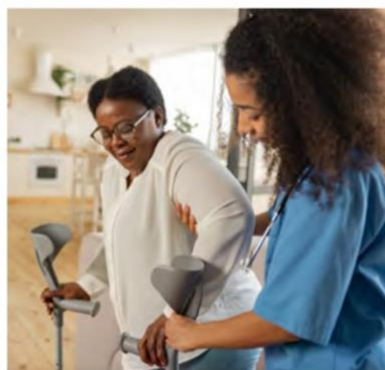
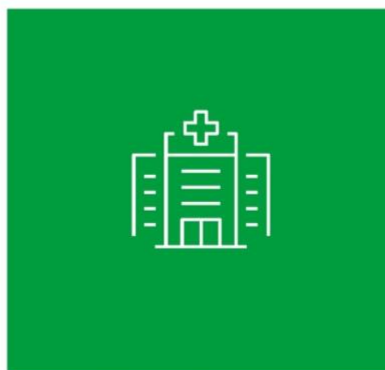


# Annual Report and Accounts Month 1-3 2022/23



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# PERFORMANCE REPORT

## Foreword

### Bringing health and care together – our year in review

This report gives you some insight into how the Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (CCG) improved patient care, spent its money and helped the NHS and the people we serve.

At the start of 2022/23 we completed our final preparations to become an Integrated Care Board (ICB) as part of the new Integrated Care System (ICS). We have been informally working in this way since 2020 and this formal step was very positive, as it genuinely brings the worlds of health and care together in a way that could have huge benefits for patients.

This will see us working in a much more joined-up way with our partners, particularly local authorities. We can increasingly take a holistic approach to each individual's needs, with issues such as housing and poverty being considered alongside health. We believe this integrated approach to health and care is essential for us to reduce health inequalities.

During this reporting period, our community showed once again how it would care for those less fortunate than ourselves. Beginning in March, the CCG provided support at the humanitarian hub at London Luton Airport for Ukrainian refugees fleeing the conflict in their homeland.

While the pandemic has at times affected staff numbers and performance levels, progress has been made in a range of areas. We developed our Primary Care Networks, improving pathways for cancer patients. We invested in mental health, both for adults and for children and young people, improving access and supporting transformation. And we invested in urgent care, so that the system remains resilient at a time of increased demand. These are just a few examples of the remarkable work of our teams, with many more to be found within the pages that follow.

We would like to give a big thank you to our colleagues, who have risen to the challenge superbly, as well as our partners. It was a tough period but our population have always been at the centre of everything we have done. Those efforts will continue throughout 2022/23 and beyond.

**Felicity Cox, Accountable Officer**

**Sarah Whiteman, Clinical Chair**

## Performance overview

This section contains a summary of our performance as an organisation during the first quarter of 2022/23, with detail about some of the more significant projects that took place.

Our transition to becoming an ICS – an Integrated Care System that sees organisations such as NHS trusts and local councils work together to improve health and care outcomes – accelerated over this reporting period.

As part of our efforts to work as a wider health and care system, the overall health and wellbeing of our population remained a primary focus. We used population health management techniques and data to help identify and address health inequalities and focus on wider health and wellbeing factors. Population health management is a way of working to help frontline teams understand current health and care needs and predict what local people will need in the future. We do this knowing that the pandemic has widened health inequalities and reduced life expectancy.

To maximise the impact of our COVID vaccination programme we used a data-driven population health approach. We monitored our performance and population uptake of the vaccine by age, underlying health condition, ethnicity and deprivation. This data was mapped at council and ward level, so we were able to easily identify any areas of lower uptake.

The CCG met its financial duties. Our allocation was £417.3m and we finished the quarter with total expenditure of £417.3m, delivering a break-even financial position against our Revenue Resource Limit.

We continued to develop the Risk Management Framework to identify and understand key risks to the organisation's ability to deliver its strategic objectives. The strategic objectives, to which all risks are aligned, were reviewed by the Board and are:

- drive improvement in health and wellbeing outcomes;
- deliver improved access and quality standards; and
- deliver financial stability.

Details of the risks faced are set out in more detail within the Annual Governance Statement within the Accountability Report (page 32).

In summary, the key risks in 2022/23 are the delivery of NHS constitutional standards, the impact of COVID on delivery of services, financial stability, resource capacity for transformational change versus business as usual and recruitment and staffing across the health and social care system. These risks were managed and monitored through the CCG's risk management process working in close proximity with performance to ensure that the risks to delivery of objectives were adequately mitigated.

In primary care, we continued to strive to make available both responsive and accessible appointments for all essential patient services. This included immunisations, cancer screening and conditions needing same-day appointments. We resumed our support to facilitate development of primary care by working with our 23 Primary Care Networks (PCNs) that operate across the four local authority areas. The transformation of services has been achieved by clinically-led initiatives, such as digitally remote monitoring and consultations, joint GP and community pharmacy services for minor conditions and a more diverse and increased GP workforce through new, innovative clinical roles.

While the pandemic has continued to dominate, we have started to focus on reset and recovery. That means a re-emphasis on the business-as-usual activity that patients need from us and working to improve some of the performance measures that have been affected by the pandemic.

**Felicity Cox**  
Accountable Officer  
27<sup>th</sup> June 2023



## About us

Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (CCG) was an NHS organisation formed on 1 April 2021 to commission health care services for the 1,069,465 people who are registered with a GP practice in our area.

The CCG was a clinically-led member organisation and, in this reporting period, made up of 95 GP practices. We also have 23 primary care networks (PCNs) in place, which bring together a number of GP practices, community health services, mental health services and social care to serve populations of 30,000-50,000 people.

Local GPs provided our Governing Body with advice and support using their local knowledge and clinical expertise to ensure we carried out our role successfully.

### Our services

The CCG commissioned the following services:

- ambulance services, Accident and Emergency (A&E) and integrated urgent care (NHS 111 and GP out-of-hours);
- non-urgent hospital care;
- community health services including community nursing, speech and language therapy services and wheelchair services;
- rehabilitation services;
- NHS continuing healthcare;
- maternity and new-born services (excluding new-born intensive care);
- children's healthcare services (mental and physical health);
- services for people with learning disabilities;
- mental health services; and
- primary medical services (co-commissioned with NHS England).

## About the Bedfordshire, Luton and Milton Keynes area

Just over one million people are registered with a GP practice in our CCG area. This area is covered by four local authorities: Bedford Borough Council, home to an estimated 174,687; Central Bedfordshire Council with a population of 294,096; Milton Keynes, covered by Milton Keynes Council (270,203 population); and Luton, covered by Luton Borough Council (213,528 population).

As part of an ICS, we work in partnership with our four local authorities to improve outcomes for the people who live in our area. As such, we have senior representation on all local Health and Wellbeing Boards, with our Accountable Officer and Clinical Chair being core members. Our operating plans respond to the priorities and needs identified through the Health and Wellbeing strategies for Bedford Borough, Central Bedfordshire, Milton Keynes and Luton.

We are one of the fastest growing areas in the country. Our population could increase by nearly 90% by 2050, and the number of people aged 85 and over is projected to double by 2035. We are also predicting higher than average growth in the number of adults aged 65 and over. As more people in these older age groups tend to have long-term and multiple health conditions, this presents a significant challenge for both health and social care. We are also expecting a higher than average growth in the number of children and young people aged 10-19 years.

Bedford Borough, Central Bedfordshire, Luton and Milton Keynes are four very different and diverse places. These differences affect what local people need from their health and social care services.

Luton is the most urban, most deprived and most ethnically diverse. Bedford Borough and Milton Keynes are mostly urban with significant ethnic minority communities and some rural areas, especially north of Bedford. In the most deprived areas of Luton and Bedford Borough, two-thirds of children are living in poverty. Central Bedfordshire is the most affluent and least diverse of the four areas. It does however have pockets of deprivation.

There are high levels of health inequality between our least and most deprived areas. In Luton, men can expect to live in good health until they are 57, but just a few miles away in Central Bedfordshire they can expect to live healthily to 66. There are significant differences within places, for example life expectancy in Bedford differs by 10.3 years on average between the most and least deprived areas.

In deprived areas, early death is mainly due to cancer, circulatory and respiratory diseases. Compared to similar areas, more people die early from heart disease in Bedford Borough and from breast cancer in Central Bedfordshire. Cancer is also an increasing cause of early death in Milton Keynes and Luton, especially colorectal cancer, and notably among women, where levels are rising compared to a declining national trend. Stroke is a factor in Luton and Milton Keynes, along with cardiovascular disease in Luton.

In Milton Keynes, death from causes considered preventable is declining but remains significantly higher than similar areas, particularly from cancer. There are a high number of deaths from lung cancer and chronic obstructive pulmonary disease (COPD), and more years of life are lost to smoking related illnesses. In Bedford Borough, preventable deaths from cardiovascular disease are high.

Across the area, two-thirds of adults in our area are overweight or obese. Also, hospital admissions for coronary heart disease are higher than nationally. Admissions for asthma in under 19s are high in Milton Keynes and admissions for cardio-pulmonary disease are high everywhere except Luton.

## Launching our Integrated Care System

Bedfordshire, Luton and Milton Keynes CCG was launched on 1 April 2021 with the support of our staff, stakeholders, GP members and the approval of NHS England. We strengthened our ways of working with our NHS Trusts, GP and local authority partners with a clear focus on improving outcomes for our whole population and in our four places: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

This work was underpinned by our values:



**Co-production:**

We work with people and communities as equal partners to achieve better outcomes



**Community:**

We value our people and our communities



**Compassion:**

We treat people with respect and compassion



**Collaboration:**

We develop trusted relationships and embrace partnership working



**Commitment:**

We deliver on our commitments, we provide continuity and we are accountable

While we recognise the distinct places and people within our area, there are significant advantages in planning healthcare services for a larger population. It allows us to provide a more joined-up service, reduce unnecessary variation in care and spread good practice. It means we can benefit from economies of scale, while cutting duplication and bureaucracy. This report showcases these achievements.

## Becoming an Integrated Care System

The Health and Care Act received Royal Assent in April 2022. This meant that the CCG was dissolved as a legal entity at midnight on 30 June 2022. The functions of the CCG (as amended by the Health and Care Act) and the assets and liabilities of the CCG transferred to a new statutory NHS organisation called NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board on 1 July 2022.

The purpose of an Integrated Care System (ICS) is to improve outcomes in health and care. It focuses on tackling inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social and economic development.

Our new ways of working of an ICS have included the establishment of:

**Integrated Care Partnership** – a statutory joint committee between the local authorities in Bedfordshire, Luton and Milton Keynes and the Integrated Care Board which will set the population health strategy;

**Integrated Care Board** – the statutory NHS organisation has taken on the CCG's functions and some new functions to deliver plans to realise the strategy set by the Integrated Care Partnership;

**Place-Based Partnerships** – partners in each of the four local authority areas working together on the collective planning, delivery and monitoring of services to populations at places based on the Joint Strategic Needs Assessment and ICP strategy;

**Provider Collaboratives** – to enable providers and wider partners to work together at scale to deliver improved outcomes and a more resilient service; and

**Primary Care Networks** – practices grouped together to build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home.

The CCG undertook a thorough process of due diligence to support a safe and secure transition to the new statutory organisation, the Integrated Care Board. The CCG's staff led the programme of work to

establish the new arrangements and the CCG Governing Body recommended the constitution of the ICB to NHS England for approval.

## Strategic objectives

In accordance with the ICS long-term plan, our goal in everything we do is to achieve the vision we have agreed as a partnership with other NHS organisations and local councils. This is to improve our people's health and wellbeing, enhance their quality of care and be a great place for our staff to work, while delivering value for money.

This plan sets out how we aim to make sure our population gets the very best care available, when they need it. We want people to live longer in good health and we are absolutely committed to spending public money wisely on the services that will make the biggest difference:



## Performance summary

### Key achievements

These are some of our key achievements from the first three months of 2022/23:

- **Working with communities to protect people against COVID-19**  
We continued to roll out of the COVID-19 vaccination programme, with a focus on the spring booster programme and rolling out vaccinations for 5-11-year-olds. This was a complex effort that required significant contributions from many different parts of the population. See page 25
- **Supporting people fleeing from war-torn Ukraine**  
We have provided support at a humanitarian hub at London Luton airport to help families arriving from Ukraine. See page 14.
- **Supporting the health and wellbeing of our healthcare professionals**  
We promoted the ShinyMind app for healthcare professionals across the CCG system to support their health and wellbeing. The app was designed to help NHS workers build resilience and reduce stress. By doing that they are better able to support patients, even in a highly pressurised environment. Read more on page 14.

### Primary care

Primary care is the day-to-day healthcare available in every local area and the first point of contact for people when they need health advice or treatment. Primary care is delivered by a range of service providers with general practice at the heart of the system so that patients see the right person at the right time.

Responsive, proactive, and accessible primary care is led by general practices. However, primary care services are much broader than that. An effective primary care system needs to work closely with community, mental, secondary, social, and voluntary care services.

General practice has worked tirelessly to deliver services throughout the pandemic. They have been at the forefront of the COVID-19 vaccination effort, and we recognise their extraordinary efforts.

### Cancer and primary care

PCNs worked on actions to implement the Cancer Directed Enhanced Service (DES) which focuses on early diagnosis. We looked at improving cancer pathways for patients locally following primary care audits. Each PCN reviewed its screening uptake data and developed an action plan to increase patient participation in the national cancer screening programmes using a mixture of traditional and innovative approaches.

The impact of Coronavirus on cancer services is well known with cancer diagnostics and treatments facing delays. GP education and clinical engagement has been a priority for the cancer programme. Opportunities for sharing best practice and keeping primary care informed of changes to cancer pathways enabled primary care to continue to influence improvements to cancer services and pathways for patients.

### General practice

General practice core practice times are 8am-6.30pm five days a week, although a small number of practices have different opening hours. Outside of core practice times, out-of-hours and urgent primary care services are provided. This includes the integrated urgent care service (111, clinical advisory service and GP out-of-hours services), urgent treatment centres and urgent GP clinics.



## **Social prescribing**

Sometimes a person's health needs go beyond treatment for a condition. They could be lonely or isolated, which can affect their general health and wellbeing. These problems became worse during the pandemic.

This is where social prescribing comes in. We have more than 40 skilled social prescribing link workers, many embedded within PCNs. Using a holistic, non-medicalised model, they play a critical role in supporting individuals by identifying and working in partnership to address the wider determinants of health.

We will continue to explore innovative ways of utilising this valuable workforce to benefit the wellbeing of the local population.

## **Urgent care**

We continued to focus on commissioning resilient urgent care services during the first quarter of 2022/23.

Urgent care is when a patient's life is not at risk but they need, or would benefit from, care on the same day. An urgent care response is usually provided by primary care. It could include an urgent or out-of-hours GP appointment, a phone consultation through NHS 111, pharmacy advice and referral to an urgent treatment centre.

NHS 111 plays a crucial role in directing a patient to the right service. The urgent care system will manage the patient's need in the most appropriate way. This could be done through a remote or face-to-face conversation with a clinician, or advice and guidance given to support self-care.

We have worked with Herts Urgent Care (HUC) to test a virtual waiting room for patients that have called 111 and, after clinical assessment, need an emergency department (ED) service. Instead of physically presenting at an A&E, patients will be called by an ED consultant who will remotely assess the patient. The consultant will have access to video consultation technology. It is expected to reduce the need to attend A&E departments.

HUC has also introduced minor injury specialist clinicians into their Clinical Assessment Service. This is expected to increase the number of 111 cases that can be managed away from A&E departments.

## **Improving primary care**

We know that improving access to primary care is impossible without the work of our partners, and we are looking forward to building on this further as we evolve as an ICS. That is why we have a multi-agency programme of work with critical system partners, including Healthwatch to represent patients, NHS England, local medical committees which represent GP practices and of course the CCG to represent commissioners.

We have supported primary care to recruit to new posts to expand their teams. This includes ongoing recruitment through the Additional Roles Reimbursement Scheme (ARRS) linked to the PCN Direct Enhanced Service (DES) which brings additional skills such as clinical pharmacist, first contact physiotherapist, paramedics and nursing associates. In addition, we have provided access to staff training and wellbeing support.

Communications has been key to making sure our population understand how to self-care and where to go to access care and support when needed.

We continued our regular forum of primary and secondary care clinicians. This means they can work closely together to review pathways between them, making sure our population gets the best possible experience.

## **Adult Mental Health, Learning Disabilities and Autism**

Collaboration has been key to making sure that the mental health system stayed resilient in the face of increased pressures. We have seen increases both in numbers of patients and also the severity of their condition, with no sign of this abating.

Recruitment has been a challenge, as it has been nationally. We worked together with providers to address this. We created new roles, expanded recruitment teams and resource and worked with Voluntary, Community and Social Enterprise (VCSE) partners.

We have developed our comprehensive programme, with East London NHS Foundation Trust and our local authorities. This transforms ways of working for people supported through Section 117 aftercare, to make sure they are receiving the right level of care to meet their needs, in the right setting and creating system efficiencies. After a successful year in 2022/23, the Section 117 Programme Board has agreed an ambitious set of priorities for 2022/23.

We made progress on our NHS Long Term Plan commitments. These include transforming community services, improving access to psychological therapies (IAPT) as reported in our performance analysis section on page 16, early intervention in psychosis services and health checks for people with serious mental illness.

## **Modernising inpatient mental health care in Bedfordshire and Luton**

Plans to modernise mental health services progressed during the first three months of 2022/23.

The programme, set out in the *Case for Change* document, aims to improve services and bring them much closer to patients. It is a partnership between Bedfordshire, Luton and Milton Keynes CCG and East London NHS Foundation Trust.

Currently acute adult inpatient mental health services are based in Luton, which can mean long distances to travel for some patients. For children and young people, there are no inpatient services commissioned by NHS England in the CCG area, with patients having to travel as far as Southampton or Scotland to get the care they need.

The programme aims to open a new, purpose-built Bedford Centre for Mental Health at Bedford Health Village, including two new wards for children and young people, and to modernise services at the Luton Centre for Mental Health.

The result will be state-of-the-art service provision, with patients benefiting from multi-disciplinary teams at two centres of excellence.

Work has been underway during this period to establish an inpatient unit for young people at a temporary home on the Luton Centre for Mental Health site.

The Evergreen Unit will open by November 2022 and has been designed and delivered with local service users.

## **Improving cancer outcomes**

A major report into cancer outcomes in Luton was published in August 2021.

The **Luton Cancer Outcomes Collaborative Project** aimed to find out why outcomes for cancers were poorer in Luton than the rest of the East of England region.

It specifically looked at lung, colorectal, breast, prostate, pancreatic and oesophageal cancers and made clear recommendations for improving outcomes among this population.

The report found that there were a range of factors which explained poorer outcomes in Luton. These included:

- delayed diagnosis and late presentation;
- public and primary care awareness of signs and symptoms of cancer;

- access to services and poorer experience of care;
- lifestyle and risk factors; and
- anecdotally, treatment location, transport mode and distance travelled also have effect on the patient treatment choice and, ultimately, cancer survival outcomes.

The report outlined three recommendations.

**Recommendation 1** outlines promotion of screening services in diverse communities, awareness and engagement to focus on early diagnosis and awareness of symptoms. It also proposes a review of referral practices in Luton and improvements to the process, including training and support.

**Recommendation 2** looks at improving access to diagnostics to ensure patients are diagnosed in a timely way. It also suggests treating patients closer to their homes, to tackle late presentations and the impact of Coronavirus. This could be implemented through regional reviews of specialist cancer centre provision or system pathway redesign.

**Recommendation 3** looks at prevention and wider determinants of health. It suggests establishing partnerships to develop initiatives for improving job and education opportunities, supporting people to give up smoking and alcohol, and promoting healthy lifestyle and diet in deprived areas.

Following the report's publication, the project moved from delivery to implementation. Early successes include a Macmillan grant to introduce a team of community connectors who will work with communities to understand health inequalities and engage on cancer signs and symptoms. These are exciting new roles and an example of partnership working across the ICS with the CCG, public health and Macmillan Cancer Charity.

### **Post-COVID Support**

The Post-COVID Assessment Service was established in December 2020. It supports patients suffering from Post-COVID symptoms that require a multi-disciplinary management approach.

Referred patients receive a thorough and detailed virtual assessment. This is followed by face-to-face assessment if required, with onward referral for further investigation or signposting to other services depending on need. Complex patients are discussed at a Multi-Disciplinary Team (MDT) meeting with specialist clinical support.

### **Patient flow and discharge**

The Coronavirus pandemic continued to require special focus during this reporting period, alongside recovering the elective surgical lists.

With these pressures, there was a real and urgent need to maintain patient flow through all services and into any onward services.

We supported new pathways for those suffering from delirium and trialled the use of 24-hour short-term care to settle people at home. This has proved successful, as we know that most people, especially those with a level of confusion, recover better at home. This is because they get back more independence sooner and need less care and support in the longer term.

We carried out a project to improve discharge processes, creating single multi-agency teams in each system. IT systems were also enhanced to support this operationally and to enable reporting to NHS England and Improvement.

A support tool for those caring for people at the end of life continued to be used. It allowed a multi-agency joined-up approach to palliative care planning for the first time. It is seen as an exemplar and is being taken up by other systems in the region.

We developed and agreed a single model for an Integrated Fall Service, which was commissioned and implemented in Milton Keynes in early summer 2021. Implementation will take place in Luton in 2022/23, while plans are being finalised for implementation in Bedfordshire.

## **Safeguarding**

The team worked with the safeguarding partnership board to address concerns of neglect, child deaths, and child exploitation in Luton through audits and development of protocols as well as through the multi-agency learning and improvement group.

### **Looked after children**

Work continued to ensure that children were seen for health assessments. Pathways were developed and implemented to establish a more robust referral process into health from social care. Regular meetings with social care colleagues were started to support the protocols and pathways to meet the health needs of children in care.

### **Special Educational Needs and Disability (SEND)**

We worked with Luton Borough Council towards addressing the areas of weakness identified in the SEND written statement of action following the last inspection in 2018. A needs assessment was refreshed in 2021 which informed the Luton SEND strategy refresh. Work is ongoing with Central Bedfordshire Council to deliver the improvements for children with SEND identified in their written statement of action. In addition, the new joint SEND strategy was published.

### **Children and Adolescent Mental Health Services (CAMHS)**

Partners in our area launched a Year of Engagement in 2022 which sees young people hosting a series of creative engagement sessions across Bedfordshire, Luton and Milton Keynes. They are using various social platforms to ensure their voices are heard, involving young people who are interested in talking about emotional health and wellbeing. This will inform and shape priorities for mental health and wellbeing and ensure services are co-produced in order to meet the needs of our diverse local communities.

During this year CAMHS teams saw a significant increase in referrals for children with Eating Disorders and a CCG-wide Clinical Reference Group has developed new treatment pathways to ensure young people are safely managed in the community.

## **Maternity**

Safe and effective maternity services have been the focus of the Local Maternity and Neonatal System (LMNS).

This follows the December 2020 publication of the interim Ockenden Report which reviewed severe issues with maternity services in the Shrewsbury and Telford Hospital NHS Trust. The final report was published in March 2022.

During the reporting period, staffing levels remained challenging and regional workforce programmes were led by our Heads of Midwifery. They focused on attrition, retention, return to practice, international recruitment, apprenticeships, advanced clinical practice, leadership development and workforce transformation.

We know that poorer pregnancy outcomes are seen nationally in black and Asian ethnic minorities, especially when combined with a high level of deprivation. There has been a particular focus on tackling inequality in the CCG and will continue as we move to an ICS. The LMNS Equity and Equality strategy has been drafted and as a result, two cultural keyworkers in Luton have been funded. The aim is to enable women in Luton to access maternity services right at the beginning of their pregnancy to get the best outcomes for both mothers and babies.

## **Boosting the health and wellbeing of healthcare professionals**

Healthcare professionals have faced increased stress due to the pressures of working during a pandemic.

In response, the ShinyMind app has been introduced to help increase the resilience of NHS staff. The app can help to reduce stress of people working on the frontline. It is the only app developed and tested in partnership with staff from all levels of the NHS.

The results from initial trials show that 96% of those who tried the app reported better stress management, while 97% reported improved resilience.

The app is open to all general practice, community pharmacy, dental and optometry staff. It aims to enable users to think, feel and perform better. It does this by giving them access to over 100 personalised masterclasses, interactive exercises and a community of people with similar experiences.

## **Yellow bracelet scheme to support better patient care**

Digital technology continued to help health and care providers deliver a more effective service to patients.

A good example of this is the yellow bracelet scheme, developed by the Bedfordshire, Luton and Milton Keynes Integrated Care System (ICS) and introduced in 2021. The bracelet is available to all people who receive care, either at home or in residential care, and can be scanned to allow instant access to medical information.

The bracelet enables health and care professionals to access information about a person's care and the support they have available in an emergency. It can be scanned in hospital, or by ambulance crews and community or care teams.

Giving health and care staff instant access to this information can help to avoid unnecessary hospital attendance or admission, reduce a patient's length of stay in hospital and help people maintain their independence at home.

## **Working with the third sector to support older people's independence**

A scheme to help more older people maintain their independence was launched in January 2022.

We worked with Age UK Bedfordshire and Milton Keynes and Age Concern Luton to provide the new service. It gives healthcare professionals, including GPs, nurses and social prescribers, the ability to refer patients to the scheme. They can do this through email and phone, which will be responded to in up to four hours who then make an assessment of the support required. The team from the charities could then make a variety of non-medical interventions, such as welfare checks, collecting prescriptions and shopping for essential items.

These interventions gave the healthcare professional the confidence that the patient would be safe at home, rather than feeling that the only option available would be to refer them to hospital.

In the April-June 2022 period, our voluntary sector has supported 495 clients with 1,612 interventions – over three intervention per client. Over three-quarters (76%) of clients were Luton residents.

## **Welcoming families seeking refuge from war**

Families seeking refuge from the conflict in Ukraine have been supported within the Bedfordshire, Luton and Milton Keynes area.

A humanitarian hub has been set up at London Luton Airport to provide practical support for air passengers arriving from Ukraine.



The hub provides a warm welcome to those suffering the trauma of being uprooted from their homeland. Arrivals are greeted by volunteers from the Bedfordshire and Luton emergency volunteers executive committee, British Red Cross and the airport chaplaincy.

Advice, information and useful contact numbers are provided to help refugees with the support they need. Paramedics from the Hearts First Ambulance Service are also on hand to provide mental and physical health support information.

The hub is organised by Bedfordshire's Local Resilience Forum, which brings together partners such as local authorities, the emergency services, charities and the airport.

## Performance Analysis

### Performance, quality, and safety of local healthcare

Clinical quality and safety of care continued to be prioritised across commissioned services. We made progress in achievement against NHS Constitution Indicators, designed to ensure patients have access to services as set out in the national NHS Constitution. They also serve as a measure of our clinical effectiveness.

The CCG tracks each indicator against the 2022/23 Planned Constitution Performance, which was developed using the planning framework and technical definitions set out by NHS England. In addition, the Governing Body routinely monitors our performance against these indicators, with oversight from NHS England and NHS Improvement.

The main areas of success in the first quarter of 2022/23 were:

- Primary care - appointments in GP practice carried out face-to-face - (76.6% average across BLMK over the quarter)
- Adult mental health – 72-hour follow ups (where at least 80% of patients should be followed up within 72 hours of discharge from psychiatric inpatient care), achievement of severe mental illness and learning disability physical health checks, the quarter one plan for diagnosis of dementia, and the early intervention in psychosis programme (EIP); and
- Children and young people – numbers accessing mental health services.

The main areas of challenge were:

- Elective recovery – Long waits including 104, 78 and 52 weeks plus;
- Cancer care – waiting times for the 2-week standard, 28-day faster diagnosis, the 62-day standards for patients to receive their first treatment following an urgent GP referral and long waits of 104 days plus;
- Adult mental health - Improving access to psychological therapy (IAPT) access;
- Children and young people - eating disorder patients seen for both urgent (one-week) and routine (four-week) referrals;
- Community services – Children's wheelchairs (% received within 18 weeks), and the number of two-hour urgent community response standard for adults with an urgent care need; and
- Quality and safety – infection control – both Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C-Diff) exceeded thresholds.

## BLMK Key Performance Indicators Dashboard Quarter 1

Area	BLMK ICB	Threshold	Frequency	Latest Data	Achievement	Trend	YTD	Regional Average (ICB position vs region)	What does good look like
Elective Recovery	RTT - % Patients Waiting 18 Weeks or less	92%	M	Jun-22	58.74%	↓	●	59.51%	High is good
	RTT - Number of 104+ Week Waits	n/a	M	Jun-22	9	↑		15	Low is good
	RTT - Number of 78+ Week Waits	n/a	M	Jun-22	491	↑		457	Low is good
	RTT - Number of 52+ Week Waits	n/a	M	Jun-22	5919	↓		3,238	Low is good
	Diagnostics Tests - 6 Week Waits	≥1%	M	Jun-22	33.09%	↓	●	32.89%	Low is good
Cancer Care	Cancer - 2 Week Waits Standard	93%	M	Jun-22	76.22%	↓	●	67.51%	High is good
	Cancer - 28 Day Faster Diagnosis Standard	75%	M	Jun-22	70.37%	↑	●	66.22%	High is good
	Cancer - 62 Day GP Referral	85%	M	Jun-22	52.16%	↓	●	57.29%	High is good
	Cancer - 104+ day waits	0	M	Jun-22	43	↓	●		Low is good
Urgent Emergency Care	Ambulance - 30 minute Handover Delays (Daily Average)	n/a	M	Jul-22	32.61	↓			Low is good
	% ED Attendances that result in emergency admission	n/a	M	Jul-22	23.65%	↑		25.20%	High is good
Primary Care	Appointments in GP Practice - % Face to Face	75%	M	Jun-22	75.17%	↓	●	68.51%	High is good
Adult Mental Health	72-Hour Follow Ups	80%	M	Jun-22	82.00%	↓	●		High is good
	SMI Healthchecks	Q1 - 3800	Q	Q1 2022/23	3944	↑	●		High is good
	Dementia Diagnosis Rate	Q1 63.16%	M	Jun-22	63.50%	↑	●	59.20%	High is good
	IAPT Access	2088	M	Jun-22	2005	↑	●		High is good
	Early Intervention in Psychosis (EIP)	60%	M	Jun-22	81%	↑	●		High is good
	Inappropriate Out Of Area Bed Days	n/a	Q	Q4 2021/22	725	↑			Low is good
Learning Disability & Autism	Learning Disability Healthchecks	Q1 6.81%	M	Jun-22	10.36%	↑	●		High is good
Children and Young People (CYP) & Maternity	Number of CYP accessing mental health services	Q1 16325	M	Jun-22	16682	↑	●		High is good
	CYP Eating Disorders - Routine	95%	Q	Q1 2022/23	83.03%	↑	●	63.17%	High is good
	CYP Eating Disorders - Urgent	95%	Q	Q1 2022/23	78.57%	↑	●	49.42%	High is good
	Perinatal Mental Health Access	107	M	Jun-22	65	↓	●		High is good
Community Services	Children's Wheelchairs - % received in 18 weeks	Q1 77.27%	Q	Q1 2022/23	75%	↓	●		High is good
	Urgent Community Referrals - 2 hour Standard	70%	M	Jun-22	97%	↑	●	79%	High is good
	Urgent Community Referrals - Responses within 2 hours	669	M	Jun-22	350	↓	●		High is good
Quality & Safety	Serious Incidents	0	M	Jun-22	16	↑			Low is good
	Infection Control - C-Difficile	12	M	Jun-22	18	↓	●	12.07	Low is good
	Infection Control - MRSA	0	M	Jun-22	1	↑	●	0.5	Low is good

**Key**  
**Trend Arrows**  
 ↑ Improving  
 ↓ Deteriorating  
 ⇔ No change  
**Achievement RAG**  
 On Track  
 Off Track  
**YTD**  
 YTD On Track  
 YTD Off Track  
**Regional RAG**  
 ICS vs Regional Average  
 ICS vs Regional Average

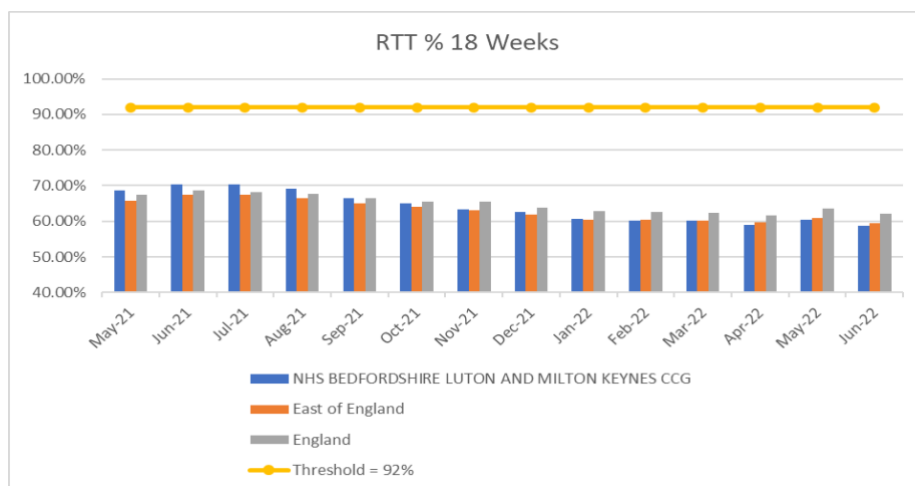
## NHS Constitution measures

These measures identify NHS responsibilities and are critical in delivering the quality services to which Bedfordshire, Luton, and Milton Keynes patients, public and staff are entitled.

The Constitution measures provide information about national requirements and operational standards that the NHS is committed to achieve, to improve the population's mental and physical health.

All NHS Constitution measures were monitored monthly by the CCG through provider and national performance reporting and monthly contract meetings with providers. This allowed the CCG to work with providers in a timely and proactive way, to understand challenges and to manage and mitigate.

### 18 weeks Referral to Treatment (RTT), 52 and 104 week-wait measures



The pandemic has had a significant impact on the number of patients and the amount of time patients are waiting to receive care.

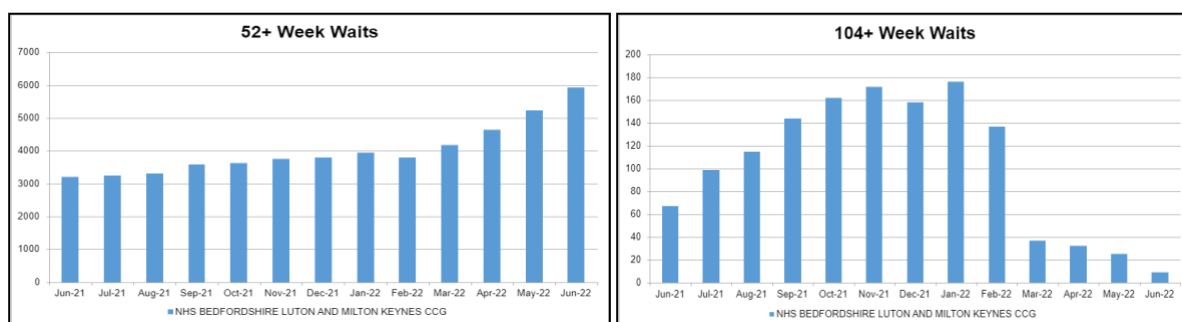
We worked with providers to hold steady performance for patients on the 18-week incomplete pathway over the quarter. Performance began and ended the quarter at 59%.

Performance has not met the national target. This was largely due to an increase in demand, workforce issues and capacity shortages. We worked collaboratively with trusts and independent sector providers (ISP) to deliver several work programmes to support overall and speciality level performance recovery.

We implemented work programmes with trusts to:

- clinically prioritise patients on the waiting list,
- manage demand through alternatives to secondary care and optimise referrals; and
- utilise the independent sector to support acute trusts, including musculoskeletal, eyecare / ophthalmology and ear services.

We saw an increase in patients who have waited 52 weeks or longer for treatment from the point of referral over the first quarter of the year. The number of patients waiting 104 weeks have been decreasing in the same period from 32 in April to 9 at the end of June.

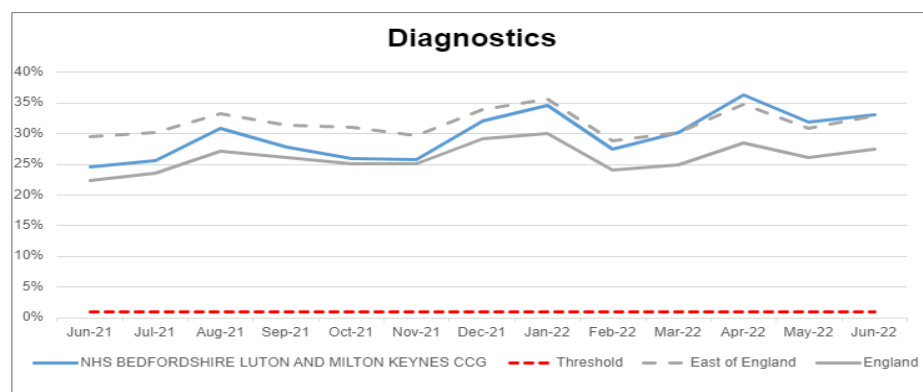


Trusts continued to implement patient-initiated follow-ups across different specialities. These allowed patients to arrange their own follow-up when they need it. This enabled the patient to access a consultation through video conferencing technology using their preferred device. We also maximised our advice and guidance service to support primary care by providing specialist clinical advice to clinicians. This allowed a patient's care to be directed to the most appropriate setting and support the safe reduction of unnecessary outpatient appointments.

Patients with the most urgent needs were prioritised in all NHS and independent hospitals throughout Bedfordshire, Luton and Milton Keynes following a national process. We continued to utilise the locally contracted independent sector to provide more surgical capacity.

## Diagnostic Waits

Diagnostic waits under six weeks (target 1% or below) remained above target throughout the quarter, starting in April with 36.24% and ending Q1 at the improved position of 33.09%. Achievement of the national target was impacted by adverse performance within several specialities, including magnetic resonance imaging (MRI), cardiology (electrophysiology) and computed tomography (CT) scans. Both trusts prioritised their imaging waiting lists which should help to improve performance. Trusts worked with provider organisations to secure additional capacity to aid recovery.



## Cancer waiting time standards

The Integrated Care System Cancer Programme, alongside the East of England Cancer Alliance, continued to focus on delivery of the Long-Term Plan ambitions for cancer to improve earlier and faster diagnosis.

Cancer continued to be a prioritised service to give all patients fair and timely access to diagnostics and treatment.

System partners worked together with oversight from our Cancer Board to improve the patient pathway and support recovery and restoration of cancer services. They did this by implementing the national best practice timed pathways for specific cancer tumour sites. Last year, despite the challenges with COVID, both hospitals implemented and maintained the new pathway for prostate cancer, upper gastrointestinal (GI) oesophageal cancer, lower GI colorectal cancer and lung cancer.

Cancer performance fluctuated against national standards. This was due to an increase in monthly referrals and demand, a growing backlog and waiting list, alongside reduced screening, and diagnostics capacity. We worked closely with the acute trusts and the regional Cancer Alliance to understand challenges and the full impact of Coronavirus on cancer care.

Genomic tests were used so that chemotherapy could be more targeted, to avoid over-treatment. As alternatives to endoscopy, we now have a colon capsule and cytosponge. For Milton Keynes and Bedfordshire patients who display symptoms that could indicate cancer, such as fatigue or vague abdominal pain, there is a new way to identify if they have the disease.

We ran a successful community engagement to encourage participation in national cancer screening programmes. Work on innovation continued with the introduction of genomic tests to identify cancers earlier.



Additionally, the breast screening unit upgraded technology to use higher quality images to identify breast cancer. Also, for breast cancer patients, we used a new oncotype test to improve treatment of the disease and upgraded technology at the breast screening unit so that imaging is of a better quality.

Work continued to engage with patients and the public on improving access to radiotherapy services, bringing care closer to home. We continued to consult with the public on bringing radiotherapy services to Milton Keynes.

### **Physical Health Checks**

For physical health checks for people with a severe mental illness, we have delivered an end-of-quarter number of 3,944 checks against a plan of 3,800. Health checks for those with a learning disability also over-achieved with an end-of-quarter total of 10.3% against a Q1 plan of 6.81%. The CCG worked with providers to deliver tailored outreach services to people with a severe mental illness and those with a learning disability to increase physical health.

### **Dementia Diagnosis**

The dementia diagnosis rate has remained steady over the reporting period, exceeding both the regional and the England national average performance beginning and ending the quarter with 63%, falling short of the end-of-year and national target. We have continued work programmes to improve the level of diagnosis for patients with dementia.

### **The Improved Access to Psychological Services (IAPT )**

The IAPT access measure at the end of Q1 underachieved the target by 83 referrals. This continues to be because of a culmination of workforce issues and referral shortages. We worked with providers to increase referrals through advertising campaigns, webinars, outreach programmes, and linking with local colleges, universities, and employers.

### **Early intervention for psychosis first treatment**

This measure was achieved consistently over the quarter, achieving 81% in June. Performance has consistently been above both the national target of 60% and the England average performance over the full year.

### **Children, Young People and Maternity**

We achieved the children and young people (CYP) mental health access with an end-of-quarter figure of 16,682 against a 16,325 plan. Commissioners and providers worked together to build further capacity within voluntary sector services. This enabled earlier intervention and support for children and young people, and reduced demand for more acute support.

For eating disorders, over Q1 we exceeded both the England and regional average performance for urgent referrals to be seen within one week by 10% and 28% respectively. However, we underachieved against the national threshold of 95% with achievement of 78.6% at the end of the quarter.

Performance for routine referrals – to be seen within four weeks – exceeded both England and regional average performance for the quarter with a rate of 83%. Programmes of work are in place to support improved outcomes for both measures. These include a virtual day service for children with eating disorders with oversight from a dedicated clinical reference group.

### **Infection Control**

June saw 18 cases of clostridium difficile (C-diff) against the monthly threshold of 12 cases and 1 case of methicillin-resistant staphylococcus aureus (MRSA) infections, against a threshold of zero. The quality team continued to provide regular infection prevention control training to GP practices, care homes and social care settings.

## Environmental Matters

We have a responsibility as an NHS organisation to take action to improve the sustainability of how we conduct our business. This includes working with providers to have similar ambitions.

As a key partner within the Bedfordshire, Luton and Milton Keynes Integrated Care System, we support the co-ordination and development of the system Green Plan. It will set key targets and define work plans to make sure that as a group of health and care partner organisations we continue to reduce carbon emissions. The plan will impact areas such as estates and travel, as well as how we procure and commission services. It will increase the expectations of our suppliers and providers to take the necessary actions to support delivery of system and national targets.

Key actions were taken during the first quarter of 2022/23 to support progress against these objectives. There was a particular focus on our office bases and how they are used. Our Corporate Estates Plan was mobilised, which entailed relocation and consolidation of CCG office space, and agile working arrangements for staff continued.

The majority of staff operate on a hybrid working arrangement, spending the majority of time working from home. Consequently, the amount of travel to and from our offices and to partner organisations for meetings remained significantly lower than in previous years. While this behaviour change will have led to increased utility consumption in colleagues' homes, there will have been a positive net impact in terms of reduced carbon emissions.

These agile working assumptions were embedded in our New Ways of Working Programme, with staff offered a high degree of flexibility in their working arrangements. This is expected to continue to help achieve similar levels of reduced travel across the organisation for the long-term.

Mobilisation of the new office bases was completed by end of July 2022. Three of the four offices are now co-located with Local Authority partners. They already have systems in place for sustainability reporting, and providing assurance around continuing to reduce carbon emissions. A key focus for the coming year will be on working with these landlords to monitor and improve energy efficiency performance for the organisation's new office spaces.

Finally, dry recycling arrangements remain in place across all sites, with the removal of plastic cups from water dispensers to reduce plastic waste.

## Improve Quality

### Quality and safety

Providing safe, quality healthcare services is incredibly important to patients.

For this reason, we have a quality and performance committee to make sure quality issues are given the right oversight. It meets on a regular basis to scrutinise the latest information on all commissioned health services.

However, we have continued to support providers of NHS-funded care to make sure people are treated and cared for in a safe environment and protected from avoidable harm.

### Infection prevention and control and coronavirus

For the first three months of 2022/23, our infection prevention and control (IPC) work was focused on the impact of Coronavirus. Working with our team of expert specialist nurses, we prioritised support for care homes who look after some of the most vulnerable elderly people in our population.

We supported the movement of patients across different care sectors, working with public health and local authority partners, in line with national guidance.

We continued to work across the health economy to reduce healthcare associated infections.

### Quality visits

We have senior leads to work in partnership across each place footprint, understanding the geography, population health needs and any associated quality challenges.

Clinical quality nurse teams were established to focus on quality improvement in care homes. We have individuals supporting homes in each specific place aligned with our local authority footprints. These teams delivered work focused on IPC, care home training on pressure area prevention, end-of-life care and nutrition.

### Serious incidents

Throughout the reporting period, we were informed of any serious incidents that occurred in our commissioned services. We have continued to work with care providers so that lessons are learned and appropriate action taken.

We have two patient safety specialists within our quality team. They work with their peers in commissioned services to help improve patient safety and quality. Our patient safety specialist roles have also been contributing and feeding into the development of the new national Patient Safety Incident Response Framework (PSIRF), working collaboratively across the ICS on its implementation by April 2023.

Over the course of 2022 we have identified an ICB patient safety lead specialist. They will have direct access to the executive lead for patient safety and the ICB quality committee and board. We will also work closely with our academic science networks and, specifically, patient safety collaboratives on implementation of the Patient Safety Strategy. This will include patients in the role of Patient Safety Partners across our system to involve in strategic discussions on their safety priorities.

### Safeguarding

We have to make sure there are safe and effective services in place for safeguarding adults and children. To do this, we work closely with our local authority colleagues, healthcare providers and the police.

We are statutory partners in the Bedfordshire, Luton and Milton Keynes Safeguarding Adults Board and are represented on the Board's executive committees. We are also statutory partners on the equivalent board for children.

All our safeguarding teams worked with partners to support people in vulnerable communities and specific areas being impacted by coronavirus, such as homelessness, mental health and hoarding.

Throughout the reporting period we supported the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2009). We maintained our work in support of lawful processes for care packages (via applications to the Court of Protection) where it is recognised that restrictions are in place for an individual and where those restrictions amount to deprivation.

We have been preparing for the awaited legal change on Liberty Protection Standards. We have developed processes for these standards and authorising arrangements for any incapacitated person's deprivation of liberty to enable care or treatment.

### **Primary care**

We continued to support primary care in quality standards and preparation for Care Quality Commission (CQC) inspections.

Our IPC specialist nurses offered beneficial support to primary care regarding IPC standards, personal protective equipment (PPE) and deep cleaning of clinical areas. They supported the preparation of primary care estates to deliver vaccinations.

### **Children and young people**

It is recognised nationally and locally that the pandemic has had an adverse impact on many children and young people.

It has led to a whole range of issues, such as school being interrupted, fragmented employment markets, social isolation and friendship challenges. It exacerbated existing mental health problems or led to eating disorders.

We made sure that children and young people had speedy access to support for mental health problems. This came through support teams in schools, the KOOTH wellbeing app, contact with voluntary sector providers and the newly launched social prescribing pilot.

More broadly, we worked closely with colleagues across the CCG, local authorities and providers to improve outcomes and experiences for children and families.

We supported children and families at greatest risk, including looked after children and those at risk of neglect or domestic abuse. We increased community support for children and young people with a learning disability or autism, having previously introduced one-off personal health budgets.

A keyworker programme was introduced and an Intensive Support Team developed across Bedfordshire, Luton and Milton Keynes for children and young people with a learning disability or autism with challenging behaviours. This has helped to prevent hospital admissions and support earlier discharge from hospital.

For children and young people with existing mental health problems we invested new transformation funding in additional staff in crisis teams, new home treatment teams and additional support for those with eating disorders.

We worked closely with both hospital and community services to plan ahead to meet the needs of unwell children, including investing in children's urgent care teams and additional medical support in A&E departments. We developed a tool, called Operational Pressures Escalation Levels (OPEL) reporting, to identify in advance when services would be under additional pressure and worked as a system to share good practice and new challenges.

### **Mental health and learning disabilities**

There has been an intense focus on people with a learning disability or mental health condition during the reporting period.

We worked with colleagues across local authorities, the NHS, independent and voluntary sectors so that vulnerable groups received support. We oversaw the alignment of mental health and learning disabilities crisis support teams. In addition, we worked with providers to ensure support could be accessed remotely

with as few barriers as possible, and supported providers with any concerns about quality of service provision.

In primary care, we increased the rate of annual health checks for people with a learning disability, and COVID vaccination aligned with health check clinics. We also made sure carers for these groups were on GP and primary care registers.

## Engaging people and communities

As we entered 2022/23, our communication and engagement with the local population continued in support of the COVID-19 vaccination programme.

March 2022 saw the introduction of the Spring Boosters targeting the older residents and clinically vulnerable population with a COVID-19 booster jab. This was followed by the extension of the vaccination programme to local children aged 5-11 years old.

Family-focused sessions were created to make it as comfortable as possible for local children to get their COVID-19 vaccination.

Welcoming graphics, colouring books and staff in fancy dress in some of the centres were all part of the effort to ensure children felt safe during their jabs.

In addition, accompanying family members were able to get any vaccines for which they were eligible, to allow families to get vaccinated together.

Our engagement included attending the COVID champions meetings with requests to amplify our messages through local networks. We are grateful for their enthusiasm, feedback and support, working alongside us in the delivery of the vaccination message.

During this period, we also attended outbreak engagement boards and strategic vaccination boards across our area to keep stakeholders updated with our roll-out plans.

### **Consultation – fertility services, gluten-free foods and pharmacies**

We carried out a consultation on three key policies between 12 October and 21 December 2021 – fertility services, Milton Keynes pharmacy first minor ailment scheme and gluten-free food prescribing. The consultation was undertaken when COVID reduced the opportunity for face-to-face meetings. However, we offered one in-person drop-in session, as well as several online sessions where people could speak to staff about the proposals.

We promoted the consultation on social media where we encouraged members of the public to give their views. Healthwatch and VCSE contacts helped us to promote the messages. The survey closed on 21 December and the decision was made by the Governing Body in March 2022 to:

- offer specialist fertility services to same sex female couples, single females, trans men and non-binary people, who are currently unable to access fertility services under existing policies. The current offer of three cycles of IVF to residents in Luton will be reduced to one cycle for all eligible residents, bringing Luton into line with the rest of Bedfordshire and Milton Keynes;
- withdraw the gluten-free bread and flour available on prescription in Luton, in line with Bedfordshire and Milton Keynes. The Governing Body however recognised increases in the cost of living and the pressures on households and agreed to make provision in the policy to allow residents who are at risk of dietary neglect to access gluten-free foods on prescription, where required; and
- continue to roll-out the Community Pharmacy Consultation Scheme (CPCS) with GP practices in Bedfordshire, Luton and Milton Keynes. In order to do this the Governing Body took the decision to withdraw the Pharmacy First Minor Ailment Scheme in Milton Keynes. This aligns the service with the current offering in Bedfordshire and Luton.

These decisions are now being implemented in this reporting period.

Fairness was at the core of these consultations – listening to our whole community and making sure everyone is part of the conversation.



Finally, we began work on the Denny Review which looks at health inequalities and other factors that prevent people from receiving the same level of care. While the pandemic has delayed this work, it will be taken forward in 2022/23.

### **Internal communications**

Our internal communications reflect the breadth and depth of the experience of our colleagues.

This can mean sharing good news stories, with the transition to an Integrated Care System (ICS) has been a point of focus.

As many staff have worked from home, fortnightly all-staff briefings from Accountable Officer Felicity Cox have taken on greater importance to help colleagues connect to our leadership. In these sessions, we included a wellbeing section to encourage colleagues to take time to focus on themselves when working at home.

Finally, we have boosted two-way communication between staff and the Executive team through our Staff Involvement Group (SIG) and Senior Leaders Group (SLG).

## Reducing health inequality

Health is sadly not a level playing field for everyone.

Some people are more likely to have a lower quality of life if they have a long-term condition. Some can take longer to recover from a health issue, and some may even end up dying at an earlier point than they should do. Unequal access to healthcare can lead to unequal outcomes.

Making things fairer couldn't be more important, not least because it is a legal requirement set out in the Health and Social Care Act 2012. The Act details that NHS services must be resourced, planned and commissioned in a way that addresses healthcare barriers and inequalities.

At Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group, we promote, recognise and value the diverse nature of our communities. We work with our partners to ensure that the inequalities programme is evidence-based and data-driven. An inequalities working group has been set up to address these issues for the local population.

The working group brings together professionals including those from public health, population health, voluntary, community and social enterprises, digital, communications and engagement and patient participation. The vision for this group is to co-produce the inequalities strategy with those with lived experience.

We work hard to integrate equality into everything we do. We are committed to designing and implementing policies, procedures and commissioning services that meet the diverse needs of our local population and workforce, so that no one is placed at a disadvantage. We do this by bringing all partners together across the system, map the work that is being undertaken through the inequalities working group to understand where the gaps and duplications lie against the population health data.

We are committed to working with the populations of interest to understand the barriers to access, experience and outcomes, and to improve the quality and value for money in our health services. Partners from across the system have come together to develop a proposal through the inequalities working group for spending the system financial allocation for supporting the delivery of Core20PLUS5, targeted at those who are experiencing the greatest health inequalities.

We carried out several pieces of work to help reduce health inequalities over the past year, such as the Luton Outcome Cancer Project or the vaccination programme.

As part of our merger preparations, we completed an equality impact assessment that highlighted things we need to do to so that people with protected characteristics, such as age or race, are not put at a disadvantage. As part of this work, we analysed population characteristics in our four boroughs and carried out a significant amount of public engagement. This will provide us with a stronger platform from which to understand and address health inequalities.

We complete equality impact assessments whenever we are considering major service changes. This allows us to understand and be clear about how any changes would impact people from all backgrounds in our community.

We use population health management techniques to help us identify and address health inequalities at a local and primary care network level. This allows us to focus on a wider range of factors that determine health and wellbeing.

We have worked with GPs and our wider health and social care partners to identify health inequalities, and use local resources to best effect to reduce inequalities and improve outcomes for our population.

## Reducing health inequality and COVID-19 vaccinations

The Coronavirus vaccination effort highlighted health inequalities which we have worked hard to tackle.

Despite having vaccination sites in each local authority, some residents were not taking up the offer of the vaccine as readily as others. To understand why, we mapped vaccination data to ethnicity and deprivation data. This showed the populations and communities that were more hesitant about taking the vaccine. Working with Public Health Intelligence teams, we developed reports that set out vaccination uptake, ethnicity and deprivation mapping.

Using this information, our vaccinations, public health and communications teams connected to a network of COVID-19 champions and faith leaders to find out more about the issues. These were related to three

Cs – Confidence, Convenience and Complacency – regarding vaccination. Underneath those factors we surfaced many challenges, such as how to use the booking system, the language letters were written in, questions about the vaccine, or the accessibility of a vaccine site.

We worked with local people to change our service so that they better met their needs. One solution was to provide a vaccine bus which provided a walk-in option where people could talk about the vaccine and get answers to their questions there and then. Families were able to come together to support and encourage each other. Faith leaders offered their facilities so people could feel confident that they were able to accept the vaccine within their belief system.

We were also able to offer a local service for the traveller community, working with schools and local leaders. Homeless people supported by the local authority were offered the vaccine as part of a health and wellbeing visit. People with learning disabilities and severe mental illness were supported by a multidisciplinary team to make informed decisions about having a vaccination in a place where they felt safe and empowered.

## **Equality, Diversity and Inclusion (EDI) Committee**

To make sure that tackling health inequalities is high up on our agenda, we established an Equality, Diversity and Inclusion (EDI) Committee in July 2020. It reported directly to our Governing Body and provides direction to ensure that equality, diversity and human rights are maintained and promoted. It makes sure healthcare provision is accessible, responsive and appropriate to patients and employees irrespective of who they are and what their background is. This includes age, disability, race, religion and sexual orientation.

A significant part of the Committee's role is to engage with a diverse range of people. It works with community groups, seldom heard voices and emerging communities to assist the CCG in carrying out assessments and grading procedures.

The Committee is chaired by a GP Governing Body member, with other members from the CCG, external stakeholders and other working groups.

Since its formation, the committee has:

- set up the BAME (Black, Asian and minority ethnic) health inequality group to address concerns around COVID that particularly affect those communities;
- developed a Workforce Race Equality Standard action plan in partnership with health and care systems support specialists Arden Gem;
- committed to the East of England Anti-Racism Strategy
- reviewed a draft Equality and Diversity Pledge and supporting behaviours policy; and
- produced and approved the equality impact assessment analysis form.

Future projects include analysing Equality and Diversity System 2 and workforce surveys, ensuring that EDI strategy aligns with corporate objectives; and enabling other groups to feed into the committee.

## **Engaging with seldom heard groups**

We know that to reduce health inequalities requires active engagement with seldom heard groups.

The Patient and Public Engagement Committee (PPEC), a formal committee of the CCG Governing Body, makes sure that meaningful engagement with these groups has taken place, and identifies if more needs to be done.

Our Governing Body lay member for patient and public engagement scrutinises our work to make sure the principles of inclusivity, equality and diversity are embedded.

Making our communications accessible to all members of our community is a vital plank in reducing inequality.

During the coronavirus pandemic, we worked closely with community and faith leaders, and organisations including Healthwatch, Age Concern and Access Bedford, so that our communications reached our diverse communities. This included those with English as a second language, people with disabilities, our

most vulnerable and those without internet access. We recognise the potential for digital exclusion and working with voluntary sector partners we are piloting community digital health champions to enable people to build their confidence and skills to access digital healthcare.

Our website [blmkccg.nhs.uk](http://blmkccg.nhs.uk) has been rated the 14<sup>th</sup> best CCG website in the country for accessibility out of 108 CCG websites tested by the independent [Silktide index](#). It rates websites according to their accessibility for people with a range of disabilities. The Bedfordshire, Luton and Milton Keynes CCG ceased to exist as of 1 July 2022; at time this report was published its website was in the process of being archived.

## Health and wellbeing strategy

The Bedfordshire, Luton and Milton Keynes Health and Wellbeing Boards have supported integration between health, social care, public health and other public service practitioners – bringing together partners to share population health information about local people. This has helped us to co-produce targeted strategies to improve the health and wellbeing of people who live in the area.

In the past year, participation in the Health and Wellbeing Board has ensured that the newly formed Bedfordshire, Luton and Milton Keynes CCG retains a firm focus on local services and funding. This has ensured strong clinical leadership that embraces partnership working to meet our shared goals for the best outcomes for our population.

By working collaboratively through the Health and Wellbeing Boards, we have developed a shared vision for our local communities. This has enabled a co-ordinated response to the roll out of public health campaigns, to address waiting lists for mental health services, cancer, elective care, and children and young people. It has also enabled the successful roll-out of our long COVID pathways.

The Health and Wellbeing Boards and its partners have been involved from the outset in the development of plans to establish the new Bedfordshire, Luton and Milton Keynes Integrated Care Board. This will allow for greater integration of health and care and improve our ability to deliver services that will prevent poor health and improve health and happiness for those who live in the area.

We are committed to tackling health inequalities. We have supported our NHS partners to improve links to communities so that we ensure the needs of local people are met through co-production, community insights and collective commissioning.

The Health and Wellbeing Boards provide a strong foundation to enable us to improve health and wellbeing in Bedfordshire, Luton and Milton Keynes and will continue to be an important statutory forum, as we establish the Integrated Care Partnership.

## Financial Review

The first quarter of 2022/23 is the final financial reporting period in which Bedfordshire, Luton and Milton Keynes CCG will exist as a separate NHS commissioning entity. This follows the decision to cease the operation of CCGs and establish statutory integrated care systems (ICSs) and integrated care boards (ICBs). This section sets out a summary of the CCG's financial performance during the first quarter of 2022/23.

The Accounts (from page 75) have been prepared under a direction issued by NHS England under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health.

### Financial Duties

CCGs have a statutory duty to keep their expenditure within the resources available. There are six separate duties with this regard, although there is some overlap between them and some were not relevant in the financial reporting period. The duties, their relevance in Q1 2022/23 and the performance of the CCG are set out in the following table. Further details are provided in Note 28 of the accounts, on page 28.

Duty [and section of 2012 Act]	Relevance in 2022/23 Q1	Achievement
Expenditure does not exceed sums allotted to the CCG plus other income received [223H(1)]	Applicable	Break-even
Capital resource use does not exceed the amount specified in Directions [223I(2)]	Not applicable No specified matters in Q1 2022/23	
Revenue resource use does not exceed the amount specified in Directions [223I(3)]	Applicable	Break-even
Capital resource use on specified matter(s) does not exceed the amount specified in Directions [223J(1)]	Not applicable No specified matters in Q1 2022/23	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions [223J(2)]	Not applicable No specified matters in Q1 2022/23	
Revenue administration resource use does not exceed the amount specified in Directions [223J(3)]	Applicable	Break-even

### 2022/23 planning guidance and financial outlook

The impact of COVID-19 on the NHS and the CCG system has been significant and will shape priorities we set for the use of our collective resources going forward. Over the past two financial years the NHS has operated with an interim financial regime. The focus has been on the timely flow of funds to ensure stability and protection to our providers during the pandemic. Our transformation plans and objectives have had to be put on hold to focus capacity on the pandemic response and vaccination programme.

The financial framework arrangements for 2022/23 build on a system-based approach to funding and planning with a focus on financial discipline and management of NHS resources within system financial balance. There is a collective local accountability and responsibility for delivering system and ICB financial balance. NHS England published one-year revenue allocations and three-year capital allocations alongside the 2022/23 planning guidance.

For 2022/23 and beyond, NHS systems are expected to return to making efficiencies and pre-pandemic levels of productivity where the context allows. Systems were given a 'glidepath' from the 2021/22 system

revenues to fair share allocations, assisted by a 'convergence' adjustment to gradually bring systems to their fair share of allocation. To manage within the funding available, while delivering national and local priorities, the ICS will need to deliver a stretching efficiency requirement. The task is made more difficult by the current level of inflation in the economy which is creating additional financial challenges for the NHS and the system to manage.

Collaborative working in the health and care system has been strengthened through the pandemic. The response has rested on different parts of the system working together to address the public health emergency, while continuing to provide essential services and support people to remain well in their communities. Over the previous financial year, system financial governance arrangements were strengthened and underpinned by set of system financial principles.

## **Closing down the CCG**

The end of the first quarter of 2022/23 signals the final financial reporting period in which Bedfordshire, Luton and Milton Keynes CCG will exist as a separate NHS commissioning entity. As mentioned above, this follows the decision to cease the operation of CCGs and establish statutory integrated care systems (ICSs) and integrated care boards (ICBs).

The CCG was abolished on 30 June 2022. From 1 July 2022 its functions, assets and liabilities were transferred to a new statutory body – Bedfordshire, Luton and Milton Keynes ICB. The closedown of the CCG and the creation of an ICB required NHS finance staff to undertake a significant number of tasks to enable a smooth transition of people, property and liabilities between organisations.



# ACCOUNTABILITY REPORT

## **Felicity Cox**

Accountable Officer

27<sup>th</sup> June 2023

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

It comprises three sections:

The Corporate Governance Report sets out how we have governed the organisation during the period 1 April to 30 June 2022, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

## **Corporate governance report**

### **Introduction and context**

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (BLMK CCG, the CCG) was a body corporate established by NHS England on 1 April 2021 under the National Health Service Act 2006 (as amended).

Our statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function was arranging the provision of services for persons for the purposes of the health service in England.

The CCG was, in particular, required to arrange for the provision of certain health services to such extent as it considered necessary to meet the reasonable requirements of its local population.

## Members' report

The Governing Body was made up of a group of individuals, appointed to the CCG with the main function of ensuring that the organisation has made appropriate governance arrangements, and for formulating policy and directing its affairs.

### **Dr Sarah Whiteman, Chair**



Formerly of the Royal Air Force, Sarah is committed to multi-professional education. This commitment is demonstrated by her having been an Associate Postgraduate Dean, in addition to roles with the National Clinical Assessment Service (NCAS) and the General Medical Council (GMC).

Her post encompassed professional leadership and development where she worked closely with many teams within the CCG. Her portfolio also includes time spent as a GP in Bedfordshire and Milton Keynes.

### **Felicity Cox, Accountable Officer**



Felicity was appointed as the Integrated Care System (ICS) Lead in autumn 2020 and started the post on 1 December 2020. She was appointed Accountable Officer for the CCG in February 2021 and in November 2021 was appointed Chief Executive Officer (Designate) for the new Integrated Care Board.

Felicity is a qualified pharmacist and maintains her clinical roots through her continuing professional development. Prior to joining the ICS she was the Director of Quality, Transformation and Delivery in the National Specialised Commissioning Team of NHS England and NHS Improvement.

She has held senior leadership positions in the NHS over many years, including Director of Commissioning Operations for NHS England.

### **Saqhib Ali, Lay Member for Audit and Governance**



Saqhib Ali is a qualified accountant and holds an Executive MBA from Cranfield University. He has worked for a leading electric vehicle charging post manufacturer and charging network provider in the UK, owned by a major energy company.

He has worked across Europe, USA and Asia. He has extensive experience in blue chip organisations and non-financial general management roles with Lloyds Banking Group, Asahi, Volvo Group, Computer Technologies and British Airways.

Saqhib began his career as an auditor with Deloitte and internal auditor with Hertz and has held previous roles as financial director, financial controller and analyst.

He is passionate about getting behind the numbers and supporting and challenging executives.

**Dr Chirag Bakhai, Member Representative**

Chirag is a GP in Luton. He was the Strategic Lead for Long Term Conditions at the CCG. He worked closely with partners across the system to improve services, reduce unwarranted variation and enhance equity in access and outcomes.

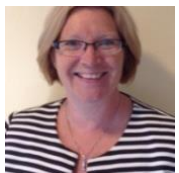
As Clinical Advisor to the NHS Diabetes Programme at NHS England and NHS Improvement, Chirag used his experience as a GP and a clinical commissioner to steer national diabetes strategy. He is particularly interested in disease prevention, supported self-management and the effective use of data in improving population health.

**Dr Anitha Bolanthur, Member Representative**

Anitha has worked in Luton for over 15 years and is a GP partner in a local practice.

She was the strategic lead for cancer for the CCG and works closely with our partners to give the best service provision to the local population. She worked closely with the East of England Cancer Alliance to support local services.

Anitha has always been passionate about cancer services. While she was Cancer Lead for Luton CCG from 2014 until 2020 she was a vocal advocate for improvements to services. Her portfolio also includes providing strategic support to the Elective Collaborative Board.

**Alison Borrett, Lay Member for Patient and Public Engagement**

Alison has lived in Bedfordshire for over 25 years. She has had a successful retail career, having worked in senior leadership positions for Marks and Spencer and the John Lewis Partnership. Her most recent appointment was as Branch Manager for Waitrose's Bedford store.

Alison joined Bedfordshire Clinical Commissioning Group in 2014 as a Lay Member for Public Participation. Since then, she has taken on the role of Vice Chair of the Bedfordshire, Luton and Milton Keynes CCG after it merged in 2021.

She is passionate about the work of the NHS in caring for people in times of greatest need.

## **Sally England, Lay Member for Finance and Performance**



Sally is an experienced, qualified accountant. She spent more than 20 years working in retail banking before joining the NHS in 2010 as Finance Director of a community services organisation. She then spent nine years in various director-level finance, performance and contracting roles at an NHS Trust in North West London, before retiring in 2019.

Sally joined Bedfordshire CCG as the Lay Member for Finance and Performance in May 2019, then Bedfordshire, Luton and Milton Keynes CCG in 2021. She was Chair of the Finance and Performance Committee and Remuneration Committee, as well as Vice-Chair of the Audit Committee and Primary Care Commissioning Committee.

## **Dr Sureena Goutam, Member Representative**



Sureena is a GP with strong roots within the CCG area, having been born and raised locally.

She completed her GP training in Luton and has enjoyed gaining experience from different GP posts in Bedfordshire and Hertfordshire. Posts, alongside a CCG clinical lead role, included working within general practice, out of hours and the General Medical Council in clinical, auditor, educator and examiner roles.

Sureena has gained further experience in areas including gynaecology and dermatology and completed an MBA in Healthcare Management.

## **Dr Roshan Jayalath, Member Representative**



Roshan is a GP partner from Bedford. He was the Strategic Clinical Lead for mental health, learning disabilities, end of life and palliative Care at the CCG. He chaired our Equality, Diversity, and Inclusion Committee, working to create an organisation where healthcare provision is accessible, responsive and appropriate.

He instigated the Bedford Substance Misuse and Mental Health Liaison groups 10 years ago.

Roshan has also taken a lead role in improving veterans' healthcare, especially through encouraging and supporting more GP practices to become accredited as veteran-friendly. As a local GP, he is committed to improving health care services in the community.

## **Hilary Jones, Independent Registered Nurse**



Hilary's nursing career began at Hammersmith Hospital before she became a practicing midwife for 21 years.

After completing an MBA, Hilary held senior managerial and associate director roles in an acute trust.

She has been CCG Deputy Director and Director of Nursing, a visiting lecturer at Buckingham University Medical School and the CCG lead for system-wide cancer and stroke pathway improvements.

Hilary has been instrumental in supporting the national programme to reduce inequalities for those living with a learning disability. She established a vaccination centre during the COVID-19 pandemic, and helped develop and implement the Population Health Segmentation and ICS Outcomes Frameworks.

## **Dr Chris Longstaff, Member Representative**



Chris worked in Bedford Hospital and Milton Keynes University Hospital before becoming a GP in a practice in Leighton Buzzard, Central Bedfordshire.

He has experience in medical education and trains new GPs in his practice as well as being an examiner for the Royal College of GPs.

His interests are in supporting patients who are particularly vulnerable and ensuring that their voices are heard.

## **Dr Shankari Mahathmakanthi, Member Representative**



Shankari does clinical triage work for Herts Urgent Care. She was the GP Early Careers Strategic Lead and Deputy Chair of the Bedfordshire, Luton and Milton Keynes Primary Care Training Hub.

Previously Shankari was a digital GP at Babylon Health and the place-based Clinical Lead for Children and Young People for Milton Keynes CCG. She has worked as a salaried and Locum GP at several practices across Milton Keynes.

Having lived in a refugee camp in her early years, Shankari is passionate about supporting vulnerable people.

Shankari has completed an Executive MBA in primary care innovation at the University of Cambridge and is also a professional coach.

**Anne Murray, Chief Nurse**

Anne has worked as a Registered Nurse since qualifying in 1983. Her experience includes a clinical career in accident and emergency, trauma and orthopaedic nursing and specialist tissue viability nursing working in acute settings.

Anne has worked in commissioning since 2009, joining the CCG from the Primary Care Trust in 2012. She has worked at Director level since 2010.

She has a wealth of knowledge from working in acute and management settings across the CCG system that has enabled her to ensure that continuous quality improvement stays at the forefront of the organisation.

**Dr Linus Onah, Member Representative**

Linus is a GP partner at Ivel Medical Centre in Central Bedfordshire. As the CCG strategic clinical lead for musculoskeletal health, he worked with patients and stakeholders across GP practices, public health, community, and secondary care providers to improve health services and outcomes.

He has also been involved in improving services for people with frailty and those living in care homes. With a postgraduate degree in public health and an executive Master of Business Administration MBA, his core interests are improving health and care systems, focusing on patient experience, safety, resource efficiency, and population health outcomes.

**Nicky Poulain, Director of Primary Care**

After working as a nurse, midwife and community specialist practitioner in London, Nicky has held a number of director roles across the NHS in Hertfordshire before moving to Luton CCG in 2014. Nicky was also the Associate Dean for Primary Education in Hertfordshire and Barnet between 1999-2003.

Nicky is passionate about collaboration and strives for an integrated and personalised health and social care system for the local population. Her main focus is on patient outcomes and improving the wellbeing of patients and their families.



**Dr Edward Sivills, Interim Medical Director**

Ed has worked with the CCG and the previously the Primary Care Trust since 2006. He has worked as a GP Partner in the same practice since 2005 and is an experienced GP trainer and appraiser. He has lifelong links to the Bedfordshire, Luton and Milton Keynes area.

**Dr Helen Turner, Secondary Care Specialist**

Helen is a Consultant in Endocrinology in Oxford where she also chairs local governance and is an appraiser.

She is involved nationally with the Society for Endocrinology Clinical Committee and Royal Society of Medicine Endocrinology and Diabetes committee.

She has been secondary care representative for several years in Luton and Bedfordshire, Luton and Milton Keynes CCG. She was a member of the Quality and Performance Committee as well as non-executive lead for emergency preparedness.

**Dean Westcott, Chief Finance Officer and ICS Executive Finance Lead**

Dean took up the joint role of Chief Finance Officer for the CCG and the Integrated Care System (ICS) Executive Finance Lead from 1 June 2021. He was previously the Director of Capital Planning and Estates for Herts and West Essex ICS. He has held Director of Finance roles for over 20 years within sustainability and transformation partnerships, CCGs and Trusts.

He is a Consultative Committee of Accountancy Bodies (CCAB) qualified accountant and has had an extensive career in finance, covering contracting, performance and informatics.

He is a past President of the Association of Chartered Certified Accountants (ACCA) and a Chairman of the Association's Pension Scheme.

The following are non-governing body member executives who work closely with the Governing Body.

**Richard Alsop, Director of Commissioning and Contracting**



With over 30 years' experience in NHS commissioning, Richard has a strong record of delivery and service transformation. He has extensive skills in the development of strategy and implementation through effective planning, procurement and performance management.

Richard has held a number of Executive Director roles and prior to his current role was Chief Operating Officer for Milton Keynes CCG.

**Geraint Davies, Director of Performance and Governance**



Geraint joined the CCG in January 2021. He has a wealth of experience working at Board level for the NHS. This includes a plethora of knowledge and experience of programme and change management in both clinical and managerial settings vital for transitioning from three to one CCG.

As well as his knowledge of service improvement Geraint's skills were paramount in his role as Director of Performance and Governance.

**Jane Meggitt, Director of Communications and Engagement**



Previously a journalist, Jane has a wealth of experience working in the NHS over the past 30 years.

Jane holds strong skills in strategy, stakeholder, citizen and public engagement and media relations, putting the patient's voice at the heart of all decision making.

She chaired the Bedfordshire Local Resilience Forum's COVID pandemic media cell and led the partner communications and engagement response to the pandemic.

Jane had commenced developing the first Bedfordshire, Luton and Milton Keynes ICS Working with People and Communities strategy.

Dedicated to professional communication and engagement, Jane co-developed the first ever masters for NHS communications professionals at Leeds Beckett University.



## **Martha Roberts, Director of People & Organisation Development**



Martha is an experienced people professional having had a long career in the NHS, joining as a graduate trainee. Martha has worked in all sectors of the NHS, managing hospitals and working in improvement and development.

Working across England supporting the turn-around of failing trusts from a clinical governance perspective, Martha is an experienced organisation development specialist. More recently Martha was responsible for health and wellbeing and staff engagement for the East Region and had corporate responsibility for organisation development in NHS England and NHS Improvement.

## 1. Member practices

Bedfordshire, Luton and Milton Keynes CCG was made up of 23 primary care networks (PCNs) during 2022/23.

The table below details our member practices and their respective PCNs at place level, including our non-core members and the four practices who decided to opt out of the PCN Direct Enhanced Service in 2022/23.

### Bedford Borough

#### Caritas

- Ashburnham Road Surgery
- King Street Surgery
- Queens Park Group
- Shortstown Medical Centre
- Wootton Vale Healthy Living Centre

#### Non-Core PCN Member

- The Village Medical Centre

#### East Bedford

- Cauldwell Medical Centre
- Linden Road Surgery
- London Road Surgery
- Putnoe Medical Centre Partnership

#### Unity

- Goldington Avenue Surgery
- Goldington Road Surgery
- Great Barford Surgery
- Harrold Medical Practice
- Priory Medical Centre
- Sharnbrook Surgery

#### North Bedford

- De Parys Group

### Central Bedfordshire

#### Chiltern Hills

- Caddington Surgery
- Eastgate Surgery
- Kingsbury Court Surgery
- Kirby Road Surgery
- Priory Gardens Surgery
- West Street Surgery

#### Sandhills

- Saffron Health Partnership
- Sandy Health Centre

#### Ivel Valley South

- Arlesey Medical Centre\*
- Dr Cakebread & Partners
- Larksfield Surgery Medical Partnership
- Dr Collins and Carragher
- Flitwick Surgery\*

#### Leighton Buzzard

- Dr J Henderson & Partners
- Leighton Road Surgery
- Salisbury House Surgery

#### Hillton

- Dr Hughes & Partners
- Greensand Surgery (Amptill)
- Houghton Close Surgery

#### Titan

- Houghton Regis Medical Centre
- Toddington Medical Centre
- Wheatfield Surgery

- **Non PCN Members\*\*** Cranfield Surgery\*\*
- Oliver Street Surgery\*\*
- Greensands (Potton)\*\*
- Ivel Medical Centre\*\*

\* Arlesey Medical Centre and Flitwick Surgery are non-core members of Ivel Valley South PCN.

\*\*Leavale is being commissioned to deliver PCN services to the registered population of these four practices in order to avoid any inequalities of service provision.

## Milton Keynes

### Watling Street

- Hilltops Medical Centre
- Stony Medical Centre
- Watling Vale Medical Centre
- Whitehouse Health Centre

### Crown

- Cobbs Garden Surgery
- The Red House Surgery
- Whaddon House Surgery

### East MK

- Ashfield Medical Centre
- Central Milton Keynes Medical Centre
- Milton Keynes Village Practice
- The Grove Surgery

### Ascent

- Asplands Medical Centre
- Fishermead Medical Centre
- Walnut Tree Health Centre

## Luton

### Medics Network

- Barton Hills Medical Group
- Bell House Medical Group
- Gardenia and Marsh Farm
- The Medici Medical Centre
- Woodland Avenue Practice

### Oasis

- Castle Medical Group
- Stopsley Village Practice
- The Town Centre Practice

### Hatters Health

- Bute House Surgery
- Dr Mirza Sukhani and Partners
- Leagrave Surgery
- Lister House Surgery
- Oakley Surgery
- Sundon Medical Centre

### eQuality

- Ashcroft Surgery
- Larkside Medical Centre
- Blenheim Medical Centre

### South West

- Bedford Street Surgery
- Parkside Medical Centre
- Westcroft Health Centre
- Westfield Road Surgery

### Nexus

- Neath Hill Health Centre
- Oakridge Park Medical Centre
- Purbeck Health Centre
- Sovereign Medical Centre
- The Stonedean Practice
- Wolverton Health Centre

### The Bridge

- Brooklands Health Centre
- Kingfisher Surgery
- Newport Pagnell Medical Centre

### Leavale

- Leavale Medical Group

### Phoenix Sunrisers

- Bramingham Park Medical Centre
- Conway Road Surgery
- Kingsway Health Centre
- Malzeard Road Surgery
- Neville Road Surgery
- Pastures Way Surgery
- Wenlock Surgery

## 2. Composition of Governing Body

The CCG had a Governing Body comprised of GP members, executive directors, registered clinical specialists and lay members. Voting members and their attendance at meetings throughout the reporting period are detailed in the table below.

Information on the work of the Governing Body can be found in the papers and minutes of the meetings, that are available on our website [www.blmkccg.nhs.net](http://www.blmkccg.nhs.net). The Bedfordshire, Luton and Milton Keynes CCG ceased to exist as of 1 July 2022; at time this report was published its website was in the process of being archived.

		Private	Public
<b>Number of meetings held during the reporting period</b>		3	1
Role	Name	Attendance	
Chair	Sarah Whiteman	3/3	1/1
Accountable Officer	Felicity Cox	3/3	1/1
Lay Member, Audit and Governance (Conflict of Interest Guardian)	Saqhib Ali	3/3	1/1
Member Representative	Chirag Bakhai	1/3	0/1
Member Representative	Anitha Bolanthur	3/3	1/1
Lay Member, Patient and Public Engagement (Freedom to Speak up Guardian)	Alison Borrett	2/3	1/1
Lay Member, Finance and Performance	Sally England	1/3	1/1
Member Representative	Sureena Goutam	2/3	1/1
Member Representative	Roshan Jayalath	1/3	1/1
Independent Nurse (Registered Nurse)	Hilary Jones	3/3	1/1
Member Representative	Christopher Longstaff	3/3	1/1
Member Representative	Shankari Mahathmakanthi	3/3	1/1
Director of Nursing and Quality (Chief Nurse)	Anne Murray	3/3	1/1
Member Representative	Linus Onah	2/3	1/1
Director of Primary Care	Nicky Poulain	1/3	1/1
Chief Finance Officer	Dean Wescott	3/3	1/1
Secondary Care Specialist	Helen Turner	2/3	1/1



### **3. Committee(s), including Audit Committee**

The Governing Body is supported by the following statutory committees. Details of these committees, a list of members and their attendance is provided in the Governance Statement starting on page 48

- Audit Committee;
- Remuneration Committee;
- Primary Care Commissioning Committee.

The Governing Body is also supported by the following non-statutory committees. Details of these committees, a list of members and their attendance is provided in the Governance Statement starting on page 50

- Equality, Diversity and Inclusion;
- Finance and Performance;
- Patient and Public Engagement; and
- Quality and Performance.

### **4. Register of interests**

The CCG maintained a register of interests that is considered and updated in advance of its Governing Body meetings. Updates, if received, were then published on the CCG's website prior to the next Governing Body meeting. The policy for managing conflicts of interests and standards of business conduct is based on the statutory guidance published by NHS England in June 2018.

The CCG's registers of interest can be found on our website [blmkccg.nhs.uk](http://blmkccg.nhs.uk). The Bedfordshire, Luton and Milton Keynes CCG ceased to exist as of 1 July 2022; at time this report was published its website was in the process of being archived.

### **5. Personal data-related incidents**

The CCG has not reported any Information Governance Serious Untoward Incidents to the Information Commissioner's Office in 2020/21.

### **6. Modern Slavery Act**

Bedfordshire, Luton and Milton Keynes CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

## Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each clinical commissioning group (CCG) shall have an Accountable Officer and that officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England appointed Felicity Cox to be the Accountable Officer of NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable;
- keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- the relevant responsibilities of accounting officers under Managing Public Money
- ensuring the CCG exercises its functions effectively, efficiently and economically, in accordance with Section 14Q of the National Health Service Act 2006 (as amended) and with a view to securing continuous improvement in the quality of services, in accordance with Section 14R of the National Health Service Act 2006 (as amended); and
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG 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;
- 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.

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 Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

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

**Felicity Cox**  
Accountable Officer  
27<sup>th</sup> June 2023

## Governance statement

### Introduction and context

Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (CCG) was a body corporate established by NHS England on 1 April 2021 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function was arranging the provision of services for persons for the purposes of the health service in England. The CCG was, 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 local population.

Between 1 April and 30 June 2022, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

### Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

### Governance arrangements and effectiveness

The main function of the Governing Body 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.

The responsibilities and decision making for the CCG were split between the Governing Body and the CCG's Executive Management Team. The definitions of roles are as follows:

- **Executive.** Appointed as employees by the CCG to deliver day-to-day management functions such as financial management and clinical governance;
- **Lay members.** Bring specific expertise and experience to the work of the CCG, offering a strategic and impartial view that is removed from the day-to-day running of the organisation. In this sense, the role is similar to non-executive directors and the CCG regards them as appropriate people to chair committees;
- **Member representatives.** Removed from the day-to-day running of the CCG and able to hold the Executive Team to account for delivery. This role is similar to non-executive directors. However, the most senior clinicians (for example the Chair) have a valid role in some senior management functions as the clinical voice of the CCG which, by its nature, should be clinically led; and
- **Secondary care clinician and independent nurse.** Removed from the day-to-day running of the organisation and are intended to provide a broader view from a primary, secondary care and nursing perspective. These roles are also similar to non-executive directors and the CCG regards them as appropriate people to chair committees.

Highlights of the work of the Governing Body can be found on page 42 of this report, and in the papers and minutes of the meetings that can be accessed through our website, [blmkccg.nhs.uk](http://blmkccg.nhs.uk). The Bedfordshire, Luton and Milton Keynes CCG ceased to exist as of 1 July 2022; at time this report was published its website was in the process of being archived. Membership and attendance records of Governing Body members can be found in section 2 of the members' report on pages 42 and 43. A list

of member practices can be found in section 1 of the members' report on pages 40 to 42, and details of the Members Forum and its work can be found below.

The Governing Body is supported by statutory and non-statutory committees, listed in section 3 of the members' report (page 43). Details of these committees of the Governing Body, their purpose, membership and attendance can be found on pages 48 to 51. Further information about the Remuneration Committee can be found in our Remuneration Report from page 62.

## **UK Corporate Governance Code**

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

While the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be good practice. This governance statement is intended to demonstrate how the CCG had regard to the principles set out in the Code which are considered appropriate for CCGs for the financial year ended 31 March 2022.

## **Governance structure**

The CCG's constitution allowed the Governing Body to appoint committees to assist with carrying out its functions. The committees are comprised of Governing Body members, executives and individuals from outside the CCG to enable the organisation to benefit from the expertise of individuals with a broad range of skills and experience.

Committees are governed by the standing orders, standing financial instructions and terms of reference for that committee.

## Members' Forum

The CCG was a membership organisation made up of 95 member practices. Following feedback from our practices, Members Forums continued to be held in each of the three former CCG geographical areas Bedfordshire, Luton, and Milton Keynes. All the GP practices in Bedfordshire, Luton and Milton Keynes are members and a representative from each practice is invited to the appropriate forum. The main function of the Members Forum is to provide an opportunity for practice members and the CCG clinical and managerial leadership team. They reviewed service and developmental priorities involving and impacting primary care but more broadly the forum facilitates practice representatives to:

- inform and influence commissioning decisions.
- provide input to the planning process and commissioning intentions.
- have direct dialogue with members of the CCG Executive/Management team.
- advise on the clinical impact of investment and disinvestment decisions from the perspective of primary care.
- receive updates from CCG on the delivery of initiatives.
- provide feedback on proposals including patient pathway redesign or service reconfiguration.

The Members' Forums are chaired by a practice representative who is not a member of the Governing Body. In bringing together the collective shared local knowledge, experience and expertise, clinical leadership is at the forefront of the CCGs commissioning of high quality, safe and effective services based on the best clinical evidence.

## Audit Committee

The Chair of the Audit Committee was Saqhib Ali, Lay Member of the Governing Body who holds audit/finance qualifications, expertise and experience that enables him to express informed views about financial management and audit matters. He leads on audit, governance and conflicts of interest matters.

The purpose of the committee was to act as the CCG's independent scrutiny function by critically reviewing and providing assurance to the Governing Body on the effectiveness of the CCG's system of internal control, financial governance, corporate governance and risk management.

The duties of the committee are driven by the organisation's objectives and the associated risks. An annual programme of business is agreed but remains flexible to new and emerging priorities and risks.

The Committee ensures an appropriate relationship with both internal and external audit is maintained.

Members and their attendance are listed in the table below.

<b>Number of meetings held during the reporting period</b>		2
<b>Role</b>	<b>Name</b>	<b>Attendance</b>
<b>Chair</b> – Lay Member, Audit and Governance (Conflict of Interest Guardian)	Saqhib Ali	2/2
<b>Deputy Chair</b> – Lay Member, Finance and Performance	Sally England	1/2
Member Representative	Sureena Goutam	2/2

## Remuneration Committee

The Remuneration Committee was a statutory Committee of, and accountable to, the CCG Governing Body. It was chaired by Sally England, Lay member for Finance and Performance.

The purpose of the committee was to determine and make recommendations to the Governing Body of the:

- remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it; and
- determining allowances payable under pension schemes established by the CCG.

Recommendations are guided by national NHS policy and best practice to ensure that individuals are motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Members and their roles are listed in the table below.

No meetings took place during this reporting period.

Role	Name
<b>Chair</b> - Lay Member, Finance and Performance	Sally England
<b>Deputy Chair</b> - Lay Member, Patient and Public Engagement	Alison Borrett
Independent Nurse (Registered Nurse)	Hilary Jones
Secondary Care Specialist	Helen Turner

## Primary Care Commissioning Committee

The Primary Care Commissioning Committee (PCCC) was chaired by the Alison Borrett, Lay Member for Patient and Public Engagement and includes the following Governing Body members: Lay Member for Finance and Performance (Deputy Chair), three GP Governing Body members, Accountable Officer, Chief Finance Officer, Medical Director, Director of Primary Care and the Director of Nursing and Quality. NHSE, Healthwatch (four local organisations), Local Medical Committees and Public Health representatives were invited to all meetings.

The committee had commissioning responsibility for primary medical (GP) services under delegated authority from NHS England (NHSE). The Committee functioned as a corporate decision-making body and provided assurance to the Governing Body and NHSE for the management of the delegated commissioning functions and the exercise of the delegated powers.

The purpose of the Committee was to make collective decisions on the review, planning, procurement and performance of primary care services for the people of Bedfordshire, Luton and Milton Keynes to reduce health inequalities and promote increased quality, efficiency and value for money.



Members and their attendance at meetings are listed in the table below.

Number of meetings held during the reporting period		Private – 2	Public – 1
Role	Name	Attendance	Attendance
<b>Chair</b> – Lay Member for Patient and Public Engagement (Freedom To Speak Up Guardian)	Alison Borrett	2/2	1/1
<b>Vice Chair</b> – Lay Member, Finance and Performance	Sally England	2/2	1/1
Accountable Officer / Integrated Care System Executive Lead	Felicity Cox	2/2	0/1
Member Representative	Sureena Goutam	1/2	0/1
Member Representative	Shankari Mahathmakanthi	1/2	1/1
Director of Nursing and Quality (Chief Nurse)	Anne Murray	*1/2	1/1
Member Representative	Linus Onah	2/2	1/1
Director of Primary Care	Nicky Poulain	2/2	1/1
Chief Finance Officer	Dean Westcott	2/2	1/1
Interim Medical Director	Ed Sivills	2/2	1/1

\* The Deputy Chief Nurse attended the meeting as deputy for the Director of Nursing and Quality (Chief Nurse)

### Equality, Diversity and Inclusion Committee

In July 2020, we established a dedicated Equality, Diversity, and Inclusion (EDI) Committee for Bedfordshire, Luton and Milton Keynes, reporting directly to the Governing Body. Its role included:

- monitoring performance in relation to equality and diversity.
- providing direction to ensure equality, diversity and human rights are maintained and promoted across the CCG.
- ensuring healthcare provision is accessible, responsive, and appropriate to patients and employees irrespective of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.
- engaging with community groups, seldom heard voices and emerging communities to assist the CCG in carrying out assessments and grading procedures.

The Committee was chaired by a GP Governing Body Member Representative, with other members from the CCG, external stakeholders, and other working groups. Since its formation, the committee:

- developed a draft Workforce Race Equality Standard (WRES) action plan in partnership with health and care systems support specialists.
- reviewed a draft CCG Equality & Diversity Pledge and supporting appropriate behaviours policy
- produced and approved the equality impact assessment analysis form.
- set up the BAME (Black, Asian and Minority Ethnic) health inequality group to address specific concerns around Covid, that particularly affects BAME communities.

Future projects include, analysing Equality and Diversity System 2 and workforce surveys, ensuring that EDI strategy aligns with corporate objectives and reviewing staff risk assessments. Specialist diversity groups will be formulated as required to address any inequalities.

Members and their roles are listed in the table below.

No meetings took place during this reporting period.

Role	Name
<b>Chair</b> – Member Representative	Roshan Jayalath
<b>Deputy Chair</b> – Director of Performance & Governance	Geraint Davies
Emergency Preparedness & Resilience & Risk Integrated Manager	Elaine Baugh
Joint Special Educational Needs & Disabilities Development Manager	Kulwinder Bola
Assistant Head of Medicines Optimisation	Tess Dawoud
Equality & Human Rights Manager, Arden and Gem	David King
Commissioning and Operations Manager	Eugena Marshall-Lewis
Senior Finance Manager	Edna Muraya
Director of Nursing and Quality (Chief Nurse)	Anne Murray
Head of Cancer Network	Kathy Nelson
Programme Manager/Personalised Care operational Lead	Sonia Okoh
Transforming Care Programme Manager (Learning Disability & Autism)	Bharti Quinn
Deputy Director of Quality and Clinical Governance / Safeguarding Representative	Jennie Russell
Head of People and Development	Emma Richards
Director of Organisation Development	Martha Roberts
Senior Transformation Manager (Adult Mental Health)	Louis Stanford
Associate Director, Communications and Engagement	Michelle Summers
One Beds, Luton & Milton Keynes Clinical Commissioning Group Programme Manager	Sandra Vanreyk
Chair of BLMK CCG (Caldicott and Wellbeing Guardians)	Sarah Whiteman

## Finance and Performance Committee

The Finance & Performance Committee was chaired by Sally England, Lay member for Finance and Performance.

The overall purpose of the Finance and Performance Committee was to provide the Governing Body with assurance on financial and operational performance, financial plan and annual budgets, contracting and procurement issues, investment proposals and associated planning issues. The Governing Body was provided with regular updates and, where appropriate, recommendations for action to ensure financial plans and performance targets were met.

The committee would usually meet monthly. All meetings were quorate and in accordance with its terms of reference. The Committee membership consisted of ten members, all of whom were Governing Body members.

Number of meetings held during the reporting period		1
Role	Name	Attendance
<b>Chair</b> – Lay Member for Finance and Performance	Sally England	1/1
<b>Deputy Chair</b> – Independent Nurse (Registered Nurse)	Hilary Jones	1/1
Director of Commissioning and Contracting	Richard Alsop	1/1
Member Representative	Chirag Bakhai	0/1
Lay Member for Patient and Public Engagement (Freedom To Speak Up Guardian)	Alison Borrett	1/1
Director for Performance and Governance	Geraint Davies	1/1
Director of Nursing and Quality (Chief Nurse)	Anne Murray	1/1
Director of Primary Care	Nicky Poulain	1/1
Chief Finance Officer	Dean Westcott	1/1

### Patient and Public Engagement Committee

The Patient and Public Engagement Committee (PPEC) was chaired by Alison Borrett. The committee was a formal sub-committee of the Governing body and provided assurance to the Governing Body that the CCG was conducting meaningful engagement with patients and the public.

The purpose of the committee was to provide advice and guidance on the CCG's approaches to patient and public engagement and review how engagement has been used to influence decisions made by the CCG. They offered views from a patient and public perspective, co-producing and approving stakeholder engagement and consultation plans.

Membership of the committee included a GP member representative, an independent nurse and the Director of Communications and Engagement. Meetings were also attended by representatives from the four local Healthwatch organisations, voluntary and community sectors, including children and young people. This broad mix encouraged robust conversations and recommendations, which have helped ensure the patient voice was heard and health inequalities addressed.

Number of meetings held during the reporting period		1
Role	Name	Attendance
<b>Chair</b> – Lay Member for Patient and Public Engagement (Freedom To Speak Up Guardian)	Alison Borrett	1/1
Independent Nurse (Registered Nurse)	Hilary Jones	0/1
Director of Communications and Engagement	Jane Meggitt	0/1
Member Representative	Chris Longstaff	1/1

### Quality and Performance Committee

The Quality and Performance Committee was Chaired by Hilary Jones, independent nurse, who was a member of the Governing Body.

The committee took on overall responsibility for leading the organisation's quality and safety agenda and reported directly to the Governing Body on these matters. It had an annual work plan which supported

the delivery of the CCG's work plans and delivered on functions delegated to it under the CCG's scheme of reservation and delegation.

It worked to ensure that commissioned services were being delivered in a high quality and safe manner, ensuring that quality and safety sat at the heart of the organisation's work. It was responsible for providing assurance and information to the Governing Body to fulfil its role and responsibilities in relation to quality and safety.

Number of meetings held during the reporting period		1
Role	Name	Attendance
<b>Chair</b> – Independent Nurse (Registered Nurse)	Hilary Jones	1/1
<b>Deputy Chair</b> – Lay Member for Patient and Public Engagement (Freedom to Speak Up Guardian)	Alison Borrett	1/1
Director of Commissioning and Contracting	Richard Alsop	1/1
Director of Communications and Engagement	Jane Meggitt	0/1
Director of Nursing and Quality (Chief Nurse)	Anne Murray	1/1
Secondary Care Specialist	Helen Turner	1/1

### Discharge of statutory functions

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

Responsibility for each duty and power was clearly allocated to a lead director. Directorates confirmed that their structures provided the necessary capability and capacity to undertake all of the CCG's statutory duties.

## **Risk management arrangements and effectiveness**

The CCG recognised that every activity we undertook or commissioned brought with it some element of risk. These could threaten or prevent the achievement of our objectives.

We responded to this by:

- encouraging a dynamic risk management culture where risk management is viewed as integral to daily activity;
- ensuring structures, policies and processes are in place to support the assessment and management of risks; and
- assuring the Governing Body, the public and patients that we manage risk effectively.

During the course of 2022/23, following the formation of the single CCG, we used the transitional Risk Management Framework to manage risk, as agreed the previous year. This was codified as the Bedfordshire, Luton and Milton Keynes CCG Risk Management Strategy in December 2021. The Strategy sets out the organisation's roadmap for management of risk. It also sets out the practical means through which risk is identified and evaluated as well as the control mechanisms through which it is managed.

It creates a framework to achieve a culture that encourages staff to:

- identify and control risks which may adversely affect the achievement of the CCG's objectives, without being too risk-averse;
- compare and prioritise risks in a consistent manner using defined risk grading guidance; and
- where possible, eliminate or transfer risks, or reduce them to an acceptable and cost effective level, or otherwise ensure the organisation accepts the remaining risk.

We maintain a risk register through an electronic reporting system which is accessible to all staff.

This formalised strategy communicates how risk management will be implemented throughout the CCG while providing potential for flexibility, innovation and best practice of its strategic objectives. It ensures that the principles, processes and procedures for best practice risk management are consistent across the organisation.

Risks are systematically reviewed at the Audit Committee and at other committees of the Governing Body, as well as by directorates, senior managers and individual risk owners. The risk register facilitates the assessment of the inherent and residual risks for their impact and likelihood and tracks the progress of individual risks over time through a standardised risk grading matrix. Risks that increase in rating and have a broad, deep, organisational or system impact are subject to additional scrutiny and review through the risk register.

Risk management is the responsibility of all our staff. It is being embedded into operational activity and strategy at all levels of the organisation. Our risk management system was given a 'reasonable' internal audit assurance rating, with a few recommended actions given which would strengthen assurance.

## **Capacity to handle risk**

All actions have an element of risk to them. Therefore, risk management is central to the effective running of any organisation. The CCG makes sure all decisions are taken with due consideration to the management of risks.

We make sure that there is clearly defined accountability and responsibility for risk management within our structure. Our Accountable Officer has overall responsibility for risk management. The Director of Performance and Governance has delegated responsibility for the day-to-day management of the organisation's risk management process. The specific responsibilities of other committees, senior officers, lay members and all other staff are set out in the organisation's Risk Management Strategy.

The Board Assurance Framework (BAF) is an integral part of our risk management arrangements. It provides the means through which risks to the achievement of the organisation's strategic objectives are clearly identified, assessed and controlled.

At the start of 2021/22, the CCG aligned the strategic risks from the previous organisations to the new organisation's strategic priorities and objectives. The BAF was reviewed regularly throughout the reporting period and was received at each meeting of the Audit Committee.

The committee provides an assurance to the Governing Body with respect to management of the risks identified within the BAF. In doing so, the committee draws upon the sources of assurance, including the work of the CCG's external auditors and a comprehensive internal audit programme.

The Audit Committee maintained oversight of the risks to the CCG through review of the corporate risk register at each of its meetings. It provides assurance to the Governing Body with respect to the control mechanisms for risk. The other committees of the Governing Body receive and review risks pertaining to their areas of responsibility at each of their meetings.

Both the BAF and the corporate risk register are reviewed by the Governing Body. The Governing Body and its Quality and Performance Committee have continued to maintain rigorous oversight of the performance of the CCG, and the Audit Committee has assessed the adequacy of the assurances available in relation to performance. Comprehensive quality and performance reports are a standing item at the Governing Body and each of these committee meetings.

Staff training on risk management is provided with additional support through the in-house Organisational Resilience Team. Good practice, where identified, is shared through training and used to inform and improve the risk management strategy.

## Risk assessment

All risks to the CCG were assessed for their consequence and likelihood to give an overall risk rating. The CCG's governance, risk management and internal control frameworks have been subject to constant review so that they remain fit for purpose. At the start of 2021/22, the merged BAF held 22 strategic risks from the three previous organisations, with 13 high (red) risks and nine medium (amber) risks. The three highest risks are detailed below:

Risk Description	Previous Organisation	Risk Score
Due to multiple factors our GP practices may not have the capacity for transformation which may adversely affect access to and delivery of services.	NHS Bedfordshire CCG	16
Due to the national Primary Care Contract settlement and the increase in GP practices in Milton Keynes to meet population growth, the expenditure on delegated primary care may exceed the allocation and the CCG may not deliver the financial control total.	NHS Milton Keynes CCG	16
Due to the financial position carried forward and new cost pressures the CCG may not meet its Financial Plan target.	NHS Milton Keynes CCG	20

All risks on the BAF were subject to review of controls to mitigate risks. Action plans to improve the controls were carried out individually by the Executive Management Team in conjunction with the appropriate lead. Wherever gaps in controls or assurances were identified, action plans were defined and allocated to a lead director to ensure that the situation was remedied.

In September 2021, the Governing Body approved the new strategic risks and organisational BAF. Legacy risks from the previous three single CCGs were reviewed and most were closed or de-escalated to the Corporate Risk Register. Four legacy risks were carried over from NHS Bedfordshire CCG as they presented live risks to the new CCG system. Only one of these was a high (red) risk:

- inability to work effectively with partners to improve service delivery and reconfigure health and social care services within Bedfordshire.



The CCG's Board Assurance Framework (BAF) details the key strategic risks which could have an adverse effect on the delivery of key objectives and future performance.

Strategic risks do not tend to change much over a three-to-five year period and, therefore, there have been no changes to these risks in the reporting period.

The two most critical strategic risks on the BAF, which have had the most impact on performance are:

- the recovery of services; and
- the pandemic response and system pressure.

As a result of the COVID-19 pandemic, waiting lists continued to grow due to increasing demand in both diagnostics and elective care. This had particular impacts on the rate of service recovery. A demand management group was put in place to explore new ideas and schemes as viable alternatives to optimising secondary care / referral. However, conversion of long-waiters from outpatient attendances into elective surgery, remains a concern, especially in ophthalmology.

With regard to system pressure, high demand across each service across the CCG has continued. However, this has been supported by continued system-wide partnership working to support operational issues and sharing of knowledge which improves quality and patient outcomes. Workforce challenges have remained across system this year and were compounded by high levels of sickness, especially during the end of quarter 3 and into quarter 4 of 2021/22 when nationally we experienced a surge in COVID-19 Omicron cases.

These risks, as with all risks, continued to be managed and monitored through the CCG's risk management process working in close proximity with performance to ensure that the risks to delivery of objectives are adequately mitigated.

We remain committed to the implementation of a risk strategy that aims to minimise risks to all its stakeholders through a comprehensive system of internal controls. The risk management strategy as described above is designed to manage or mitigate rather than eliminate the risks to achieving business objectives. Additional controls include business continuity plans to enable the organisation to continue with minimum disruption in the event of a disaster.

We support well-managed and controlled risk taking and will ensure that the skills, ability and knowledge are in place to support innovation and to maximise opportunities to further improve services for the population we serve.

### **Emergency Preparedness, Resilience and Response (EPRR)**

In 2020 and in response to the pandemic, the CCG integrated risk management with emergency planning, resilience and response (EPRR). We did this to develop and maintain an active programme of engagement with the public and other key stakeholders on key strategic and service decisions. In addition we considered our plans not just in the light of any risks identified but also ensuring that resilient control mechanisms are put in place.

The integration of EPRR and business continuity with risk management ensures that resilience becomes inbuilt into risk assessments across the organisation. In accordance with NHS England guidance, our Director of Performance and Performance is our Accountable Emergency Officer supported by the Head of Organisational Resilience.

Risks are managed across organisational boundaries because it is often at the interface between organisations that the highest risks exist. Only by working collaboratively with a wide range of partner organisations can these risk areas be identified, properly managed and afforded an appropriate priority within risk action plans.

We have an overarching incident response plan in place, as well as a business continuity plan. We also maintain a health economy escalation framework in line with the NHS EPRR Framework (November 2015) and the NHS England Core Standards for EPRR.

We take part in the annual NHS EPRR assurance process and work closely with the main health partners. We do this to make sure that we have appropriate incident response and business continuity plans in



place, providing compliance to the requirements of the Civil Contingencies Act (2004), the NHS Act 2006 (as amended) and other NHS England EPRR guidance. In 2022/23, the CCG maintained 'substantial' compliance with the NHS England Core Standards for EPRR.

### **Internal control framework**

***A system of internal control is the set of processes and procedures were in place in the CCG to ensure it delivered its policies, aims and objectives. It was 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.

### **Standing Financial Instructions**

Our Standing Financial Instructions (SFIs) are issued in accordance with the directions issued by the Secretary of State for Health under the provisions of the National Health Service Act 2006 and as amended by the Health and Social Care Act 2012. They support the SFIs contained in our constitution.

They detail the financial responsibilities, policies and procedures that have been adopted and are designed to ensure that financial transactions are carried out in accordance with the law and in line with government policy, in order to ensure probity, accuracy, economy, efficiency and effectiveness.

### **Internal audit**

Our internal audit programme adopts a risk-based approach to planning its work, referring to the organisational risk registers in identifying topics for review. In addition to the individual audit reports, the Head of Internal Audit produces an annual audit opinion on risk management, control and governance.

### **External audit**

Our external auditors provide an opinion on whether the financial statements give a true and fair view of our financial position and the income and expenditure for the year. They also conclude whether or not the organisation has put in place the proper arrangements to secure value for money in the use of its resources.

### **Local counter fraud service**

The CCG commissioned BDO's local counter fraud specialist (LCFS) to continue their counter fraud service during the period. A work plan was developed in line with the NHS Counter Fraud Functional Standards, which was approved by the Audit Committee.

The CCG's Chief Finance Officer was proactively and demonstrably responsible for tackling fraud, bribery and corruption.

### **Board assurance framework**

The board assurance framework (BAF) is the key document used to record and report on the progress of the strategic objectives, the most substantial risks, what controls and assurances are in place and to identify any significant weaknesses that need to be overcome to achieve those objectives.

### **Annual audit of conflicts of interest management**

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management.

To support CCGs to undertake this task, NHS England has published a template audit framework. The organisation received Moderate assurance (significantly meets expectations) for this audit, which was conducted January 2022.

## **Data quality**

The CCG recognises that good quality data is essential for the effective commissioning of services and underpins the delivery of high quality patient care. Data quality is central to the organisation's ongoing ability to meet its statutory, legal and financial responsibilities.

All the CCG's main providers are required, under their contracts, to have good quality data that is compliant with national standards. The CCG undertakes validation processes to ensure that it is complete, accurate, relevant and timely.

In addition, the CCG has responsibility for monitoring the data quality of the services it commissions and this is achieved through formal contract monitoring arrangements. Executive leads take responsibility for ensuring that all data presented to the Governing Body and GP member practices is of high quality, accurate and fit for purpose.

The CCG Performance Report is submitted to the Governing Body and associated committees on a monthly basis. Data presented in the reports comes from a number of different nationally published websites, where data will always be two months in arrears in order to allow for national quality checking and verification. In addition, the CCG's Business Intelligence provider NHS Arden & GEM Commissioning Support Unit carry out validation checks for data completeness and accuracy on all data reports provided to the CCG.

Many data measures will be subject to change following a period of validation, and as such, annual data tables are refreshed monthly to ensure that the CCG has available the most accurate, timely and complete data.

No concerns have been raised by members of the Governing Body about the quality of data.

## **Information governance**

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

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

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

We undertook an assessment of our position against the data security and protection toolkit and submitted a 'standards met' assessment for 2021/22 (on 30 June 2022, as mandated for CCGs).

## **Business critical models**

Following the 2013 MacPherson review, we have concluded that we do not operate any business critical analytical models that would be subject to quality assurance in line with recommendations.

## **Third party assurances**

Where the CCG relies on third party providers for support services, the contract is overseen by an executive director, with input and operational management provided by subject matter and contracting experts. Regular review meetings are held which receive performance and KPI reports, and which allow discussion of any issues needing resolution. Where services are new or undergoing significant change,

this is typically managed through a Mobilisation and Delivery Board structure. No significant issues or concerns have been raised during the year.

### **Control issues**

The CCG has no substantial control issues requiring remedial action.

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

The Governing Body has overarching responsibility for ensuring the organisation has appropriate arrangements in place in exercising its functions economically, efficiently and effectively in the use of its resources and in accordance with the principles of good governance. It ensures that the organisation has robust financial controls including detailed financial policies, standing financial instructions, agreed expenditure approval limits for staff, a monthly budget holder accountability process and an internal audit function, which focuses its work on the areas of financial control risk, as agreed with the Audit Committee.

In our constitution's scheme of reservation and delegation, there are appropriate arrangements in place within the CCG so it can discharge its responsibilities accordingly. The Chief Finance Officer has delegated responsibility to determine arrangements to ensure the CCG has a sound and robust system of financial control.

We produced monthly finance reports, which are reviewed by the Finance and Performance Committee and the Executive Management Team prior to reporting to the Governing Body. The Audit Committee receives opinion from the work of the internal and external auditors and is able to advise the Governing Body on the assurances available with regard to the economic, efficient and effective use of resources.

In addition, senior managers meet with NHS England's Assurance Team to ensure that the CCG is meeting its financial responsibilities in accordance with NHS England's regulations.

Furthermore, the organisation's Annual Report and Accounts are audited by external auditors who report to the Audit Committee on behalf of the Governing Body.

### **Delegation of functions**

The CCG has had responsibility for primary care commissioning since 1 April 2019. It delegated no functions during this reporting period.

### **Counter fraud arrangements**

The local counter fraud specialist undertook a work plan to establish whether the organisation was compliant with the national standards for countering NHS fraud, and whether it complied with the requirement for adequate procedures in line with the Bribery Act 2010.

The Chief Finance Officer was responsible for ensuring compliance with the NHS Counter Fraud Authority strategy for countering fraud, bribery and corruption and the application of the related NHS Counter Fraud Authority Functional Standards.

The CCG undertook comprehensive risk assessments to identify and manage its fraud, bribery and corruption risks, ensuring that counter fraud activities were prioritised and focused towards areas of greatest risk.

The CCG's Counter Fraud Service was provided by an accredited Local Counter Fraud Specialist (LCFS) – during the period our counter fraud service was provided by BDO. The LCFS works to a risk-based annual plan which has been agreed by the Chief Finance Officer and the Audit Committee. The plan is designed around the NHS Counter Fraud Authority's Functional Standards, and compliance with these standards is reported to the Audit Committee on an annual basis.

The LCFS attended meetings of the Audit Committee to provide updates on progress against the annual work plan and compliance with the Functional Standards.

All concerns of fraud, bribery and corruption at the CCG were referred to the Local Counter Fraud Specialist and addressed in accordance with the CCG's fraud, bribery and corruption policy. The Local Counter Fraud Specialist reports annually on all work undertaken, including the outcome of investigations.

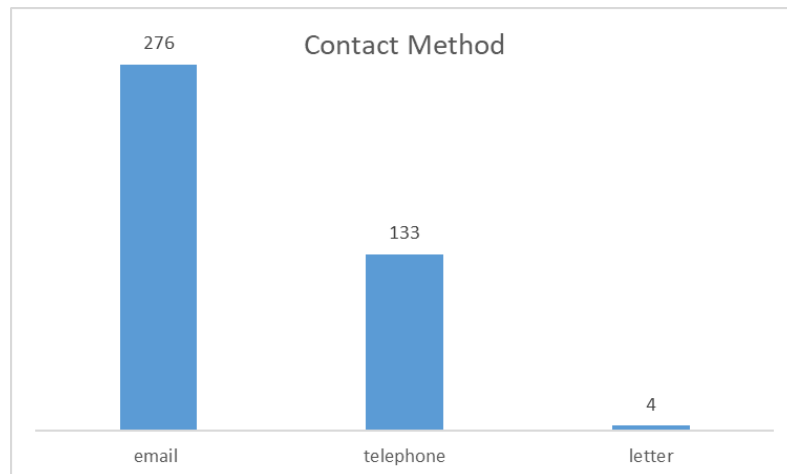
## Enquiries and Complaints

To provide context, most of the contacts the CCG received were in relation to enquiries and concerns about healthcare matters. During the reporting period, we received 412 contacts in total (emails, telephone calls and letters). Our objective was to acknowledge all contacts within three working days, and to resolve any issues arising within 20.

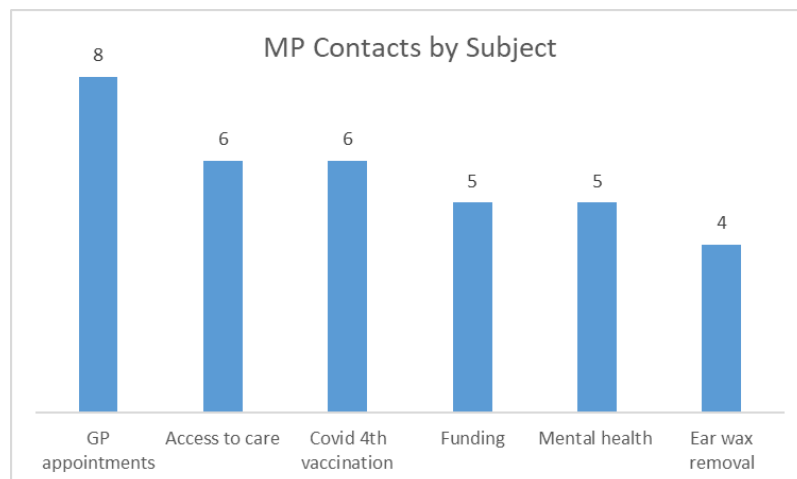
Top three themes were:

- Covid vaccinations - 61 (15%)
- Funding (CHC and IFR) - 57 (14%)
- Referrals (Primary & Secondary care) - 39 (9%)

The chart below shows the method of contact:



We received 50 enquiries from MPs, the chart below shows the top themes:



We did not submit any formal complaints during this reporting period as part of our KO41A submission to NHS Digital for national monitoring of complaints (formal complaint definition explained in the CCG's complaints policy).

We used the information and data we gather from enquiries and complaints to inform the directorates about emerging themes and trends.

## **Freedom of Information requests**

The Freedom of Information (FOI) Act 2000 and the Environmental Information Regulations 2004 give members of the public the right to request recorded information held by public authorities.

Our objective is to acknowledge all FOI requests within three working days, and in line with the act, provide the requested information (unless an exemption to withhold the information applies) within 20 working days.

We received 61 FOI requests in this reporting period and met the legal response deadline for all requests.

## **Head of Internal Audit Opinion**

The Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control.

The Head of Internal Audit concluded that 'overall, we are able to provide moderate assurance that there is a sound system of internal control designed to meet the CCG'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'.

## **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 directors, managers and clinical leads within the CCG 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 Governing Body assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

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

- Governing Body;
- Audit Committee;
- Quality and Performance Committee;
- Finance and Performance Committee;
- Internal Audit; and
- External Audit.

## **Conclusion**

As Accountable Officer, and based on the review processes outlined above, I can confirm that the governance statement is a balanced reflection of the actual controls position.

**Felicity Cox**

Accountable Officer

27<sup>th</sup> June 2023

# Remuneration and Staff Report

## Remuneration Report

### Remuneration Committee

We provide appropriate levels of remuneration to attract the right people with the right skills to Bedfordshire, Luton and Milton Keynes. Remuneration is managed in conjunction with the Remuneration Committee, which includes lay members, a secondary care specialist doctor and the Governing Body registered nurse, none of whom is an employee of the organisation. More information is provided on page 48 of this report.

### Percentage change in remuneration of highest paid director (subject to audit)

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.97%	0.00%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	0.04%	0.00%

The salary of the highest paid director has increased by 5.97% compared to 2021/22. At the start of 2021/22 the highest paid director was the CCG Accountable Officer, the post holder was subsequently appointed as ICB Chief Executive designate and their salary was increased to reflect the additional complexities and accountabilities of the new role. The new salary was based on guidance issued by NHS England and was approved by both the CCG remuneration committee and NHS England.

The average percentage change in salary for employees of the CCG was 0.04% compared to 2021/22 financial year. The agenda for change pay award for 2022/23 was not confirmed until July 2022 so no uplift has been included in the 3 months to 30<sup>th</sup> June 2022. A flat rate annual increase of £1,400 was paid to relevant staff in September 2022.

Two one off non-consolidated payments relating to the 2022/23 Financial year were agreed in May 2023, these were an additional 2% non-consolidated payment made to all staff on Agenda for change terms and conditions plus a backlog bonus of between £1,250 and £1,600 per employee.

No performance pay or bonuses were paid in the two periods in question.

## 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 the clinical commissioning group for the 3 month period ending 30 June 2022 was £177,500 (167,500, 2021/22).

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

2022/23	25 <sup>th</sup> percentile	Median pay ratio	75 <sup>th</sup> percentile pay ratio
Pay ratio information	4.55:1	3.65:1	2.34:1
2021/22			
Pay ratio information	4.3:1	3.26:1	2.21:1

In the 3 month period ending 30 June 2022, no employees received remuneration in excess of the highest-paid director / member (in 2021/22 no employees received remuneration in excess of the highest-paid director / member). Remuneration ranged from £17,500 to £177,500 (£17,500 to £167,500, 2021/22).

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.

The movement in the pay ratio can be explained by the following factors:

- The salary of the highest paid director in the 3 months ending 30<sup>th</sup> June 2022 was higher than that in the year ending 31<sup>st</sup> March 2022.
- No Agenda for Change pay award was actioned during the 3 month reporting period ending 30<sup>th</sup> June 2022.
- The median salary has been calculated as a lower salary point in the 3 months ending 30<sup>th</sup> June 2022/23 compared to the year ending 31<sup>st</sup> March 2021/22. This is due to fewer interim staff being employed during the 3 month period in 2022/23. Interim staff are usually paid at a higher rate than substantive staff due to the short-term nature of their contracts. Having fewer interim staff included in the calculation for 2022/23 has resulted in a lower mid-point in the range of remuneration. The calculation of the fair pay ratio requires all staff to be accounted for as if they had been in post for a full year, so the impact of fewer interim staff in 2022/23 is likely to be due to the shorter reporting period rather than a general decrease in use of interim staff.



## **Policy on the remuneration of senior managers**

- The Remuneration Committee sets salaries and terms and conditions of service for all Governing Body members apart from lay members, which are set by a special remuneration.
- All staff are paid either in accordance with 'Agenda for Change' terms, or on very senior manager (VSM) terms and conditions of service, including notice periods. Objectives are set and performance is measured using the objective-setting and appraisal process in conjunction with other relevant policies. Remuneration is basic salary, with no awards. All roles in the CCG were subject to job evaluation. In respect of executive remuneration, the committee is guided by the key principles set out in the Hutton Review of Fair Play (2011), job evaluation methods and pay guidelines set for chief officers and chief finance officers by NHS England.

## **Remuneration of very senior managers**

- The CCG had one senior manager on a VSM contract which provides for a contractual salary of £150,000 or greater per annum. The salary related to the Chief Executive Officer (CEO) who was appointed in February 2021.
- As part of the appointment process, the remuneration for the post was reviewed and discussed at the CCG Remuneration Committee to ascertain its reasonableness in line with current salary guidance. Approval for the appointment and salary was sought from NHS England.
- Where the salary was greater than £150k, a business case was submitted to HM Treasury seeking approval. Where appointments are made to a salary above the £150k threshold, we follow the above process and gain approval from HM Treasury.

**Senior manager remuneration 1 April to 30 June 2022 (subject to audit)**

Name	Title	Salary (bands of £5,000) £'000	Taxable benefits (total to nearest £100) £	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits * (bands of £2,500) £'000	Total (bands of £5,000) £'000
<b>Executive Team</b>							
Dr Sarah Whiteman	Chair	35-40	0	0	0	0	35-40
Felicity Cox	Accountable Officer/ ICB Chief Executive Designate	40-45	0	0	0	25-27.5	70-75
Dean Westcott	Chief Finance Officer	35-40	0	0	0	52.5-55	90-95
Dr Edward Sivills	Interim Medical Director	10-15	0	0	0	0	10-15
Geraint Davies	Director of Performance and Governance	25-30	0	0	0	0	25-30
Richard Alsop	Director of Commissioning and Contracting	30-35	0	0	0	0	30-35
Anne Murray	Director of Nursing and Quality	15-20	0	0	0	0	15-20
Jane Meggitt	Director of Communication and Engagement	25-30	0	0	0	0-2.5	25-30
Nicky Poulain	Director of Primary Care	30-35	0	0	0	20-22.5	50-55
Martha Roberts	Director of Organisational Development	30-35	0	0	0	25-27.5	55-60
<b>GP Members</b>							
Dr Roshan Jayalath	Member Representative	20-25	0	0	0	0	20-25
Dr Linus Onah	Member Representative	15-20	0	0	0	0	15-20
Dr Christopher Longstaff	Member Representative	5-10	0	0	0	0	5-10
Dr Chirag Bakhai	Member Representative	35-40	0	0	0	0	35-40
Dr Sureena Goutam	Member Representative	10-15	0	0	0	0	10-15
Dr Shankari Mahathmakanthi	Member Representative	20-25	0	0	0	0	20-25
Dr Anitha Bolanthur	Member Representative	15-20	0	0	0	0	15-20
Dr Helen Turner	Secondary Care Specialist	5-10	0	0	0	2.5-5	5-10
Hilary Jones	Independent Nurse (Registered Nurse)	5-10	100	0	0	0	5-10
<b>Lay Members</b>							
Alison Borrett	Lay Member	10-15	0	0	0	0	10-15
Saqhib Ali	Lay Member	0-5	0	0	0	0	0-5
Sally England	Lay Member	5-10	0	0	0	0	5-10

**Notes:**

- Dr Sarah Whiteman received £0-5k for her roles as Caldicott and Health and Wellbeing Guardians from 1 April 2022 to 30 June 2022;
- Dr Roshan Jayalath received £10-15k for his role as Clinical Lead for Mental Health from 1 April 2022 to 30 June 2022;
- Dr Linus Onah received £5-10k for his role as Clinical Lead for MSK from 1 April 2022 to 30 June 2022;
- Dr Chirag Bakhai received £25-30k for his roles as NHSE Diabetes Lead and Clinical Lead for Long Term Conditions from 1 April 2022 to 30 June 2022;
- Dr Sureena Goutam received £0-5k for her role as a Placed Based Clinical Lead from 1 April 2022 to 30 June 2022;
- Dr Shankari Mahathmakanthi received £10-15k for her roles as GP Early Careers Strategic Lead and Deputy Chair of BLMK ICS Primary Care Training from 1 April 2022 to 30 June 2022;
- Dr Anitha Bolanthur received £5-10k for her role as a Clinical Lead for Cancer from 1 April 2022 to 30 June 2022; and
- Hilary Jones received £5-10k for her role in providing Clinical Support to the Covid vaccination programme from 1 April 2022 to 30 June 2022
- Alison Borrett received £0-5k for her role as an incumbent Non-Executive Member for the new Integrated Care Board from 1 April 2022 to 30 June 2022.



## Senior manager remuneration 2021/22

Name	Title	Salary (bands of £5,000) £'000	Taxable benefits (total to nearest £100) £	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
<b>Executive Team</b>							
Dr Sarah Whiteman	Chair	130-135	0	0	0	0	130-135
Felicity Cox	Accountable Officer	165-170	0	0	0	85-87.5	250-255
Dean Westcott	Chief Finance Officer (from 1 June 2021)	110-115	0	0	0	127.5-130	240-245
Stephen Makin	Acting Chief Finance Officer (to 31 May 2021)	15-20	0	0	0	5-7.5	25-30
Dr Edward Sivills	Interim Medical Director	45-50	0	0	0	0	45-50
Geraint Davies	Director of Performance and Governance	115-120	0	0	0	0	115-120
Richard Alsop	Director of Commissioning and Contracting	130-135	0	0	0	0	130-135
Anne Murray	Director Of Nursing and Quality	120-125	0	0	0	0	120-125
Jane Meggitt	Director of Communication and Engagement	105-110	0	0	0	22.5-25	130-135
Nicky Poulain	Director of Primary Care	120-125	0	0	0	25-27.5	145-150
Martha Roberts	Director of Organisational Development (from 1 August 2021)	60-65	0	0	0	60-62.5	120-125
<b>GP Members</b>							
Dr Roshan Jayalath	Member Representative	80-85	0	0	0	0	80-85
Dr Linus Onah	Member Representative	65-70	0	0	0	0	65-70
Dr Christopher Longstaff	Member Representative	25-30	0	0	0	0	25-30
Dr Chirag Bakhai	Member Representative	155-160	0	0	0	0	155-160
Dr Sureena Goutam	Member Representative	50-55	0	0	0	0	50-55
Dr Shankari Mahathmakanthi	Member Representative	80-85	0	0	0	0	80-85
Dr Anitha Bolanthur	Member Representative	65-70	0	0	0	0	65-70
Dr Helen Turner	Secondary Care Specialist	25-30	0	0	0	37.5-40	60-65
Hilary Jones	Independent Nurse (Registered Nurse)	10-15	0	0	0	0	10-15
<b>Lay Members</b>							
Alison Borrett	Lay Member	25-30	0	0	0	0	25-30
Saqhib Ali	Lay Member	5-10	0	0	0	0	5-10
Sally England	Lay Member	20-25	0	0	0	0	20-25

### Notes:

- Dr Sarah Whiteman received £25-30k for her roles as Caldicott and Health and Wellbeing Guardians in 2021/22;
- Dr Roshan Jayalath received £40-45k for his role as Clinical Lead for Mental Health in 2021/22;
- Dr Linus Onah received £25-30k for his role as Clinical Lead for MSK in 2021/22;
- Dr Chirag Bakhai received £115-120k for his roles as NHSE Diabetes Lead and Clinical Lead for Long Term Conditions in 2021/22;
- Dr Sureena Goutam received £10-15k for her role as a Placed Based Clinical Lead in 2021/22;
- Dr Shankari Mahathmakanthi received £40-45k for her roles as GP Early Careers Strategic Lead and Deputy Chair of BLMK ICS Primary Care Training in 2021/22; and
- Dr Anitha Bolanthur received £25-30k for her role as a Clinical Lead for Cancer in 2021/22.

## Directors' pension entitlements 1 April to 30 June 2022 (Subject to audit)

		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 30 June (bands of £5,000)*	Lump sum at pension age related to accrued pension at 30 June 2023 (bands of £5,000)*	Cash Equivalent Transfer Value at 1 April 2022	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 30 June 2022**	Employers Contribution to partnership pension
Name	Title	£000	£000	£000	£000	£000	£000	£000	£000
Felicity Cox	Accountable Officer/ ICB Chief Executive Designate	0-2.5	0-2.5	35-40	100-105	870	0	685	0
Dean Westcott	Chief Finance Officer	2.5-5	5-7.5	75-80	220-225	0	7	12	0
Jane Meggitt	Director of Communication and Engagement	0-2.5	0	40-45	100-105	933	4	947	0
Nicky Poulain	Director of Primary Care	0-2.5	0-2.5	50-55	120-125	1,116	26	1,155	0
Martha Roberts	Director of Organisational Development	0-2.5	2.5-5	30-35	60-65	542	25	583	0
Dr Helen Turner	Secondary Care Specialist	0-2.5	0	10-15	15-20	254	2	261	0

\* Total accrued pension at pension and total lump sum at pension age as at 30th June 2022 has been calculated based on 31st March 2022 value provided by NHS Pensions plus 91 days pro-rata share of the increase in between 31st March 2022 and 31st March 2023.

\*\*CETV value at 30th June 2022 has been calculated based on 31st March 2022 value provided by NHS Pensions plus 91 days pro-rata share of the increase in CETV between 31st March 2022 and 31st March 2023.

## Directors' pension entitlements 2021/22

		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 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
Name	Title	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Felicity Cox	Accountable Officer	5.0-7.5	5.0-7.5	35-40	100-105	752	91	870	0
Dean Westcott	Chief Finance Officer (from 1 June 2021)	5.0-7.5	17.5-20	70-75	215-220	N/A	N/A	N/A	0
Stephen Makin	Acting Chief Finance Officer (to 31 May 2021)	0.0-2.5	0.0-2.5	35-40	70-75	545	0	596	0
Jane Meggitt	Director of Communication and Engagement	0.0-2.5	0.0-2.5	40-45	100-105	882	32	933	0
Nicky Poulain	Director of Primary Care	0.0-2.5	0.0-2.5	50-55	115-120	1,057	37	1,116	0
Dr Helen Turner	Secondary Care Specialist	0.0-2.5	0.0-2.5	10-15	15-20	220	29	254	0
Martha Roberts	Director of Organisational Development	2.5-5.0	5.0-7.5	25-30	55-60	445	52	542	0

### Notes:

- 'Real increase' 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 pension scheme or arrangement)
- Lay members do not receive pensionable remuneration, therefore there will be no entries in respect of pensions for them.

## Cash equivalent transfer values (CETV)

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, an arrangement to secure pension benefits in another pension scheme or an 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.

The 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 2023-24 CETV figures.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a Career Average Revalued Earnings (CARE) benefit design in 2015 for all but the oldest members, who retained a final salary design.

### **Real increase in CETV**

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

### **Compensation on early retirement or for loss of office (subject to audit)**

There have been no payments made for compensation on early retirement or for loss of office.

### **Payments to past directors (subject to audit)**

There have been no payments to past directors.

## Staff Report

### Number of senior managers

At the end of the first quarter of 2022/23 Bedfordshire, Luton and Milton Keynes CCG employed 15 very senior managers (VSMs) including Band 9s.

### Staff numbers and costs (subject to audit)

Employee benefits	Permanent employees £000s	Other £000s	Total £000s
Salaries and wages	4,664	744	5,408
Social security costs	547	0	547
Employer contributions to NHS pension scheme	803	0	803
Other pension costs	0	0	0
Apprenticeship levy	19	0	19
Termination benefits	0	0	0
<b>Gross employee benefits expenditure</b>	<b>6,033</b>	<b>744</b>	<b>6,777</b>

### Staff composition

Governing Body members on the CCG payroll, excluding senior executive / senior management members.

Male		Female	
Headcount	%	Headcount	%
5	41.67	7	58.33

Senior managers and VSMs, excluding Governing Body.

Male		Female	
Headcount	%	Headcount	%
7	46.67	8	53.33

All other employees not included in the previous two categories (Bands 1 – 8d)

Male		Female	
Headcount	%	Headcount	%
50	14.37	298	85.63

Note: Headcount figures as at the end of the first quarter for 2022/23 and exclude off-payroll staff.

### Sickness absence data

Under guidance issued by NHS England, guidance on Sickness Absence Data Reporting for NHS Bodies 2013–14 (2014), CCGs are required to report on a calendar year.

We supported employees' health and wellbeing (see above) through access to an Occupational Health Service, Employee Assistance Programme, absence management process. We also reinforced an 'open-door' culture, with colleagues encouraged to speak with their line manager or appropriate senior manager regarding any matters of concern.

The sickness absence data for the first three months of 2022/23 showed an average 1.9 working days lost per full-time employee. It should be noted that the days lost were attributed to a number of long-

term illnesses and a reduced amount of short-term absences. The CCG had minimal absence related to COVID.

### **Staff turnover percentages**

The staff turnover percentage for the CCG, as at the end of the first quarter of 2022/23, was 2.75%.

### **Staff engagement percentages**

The CCG recognised it had been a challenging period and worked hard to provide focused support for staff wellbeing.

### **Developing a diverse workforce**

The CCG was committed to providing a safe and thriving environment for all of our colleagues.

This meant making sure that our workplace was free from discrimination and racism, and actively promoting opportunities for all staff, regardless of background, race, ethnicity or disability. The CCG workforce consisted of 21.5% BAME and 75.5% white, 3% not stated as at the end of the first quarter of 2022/23. Our Governing Body consisted of 42% BAME, 50% white and 8% not stated.

Developing an inclusive and diverse workforce was important to the CCG and we worked hard to ensure that our workforce processes and practices supported this aim and align to our Equality, Diversity and Inclusion Policy. This approach was enhanced by the establishment of an Equality, Diversity and Inclusion Committee that reported to the Governing Body. We continued to progress the development of a diverse workforce during month the first quarter of 2022/23.

Equality and Diversity training was delivered online to all CCG staff, ensuring compliance with the Equality Act 2010. Equality and Diversity training was completed by 83% of CCG staff as at the end of the first quarter of 2022/23. This training helped to enhance the role and importance of diversity within the organisation, supporting respect for and among the workforce.

The CCG was an equal opportunities employer. When recruiting to posts we utilised best practice. We ensured that vacancies were advertised on NHS Jobs, which shares information directly with Jobcentre Plus, helping to increase access and support employment in local communities. Where appropriate, to ensure access to a wider and more diverse audience, we utilised other advertising mechanisms including jobsites, online media, newspapers and forums.

In addition to new hires, we sought to develop and promote staff internally to vacant positions. All opportunities were promoted internally as standard. We also sought to use other channels for development, this included training, mentoring, coaching and secondments. We recognised that staff can develop through partnership with external organisations. The CCG worked with other organisations to arrange secondments where appropriate.

### **Disabled employees**

We sought to be an inclusive employer and our policy on disabled persons ensured that:

- full and fair consideration was given to applications for employment made by disabled persons, having regard to their particular aptitude and abilities;
- we continued the employment of, and arrange appropriate training for, employees who had become disabled during the period when they were employed by the CCG; and
- we provided training, career development and promotion of disabled people that we employ.

Of our staff, 4.95% declared a disability. It is not mandatory for staff to declare disabilities.



## Staff policies

As a statutory body, we ensured that we had robust employment policies that were compliant with current employment legislation, best practice and reflected our culture and values.

Throughout the previous year, we conducted a review of our workforce policies following the merger from three CCGs into one. We continued to implement an inclusive programme of work to align policies for use by the single CCG based on best practice and current legislation, working alongside employee and trade union representatives.

All policies were reviewed by the appropriate Governing Body committee, before implementation.

All our workforce policies can be viewed on our website.

## Support for staff

We were fully committed to the health and wellbeing of our employees and understand that a healthy and happy workforce is crucial to delivering improvements in patient care.

COVID-19 brought challenges for our staff since 2020, which required the use of new initiatives, creative thinking and additional support for staff who were remote working. Our learning from that period continued into 2022/23, focusing our efforts on staff wellbeing by retaining and enhancing existing measures and support available to staff.

These measures were:

- remote working guidance and regular communication and contact between managers and staff members;
- quarterly appraisals and wellbeing conversations between managers and staff;
- provision of a suite of wellbeing advice and tools and regular staff sessions on topics such as stress awareness and resilience;
- use of technology in terms of social applications and fortnightly Teams meetings with our Accountable Officer to keep staff updated;
- DSE assessments for homeworking; and
- recognition of the improved work / life balance available through remote working by formalising the arrangements.

Managers maintained regular contact with their teams to provide environments in which individuals could raise concerns, express their feelings and discuss their physical and mental wellbeing.

We offered an employee assistance programme (EAP), accessed through a free and confidential helpline, and occupational health services, to support staff with health concerns.

## Health and safety

The CCG was fully committed to the health, safety and welfare of our employees, patients and visitors. We undertook all reasonably practicable measures to ensure compliance with the Health and Safety at Work Act 1974 and associated safety legislation, including all new health and safety regulations. Our health and safety policies can be found on our website at [on our website](#). The Bedfordshire, Luton and Milton Keynes CCG ceased to exist as of 1 July 2022; at time this report was published its website was in the process of being archived.

## Consultations

During 2019/20, the Bedfordshire, Luton and Milton Keynes CCGs implemented a single Executive Team and consulted with their senior managers. During 2020/21, we implemented a new senior management structure and began a restructure for the remainder of the workforce across the three CCGs. In 2021/22, the three former CCGs merged to become a single CCG and the wider restructure of staff was completed. Due process was followed in respect of legislation and the CCG Management of Change Policy. We worked closely with our recognised trade unions and employees.

Towards the latter part 2021/22, we consulted on formalising the remote working arrangements we had enforced during the initial COVID-19 lockdown. There was an appetite for a new way of working among

staff who valued the improved work / life balance presented by the flexibility of home and office working. Implementation of the outcome of the consultation took place in 2022/23.

### Trade unions

We worked in partnership with the recognised unions and, during this reporting period, set up a formal Partnership Forum which has participation from regional and local representatives. The Forum is chaired by our Head of People and Development.

In accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017, public sector organisations are required to report on trade union facility time. As at the end of the first quarter of 2022/23 we had three employees who were engaged by trade unions to act as their formal representative.

We have agreed a facilities time policy with the trade unions.

**Table 1: Relevant union officials**

Number of employees who were relevant union officials during the relevant period	Full time equivalent employee number
3	2.60

**Table 2: Percentage of time spent on facility time**

Percentage of time	Number of employees
0%	0
1-50%	3
51%-99%	0
100%	0

**Table 3: Percentage of pay bill spent on facility time**

Total cost of facility time	£32,944
Total pay bill	£6,777,308
Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time ÷ total pay bill) x 100	0.49%

**Table 4: Paid trade union activities**

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	30%
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### Expenditure on consultancy

Expenditure on consultancy was £15,988.

## Off-payroll engagements

**Table 1: Length of all highly paid off-payroll engagements** as at the end of the first quarter of 2022/23 **earning £245 per day or greater.**

This table shows all off-payroll engagements as at 30 June 2022, earning more than £245 a day.

Number of existing engagements as at 30 June 2022 earning more than £245 a day	24
<i>of which, the number that have existed:</i>	
• for less than 1 year at the time of reporting	20
• for between 1 and 2 years at the time of reporting	4
• 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

All existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, and where necessary, that assurance has been sought.

**Table 2: All highly paid off-payroll workers engaged at any point during the first three months of 22/23 , earning £245 per day or greater.**

This table shows all new off-payroll engagements, between 1 April 2022 and 30 June 2022, earning more than £245 a day.

Number of temporary off-payroll workers engaged between 1 April and 30 June 2022	2
<i>of which</i>	
Not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	2
Number subject to off-payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

**Table 3: Off-payroll board member/senior official engagements**

This table shows all off-payroll engagements of Board members, and / or senior officials with significant financial responsibility, between 1 April and 30 June 2022.

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year		0
Total number of individuals on payroll and off-payroll that have been deemed 'Board members, and/or, senior officials with significant financial responsibility' during the financial year (includes both off-payroll and on-payroll engagements)		23

## Exit packages, including special (non-contractual) payments (subject to audit)

There was one exit package in the first three months of 2022/23. This was ill health-related and complied with contractual terms and conditions under PILON.

**Table 1: Exit Packages**

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	1	7,640	1	7,640	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0		0	0	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
<b>TOTALS</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>7,640</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

**Table 2: Analysis of Other Departures**

	<b>Agreements</b>	<b>Total Value of agreements</b>
	<b>Number</b>	<b>£000s</b>
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	1	7,640
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
<b>TOTAL</b>	<b>0</b>	<b>7,640</b>

## Parliamentary Accountability and Audit Report

Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.



# Independent auditor's report to the members of the Board of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board in respect of NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group

## Report on the audit of the financial statements

### Opinion on financial statements

We have audited the financial statements of NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

### Basis for opinion

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

### Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Bedfordshire, Luton and Milton Keynes CCG transferred to NHS Bedfordshire, Luton and Milton Keynes ICB on 1 July 2022. When NHS Bedfordshire, Luton and Milton Keynes CCG ceased to exist on 1 July 2022, its services continued to be provided by NHS Bedfordshire, Luton and Milton Keynes ICB.

### Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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

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

### **Other information**

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

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

### **Opinion on other matters required by the Code of Audit Practice**

In our opinion:

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

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

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

## **Matters on which we are required to report by exception**

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

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

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

## **Responsibilities of the Accountable Officer**

As explained more fully in the Statement of Accountable Officer's responsibilities set out on page 45, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

## **Auditor's responsibilities for the audit of the financial statements**

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

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

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).

We enquired of management and the Audit committee, concerning the CCG's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;

- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

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

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

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

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

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

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

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

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

- The CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: [www.frc.org.uk/auditorsresponsibilities](http://www.frc.org.uk/auditorsresponsibilities). This description forms part of our auditor's report.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

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

### **Responsibilities of the Accountable Officer**

As explained in the Corporate Governance Report, the Accountable Officer was responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG 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 CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively during the three month period ended 30 June 2022.

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

- Financial sustainability: how the CCG planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

## **Report on other legal and regulatory requirements – Certificate**

We certify that we have completed the audit of NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

## Use of our report

This report is made solely to the members of the Board of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board, as a body, in respect of the CCG, 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 NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board and the CCG and the members of the Board of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Signature: **Joanne Brown**

Joanne Brown, Key Audit Partner

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

London

Date: 29 June 2023

# ANNUAL ACCOUNTS

**Felicity Cox**

Accountable Officer

27<sup>th</sup> June 2023



## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

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NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Statement of Comprehensive Net Expenditure for the period ended  
30 June 2022**

	Note	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(440)	(1,514)
Other operating income	2	<u>(16)</u>	<u>(106)</u>
<b>Total operating income</b>		<b>(456)</b>	<b>(1,620)</b>
Staff costs	4	6,777	24,390
Purchase of goods and services	5	412,524	1,723,790
Depreciation and impairment charges	5	39	216
Provision expense	5	(1,738)	2,286
Other Operating Expenditure	5	<u>182</u>	<u>804</u>
<b>Total operating expenditure</b>		<b>417,785</b>	<b>1,751,486</b>
<b>Net Operating Expenditure</b>		<b>417,329</b>	<b>1,749,866</b>
Finance expense		9	221
<b>Net expenditure for the Year</b>		<b>417,338</b>	<b>1,750,087</b>
Net (Gain)/Loss on Transfer by Absorption		<u>-</u>	<u>125,400</u>
<b>Total Net Expenditure for the Financial Year</b>		<b>417,338</b>	<b>1,875,487</b>
<b>Comprehensive Expenditure for the year</b>		<b>417,338</b>	<b>1,875,487</b>

The notes on pages 5 to 28 form part of this statement.

NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Statement of Financial Position as at  
30 June 2022**

		<b>30-Jun-22</b>	<b>31-Mar-22</b>
	<b>Note</b>	<b>£'000</b>	<b>£'000</b>
<b>Non-current assets:</b>			
Property, plant and equipment	10	55	68
Right-of-use assets	11	<u>209</u>	<u>0</u>
<b>Total non-current assets</b>		<b>264</b>	<b>68</b>
<b>Current assets:</b>			
Inventories	13	94	67
Trade and other receivables	14	13,543	19,063
Cash and cash equivalents	15	<u>(406)</u>	<u>(405)</u>
<b>Total current assets</b>		<b>13,232</b>	<b>18,725</b>
<b>Total assets</b>		<b><u>13,496</u></b>	<b><u>18,793</u></b>
<b>Current liabilities</b>			
Trade and other payables	16	(91,476)	(133,719)
Lease liabilities		(209)	-
Borrowings	17	(12,830)	(299)
Provisions	18	(2,344)	(4,293)
<b>Total current liabilities</b>		<b>(106,859)</b>	<b>(138,311)</b>
<b>Non-Current Assets plus/less Net Current Assets/Liabilities</b>		<b><u>(93,364)</u></b>	<b><u>(119,518)</u></b>
<b>Non-current liabilities</b>			
Provisions	18	(812)	(984)
<b>Total non-current liabilities</b>		<b>(812)</b>	<b>(984)</b>
<b>Assets less Liabilities</b>		<b><u>(94,176)</u></b>	<b><u>(120,502)</u></b>
<b>Financed by Taxpayers' Equity</b>			
General fund		<u>(94,176)</u>	<u>(120,502)</u>
<b>Total taxpayers' equity:</b>		<b><u>(94,176)</u></b>	<b><u>(120,502)</u></b>

The notes on pages 5 to 28 form part of this statement.

The financial statements on pages 1 to 28 were approved by the Governing Body on 23 June 2023 and signed on its behalf by:

Felicity Cox  
 Chief Accountable Officer  
 Date: 27 June 2023

NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Statement of Changes In Taxpayers Equity for the period ended  
30 June 2022**

	<b>General fund £'000</b>	<b>Total reserves £'000</b>
<b>Changes in taxpayers' equity for 1 April 2022 - 30 June 2022</b>		
<b>Balance at 01 April 2022</b>	(120,502)	<b>(120,502)</b>
<b>Changes in NHS Clinical Commissioning Group taxpayers' equity for 1 April 2022 - 30 June 2022</b>		
Net operating expenditure for the financial year	(417 ,338)	<b>(417,338)</b>
Transfers by absorption to (from) other bodies	-	-
<b>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year</b>	<b>(537,840)</b>	<b>(537,840)</b>
Net funding	443,664	<b>443,664</b>
<b>Balance at 30 June 2022</b>	<b>(94,176)</b>	<b>(94,176)</b>

The notes on pages 5 to 28 form part of this statement.

NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Statement of Cash Flows for the period ended  
30 June 2022**

		<b>1 April 2022 - 30 June 2022</b>	<b>2021-22</b>
	Not	<b>£'000</b>	<b>£'000</b>
<b>Cash Flows from Operating Activities</b>			
Net operating expenditure for the financial year		(417,338)	(1,750,087)
Depreciation and amortisation	5	39	216
Other gains & losses		-	221
Unwinding of discounts		8	-
(Increase)/decrease in inventories		(27)	30
(Increase)/decrease in trade & other receivables	13	5,520	(9,454)
Increase/(decrease) in trade & other payables	16	(42,243)	7,637
Provisions utilised	18	(391)	(425)
Increase/(decrease) in provisions	18	(1,738)	2,286
<b>Net Cash Inflow (Outflow) from Operating Activities</b>		<b>(456,169)</b>	<b>(1,749,576)</b>
<b>Net Cash Inflow (Outflow) before Financing</b>		<b>(456,169)</b>	<b>(1,749,576)</b>
<b>Cash Flows from Financing Activities</b>			
Net funding received		443,664	1,754,985
Repayment of lease liabilities		(26)	-
<b>Net Cash Inflow (Outflow) from Financing Activities</b>		<b>443,638</b>	<b>1,754,985</b>
<b>Net Increase (Decrease) in Cash &amp; Cash Equivalents</b>	15	<b>(12,531)</b>	<b>5,409</b>
<b>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</b>		<b>(705)</b>	<b>(6,113)</b>
<b>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</b>		<b>(13,236)</b>	<b>(704)</b>

The notes on pages 5 to 28 form part of this statement.

NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

## Notes to the financial statements

### 1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, 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 clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

NHS Bedfordshire, Luton and Milton Keynes clinical commissioning group was approved by NHS England to operate from 1 April 2021 and was created from the merger of NHS Bedfordshire CCG, NHS Luton CCG and NHS Milton Keynes CCG. Closing balances from the three predecessor CCGs were transferred to NHS Bedfordshire, Luton and Milton Keynes CCG at 1 April 2021. The transfer of balances is detailed in Note 9 of these accounts.

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs. Other transfers of assets and liabilities within the Department of Health and Social Care group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

#### 1.1 Going Concern

These accounts have been prepared on a going concern basis.

The Health and Care Act (2022) received Royal Assent in April 2022. It introduced significant reforms to the organisation and delivery of health and care services in England. The Act abolishes Clinical Commissioning Groups (CCG) and establishes Integrated Care Boards (ICB). ICBs will take on commissioning functions of CCGs and the assets and liabilities of the CCG will transfer to the ICB.

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

#### 1.2 Accounting Convention

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

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

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

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

NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

## Notes to the financial statements

### 1.4 Pooled Budgets

The clinical commissioning group has entered into pooled budget arrangements with Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Community Equipment, Learning Disabilities and the Better Care Fund and Note 23 to the accounts provides details of the income and expenditure.

The pools are hosted by Bedford Borough Council, Central Bedfordshire council, Luton Borough Council and Milton Keynes Council. As a commissioner of healthcare services, the clinical commissioning group makes contributions to the pool, which are then used to purchase healthcare services. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

### 1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

### 1.6 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 clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group 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 FRoM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group 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.

### 1.7 Employee Benefits

#### 1.7.1 Short-term Employee Benefits

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

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

#### 1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions).

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 clinical commissioning group 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.



## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Notes to the financial statements****1.7.3 Local Government Pensions**

Some employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. The interest earned during the year from scheme assets is recognised within finance income. Re-measurements of the defined benefit plan are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive income/net expenditure.

**1.8 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.

**1.9 Grants Payable**

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

**1.10 Property, Plant & Equipment****1.10.1 Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- 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 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.

Equipment is carried at depreciated historical cost as this is not considered to be materially different from current value in existing use.

**1.1 .2 Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

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

## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Notes to the financial statements**

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

**1.10.3 Subsequent Expenditure**

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

**1.11 Intangible Assets****1.11.1 Recognition**

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

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

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

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

**1.11.2 Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

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

**1.11.3 Depreciation, Amortisation & Impairments**

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 clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

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

## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Notes to the financial statements**

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

**1.12 Leases**

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 Clinical Commissioning Group 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 clinical commissioning group'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.

**1.13 Inventories**

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula.

**1.14 Cash & Cash Equivalents**

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

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

**1.15 Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. 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 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.70% (2020-21: 0.18%) 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 0.95% (2020-21: 1.99%) 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 0.66% (2020-21: 1.99%) 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.

## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**Notes to the financial statements**

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

**1.16 Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group 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 clinical commissioning group.

**1.17 Non-clinical Risk Pooling**

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

**1.18 Contingent liabilities and contingent assets**

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

**1.19 Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

**1.19.1 Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

**1.20 Financial Liabilities**

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

**1.21 Value Added Tax**

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

NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

## Notes to the financial statements

### 1.22 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

### 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 clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

### 1.24 Critical accounting judgements and key sources of estimation uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. 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 accounting judgements in applying accounting policies

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The clinical commissioning group has entered into four separate partnership agreements and pooled budgets with the four local authorities; Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council. These agreements have been judged to be joint operations under joint control, as all parties share control over the decisions about the relevant activities within each pool. This is a national policy initiative and the funds involved are material in the clinical commissioning group accounts. Having reviewed the terms of the partnership agreement and the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care, the clinical commissioning group has accounted for its share of the assets, liabilities, income and expenditure as described in Note 1.4 above.

#### 1.24.2 Sources of estimation uncertainty

There are no key estimations made by management in the process of applying the clinical commissioning group's accounting policies that have a significant effect on the amounts recognised in the financial statements.

### 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.

### 1.26 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

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

## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**2 Other Operating Revenue**

	1 April 2022 - 30 June 2022 Total £'000	2021-22 Total £'000
<b>Income from sale of goods and services (contracts)</b>		
Non-patient care services to other bodies	242	744
Other Contract income	118	513
Recoveries in respect of employee benefits	79	257
<b>Total Income from sale of goods and services</b>	<b>440</b>	<b>1,514</b>
<b>Other operating income</b>		
Charitable and other contributions to revenue expenditure: non-NHS	-	12
Other non contract revenue	16	93
<b>Total Other operating income</b>	<b>16</b>	<b>106</b>
<b>Total Operating Income</b>	<b>456</b>	<b>1,620</b>

**3.1 Disaggregation of Income - Income from sale of good and services (contracts)**

	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000	1 April 2022 - 30 June 2022 £'000
<b>Source of Revenue</b>				
NHS	202	117	56	375
Non NHS	40	1	23	64
<b>Total</b>	<b>242</b>	<b>118</b>	<b>79</b>	<b>439</b>
<b>Timing of Revenue</b>				
Over time	242	118	79	439
<b>Total</b>	<b>242</b>	<b>118</b>	<b>79</b>	<b>439</b>
				<b>2021-22 Total</b>
				<b>£'000</b>
<b>Source of Revenue</b>				
NHS	522	491	79	1,092
Non NHS	222	22	178	422
<b>Total</b>	<b>744</b>	<b>513</b>	<b>257</b>	<b>1,514</b>
<b>Timing of Revenue</b>				
Over time	744	513	257	1,514
<b>Total</b>	<b>744</b>	<b>513</b>	<b>257</b>	<b>1,514</b>

**3.2 Transaction price to remaining contract performance obligations**

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group had no contract revenue expected to be recognised in future periods relating to contract performance (nil 2021-22).

NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**4 Employee benefits and staff numbers****4.1.1 Employee benefits**

	1 April 2022 - 30 June 2022		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
<b>Employee Benefits</b>			
Salaries and wages	4,664	744	5,408
Social security costs	547	-	547
Employer Contributions to NHS Pension scheme	803	-	803
Apprenticeship Levy	19	-	19
<b>Gross employee benefits expenditure</b>	<b>6,033</b>	<b>744</b>	<b>6,777</b>

Less recoveries in respect of employee benefits (note 4.1.2)

**Net employee benefits excluding capitalised costs**

	2021-22		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
<b>Employee Benefits</b>			
Salaries and wages	17,090	2,655	19,745
Social security costs	1,911	-	1,911
Employer Contributions to NHS Pension scheme	2,688	-	2,688
Apprenticeship Levy	46	-	46
<b>Gross employee benefits expenditure</b>	<b>21,735</b>	<b>2,655</b>	<b>24,390</b>
Less recoveries in respect of employee benefits (note 4.1.2)	(257)	-	(257)
<b>Net employee benefits excluding capitalised costs</b>	<b>21,478</b>	<b>2,655</b>	<b>24,133</b>

**4.1.2 Recoveries in respect of employee benefits**

	1 April 2022 - 30 June 2022		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
<b>Employee Benefits - Revenue</b>			
Salaries and wages	(77)	-	(77)
Social security costs	(1)	-	(1)
Employer contributions to the NHS Pension Scheme	(2)	-	(2)
<b>Total recoveries in respect of employee benefits</b>	<b>(79)</b>	<b>-</b>	<b>(79)</b>
	2021-22		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
<b>Employee Benefits - Revenue</b>			
Salaries and wages	(236)	-	(236)
Social security costs	(11)	-	(11)
Employer contributions to the NHS Pension Scheme	(10)	-	(10)
<b>Total recoveries in respect of employee benefits</b>	<b>(257)</b>	<b>-</b>	<b>(257)</b>

**4.2 Average number of people employed**

	Permanent Employees	Other	Total
	Number	Number	Number
Total 1 April 2022 to 30 June 2022	342.63	25.40	368.03
Total 2021-22	320.38	26.16	346.54

No people were engaged on capital projects in the period 1 April 2022 to 30 June 2022 (nil 2021-22).



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**4.3 Exit packages agreed in the financial year**

	<b>1 April 2022 - 30 June 2022</b>		<b>1 April 2022 - 30 June 2022</b>		<b>1 April 2022 - 30 June 2022</b>	
	<b>Compulsory redundancies</b>		<b>Other agreed departures</b>		<b>Total</b>	
	<b>Number</b>	<b>£</b>	<b>Number</b>	<b>£</b>	<b>Number</b>	<b>£</b>
Less than £10,000	-	-	1	7,640	1	7,640
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
<b>Total</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>7,640</b>	<b>1</b>	<b>7,640</b>

	<b>2021-22</b>		<b>2021-22</b>		<b>2021-22</b>	
	<b>Compulsory redundancies</b>		<b>Other agreed departures</b>		<b>Total</b>	
	<b>Number</b>	<b>£</b>	<b>Number</b>	<b>£</b>	<b>Number</b>	<b>£</b>
Less than £10,000	-	-	1	9,266	1	9,266
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	30,229	-	-	1	30,229
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	102,189	-	-	1	102,189
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
<b>Total</b>	<b>2</b>	<b>132,419</b>	<b>1</b>	<b>9,266</b>	<b>3</b>	<b>141,685</b>

There were no other agreed departures where special payments have been made in 2022-23 (nil 2021-22)

**Analysis of Other Agreed Departures**

	<b>1 April 2022 - 30 June 2022</b>		<b>2021-22</b>	
	<b>Other agreed departures</b>		<b>Other agreed departures</b>	
	<b>Number</b>	<b>£</b>	<b>Number</b>	<b>£</b>
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	7,640	1	9,266
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
<b>Total</b>	<b>1</b>	<b>7,640</b>	<b>1</b>	<b>9,266</b>

The tables above report the number and value of exit packages agreed in the financial year.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook (Agenda for Change).

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

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

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme, and are included in the tables.

Ill-health retirement costs are met by the NHS Pension Scheme and are not included in these tables. In 1 April 2022 to 30 June 2022 there has been no such payment (£120,712 in 2021/22 full year).

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#### 4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://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:

##### a) 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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.

##### b) 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>.

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**5 Operating expenses**

	<b>1 April 2022 - 30 June 2022 Total £'000</b>	<b>2021-22 Total £'000</b>
<b>Purchase of goods and services</b>		
Services from other CCGs and NHS England	882	6,211
Services from foundation trusts	257,398	1,067,266
Services from other NHS trusts	28,244	103,842
Purchase of healthcare from non-NHS bodies	54,903	239,122
Purchase of social care	49	368
Prescribing costs	33,295	134,756
GPMS/APMS and PCTMS	35,872	149,503
Supplies and services – clinical	152	741
Supplies and services – general	(1,104)	2,538
Consultancy services	16	151
Establishment	(194)	7,623
Transport	1,986	7,621
Premises	628	2,603
Audit fees	100	124
Other professional fees	298	405
Legal fees	59	238
Education, training and conferences	(59)	677
<b>Total Purchase of goods and services</b>	<b><u>412,524</u></b>	<b><u>1,723,790</u></b>
<b>Depreciation and impairment charges</b>		
Depreciation	39	199
Amortisation	0	16
<b>Total Depreciation and impairment charges</b>	<b><u>39</u></b>	<b><u>216</u></b>
<b>Provision expense</b>		
Provisions	(1,738)	2,286
<b>Total Provision expense</b>	<b><u>(1,738)</u></b>	<b><u>2,286</u></b>
<b>Other Operating Expenditure</b>		
Chair and Non Executive Members	184	596
Grants to Other bodies	-	50
Research and development (excluding staff costs)	-	50
Expected credit loss on receivables	(1)	3
Inventories consumed	-	30
Other expenditure	-	76
<b>Total Other Operating Expenditure</b>	<b><u>182</u></b>	<b><u>804</u></b>
<b>Total operating expenses</b>	<b><u>411,008</u></b>	<b><u>1,727,096</u></b>

## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**5 Operating expenses contd****5.1 Auditor Liability Limitation Agreement**

In accordance with SI2008 no.489, the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, if the clinical commissioning group contract with its auditors provides for a limitation of the auditor's liability, it is required to disclose the principle terms of this limitation.

In the contract the clinical commissioning group holds with its external auditors, the total aggregate liability (whether those liabilities are expressed as an indemnity or otherwise) for each year of this contract shall be:

Liability for all defaults resulting in direct loss or damage to property shall be subject to a limit of £2 million (two million pounds) unless otherwise stipulated by the clinical commissioning group in the letter of appointment.

In respect of all other defaults, claims, losses or damages whether arising from breach of contract, misrepresentation (whether tortious or statutory), tort (including negligence), breach of statutory duty or otherwise shall in no event exceed the greater of the sum of £2 million (two million pounds) or a sum equivalent to 125% (one hundred and twenty-five per cent) of the contract charges paid or payable to the clinical commissioning group in the relevant year of the contract calculated at the date of the event giving rise to the liability (estimated for the full year if the event occurs in the first year of the contract) unless a different aggregate limit or limits is otherwise stipulated by the clinical commissioning group in the letter of appointment following a further competition.

**6 Better Payment Practice Code**

Measure of compliance	1 April 2022 - 30 June 2022 Number	1 April 2022 - 30 June 2022 £'000	2021-22 Number	2021-22 £'000
<b>Non-NHS Payables</b>				
Total Non-NHS Trade Invoices paid in the Year	7,041	110,352	31,775	401,468
Total Non-NHS Trade Invoices paid within target	6,669	103,496	30,373	382,993
<b>Percentage of Non-NHS Trade invoices paid within target</b>	<b>94.72%</b>	<b>93.79%</b>	<b>95.59%</b>	<b>95.40%</b>
<b>NHS Payables</b>				
Total NHS Trade Invoices Paid in the Year	272	290,700	1,198	1,197,646
Total NHS Trade Invoices Paid within target	242	290,126	1,120	1,195,373
<b>Percentage of NHS Trade Invoices paid within target</b>	<b>88.97%</b>	<b>99.80%</b>	<b>93.49%</b>	<b>99.81%</b>

**6.1 The Late Payment of Commercial Debts (Interest) Act 1998**

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group incurred £nil in the period from 1 April 2022 to 30 June 2022 (nil 2021-22) relating to claims made under this legislation.

**7 Other gains and losses**

	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
(Gain)/loss on disposal of property, plant and equipment assets other than by sale	-	221
<b>Total</b>	<b>-</b>	<b>221</b>

**8 Finance Costs**

	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
Interest on lease liabilities	1	-
Provisions: unwinding of discount	8	-
<b>Total</b>	<b>9</b>	<b>-</b>

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### 9 Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
Transfer of property plant and equipment	-	477
Transfer of intangibles	-	28
Transfer of inventories	-	97
Transfer of receivables	-	9,609
Transfer of payables	-	(132,196)
Transfer of provisions	-	(3,415)
<b>Net loss on transfers by absorption</b>	<b>-</b>	<b>(125,400)</b>

### 10. Property, plant and equipment

	1 April 2022 - 30 June 2022 Plant & machinery £'000	1 April 2022 - 30 June 2022 Information technology £'000	1 April 2022 - 30 June 2022 Furniture & fittings £'000	1 April 2022 - 30 June 2022 Total £'000
<b>Cost or valuation at 01 April 2022</b>	47	866	-	913
Additions purchased	-	-	-	-
Reclassifications	-	-	-	-
Disposals other than by sale	(14)	(760)	-	(773)
<b>Cost/Valuation at 30 June 2022</b>	<b>33</b>	<b>106</b>	<b>-</b>	<b>139</b>
<b>Depreciation 01 April 2022</b>	35	809	-	844
Reclassifications	0	0	-	0
Disposals other than by sale	(14)	(760)	-	(773)
Charged during the year	2	12	-	13
<b>Depreciation at 30 June 2022</b>	<b>23</b>	<b>61</b>	<b>-</b>	<b>84</b>
<b>Net Book Value at 30 June 2022</b>	<b>10</b>	<b>45</b>	<b>-</b>	<b>55</b>
Purchased	10	45	-	55
Donated	-	-	-	-
Government Granted	-	-	-	-
<b>Total at 30 June 2022</b>	<b>10</b>	<b>45</b>	<b>-</b>	<b>55</b>
<b>Asset financing:</b>				
Owned	10	45	-	55
Held on finance lease	-	-	-	-
<b>Total at 30 June 2022</b>	<b>10</b>	<b>45</b>	<b>-</b>	<b>55</b>

### Revaluation Reserve Balance for Property, Plant & Equipment

No revaluation reserve balance was held for property, plant and equipment in the period 01 April 2022 to 30 June 2022.

### 10.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
Plant & machinery	-	14
Information technology	-	293
<b>Total</b>	<b>-</b>	<b>307</b>

### 10.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	5	5
Information technology	3	5

	2021-22 Plant & machinery £'000	2021-22 Information technology £'000	2021-22 Furniture & fittings	2021-22 Total £'000
<b>Cost or valuation at 01 April 2021</b>	47	966	218	1,231
Additions purchased	-	-	-	-
Reclassifications	-	-	-	-
Disposals other than by sale	-	(100)	(218)	(319)
<b>Cost/Valuation at 31 March 2022</b>	<b>47</b>	<b>866</b>	<b>-</b>	<b>913</b>
<b>Depreciation 01 April 2022</b>	26	692	37	754
Reclassifications	-	-	-	-
Disposals other than by sale	-	(57)	(52)	(109)
Charged during the year	9	175	15	199
<b>Depreciation at 30 June 2022</b>	<b>35</b>	<b>809</b>	<b>-</b>	<b>844</b>
<b>Net Book Value at 31 March 2022</b>	<b>12</b>	<b>57</b>	<b>-</b>	<b>68</b>
Purchased	12	57	-	68
Donated	-	-	-	-
Government Granted	-	-	-	-
<b>Total at 31 March 2022</b>	<b>12</b>	<b>57</b>	<b>-</b>	<b>68</b>
<b>Asset financing:</b>				
Owned	12	57	-	68
Held on finance lease	-	-	-	0
<b>Total at 31 March 2022</b>	<b>12</b>	<b>57</b>	<b>-</b>	<b>68</b>



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**11. Leases Right-of-use Assets**

	1 April 2022 - 30 June 2022 Buildings excluding Dwellings £'000	1 April 2022 - 30 June 2022 Total £'000	1 April 2022 - 30 June 2022 Of which: leased from DHSC group bodies £'000	2021-22 £'000
<b>Cost or valuation at 01 April 2022</b>	-	-	-	-
IFRS 16 transition adjustment	235	235	159	-
<b>Cost/Valuation at 30 June 2022</b>	<u>235</u>	<u>235</u>	<u>159</u>	-
<b>Depreciation 01 April 2022</b>	-	-	-	-
Charged during the year	26	26	20	-
<b>Depreciation at 30 June 2022</b>	<u>26</u>	<u>26</u>	<u>20</u>	-
<b>Net Book Value at 30 June 2022</b>	<u>209</u>	<u>209</u>	<u>139</u>	-
<b>NBV by counterparty</b>				
Leased from other group bodies	139	139	-	-
Leased externally	70	70	-	-
<b>Net Book Value at 30 June 2022</b>	<u>209</u>	<u>209</u>		<u>0</u>

**Revaluation Reserve Balance for Right-of-use Assets**

No revaluation reserve balance was held for right-of-use assets in the period 01 April to 30 June 2022.

**11.1 Lease liabilities**

	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
<b>Lease liabilities at 01 April 2022</b>	-	-
IFRS 16 transition adjustment	235	-
Interest expense relating to lease liabilities	1	-
Repayment of lease liabilities (capital and interest)	(26)	-
<b>Lease liabilities at 30 June 2022</b>	<u>209</u>	-

**11.2 Lease liabilities maturity analysis of undiscounted future lease payments**

	1 April 2022 - 30 June 2022 £'000	1 April 2022 - 30 June 2022 Total £'000	1 April 2022 - 30 June 2022 Of which: leased from DHSC group bodies £'000	2021-22 £'000
Within one year	(106)	(106)	(80)	-
Between one and five years	(105)	(105)	(59)	-
	<u>(211)</u>	<u>(211)</u>	<u>(139)</u>	-

**11.3 Amounts recognised in Statement of Comprehensive Net Expenditure**

	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
Depreciation expense on right-of-use assets	26	-
Interest expense on lease liabilities	1	-
Expense relating to short-term leases	77	-
	<u>104</u>	-

**11.4 Amounts recognised in cashflow**

	1 April 2022 - 30 June 2022 £'000	2021-22 £'000
Total cash outflow on leases under IFRS 16	(26)	-
Total cash outflow for lease payments not included within the measurement of lease liabilities	(112)	-
	<u>(139)</u>	-

Future cash outflows to which the entity is exposed that are not included in the measurement of lease liabilities include £800k committed leases not yet commenced.

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**12 Intangible non-current assets**

	<b>Computer Software: Purchased</b>	<b>Development Expenditure (internally generated)</b>	<b>Total</b>
	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>
<b>Cost or valuation at 01 April 2022</b>	227	19	247
Disposals other than by sale	(227)	(19)	(247)
<b>Cost / Valuation At 30 June 2022</b>	-	-	-
<b>Amortisation 01 April 2022</b>	227	19	247
Disposals other than by sale	(227)	(19)	(247)
<b>Amortisation At 30 June 2022</b>	(0)	-	(0)
<b>Net Book Value at 30 June 2022</b>	0	-	0

**Revaluation Reserve Balance for intangible assets**

No revaluation reserve balance was held for intangible assets in the period 1 April 2022 to 30 June 2022.

**12.1 Cost or valuation of fully amortised assets**

The cost or valuation of fully depreciated assets still in use was as follows:

	<b>1 April 2022 - 30 June 2022 £'000</b>	<b>2021-22 £'000</b>
Computer software: purchased	-	247
<b>Total</b>	-	247

**12.2 Economic lives**

	<b>Minimum Life (years)</b>	<b>Maximum Life (Years)</b>
Computer software: purchased	3	5
Development expenditure (internally generated)	3	5

**13 Inventories**

	<b>Loan Equipment £'000</b>	<b>Total £'000</b>
<b>Balance at 01 April 2022</b>	67	67
Additions	27	27
Inventories recognised as an expense in the period	-	-
<b>Balance at 30 June 2022</b>	94	94



## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**14.1 Trade and other receivables**

	Current 1 April 2022 - 30 June 2022 £'000	Current 2021-22 £'000
NHS receivables: Revenue	1,705	4,201
NHS prepayments	2,177	0
NHS accrued income	257	936
Non-NHS and Other WGA receivables: Revenue	3,602	9,444
Non-NHS and Other WGA prepayments	1,830	778
Non-NHS and Other WGA accrued income	3,008	2,483
Expected credit loss allowance-receivables	(2)	(4)
VAT	953	1,210
Other receivables and accruals	12	14
<b>Total Trade &amp; other receivables</b>	<b>13,543</b>	<b>19,063</b>

The clinical commissioning group did not prepay any pension contributions at 30 June 2022 (nil 31 March 2022).

**14.2 Receivables past their due date but not impaired**

	1 April 2022 - 30 June 2022 DHSC Group Bodies £'000	1 April 2022 - 30 June 2022 Non DHSC Group Bodies £'000
By up to three months	27	314
By three to six months	88	301
By more than six months	1	16
<b>Total</b>	<b>116</b>	<b>631</b>

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	223	8,621
By three to six months	5	28
By more than six months	95	15
<b>Total</b>	<b>323</b>	<b>8,664</b>

The clinical commissioning group did not hold any collateral against receivables outstanding at 30 June 2022 (nil 31 March 2022).

**14.3 Loss allowance on asset classes**

	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 01 April 2022	(4)	(4)
Lifetime expected credit losses on trade and other receivables-Stage 2	2	2
<b>Total</b>	<b>(2)</b>	<b>(2)</b>

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**15 Cash and cash equivalents**

	<b>1 April 2022 - 30 June 2022 £'000</b>	<b>2021-22 £'000</b>
<b>Balance at 01 April 2022</b>	(705)	(6,113)
Net change in year	(12,531)	5,409
<b>Balance at 30 June 2022</b>	<b>(13,236)</b>	<b>(704)</b>
Made up of:		
Cash held in Pooled Budget	(406)	(405)
<b>Cash and cash equivalents as in statement of financial position</b>	<b>(406)</b>	<b>(405)</b>
Bank overdraft: Government Banking Service	(12,830)	(299)
<b>Total bank overdrafts</b>	<b>(12,830)</b>	<b>(299)</b>
<b>Balance at 30 June 2022</b>	<b>(13,236)</b>	<b>(704)</b>

The bank overdraft is a technical overdraft representing the clinical commissioning group's cash book position. The actual bank balance was in credit by £3,642k (£230k 2021-22).

Included within cash held in Pooled Budget is an overdrawn balance of £406k held on behalf of the clinical commissioning group by Milton Keynes Council for the Integrated Community Equipment Service and Learning Disability Service pooled budgets.

**16 Trade and other payables**

	<b>Current 1 April 2022 - 30 June 2022 £'000</b>	<b>Current 2021-22 £'000</b>
NHS payables: Revenue	3,043	2,326
NHS accruals	10,147	9,059
NHS deferred income	270	233
Non-NHS and Other WGA payables: Revenue	3,399	36,655
Non-NHS and Other WGA accruals	68,525	76,859
Non-NHS and Other WGA deferred income	78	67
Social security costs	298	292
Tax	259	257
Payments received on account	0	6
Other payables and accruals	5,458	7,965
<b>Total Trade &amp; Other Payables</b>	<b>91,476</b>	<b>133,719</b>

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**17 Borrowings**

	Current 1 April 2022 - 30 June 2022 £'000	Current 2021-22 £'000
<b>Bank overdrafts:</b>		
· Government banking service	12,830	299
<b>Total overdrafts</b>	<b>12,830</b>	<b>299</b>
<b>Total Borrowings</b>	<b>12,830</b>	<b>299</b>

**17.1 Repayment of principal falling due**

	Department of Health 1 April 2022 - 30 June 2022 £'000	Other 1 April 2022 - 30 June 2022 £'000	Total 1 April 2022 - 30 June 2022 £'000	Department of Health 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Within one year		£'000	£'000			
<b>Total</b>	0	12,830	12,830	0	299	299
<b>18 Provisions</b>	<b>0</b>	<b>12,830</b>	<b>12,830</b>	<b>0</b>	<b>299</b>	<b>299</b>

	Current 1 April 2022 - 30 June 2022 £'000	Non-current 1 April 2022 - 30 June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Restructuring				
Redundancy	784	812	784	984
Legal claims	255	-	496	-
Continuing care	3	-	3	-
Other	752	-	846	-
<b>Total</b>	<b>550</b>	<b>-</b>	<b>2,164</b>	<b>-</b>
<b>Total current and non-current</b>	<b>2,344</b>	<b>812</b>	<b>4,293</b>	<b>984</b>
	<b>3,156</b>		<b>5,277</b>	

	Restructuring £'000	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
<b>Balance at 01 April 2022</b>	<b>1,768</b>	<b>496</b>	<b>3</b>	<b>846</b>	<b>2,164</b>	<b>5,277</b>
Arising during the year	9	77	-	176	-	261
Utilised during the year	(189)	-	-	(202)	-	(391)
Reversed unused	-	(317)	-	(69)	(1,614)	(1,999)
Unwinding of discount	8	-	-	0	-	8
<b>Balance at 30 June 2022</b>	<b>1,596</b>	<b>255</b>	<b>3</b>	<b>752</b>	<b>550</b>	<b>3,156</b>
<b>Expected timing of cash flows:</b>						
Within one year	784	255	3	752	550	2,344
Between one and five years	812	-	-	-	-	812
After five years	-	-	-	-	-	-
<b>Balance at 30 June 2022</b>	<b>1,596</b>	<b>255</b>	<b>3</b>	<b>752</b>	<b>550</b>	<b>3,156</b>

Over the last two years, the role and function of the clinical commissioning group's corporate office spaces has changed significantly with a more flexible approach to working from home. The clinical commissioning group's future corporate estates requirements have been re-assessed and also taking account for the requirements of the future Integrated Care Board (ICB) it has been agreed that the office bases across Bedfordshire, Luton and Milton Keynes be rationalised. Several bases will be downscaled. Whilst the clinical commissioning group is attempting to seek additional tenants, the clinical commissioning group will continue to be liable for lease costs for the excess areas until the lease-end/break clause dates in 2025 and 2024 respectively. This restructuring provision £1,596k (£1,768k 2021-22) relates to the ongoing liability for costs of this excess space.

As part of the planned creation of an Integrated Care Board (ICB) from 1 July 2022 there is a requirement to establish a new Integrated Care Board structure. The process to establish the new Integrated Care Board has placed some Executive Directors of the clinical commissioning group at risk. A £255k redundancy provision (£496k 2021-22) reflects an estimate of the financial risk associated with this.

Legal Claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them.

The provision for Continuing Health Care relates to cases from 1 April 2013 to 31 March 2021 that are undergoing an appeal process. The clinical commissioning group has assessed the likelihood of a successful appeal based on the outcome of previous appeals and the remaining balance has been reported as a contingent liability in Note 18.

Other provisions are made up of a legacy £470k employer superannuation liability and £80k for dilapidations on terminating a lease agreement on premises relating to the restructuring of the clinical commissioning group (£470k and £80k respectively 2021-22). The 2021-22 provision for liabilities with partner organisations regarding the COVID-19 pandemic response £1,614k was reversed unused in quarter one of 2022-23.

## NHS Bedfordshire, Luton and Milton Keynes CCG - Annual Accounts 1 April 2022 - 30 June 2022

**19 Contingencies**

	<b>1 April 2022 - 30 June 2022 £'000</b>	<b>2021-22 £'000</b>
<b>Contingent liabilities</b>		
Continuing Healthcare	<u>1,455</u>	<u>1,325</u>
<b>Net value of contingent liabilities</b>	<u>1,455</u>	<u>1,325</u>

The contingent liability for Continuing Health Care relates to cases from April 2013 to March 2021 that are undergoing an appeal process. A provision has been established for the likely cost of successful appeals (see Note 18) with the contingency above reflecting the remainder of the liability should the outcome of the appeals go against the clinical commissioning group.

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group identified £nil in the period from 1 April 2022 to 30 June 2022 (£nil 2021-22) relating to contingent assets.

**20 Commitments**

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group had £nil capital commitments or other financial commitments in the period from 1 April 2022 to 30 June 2022 (£nil 2021-22).

**21 Financial instruments****21.1 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 NHS clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

**21.1.1 Currency risk**

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

**21.1.2 Interest rate risk**

The clinical commissioning group 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 clinical commissioning group therefore has low exposure to interest rate fluctuations.

**21.1.3 Credit risk**

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group 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.

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**21 Financial instruments cont'd****21.1.4 Liquidity risk**

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

**21.1.5 Financial Instruments**

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

**21.2 Financial assets**

	<b>1 April 2022 - 30 June 2022 Financial Assets measured at amortised cost £'000</b>	<b>2021-22 Financial Assets measured at amortised cost £'000</b>
Trade and other receivables with NHSE bodies	1,666	4,931
Trade and other receivables with other DHSC group bodies	3,291	2,716
Trade and other receivables with external bodies	3,628	9,431
Cash and cash equivalents	(406)	(406)
<b>Total at 30 June 2022</b>	<b>8,179</b>	<b>16,673</b>

**21.3 Financial liabilities**

	<b>1 April 2022 - 30 June 2022 Financial Liabilities measured at amortised cost £'000</b>	<b>2021-22 Financial Liabilities measured at amortised cost £'000</b>
Loans with external bodies	12,830	299
Trade and other payables with NHSE bodies	1,056	1,100
Trade and other payables with other DHSC group bodies	12,255	10,260
Trade and other payables with external bodies	77,470	121,503
<b>Total at 30 June 2022</b>	<b>103,611</b>	<b>133,162</b>

**21.4 Fair Value**

In reporting the value of the financial assets and liabilities in notes 21.2 and 21.3 the clinical commissioning group has assessed that given the nature of its financial assets and liabilities the fair value is equal to the current value and therefore no further disclosure is required.

**22 Operating segments**

The Clinical Commissioning Group operates as one operating segment and that is to commission healthcare.



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**23 Pooled budgets**

NHS Bedfordshire, Luton and Milton Keynes clinical commissioning group entered in to pooled budgets with Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council.

Under each arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budgets are hosted by the four Councils and are for Community Equipment Services, the Learning Disability Service and Children Service Pools, the Better Care Fund, Winter Funds and Discharge Arrangements, as listed below. £

<b>Bedford Borough Locality Arrangement</b>	<b>Total £'000</b>	<b>Better Care Fund £'000</b>	<b>Hospital Discharge Fund £'000</b>	<b>Community Equipment * £'000</b>	<b>Childrens Services £'000</b>	<b>Learning Disabilities £'000</b>
<b>Contribution</b>						
Bedford Borough Council	1,799	1,747	-	52	-	-
Bedfordshire, Luton & Milton Keynes ICB	<u>1,592</u>	<u>1,426</u>	-	<u>166</u>	-	-
<b>Total Funding</b>	<b><u>3,391</u></b>	<b><u>3,173</u></b>	<b>-</b>	<b><u>218</u></b>	<b>-</b>	<b>-</b>
<b>Expenditure</b>						
Bedford Borough Council	1,799	1,747	-	52	-	-
Bedfordshire, Luton & Milton Keynes ICB	<u>1,592</u>	<u>1,426</u>	-	<u>166</u>	-	-
<b>Total Expenditure</b>	<b><u>3,391</u></b>	<b><u>3,173</u></b>	<b>-</b>	<b><u>218</u></b>	<b>-</b>	<b>-</b>
<b>Net Overspend / (Underspend)</b>						
Bedford Borough Council	-	-	-	-	-	-
Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	-	-
<b>Total Overspend / (Underspend)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

\* The community equipment funds are pool agreement as below ed with Central Bedfordshire Council and Milton Keynes ICB in a three way agreement as below

<b>Central Bedfordshire Locality Arrangement</b>	<b>Total £'000</b>	<b>Better Care Fund £'000</b>	<b>Hospital Discharge Fund £'000</b>	<b>Community Equipment * £'000</b>	<b>Childrens Services £'000</b>	<b>Learning Disabilities £'000</b>
<b>Contribution</b>						
Central Bedfordshire Council	1,908	1,828	-	80	-	-
Bedfordshire, Luton & Milton Keynes ICB	<u>3,461</u>	<u>3,206</u>	-	<u>255</u>	-	-
<b>Total Funding</b>	<b><u>5,369</u></b>	<b><u>5,034</u></b>	<b>-</b>	<b><u>355</u></b>	<b>-</b>	<b>-</b>
<b>Expenditure</b>						
Central Bedfordshire Council	1,908	1,828	-	80	-	-
Bedfordshire, Luton & Milton Keynes ICB	<u>3,461</u>	<u>3,206</u>	-	<u>255</u>	-	-
<b>Total Expenditure</b>	<b><u>5,369</u></b>	<b><u>5,034</u></b>	<b>-</b>	<b><u>355</u></b>	<b>-</b>	<b>-</b>
<b>Net Overspend / (Underspend)</b>						
Central Bedfordshire Council	-	-	-	-	-	-
Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	-	-
<b>Total Overspend / (Underspend)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

\* The community equipment funds are pool agreement as below ed with Central Bedfordshire Council and Milton Keynes ICB in a three way agreement as below

<b>Luton Borough Locality Arrangement</b>	<b>Total £'000</b>	<b>Better Care Fund £'000</b>	<b>Hospital Discharge Fund £'000</b>	<b>Community Equipment * £'000</b>	<b>Childrens Services £'000</b>	<b>Learning Disabilities £'000</b>
<b>Contribution</b>						
Luton Borough Council	3,283	1,878	-	-	418	986
Bedfordshire, Luton & Milton Keynes ICB	<u>3,409</u>	<u>2,213</u>	-	-	<u>210</u>	<u>986</u>
<b>Total Funding</b>	<b><u>6,692</u></b>	<b><u>4,091</u></b>	<b>-</b>	<b>-</b>	<b><u>628</u></b>	<b><u>1,973</u></b>
<b>Expenditure</b>						
Luton Borough Council	3,283	1,878	-	-	418	986
Bedfordshire, Luton & Milton Keynes ICB	<u>3,409</u>	<u>2,213</u>	-	-	<u>210</u>	<u>986</u>
<b>Total Expenditure</b>	<b><u>6,692</u></b>	<b><u>4,091</u></b>	<b>-</b>	<b>-</b>	<b><u>628</u></b>	<b><u>1,973</u></b>
<b>Net Overspend / (Underspend)</b>						
Luton Borough Council	-	-	-	-	-	-
Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	-	-
<b>Total Overspend / (Underspend)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

<b>Milton Keynes Locality Arrangement</b>	<b>Total £'000</b>	<b>Better Care Fund £'000</b>	<b>Hospital Discharge Fund £'000</b>	<b>Community Equipment * £'000</b>	<b>Childrens Services £'000</b>	<b>Learning Disabilities £'000</b>
<b>Contribution</b>						
Milton Keynes Council	8,695	1,857	-	188	-	6,650
Bedfordshire, Luton & Milton Keynes ICB	<u>3,401</u>	<u>2,790</u>	-	<u>237</u>	-	<u>374</u>
Other Grant Funds	<u>36</u>	-	-	<u>36</u>	-	-
<b>Total Funding</b>	<b><u>12,132</u></b>	<b><u>4,647</u></b>	<b>-</b>	<b><u>461</u></b>	<b>-</b>	<b><u>7,024</u></b>
<b>Expenditure</b>						
Milton Keynes Council	8,545	1,878	-	224	-	6,464
Bedfordshire, Luton & Milton Keynes ICB	<u>3,401</u>	<u>2,790</u>	-	<u>237</u>	-	<u>374</u>
<b>Total Expenditure</b>	<b><u>11,946</u></b>	<b><u>4,647</u></b>	<b>-</b>	<b><u>461</u></b>	<b>-</b>	<b><u>6,838</u></b>
<b>Net Overspend / (Underspend)</b>						
Milton Keynes Council	(186)	-	-	-	-	(186)
Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	-	-
<b>Total Overspend / (Underspend)</b>	<b>(186)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(186)</b>

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## 24 Related party transactions

Individual Governing Body members, having significant influence over the management of the Clinical Commissioning Group, are considered to be related parties. Details of transactions between the CCG and Governing Body members are detailed in the Remuneration Report within the Annual Report.

Entities controlled by Governing Body members, or a close family member, are also considered to be a related party as defined by IAS 24. There were no entities that fell within this definition in the period from 1 April 2022 to 30 June 2022 (nil 2021-22).

Under IAS 24 entities in the same group as the Department of Health are considered to be related parties.

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group had a number of material transactions with other NHS and other government bodies. Materiality in this context is considered to be over £2.5m and transactions have been prepared on an accruals basis.

Bedfordshire Hospitals NHS Foundation Trust  
 Buckinghamshire Healthcare NHS Trust  
 Cambridgeshire Community Services NHS Trust  
 Cambridge University Hospitals NHS Foundation Trust  
 Central and North West London NHS Foundation Trust  
 East London NHS Foundation Trust  
 East and North Hertfordshire NHS Trust  
 East of England Ambulance Service NHS Trust  
 Milton Keynes Hospital NHS Trust  
 Oxford University Hospitals NHS Foundation Trust  
 South Central Ambulance Service NHS Foundation Trust  
 Central Bedfordshire Council  
 Luton Borough Council  
 Milton Keynes Council

## 25 Events after the end of the reporting period

The Health and Care Act (2022) received Royal Assent on the 28 April 2022, after the end of the reporting period. It introduced significant reforms to the organisation and delivery of health and care services in England. The Act abolishes Clinical Commissioning Groups (CCG) and establishes Integrated Care Boards (ICB). NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board will take on the commissioning function of the CCG and the assets and liabilities of the CCG will transfer to the ICB. The expected date for the transfer is 01 July 2022. It is classified as a non-adjusting event as it is an event that arose after the end of the reporting period and therefore does not result in adjustment to the financial statements. It is disclosed for completeness, to support the users of the financial statements to reach a proper understanding of the financial position of the CCG; the disclosure supplements Note 1.1.

There are no other adjusting events after the reporting period which will have a material effect on the financial statements of NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group.

## 26 Losses and special payments

### 26.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	<b>Total Number of Cases 1 April 2022 - 30 June 2022 Number</b>	<b>Total Value of Cases 1 April 2022 - 30 June 2022 £'000</b>	<b>Total Number of Cases 2021-22 Number</b>	<b>Total Value of Cases 2021-22 £'000</b>
Fruitless payments	-	-	1	22
<b>Total</b>	-	-	<b>1</b>	<b>22</b>

### 26.2 Special payments

The clinical commissioning group made no special payments during the period from 1 April 2022 to 30 June 2022 (nil 2021-22).

## 27 Third party assets

The clinical commissioning group had £nil third party assets during the period from 1 April 2022 to 30 June 2022 (nil 2021-22).



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**28 Financial performance targets**

The clinical commissioning group has a number of financial duties under the NHS Act 2006 (as amended).

The clinical commissioning group's performance against those duties was as follows:

	1 April 2022 - 30 June 2022	1 April 2022 - 30 June 2022	1 April 2022 - 30 June 2022	Duty Achieved
	Target £'000	Performance £'000	Variance £'000	
Expenditure not to exceed income	417,795	417,794	1	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	417,339	417,338	1	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	4,382	4,381	1	Yes
	2021-22 Target £'000	2021-22 Performance £'000	2021-22 Variance £'000	Duty Achieved
Expenditure not to exceed income	1,763,304	1,751,707	11,597	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	1,761,684	1,750,087	11,597	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	19,258	18,664	594	Yes

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**29. Accountability - Staff**

	Admin			Programme			Total			1 April 2022 - 30 June 2022
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	
Employee Benefits										
Salaries and wages	2,441	236	2,677	2,223	508	2,730	4,664	744	5,408	
Social security costs	290	-	290	257	-	257	547	-	547	
Employer contributions to the NHS Pension Scheme	525	-	525	278	-	278	803	-	803	
Other pension costs	-	-	-	-	-	-	-	-	-	
Apprenticeship Levy	19	-	19	-	-	-	19	-	19	
Other post-employment benefits	-	-	-	-	-	-	-	-	-	
Other employment benefits	-	-	-	-	-	-	-	-	-	
Termination benefits	-	-	-	-	-	-	-	-	-	
<b>Gross employee benefits expenditure</b>	<b>3,275</b>	<b>236</b>	<b>3,511</b>	<b>2,758</b>	<b>508</b>	<b>3,266</b>	<b>6,033</b>	<b>744</b>	<b>6,777</b>	
Less recoveries in respect of employee benefits (note 4.1.2)	(15)	-	(15)	(65)	-	(65)	(79)	-	(79)	
<b>Total - Net admin employee benefits including capitalised costs</b>	<b>3,260</b>	<b>236</b>	<b>3,497</b>	<b>2,693</b>	<b>508</b>	<b>3,201</b>	<b>5,954</b>	<b>744</b>	<b>6,698</b>	
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-	
<b>Net employee benefits excluding capitalised costs</b>	<b>3,260</b>	<b>236</b>	<b>3,497</b>	<b>2,693</b>	<b>508</b>	<b>3,201</b>	<b>5,954</b>	<b>744</b>	<b>6,698</b>	

**29.1 Accountability - Staff 2021-22**

	Admin			Programme			Total			2021-22
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	
Employee Benefits										
Salaries and wages	9,239	937	10,176	7,851	1,718	9,569	17,090	2,655	19,745	
Social security costs	1,060	-	1,060	851	-	851	1,911	-	1,911	
Employer contributions to the NHS Pension Scheme	2,098	-	2,098	590	-	590	2,688	-	2,688	
Other pension costs	-	-	-	-	-	-	-	-	-	
Apprenticeship Levy	46	-	46	-	-	-	46	-	46	
Other post-employment benefits	-	-	-	-	-	-	-	-	-	
Other employment benefits	-	-	-	-	-	-	-	-	-	
Termination benefits	-	-	-	-	-	-	-	-	-	
<b>Gross employee benefits expenditure</b>	<b>12,443</b>	<b>937</b>	<b>13,380</b>	<b>9,291</b>	<b>1,718</b>	<b>11,010</b>	<b>21,735</b>	<b>2,655</b>	<b>24,390</b>	
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-	(257)	-	(257)	(257)	-	(257)	
<b>Total - Net admin employee benefits including capitalised costs</b>	<b>12,443</b>	<b>937</b>	<b>13,380</b>	<b>9,034</b>	<b>1,718</b>	<b>10,753</b>	<b>21,478</b>	<b>2,655</b>	<b>24,133</b>	
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-	
<b>Net employee benefits excluding capitalised costs</b>	<b>12,443</b>	<b>937</b>	<b>13,380</b>	<b>9,034</b>	<b>1,718</b>	<b>10,753</b>	<b>21,478</b>	<b>2,655</b>	<b>24,133</b>	

