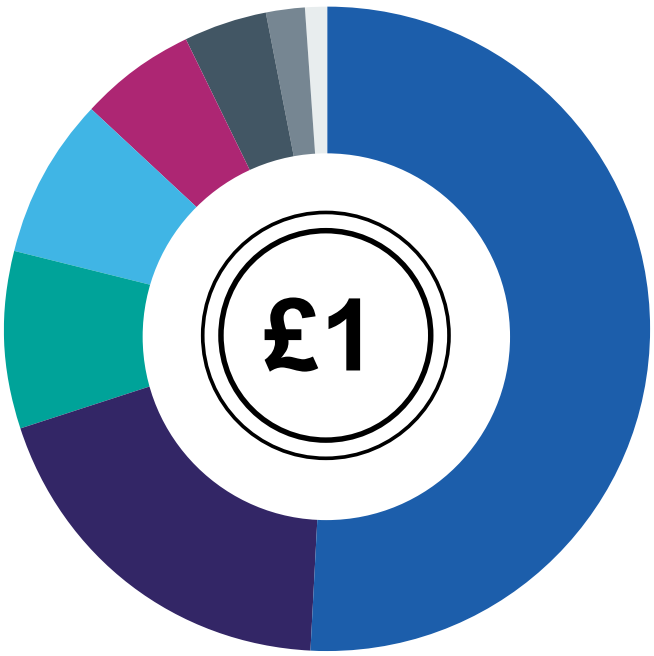
In 2022/23, NHS Dorset has paid 97% of its NHS and non-NHS suppliers within 30 days.

How we spent our budget

NHS Dorset utilises funds to commission (buy) services from a range of NHS and non-NHS organisations including Local Authorities. The charts that follow show how we applied expenditure across the various commissioning areas.

Where were ICB funds spent?

For every £1 spent on health in Dorset in 2022/23, the amounts spent on our range of services were as follows:



51p Secondary Care
Acute hospitals & ambulance services

19p Primary Care
Prescribing & GP contracts

9p Mental Health & Learning Disabilities
NHS & non-NHS providers services

8p Personal Health Commissioning
Individual care packages & care homes

6p Community Health Services
Community hospitals, hospices and voluntary sector

4p Better Care Fund
Community hospitals, hospices and voluntary sector

2p Staff & HQ Costs
NHS Dorset payroll & support expenses

1p Other Healthcare commissioning
Includes patient transprt services (PTS) & projects

Future financial outlook

The accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The NHS announced its draft '2023/24 priorities and operational planning guidance' on 23 December 2022.

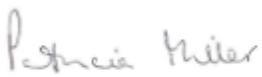
One of the main aims for 2023/24 is to work collaboratively across the Integrated Care System to deliver the following priorities:

- Recovering core services and productivity
    - Improve ambulance response and A&E waiting times
    - Reduce elective long waits and cancer backlogs, and improve performance against diagnostic standards
    - Make it easier for people to access primary care services, particularly general practice
- Delivering the NHS Long Term Plan ambitions
    - Prevention and effective management of long-term conditions
    - Sustainable workforce
    - Digital transformation
- Transform the NHS
    - Development of the Integrated Care Partnership Strategy and Joint Five Year Forward Plan
    - Maturing ways of working including provider collaboratives and place-based partnership arrangements

For the financial year ending 31 March 2024, the Integrated Care System NHS bodies in Dorset will again receive a fixed financial envelope to deliver all aspects of healthcare.

Additional funding has been made available to assist with tackling the growth in numbers of patients waiting for elective procedures, dependant on reaching a level of elective recovery greater than pre pandemic levels. This variable payment mechanism means that providers will only get paid for the elective activity they achieve, therefore there is an additional income risk if recovery is not at the level planned.

NHS Providers are also managing a number of inflationary pressures including price rises for utilities and drugs. For NHS Dorset the impact of the rise in the National Living Wage on the care market continues to be challenging, along with similar pressures to providers within other non-pay expenditure such as prescribing. As a result, the Integrated Care System has set itself a challenging and stretching efficiency programme in order to achieve the proposed breakeven plan for 2023/24. This contains significant risk however, and it is likely that if financial balance is achieved it will be at least in part due to non-recurrent measures. Dorset NHS Integrated Care System will be required to manage a significant underlying deficit position in future years, and an ambitious transformation programme will be embarked upon to ensure services continue to be value for money for our population.



Patricia Miller
Accountable Officer

19 June 2023

Accountability Report

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 July 2022 to 31 March 2023, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

Members' Report

Member profiles

Profiles detailing the professional backgrounds of our Board Members and Chief Officers can be found by following the links below:-

- NHS Dorset ICB Board Members
- NHS Dorset ICB Chief Officers

Composition of NHS Dorset Integrated Care Board (ICB) Board

Our NHS Dorset ICB Board is made up of the following members:-

- Chair
- Chief Executive
- Two Partner Members – NHS Trust and Foundation Trust (including Mental Health)
- Two Partner Members – Primary Medical Services
- Two Partner Members – Local Authorities
- Six Non-Executive Members
- Chief Finance Officer
- Chief Medical Officer
- Chief Nursing Officer

Our Chair is Jenni Douglas-Todd and our Chief Executive Officer is Patricia Miller.

The Board has a responsibility to ensure there are appropriate healthcare services for the people of Dorset. The composition and attendance records of our Board from 1 July 2022 to 31 March 2023 can be seen in Table 11 below.

Table 11: Integrated Care Board – Board composition, term of office and attendance record

Name	Role	Term of Office			Attendance Record (6 meetings held during the period 1 July 2022 to 31 March 2023)
		Date appointed	Re-election/ reappointment date	Date left role (if applicable)	
Jenni Douglas-Todd	Chair	1 July 2022	1 July 2024	N/A	6 of 6
Patricia Miller	NHS Dorset Chief Executive Officer	1 July 2022	-	N/A	5 of 6
John Beswick	Non-Executive Member	1 July 2022	1 July 2025	N/A	5 of 6
Philip Broadhead	Local Authority Partner Member	29 March 2023	29 March 2026	N/A	0 of 0
Cecilia Bufton	Non-Executive Member	1 July 2022	1 July 2025	31 March 2023	6 of 6
Jonathon Carr-Brown	Non-Executive Member	1 July 2022	1 July 2025		6 of 6
Dawn Dawson	NHS Trust and Foundation Trust Partner Member (Mental Health)	1 July 2022	1 July 2025	N/A	5 of 6
Spencer Flower	Local Authority Partner Member	1 July 2022	1 July 2025	N/A	6 of 6
Siobhan Harrington	NHS Trust and Foundation Trust Partner Member	1 July 2022	1 July 2025	N/A	5 of 6
Paul Johnson	NHS Dorset Chief Medical Officer	1 July 2022	-	N/A	6 of 6
Drew Mellor	Local Authority Partner Member	1 July 2022	1 July 2025	29 March 2023	4 of 6
Robert Morgan	NHS Dorset Chief Finance Officer	1 July 2022	-	N/A	6 of 6
Vanessa Read	NHS Dorset Chief Nursing Officer (interim)	1 July 2022	-	30 September 2022	2 of 3
Ben Sharland	Primary Medical Services Partner Member	1 July 2022	-	9 December 2022	2 of 4

Debbie Simmons	NHS Dorset Chief Nursing Officer	26 Sept 2022	-	N/A	3 of 3
Manish Tayal	Non-Executive Member (interim)	1 August 2022	-	to 31 May 2023	2 of 4
Kay Taylor	Non-Executive Member	1 July 2022	1 July 2025	N/A	6 of 6
Forbes Watson	Non-Executive Member Primary Medical Services Partner Member	1 July 2022 9 Dec 2022	31 July 2022 9 Dec 2025	N/A	2 of 2 2 of 2
Dan Worsley	Non-Executive Member	1 July 2022	1 July 2025	N/A	5 of 6
Simone Yule	Primary Medical Services Partner Member	1 July 2022	-	9 December 2022	4 of 4

Our Board meetings also have regular attendance by invited participants in order to inform its decision-making and the discharge of its functions. These are detailed below:-

- NHS Dorset Chief Strategy and Transformation Officer
- NHS Dorset Chief Commissioning Officer
- NHS Dorset Chief Operating Officer
- NHS Dorset Chief People Officer
- NHS Dorset Chief Digital and Information Officer
- NHS Dorset Associate Non-Executive Members
- Manager, Healthwatch Dorset
- Director of Public Health Dorset
- Chief Executive, Bournemouth, Christchurch and Poole Council
- Chief Executive, Dorset Council
- Acting Chief Executive, Dorset County Hospital NHS Foundation Trust
- Primary Care representative
- Chief Executive, Community Action Need
- Chief Executive, Help and Kindness.

Our Committees

The Terms of Reference for all Committees can be found in our Governance Handbook. These Terms of Reference, alongside the Committee workplans, were reviewed mid-year and the amendments were approved by the NHS Dorset ICB Board. A further review will be conducted in June 2023, after the Committees have been in existence for one year, and this will be accompanied by a review of the effectiveness of the Committees. Following their bi-monthly meetings, each Committee provides a summary report to the Board covering the main items discussed, decisions made, items for escalation to the Board, and highlighting any items which impact on the Corporate Risk Register or Board Assurance Framework.

Clinical Commissioning Committee

The purpose of the Clinical Commissioning Committee is to make decisions on the review, planning and commissioning of clinical services and policies under delegated authority from the NHS Dorset ICB Board. It provides clinical leadership to the system, informing the clinical strategy and supporting the Quality and Safety Committee in discharging its responsibility for clinical governance for commissioning services and oversight of the delivery of the clinical strategy.

The Committee is chaired by Jonathon Carr-Brown, NHS Dorset ICB Board Non-Executive Member. Other members from 1 July 2022 to 31 March 2023 and their attendance records are detailed below:-

Table 12: Clinical Commissioning Committee composition and attendance record

Name	Role	Attendance Record (5 meetings held during the period 1 July 2022 to 31 March 2023)
John Beswick	NHS Dorset ICB Board Non-Executive Member	2 of 5
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member and Committee Chair	5 of 5
Sam Crowe	Director of Public Health Dorset	0 of 5
David Freeman	NHS Dorset Chief Commissioning Officer	5 of 5
Phil Hornsby	Director of Commissioning (People), Bournemouth, Christchurch and Poole Council (Local Authority Lead East)	2 of 5
Jo Howarth	Chief Nursing Officer, Dorset County Hospital	1 of 2
Alastair Hutchison	Chief Medical Officer, Dorset County Hospital	4 of 5
Paul Johnson	NHS Dorset Chief Medical Officer	3 of 5
Patricia Miller	NHS Dorset Chief Executive Officer	2 of 5
Robert Morgan	NHS Dorset Chief Finance Officer	4 of 5
Jon Price	Director, Dorset Council (Local Authority Lead West)	0 of 5
Vanessa Read	NHS Dorset Chief Nursing Officer (interim to 30 September 2022)	1 of 2
Faisil Sethi	Chief Medical Officer, Dorset Healthcare	1 of 5
Paula Shobbrook	Chief Nursing Officer, University Hospitals Dorset	4 of 5
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	3 of 3

Cara Southgate	Acting Chief Nursing Officer, Dorset Healthcare	4 of 5
Dean Spencer	NHS Dorset Chief Operating Officer	3 of 5
Manish Tayal	Non-Executive Member (interim) (from 1 August 2022)	2 of 3
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	4 of 5
Ruth Williamson	Interim Chief Medical Officer, University Hospitals Dorset	1 of 2
Forbes Watson	NHS Dorset ICB Board Primary Medical Services Partner Member (Chair of the Dorset GP Alliance) (attendance from December 2022)	2 of 2

During the period 1 July 2022 to 31 March 2023, the key highlights of the work of the Committee have included:

- supporting the Continuous Glucose Monitoring (CGM) Policy, approving the SEND Joint Commissioning Plan for 2022-23 and supporting the contract extension for the Citizens Advice Central Dorset Independent and Confidential Advice and Information service
- supporting the proposed development of an Integrated Neighbourhood and Community Programme Board, the updated Cardiovascular Disease Service Specifications, and the adoption of national evidence-based intervention policies
- re-commissioning the Dorset Self-Management Services contract
- reviewing the plans for the delegation of pharmacy, optometry and dental services to NHS Dorset from 1 April 2023
- receiving updates on Integrated Urgent Care and the Adult Mental Health Integrated Community Care Programme including the multi-agency collaboration work led by the Voluntary, Community and Social Enterprise (VCSE) sector
- reviewing the risks held on the Corporate Risk Register relevant to the Committee.

<u>Finance and Performance Committee</u>

The purpose of the Finance and Performance Committee is to assure the Board that financial and operational performance is delivered in accordance with the agreed strategy, plans and trajectories. It provides overview and scrutiny in any areas of financial and operational performance referred to it by the Board.

The Committee is chaired by Dan Worsley, NHS Dorset ICB Board Non-Executive Member. Other members from 1 July 2022 to 31 March 2023 and their attendance records are detailed below:-

Table 13: Finance and Performance Committee composition and attendance record

Name	Role	Attendance Record (5 meetings held during the period 1 July 2022 to 31 March 2023)
Neil Bacon	NHS Dorset Chief Strategy and Transformation Officer	4 of 5
John Beswick	NHS Dorset ICB Board Non-Executive Member	2 of 5
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	3 of 5
Nick Johnson	Acting Chief Executive, Dorset County Hospital (Provider Chief Executive)	2 of 5
Patricia Miller	NHS Dorset Chief Executive Officer	3 of 5
Robert Morgan	NHS Dorset Chief Finance Officer	5 of 5
Dean Spencer	NHS Dorset Chief Operating Officer	4 of 5
Dan Worsley	NHS Dorset ICB Board Non-Executive Member and Committee Chair	4 of 5

During the period 1 July 2022 to 31 March 2023, the key highlights of the work of the Committee have been:

- reviewing regular finance and performance reporting updates across the Dorset system including any emerging risks, and deep dives into key areas of performance
- approving the NHS Oversight Framework segmentation of Dorset providers
- reviewing the progress and development of the Dorset Integrated Care System Winter Plan
- receiving regular updates on the performance of the Personal Health Commissioning service
- scrutinising and supporting business cases including for a contract management system, and funding for the stroke and neurology pathway
- considering the development of the NHS Dorset Operational Plan
- reviewing the Section 117 pooled budget and hub arrangements effective April 2023
- reviewing the risks held on the Corporate Risk Register relevant to the Committee.

People and Culture Committee

The purpose of the People and Culture Committee is to provide oversight and assurance to the Board on people and culture for NHS Dorset and its partner constituents. The Committee also has responsibility for leadership development and talent management, workforce planning and forecasting, recruitment and retention, education and training, people policies, processes and systems, diversity and inclusion, health and wellbeing and developing a culture that will deliver a workforce fit for the future. It also plays a key role, through the provider assurance framework, in ensuring that NHS partner organisations meet expectations in terms of people and culture.

The Committee is chaired by Cecilia Bufton, NHS Dorset ICB Board Non-Executive Member. Other members from 1 July 2022 to 31 March 2023 and their attendance records are detailed below:-

Table 14: People and Culture Committee composition and attendance record

Name	Role	Attendance Record (5 meetings held during the period 1 July 2022 to 31 March 2023)
Cecilia Bufton	NHS Dorset ICB Board Non-Executive Member and Committee Chair	5 of 5
Siobhan Harrington	Chief Executive, University Hospitals Dorset (Provider Chief Executive)	3 of 5
Dawn Harvey	NHS Dorset Chief People Officer	3 of 5
Patricia Miller	NHS Dorset Chief Executive Officer	2 of 5
Vanessa Read	NHS Dorset Chief Nursing Officer (interim to 30 September 2022)	1 of 2
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	3 of 3
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	4 of 5
Manish Tayal	NHS Dorset ICB Board Non-Executive Member (interim) (from 1 August 2022)	4 of 5
Forbes Watson	NHS Dorset ICB Board Primary Medical Services Partner Member (Chair of the Dorset GP Alliance) (attendance from September 2022)	0 of 4

During the period 1 July 2022 to 30 March 2023, the key highlights of the work of the Committee have been:

- reviewing the NHS Dorset People Dashboard data and People Performance report, including workforce information from across the Dorset Integrated Care System
- reviewing the development of the Integrated Care System People Plan
- receiving an update on the Dorset providers' equality, diversity and inclusion priorities and considering actions resulting from the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)
- receiving updates on the progress and next steps in relation to the 100 conversations project, Care Leaver Covenant programme, Voluntary and Community Sector Assembly, Primary Care Training Hub, Enhanced Health and Wellbeing Service Health and Social Care Vocational Scholarship Scheme and Integrated Care System brand identity
- receiving annual internal workplans for the Communications and Engagement and People teams, and HR policy updates
- reviewing the risks held on the Corporate Risk Register relevant to the Committee.

Primary Care Commissioning Committee

The purpose of the Primary Care Commissioning Committee is to make decisions on the review, planning and procurement of primary care services in Dorset and other direct commissioning under delegated authority from NHS England.

The Primary Care Commissioning Committee is chaired by Kay Taylor, NHS Dorset ICB Board Non-Executive Member. Other members from 1 July 2022 to 31 March 2023 and their attendance records are detailed below:-

Table 15: Primary Care Commissioning Committee composition and attendance record

Name	Role	Attendance Record (5 meetings held during the period 1 July 2022 to 31 March 2023)
Cecilia Bufton	NHS Dorset ICB Board Non-Executive Member	5 of 5
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	4 of 5
Sam Crowe	Director of Public Health Dorset	2 of 5
David Freeman	NHS Dorset Chief Commissioning Officer	5 of 5
Paul Johnson	NHS Dorset Chief Medical Officer	4 of 5
Patricia Miller	NHS Dorset Chief Executive Officer	3 of 5
Robert Morgan	NHS Dorset Chief Finance Officer	3 of 5
Andy Purbrick	Chief Executive Local Medical Committees	0 of 5
Vanessa Read	NHS Dorset Chief Nursing Officer (interim to 30 September 2022)	1 of 2
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	3 of 5
Kay Taylor	NHS Dorset ICB Board Non-Executive Member and Committee Chair	4 of 5
Forbes Watson	NHS Dorset ICB Board Primary Medical Services Partner Member	3 of 5
Simone Yule	Dorset GP Alliance Deputy Chair	4 of 5

During the period 1 July 2022 to 31 March 2023, the key highlights of the work of the Committee have been:

- reviewing the performance, quality, practice profiling and risks in primary care services
- reviewing and supporting the proposals for the delegation of pharmacy, optometry and dental services to NHS Dorset from 1 April 2023
- reviewing the primary care estate, primary care provision for asylum seekers, refugees and migrants, Cardiovascular Disease Service specifications, medicines

management, the Dorset General Practice Winter Sustainability Plan, and areas of work being undertaken to support the Primary Care Commissioning Strategy
- receiving updates from Public Health Dorset
- supporting the Clinical Commissioning Local Improvement Plan incentive scheme for 2023-24
- reviewing the risks held on the Corporate Risk Register relevant to the Committee.

Quality and Safety Committee

The purpose of the Quality and Safety Committee is to provide oversight and assurance to the Board on the delivery of quality and safety by NHS Dorset and its partners. It does this by scrutinising delivery of quality care and strategy outcomes. It has a key role, through the provider assurance framework, in ensuring that NHS partner organisations meet expectations in terms of quality and safety as outlined in the provider accountability framework. The Committee ensures that all aspects of quality governance, patient safety and experience are subject to scrutiny in order to provide assurance to the Board.

The Quality and Safety Committee is chaired by Manish Tayal, NHS Dorset ICB Board Interim Non-Executive Member. Other members from 1 July 2022 to 31 March 2023 and their attendance records are detailed below:-

Table 16: Quality and Safety Committee composition and attendance record

Name	Role	Attendance Record (5 meetings held during the period 1 July 2022 to 31 March 2023)
Cecilia Bufton	NHS Dorset ICB Board Non-Executive Member	5 of 5
Dawn Dawson	NHS Trust Partner Member (Mental Health)	3 of 5
Paul Johnson	NHS Dorset Chief Medical Officer	3 of 5
Patricia Miller	NHS Dorset Chief Executive Officer	3 of 5
Vanessa Read	NHS Dorset Chief Nursing Officer (interim to 30 September 2022)	1 of 2
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	3 of 3
Manish Tayal	NHS Dorset ICB Board Non-Executive Member (interim) and Committee Chair	5 of 5
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	4 of 5

During the period 1 July 2022 to 31 March 2023, the key highlights of the work of the Committee have been:

- reviewing the regular Quality Reports regarding key quality issues within the system
- receiving updates in relation to quality and safety in maternity services and provider Trusts in relation to the wider Dorset Local Maternity and Neonatal System
- receiving updates on medicines optimisation, the urgent and emergency care pathway, palliative and end of life care services and patient safety and mortality in NHS Dorset's commissioned services
- reviewing and supporting the Dorset system Quality Framework which sets out how the integrated care system will use a strengths-based approach to system-wide quality improvement to deliver the quality objective
- reviewing the risks held on the Corporate Risk Register relevant to the Committee

Risk and Audit Committee

The Risk and Audit Committee is responsible for providing the Board with oversight and assurance on governance, risk management and internal control processes within NHS Dorset. This is achieved by ensuring there are effective systems of financial and corporate governance, risk management and internal controls in place. The Committee is also responsible for the oversight of the delivery of internal and external audit programmes.

The Committee is chaired by John Beswick, NHS Dorset ICB Board Non-Executive Member. Other members from 1 July 2022 to 31 March 2023 and their attendance records are detailed below:-

Table 17: Risk and Audit Committee composition and attendance record

Name	Role	Attendance Record (3 meetings held during the period 1 July 2022 to 31 March 2023)
John Beswick	NHS Dorset ICB Board Non-Executive Member and Committee Chair	3 of 3
Paul Johnson	NHS Dorset Chief Medical Officer	2 of 3
Robert Morgan	NHS Dorset Chief Finance Officer	3 of 3
Vanessa Read	NHS Dorset Chief Nursing Officer (interim to 30 September 2022)	0 of 1
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	2 of 2
Dean Spencer	NHS Dorset Chief Operating Officer	2 of 3
Manish Tayal	NHS Dorset ICB Non-Executive Member (interim) (from 1 August 2022)	3 of 3
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	2 of 3
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	2 of 3

During the period 1 July 2022 to 30 March 2023, matters reviewed by the Committee in the discharging their duty have included:

- the external auditors' annual work plan and progress reports on their work
- the internal audit work programme, internal audit reports and periodic progress reports on its work
- the Counter Fraud service's annual work plan and reports
- the organisation's operational and strategic risks through consideration of the Corporate Risk Register and Board Assurance Framework, noting that the current Board Assurance Framework has been retained from the Clinical Commissioning Group and will be revised in the new financial year
- the Data Security and Protection work including compliance with the Data Security and Protection Toolkit
- NHS Dorset's internal controls and their effectiveness, including awards of contract without competition
- the declarations of interest, gifts, hospitality and sponsorship
- the reporting requirements for NHS Dorset's financial statements to 31 March 2023.

The Committee has also approved the appointment of the internal and external auditors.

The Committee has wide powers to establish special investigations in the event that any wrongdoing is brought to its notice, in particular, in the case of embezzlement, fraud or theft. There were no cases requiring the exercise of these powers during the reporting period.

Remuneration Committee

The purpose of the Remuneration Committee is to make decisions in relation to the appointment of the Chief Executive and Chief Officers. It is also responsible for decisions regarding remuneration and any special payment packages for the Chief Executive, Chief Officers, and other senior managers reporting directly to the Chief Executive. The Committee makes recommendations to the Board on its executive composition, balance and skill mix, and succession planning, taking into considering the future challenges, risks and opportunities facing the system and the skills and expertise that are required within the Board to meet them.

The Remuneration Committee is chaired by Cecilia Bufton, NHS Dorset ICB Board Non-Executive Member. Other members from 1 July 2022 to 31 March 2023 and their attendance records are detailed below:-

Table 18: Remuneration Committee composition and attendance record

Name	Role	Attendance Record (6 meetings held during the period 1 July 2022 to 31 March 2023)
John Beswick	NHS Dorset ICB Board Non-Executive Member	4 of 6
Cecilia Bufton	NHS Dorset ICB Non-Executive Member and Committee Chair	4 of 6
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	5 of 6
Jenni Douglas-Todd	NHS Dorset ICB Board Chair (in attendance)	6 of 6
Manish Tayal	NHS Dorset ICB Board Non-Executive Member (interim) (from 1 August 2022)	1 of 3
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	6 of 6
Forbes Watson	NHS Dorset ICB Board Non-Executive Member (until 31 July 2022)	1 of 2
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	4 of 6

During the period 1 July 2022 to 30 March 2023, the key highlights of the work of the Committee have been:

- determining the pay award, severance and exit arrangements for former Dorset Clinical Commissioning Committee executives
- determining matters of pay for NHS Dorset Chief Officers
- determining the employment terms for NHS Dorset Chief Officer appointments including a Deputy Chief Executive.

Register of Interests

In line with our values of openness and honesty and statutory guidance, it is a requirement that all members of the NHS Dorset ICB Board, its Committees, Sub-Committees and all NHS Dorset staff including agency, seconded and contractual, should declare any interests that they have that may conflict with the interests of NHS Dorset itself. These can be found on our website.

Personal data related incidents

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

If we experience a personal data breach at NHS Dorset, we need to consider whether this poses a risk to people and the likelihood and severity of the risk to people's rights and freedoms following the breach. Once this assessment has been made by the Data Protection Officer, if it is likely there will be a risk then we will notify the Information

Commissioner's Office (ICO). If it is unlikely then we will deal with the breach according to NHS Dorset policies, without reporting to the ICO.

On 14 June 2022 a Decision Support Tool was emailed to the wrong member of the public. Due to the sensitive nature of the information contained, a report was made to the ICO. An internal investigation highlighted the error and recommended improvements to processes were put in place. The ICO decided to take no further action.

On 20 September 2022 a Subject Access Request was released to a member of the public. The documents contained text relating to a safeguarding incident, reported by a carer. The safeguarding information allowed the family to identify the carer. The ICO was notified. An internal investigation highlighted the error and recommended improvements to processes were put in place. The ICO decided to take no further action.

Modern Slavery Act

NHS Dorset fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2023 is published on our website at NHS-Dorset-Modern-Slavery-statement-2022-2023.pdf (nhsdorset.nhs.uk).

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 NHS Dorset and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

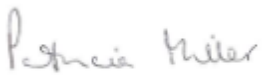
In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

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

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Dorset. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Dorset assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

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



Patricia Miller
Accountable Officer

19 June 2023

Governance Statement

Introduction and context

NHS Dorset is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS Dorset's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Between 1 July 2022 and 31 March 2023, NHS Dorset Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

I am responsible for ensuring that NHS Dorset 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 NHS Dorset as set out in this governance statement.

Governance arrangements and effectiveness

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

NHS Dorset's ICB Board meets for formal meetings bi-monthly. The first part of these meetings take place in public, with the public being welcome to attend in person at Vespasian House or watch via livestream. Recordings of the livestreams are available on our website along with the NHS Dorset ICB Board agendas and papers. Details of Board membership and attendance can be found in the section on the Composition of NHS Dorset Integrated Care Board above.

On alternate months NHS Dorset ICB Board holds a Development Session. These sessions cover a range of topics which provide education, development and training for Board members and participants. Topics covered included presentations on risk, emergency preparedness, resilience and response, adult social care, primary care including general practice and pharmaceutical, optometry and dental services, the Integrated Care Partnership strategy, NHS Dorset's Operational Plan and the Joint Five Year Forward Plan. As part of their development work the Board also undertook a 'Fresh Eyes' review as a group. This was based on a strengths, weaknesses, opportunities and threats analysis methodology (SWOT) considering the role of NHS Dorset to date and the function of the Board as part of NHS Dorset's performance. Further review of NHS Dorset ICB Board's effectiveness will be undertaken as we head towards the end of our first year of establishment.

The Board is supported by the Board Committees, including a Risk and Audit Committee, which provide oversight and assurance on the subject areas in their remit. Details of the Committee memberships and attendance, and the role of each Committee can be found in the Corporate Governance Report above.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance however this annual report sets out our corporate governance arrangements and the steps

NHS Dorset has taken to ensure that corporate governance best practice is followed. More information can be found in our Governance Handbook on our website.

Discharge of Statutory Functions

NHS Dorset 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 NHS Dorset 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 Chief Officer. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of NHS Dorset's statutory duties.

Risk management arrangements and effectiveness

To enable the transition of the Clinical Commissioning Group to become an Integrated Care Board, an NHS Dorset Integrated Care Board Risk Framework was developed between March 2022 and June 2022. The final version, which was extensively consulted upon, was approved at the first Board meeting on 1 July 2022.

The Risk Framework:

- Standardises and clarifies the terminology of risk management.
- Sets out the organisation's objective to identify, treat and mitigate risk.
- Details NHS Dorset's risk appetite statement (updated at least annually).
- Explains the roles and responsibilities within NHS Dorset relating to risk.
- Defines the role and objectives of the organisation's committees and groups.
- Clearly explains the tools (Corporate Risk Register and Board Assurance Framework) used by NHS Dorset to document and manage risks to the organisation, detailing the clear, consistent, and effective risk scoring systems used.
- Details how the organisation has a clear view of the risks affecting each area of its activity, how the risks are being managed and their potential impact on the organisational objectives.
- Assures the public, patients and their carers/representatives, staff, and partner organisations that NHS Dorset is committed to managing risk appropriately.

This documented approach to managing identified risk helps us achieve agreed standards, reduce overall costs, and maintain and enhance the standard of service provided.

It was also agreed that we would continue to use the Board Assurance Framework previously adopted by the Clinical Commissioning Group as we transitioned to an Integrated Care Board. This would allow us time to develop new plans for our assurance, with a new approach to be adopted in the new financial year following the publication of strategic objectives in the Joint Five Year Forward Plan.

Our new Board Assurance Framework will be built on a top-down critical analysis of our objectives however, for operational risks, the risk management process is a bottom-up

approach. Within each Directorate there are considerations of what the risks are in their own areas and how they affect the organisation. High scoring risks are escalated from a Directorate, or local, risk register to the Corporate Risk Register.

The Corporate Risk Register is a risk management tool which acts as a central repository for all the locally considered higher risks, or those that have the potential to be high risks. These risks are recorded and managed via the Ulysses software Safeguard Risk Management System and are mapped, where applicable, to the strategic objectives of the organisation within the Board Assurance Framework.

It is important to match the balance between the two approaches and ensure there are assurances against both to demonstrate controls are working effectively and risks managed to below the desired level, in line with our risk appetite statement.

The Board Assurance Framework template which we adopted from the Clinical Commissioning Group documents each of our objectives and details:

- The corresponding strategic risk of not achieving the objective.
- The inherent risk score (the score before controls were put in place).
- The corresponding NHS Dorset risk appetite domain and risk appetite score.
- Sources of assurance.
- Controls.
- Identified risks and actions taking place to reduce the risk level, including reference to any corresponding risks on the Corporate Risk Register.
- Remaining gaps in assurance/control.
- The residual risk score (the score remaining once the controls have been put in place).

This detailed method ensured an enhanced approach to assurance which enabled the Board and its Committees to focus only upon objectives with a remaining high residual risk, and the associated remedial action plan. For those objectives with a residual risk score of 15+, an exception report was produced monthly by the responsible Chief Officer. All assurance lines were updated at least quarterly, or more frequently if required.

Any changes to the residual risk scores made either through the monthly or quarterly review process were documented on a ‘Board Assurance Framework Risk Score tracker’ to allow the Board, Risk and Audit Committee and Chief Officers to see how the residual risk score changes over time. The tracker was ordered with the highest residual risk scores at the top, and the lowest at the bottom. This tracker was submitted to the Board, Risk and Audit Committee and Quality and Safety Committee when any scores change, but at least quarterly.

Risk management is embedded in all aspects of the organisation’s work through a range of methods including:

- **Equality Impact Assessments:** we are committed to ensuring a reduction in health inequalities and places the needs of people and communities at the heart of all commissioning functions. Equality analysis is undertaken when reviewing services,

making changes to services, commissioning services, and using information within services and within the policies that are used. We work with an independent Lay Assessor to ensure high quality and comprehensive Equality Impact Assessments (EIAs) are conducted.

Additionally, we have an Equality, Diversity and Inclusion (EDI) Steering Group and publish an annual Equality, Diversity and Inclusion Report which acknowledges the organisation's successes in relation to equality and diversity, as well as making recommendations for improvement. We have started to explore the use of a Health Equity Assessment Toolkit (HEAT) which considers equality beyond the nine protected characteristics, including the socioeconomic position, occupation, geographic deprivation, and membership of a vulnerable group. This has currently been trialled within the maternity services team and is being considered as an equality, diversity and inclusion system approach.

- **Incident reporting**: Adverse and serious incident reporting is openly encouraged from all staff, GP practices and the provider organisations (both NHS and non-NHS) that are commissioned by us. This information is analysed and used to identify any risks which may impact the business of NHS Dorset.

- **Stakeholder engagement:** In line with our duty to involve, we actively collaborate with people and communities in the planning and development of locally commissioned services. We collaborated with local stakeholders to co-create our strategic approach to working with people and communities which is in line with national statutory guidance and our duty to involve. We recognise that it is important to engage with, reach out to and include the widest group of stakeholders, people and communities possible, so that we can identify people's unique and diverse needs. We recognise the importance of building relationships based on trust, especially with those affected by health inequalities. It is vital to listen and understand people's beliefs, concerns, behaviours, culture, religion, experiences and aspirations.

  We have regular meetings with the public, community, voluntary and patient participation groups to enable stakeholder engagement and inform communications. We are leading a system wide programme of community conversations, reaching out to stakeholders, people and communities to explore their lives and understand what impacts on their health and wellbeing. We provide advice and guidance to teams across NHS Dorset to support stakeholder engagement. We carry out stakeholder analysis and equality impact assessments for each programme of service improvement work and maintain a detailed engagement planner to manage and track engagement.

  Our People and Culture Committee receives regular assurance reports from the engagement and communications team. We work closely with Healthwatch Dorset to discuss and inform our approaches to stakeholder engagement. We also work closely with the Dorset Public Engagement Group (PEG) and the Digital PEG to

discuss and inform our approaches to stakeholder engagement with the PEG and DPEG Chairs attendees of the Integrated Care Partnership meetings. NHS Dorset facilitates a vibrant monthly meeting of all Integrated Care System partner engagement leads, to discuss stakeholder engagement, enable collaboration and avoid duplication. We contribute to regional and national engagement meetings led by NHS England.

We have supported the Voluntary and Community Sector (VCS) in its co-design of an Assembly which will bring together the voices of the VCS, engaging with thousands of voluntary and community groups and community members, building on existing networks, strengthening community partnerships and embedding the sector as partners in system level governance and decision-making arrangements.

- **Counter fraud methodology:** We are required under the terms of the Standard NHS Contract and in accordance with the new Government Functional Standard GovS 013: Counter fraud – Counter Fraud, Bribery and Corruption, to ensure that appropriate counter fraud measures are in place.

  There is a robust programme of counter fraud and anti-bribery activity, supported by the accredited Anti-Crime Specialist whose annual proportionate proactive work plan to address identified risks is monitored by the Chief Finance Officer and the Risk and Audit Committee. The Chief Finance Officer is the first point of contact for any issues to be raised by the Anti-Crime Specialist.

  Counter fraud material is disseminated to staff regularly through the intranet and email. The Anti-Crime Specialist has attended various directorate team meetings during 2022/23 to raise awareness of the issues regarding fraud, bribery and corruption in the NHS and remind all staff of the appropriate reporting lines. The Anti-Crime Specialist inputs to the review of various policies, including the Anti-Fraud, Bribery and Corruption Policy to ensure that they are up-to-date and accurate. Policies are reviewed in line with current legislation, from a best practice and counter fraud perspective. Details of all policies, procedures and key documents reviewed are reported to the Risk and Audit Committee.

  The Anti-Crime Specialist regularly attends the Risk and Audit Committee meetings to provide progress reports and updates, as well as providing an Annual Report of the Counter Fraud Work undertaken. The Government Functional Standard GovS 013 Counter fraud - Counter Fraud, Bribery and Corruption Return was completed by the Anti-Crime Specialist and was submitted with an overall score of Green. Appropriate action would be taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

  The Anti-Crime Specialist issued NHS Counter Fraud Authority Intelligence Bulletins and various TIAA Fraud Alerts during 2022/23 regarding ongoing fraud issues nationally within the NHS and the wider public sector including suspicious bank accounts, council tax rebate scam, push payment fraud, cost of living fraud, festive frauds, and phishing emails.

Capacity to Handle Risk

In relation to risk management, NHS Dorset is responsible for:

- Articulating the organisation's strategic objectives, within the Board Assurance Framework (BAF).
- Identifying risks to the achievement of its strategic objectives, within the BAF.
- Protecting the reputation of the organisation.
- Providing leadership, active involvement, and support for risk management.
- Determining the risk appetite for the organisation.
- Ensuring the approach to risk management is consistently applied.
- Ensuring that there is a structure in place for the effective management of risk throughout the organisation and that this structure is consistently applied.
- Monitoring these processes on an on-going basis via the BAF and Corporate Risk Register.
- Reviewing and approving the Risk Management Framework on an annual basis.

NHS Dorset can assure itself of the validity of the Governance Statement in a number of ways. These are:

- Adherence to the Risk Management Framework.
- Adherence to the organisation's Committee structure, Committee Terms of Reference, and reporting framework.
- Scrutiny of the Annual Governance Statement by the Risk and Audit Committee, ahead of authorisation by the Board.

Leadership for the organisation's risk management process is provided via the Board, with responsibility delegated to the Risk and Audit Committee. The organisational structure has been established to assist with this process and is described in the following paragraphs.

The organisation's Chief Nursing Officer is the designated lead for risk and patient safety and is responsible for ensuring that the Risk Management Framework is implemented and evaluated effectively.

All Chief Officers, Deputy Chief Officers and managers have delegated responsibility and authority regarding the management of risks within their specific areas of work, including compliance with the Risk Management Framework and for ensuring that remedial action is taken wherever key risks are identified within their area of responsibility, including:

- The reporting of adverse incidents, together with actions to prevent or minimise a recurrence.
- Identifying and adding risks to the Corporate Risk Register in a timely manner.
- Co-ordinating the application of resources to minimise, manage and control the likelihood and/or impact of the risk.
- Undertaking risk assessments and actions implemented.
- Ensuring staff undertake mandatory and statutory training.

NHS Dorset has clear governance structures with delegation of responsibility clearly articulated in the Terms of Reference for Committees and Groups. All Committees review their effectiveness annually and there are clear lines of reporting from all Committees and groups to the Board. The Board, through reports and updates, reviews the quality, performance, and financial stewardship of the organisation. Any risks identified relating to these areas have been recorded in the Corporate Risk Register and/or the Board Assurance Framework.

The organisation holds a mandatory Declarations of Interest Register and undertakes an annual review of declarations. Potential conflicts of interest are considered in all aspects of the organisation's business. Declarations of interest are considered and recorded as required at every formal Board, Committee and group meeting.

The Head of Nursing and Quality (Quality, Governance and Risk), supported by the Patient Safety and Risk Manager, has delegated responsibility for:

- Co-ordinating and managing activities relating to clinical, corporate, and financial risks for the organisation.
- Monitoring risk management and patient safety within commissioned and corporate services for the organisation.
- Maintaining the Corporate Risk Register and Board Assurance Framework through engagement with the Chief Officers and Directorate Risk Leads.
- The management of all Never Events, serious incidents, and adverse incidents.

The Patient Safety and Risk team supports the consistent identification, assessment, and management of risk across the organisation and, as a team, are central to the dissemination and application of best practice. Additionally, the team undertakes the key administration and system processes and acts as a central resource and advisory function in relation to risk and risk management.

New staff to the organisation receive information on risk management as part of their NHS Dorset induction and all Board members receive annual risk training.

The cumulative contribution of the above mechanisms assist in the assurance of commissioning services that ensure patient safety is high profile.

The current information security landscape

The health industry was the third most targeted industry globally through 2022 showing a 60% increase in the number of cyber attacks over 2021, and it was the most targeted industry for Ransomware attacks in the third quarter of 2022. (Source Checkpoint Ltd)

We have seen attack activity in the form of denial-of-service attacks on public websites and targeted phishing campaigns aimed at staff.

We have been paying particular attention to activity coming from criminal groups and certain state actors and blocking activity and countries from which the threat activity has been seen to have increased.

Implementation of new email security has helped prevent targeted phishing attacks, provided additional protection in the form of easy-to-use email encryption, and lowered the number of potential incidents caused by misdirected email.

We continue to make good use of services and intelligence received from Government and NHS centralised security services. These allow proactive monitoring and reduces the opportunity for attack on our systems.

We remain engaged at a regional level with all other NHS organisations across the South West and are an active participant in the South West Cyber Security Forum which discusses development of Cyber Security strategy and best practice across the region.

NHS Dorset has not been materially impacted by any successful cyber-attacks between 1 July 2022 and 31 March 2023, including both the Capita and Advanced breaches which impacted NHS organisations. We have seen the usual phishing attacks and reconnaissance activity aimed at our public-facing services from outside of the UK.

Emergency Preparedness, Resilience and Response

The emergency preparedness, resilience, and response (EPRR) function of the NHS remains high profile.

On 19 May 2022 the Incident Response Level for Covid-19 reduced from a Level 4 (National) Incident to a Level 3 (Regional) Incident and remains at Level 3 on 31 March 2023.

From 1 July 2023 Integrated Care Boards became Category 1 responders, increasing the accountability of the organisation within the Civil Contingencies Act by:

- Assessing the risk of emergencies occurring.
- Putting in place emergency plans and business continuity management arrangements.
- Maintaining plans to inform and advise the public in the event of an emergency.
- Sharing information with other local responders to enhance co-ordination.
- Co-operating with other local responders to enhance coordination and efficiency.

NHS Dorset has an Accountable Emergency Officer (AEO) and Deputy Accountable Emergency Officer (DAEO) to ensure these responsibilities are met.

Risk Assessment

NHS Dorset continues to develop and embed its approaches to risk management both internally in the organisation and as a partner within the Integrated Care System. The organisation views integrated risk management as a key element in the successful delivery of both NHS Dorset and Integrated Care System business and remains committed to ensuring staff are equipped to assess, manage, escalate, and report risks.

The Board receives regular assurance on the management of risk from the Risk and Audit Committee. Reports are also received bi-monthly by Chief Officers summarising the top

risks to the organisation (those scoring 15 and over), new risks, closed risks, and any other key risk issues.

All risks identified in the Corporate Risk Register require the formulation of an action plan. The Patient Safety and Risk team communicates with risk leads on a monthly or quarterly basis (dependant on risk level) to record progress against action plans and documents the effect these are having on the residual risk score. All action plans are formally reported via the Corporate Risk Register. The document includes all risks that may impact on the achievement of the organisation's objectives.

Risks are scored on a matrix which multiplies likelihood by consequence to score the potential severity of a risk being realised. Risks scored above 15 are categorised as 'high risk'.

Between 1 July 2022 and 31 March 2023, the process to record operational risks associated with development projects continued, with a clear route to escalate any of the risks identified to the Corporate Risk Register.

Between 1 July 2022 and 31 March 2023, there was an atypical level of opening and closing of risks on the Corporate Risk Register due to the need to re-frame risks from the perspective of NHS Dorset following the transition from the Clinical Commissioning Group. During this nine-month period 21 risks were added to the Corporate Risk Register, and 37 risk were closed. At the end of the reporting period, 13 risks remain open.

Of the 13 open risks as at 31 March 2023 seven are assessed as high. These relate to:

- Managing expenditure within the financial envelope (two risks).
- Response times for 999 responses.
- Workforce – recruitment and sustainability.
- Capacity issues within the Continuous Positive Airway Pressure (CPAP) treatment service and the resulting risk of harm to patients awaiting review/treatment.
- Community capacity challenges for the care of patients with lower limb ulceration, and the care impact on this patient cohort.
- The challenges of current demand for acute mental health inpatient beds.

Our risk profile will be subject to on-going in-year revision.

As Accountable Officer I can confirm that there have been no significant lapses of protective security.

Other sources of assurance

Internal Control Framework

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

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

The internal control framework is underpinned by the finance system, the Integrated Single Financial Environment (ISFE) which is mandated for all Integrated Care Boards by NHS England. The system is set up to reflect the delegated financial limits laid down in the Standing Financial Instructions and forces access control and segregation of duties which reduces the risk of fraud and error. Other key components include:

- control environment
- budgetary control
- management checks, authorisations, and oversight
- control account reconciliations
- internal audit and counter fraud activity.

The Risk and Audit Committee ensures that effective internal control is in place and provides relevant assurance to the Board.

The Internal Control Framework, in conjunction with the Risk Framework, provides assurance to the Board of the controls that are in place to mitigate the key risks that could impact on the organisation's delivery of its strategic objectives.

Annual Audit of Conflicts of Interest Management

The revised statutory Guidance on Managing Conflicts of Interest (published June 2017) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support Integrated Care Boards to undertake this task, NHS England has published a template audit framework.

In January 2023, the annual Conflicts of Interest Internal Audit commenced with the final report provided in April 2023.

The scope of this audit covered the areas set out by NHS England in their published audit template for this nationally mandated review. The audit looked at compliance over the five key areas:

- governance arrangements
- declarations of interests, gifts, and hospitality

- registers of interests, gifts and hospitality and procurement decisions and contracts
- decision making processes and contract monitoring
- reporting of concerns and areas of non-compliance.

An overall assurance of 'substantial' was achieved for the design and 'moderate' for operational effectiveness. It was noted NHS Dorset has sound controls in place to manage and monitor conflicts of interest through clear guidance set by the policies and committee meeting discussions. However, there were two findings: one relating to the declaration of a Board member and one regarding the publication of the Procurement Register. Actions have been taken to redress these findings and plans put in place to mitigate recurrence.

Data Quality

The data used by our Board, Committees and Groups is obtained from various sources, the majority of which are national systems and official NHS data sets. Provider data is quality assured through a number of mechanisms including contract and performance monitoring but also through system control center and other system resilience processes.

The specific governance of data quality and consistency across the Integrated Care System providers is owned by the system-wide Operations and Finance Reference Group. NHS Dorset maintains good close working relationships with the local providers and addresses any data quality issues in a timely and productive way.

In December, as part of their programme of development sessions, the Board received a presentation on the use of Statistical Process Control (SPC), an analytical technique which plots data over time. The Board welcomed the benefits of using SPC over other statistical methodologies, especially for understanding impact when implementing change. In line with many NHS organisations, the use of SPC has been adopted for much of our reporting, and this can be seen in the regular Board papers on quality and performance. In addition, the positive uses of the data from the Dorset Intelligence and Insight Service (DiiS) has been discussed regularly by the Board, including in relation to targeting prevention and treatment, and in addressing health inequalities. More information regarding the DiiS and health inequalities can be found in the Reducing Health Inequality section above. The Board have raised no concerns about the quality of data they receive.

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 NHS Dorset, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance (IG) systems and processes in place to manage data security risks and the protection of patient and corporate information.

Responsibility for Information Governance rests with me, and as Accountable Officer I have delegated authority to the Information Asset Owners' Group (IAOG). A range of measures are used to manage and mitigate information risks, including annual mandatory staff training, physical security, data encryption, access controls and departmental spot checks.

The organisation's IG status is regularly reviewed by the IAOG which is a standing group that reports to the Board via the Risk and Audit Committee. Its purpose is to support and drive the broader IG agenda and provide assurance to the Board that effective IG best practice mechanisms are in place. Risks to information, including data protection, data security, confidentiality, integrity, and availability, are managed and controlled via this group which meets quarterly.

The Senior Information Risk Owner (SIRO) has responsibility for leading and implementing the information asset risk assessment and management processes within NHS Dorset in addition to advising the Board on the effectiveness of information risk management throughout the organisation.

As part of the annual Data Security and Protection toolkit (DSP) submission, a comprehensive assessment of information security is undertaken. The effectiveness of this assessment is reported to, and monitored by, the IAOG. This includes details of any personal data related serious incidents, NHS Dorset's annual DSP toolkit submission and reports of other IG incidents and audit reviews. Regular reports are received in relation to policies, the Caldicott risk register, information assets and records management.

There is a staff handbook in place to ensure that staff are aware of their roles and responsibilities under IG and the Data Protection Act 2018.

We are making good progress towards our aim to publish 'standards met' for the DSP toolkit for 2022/23 and confirmation of the outcome is expected in July 2023.

There are processes in place for incident reporting and investigation of serious incidents.

Information risk assessment and management procedures have been established via the IAOG, the SIRO and the risk management team. Work continually takes place to ensure that these are embedded throughout the organisation. All incidents which have a data protection element are investigated with lessons learnt shared via the IAOG.

There have been two serious breaches of the Data Protection Act (Level 2 reportable) between 1 July 2022 and 31 March 2023 which were reported to the Information Commissioners Office (ICO), the details of which are set out in the section on Personal Data Related Incidents above.

Business Critical Models

As Accountable Officer I can confirm that there is an appropriate framework and environment in place to provide quality assurance of business-critical models, in line with the recommendations in the Macpherson Report for government departments and their arm's length bodies.

Having reviewed the guidance around business-critical models and the detail held by HM Treasury, although ICBs make use of the models, we do not own them, and are unable to change their content. For example, the models include the ICB allocations formula and the modelling for the national tariff; we receive the outputs of these models but have no control or input to their use.

Third party assurances

NHS Dorset contracts for goods and services using the recommended or statutorily mandated contract forms which contain robust provisions around third party (sub-contracting) rights and assurances. These are scrutinised through the contract review process.

Control Issues

There were no significant control issues identified between 1 July 2022 and 31 March 2023.

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

The Scheme of Reservation and Delegation sets out the routes for all NHS Dorset decisions, including those relating to economy, efficiency and effectiveness of the use of resources. Alongside this, the Standing Financial Instructions and Detailed Delegation Limits ensure that we fulfil our statutory duty to carry out our functions effectively, efficiently and economically. As part of our control measures for managing the organisation's financial affairs, the Standing Financial Instructions define our purpose, responsibilities, legal framework and operating environment. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

Our Chief Executive Officer is the Accountable Officer for NHS Dorset and is personally accountable to NHS England for the stewardship of our allocated resources. The Standing Financial Instructions set out the financial responsibilities that are delegated from our Chief Executive Officer to our Chief Finance Officer, who has a key role in supporting a strong culture of public accountability, probity, and governance.

Our Board and the Board Committees provide assurance and oversight on the economy, efficiency and effectiveness of the use of resources. Details of the work of the Board Committees are given in the Accountability Report above. This includes the work of the Risk and Audit Committee, whose functions include oversight of the internal audit programme. Each year the Head of Internal Audit must provide an opinion on the overall adequacy and effectiveness of our framework of governance, risk management and internal control, and this can be read below.

We continue to operate as part of an Integrated Care System and have in place a system control total in partnership with the three Foundation Trusts within Dorset. Being part of this arrangement enables the partners to work together to ensure maximum resources are available and collective management of risk. South Western Ambulance Service NHS Foundation Trust is also part of the Dorset system control total, however where there are

issues relating to the quantum of funding this is picked up through the Ambulance Joint Commissioning Committee for resolution on a regional footprint.

Arrangements continue to be in place to operate as an Integrated Care System including monthly monitoring of actions, performance and financial metrics through the Finance and Performance Committee and the System Executive Group (SEG), alongside the Board and provider board to board meetings.

In 2023/24 an allocation-based financial regime remains, with final plans agreed in May 2023. Processes continue to be in place to record and monitor costs within NHS Dorset as with the Clinical Commissioning Group. In addition, NHS Dorset has set ambitious savings targets for 2023/24 to look for opportunities to reduce the cost base and therefore deliver on its break-even duty for the financial year. There will be continued scrutiny and oversight of the delivery of this programme.

Regular reporting is in place to Chief Officers, with bi-monthly reporting to our Board on financial performance and delivery against the agreed plan. For 2023/24 the first report will be for the position as at the end of May, due to reporting cycles and information availability; this reporting will include proposed mitigations for any variance to plan that could lead to non-delivery. Quality, innovation, productivity and prevention deep dives, where appropriate, are requested by the Finance and Performance Committee providing an additional level of scrutiny and assurance to the Board.

The underlying recurrent financial position is recognised by Dorset Integrated Care System partners to be a deficit position with all partners committed to the delivery of ambitious savings targets. The progression of the financial strategy alongside delivery of savings programmes remains critical to ensure that we develop and deliver a strategy that will achieve and maintain a financial balance. This has been identified on the Board Assurance Framework as a high rated risk. The consequences of not returning to a financially sustainable position would be increased regulatory scrutiny, restrictions on cash and limited investment being available for improving services.

As set out in the Performance Synopsis earlier in this document, the Clinical Commissioning Group Improvement and Assessment Framework was replaced by the NHS Oversight Framework in 2019/20. The NHS System Oversight Framework 2022/23 describes NHS England's approach to NHS oversight for 2022/23. Its metrics align to the five national themes of the System Oversight Framework of quality of care, access and outcomes, preventing ill health and reducing inequalities, people, finance and use of resources, and leadership and capability. The annual performance review between NHS Dorset and NHS England for 2022/23 is currently being finalised, with a draft rating of Segment 2 applied to NHS Dorset. As per the framework, this is the default segment that all ICBs and Trusts will be allocated to unless the criteria for moving into another segment are met.

Where ICBs and Trusts have significant support needs that may require formal intervention and mandated support, they will be placed into segment 3 or 4. They will be subject to enhanced direct oversight by NHS England (in the case of individual Trusts this will happen in partnership with the ICB) and, depending on the nature of the problem(s) identified, additional reporting requirements and financial controls.

Delegation of functions

The Scheme of Reservation and Delegation sets out those matters that are reserved for NHS Dorset ICB Board and which are delegated to the Board Committees and Chief Officers. The Scheme of Reservation and Delegation is available as part of our Governance Handbook which is available on our website. Board Committees submit a report on their activities to the Board after each Committee meeting. The remit of each Committee, and their attendees, are detailed in the Corporate Governance Report above.

The Risk and Audit Committee, in line with our Scheme of Reservation and Delegation, monitors the financial stewardship of the organisation and is responsible for scrutinising the end of year financial accounts and recommending approval to the Board. At year end NHS Dorset achieved its break-even statutory duty.

The Risk and Audit Committee retains oversight of all operational and strategic risks and are responsible for ensuring that relevant mitigating actions are undertaken. There have been no significant internal control failures identified between 1 July 2022 and 31 March 2023.

Internal Audit has found no significant lapses in key controls tested in any of the audits that have been undertaken in this financial period.

NHS Dorset commissions support services from other NHS organisations under the NHS contract for goods and services for the provision of back-office functions such as payroll and occupational health. The contract form provides the framework under which assurance on performance can be monitored and managed.

Freedom to speak up: raising concerns (whistleblowing) effectiveness

NHS Dorset is committed to creating the right environment for staff and ensuring staff feel they have a voice is reflected in the priorities of the NHS Dorset People Plan. We encourage staff to raise concerns or suggestions they may have to inform and improve how NHS Dorset conducts itself. We are committed to ensuring staff know their voice can be heard, and that their concerns and suggestions raised will be acted upon.

To support staff to speak up we have a Freedom to Speak Up Policy, which was recently reviewed and aligned to national guidance. We have a Freedom to Speak Up Chief Officer and Non-Executive Member with overall responsibility for raising concerns. Staff are also encouraged to raise concerns or suggestions to their line manager, through their team or through the Staff Council. In the coming months we will be also appointing a member of staff as a Freedom to Speak up Guardian. Our Freedom to Speak Up arrangements are reviewed by the Risk and Audit Committee, who provide assurance to the Board that appropriate processes are in place.

In line with national guidance, all Freedom to Speak Up concerns are logged and included on the National Guardian Officer website. Up to December 2022, one case had been raised at NHS Dorset. This related to someone working at Vespasian House who was not employed by NHS Dorset.

In addition, we have recently established three staff networks focused on ethnicity, sexuality and disability, each chaired by a member of staff. The networks are supported by the organisation but chaired independently. NHS Dorset also has a longstanding Trade Union Partnership forum attended by local and regional representatives.

Counter fraud arrangements

NHS Dorset is required, under the terms of the Standard NHS Contract and in accordance with the 'Government Functional Standard GovS 013: Counter fraud – management of counter fraud, bribery and corruption activity' to ensure that appropriate counter fraud measures are in place. The organisation's accountable officer for fraud, bribery and corruption is the Chief Finance Officer, who is responsible for authorising investigations, including the arrest, interviewing and prosecution of subjects and the recovery or proposal to write-off any sums lost to fraud.

We have an accredited local counter fraud specialist (LCFS) who is nominated and responsible for the investigation of any allegations of fraud, bribery, and corruption and for the delivery of a programme of proactive counter fraud work, as detailed in the annual risk-based work-plan approved by the Risk and Audit Committee. Where fraud is established or improvements to systems or processes identified, the LCFS will recommend appropriate action to the organisation. The LCFS collaborates closely with the workforce team when investigating cases involving members of staff and provides evidence to our investigating officer for disciplinary matters.

NHS Dorset has a nominated in-house Counter Fraud Champion whose role is to support the LCFS in promoting awareness of fraud across the organisation.

Monitoring of the organisation's counter fraud arrangements is undertaken by the Risk and Audit Committee. The LCFS, who is responsible for the investigation of any allegations of fraud, bribery, and corruption and for the delivery of a programme of proactive counter fraud work, attends each Risk and Audit Committee meeting to report progress against the agreed counter fraud work plan and advise the outcome of any completed investigations or proactive exercises.

NHS Dorset is required to submit an annual counter fraud functional standard return (CFFSR) against 'Government Functional Standard GovS 013: Counter fraud – management of counter fraud, bribery and corruption activity' which provides assurance of compliance to the requirements of the standard.

A fraud response plan is in place which sets out these roles and responsibilities and the steps to be taken by us if fraud is suspected. All staff are required to report any suspicions of fraud, bribery, or corruption that they may have either to the LCFS, NHS Counter Fraud Authority, Chief Finance Officer or the organisation's Counter Fraud Champion.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 July 2022 to 31 March 2023 for NHS Dorset, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS Dorset's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The role of internal audit is to provide an opinion to the Board, through the Risk and Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control, and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period. The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Board Assurance Framework and supporting processes.
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year, taking account of the relative materiality of these areas and management's progress in addressing control weaknesses.
- Any reliance that is being placed upon third party assurances.

Overall, we provide moderate assurance that there is a sound system of internal control designed to meet the ICB's objectives and that controls are being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

In forming our view we have taken into account that:

- The ICB planned for and it has delivered (subject to external audit) a break-even income and expenditure financial position for the period July 2022 to March 2023.
- For 2022/23, NHS Dorset ICB was issued a single control total to be managed across two financial periods, April to June for Dorset CCG and July to March for the newly formed Dorset ICB. This was achieved.
- The ICB has displayed strong controls in relation to the key financial systems and delegated primary medical care functions.
- The ICB has risk management processes in place, however, the new format of the Board Assurance Framework is under development.
- Good progress has been made during the year with the implementation of the actions arising from our audit work.

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

Area of Audit	Level of Assurance Given
Conflicts of Interest	Design – Substantial Operational Effectiveness – Moderate
Key Financial Systems	Design – Substantial Operational Effectiveness – Substantial
Primary Care Commissioning	Design – Substantial Operational Effectiveness - Substantial

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 NHS Dorset who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

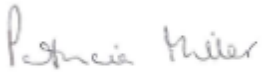
My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

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

This review is supported by:

- The assurance work of the Board Committees, especially the Risk and Audit Committee.
- The oversight work of the Board.
- The work of the internal auditors.
- The Risk Framework, Internal Control Framework, Board Assurance Framework and Corporate Risk Register as detailed in the Governance Statement above, which provide evidence of the effectiveness of governance, risk management and internal controls.

In conclusion, I can confirm that no significant internal control issues have been identified.



Patricia Miller
Accountable Officer

19 June 2023

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Pay ratio information (subject to audit)

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

The banded remuneration of the highest paid director/member in NHS Dorset in the reporting period 1 July 2022 to 31 March 2023 was £190,000 to £195,000.

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

As at 31 March 2023, remuneration ranged from £21,730 to £193,600 based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration of NHS Dorset staff is shown in the table below.

Table 19: Remuneration

	25th Percentile (£'000)	Median (£'000)	75th Percentile (£'000)
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	33	41	55
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	33	41	55

The ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director, is illustrated in the table below.

Remuneration of NHS Dorset staff is shown in Table 19.

Table 20: Ratio – staff against highest paid director

Year	25th Percentile pay ratio	Median pay ratio	75th Percentile pay ratio
2022/23	5.8:1	4.7:1	3.5:1

The banded remuneration of the highest paid director/member in NHS Dorset ICB in the financial period was £190,000-£195,000 and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Table 21: Ratio – highest paid director and relationship with workforce

Year	25th Percentile total Remuneration ratio	25th Percentile salary ratio	Median total Remuneration ratio	Median salary ratio	75th Percentile total Remuneration ratio	75th Percentile salary ratio
2022/23	5.8:1	5.8:1	4.7:1	4.7:1	3.5:1	3.5:1

In 2022/23, 0 employees received remuneration in excess of the highest-paid director/member.

The median pay ratio, is reflective of the ICB's policies, reflecting the nationally mandated Agenda for Change pay progression and the move within the ICB to additional higher banded staff roles.

Policy and the remuneration of very senior managers

At NHS Dorset, we have actively recruited an executive leadership team with the skills, experience, values and behaviours to lead our organisation. We are satisfied that for those earning above £150,000, as with all the executive team, that their remuneration reflects the wealth of experience they bring. Each appointment has been in line with national guidance and the very senior manager pay framework.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

(all appointed on 1 July 2022 unless stated otherwise below)

Table 22: Senior manager remuneration

Name and Title	1 July 2022 to 31 March 2023					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Executive Directors						
Jenni Douglas-Todd, Integrated Care Board Chair	45 - 50	0	0	0	0	45 - 50
Patricia Miller, Chief Executive Officer	145 - 150	0	0	0	47.5 - 50	190 - 195
Rob Morgan, Chief Finance Officer	105 - 110	0	0	0	25 - 27.5	135 - 140
Paul Johnson, Chief Medical Officer	110 - 115	0	0	0	55 - 57.5	165 - 170
Debbie Simmons, Chief Nursing Officer (appointed 26 September 2022)	70 - 75	0	0	0	42.5 – 45	110 – 115
Stephen Slough, Chief Information Officer	90 - 95	0	0	0	20 - 22.5	110 – 115
David Freeman, Chief Commissioning Officer	90 - 95	0	0	0	17.5 – 20	110 – 115
Dawn Harvey, Chief People Officer (appointed 15 August 2022)	75 - 80	0	0	0	15 - 17.5	95 – 100
Neil Bacon, Chief Strategy and Transformation Officer (appointed 1 August 2022)	90 - 95	0	0	0	17.5 – 20	110 – 115
Dean Spencer, Chief Operating Officer (appointed 1 September 2022)	80 - 85	0	0	0	0	80 - 85

Name and Title	1 July 2022 to 31 March 2023					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Non-Executive Members						
John Beswick, ICB Board Non-Executive Member	10 - 15	0	0	0	0	10 - 15
Cecilia Bufton, ICB Board Non-Executive Member	10 - 15	0	0	0	0	10 - 15
Jonathon Carr-Brown, ICB Board Non-Executive Member	10 - 15	0	0	0	0	10 - 15
Manish Tayal, Interim ICB Board Non-Executive Member (appointed 1 August 2022)	10 - 15	0	0	0	0	10 - 15
Kathleen Taylor, ICB Board Non-Executive Member	10 - 15	0	0	0	0	10 - 15
Forbes Watson, ICB Board Non-Executive Member (appointed 1 July 2022; resigned 31 July 2022)	0 - 5	0	0	0	0	0 - 5
Dan Worsley, ICB Board Non-Executive Member	10 - 15	0	0	0	0	10 - 15

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

Notes:

1. Taxable Benefits relate to on-call and mileage above taxation threshold.

Pension Benefits (subject to audit)

Table 23: Pension benefits as at 31 March 2023 (subject to audit)

Name and Title	Scheme	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2022	Real Increase in Cash Equivalent Transfer Value at 31 March 2023	Cash Equivalent Transfer Value at 31 March 2023	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Patricia Miller Chief Executive Officer	Old	0 - 2.5	0 - 2.5	30 - 35	95 - 100	667	40	727	0
	2015	2.5 - 5	7.5 - 10	25 - 30	80 - 85	321	27	387	0
Rob Morgan Chief Finance Officer	Old	0 - 2.5	0 - 2.5	5 - 10	15 - 20	74	4	80	0
	2015	0 - 2.5	5 - 7.5	15 - 20	55 - 60	206	19	254	0
Paul Johnson Chief Medical Officer	Old	0 - 2.5	2.5 - 5	20 - 25	70 - 75	434	41	493	0
	2015	0 - 2.5	5 - 7.5	10 - 15	40 - 45	124	19	172	0
Debbie Simmons Chief Nursing Officer	Old	0 - 2.5	2.5 - 5	30 - 35	90 - 95	655	45	765	0
	2015	0 - 2.5	2.5 - 5	10 - 15	30 - 35	119	15	173	0
Stephen Slough Chief Information Officer	2015	0 - 2.5	5 - 7.5	10 - 15	40 - 45	126	12	160	0
David Freeman Chief Commissioning Officer	Old	0	0	20 - 25	60 - 65	396	14	418	0
	2015	0 - 2.5	5 - 7.5	15 - 20	55 - 60	190	16	231	0
Dawn Harvey Chief People Officer	Old	0 - 2.5	0 - 2.5	0 - 5	10 - 15	57	4	65	0
	2015	0 - 2.5	2.5 - 5	10 - 15	35 - 40	139	9	172	0
Neil Bacon Chief Strategy and Transformation Officer	Old	0	0	5 - 10	25 - 30	211	5	223	0
	2015	0 - 2.5	5 - 7.5	0 - 5	5 - 10	-	11	24	0
Dean Spencer Chief Operating Officer	Old	0	0	40 - 45	130 - 135	933	7	967	0
	2015	0 - 2.5	2.5 - 5	20 - 25	65 - 70	249	12	301	0

Notes:

1. Non-Executive Members do not receive pensionable remuneration.
2. Full details of the accounting policy regarding pension costs can be found within Note 4 of the full set of audited financial statements.
3. '0' is shown above where a Senior Manager is part of the 2008 NHS Pension Scheme, which does not have a Lump sum entitlement.
4. The factors used to calculate the Cash Equivalent Transfer Value (CETV) increased by 3.1% for 2022/23. 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.
5. Where partial or full benefits have been taken the NHS Pension Agency can no longer provide CETV figures and '0' is shown above.
6. NHS Business Services Authority (NHS BSA) only provide information as at 31 March each year. With the ICB commencing 1 July 2022, following national guidance when calculating increases opening amounts needed to be re-calculated on a pro rata basis to 30 June 2022. This was determined to be the best available approach given NHS BSA information was only available for 31 March 2022 and 31 March 2023

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Pension Liabilities

For more information regarding pension benefits and costs please see the Financial Statements section on page 11 (see Note 1.5.2 Accounting Policies, Note 4 Employee Benefits and Note 14 Trade and other Payables).

Losses and special payments

There were no losses in 2022-23 and one special payment totalling £3,500.

Compensation on early retirement for loss of office

There were no ill-health retirements in 2022-23. Please see Table 34 : Exit Packages for other departures.

Payments to past directors

There were no payments to past directors in 2022-23.

Staff Report

Number of senior managers

As at 31 March 2023, NHS Dorset employed the following number of Senior Managers:

Table 24: No. of senior managers

NHS Dorset	Number as at 31 March 2023
Very Senior Manager	5
Band 9	7
Band 8d	12
Band 8c	28
Band 8b	38
Band 8a	59
Total	149

Staff numbers and costs

Table 25: Average staff numbers by whole-time equivalent (wte) (subject to audit)

Average staff Numbers	2022/23		
	Permanently employed	Other	Total
	No.	No.	No.
Total staff (average wte)	434	47	481
Total	434	47	481

Table 26: Staff costs

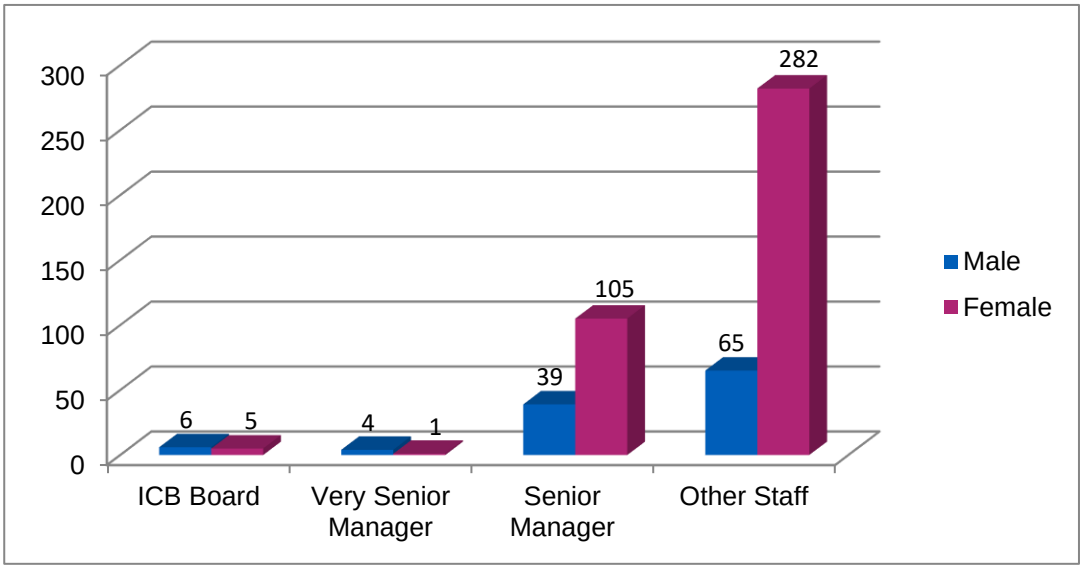
	Permanent employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	16,463	1,964	18,427
Social security costs	1,752	0	1,752
Employer contributions to the NHS Pension Scheme	2,725	0	2,725
Apprenticeship levy	68	0	68
Termination benefits	255	0	255
Gross admin employee benefits expenditure	21,264	1,964	23,227
Less: Recoveries in respect of employee benefits	(1,220)	0	(1,220)
Net admin employee benefits expenditure including capitalised costs	20,044	1,964	22,007
Less: Employee costs capitalised	0	0	0
Net admin employee benefits expenditure excluding capitalised costs	20,044	1,964	22,007
Total average number of people employed	434	47	481
Of above, number of whole-time equivalent people engaged on capital projects	0.00	0.00	0.00

Staff composition

As at 31 March 2023, NHS Dorset employed the following staff composition:

Table 27: Staff composition

	Male	Female	Total
ICB Board	6	5	11
Very Senior Managers	4	1	5
Senior Managers	39	105	144
Other employees	65	282	347
Total	**114**	**393**	**507**



Sickness absence data

Table 28: Staff sickness absence

	%
Monthly Sickness Absence Rates for English NHS bodies – December 2022	6.28
Monthly Sickness Absence Rate for NHS Dorset Integrated Care Board – December 2022	3.06
Monthly Sickness Absence Rate for NHS Dorset Integrated Care Board - Average for 2022-23	3.78

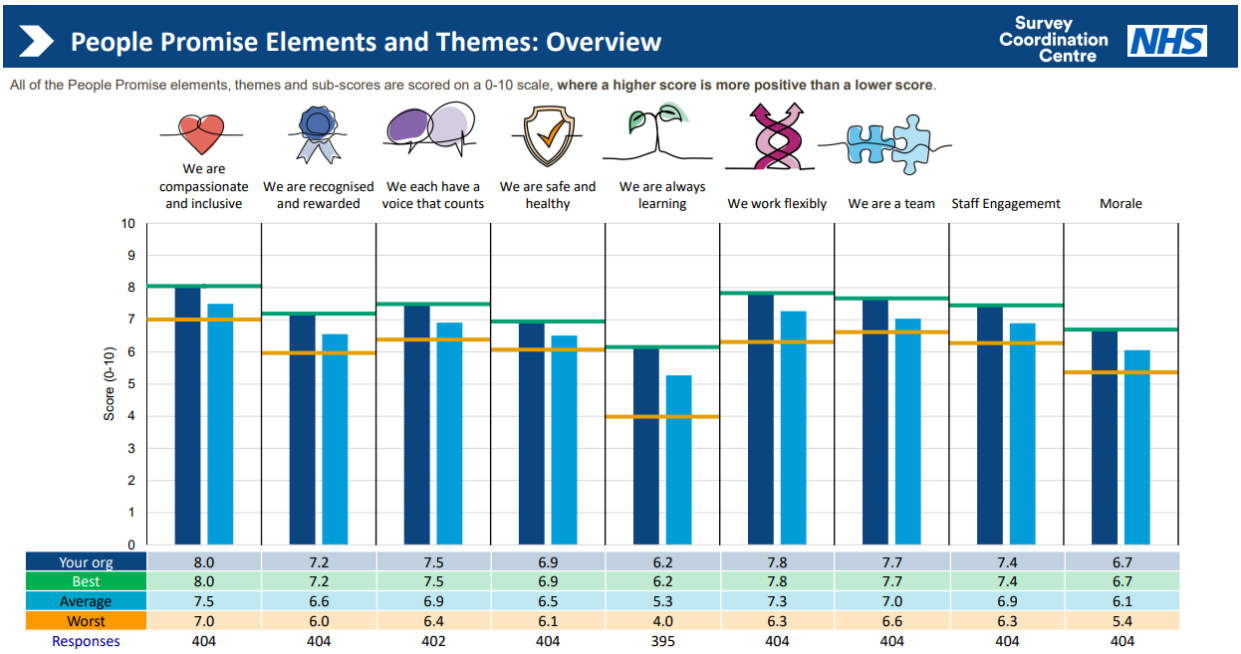
The figures in Table 28 above are provided by NHS Digital and can be found on the website.

Staff turnover percentages

For the period 1 July 2022 to 31 March 2023, NHS Dorset employee turnover was 13.93%.

Staff engagement percentages

In the 2022 NHS Staff Survey, NHS Dorset's engagement score was 7.4. This compared favourably to the average score for Integrated Care Boards which was 6.9.



The results of the NHS staff survey are themed by the NHS People Promise elements. In each of these elements, plus Staff Engagement and Morale, NHS Dorset recorded the most positive responses of any Integrated Care Board nationally.

Staff policies

NHS Dorset has policies in place to provide guidance to all employees. All human resource policies have been written to ensure equality and diversity is upheld in the workplace.

In the transition from a Clinical Commissioning Group to an Integrated Care Board we agreed with our trade union partners that the existing policies were fit for purpose and would carry forward to NHS Dorset on its establishment.

From October 2022 to March 2023, we undertook a review of all human resource policies which was completed jointly with a working group of employees and our trade union partners. The working group was drawn from across the organisation with 35 employees involved in total. The group met twice monthly.

Their views were taken into account during the review process, with the main focus being on fairness with the incorporation of Just and Learning Culture principles being a key

element. The review also focused on keeping the policies concise and easy to be interpreted, to ensure consistency of application.

This work was concluded in March 2023 with all policies approved by our Chief Officers and the trade union partnership. Policies were then noted at the People and Culture Committee.

Table 29: Trade Union Facility Time Reporting Requirements

Number of employees who were relevant union officials during 1 July 2022 to 31 March 2023	Full-time equivalent employee number
4	3.60

Number of employees who were relevant union officials employed during the relevant period spent their working hours on facility time	
Percentage of time	**Number of employees**
0%	0
1% - 50%	4
51% - 99%	0
100%	0

Pay bill spent on facility time	
Total cost of facility time	£7,914.12
Total pay bill	£21,263,805.36
Percentage of the total pay bill spent on facility time	0.04%

The time spent on paid trade union activities as a percentage of total paid facility time hours is 100%.

Other employee matters

Staff health and wellbeing

We are committed to the health and wellbeing of our staff and in addition to the work we do to support absence management, we continued to develop our wider offering during 2022/23.

- We have maintained a long-standing wellbeing support group chaired by an human resources team member and including at least one representative from each directorate. The group meets regularly to look at key areas highlighted by our staff.

- We have a published calendar of when Wellbeing Champions will be present on site to allow informal sessions to take place with employees who need support.
- We have maintained ‘Wellbeing Wednesdays’ to share wellbeing messages on a weekly basis.
- We are part of an Integrated Care System-wide wellbeing leads group who regularly meet to share good practice and to develop a more consistent and effective offering.
- We have supported awareness sessions throughout 2022-23 which included Carefirst and LiveWell Dorset providing virtual courses on wellness, wellbeing, mental health and physical health.
- We held our first Wellbeing Event at the Hamworthy Club in November 2022 with stands from Mental Health providers, Wellnet, Trade Unions, Men’s Health organisations and many others to promote wellbeing support available in NHS Dorset.

The result of all the above can be seen in our staff survey results:

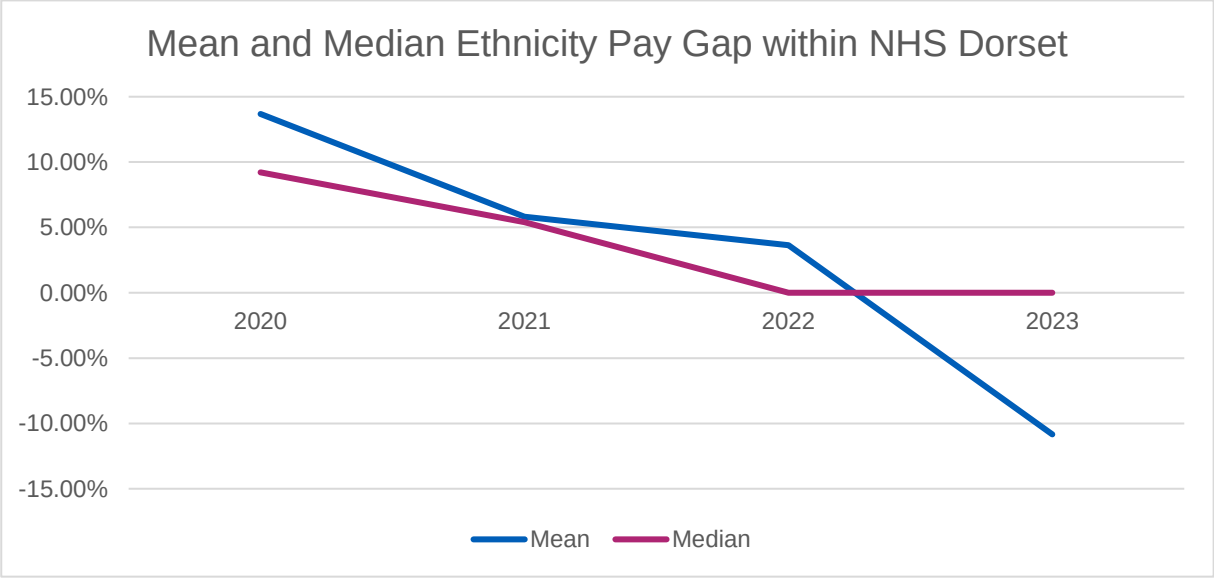
Organisation takes positive action on health and wellbeing

* NHS Dorset	88.0%
* Average of Integrated Care Boards nationally	66.9%

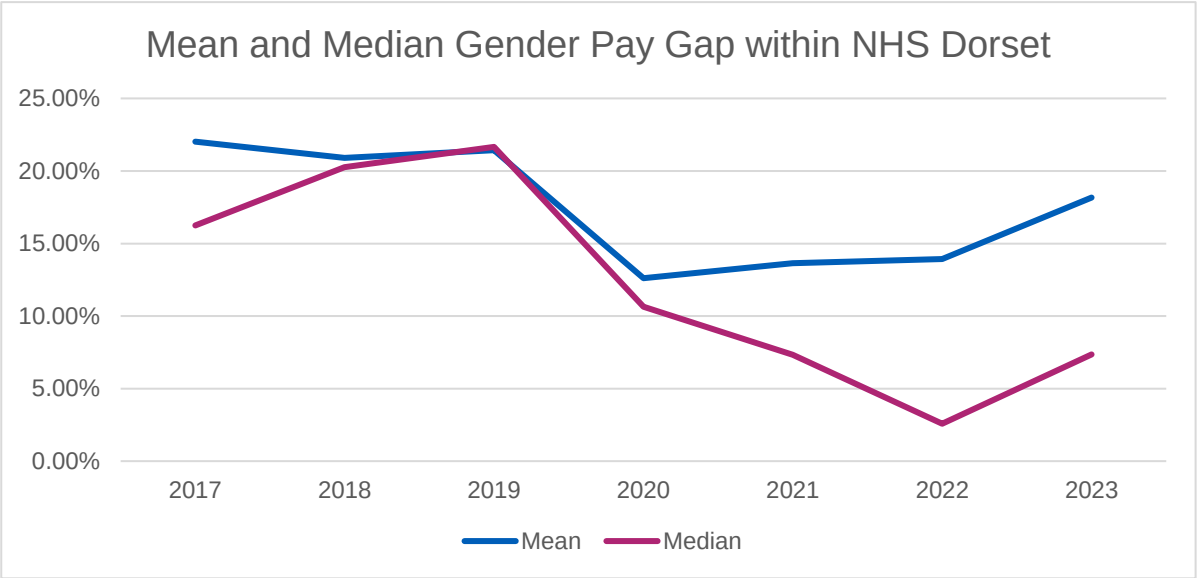
Diversity and inclusion

Since the formation of NHS Dorset, we have launched three new staff networks around Sexuality, Ethnicity and Disability. Each is independently chaired by an employee of the organisation. Administration support is provided by the organisation, but each network runs independently. We have supported Black History Month, Disability History Month and LGBTQ+ History Month.

We are committed to reporting annually on ethnicity pay gap, in line with gender pay gap report.



The median ethnicity pay gap has remained at 0% for the last two years. This means that the median white employee is paid the same as the median employee from a minority ethnic community. The mean ethnicity pay gap is now below zero. This means that, on average earnings, employees from a minority ethnic community are higher paid than white employees within NHS Dorset.



The most recognised measure of gender pay gap is the median figure. This number dropped consistently from 2019 to 2022 but has risen again in the most recent figure for March 2023.

We have seen an increase of staff reporting diverse sexualities in 2022-23 as well as year on year increases in the number of staff from black minority ethnic (BME) backgrounds and staff reporting long term health conditions.

Disabled employees

The NHS staff survey asks the question 'Disability: organisation made adequate adjustment(s) to enable me to carry out work'. NHS Dorset scored 90.0% against the national average for ICBs of 79.2%.

We continue to be proactive in our recruitment of disabled employees and remain committed to the national disability confident scheme (previously 'Two Ticks'). We achieved disability confident employer status which means we have committed to:

- interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities,
- make every effort when employees become disabled to make sure they stay in employment,
- take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work,
- we also trained a number of workstation assessors on both of our sites to allow more informal assessments to be undertaken ahead of any occupational health referrals.

Expenditure on consultancy

Table 30: Expenditure on Consultancy

Supplier	Details	£'000
PricewaterhouseCoopers	Accelerating working at Place	60
Deloitte	Electronic Patient Record and Digital Transformation	354
OAP Ltd	Build capability for high-value health systems	43
Total for the period		457

Off-payroll engagements

Between 1 July 2022 and 31 March 2023, NHS Dorset has engaged off-payroll engagements as set out in the tables below.

Table 31: 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 31 March 2023	13
Of which, the number that have existed:	
for less than one year at the time of reporting	13
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 32: Off-payroll workers engaged at any point during the financial period

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245[(1)] per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	13
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)]	13
the number of engagements reassessed for compliance or assurance purposes during the year	30
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 33: 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 and 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.	16

Exit packages, including special (non-contractual) payments

Table 34: Exit Packages 1 July 2022 to 31 March 2023 (subject to audit)

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	2	10,228	2	10,228	0	0
£10,000 - £25,000	5	71,455	0	0	5	71,455	0	0
£25,001 - £50,000	3	114,835	0	0	3	114,835	0	0
£50,001 - £100,000	1	58,969	0	0	1	58,969	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**9**	**245,259**	**2**	**10,228**	**11**	**255,487**	**0**	**0**

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where NHS Dorset has agreed early retirements, the additional costs are met by NHS Dorset and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 35: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	2	10,228
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	2	10,228

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4.4 of the accounts which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

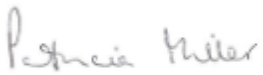
**includes any non-contractual severance payment made following judicial mediation, and zero relating to non-contractual payments in lieu of notice.

Zero non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

NHS Dorset is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report here. An audit certificate and report is also included in this Annual Report from page 138.



Patricia Miller
Accountable Officer

19 June 2023

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS DORSET INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Dorset Integrated Care Board ("the ICB") for the nine-month period ended 31 March 2023 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the ICB's affairs as at 31 March 2023 and of its income and expenditure for the nine month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 26 April 2023 as being relevant to ICBs in England and included in 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).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Risk and Audit Committee and internal audit, and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the ICB's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Risk and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries. In line with the guidance set

out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition, specifically, the risk associated with the recognition of NHS and non-NHS Expenditure, excluding primary care and prescribing expenditure, at the period end.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual postings to cash, unusual postings to expenditure, and journals that move expenditure between programme and administrative expenditure.

- Inspecting transactions in the period prior to and following 31 March 2023 to verify expenditure had been recognised in the correct accounting period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the ICB is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even

though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial period is consistent with the financial statements.

Annual Governance Statement

We are required by 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") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on pages 100 and 101, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

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 conform to the authorities which govern them.

Report on 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 if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on pages 100 and 101, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. 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 planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England 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.

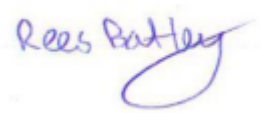
We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Dorset 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, as a body, 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 Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Dorset ICB for the nine month period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
21 June 2023

Annual Accounts

Statement of Comprehensive Net Expenditure for period ended 31-March-2023

	NOTE	2022-23 Total £000
Revenue from sale of goods and services	2	(12,756)
Other operating revenue	2	(64)
Total Operating Revenue		**(12,820)**
Staff costs	4	23,227
Purchase of goods and services	5	1,278,432
Depreciation and impairment charges	5	417
Provision expense	5	2,203
Other operating expenditure	5	1,402
Total Operating Expenditure		**1,305,681**
Net Operating Expenditure		**1,292,861**
Financing		
Finance expense	7	131
Net financing costs for the financial year		**131**
Total Comprehensive Net Expenditure for the financial year		**1,292,992**

The notes on pages 5 to 22 form part of this statement.

The purpose of this statement is to summarise, on an accruals basis, the net operating costs of the Integrated Care Board. The statement identifies gross operating costs, less miscellaneous income, to arrive at the net operating costs of the Integrated Care Board.

Statement of Financial Position at 31-March-2023

	NOTE	31-March-2023 £000	01-July-2022 £000
Non-Current Assets			
Property, plant and equipment	9	461	452
Right-of-use Assets		1,107	653
Intangible assets	10	87	50
Total Non-Current Assets		**1,655**	1,155
Current Assets			
Inventories	11	1,831	1,738
Trade & other receivables	12	3,783	3,595
Cash & cash equivalents	13	41	3,187
Total Current Assets		**5,655**	8,520
Total Assets		**7,310**	9,674
Current Liabilities			
Trade & other payables	14	(123,363)	(82,639)
Lease liabilities		(1,063)	(221)
Provisions	15	(3,346)	(2,791)
Total Current Liabilities		**(127,772)**	(85,651)
Total Assets less Current Liabilities		**(120,462)**	(75,977)
Non-Current Liabilities			
Lease liabilities		0	(429)
Provisions	15	(922)	(874)
Total Non-Current Liabilities		**(922)**	(1,303)
Total Assets less Liabilities		**(121,384)**	(77,281)
Financed by Taxpayers' Equity			
General fund		(121,384)	(77,281)
Total Taxpayers' Equity		**(121,384)**	(77,281)

The notes on pages 5 to 22 form part of this statement.

The financial statements on pages 1 to 4 were approved by the ICB Board on 19 June 2023 and signed on its behalf by: -

Patricia Miller

Accountable Officer: Patricia Miller
Date 19 June 2023

Statement of Changes In Taxpayers' Equity for the period ended 31-March-2023

	General Fund £000	Total £000
Balance at 01-July-2022	**0**	**0**
Net operating costs for the financial year	**(1,292,992)**	**(1,292,992)**
Transfers by absorption to/(from) other bodies	(77,281)	(77,281)
	(1,370,273)	**(1,370,273)**
Net funding	1,248,888	1,248,888
Balance at 31-March-2023	**(121,384)**	**(121,384)**

	General Fund £000	Total £000
Changes in taxpayers' equity for 2022-23 (ICB Opening)		
Balance at 01-April-2022	(98,121)	(98,121)
Net operating costs for the financial year	(399,496)	(399,496)
	(497,617)	(497,617)
Net funding	420,336	420,336
Balance at 01-July-2022	(77,281)	(77,281)

Changes in an entity's equity between the beginning and the end of the reporting period reflect the increase or decrease in its net assets during the period. The Statement has been interpreted to include figures for net operating costs for the year and funding for the year.

Statement of Cash Flows for the period ended 31-March-2023

	NOTE	2022-23 £000
Cash Flows from Operating Activities		
Net operating expenses for the financial year	2 & 5	(1,292,992)
Depreciation and amortisation	5, 9 & 10	417
Movement due to transfer by Modified Absorption		(74,120)
Finance costs	5 & 15	(175)
Unwinding of discounts	15	127
Increase in inventories	11	(1,831)
(Increase)/decrease in trade & other receivables	12	(3,783)
Increase/(decrease) in trade & other payables	14	123,363
Provisions utilised	15	(1,726)
Increase/(decrease) in provisions	15	2,378
Net Cash Outflow from Operating Activities		**(1,248,343)**
Cash Flows from Investing Activities		
Interest received		4
Payments for property, plant and equipment	9	(239)
Payments for intangible assets	10	(65)
Net Cash Outflow from Investing Activities		**(300)**
Net Cash Outflow before Financing		**(1,248,642)**
Cash Flows from Financing Activities		
Net funding received		1,248,888
Repayment of lease liabilities		(205)
Net Cash Inflow from Financing Activities		**1,248,683**
Net Increase in Cash & Cash Equivalents	13	**41**
Cash & Cash Equivalents at the Beginning of the Financial Year		0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	13	**41**

The Statement of Cash Flows provides information on Integrated Care Board liquidity, viability and financial adaptability.

NOTES TO THE ACCOUNTS

The notes to the accounts provide additional details on the entries on the primary statements as well as additional disclosures, such as the accounting policies that the organisation follows when preparing its accounts.

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

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

When Clinical Commissioning Groups ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

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 Operating Segments

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

1.4 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 Integrated Care Board will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;

• The Integrated Care Board 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 HM Treasury published Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Integrated Care Board to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Integrated Care Board 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. There is also revenue from other Integrated Care Boards.

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 activity that is to be delivered in the following year, that income is deferred.

Payment terms are standard reflecting cross-government principles. Significant terms include payment within 30 days, more details can be found in Note 6 - Better Payment Practice Code, to the Accounts.

The value of the benefit received when the Integrated Care Board accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.5 Employee Benefits

1.5.1 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.

The Integrated Care Board allows a maximum of five days to be carried forward, but only in exceptional circumstances.

1.5.2 Retirement Benefit Costs

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs 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.

1.6 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.

1.7 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.8 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment are 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.

1.8.2 Measurement

All property, plant and equipment are 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. All assets are measured subsequently at valuation.
Land and buildings used for the Integrated Care Board's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Fixtures and equipment are carried at depreciated historic cost 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.

1.8.3 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.

1.9 Intangible Assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Integrated Care Board's business or which arise from contractual or other legal rights. They are recognised only: -
• When it is probable that future economic benefits will flow to, or service potential be provided to, the Integrated Care Board;
• Where the cost of the asset can be measured reliably;
• Where the cost is 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.

Intangible assets acquired separately are initially recognised at fair value. 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.

1.9.2 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.

1.10 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Integrated Care Board checks whether there is any indication that any of its tangible 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.

1.11 Government Grants

The value of assets received by means of a government grant are credited directly to income. The Integrated Care Board has no deferred income.

1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.12.1 The Integrated Care Board as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Integrated Care Board's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.12.2 The Integrated Care Board as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Integrated Care Board's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Integrated Care Board's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.14 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Integrated Care Board's cash management.

1.15 Provisions

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

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

• A nominal short-term rate of 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.

1.16 Clinical Negligence Costs

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

1.17 Non-clinical Risk Pooling

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to 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 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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 Integrated Care Board. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.19 Financial Assets

Financial assets are recognised when the Integrated Care Board becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories: -
• Financial assets at amortised cost;
• Financial assets at fair value through other comprehensive income; and
• Financial assets at fair value through profit and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.19.1 Financial Assets at Amortised cost

The Integrated Care Board holds no financial assets at amortised cost.

1.19.2 Financial Assets at fair value through other comprehensive income

The Integrated Care Board holds no financial assets at fair value through other comprehensive income.

1.19.3 Financial Assets at fair value through profit and loss

The Integrated Care Board holds no financial assets at fair value through profit and loss.

1.19.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Integrated Care Board recognises a loss allowance representing the expected credit losses on the financial asset.

The Integrated Care Board adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 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 Integrated Care Board therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Integrated Care Board does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

The Integrated Care Board holds no Loans, only Receivables.

1.20 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the Integrated Care Board becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.20.1 Financial Guarantee Contract Liabilities

Financial Guarantee Contract Liabilities are subsequently measured at the higher of: -

• The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and

• The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

The Integrated Care Board holds no Financial Guarantee Contract Liabilities.

1.20.2 Financial Liabilities at Fair Value Through Profit and Loss

The Integrated Care Board holds no Financial Liabilities with embedded derivatives.

1.20.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Value Added Tax (VAT)

Most of the activities of the Integrated Care Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign Currencies

The Integrated Care Board's functional currency and presentational currency is sterling. 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 Integrated Care Board's surplus/deficit in the period in which they arise.

1.23 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Integrated Care Board not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Critical Accounting Judgments & Key Sources of Estimation Uncertainty

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

1.24.1 Critical Judgments in Applying Accounting Policies

No critical judgments with a significant effect on the amounts recognised on the financial statements were required.

1.24.2 Key Sources of Estimation Uncertainty

No key sources of estimation uncertainty with a significant effect on the amounts recognised on the financial statements were required.

1.25 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. The Integrated Care Boards Gifts, Hospitality Sponsorship register can be found on our website www.nhsdorset.nhs.uk/about/constitution/#gifts.

1.26 New and revised IFRS Standards in issue but not yet effective

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

2. Other Operating Revenue

	2022-23 Total £000
Revenue from sale of goods and services (contracts)	
Education, training and research	**(206)**
Non-patient care services to other bodies	**(11,185)**
Other Contract revenue	**(145)**
Recoveries in respect of employee benefits	**(1,220)**
Total Revenue from sale of goods and services	**(12,756)**
Other Operating Revenue	
Charitable and other contributions to expenditure: non-NHS	**(62)**
Other revenue	**(2)**
Total Other Operating Revenue	**(64)**
Total Operating Revenue	**(12,820)**

This note discloses the revenue that relates directly to the operating activities of the Integrated Care Board, it excludes cash received from NHS England by the Integrated Care Board, which is credited directly to the General Fund.

3. Disaggregation of Revenue - revenue from sale of good and services (contracts)

Source of Revenue	NHS £000	Non NHS £000	2022-23 Total £000
Education, training and research	(194)	(12)	**(206)**
Non-patient care services to other bodies	(4,645)	(6,540)	**(11,185)**
Other contract revenue	(9)	(136)	**(145)**
Recoveries in respect of employee benefits	(767)	(453)	**(1,220)**
Total	**(5,615)**	**(7,141)**	**(12,756)**

Revenue received is totally from the supply of services. The Integrated Care Board receives no revenue from the sale of goods.

4. Employee Benefits

Please refer to the Annual Report for details of Employee Benefits and Staff Numbers.

4.1 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:

4.1.1 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.

4.1.2 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 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

	2022-23 £000
Employers’ contributions payable to the NHS Pensions Scheme	**2,725**
	%
Payable to the NHS Pension Scheme of pensionable pay, at the rate of	**20.60**

4.2 Staff Costs

	2022-23 Permanent Employees	2022-23 Other	2022-23 Total
	£'000	£'000	£'000
Salaries and wages	16,463	1,964	18,427
Social security costs	1,752	0	1,752
Employer contributions to the NHS Pension Scheme	2,725	0	2,725
Apprenticeship levy	68	0	68
Termination benefits	255	0	255
Gross admin employee benefits expenditure	**21,264**	**1,964**	**23,227**
Less: Recoveries in respect of employee benefits	(1,220)	0	(1,220)
Net admin employee benefits expenditure including capitalised costs	**20,044**	**1,964**	**22,007**
Less: Employee costs capitalised	0	0	0
Net admin employee benefits expenditure excluding capitalised costs	**20,044**	**1,964**	**22,007**
Total average number of people employed	434	47	481
Of above number of whole time equivalent people engaged on capital projects	0	0	0

4.3 Exit packages agreed in the financial year

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.

Agreed exit package banding	2022-23 Compulsory Redundancies	2022-23 Compulsory Redundancies	2022-23 Other Agreed Departures	2022-23 Other Agreed Departures	2022-23 Total	2022-23 Total
	Number	£	Number	£	Number	£
Less than £10,000	0	0	2	10,228	2	10,228
£10,001 to £25,000	5	71,455	0	0	5	71,455
£25,001 to £50,000	3	114,835	0	0	3	114,835
£50,001 to £100,000	1	58,969	0	0	1	58,969
Total	**9**	**245,259**	**2**	**10,228**	**11**	**255,487**

5. Operating Expenses

	2022-23 Total £000
Purchase of Goods and Services	
Services from other ICBs and NHS England	**(59)**
Services from foundation trusts	**850,129**
Services from other NHS trusts	**3,256**
Services from other WGA bodies	**5**
Purchase of healthcare from non-NHS bodies	**179,398**
Purchase of social care	**3,320**
Prescribing costs	**116,793**
General ophthalmic services	**181**
GPMS/APMS and PCTMS	**114,987**
Supplies and services – general	**2,014**
Consultancy services	**457**
Establishment	**5,898**
Transport	**22**
Premises	**542**
Audit fees	**96**
Other non statutory audit expenditure	
• Other services	**15**
Other professional fees (excluding statutory audit)	**337**
Legal fees	**231**
Education and training	**812**
Total Purchase of Goods and Services	**1,278,432**
Depreciation and Impairment Charges	
Depreciation	**388**
Amortisation	**28**
Total Depreciation and Impairment Charges	**417**
Provision Expense	
Change in discount rate	**(175)**
Provisions	**2,378**
Total Provision Expense	**2,203**
Other Operating Expenditure	
Chair and lay membership body and governing body members	**333**
Grants to other bodies	**141**
Clinical negligence	**12**
Research and development (excluding staff costs)	**20**
Expected credit loss on receivables	**(26)**
Inventories consumed	**918**
Other expenditure	**3**
Total Other Operating Expenditure	**1,402**
Total Operating Expenses	**1,282,453**

GPMS/APMS and PCTMS - shows costs related to primary care services.

External Audit The figures in the 'Audit fees' line above include VAT. The net figure is £80,000 for 2022-23. The Audit liability for KPMG is restricted to £1,000,000.
'Other services' were for the external assurance on the mental health investment standard (MHIS), as procured by NHS England relating to 2021-22.

Internal Audit - As Internal Audit is carried out by a different organisation to our Statutory Audit, the Department of Health and Social Care guidance is to show Internal Audit costs in 'Other professional fees'.

6. Better Payment Practice Code

	2022-23 Number	2022-23 £000
Non-NHS Payables		
Total Non-NHS trade invoices paid in the year	23,078	304,323
Total Non-NHS trade invoices paid within target	22,393	296,067
Percentage of Non-NHS trade invoices paid within target	**97.03%**	**97.29%**
NHS Payables		
Total NHS trade invoices paid in the year	863	851,767
Total NHS trade invoices paid within target	844	851,741
Percentage of NHS trade invoices paid within target	**97.80%**	**100.00%**

Where the percentage of invoices paid within target is greater than 100%, this is due to the effect of credit notes.

This note shows the Integrated Care Board's performance against its administrative duty to pay all creditors within 30 calendar days of receipt of goods or valid invoice, whichever is later, unless other payment terms have been agreed. There is a performance target of 95% for each measure.

7. Finance Costs

	2022-23 £000
Interest on lease liabilities	4
Provisions - unwinding of discount	127
Total Finance Costs	**131**

This note identifies the Integrated Care Board's interest costs, including the unwinding of discounts on provisions, and corresponds with the amount shown on the Statement of Comprehensive Net Expenditure.

8. Net gain/(loss) on transfer by absorption

	2022-23	
	Total £'000	NHS England Group Entities (non parent) £'000
Transfer of property plant and equipment	452	452
Transfer of Right of Use assets	653	653
Transfer of intangibles	50	50
Transfer of inventories	1,738	1,738
Transfer of cash and cash equivalents	3,187	3,187
Transfer of receivables	3,595	3,595
Transfer of payables	(82,639)	(82,639)
Transfer of provisions	(3,665)	(3,665)
Transfer of Right Of Use liabilities	(651)	(651)
Net loss on transfers by absorption	**(77,281)**	**(77,281)**

In line with the Government Financial Reporting Manual, issued by HM Treasury, previous Clinical Commissioning Group balances that are attributable to the Integrated Care Board need to be accounted for through absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of balances required when functions transfer within the public sector.

9. Property, Plant and Equipment

2022-23	Buildings excluding £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or Valuation at 01-July-2022	0	0	0	0	**0**
Additions Purchased	0	0	145	94	**239**
Disposals other than for sale	0	0	(227)	0	**(227)**
Transfer (to) from other public sector body	0	150	1,372	228	**1,749**
Cost or Valuation at 31-March-2023	**0**	**150**	**1,290**	**322**	**1,761**
Depreciation at 01-July-2022	0	0	0	0	**0**
Disposals other than for sale	0	0	(227)	0	**(227)**
Charged during the Year	0	0	223	6	**230**
Transfer (to) from other public sector body	0	150	935	213	**1,298**
Depreciation at 31-March-2023	**0**	**150**	**931**	**219**	**1,300**
Net Book Value at 31-March-2023	**0**	**0**	**359**	**102**	**461**
Purchased	0	0	359	102	**461**
Total at 31-March-2023	**0**	**0**	**359**	**102**	**461**
Asset financing:					
Owned	0	0	359	102	**461**
Total at 31-March-2023	**0**	**0**	**359**	**102**	**461**

10.1 Economic Lives

	Minimum Life (Years)	Maximum Life (Years)
Information Technology	0	0
Furniture and Fittings	3	3

This note records the range of remaining useful economic lives of property, plant and equipment employed by the Integrated Care Board.

9a Leases

9a.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000	Plant & Machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 July 2022	0	0	0	0	0
Additions	613	0	0	0	613
Transfer (to) from other public sector body	706	0	0	0	706
Cost/Valuation at 31 March 2023	**1,319**	**0**	**0**	**0**	**1,319**
Depreciation 01 July 2022	0	0	0	0	0
Charged during the year	159	0	0	0	159
Transfer (to) from other public sector body	53	0	0	0	53
Depreciation at 31 March 2023	**212**	**0**	**0**	**0**	**212**
Net Book Value at 31 March 2023	**1,107**	**0**	**0**	**0**	**1,107**

9a Leases

9a.2 Lease liabilities

2022-23	2022-23 £'000
Lease liabilities at 01 July 2022	0
Additions purchased	(613)
Interest expense relating to lease liabilities	(4)
Repayment of lease liabilities (including interest)	205
Transfer (to) from other public sector body	(651)
Lease liabilities at 31 March 2023	**(1,063)**

9a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000
Within one year	(1,063)
Between one and five years	0
Balance at 31 March 2023	**(1,063)**
Effect of discounting	0
Included in:	
Current lease liabilities	(1,063)
Non-current lease liabilities	0
Balance at 31 March 2023	**(1,063)**

All lease liability amounts relate to intra group lease, with 100% attributable to NHS Property Services Ltd.

9a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	2022-23 £'000
Depreciation expense on right-of-use assets	159
Interest expense on lease liabilities	4

9a.5 Amounts recognised in Statement of Cash Flows

	2022-23 £'000
Total cash outflow on leases under IFRS 16	205
Total cash outflow for lease payments not included within the measurement of lease liabilities	0

Nature of lessee's leasing activities
Future cash outflows to which the lessee is potentially exposed that are not reflected in the measurement of lease liabilities. This includes exposure arising from
* Variable lease payments
* Extension and termination options
* Residual value guarantee
* Restrictions or covenants imposed by leases
* Leases not yet commenced to which the lessee is committed

10. Intangible non-current assets

2022-23	Computer Software: Purchased £000	Total £000
Cost or valuation at 1 July 2022	0	0
Additions purchased	65	65
Disposals other than by sale	0	0
Transfer (to)/from other public sector body	138	138
Cost / Valuation at 31 March 2023	**202**	**202**
Amortisation 1 July 2022	0	0
Disposals other than by sale	0	0
Charged during the year	28	28
Transfer (to) from other public sector body	87	87
Amortisation at 31 March 2023	**116**	**116**
Net Book Value at 31 March 2023	**87**	**87**
Purchased	87	87
Total at 31 March 2023	**87**	**87**

11.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	2	5

Intangible non-current assets are defined as brand value or some other right, which although invisible is likely to derive financial benefit for its owner in the future, and for which you might be willing to pay.

11. Inventories

	Loan Equipment	Total
	£000	**£000**
Balance at 01-July-2022	0	**0**
Additions	1,011	**1,011**
Inventories recognised as an expense in the period	(918)	**(918)**
Transfer (to)/from Goods for resale	1,738	**1,738**
Balance at 31-March-2023	**1,831**	**1,831**

	Loan Equipment	Total
	£000	£000
Balance at 01-April-2022	1,726	1,726
Additions	307	307
Inventories recognised as an expense in the period	(295)	(295)
Balance at 01-July-2022	1,738	1,738

The Integrated Community Equipment is managed by Bournemouth, Christchurch and Poole Council.

The total value of inventories corresponds with the amount shown on the face of the Statement of Financial Position. Finished processed goods is the value of stocks after completion of manufacture or processing and where the goods concerned are to be sold or consumed in a future accounting period.

This note does not include the provision of health care services under partially completed contracts; or assets in the course of construction.

12. Trade and Other Receivables

	Current		Non-current	
	31-March-2023	01-July-2022	**31-March-2023**	01-July-2022
	£000	£000	**£000**	£000
NHS receivables: revenue	1,205	272	0	0
NHS accrued income	1,784	1,154	0	0
Non-NHS and other WGA receivables: Revenue	220	623	0	0
Non-NHS and other WGA prepayments	78	1,395	0	0
Non-NHS and other WGA accrued income	250	(107)	0	0
Expected credit loss allowance - receivables	(9)	(35)	0	0
VAT	250	292	0	0
Other receivables	6	(0)	0	0
Total	**3,783**	3,595	**0**	0
Total Current and Non-current	**3,783**	3,595		
Included in NHS receivables are pre-paid pension contributions	**0**	0		

The great majority of trade is with NHS England. As NHS England is funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. The level of trade with non-NHS organisations is immaterial and is covered by contractual terms, therefore no credit scoring of them is considered necessary.

This note analyses the amounts owing to the Integrated Care Board at the Statement of Financial Position date.

12.1 Receivables Past Their Due Date But Not Impaired

	31-March-2023 DHSC Group Bodies	31-March-2023 Non DHSC Group Bodies	01-July-2022 DHSC Group Bodies	01-July-2022 Non DHSC Group Bodies
	£000	**£000**	£000	£000
By up to three months	**463**	**117**	65	88
By three to six months	**0**	**0**	0	0
By more than six months	**0**	**56**	0	329
Total	**463**	**173**	65	417

£452,587.19 (as at 2 June 23) of the amount above has subsequently been recovered post the Statement of Financial Position date.

This note analyses the length of time beyond their due date the amounts owing to the Integrated Care Board at the Statement of Financial Position date have been outstanding.

12.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Total
	£000	**£000**
Balance as at 01-July-2022	0	0
Lifetime expected credit losses on trade and other receivables - Stage 2	(9)	(9)
Total	**(9)**	(9)

This is an estimate linked to expected credit losses on a financial asset that is applied to reduce the carrying amount of the financial asset in the statement of financial position.

13. Cash and Cash Equivalents

	31-March-2023	01-July-2022
	£000	£000
Opening balance	0	116
Net change in year	41	3,072
Closing balance	**41**	3,187
Made up of:		
Cash with Government Banking Service	28	3,176
Cash in hand	13	11
Cash and cash equivalents as in Statement of Financial Position	**41**	3,187
Bank overdraft - Government Banking Service	0	0
Cash and cash equivalents as in Statement of Cash Flows	**41**	3,187
Patients' money held by the Integrated Care Board, not included above	**0**	0

14. Trade and Other Payables

	Current		Non-current	
	31-March-2023	01-July-2022	**31-March-2023**	01-July-2022
	£000	£000	**£000**	£000
Interest payable	0	0	0	0
NHS payables: revenue	(402)	(617)	0	0
NHS payables: capital	0	0	0	0
NHS accruals	(5,289)	(1,926)	0	0
NHS deferred income	0	0	0	0
NHS contract liabilities	0	0	0	0
Non-NHS and other WGA payables: revenue	(4,401)	(1,325)	0	0
Non-NHS and other WGA payables: capital	0	0	0	0
Non-NHS and other WGA accruals	(58,780)	(41,480)	0	0
Non-NHS and other WGA deferred income	0	0	0	0
Non-NHS contract liabilities	0	0	0	0
Social security costs	(308)	(307)	0	0
VAT	0	0	0	0
Tax	(393)	(321)	0	0
Payments received on account	0	0	0	0
Other payables and accruals	(53,791)	(36,663)	0	0
Total	**(123,363)**	(82,639)	**0**	0
Total Current and Non-current	**(123,363)**		(82,639)	

	31-March-2023	01-July-2022
	£000	£000
Included above are liabilities, due in future years under arrangements to buy out the liability for early retirement over 5 years.	**0**	0
Other payables include outstanding pension contributions. The increase in outstanding pension contributions is due to the Integrated Care Board taking on the devolved primary care co-commissioning role from NHS England.	**1,203**	1,735
Other payables also includes accruals for invoices registered on the finance ledger, but not approved.	**4,426**	825
Other payables also includes primary care accruals, which is due to the Integrated Care Board taking on the devolved primary care co-commissioning role from NHS England.	**46,695**	34,151

This note analyses the amounts owed by the Integrated Care Board at the Statement of Financial Position date.

15. Provisions

	Current	Current	**Non Current**	Non-Current
	31-March-2023	01-July-2022	**31-March-2023**	01-July-2022
	£000	£000	**£000**	£000
Redundancy	0	(723)	0	0
Legal claims	(574)	0	0	0
Continuing care	(2,772)	(2,068)	(555)	(483)
Other	0	0	(368)	(391)
Total	**(3,346)**	(2,791)	**(922)**	(874)
Total Current and Non-Current	**(4,269)**	(3,665)		

Comprising:

	Redundancy	**Continuing Care**	**Legal Claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Arising during the year	0	(3,582)	(551)	0	**(4,133)**
Utilised during the year	723	1,003	0	0	**1,726**
Reversed unused	0	1,756	0	0	**1,756**
Unwinding of discount	0	(99)	(22)	(5)	**(127)**
Change in discount rate	0	146	0	29	**175**
Transfer (to) from other public sector body	(723)	(2,551)	0	(391)	**(3,665)**
Balance at 31-March-2023	**0**	**(3,327)**	**(574)**	**(368)**	**(4,269)**
Expected Timing of Cash Flows:					
No Later than One Year	0	(2,772)	(574)	0	**(3,346)**
Later than One Year and not later than Five Years	0	(555)	0	(368)	**(922)**
Balance at 31-March-2023	**0**	**(3,327)**	**(574)**	**(368)**	**(4,269)**

Amount Included in the Provisions of NHS Resolution in Respect of Clinical Negligence Liabilities:

	£000
As at 31-March-2023	0
As at 01-July-2022	0

Finance costs on the Statement of Cash Flows refers to the change in discount rate, shown above.

The balance of the Continuing Care provision is reversed out of the Ledger in March and shows here as 'Reversed unused' and then the new provision is created and this is shown as 'Arising during the year'. This approach is taken because the provision is calculated case by case during March.

15. Provisions continued

Critical accounting judgments and key sources of estimation uncertainty:

The provisions shown under the heading 'Other' relates to dilapidation costs associated with leases for Vespasian House, and the future costs are uncertain.

A provision has been made against applications for continuing healthcare support where a panel has not yet met to determine whether the application is approved. The provision is calculated on a named basis for the period that continuing healthcare may be eligible, at the probability rate of the application being awarded.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Integrated Care Board. However, the legal liability remains with the Integrated Care Board.

This note analyses the amounts recorded as provisions by the Integrated Care Board at the Statement of Financial Position date.

16. Contingencies

	31-March-2023 £000
Contingent liabilities	
Continuing Healthcare	1,140
Net Value of Contingent Liabilities	**1,140**

There are no contingent Assets

The contingent liability above relates to continuing care claims, and is directly linked with the continuing care provision included in the Provisions Note. An estimation has been made of the value based upon the amounts claimed. The uncertainties relate to the eligibility of the claims.

The purpose of this note is to disclose material contingent liabilities or assets, if there is more than a remote possibility that there will be a transfer of 'economic benefit' as a result of events that existed before the Statement of Financial Position date.

17. Commitments

17.1 Other financial commitments

The Integrated Care Board has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements), for information management and technology equipment and support. The payments to which the Integrated Care Board are committed are as follows: -

	31-March-2023 £000
Not later than one year	3,709
Later than one year and not later than five years	5,427
Later than five years	0
Total	**9,136**

The Integrated Care Board has two contracts that exceeds one million pounds, for software and healthcare managed services.

This note discloses undertakings that have been committed at a future date.

18. Financial Instruments

18.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Integrated Care Board's Standing Financial Instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Integrated Care Board's internal auditors.

Only where the Integrated Care Board is exposed to material risk should the appropriate IFRS 7 disclosures be made. The headings in IFRS 7 should be used to the extent that they are relevant.

18.1.1 Currency Risk
The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Integrated Care Board has no overseas operations. The Integrated Care Board therefore has low exposure to currency rate fluctuations.

18.1.2 Interest Rate Risk
The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

18.1.3 Credit Risk
Because the majority of the Integrated Care Board's revenue comes from parliamentary funding, the Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

18.1.4 Liquidity Risk
The Integrated Care Board is required to operate within resource allocations agreed with NHS England, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, from NHS England, as the need arises, unrelated to its performance against resource limits. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

18.2 Financial Assets

	Financial Assets measured at amortised cost 2022-23 £000	Total 2022-23 £000
Trade and other receivables with NHSE bodies	2,662	2,662
Trade and other receivables with other DHSC group bodies	585	585
Trade and other receivables with external bodies	218	218
Cash and cash equivalents	41	41
Total at 31 March 2023	**3,506**	**3,506**

18.3 Financial Liabilities

	Financial Liabilities measured at amortised cost 2022-23 £000	Total 2022-23 £000
Trade and other payables with NHSE bodies	213	213
Trade and other payables with other DHSC group bodies	5,556	5,556
Trade and other payables with external bodies	117,957	117,957
Total at 31 March 2023	123,726	123,726

Due to the short-term nature of these transactions, the fair value of these financial assets and liabilities approximate the carrying amounts at the balance sheet date.

Financial instruments are a broad range of assets and liabilities that arise from contracts and result in a financial asset being created in one entity and a financial liability in another. This note discloses the interest rate risks arising from the Integrated Care Board's financial assets and liabilities, which largely comprise items due after more than one year, such as long-term debtors and creditors, and provisions made under contract.

19. Operating Segments

The Integrated Care Board has only one operating segment, that of commissioning healthcare services for the population of Dorset.

An operating segment is a component of an entity:
* that engages in business activities from which it may earn revenues and incur expenses,
* whose operating results are regularly reviewed by the entity's chief operating decision maker to make decisions about resources to be allocated to the segment and assess its performance, and
* for which discrete financial information is available.

20. Related Party Transactions

The Department of Health is regarded as a related party. During the year the Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example: -

- NHS England (including commissioning support units);
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution; and
- NHS Business Services Authority.

In addition, the Integrated Care Board 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 Dorset Council and Bournemouth, Christchurch & Poole Council in respect of Better Care Fund arrangements.

The Integrated Care Board has received revenue grant monies from Macmillan Cancer Support. No capital payments have been received from charitable funds.

Dorset Integrated Care Board is a body corporate established by order of the Secretary of State for Health.

		Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
1	John Beswick - ICB Non-Executive Director and Chair of Risk & Audit Committee, Chief Finance Officer (CFO) at Great Ormond Street Hospital. Transactions disclosed for Great Ormond Street Hospital.	28.0	0.0	0.0	0.0
2	John Beswick - ICB Non-Executive Director and Chair of Risk & Audit Committee, Bournemouth University non-exec director. Transactions disclosed for Bournemouth University.	28.0	0.0	0.0	0.0
3	John Beswick - ICB Non-Executive Director and Chair of Risk & Audit Committee, Divisional Chief Finance Officer, BT Group Plc. Transactions disclosed for BT Group Plc.	9.0	0.0	0.0	8.0
4	Dawn Dawson - Dorset HealthCare University NHS Foundation Trust, Acting Chief Executive, Transactions disclosed for Dorset Healthcare University NHS Foundation Trust.	205,879.0	2,737.0	0.0	448.0
5	Jenni Douglas-Todd - Chair, NHS Dorset, University Hospital Southampton NHS Foundation Trust Chair. Transactions disclosed for University Hospital Southampton NHS Foundation Trust.	7,442.0	160.0	79.0	10.0
6	Spencer Flower - Dorset Council, Leader, Transactions disclosed for Dorset Council.	25,052.0	2,839.0	11,478.0	35.0
7	Siobhan Harrington - University Hospitals Dorset NHS Foundation Trust, Chief Executive, Transactions disclosed for University Hospitals Dorset.	390,564.0	436.0	1,429.0	3.0
8	Phillip Broadhead - Bournemouth, Christchurch & Poole Council, Leader, Transactions disclosed for Bournemouth, Christchurch & Poole Council.	24,036.0	386.0	12,318.0	77.0
9	Patricia Miller - Chief Officer, NHS Providers Board Member. Transactions disclosed for NHS Providers.	5.0	0.0	0.0	0.0
10	Stephen Slough - Chief Information Officer, CIO and Executive Director at Dorset County Hospital NHS Foundation Trust. Transactions disclosed for Dorset County Hospital NHS Foundation Trust.	153,200.0	904.0	2,694.0	312.0
		806,243.0	**7,462.0**	**27,998.0**	**893.0**

The Department of Health and Social Care has identified a number of individuals and entities as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) and these are also deemed to be related parties of entities within the Departmental Group. Of these individuals and entities, Dorset Integrated Care Board has had the following transactions in 2022/23:

		Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
1	Leeds Teaching Hospitals NHS Trust	34.0	0.0	0.0	0.0
2	NHS Providers	5.0	0.0	0.0	0.0
		39.0	**0.0**	**0.0**	**0.0**

In formulating this note the Integrated Care Board has considered all declarations of interest for Governing Body Members. Under IAS 24, related party transactions have only been disclosed where they meet the following criteria:
(i) have 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.
The Declaration of Interest register can be found on our web site www.nhsdorset.nhs.uk/about/constitution/#doi

21. Events after the end of the Reporting Period

The Integrated Care Board has been approved under delegated commissioning arrangements to assume full responsibility for contractual Pharmacy, Optometry and Dentistry performance management, budget management and the design and implementation of local incentive schemes from 1 April 2023, from NHS England. The value of the delegation is £73,775,000 for 2023-24.

This note discloses the financial consequences of events (both favourable or unfavourable) that occur between the Statement of Financial Position date and the date on which the financial statements are approved by the Board, if appropriate. Two types of events can be identified: -
* those that provide evidence of conditions that existed at the end of the reporting period (adjusting events); and
* those that are indicative of conditions that arose after the reporting period (non-adjusting events).

22. Financial Performance Targets

Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
The Integrated Care Board's performance against those duties was as follows:

National Health Service Act Section	Duty	Target	2022-23 Performance	Duty Achieved?
		£'000	£'000	
223H(1)	Expenditure not to exceed income	1,330,608	1,306,729	Yes
223I(2)	Capital resource use does not exceed the amount specified in Directions	917	917	Yes
223I(3)	Revenue resource use does not exceed the amount specified in Directions	1,316,871	1,292,992	Yes
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	1,062	1,062	Yes
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	13,047	13,047	Yes

The planned expenditure not to exceed income target was set at breakeven in period, with an opening historic surplus of £23,879k which was maintained as the ICB's closing historic surplus.

The Revenue resource use on specified matter(s) refers to the the full amount of the agenda for change pay offer allocation, which was fully used to support the agenda for change pay award.

The purpose of this note is to disclose the Financial Performance of the Integrated Care Board. Where a Integrated Care Board breaches, or plans to breach, one of the statutory financial provisions, even if this is agreed with NHS England (e.g. setting a deficit budget) local auditors are under a duty to make a report to the Secretary of State for Health under Section 28 of the Audit Commission Act 1998.

23. Other

The Integrated Care Board has considered the following areas and has no details to disclose under these headings: -

- The Late Payment of Commercial Debts (Interest) Act 1998
- Income Generation Activities
- Investment Revenue
- Impairments & Reversals
- Investment Property
- Other Financial Assets
- PFI & LIFT Contracts
- Other Current Assets
- Non-Current Assets Held for Sale
- Analysis of Impairments and Reversals
- Other Financial Liabilities
- Other Liabilities
- Borrowings
- Other Gains & Losses
- NHS LIFT Investments
- Finance Lease Obligations
- Finance Lease Receivables
- Third Party Assets
- Impact of IFRS Treatment
- Analysis of Charitable Reserve

GLOSSARY OF FINANCIAL TERMS

Accruals	An accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and inventory. This means that the accounts show all of the income and expenditure that related to the financial year.
Assets	An item that has a value in the future. For example, a debtor (someone who owes money) is an asset, as they will in future pay. A building is an asset, because it houses activity that will provide a future income stream.
Assurance	Process through which accurate and current information is provided to stakeholders about the efficiency and effectiveness of policies and operations, and the status of compliance with statutory obligations.
Audit	The process of validation of the accuracy, completeness and adequacy of disclosure of financial records.
Capital	Land, buildings, equipment and other non-current assets owned by the Integrated Care Board, the cost of which exceeds £5,000 and has an expected life of more than one year.
Cash limit	A limit set by the NHS England which restricts the amount of cash drawings that the Integrated Care Board can make in the financial year. There is a combined cash limit for both revenue and capital.
Co-Commissioning	Refers to the process whereby the Integrated Care Board can directly commission primary medical services and performance manage practices but not individuals. This role was transferred from NHS England on the 1 April 2016.
Commissioning	Purchase of healthcare from external service providers (NHS, other public sector, private and voluntary) to meet the needs of the population.
Current Assets	Trade receivables, inventories, cash or similar, whose value is, or can be converted into, cash within the next twelve months.
Deep dive	A technique to rapidly immerse a group or team into a situation for problem solving or idea creation. It is often used for brainstorming product or process development.
Governance	The framework of rules and practices by which a board of directors ensures accountability, fairness, and transparency in relationships with its stakeholders. Corporate governance should underpin all that an organisation does. This means it must encompass clinical, financial and organisational aspects in the NHS.
Gross Operating Costs	This is the total revenue expenditure, including accruals and provisions, incurred in the course of performing all aspects of the Integrated Care Board's functions during the year.
Intangible Assets	Brand value or some other right (for example, a software licence), which although invisible is likely to derive financial benefit for its owner in the future, and for which you might be willing to pay.
Locality	In general meaning a community in which people live. Specifically to the Integrated Care Board this refers to the 13 different geographical areas in Dorset for which we commission services.
Locality Cluster	This refers to the 3 clusters made up of the 13 geographical localities in Dorset.
Miscellaneous Income	Income that relates directly to the operating activities of the Integrated Care Board. This excludes cash from NHS England, which is credited to the general fund.
NHS Constitution	The constitution brings together in one place details of what staff, patients and the public can expect from the NHS.
Non-Current Assets	Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.
Procurement	The act of obtaining or buying goods and services. The process includes preparation and processing of a demand as well as the end receipt and approval of payment.
Quality Premium	Is intended to reward Integrated Care Boards for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.
Remuneration	Reward for employment in the form of pay, salary, or wage, including allowances, benefits (such as company car, medical plan, pension plan), bonuses, cash incentives, and monetary value of the noncash incentives.
Resource limit	Expenditure limits are determined for each NHS organisation by NHS England for both revenue and capital, which limit the amount that may be expended on revenue purchases, as assessed on an accruals basis (that is, after adjusting for receivables and payables).
Transformation	A process of profound and radical change that orients an organisation in a new direction and takes it to an entirely different level of effectiveness.
Safeguarding	Protecting from harm or damage with an appropriate measure.
Stakeholders	A person, group or organisation that has interest or concern in an organisation.
Sustainability	An approach that creates long-term strategy aimed toward the natural environment and taking into consideration every dimension of how a business operates in the social, cultural, and economic environment.
WGA	Whole of Government Accounting (WGA) are organisations such as Local Authorities, Scottish and Welsh NHS bodies, NHS Property Services and NHS Resolution, etc.

How to contact us

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