NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Annual Reports and Accounts

1 July 2022 – 31 March 2023

Table of Contents

Delivering better health outcomes for residents

Foreword by Dr Rima Makarem

Chair of Bedfordshire, Luton and Milton Keynes Integrated Care Board

Welcome to our Annual Report

The Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) came into operation on 1 July 2022, as the statutory Board of the new Integrated Care System (ICS). It marks a bold, new beginning for health and care in our area.

This is our new organisation's first Annual Report.

Throughout the Report we've drawn a direct line to the real-world impact of our work with partners, and we've included lots of relevant case studies to that end.

The mission is clear: ICBs have been created to work together as a partnership to improve health outcomes for our residents. That's because health is not just about the quality of care a person receives when they are at the doctor or in a hospital, it's also about enjoying more healthy years and having the best possible quality of life. Does a person have a decent home? Do they have enough money to buy healthy food and stay warm? Do they have a healthy lifestyle, and are they connected to friends, family and their local community?

These factors, and many more, all need to be considered if we are to make sure residents can live healthier lives for longer.

It is because the determinants of health are so varied – and so much wider than the reach of NHS services – that the way we deliver health and care in our area is changing.

The NHS, local authorities, voluntary organisations and community leaders are working much more closely together. Our new ways of working mean that more decisions are being taken closer to and with the people they affect, and we're proud to be building our place-based partnerships to implement local health and care plans.

This Annual Report gives only a flavour of the ICB's activity over our first nine months of its existence, from building the health and care workforce of the future to pioneering new research partnerships; from understanding how inequalities are impacting our residents to fresh, new initiatives to support disabled people to access services more easily; from cutting-edge technological solutions which are saving lives and reducing demand on hospitals to designing new ways of working in partnership with our brilliant voluntary and community sector partners.

It really has been a busy nine months. I am particularly proud of the launch of the Integrated Care System's Health and Care Strategy in January. It's clear vision – for everyone in our towns, villages and communities to live a longer, healthier life – is guiding everything we do.

Of course, we're only at the beginning of our journey. Much more innovation and transformation of services can be expected in years to come.

Finally, there are ever more opportunities for you, the residents of BLMK, to play an active role in creating the services you want to see. So please get in touch. Tell us your thoughts. And, if you would like to, participate in the exciting work to make local services as good as they can be. The ICB is an organisation committed to continuously improving based on the feedback we're getting from residents and we are clear that our most important partners are the residents of Bedfordshire, Luton and Milton Keynes.

I am grateful to everyone who has contributed to the development of our Partnership during 2022/23 and I look forward to achieving more, together in the year ahead.

PERFORMANCE REPORT

Performance overview

The performance overview section of the Annual Report provides a look at how the ICB operates, its structures and strategic priorities, and our progress during the reporting period. It also describes the area in which we work, detailing our four places, and the work being done to make sure that services are being delivered in a joined-up, integrated way, as close as possible to where residents live.

Statement by Felicity Cox

Chief Executive of Bedfordshire, Luton and Milton Keynes Integrated Care Board

The ICB is ambitious for the health and wellbeing of the great people who live in our city, towns, villages and communities. We want to help them to live more years in good health.

This section contains a summary of the ICB's performance as an organisation from 1 July 2022 to 31 March 2023, and highlights some of the most significant achievements of our first nine months of operation.

As Rima said, we know good health for our residents in BLMK isn't just about NHS services. All our partners understand this, and I'm proud of the start we've made together.

Patient appointments in GP practices across our area have increased to almost 30,000 per day, giving residents better access to services when they need them. This helps us to keep pace with rising demand from a growing population. The Primary Care Training Hub is working with practices and Primary Care Networks to develop a diverse primary care workforce so more people get the right care at the right time from a range of clinical staff. These include GPs, pharmacists, nurses and allied health professionals.

The ICB has teamed up with voluntary and community sector partners to transform lives, such as a new project with a local football club helping young people from deprived backgrounds improve their physical and mental health, and connect socially with each other.

The ICB is funding services that are making a real difference: new community ambulances to help with discharging vulnerable people from hospital and more mental health crisis cafés delivered through a vibrant collaboration of mental health providers and voluntary organisations, are just two examples.

Across the health and care system, more cutting-edge digital technology is being used – robots in hospitals and state-of-the-art home monitoring equipment to help people live independently for as long as possible.

Almost 250 people have completed the ICB's co-production training. Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership. It engages groups of people at the earliest stages of service design, development and evaluation. This ensures residents are at the heart of everything the ICB does. It is one part of the

ongoing delivery of our landmark Working with People and Communities Strategy which aims to focus us on the priorities that matter most to our residents. I'm particularly pleased that we commissioned the Denny Review, which looked at health inequalities across Bedfordshire, Luton and Milton Keynes. It produced useful findings which will shape how we tackle inequalities in the months and years ahead.

While the ICB aims to innovate the way that health and care are delivered together, we are also committed to improving the services you can expect specifically from the NHS. The balance of delivering care and treatment, supporting services to recover and reducing waiting lists from the pandemic while maintaining and delivering our financial duties has been challenging. The ICB has nevertheless met our financial duties. Our allocation was £1,406m and we finished the year with total expenditure of £1,405.7m, delivering a small surplus of £0.3m against our Revenue Resource Limit.

In this strained financial context, it is important we understand the risks we face, and to this end a new Risk Management Framework and Strategy has provided the ICB with a structure for managing risk

across our system. Details of the key risks we face are set out in more detail in the Accountability Report (page 92).

These are challenging times in which we are making difficult decisions about what to prioritise, but they're also times of great opportunity. It's only year one, but, with the strong support of our partners, we've made a good start on which to build next year.

Felicity Cox
Accountable Officer
27th June 2023

About Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB)

Becoming an Integrated Care System

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; enhancing productivity and value for money; and helping the NHS support broader social and economic development.

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

Integrated Care Partnership (ICP) – Known as the BLMK Health and Care Partnership - a statutory joint committee between the local authorities in Bedfordshire, Luton and Milton Keynes and the Integrated Care Board which has agreed and will continue to develop our integrated health and care strategy;

Integrated Care Board (ICB) – the statutory Board of the ICS which is responsible for delivering plans to realise the strategy set by the Integrated Care Partnership. It is entrusted with the total NHS budget for BLMK and it has absorbed the functions of the former Clinical Commissioning Group, and some new functions. The new Bedfordshire, Luton and Milton Keynes Integrated Care Board came into operation on 1 July 2022. A table of our ICB duties and where they can be found throughout this report can be found below.

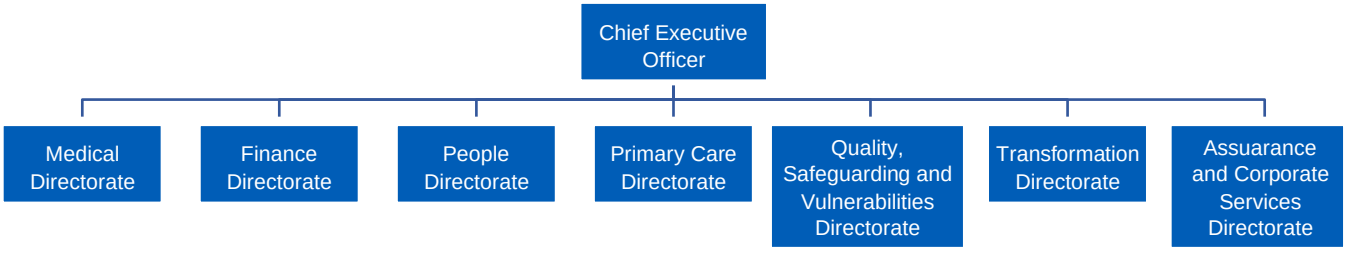
Place-based Partnerships – health and care partners in four local authority areas working together on the collective planning, delivery and monitoring of services to populations at places based on the Joint Strategic Needs Assessment and integrated health and care strategy;

Provider Collaboratives – set up to enable providers and wider partners working together at scale to deliver improved outcomes and a more resilient service; for example, the Bedfordshire Care Alliance and the mental health, learning disability and autism collaborative (more information on page 16)**,** and

Primary Care Networks (PCNs) – GP 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.

Organisational structure

Since the organisation was established in July 2022, the ICB has started to align and reshape its organisational structure to make sure the organisation is focused on supporting residents to improve their health



The ICB is responsible for:

- Ensuring delivery of the strategy for the health and wellbeing of the population as agreed by the Integrated Care Partnership;
- Developing a plan for the delivery of NHS services;
- Allocating resources;
- Establishing joint working arrangements;
- Establishing system governance;
- Arranging health service provision;
- Using data and digital to improve services;
- Supporting and developing the health and care workforce;
- Emergency preparedness, resilience and response;
- Delegated functions from NHS England;
- Data and digital improvements and innovation;
- Achieving social and economic development and sustainability goals; and
- Maximising value for money.

Our values:

Our principles and behaviours

We have developed a Leadership Charter, which outlines the values and behaviours that strengthen our collective leadership culture.

It is underpinned by shared principles for working together in ways that are:

- People-led;
- Collaborative;
- Integrated;
- Inclusive; and
- Altruistic.

Our behaviours apply equally to for individual leaders and to our collective leadership group. These behaviours demonstrate a clear commitment to openness, accountability, taking and sharing responsibility and learning. They outline how we will develop staff within the right environment, nurture working relationships and inspire continuous improvement.

Collectively, we are committed to keep the needs of residents at the heart of everything we do, while reinforcing the need for high quality, joined-up services. It includes a drive to create a culture of innovation and improvement; giving honest feedback on inappropriate behaviour and resolving conflicts collaboratively; building our future together; and collective responsibility for resources and population health.

The ICB's strategic priorities

The ICB's five priorities to help improve residents' health outcomes

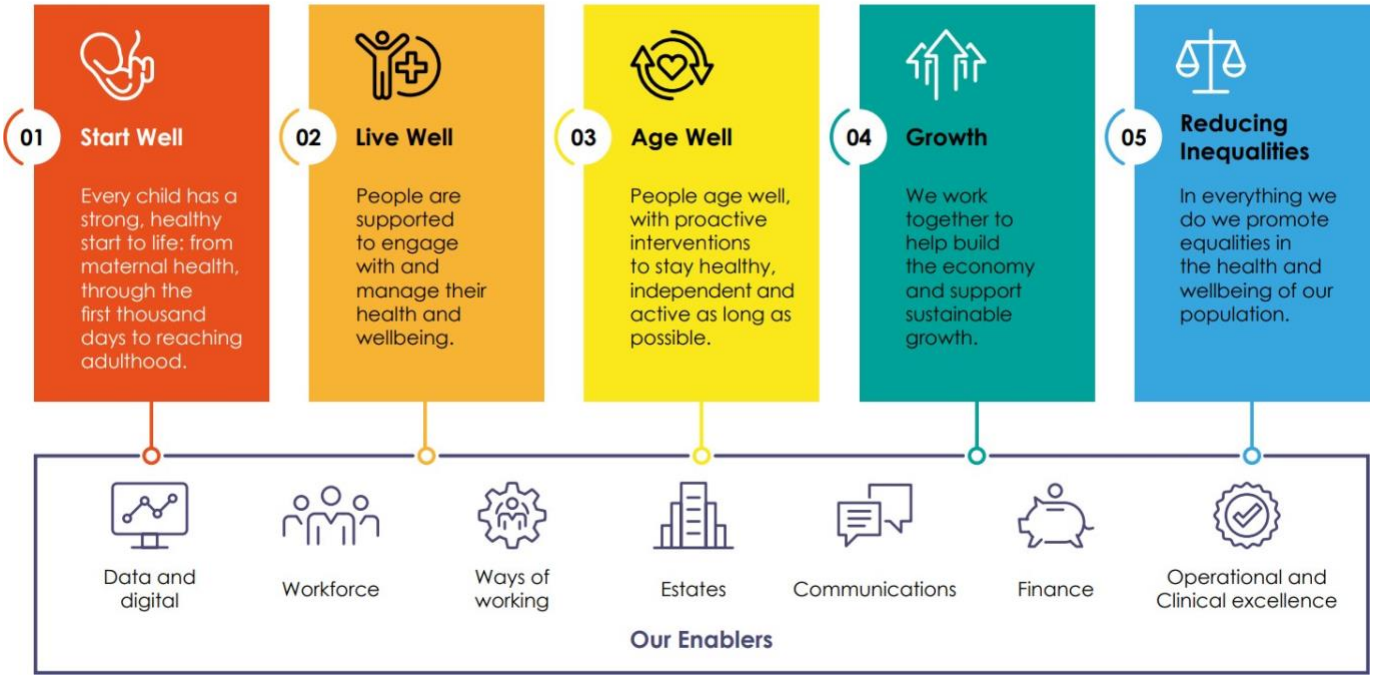
Following discussions with our partners, local people and patient forums, our Integrated Care System (ICS) has identified five priorities for health and social care across our area.

These build on the factors we know support a healthy life, including access to high quality health care, healthy behaviours, education, economic stability, employment and the built environment.

Focused on improving health outcomes for our whole population, these priorities are informed by, and take account of, the strategic objectives of our partner organisations. They aim to improve health and wellbeing and equality in our communities, make the best use of resources, and will shape the way we work as a system.

These priorities are supported by seven cross-cutting operational 'enablers' as described below.

Our Strategic Priorities



About our area

Our area

The four places in our Integrated Care System are vibrant and culturally diverse and cover a population of 1million. Whilst there are health inequalities, there is growth and opportunities for us to improve the health and wellbeing of people who live here.

Bedford Borough

Primarily an urban area surrounded by many villages. Over 100 languages are spoken by an ethnically diverse population.

Milton Keynes

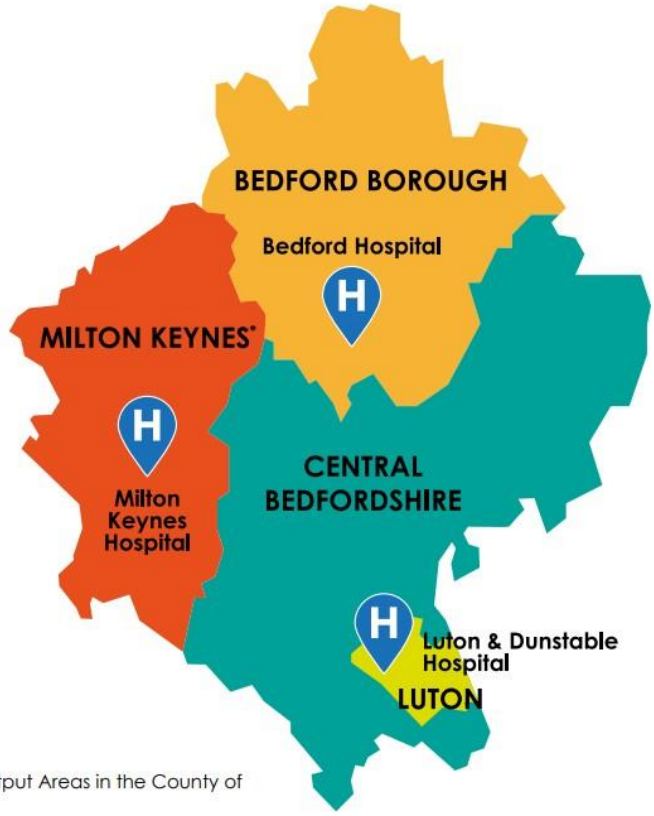
Ethnically diverse population with 90% of people living in Milton Keynes itself and 10% living in rural areas.

Central Bedfordshire

Older, more affluent population with less ethnic diversity than its neighbours. Life expectancy is better than the national average.

Luton

Young and highly culturally diverse population living in our most urban of areas.



*The area covered by the ICB also includes the following Lower Layer Super Output Areas in the County of Buckinghamshire: E01017695, E01017696, E01017669, E01017670

Our places, people and their health

Bedfordshire, Luton and Milton Keynes supports two million jobs locally – it is one of the fastest growing economies in England, contributing £110 billion to the UK every year. Around a million people live in the area.

The Bedfordshire, Luton and Milton Keynes area is covered by five local authorities. Bedford Borough Council, which has 186,000 residents. Central Bedfordshire Council, with a population of 296,000. Milton Keynes City Council has over 288,000 residents in its area while Luton Borough Council has about 225,000 residents. the ICB calls the four areas covered by these local authorities our places. Around 6,000 Buckinghamshire residents are also part of the ICB's geography, and we're proud to work closely with Buckinghamshire Council too.

The ICB works with local authorities to improve people's health outcomes. As such, we have senior representation on all local Health and Wellbeing Boards, with our Accountable Officer, Clinical Chair and Place Link Directors being core members. The ICB's work is informed by and responds to the priorities identified locally and developed into health and wellbeing strategies.

A fast-growing area

It's not just the economy that's growing quickly in Bedfordshire, Luton and Milton Keynes – the population is too. Three of our four places saw population growth of over 15% in the decade to 2021.

It is one of the fastest growing areas in the country. According to the Office for National Statistics (ONS) the population of Bedfordshire, Luton and Milton Keynes is projected to increase by 5.6%

between 2020 and 2040. This is likely to be an underestimate as it doesn't account for all the planned housing developments which suggest around 6,000 new homes will be built each year. The number of people aged 85 and over in our area is projected to almost double between 2020 and 2040, increasing by 89%.

The number of people aged 65 and over in Bedfordshire, Luton and Milton Keynes is projected to increase by 44% between 2020 and 2040. More people in these older age groups tend to have long-term and multiple health conditions. This presents a big challenge for both health and social care, both in terms of caring for people with multiple health conditions but also supporting people to live well.

ONS projections indicate that the number of children and young people from the first year of life up to 19 years old will go down by 7% between 2020 and 2040. However, as we have noted that these estimates do not fully account for planned housing growth and new homes tend to attract young families, it is unlikely that the number of children and young people will fall over this period.

An area proud of its differences

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

Milton Keynes is mostly urban with significant ethnic minority communities and some rural areas. Bedford Borough has both rural and urban areas with about two-thirds of the population living in the towns of Bedford and Kempston. Central Bedfordshire comprises of a mix of market towns and rural villages.

Luton is the most urban, deprived and ethnically diverse. In the most deprived areas of Bedford Borough, Luton and Milton Keynes 1 in 4 children aged from 0 to 15 are living in families experiencing income deprivation. Central Bedfordshire is the most affluent and least ethnically diverse of the four areas. It does, however, have pockets of deprivation and an ageing population.

Health differences

There are high levels of health inequality within and between places. For example, male life expectancy in Bedford Borough is nearly nine years longer on average between the most and least deprived areas. In Luton, men can expect to live in good health until they are 59. But just a few miles away in Central Bedfordshire they can expect to live healthily to 68.

In deprived areas, early deaths are mainly due to cancer, heart and blood disease, and diseases to do with breathing problems, such as asthma. Hospital admissions for heart disease are higher when compared nationally, particularly for Luton and Milton Keynes. Admissions for asthma in under-19s are higher than average in Luton and Bedford. This shows other factors which affect people's health, such as air quality and pollution, and smoking need to be addressed.

Obesity is another significant health issue, with two out of three adults either overweight or obese. The prevalence of overweight and obesity is lowest in Bedford Borough (63%) and highest in Milton Keynes (69%). One in five children entering primary school are overweight or obese, rising to two in five by the time they leave primary school; although by this age there is significant variation across the area with the proportion overweight or obese ranging from 34% in Central Bedfordshire to 44% in Luton.

Working at place

Our four places and their health and care priorities

The ICB's 'places' refer to the geographical areas covered by the four local authorities across Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

We are committed to providing services as close to residents as possible and we also work at a more local individual level including neighbourhoods. This allows us to tailor services based on the needs of local people. To do this, we have worked in partnership with local authorities, NHS Trusts and other local organisations to establish place-based working in our four places. Each place develops their own plan based on local priorities.

Bedford Borough - Place Foreword

Bedford Borough is working to create a 'place to grow' where people and communities thrive. Recognising the impact that housing, education, employment and social connection have on health, the focus in Bedford Borough is to:

- Develop places;
- Enable prosperity;
- Support people; and
- Empower communities.

The Bedford Borough Health and Wellbeing Board, which is a partnership between the local authority and NHS, sets the priorities for the town. The council has established an Executive Delivery Group that oversees the delivery of plans and reports progress to the Health and Wellbeing Board.

The Bedford Borough local plan recognises two important factors in helping residents to live longer lives in good health. These are growing a vibrant and strong local economy, and establishing a green agenda to drive an active response to climate change. These factors will not only provide local employment opportunities but also create a healthier environment and clean air for residents. From this foundation residents from Bedford's diverse communities will be able to thrive and realise their potential.

Bedford Borough's priorities

The Bedford Borough place plan, developed by the Health and Wellbeing Board, commits to:

- Better understanding local communities to reduce health inequalities;
- Focusing on the prevention of ill health and promoting positive behaviours; and
- Transforming primary care with input and support from voluntary, charity and social enterprise sector (VCSE).

In addition to a team working at place, we are also working with colleagues across the county of Bedfordshire, through the Bedfordshire Care Alliance to maximise benefits of delivering services across a wider geography.

Central Bedfordshire – Place Foreword

Central Bedfordshire Health and Wellbeing Board (HWB) provides the strategic leadership at 'Place' for improving the quality of life for residents and promoting greater integration of health and care services. The Board was chaired by Councillor Tracey Stock, Central Bedfordshire Council's Executive Member for Health, Wellbeing and Communities and Chair of Bedfordshire, Luton and Milton Keynes Health and Care Partnership. Anne Brierley, ICB Chief Transformation Officer, is the Deputy Chair of the HWB.

A Place Board which oversees the delivery of health and wellbeing strategies at Place has been established and reports to the Health and Wellbeing Board. The Board is responsible for the use of the Better Care Fund, Adult Social Care Discharge Fund and has oversight on the delivery of ICB priorities at Place on behalf of the Health and Wellbeing Board.

A Place Plan which reflects the ambitions of the Joint Health and Wellbeing Strategy and informs the ICS's Integrated Care Strategy, has been published. The Plan is informed by the joint strategic needs assessment and population health information. It sets out the priority health and wellbeing outcomes for the local population. It commits to three key priorities for:

- **Promoting fairness and community cohesion** – tackling inequalities and the wider determinants of health and wellbeing.
- **Living well** – improving access and supporting healthy choices;
- **Ageing well** – supporting independence for older people; and

The HWB has agreed the priority outcomes for 2023-24 as follows:

- Primary care access, including dentistry;
- Cancer diagnosis and improving outcomes;
- Mental health, learning disability and autism (all ages);
- Children's mental health and emotional wellbeing;
- Excess weight; and
- Working together 'one team' approach for intermediate care services.

The HWB receives a regular update from the ICB on how it is working to support the delivery of Place priorities as reflected in the joint health and wellbeing strategies and on the development of joint forward plans. The HWB provides Place leadership on issues which support primary care access and pressures. It works with local politicians to communicate with residents on the new roles in primary care.

The Place Board has worked with the ICB to develop an action plan to improve the discharge process and flow of medically fit residents from its Acute Trusts.

The Place Board oversees the ICB funded multi-agency population health management programme in Central Bedfordshire. The programme aims to improve the mental health of vulnerable young people, taking a Population Health Management approach to target evidence-based interventions for young people aged 16 to 25 years who are most in need of mental health support.

The Place Board has continued investment in its community referral programme for community referral using Community Wellbeing Champions in alignment with the Primary Care Networks link workers. It is using a collaborative, multi-disciplinary approach to create 'one integrated team' across a Primary Care Network and neighbourhood footprint and is refining a model for delivering integrated outcomes for people. There is ongoing work, in partnership with the ICB, to develop the concept of Place, in Central Bedfordshire.

Progress in Central Bedfordshire

There was early progress in the development of a multi-disciplinary approach for co-located services. This was focused on management of frailty, long-term conditions and mental health issues in children and young people. A population health approach was used to cover the Chiltern Hills Primary Care Network, which has a population of around 55,000 people.

Central Bedfordshire worked with the ICB to deliver a programme of integrated health and care hubs. They enable the co-location of multidisciplinary teams to facilitate delivery of more community based, joined-up services.

The Grove View integrated health and care hub was completed in March 2023.It is a purpose-built centre for primary care and other services. It supports Priory Gardens Surgery and wider PCN services for Dunstable and surrounding towns and villages. It is designed to support new ways of working and has the flexibility to meet demands from a growing population.

Central Bedfordshire Place hosts the ICB's programme for Digitising Social Care on behalf of the four places within Bedfordshire, Luton and Milton Keynes. In its first year, the programme achieved the requirement for 60% of adult social care providers to have a digitised care management system.

Luton – Place Foreword

Luton has a long history of partners developing collaborative approaches to joint planning and delivering of health, social care, public health services and other partnership services.

Arrangements in Luton have historically gone beyond strategic planning. They include shared roles, joint commissioning between local authorities and the NHS, and integrated service delivery by a range of providers. This has been enabled and supported through a comprehensive agreement to pool funds between the local authority and the ICB, the Better Care Fund, and collective governance, through the Health and Wellbeing Board, the Joint Strategic Commissioning Group and the associated Joint Financial sub-Group.

The Luton Place Board Partnership has utilised the longstanding working relationships between partners. It aims to strengthen the strategic cohesion, as set out in the Luton Population and Wellbeing Strategy, the Luton 2040 Plan, the Bedfordshire, Luton and Milton Keynes ICS priorities.

The Partnership Board aims to reinforce the shared ambition to deliver the best care and outcomes possible for the people living in the Borough of Luton. This is through the seven co-designed strategic aims and the four key priorities: early prevention and interventions, supporting timely access to health and care needs, empowering people to build resilience and personalised support to people with complex health and care needs.

The ICB has focussed on supporting the development of the town-wide vision for Luton 2040 which is a place where everyone thrives, and no-one is living in poverty.

By 2040, the vision is for Luton to be a healthy, fair and sustainable town, where everyone can thrive and no-one has to live in poverty.

This vision is supported by three priorities:

- A town built on fairness – tackling inequality;
- A child friendly town – investing in young people; and
- A carbon neutral town – addressing the impact of climate change.

The Luton Place Board membership has expanded over the last year. It means it has the right people around the table including the six Primary Care Network clinical directors to support the collective wellbeing agenda. In addition to core membership, specialist partners are regularly invited to support specific areas of work.

The Board works is guided by the latest evidence on integrating primary care within the health, care and VCSE and the Marmot Town report to reduce health inequalities in Luton. The Marmot Town report was published by the Institute of Health Equity, part of UCL, a leading university.

Luton is the first town to become a 'Marmot Town' and joins a growing number of 'Marmot Places', which include cities and regions, that are working with the Institute of Health Equity to reduce health inequalities. A Marmot place is one which has a significant commitment to tackle health inequalities through action on the social determinants of health - the social and economic conditions which shape our health - and has strong and effective plans and policies to achieve these reductions in health inequalities. The Place Board also works in tandem with other Luton boards, covering inequalities in children's health issues.

Collaboration with VCSE partners is critical to the Board's work. Members are currently working to strengthen links with other local partners including the fire, probation and police service.

The Luton Place Board has developed a place plan which commits to:

- Giving every child the best start in life;
- Sustainable communities, and tackling inequalities; and
- Reducing frailty and supporting independence.

An operational plan was developed, utilising the existing community assets to support the delivery of the priorities identified in the Luton place plan. Success measures, focused on the positive impact to residents, continue to be co-designed to monitor progress and the impact to local people.

Milton Keynes – Place Foreword

The Milton Keynes Health and Care Partnership performs two functions as part of the local Integrated Care System.

It delivers the functions of the MK Health and Wellbeing Board and the MK Place Based Partnership. The MK Deal is an agreement made in October 2022 between the ICB and the MK Health and Care

Partnership. It is the first agreement of its kind in Bedfordshire, Luton and Milton Keynes. It is helping to shape future ways of working across the system. The MK Deal formalises the commitment of the main local NHS partners and the City Council to work more closely together.

It has three key aims:

- Closer working;
- Driving forward change in local priorities; and
- Establishing a clear remit and resourcing.

MK Deal priorities are:

- **Improving system flow** – with a focus on urgent and emergency care services for older, frail or complex service users. It aims to develop an integrated multi-disciplinary team 'without walls' to provide more effective joined-up care for residents;
- **Tackling obesity** – helping people to maintain a healthy weight through accessible weight management programmes, using technology, pharmacological therapies and education and prevention work. It includes a digital incentive scheme to promote physical activity to at least 600 residents with type 2 diabetes;
- **Children and young people's mental health** – is aiming to make it easier for residents to access appropriate help by working in a more integrated way; and
- **Complex care** – work is underway to scope and launch the fourth priority of complex care. The aim is to develop an integrated approach to the funding and case management of children, young people and adults who have complex needs to improve their outcomes and experience.

MK partners are developing a potential an additional priority on **locality working** – this relates to the development of integrated neighbourhood teams. Milton Keynes is developing a proposal to take a pathfinder approach to this work across the city. Integrated neighbourhood teams will bring together a wide range of partners from health, social care, VCSE, housing, schools and potentially others services such as the police and fire service to provide joined-up services to local residents. Integrated working would focus on prevention and supporting people, families and communities with more complex longer- term needs.

A Joint Leadership Team has been established, bringing together partners from across MK including MK City Council's CEO, Director of Adult Services, Director of Public Health, MK University Hospital's CEO and Medical Director, CNWL's Director of Strategy and Divisional Director, Clinical Directors from two Primary Care Networks and the ICB Place Link Director and Head of MK Improvement Action Team. VCSE and Healthwatch colleagues are involved in the delivery of the workstreams which are led by members of the Joint Leadership Team.

Working with people and organisations across our community

Bedfordshire Care Alliance

The Bedfordshire Care Alliance (BCA) is an emergent provider collaborative and Committee of the Board of the ICB. Its membership includes Bedfordshire Hospitals Trust, East London NHS Foundation Trust, Cambridgeshire Community Services NHS Trust, Primary Care Networks, the three Councils in Bedfordshire, the ICB and Healthwatch.

It has been established to identify and transform services at scale across Bedfordshire and Luton, whilst recognising local differences, for example digital transformation. The BCA has identified the following priorities:

The following priorities have been agreed for 2023/24:

- Digital and data: focusing on the local implementation of data, the digital and population health management strategies, and shared care records.
- Frailty and complex care: focusing on falls, end of life care, developing interface services, such as same-day emergency care with residents and developing a care model which anticipates needs, and virtual wards.
- Workforce: focusing on careers promotion, pastoral support, international recruitment, apprenticeships and collaborative banks, which is a way of sharing staff with each other across systems.

Mental health, learning disability and autism collaborative

A mental health, learning disability and autism collaborative is being established by two NHS Trusts providing services in our area.

East London NHS Foundation Trust provides mental health services in Bedfordshire and Luton, while Central and North West London NHS Foundation Trust provides these services in Milton Keynes. They have worked collaboratively on the mental health programme since 2015.

A proposal to start detailed design and planning for the collaborative was endorsed by the ICB in November 2022.

A full proposal is being developed with service users and system partners. This will create an operating environment that brings together expertise across the system to deliver the best possible outcomes for our residents.

The design process will seek to understand and develop thinking on the role of collaboration in planning services to meet the needs of people with learning disabilities and autism. Planning and design work around learning disabilities and autism is less advanced than for mental health. Engagement with key stakeholders from the ICB and Places in the early part of 2023/24 will further scope this out.

There is a “one team” approach across commissioners, providers and local authorities in the development of the collaborative to best serve the needs of residents. The collaborative will initially be established as a committee of the Board of the ICB in 2023/24. One of the key successes of the year was setting up the Evergreen mental health inpatient unit for children and young people in Luton. For more on this go to page 35.

Voluntary, community and social enterprises – providing support where you are

The voluntary, community and social enterprise (VCSE) sector plays a vital role in supporting people to stay well, and lead independent lives, and in improving health and care outcomes for people in our area.

There is an estimated 4,000 VCSE organisations in across Bedfordshire, Luton and Milton Keynes, ranging from national charities to small groups established for specific interests, issues or neighbourhoods.

They work in a huge range of areas, such as in mental health partnership working, for children and young people, bereavement support and adult crisis care.

Now, the VCSE sector is an equal partner with strategic organisations in the new Health and Care Partnership. A memorandum of understanding between the VCSE and the Integrated Care Board was agreed in November 2022. This is a formal statement of our commitment to working together.

The pandemic saw VCSE organisations step up to help residents. Where there was a gap in provision, new community groups were created, such as the Leighton Linslade Helpers. This group were very active in helping local people, and even created a foodbank and community kitchen to make sure that people had the food they needed.

VCSE organisations have been supporting mental health projects across our area. This has included projects for children and young people, bereavement, dementia, advocacy, suicide prevention and digital.

The ICB has 16 organisations actively involved in initiatives to prevent suicide. This is the biggest cause of death of men and women aged 20-34. An example is YiS Young People's Mental Health which provides counselling for young people at risk of suicide. Another programme is Boxing Saves Lives, which uses boxing to improve mental health, build confidence and reduce harmful behaviours. Other programmes help people to maintain good health and wellbeing, through a range of interventions in a variety of settings.

We have invested in more people and resources so that these organisations have the right support in place. This includes a part-time lead and full-time support role.

For much of the sector, this means more engagement in place-based working and further involvement in delivering projects.

VCSE's co-production and engagement work will be an important part of delivering our people and communities strategy. Having representatives on the ICB's Working with People and Communities Committee strengthens the role of the VCSE in our governance.

A process for engaging the wider VCSE sector in the work of the committee has been developed. It is recognised that organisations can help understanding residents' lived experience or providing services. Principles for engaging and resourcing the VCSE to carry out these different roles are being developed with the VCSE strategy group.

Melanie Hawman, Chief Executive Officer of the Disability Resource Centre, Bedfordshire, said:

"We are highly motivated to help residents with a disability or health condition have access to the tools and support they need to live fulfilled and healthy lives.

We do this by working with partners across the health and care system, from the ICB through to Healthwatch and a variety of VCSE organisations. We value the ICB's proactive approach to making sure that system-wide working is facilitated.

This collaborative way of working is the best way to provide a personalised support for individual health and care needs and we look forward to this way of working becoming even stronger in the coming years."

Clare Walton, Chief Executive of Community Action: MK, said:

"We are the local infrastructure organisation for groups in Milton Keynes. Our work with the ICS enables VCSE organisations to be involved in designing and delivering health and wellbeing support in communities.

"We facilitate the MK Mental Health Alliance as part of Community Mental Health Transformation. Groups tell us this integrated way of working is changing the relationship between the VCSE and the public sector. Approximately £300k of NHS funding has been invested in the Mental Health Alliance to deliver support through VCSE organisations and the infrastructure to coordinate the sector.

"We think that this approach to partnership working offers a blueprint for all community health services."

Promoting integration

Joining up services and making them more accessible

We are committed to integrating our services so that residents receive a joined-up health and care service. This should improve the experience and outcomes for residents.

We aim to deliver services as close to people as possible. This would typically be in one of our four places

Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. We think that this approach is the best way to improve the health and wellbeing of the population moving forward. It will create a safe and sustainable health and care system that is fit for the future.

For example, delivering effective primary care requires close working between partners across health and care. This includes partners in public health, local authorities, community and mental health services, and the voluntary sector. Our goal is clear: more responsive and accessible primary care services, delivered by those best able to understand – and meet – the health and wellbeing needs of the local communities they are proud to serve.

Pooled budgets are hosted with the four local authorities and are for community equipment services, the learning disability service (in Luton and Milton Keynes), children services (in Luton), the Better Care fund, winter funds and discharge arrangements, please see more information in our Accounts page 25. Pooled budgets enable joint commissioning and commissioning of integrated services. This allows resources to be used more effectively; therefore improving the quality and efficiency of health and social care services provided. These agreements operationalise and prioritise the aims of the joint health and wellbeing strategies across each local authority area within BLMK.

At the heart of this collaborative approach is co-production. This is a way of working with residents and people in the health and care system to design services which meet the needs of people in the neighbourhoods they call home.

Integrated health and care strategy

How we will reduce health inequalities and improve health outcomes

The Bedfordshire, Luton and Milton Keynes Integrated Health and Care Partnership Strategy was published at the start of January 2023.

It sets out our overall ambition to tackle inequalities and improve health outcomes for all residents. Our overarching goal is to help people who live in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes to live longer, healthier lives, as well as reducing inequalities across our populations.

The strategy aims to:

- Reflect our strategic priorities (see graphic earlier);
- Deliver our commitment to subsidiarity, which means planning, making decisions and delivering services as close to the resident as possible, in the place they live in;
- Emphasise our ambition to go further using our partnerships to support residents to live longer, and live more years in good health. It also underlines the central role played by

voluntary, charity and social enterprise (VCSE) partners in supporting residents to thrive; and
- Speak to real examples that make a difference to local people.

We will achieve these aims by:

- **Reviewing of existing strategies and plans** – including health and wellbeing strategies, place plans and joint strategic needs assessments
- **Analysing our population data** – identifying those areas where we are adrift from the national average, identifying opportunities where improvements could be made
- **Engaging with our partners** – to identify the priorities and plans we need to reflect in our strategy, and to shape our ambitions for improving population health and how we can work as a system to achieve this; and
- **Listening to the views of our people and communities** – drawn together through a review of existing insight and follow-up engagement with specific groups.

Our area is one of the fastest growing areas in the country, with approximately 6,000 homes expected to be built every year for the next decade. This growth in population is expected to add to the health inequalities in BLMK, with more people coming into the area with their own health and care needs.

To better understand the health inequalities prevalent in our area, we have commissioned a review to understand what the barriers to health are. Led by Reverend Lloyd Denny, a Pastor from Luton, we carried our a Literature Review with the University of Sheffield, which outlined the inequalities experienced in our area and the populations most affected.

In August 2022, engagement work was undertaken to listen to the lived experiences of:

- Gypsy, Roma, Traveller people
- LGBTQI people
- People from ethnic minorities who live in deprived areas
- Women who have experienced forced marriage and serious violence
- People who have physical and learning disabilities and live in areas of deprivation
- Homeless people

The engagement highlighted several common themes including barriers to access, a lack of understanding of how health and care services work, the cultural competency of health and care professionals, challenges with communication and unconscious bias.

The Steering Group, which was established at the start of this programme and includes representatives from local authorities, NHS providers and local residents / advocacy groups is currently working to agree a series of recommendations, which will respond to the insights provided and improve the experience of local people.

Joint forward plan

A plan to tackle difficult challenges with our partners

Integrated care systems have been asked to develop five-year Joint Forward Plans. The first iteration of these plans will be developed with system partners and published by the end of June 2023.

These plans will build on joint strategic needs assessments, health and wellbeing plans and place plans and will benefit from engagement with partners and the public.

The ICB Joint Forward Plan will cover the time period up to 2040, going beyond the NHS five-year requirement to align with local authority planning timelines.

The plan will support delivery of longer-term enablers. These include:

- Understanding our population and inequalities;
- The benefits of digital integration and workforce reform; and
- Forward planning health resources to improve health outcomes.

The Joint Forward Plan will identify our key strategic objectives to address the changing needs of our population within workforce and funding constraints. It will align with the 20–25-year approach to planning used by local authority partners, recognising that the infrastructure and workforce elements will be resolved over longer than a five-year period.

This approach will focus on tackling our most difficult challenges. These include meeting the increased care needs and complex frailty of our population after the pandemic, maximising prevention, and recovering elective waiting times. Other challenges are supporting children and young people experiencing mental illness and acute emotional distress and increasing primary care access and capacity through neighbourhood teams.

The way we use the collective opportunities available through our partnerships will significantly influence our ability to address these challenges sustainably into the long term.

It is expected that this plan will be built around the priority maximum impact interventions identified within updated place plans. On 24 March 2023, the Board agreed our approach to developing the Joint Forward Plan. We will be engaging through Health and Wellbeing Boards on this in spring 2023.

Seeking appropriate advice

How we involve clinical and public health specialists to ensure we meet the needs of residents

As an Integrated Care Board (ICB) we have a duty to seek appropriate advice to work as effectively as possible. We take advice in two main areas:

1. Clinical advice to support the prevention, diagnosis or treatment of illness; and
2. The protection or improvement of public health.

On the Board itself, we have three Primary Medical Services (PMS) Partner Member roles, a Chief Medical Director and a Chief Nursing Officer to ensure that the voice of clinicians is heard. The PMS members currently include a GP and a community pharmacist.

Both Public Health Directors are participant members of our Board. In addition, our Chief Executive is a qualified pharmacist and our Chief Primary Care Officer is a registered nurse.

As part of our governance and Board sub-committee structure we have an established health and care senate. This acts as an advisory body from a range of professions to the ICB. The group meets every three months and makes advice based on the latest evidence. Discussions have included cardiology, head and neck cancer services, falls and polypharmacy. Its work is closely linked to our clinical improvement and transformation agenda. A particular focus is on prevention in line with the Fuller Report into the integration of primary care services and our preferred approach to public health.

Through collaborative working we gain informal advice also, for instance working closely with our Public Health Directors. We also have aligned clinical leadership to all of our programmes of work, including 5 integral Primary Care Strategic Leaders across BLMK. This includes 1 strategic leader for long term conditions, 1 for mental health and learning disability, 1 for access to primary care, 1 for training and development, and 1 for Children and Young People. These 5 BLMK Primary care strategic leaders are working with funded place clinical leads, for GPs to prioritise work local to the needs of that place.

Health and Care Professional leadership charter

The ICB has a health and care professional leadership charter in place detailing.

vision of the charter is to empower current and future health and care professionals to deliver high-quality, compassionate and inclusive care at every level, in the pursuit of improving health and care outcomes for the ICB's local population.

Principles:

1. Integrating health and care professionals in the decision-making at every level of the ICS;
2. Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities;
3. Ensuring our health and care professional leaders have appropriate skills and competencies to carry out their system role(s);
4. Identifying, recruiting and creating a pipeline of health and care professional leaders; and
5. Providing dedicated leadership development for all health and care professionals.

Commitments:

1. Nurture a culture that embraces shared learning and champions collaboration across organisational boundaries;
2. Develop a health and care professional community of practice to enable the identification of health and care leaders to be engaged into system decision making at all levels;
3. Identify current training needs and create new and innovative opportunities to develop and support our clinical and care leaders; and
4. Create a leadership resource from diverse backgrounds that reflects health and care professionals across the system (sub-system, place and neighbourhood).

In addition to the clinical advice available, we also work closely with residents to ensure that their views are included and considered when making decisions. The Working with People and Communities Committee was established in July 2022 and includes representatives from local authorities, the VCSE, Healthwatch and clinicians.

The Committee provides a voice to experts by experience and partners to provide advice on the best way to engage locally and to inform consultation, co-production and engagement on all service changes for the Integrated Care Board, before consulting formally with statutory committees including Health Overview and Scrutiny Committees, and Health and Wellbeing Boards.

The ICB also obtains corporate governance advice from NHSE and from the ICB's legal advisors for queries not covered in available guidance.

Making effective decisions

The Board of the ICB created a number of committees to support it in its functions. These committees are described on page 107 of the Corporate Governance Report. In exercising its functions, the ICB uses a range of sources and intelligence to ensure it makes the most effective decisions possible.

These include:

- The Board explicitly includes among its membership representatives from partner organisations, such as NHS providers, local authorities and the voluntary and community sector, so that their views inform decision-making;
- The finance and investment committee advises the Board on value for money and effective uses of resources;
- The quality and performance committee advises the Board on service quality and improving patient experience;
- For policies, programmes, projects or savings schemes, a two-stage quality impact assessment is undertaken. This includes screening the proposal and then, if quality implications are identified, reviewing it from safety, clinical effectiveness and patient and wider population experience and involvement perspectives, seeking mitigations where patient quality may be impacted. It is signed off by either the Chief Nursing Director or Chief Medical Director before a decision is made;
- The audit and risk assurance committee provides assurance to the Board by reviewing overall governance arrangements including the risk management framework and ensuring good financial management;

- The working with people and communities committee' provides assurance to the Board that residents are involved in decisions on the planning and delivery of health and care services in all four places; and
- There are strong and growing relationships between our four places and the ICB Board. Regular reports on the work of the ICB are presented to the place boards, or equivalent, and they are encouraged to raise any issues with the Board.
- The use of a standard cover template for Board reports for authors to demonstrate which of the ICB's strategic priorities the report addresses; and
- The template also requires authors to describe how the report will address inequalities, Green Plan commitments and identify any financial, workforce and other resource implications.

Keeping the experience of members under review

As a new organisation, arrangements for Board succession and the development of individual board members are still to be fully established. However, the following activities have already taken place:

- A robust appointment process so that all Board members have the necessary experience and expertise;
- Board members were offered induction sessions on key areas of the ICB's role and functions;
- All Board members subject to the fit and proper persons regulations and make a declaration upon appointment stating that they comply with them; and
- Board seminars are held to help to develop members' knowledge, and to support team building and collaborative ways of working.

The remuneration committee has responsibility for reviewing the talent on the Board and determining succession planning.

Performance summary

Stand-out stories of how we have worked with partners to improve health and care outcomes in 2022/23

Since the Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) was established in July 2022, we have worked with partners across the system to improve access and experience to help people who live in our area live longer lives in good health.

Some of our successes in responding to areas for improvement identified by our residents and partners include:

Support to care homes - We have introduced digital WHZAN boxes, which monitor patients and highlight early warning signs to prevent deterioration in health. We are also rolling out a yellow bracelet scheme to care home residents which provides instant access to health records for staff, raiser chairs to lift patients after a fall and acoustic monitoring to help alert staff to patient needs during the night. More information on page 65.

Digitising care for children – A new app called 'Patient Knows Best' has been released to support the parents of children with epilepsy. The app allows parents to record their child's medication and log seizures so that they can spot early warning signs or triggers.

Cancer outcomes – we are rolling out the Lung Health check scheme in areas where there is poor take up of screening and where cancer diagnosis often comes as late as stage 4. As a result, we have seen an increase in the numbers of people accessing screening and early diagnosis of lung cancer in those accessing the lung health check.

Cancer community connectors – working with Macmillan, we have introduced an innovative new scheme to recruit community connectors who work with South Asian, Black and Caribbean and Eastern European communities, where cancer outcomes are poorest. The Community Connectors help people who have been diagnosed with and are receiving treatment and care for cancer.

The Shine Programme – we have taken the ShinyMind app, which was developed and co-created with NHS Staff into primary care so that we can improve and empower staff wellbeing and resilience. A confidential research questionnaire found that 91% of staff engaging with the programme improved their health and wellbeing and 64% of users said that after using the app, they would continue to work in primary care.

Acting on feedback – we have undertaken an extensive engagement review into health inequalities and listened to local people about the barriers to health. We are acting on this feedback by rolling out training to primary care to help them better understand and support people who are deaf and transgender.

Guide to services

It's important that residents know which is the right service to access. For this reason, we have developed our Guide to local health services, which includes information on self-care, the NHS app, accessing information online, through to GP services, urgent care services, and who to access in case of a mental health crisis. It also includes information for parents and carers about what signs and symptoms to look out for if a child becomes ill, with a traffic light system to indicate the level of urgency required.

Primary care

How we are improving primary care services for residents. This includes the work of the Primary Care Networks (PCNs) to deliver services in our communities.

Accessing appointments in primary care has been a challenge for residents since the pandemic, as demand for care has increased. More residents in Bedfordshire, Luton and Milton Keynes are living with pain while on waiting lists for elective care. This is putting existing services under pressure. However, primary care teams have been working hard to tackle this for residents.

In this reporting period, we have supported with the recruitment of new first practitioners for PCNs including physiotherapists, paramedics, physicians' associates, health and wellbeing coaches and care coordinators.

Through the Nursing Associate Training Programme, we're also supporting healthcare assistants in upskilling and achieving further qualifications to help them provide additional support in primary care. In February, we were delighted to welcome Health Minister, Will Quince MP, to Bedford during National Apprenticeship Week to celebrate the achievement of 25 nursing associates who had achieved new qualifications and were working in general practice across the system.

Will Quince MP with Nursing Associates, February 2023

In addition to adding capacity through the workforce, we are rolling out new telephony across practices in the ICB area. This will increase capacity and reduce the number of dropped calls while increasing the number of available appointments. We were successful in increasing the number of appointments by 17,000 to January 2023, compared with the same period for the previous year (November 2021 to January 2022).

The primary care team is currently working to bring a long-term solution to challenges in primary care. This will be achieved through the development of the Fuller Neighbourhood programme, which aims to integrate services at place, closer to where people live. In addition to managing pressure in primary care, the ICB has also worked closely with clinical colleagues in general practice to deliver the following programmes of work.

Learning disability health checks

The ICB worked with partners to carry out a successful campaign to increase the numbers of people taking learning disability health checks since the pandemic. The NHS Long Term Plan set an ambition that, by 2023/24, at least 75% of people aged 14 or over with a learning disability will have had an annual health check. For 2022/23, the ICB achieved the target, reaching 75.45%, delivering 3735 health checks. This means more people with learning disabilities are getting the health support they need.

A steering group was established to share performance data and health care inequalities intelligence. This helped commissioners, clinical and nursing leads, and other specialists to make data-driven decisions when addressing healthcare inequalities among the Learning Disability population.

A communications campaign was produced which raised awareness about health checks to children's services, social care, health visiting, families and carers. There were also leaflets and posters produced aimed at different groups, such as young people and their parents or carers, and messages put out on social media.

Acute respiratory hubs

To support winter operational pressures, primary care rapidly mobilised Acute Respiratory Hubs during the Christmas/New Year period. These were delivered either at place level.

Extra capacity was created so that both adults and children who presented with respiratory symptoms could get the care they needed. Between January and March 2023 over 7500 acute respiratory appointments were booked across Bedfordshire, Luton and Milton Keynes, which provided an alternative service to people attending hospital.

MMR vaccination campaign

We have focused on improving the vaccination rate for MMR and worked alongside partner organisation, National Services for Health Improvement, on a project that ran through the pandemic and continued during this year.

This has seen immunisation rates of 92% for children aged two years old who have had one dose. The percentage of children aged five years old who have had two MMR vaccines was 87%. This is below the national target of 95%.

Luton Health and Wellbeing Hub

During the year we set up the Luton Health and Wellbeing Hub in the Mall in the town centre. This is a collaborative public health programme.

The Luton Wellbeing Hub responded to resident's feedback by offering various vaccinations and the opportunity to have records updated all in one place at the same time. The opportunity to speak to a social prescribing link worker about other issues added to the experience. Also, the convenience of a town centre location, adjacent to a supermarket, improved accessibility for many residents. A total of 19,692 COVID-19 vaccinations were delivered at the hub during 2022/23.

Through our Primary Care Networks we now have a range of appointments available to residents up to 8pm Monday to Friday and on Saturdays with a number of PCNs also offering Sunday appointments as well.

The hub was held up as a national exemplar at the King's Fund conference in November 2022.

Over 96% of people said they were "very satisfied" when asked to rate their visit and 94% said they would recommend the hub to a friend.

One person who visited the hub said:

"I was extremely nervous to have my COVID vaccine due to my last reaction and a new fear of needles. However, at the hub I was given a thorough assessment by the nurse and pharmacist, referred to the needle phobia practitioner and was given my vaccination. I was [also referred] for my mental health and living with the long-term condition of cancer."

Helping people with type 2 diabetes

Many of our GP practices have been promoting a resource which helps to educate people about type 2 diabetes.

The NHS England online resource is called 'Healthy Living'. It is an online structured education programme from to help type 2 diabetes patients to understand their condition better and empower them to improve their self-management of their condition.

Last year we asked practices to send a text out to their type 2 diabetes patients signposting to the online resource. In total, four out of five practices of our GP practices took part and 44,000 texts were sent to residents.

People were encouraged to register and access a range of self-management and education resources. Over 4,300 people registered in January and February alone as a result of the campaign. The Bedfordshire, Luton and Milton Keynes area now has the highest registration rate in England to the Healthy Living Programme.

Case study: Janeth - How one Luton woman changed her lifestyle to help prevent diabetes

When Janeth learned she was at risk of type 2 diabetes, she was worried about how it would affect her everyday life. She was referred to the NHS Diabetes Prevention Programme, which refers people at risk onto a nine-month, evidence-based lifestyle change programme.

Janeth said:

"The programme taught me everything I needed to know about nutrition, exercise, habits and motivation. My coach was amazing at explaining things and delivering the sessions. I felt my worries start to disappear as I learnt more about how to live a healthier lifestyle.

"I'm now much happier with my lifestyle and can talk with confidence to people about my health. I've lost 15 lbs…in four months. I feel more energetic and generally better in myself. I will definitely be continuing to follow the programme after I have finished."

Beyond health – helping the whole person

Our Primary Care Networks (PCNs) now employ people who support residents beyond their immediate health needs.

One example of this is a monthly drop-in coffee morning has been launched by East Bedford PCN. The PCN covers some of the most deprived areas of Bedford. This is attended by a variety of people from partner organisations, including the PCN's health and wellbeing coach, to build relationships and link residents with the services and organisations they need.

The first coffee morning was in September 2022, attended by 12 different organisations, and about 25 local residents. It has continued to be a success since then.

Case study: "Sandra's" Coffee Morning Story – East Bedford PCN

How help at a coffee morning helped a carer and her mother

"Sandra" – name changed to protect her identity – is a woman in her 60s from Bedford who cares for her elderly mother, who is living with dementia. She had been struggling for years with caring for her mother and needed some help.

Sandra decided to go to the coffee morning to find out if there was anything that could be done to support her and her mother.

At the event, she was greeted by a friendly group who were interested in listening to her struggles. They assured her that she no longer needs to feel alone and that there is help and support available.

Sandra was introduced to the team from Tibbs Dementia Foundation, a charity which provides a wide range of activities to provide stimulation for people diagnosed with dementia and those who support them.

The team listened to everything she had to say and informed her about the activities and support they could provide. Since then, Sandra and her mother have been attending various activities and support groups each week. She is feeling much more supported and no longer struggling to support her mother.

Case study: Helping a person with dementia live at home and avoid a hospital admission

"Denise" - name changed to protect identity - from Leighton Buzzard, suffers with dementia and it was very important for her to stay at home.

However, her respiratory condition had deteriorated and she was unable to climb the stairs to get to bed. Her main carer, her husband, was elderly and unable to help.

Denise's situation was brought to the attention of the Working Together Leighton Buzzard team (WTLB) via a referral from a Nurse at her GP Practice. WTLB is a programme that brings together GP practices, mental health services and social care to better coordinate care across organisations.

Various professionals within the WTLB team reviewed Denise's case and, following discussion, a joint visit was arranged with the district nurse and social worker for the following day. They undertook a holistic assessment of Denise and created a care plan with input from her husband.

They also made an occupational therapist referral and ordered a new bed so that she could comfortably and safely remain sleeping downstairs.

Denise's husband was also assessed as the main carer and he was offered any necessary support. A review of Denise's medications was undertaken by the community pharmacy technician and, following liaison with her GP, further medications were prescribed in order to improve her respiratory function.

By working together across organisations, the WTLB team managed to co-ordinate a timely and appropriate response for this person and prevented what would otherwise have been a hospital admission.

While primary care has remained challenged for much of this reporting period, we have worked to respond to the feedback from residents and improve services where possible.

You said	We're doing
We can't get through on the phone. My call keeps getting dropped.	We recognise that the telephone systems for a number of our surgeries do not have the technical capacity to meet the demand of calls. We have been able to offer some of our surgeries advanced cloud-based telephony systems to improve the experience of patients trying to contact their practice. Currently we have 46 practices on cloud- based telephony across the system and we are planning to expand this.
We can't access an appointment with our GP	On a busy day general practice teams in our area see 29,000 patients. This reduces to 25,000 on quieter days.
-	We recognise we need to do more to meet demand and we have invested in recruiting into new roles including paramedics, community pharmacists, physios, physician's associates and nursing associates, which frees up GP time to see patients they definitely need to see and bolsters the number of appointments available. Between November 2022 and January 2023, we increased appointments in our general practice teams across our area by 17,000 compared to the same period for the previous year (November 2021 to January 2022).
We can't access face to face appointments with a GP	Practice teams offer a greater range of choice to patients so they can choose whether they would prefer to access a virtual consultation or a face-to-face appointment. The ICS consistently provides a higher number of appointments face to face than the England average. For the period November 2022 to January 2023 80% of all general practice appointments in our area were conducted face to face, compared with the England average of 69%.

There are not enough doctors to see everyone	The shortage of GPs is a national issue. Through our workforce plan, we are working to recruit GPs internationally and through the GP Fellowship Scheme. We are supporting them to stay after they have completed their training. We are also recruiting additional roles to primary care to support capacity and expand the multi-disciplinary team to ensure that we can provide appointments with the right professional for the patients need. Under the Additional Roles scheme over 100 new primary care clinicians have been recruited.
The ICB is not investing enough in primary care	In January, the ICB allocated an additional £1.95m per year to support practices and PCNs across Bedfordshire, Luton and Milton Keynes to improve their premises so they can meet growing demand. This is a 22% increase in our investment in our primary care estate, taking the total to just under £11m a year by 2025/26. This allowed the ICB to support 23 local projects in Bedfordshire, Luton and Milton Keynes that were requested by general practice teams.
We want a Health and Care Hub or additional primary care facilities in our local area	We recognise that there are places where housing and population growth is putting pressure on local surgeries and that some people might have to travel to access same day or urgent care. We have listened carefully to the views and concerns of local people and are working with partners to identify solutions.

Urgent or same day care

Transforming access to urgent or same day care services

Urgent or same day care is needed when a person's life is not at risk but they would benefit from care on the same day they have presented to a healthcare professional.

A same day response is usually provided by primary care services. These include GP practices, out-of- hours services, urgent treatment centres, pharmacies, dentists and mental health services.

The NHS 111 service, available online or by telephone, plays a crucial role in directing a patient to the right service for them. Through NHS 111, a patient may be assessed remotely by a clinician who can give advice and guidance to support self-care.

If the person needs an alternative service then they will be told how they can access it or a referral and booking made for them. On average there are over 1,100 calls to NHS 111 and over 300 online contacts to the service made each day in our area.

Last year, we provided funding to recruit and train additional call handling staff to manage the growth in calls and to provide more clinical staffing.

In May 2022, a major report into improving the integration of primary care services was published by NHS England. The Fuller Stocktake report concluded that inadequate access to urgent care was impacting GP's ability to provide continuity of care to patients who need it most.

The report set out a vision to streamline access to care and advice for people who get ill but only use health services infrequently. This would provide people with more choice about how they access care and make sure it is always available in their community when they need it. We have put a program of work in place to transform access to primary care, including urgent and same day care.

From 1 October 2022, the additional extended access and extended hours primary care services were re-configured into one service offer. This is called enhanced access. The new service is being delivered by Primary Care Networks as part of the PCN Directed Enhanced Service. It is delivering more primary care capacity across the whole of our area.

Adult mental health, learning disabilities and autism

BLMK mental health services have stayed strong in the face of continued pressures have done this through a high level of collaborative working, and a 'one team' approach. This has brought commissioners and providers much closer together and led to improved outcomes, quality and value for residents.

BLMK crisis and inpatient services saw increases both in patient numbers and severity of condition over the past year. We have directed winter, urgent and emergency care funding into the mental health system. This has helped to increase bed availability and flow of patients in particular.

The Mental Health Investment Standard (MHIS) standard requires Integrated Care Boards to increase investment in mental health services at a higher percentage than their overall rise in allocation from NHS England each year. Subject to confirmation through independent audit, the ICB has met the Mental Health Investment Standard (MHIS) in 2022/23. This was achieved

through collaboration with our main providers, creating a funding and investment package to meet our strategic priorities and the needs of residents.

During the year, we received additional funding for specific projects from NHS England and Health Education England. This helped us to deliver service improvements, training and recruitment. Recruitment continues to be a challenge, however, as it has been nationally. To address this, our providers have worked with voluntary, community and social enterprise (VCSE) partners.

We have worked with East London NHS Foundation Trust and our Bedfordshire local authorities to transform how people are supported through Section 117 aftercare. This is care after people come out of hospital for a mental health related reason. We are working with Central and North West London NHS Foundation Trust to take that learning across our system into Milton Keynes.

Making progress on our NHS Long Term Plan commitments

Health checks for people with severe mental illness

The ICB worked with partners to complete 5,353 health checks by the end of March 2023. The Luton GP federation and Bedoc, which helps to provide primary health care appointments in the weekend and evenings, has delivered outreach services. These are for people living with a severe mental illness so they can receive their physical health check.

Evening, weekend and home visiting appointments were offered to meet individual needs. We have worked with Carers in Bedfordshire to appoint a nurse to work specifically with carers and the people they care for so health checks can be completed in a community setting.

Improving dementia diagnosis

The national ambition is to diagnose 66.7% of the estimated number of people thought to have dementia and that those diagnosed and their families have access to post-diagnostic support services.

In our area, 6,373 people are recorded as having dementia which is 63.9% against the number estimated to have the condition. We expect to hit the national ambition in 2023/24.

East London NHS Foundation Trust was part of a national NHS pilot and set up a new specialist dementia diagnosis service in Central Bedfordshire this year.

Through the new programme healthcare professionals seek out care home residents who do not have a dementia diagnosis and ensure they are given a full face-to-face assessment at their home.

The clinician reviews a person’s use of anti-psychotic medication as well as speaking to the care home resident’s family and friends to determine whether they have dementia.

A dementia diagnosis helps NHS and care home staff manage people’s condition better and ensures they are not prescribed unnecessary medication.

Our excellent working relationships with our voluntary sector colleagues remain in place. They continue to offer a range of post-diagnostic interventions to people living with dementia and their carers.

Sharon Jackson, Service Manager Bedford Community Mental Health Services, from the East London NHS Foundation Trust, said: “[The scheme] is important for the communities we serve in Central Bedfordshire, where we have a high population of over 65-year-olds but consistently low numbers of confirmed dementia diagnosis.”

Community mental health transformation

Community support is a way of giving adults with serious mental illness access to new and integrated mental health services.

It includes physical health checks, employment support, psychological therapies, personalised care planning, across a range of care pathways. A pathway is the route a patient for their condition once they have been referred by their GP.

In Milton Keynes, Central and North West London NHS Foundation Trust have supported a series of journey mapping workshops for people with eating disorders. This has had positive feedback and has contributed to developing the eating disorders pathway.

In Bedford, waiting times for a first appointment to access mental health services has been reduced from seven to three weeks. This has been achieved by East London NHS Foundation Trust which has worked with system partners.

In Luton, 85% of people rated mental health services as good or very good in quarter three (latest data available). Service users in Luton are aware of the blended offer combining NHS and charity sector support and are actively requesting these services.

In Central Bedfordshire service users have been given early access to a range of different services ahead of its formal service transformation. This has been achieved through partnership working with charities, community groups and carers.

Helping residents in a time of crisis

People in Bedfordshire, Luton and Milton Keynes are benefitting from access to mental health crisis support 365 days a year thanks to drop-in crisis cafés.

We fund the Mental Health Crisis Cafés, which are delivered by Mind BLMK, working in partnership with East London NHS Foundation Trust and Central North West London NHS Foundation Trust. They can be found across our area, in Bedford, Houghton Regis, Luton and Milton Keynes.

The crisis cafés can support individuals with a range of different mental health problems, including post- traumatic stress disorder (PTSD), bereavement, depression and anxiety.

They are safe, non-judgemental spaces that anyone can drop into if they find themselves in a crisis or mental distress in the evenings. They will be met with a trained mental health worker who will listen and help to identify ways to address any problems they are facing.

Case study: Alice's story of how a crisis café helped her

"Alice" (name changed to protect her identity) is an example of residents who are receiving support from crisis cafés across Bedfordshire, Luton and Milton Keynes. She attended her local Crisis Café over the Christmas period needing crisis support. She was suffering from low mood and anxiety. She reported she was on the verge of breaking point.

Following a discussion with a trained and experienced mental health worker, Alice was able to talk through her problems and the support worker was able to de-escalate and identify the support that she needed. They put a wellbeing plan in place to support her journey to improved mental health. This included making plans for managing her PTSD flashbacks and putting in place coping mechanisms such as cycling, relaxation and socialising.

After attending the Crisis Café, Alice is now feeling more regulated with her moods, and acknowledges the benefits of being able to talk through her problems.

She said:

"This service came at the right time for me. It has been very beneficial with not only Christmas but also helping and substituting the support that I usually have but that was closed for the Christmas period."

Reducing health inequalities – learning disabilities and autism

We have developed a strategy to reduce health inequalities, with a focus on quality improvement.

Face-to-face sessions have been arranged during March and April with local people with learning disabilities and autism, facilitated by charity or voluntary groups and people participation leads.

Feedback from these sessions will be used to inform the strategy across the system and we have committed to going back to the groups who contributed to show how the information has been used. So far, the group has heard people's stories, some positive and some not so positive. The groups have been energetic and informative with useful insight into the experiences of local people who have learning disabilities and autism and their carers. There is one more planned session to be held in Luton and following this, the information will be pulled together and reviewed before we feedback to stakeholders and plan next steps.

Alongside the feedback from local people, the strategy will take the emerging themes and learning from the learning from lives and deaths programme to inform strategic priorities at a local level.

Two important projects have been developed already as a result of this work:

1. **Reducing health inequalities link worker project**

This project aims to get a detailed understanding of the experience of people with learning disabilities and autism and their carers and families. The particular focus is on access to health and care services so that services can be improved and barriers eliminated based on residents' experiences.

2. **Autism Bedfordshire diabetes project**

This project is led by people with autism, supported by the voluntary sector. The aim is to give people with autism access to information about type 2 diabetes. Short videos are being created for people to access at home.

This provides an alternative to group sessions and allows carers and families of people with autism to also access the right information and support people with diabetes. People with learning disabilities and autism will design the videos' content to make sure they are fit for purpose and useful to the intended audience.

Learning disabilities and autism – transforming care for children and young people and adults

Transforming care is all about improving services so that more people with a learning disability and autism can live in the community, with the right support close to home. This means fewer people will need to go into hospital for their care.

The ICB is committed to making sure that children, young people and adults with a learning disability or autism have the same opportunities as anyone else. For those people with the highest needs, we want to ensure the support they require is available in their community and, in particular, for children and young people where it is safe for them to remain at home. If a hospital admission is needed we want them to be discharged back to their home as quickly as possible.

As part of NHS England regional commitments we have continued to deliver the NHS Long Term Plan for children, young people and adults with learning disabilities and autism. We work to maintain our children, young people and our adult inpatient NHS England targets to minimise the number of admissions to and stays in hospital.

The ICB has established a new intensive support team for children who become very unwell. The team can provide daily visits to a young person's home, if needed, and intensive therapeutic interventions to reduce or avoid crisis. During 2022/23, we saw the positive impact of this increased support in the reduction of young people being admitted as inpatients in mental health hospitals. We will start 2023/24 having finally achieved our expected admission rate of three patients at any one time as an outcome of this investment.

The ICB carried out in-depth safe and wellbeing reviews for all inpatients from October to December 2022. We conducted a length-of-stay review in early 2023 for inpatients who had been in hospital for over three years. Actions were implemented promptly following these reviews.

People with a learning disability often have poorer physical and mental health than other people. An annual health check can improve people's health with earlier identification of health concerns. The NHS Long Term Plan set an ambition that by 2023/24, at least 75% of people aged 14 or over with a learning disability will have had an annual health check. In 2022/23 BLMK achieved the target reaching 75.5%.

We continued to work in collaboration with primary care and health facilitation teams across the Integrated Care System so that people with a learning disability have an annual health check and health action plan.

The quality of health action plans has improved. We worked closely with health facilitation teams to visit surgeries not offering annual health checks and identifying hard-to-reach communities and those people less likely to have a learning disability check.

During 2022/23, the ICB expanded its key worker function to support young people up to the age of 25 who are at most risk of admission. It was previously only available for children up to the age of 17. It

enables families to be fully involved in the care planning for their child. It supports people to access health, education and local authority services. All children and young people who are inpatients and on the dynamic support register had an allocated keyworker. This follows a successful pilot and work focusing on 18-25 year olds, looked after children, and at risk children. Reduced numbers of children and young people patients has been a result of work between commissioners to work with care co-ordinators on delayed discharges.

The review of lives and deaths quality assurance panel looked at key episodes of health and social care the person received. The reviews identified areas of good practice and areas that need improvement, which were shared with our partners.

Learning disability and autism training for staff

The Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role. The Oliver McGowan mandatory training on learning disability and autism has been co-produced, trialled, independently evaluated and will be co-delivered by trainers with lived experience of learning disability and autism.

The Oliver McGowan training is the Government's preferred and recommended training for health and social care staff to undertake. Whilst mandatory training remain the responsibility of the employer, the ICB has received funding to support the set-up and initial roll-out of the training. It uses a 'train the trainer' model, where the initial three people trained, themselves train other groups of three. Each trio comprises a lead trainer, and two experts by experience, one with autism and one with a learning disability.

The ICB has partnered with our charity partner Autism Bedfordshire to deliver the first wave of the programme roll-out across the system throughout 2023/24. Autism Bedfordshire will offer training and utilise any extra capacity to train frontline staff.

Children and young people transitioning to adult services

The ICB received grant funding and prioritised children and young people transitioning to adult services. This decision was due to the high number of children and young people in inpatients and followed advice from NHS England East of England region. We worked with Autism Bedfordshire to fund personal health budgets to children in our area. Due to the high amount requested we reviewed the costs creatively and used other funding, as well as looking to support some additional personal health budgets for children and young people. These small grants helped to facilitate hospital discharge and prevent admissions, offering truly personalised support.

Learning disabilities pilot

We launched a pilot to improve quality and wellbeing for people with complex learning disabilities and autism across our area last year.

The two-year project is a partnership with the ICB and East London NHS Foundation Trust, under the Transforming Care Programme.

We used a phased approach to introducing the programme, starting with Bedford and Central Bedfordshire, with Milton Keynes added from January. The final phase will bring the project to Luton.

The aim is to ensure that people supported through the programme receive higher quality and timely support in the community. This is done through bringing expertise together.

We have had positive feedback and are exploring ways to work with local universities to create student placements within the team for trainee learning disability / mental health nurses and social workers.

Children and young people

How we have delivered a range of successful interventions for children and young people

In this section we detail a range of work to support children and young people.
This links to our work on reducing inequalities work, known as Core20+5, which is found on page 79.

Healthier Together

Young people and their parents or carers can be concerned by a broad range of subjects. They range from common childhood illnesses, childhood development, mental health, sexual health and many others. It is a common complaint of young people and parents that it can be difficult to find trusted and reliable information regarding their health concerns.

Our Healthier Together website provides clinically validated information in an accessible format - available within a few clicks. Information is set out in a way that is easy to understand. Young people were consulted on the topics of interest and format, and the website facilitates translation into over 100 languages.

The website aims to make useful information easily available to concerned young people and parents, therefore offering help and reassurance, and promoting appropriate service use.

Plans are in place to further develop the website. This will add more information, and a section dedicated to providing relevant information for clinicians.

The website has been through a soft-launch in this reporting period. There will be a full public launch in 2023/24.

Responding to strep A infections among children and young people

Early winter saw a spike in the number of cases of streptococcus A (strep A) infections, which can be potentially very serious in children. The outbreak triggered a national and local response.

Our children and young people's resilience group stepped up its activities. The group includes all acute, community, mental health, public health, and other services as required. The group ensured that system partners had the latest guidance and gave a quick route for questions and discussion.

It also facilitated information sharing, such as where there was supply available of medications, and made sure that a consistent message was being given across the system, and for parents in need of reassurance.

It met weekly so that system partners had the latest guidance, infection rates and the actions being taken locally. The group also co-ordinated the system response.

Training was quickly arranged and delivered for GPs to help understand the symptoms. Local protocols were put in place for children with potential strep A infections.

Information for parents were communicated through providers to promote the prompt diagnosis and treatment of strep A, with reassurance where infection was not indicated.

In line with national guidance, acute respiratory infection hubs were established. The guidance relevant to children and young people was built into the operating procedures for local services. This made sure that children and young people were well served by this service.

New mental health inpatient unit for children and young people

A new acute mental health inpatient unit for children and young people across Bedfordshire, Luton and Milton Keynes opened in February 2023.

Funding of £17m has been provided by NHS England to create a dedicated centre in our area for the first time, keeping children and young people close to their loved ones.

The interim, eight-bed centre will provide specialist, short-term care for children and young people with severe or complex mental health difficulties.

The funding is to establish, staff and run the centre for three years. The unit will also be open to admissions for children and young people under the care of other NHS services across the East of England.

East London NHS Foundation Trust (ELFT), which provides mental health services in Bedfordshire and Luton, is the project lead. ELFT is working in partnership with Central and North West London Foundation Trust (CNWL), which provides mental health services in Milton Keynes, and with the ICB.

The interim unit is based at the Luton Centre for Mental Health, part of the Luton & Dunstable Hospital site.

Its development was completed in partnership with service users and carers, who have chosen the name ‘Evergreen’ for the unit.

Partners are also developing a long-term plan to provide a permanent inpatient unit for children and young people within Bedfordshire, Luton and Milton Keynes, which would replace this interim service.

Staff recruitment began in May 2022. Clinical guidelines, a service philosophy, a young persons’ welcome pack and activities calendar was produced in autumn 2022.

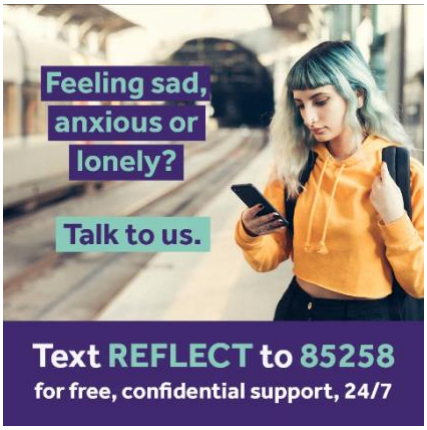
Designs and decorations for the unit were chosen by young people. Staff were given autism training, and gender identity training by experts by experience.

ELFT Chief Executive Paul Calaminus said:

"Establishing an inpatient unit is a huge step forward in how we care for children and young people across the East of England.

"This will enable those young people who need specialist help and support to stay close to their loved ones, friends and school – which can play a significant part in helping them with their recovery."

Digital mental health support offer



A new digital support offer for children and young people was launched in February 2023.

It is a simple to access service. All users have to do is text REFLECT to 85258 to get free, around-the- clock support.

We developed the service in partnership with local authority public health teams. It followed an evaluation of mental health advice and support services.

The REFLECT service was developed with young people's feedback from focus groups, and from an online survey of professionals who work with young people such as teachers and clinicians.

Young people said that getting a response straight away if needed was important. Being able to access advice and support directly without waiting lists or a referral process was also raised. In addition, they felt 24/7 support was important, as young people reported finding night times the hardest and when they felt there was no place to which they could turn.

Professionals also raised the importance of 24-hour access for digital services and flexible opening times, including weekends.

The recommendations for future provision including:

- Provision is required for 11-to 25-year-olds;
- A mix of online and face to face provision is required;
- Digital provision should be out of school hours, ideally 24/7 and responsive; and
- Face-to-face provision should offer peer support and facilitated group activities

The move to this provision has been delivered through a process of joint evaluation, where the voice of young people has been taken into consideration and through joint commissioning arrangements with our Local Councils.

Tackling depression and obesity with MK Dons - An innovative scheme to help improve young people's health

We know exercise can help to improve mental and physical health.

To help with this issue, we worked with partners to launch an innovative new scheme to help young people to tackle obesity, depression and social isolation in Milton Keynes.

The partnership is between the ICB, MK Dons Sport and Education Trust, and Milton Keynes Council. It brings together coaches, mentors and mental health professionals to help young people learn new skills, develop confidence so they can live healthier lives.

The programme offers young people a safe place to talk about their thoughts, feelings and mental health self-management techniques, while developing their football skills.

Kelly Day, Inclusion Manager, MK Dons Sport Education Trust, said:

"Many young people experience everyday battles that we often can't see. Through the power of football, we're helping young people from all backgrounds in Milton Keynes to break down barriers, get active and take steps to helping to manage their own mental health."

Case Study: Ahmad's experience - how playing football improved his health

"Ahmad" - name changed to protect his identity- is a refugee from Afghanistan and lives in Milton Keynes. He has struggled with his mental health for some time and decided to attend the programme after MK Dons Sport Education Trust contacted his community. This followed a request for mental health and wellbeing support in the refugee community from local GPs.

Ahmad attended the first session, bringing along a few friends from his community. They did not have the correct footwear so were given football boots so they could take part. He played a vital role throughout the sessions, translating the conversation for his friends from the coaches and to enjoy the training session.

The sessions enabled Ahmad to play football regularly, significantly improving his fitness. It has boosted his confidence to go out more, make friends and follower a healthier diet.

Ahmad said:

"Since being in England, I have found it hard to be happy. MK Dons Sport Education Trust have helped me with this by letting me play football and helping me with the football boots. I recommend this to anyone. It does help and I have now found some more friends."

Preconception care

Helping people to be in good health before conceiving a baby

As part of the drive to reduce the gap in health inequalities, the local maternity and neonatal system in the ICB area has initiated a year-long programme with the overall aim of raising the awareness and importance of being in the best health possible before, during and after pregnancy.

Preconception health relates to the behaviours, risk factors and other factors for women and men of reproductive age which impact on maternal, infant and child outcomes.

There are a wide range of factors which can have an effect. These include maternal weight and age, smoking, alcohol and substance misuse and domestic violence. Folic acid intake, immunisations, long- term physical and mental health conditions, previous pregnancy complications, consanguineous relationships (between two individuals who are related as second cousins or closer) can all influence these outcomes.

Preconception care primarily aims to improve maternal and child outcomes through better planning and fitness for pregnancy. It also brings health benefits to children, young people and adults, both female and male, irrespective of their plans to become parents.

Preconception care is not a new service. It is about making sure that services promote healthy behaviours and support early interventions to manage emerging risks across a person's life, prior to first pregnancy, and then looking ahead to the next baby and beyond.

In February 2023, we held a launch event to commence a focus on preconception care. The aim of the event was to:

- Connect and network with system stakeholders;
- Work together to identify opportunities to support future parents to be in the best health possible;
- Identify ways to work across the system to deliver the outcomes we aspire to for our residents;
- Reflect on our areas of work and roles and what we can do to contribute to the overall aim; and
- Share information on the change ideas and improvements such as the Tommy's Preconception tool and preconception clinics, we are beginning to work on.
- The event also included a keynote speech from Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer for NHS England and was an opportunity for our system stakeholders to hear the national perspective on improving health before pregnancy.

By the end of 2023/24, Bedfordshire, Luton and Milton Keynes residents who are thinking about getting pregnant will be aware of and able to access resources and support. This includes the Tommy's Preconception tool, speaking to pharmacists about optimising management of diabetes or speaking to a healthcare professional or consultant for advice about pre-existing health conditions before becoming pregnant.

This will mean that residents will be better informed and in a position to make informed and personalised choices about their preconception journey, pregnancy journey and beyond.

Planned care

How we are cutting waiting lists for planned scans, surgery and treatment

Elective care services are services that are planned, non-urgent and usually delivered in hospitals. They include tests, scans, surgery and cancer treatment.

Waiting lists for these services grew last year as referrals went back up to levels seen before the pandemic. Efforts were made to deliver as many planned treatments as possible whilst having to manage urgent care patients.

Some patients have had to wait more than two years for elective care, which is much longer than we would want. In 2022/23, acute providers worked alongside the ICB and independent sector partners to treat all patients waiting more than two years.

Significant progress has also been made in reducing the number of people waiting over a year-and-a- half for treatments. The position in March 2023 was a total of 50 patients waiting over 78 weeks. Local providers are working hard to reduce that number to zero in the coming months, as well as reduce the number of patients waiting over 65 weeks to zero by March 2024.

Industrial Action undertaken by Registered Nurses and Junior Doctors during this reporting period has unfortunately impacted on waiting times, with some elective procedures being cancelled because of strike action.

During this time, the ICB has worked hard with partners across the system to support the delivery of a safe service and where possible keep disruption to a minimum. Local authorities, acute hospital trusts and the ICB have worked together to look for safe and supported discharge of patients to keep the system flowing and Registered Nurses and GPs from the ICB have been released from their duties to cover shifts in hospitals.

Patient-initiated follow-ups

The ICB has made changes to the way it has delivered outpatient care, with nearly 14,000 appointments (3.4% of total follow-ups) coming through patient-initiated follow-ups. This is when a patient asks for an appointment when they need one, based on their symptoms and circumstances. Patient-initiated follow- ups improves people's experience and outcomes.

In addition, around 195,000 appointments were delivered by video call through a phone, tablet or laptop, improving accessibility and experience of care whilst reducing travel implications to the environment, patients and carers.

GPs have also been increasingly getting advice and guidance from consultants. Over 73,000 episodes of advice and guidance contacts were delivered throughout the year, meaning more care could be managed without the need for a referral. The utilisation rate of advice and guidance increased from 17% in 2021/22 to 26% from April 2022 to February 2023.

Feedback from system colleagues, both from those who utilise advice and guidance as well as those who respond to requests, have said that it improves confidence in treating patients through a shared decision- making process. It improves integration between local GPs and consultants as well as reducing inappropriate referrals to secondary care.

Waiting Well

As a result of the pandemic, some patients understandably became concerned about the length of time they were waiting to receive their treatment. To support patients through this difficult time, the Integrated Care Board and hospital Trust partners developed information on average wait times for certain treatments, with links to information that would help people to 'wait well'.

Access to this information can be found at:

My hospital journey – Bedfordshire Hospitals NHS Trust

My Hospital Journey – Milton Keynes University Hospital (mkuh.nhs.uk)

Post-COVID support

The post-COVID assessment service was established in December 2020. The service supports patients suffering from Post-COVID symptoms. The service delivers a multi-disciplinary management approach which is initiated through a detailed virtual assessment and where necessary, a face-to-face assessment.

In 2022, the services had supported nearly 1000 patients to manage their condition, enabling them to address their health needs through a multitude of different providers.

Diagnostic Waits

Diagnostic waits over six weeks remain above the 'no more than 1%' target although significant improvements have been made and currently 67% of patients have waited less than 6 weeks.

Staff shortages and increased demands for scans for elective and cancer care impacted performance.

Magnetic resonance imaging (MRI), cardiology (electrophysiology) and computed tomography (CT) scans were in particular demand. Diagnostic tests for cancer and urgent care were prioritised, alongside all-round access to other diagnostic services. Hospital Trusts continue to work with provider organisations to help more patients get the tests they need.

The system received confirmation of funding to develop community diagnostic centres (CDCs) across our area in January 2022.

They will be in:

- Bedford – North Bedford Health Village;
- Milton Keynes – Lloyds Court; and
- Milton Keynes – Whitehouse Health Centre.

The centres will increase capacity and access to diagnostics to some of our most deprived areas. They will help to improve patient outcomes and provide GPs with direct access to tests that would have ordinarily only been accessible through secondary care. These services will begin to become operational in 2023/24.

Further work to scope a CDC for Luton and South Bedfordshire residents is ongoing with the intention of seeking additional funding during 2023/24.

Percutaneous coronary intervention (PCI)

In July 2022 the ICB undertook a review of Percutaneous Coronary Intervention (PCI) services across BLMK. PCI is a minimally invasive procedure to open blocked arteries in the heart. It consists of a traditional 'Angioplasty' (using a balloon to stretch open a narrowed or blocked artery) coupled with a stent inserted into the artery. This stent remains in place permanently, allowing blood to flow more freely. This combination of angioplasty with stenting is known as PCI. Patients from Milton Keynes told us of their difficulties accessing services outside of Milton Keynes and the impact this was having on them and their families. Delays were occurring due to the lack of availability of beds and the need for an ambulance to transport the patient.

The ICB, in collaboration with Acute Trust partners agreed to develop a local service in Milton Keynes with support from clinicians in Oxford. This service went live in February 2023. Patients who now require a PCI procedure, either on a planned or emergency basis, will receive care at the Milton Keynes Hospital site, provided by the Oxford Satellite Team rather than having to travel out of area. The change will enable a better experience for patients, a quicker waiting time for the procedure, a more localised specialist service and a shorter stay in hospital.

Community musculoskeletal (MSK) and pain services

Community musculoskeletal (MSK) and pain services are currently being reviewed by the ICB. We have worked with residents and system partners to understand what works well, what could be improved and what matters to people as individuals.

An MSK health needs assessment was completed in partnership with public health leads. It described the prevalence of MSK in our area as well as how a rise in risk factors and population growth is expected to increase the demand for MSK.

Patient engagement has been sought throughout the work in developing the MSK case for change. This has included patient surveys, focus groups, one-to-one interviews, and engagement through community events. The feedback highlighted positive experiences, particularly the professionalism and knowledge of the clinicians in the Community MSK service. The areas that were identified for improvement were waiting times, communication, fragmentation of services, access and discharge, life choices and support. The ICB will continue to work with patients to co-design the future of MSK services.

Within Community MSK services, the number of patients on waiting lists have reduced by approximately 50% and the average waiting time has reduced by approximately 30%. The difference between these two figures represents a rise in the complexity of patient needs. Providers have worked hard to reduce waiting times and have delivered additional capacity by providing extra clinics and improved remote consultation capacity.

Self-referral to MSK and other services in Bedfordshire, Luton and Milton Keynes was promoted by a booklet drop to every household in our area. The ICB has worked with the community provider in Luton to begin a pilot for self-referral with the aim of expanding to all patients in 2023/24. Patients have also been given increased access to self-management resources whilst waiting for appointments.

The ability for clinicians to refer between Community MSK, hospital and other services has been improved by removing the requirement for further GP referrals. This has reduced delays for patients and saved GP practices' time.

National clinical and strategy leads for MSK have worked with the ICB to assess local provision against best practice to determine where further improvements could be made. This work will be reflected in the new model of care.

The services available across our area vary significantly. The ICB recognises the opportunities to align services, ensuring there is an equitable offer for all patients. This will build on the things that work well, making improvements where needed, but ultimately improving the quality of life for people with an MSK illness. We will do this by focussing on the whole person. We will create a personalised care plan that goes beyond just treating the MSK illness and looks at what might be causing the illness or making it worse, such as diet, smoking and lack of exercise.

The ICB is intending to secure future services by competitive procurement with the process intended to start during 2023/24.

Improving cancer outcomes

Improving patient experience, quality of life and reducing inequalities

Cancer is a priority service for us.

We aim to provide fair and timely access to cancer diagnostics and treatment for all.

There are two main ambitions in the NHS Long Term Plan for Cancer to reach by 2028. First, 55,000 more people in England each year will survive their cancer for five years or more. Second, three out of every four people with cancer will be diagnosed at an early stage. Stage one or two cancer is considered to be early.

The ambitions will be delivered in a way that:

- Improves quality of life outcomes;
- Improves patient experience; and
- Reduces variation and inequalities.

Cancer performance when compared with national standards has varied during the year.

Delivering the performance metrics for cancer recovery and restoration has been a key focus. We are now seeing cancer referrals, early stage and emergency presentations overall returning to pre-pandemic levels.

Many people referred into cancer services on a two-week wait pathway do not have cancer. But for the small minority who do have cancer, timely presentation and early diagnosis is vital to improving their outcome.

Transformation successes in 2022/23 to improving cancer outcomes

Faster diagnosis standard

This standard is to make sure that three out of every four patients are diagnosed with cancer, or have the disease ruled out, within 28 days from referral.

Milton Keynes Hospital has been nationally recognised for improvements to the colorectal cancer faster diagnosis pathway. That has seen performance well above the England average. We are performing well against this standard and will be on track to achieve the standard by March 2024 as set out in the NHS operational plan.

Cancer screening

The ICB aims to improve the uptake of cancer screening programmes and reduce variation in performance.

Our bowel cancer screening coverage improved this year by two percentage points and remained above the England average. It went up from 67.5% to 69.7%, while the England average is just below 67%. This was achieved through targeted primary care action plans. We continued work to improve breast and cervical screening uptake. This included plans to work closely with the ICB's learning disability and autism team to improve screening uptake for people with a learning disability or autism. The action plans include targeted follow-up from practice staff for patients who have not attended. Some practices send messages to patients in their main language where English may not be their first language.

The ICB has undertaken joint work with the learning disability and autism team to support people with those conditions. The ICB has used funding to provide specialist cancer rehabilitation training courses for personal trainers across our area. The personal trainers can then support cancer patients with exercise before and during treatment. This is a great example of partnership working to improve health outcomes.

Targeted lung health-checks

We expanded our lung health-check programme which aims to help diagnose lung cancer at an earlier stage, when treatment may be more successful.

Our lung health-check mobile unit completed invites and screens for eligible residents in Luton. It expanded into Central Bedfordshire to cover a further 10 practices.

A key success was that nine lung cancers and two other cancers were detected at an early stage. This improves the range of treatment options that aim to cure the disease in those patients.

Using innovation to detect cancers earlier

Bedfordshire Hospitals NHS Trust has been selected to take part in a nationally funded innovation known as cytosponge. This tool is used to detect patients with oesophageal cancer earlier. To date, the team have used the test on over 200 people and avoided the need for 120 invasive procedures. There are plans to roll this innovation out across the rest of Bedfordshire, Luton and Milton Keynes in 2023/24.The eventual aim will be to bring this service into community settings.

Patient capacity and flow

Improving a person's experience when they are in hospital

Much of our work this year has focused on working with partners so that more people are supported safely at home following a stay at hospital.

We have implemented virtual wards, which help people to avoid a hospital admission and provide support so that patients can leave hospitals sooner and continue their care at home.

We have also implemented real time system monitoring and reporting with robust escalation processes when systems are at risk of being overwhelmed.

There have been several improvements to 999 services. This includes the Silver Frailty Line, a scheme set up to speed up and improve the care that elderly residents receive. It is a partnership between East of England Ambulance Trust, Primary Care and Bedfordshire Hospitals Foundation Trust.

The new scheme connects ambulance crews to Geriatricians, frailty nurse practitioners and consultants within the hospital so that clinicians either from primary care or emergency services can contact specialist clinicians at the hospitals to seek advice on a patient. This advice can either lead to a patient being fast tracked through to a ward in the hospital or clinical advice being given so that the patient can be treated safely in their own home.

Through the winter period, we worked hard with partners to keep patients flowing through hospital and to keep ambulance handovers to a minimum. We established a System Control Centre (SCC) to manage hospital flows through the winter and by integrating more effectively, East London Foundation Trust (ELFT) and Cambridge Community Services (CCS) were given access to the call screens for both of our local ambulance services, East of England Ambulance Services (EEAST) and South Central Ambulance Service (SCAS). This meant that people who called for an ambulance with mental or community health needs were picked up by other partners. This reduced the wait for those patients and allowed the ambulance service to focus on priority patients who needed emergency, life saving care.

This improved ambulance handover practice, was recognised by NHS England for performing well against ambulance handover delays and the Association of Ambulance chief executives recognised Milton Keynes University Hospital in particular, as providing a good service to local people.

Palliative and end of life care

Integrated Care Boards (ICBs) have a legal responsibility to commission palliative care services that meet their population needs.

System partners across health and social care have been working together to design a draft model of integrated care for wider consultation that is deemed appropriate to deliver improved personalised and integrated care that meets our population needs.

We commission a range of health, social and third sector services to deliver care for people with life- limiting illnesses and advancing disease who will become palliative and end of life. However, services could be more formally integrated, more personalised and streamlined for individuals and their families and carers.

The emerging model to address these priorities is to have a single point of access that directs people into existing services for people suffering from life-limiting illnesses and advancing disease. This function then is responsible for the person's palliative journey.

The main benefits will be:

1. Patients, their families and loved ones will receive integrated and streamlined care against an equitable strategic model but delivered sensitively at place;
2. Reduced admissions and hospital stay due to more community support;
3. Earlier identification of patients with life-limiting illnesses so that the person and their families can decide how best to manage their condition and care needs;
4. Early and integrated involvement with the patient and their families that facilitates access to existing social care staff and services;
5. Measurable outcomes for the patient cohort, families and carers; and
6. Compliance with the Health and Care Act amendment 2022.

Our priorities and achievements during 2022/23

We produced a draft model for consultation to redesign the adult pathway of care so that it is integrated and streamlined. We also drafted a revised pathway for consultation for children and young people to ensure that it is integrated and streamlined and helps a young person make the transition into adulthood. These consultations will take place during 2023/24, with the models finalised and will start to be implemented.

We reviewed the information management and technology systems which support palliative and end of live care. We put in place improvements that enable data capture and the sharing of care records across organisational boundaries.

We developed clinically and professionally led business intelligence dashboard that includes information across all sectors and population health data. This is available so that all providers can access to help monitor care delivery and target areas of service that may need support.

We ensured that all training and development opportunities are accessible to our staff. This includes a range of support to identify and deliver the required competency levels of all health and social care staff.

Finally, during the year we developed networks to involve residents in all our plans, including the redesign of our care pathways.

Performance analysis

The performance analysis section takes a detailed look at the ICB's performance across the reporting period. It provides data and provides analysis about our performance against targets, in areas such as waiting times, access to services and quality and safety of services.

Performance, quality, and safety of local healthcare

The NHS 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.

These measures identify NHS responsibilities and are critical in delivering the quality of services which Bedfordshire, Luton, and Milton Keynes patients, public and staff are entitled to. Clinical quality, safety of care and the reduction of harm continued to be prioritised over the year, across the services we commissioned.

We monitor NHS Constitution measures through monthly provider and national performance reporting and regular contract meetings with providers. This allows us to work in collaboration with providers in a timely and proactive way, to understand challenges and to manage or mitigate performance deviation. In addition, the Board routinely monitors our performance against these indicators, with oversight from NHS England.

The ICB worked toward improving patient care and services over year, and we made good progress in achievement against several NHS Constitution indicators and the main areas of success were:

- GP face to face appointments in primary care increasing by 3% over the year, with a total year achievement of 78% against at 75% target;
- the rate of dementia diagnosis increased over the year from 64% to 67% at the end of March, exceeding the national target of 66.7% (total year performance was below target at 64%);
- we ended the early intervention in psychosis (EIP) programme in quarter four (February data) above the 60% target with 78%. This metric has consistently achieved above target with an average achievement of 76% over the year;
- we worked with partners to carry out a total of 3,735 learning disability health checks which meant we achieved 75% delivery against our local / national target of 75%;
- we have been working to increase the numbers of children and young people accessing mental health services, and we saw a total of 17,570 by the end of February, against our target of 16,458.
- within adult mental health we saw 72-hour follow ups (where at least 80% of patients should be followed up within 72 hours of discharge from psychiatric inpatient care, ending quarter four (February data) just short of the target with 79%; however, over the year we exceeded the target by achieving a total of 82%.

The ICB faced several challenges over the year which meant that there were some areas where we were unable to meet the national target, these included:

- Long waits for planned treatment over 75 weeks, this was a significantly improved but underachieving position from 547 patients in quarter two to 50 patients in quarter four. A successful reduction of 91% reduction against a zero patient by March 2023 target;
- Similarly, long waits for planned treatment over 52 weeks was also an improved but underachieving position from 7,215 patients in quarter two to 6,562 in quarter four seeing a 9% reduction over the year;
- The 6-week diagnostic wait time for tests with a target of 1% was not achieved, with 36% in quarter two and 29% in quarter, however we did deliver a 7.5% reduction in wait times over the year;
- The cancer standard for two-week wait times for treatment held steady over the year starting quarter two and ending quarter four with 83% against a target of 93%;
- The cancer 28-day standard for faster diagnosis also held position over the year starting quarter Two and ending quarter four with 71% against a target of 75%;
- Cancer 62-day wait times for patients to receive their first treatment following an urgent GP referral saw an improvement from 59% in quarter two to 66% in quarter 3 however ending quarter four 60% against a target of 85%;
- Long waits for treatment of 104 days or longer saw a slight increase from 39 patients in quarter two to a quarter four figure of 42 patients against a zero-patient tolerance
- Ambulance handovers ended quarter four with a daily average figure of 27 improving from 50 in quarter three (target NA);
- Emergency attendances resulting in an emergency admission remained largely flat over quarters two to four, ending in quarter four with 27%, with a 2% increase from quarter two;
- We delivered a cumulative increase in physical health checks for people with severe mental illness over the year, ending quarter four marginally under target with 5,353 against our target of 5,392;
- Delivery of our improving access to psychological therapy (IAPT) ended quarter four 5% below our quarter four target of 2,331 with 2,210;
- IAPT moving to recovery ended quarter four under the 50% target with 48% with a total of 49% of patients moving to recovery over the year;
- We exceeded our threshold of 34 inappropriate out of area bed days, ending quarter four with 815; this is a 13% reduction on quarter three;
- Children and young people's eating disorder patients seen for routine referrals (need to be seen within four-weeks), ended quarter four with 83% seen against the 95% target;
- Similarly, eating disorder patients seen for urgent referrals (need to be seen within one-week), ended quarter four with 69% seen, against the 95% target; a total of 74% were seen over the year;

- Community delivered children's waiting time for wheelchairs (the percentage received within 18 weeks) ended quarter four with 54% against the local target 74%; over the year a total of 66% were delivered within timeframe;
- Quality and safety serious incidents exceeded the threshold of zero with 13 at the end of quarter four and a total of 261 incidents over the year;
- Infection control metric Clostridium Difficile (C-Diff) exceeded the threshold of 148 cases with 20 at the end of quarter four and a total of 187 cases for the year; and
- infection control - Methicillin-Resistant Staphylococcus Aureus (MRSA) also exceeded the threshold of zero cases with 1 at the end of quarter four and 23 in total over the year.

During 2023/24 we will be developing further outcome metrics which will support us to better identify, track and measure the difference we are making across BLMK. We will also report separately on performance for children and young people to allow a greater focus on this population cohort as part of our start well priority. We will be continuing our work with providers, our Business Intelligence provider (Arden GEM CSU) and our public health partners to streamline and consolidate our reporting of performance into a 'single source of the truth' via the establishment of a Population Health Intelligence Unit. This will help us to increase our focus on reducing inequalities and improving quality and performance as a system.

Details on risk management can be found in the Accountability Report on page 133.

Planned care (More information on pages 38-43)

Achievement RAG	
	On Track
	Off Track

Area	BLMK ICB	Threshold	Q2 - September Snapshot Achievement	Q3 - December Snapshot Achievement	Q4 - March Snapshot Achievement	Total Year Performance	What does good look like
Planned Care	RTT - % Patients Waiting 18 Weeks or less	92%	55%	53%	54%	56%	High
	RTT - Number of 104+ Week Waits		7	0	2	NA	Low
	RTT - Number of 78+ Week Waits		547	645	50	NA	Low
	RTT - Number of 52+ Week Waits		7,215	7,376	6,562	NA	Low
	Diagnostics Tests - 6 Week Waits	1%	36%	32%	29%	32%	Low

18 weeks referral to treatment (RTT), 52 and 104 week-wait measures

The COVID-19 pandemic continued to have significant impact on patient demand and their wait times for appointments and treatments. We worked with providers to manage performance for patients on the 18-week incomplete pathway (the measure of patients' constitutional right to start treatment within 18 weeks).

We achieved 56% by year end against the national target of 92%. This was largely due to an increase in demand impacting on the waiting list (we have 17% more people on the 18-week RTT waiting list in March 2023 than we had in March 2022), and workforce and capacity shortages, including industrial action in the year. These factors have also affected elective long waits list for residents which has remained challenged over the year. Reducing long waits has remained a priority for the BLMK system, whilst being respectful of patient choice and cancellations. We worked towards reducing the number of patients waiting 52 weeks or longer for treatment from the point of referral by 9% by the end of quarter four. In March there were two patients waiting 104 weeks or more for treatment, both were awaiting treatment for “other” medical services at our independent sector trusts.

Over the year, pathways with the longest waits were ophthalmology, ear, nose and throat, and trauma and orthopaedics. Ongoing system discussions take place to identify and mitigate any additional harm caused to patients because of time they need to wait for treatment.

The ICB work with trusts and independent sector providers to implement and deliver several supporting work programmes to support overall and speciality level performance recovery and improvement, these include:

Clinically prioritise patients on the waiting list;

- Manage demand through alternatives to secondary care and optimise referrals;
- Utilise the independent sector to support acute Trusts, including musculoskeletal, eyecare / ophthalmology and ear services;
- A long-term system wide ophthalmology strategy developed in conjunction with system partners; and
- Implementing recommendations from the recent national Getting It Right First Time (GIRFT) programme visit for Ophthalmology.

Trusts continued to implement patient-initiated follow-ups (PIFU) across different specialities, delivering almost 14,000 of total follow up appointments through this pathway. These allow patients to arrange their own follow-up appointments when they need them. Patient were enabled 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 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 and we continued to utilise the locally contracted independent sector to provide more surgical capacity. To lend further support, our places priorities will support improvements for several our service areas including primary care, cancer, children and young people, mental health and general welling areas including tackling obesity, reducing inequalities, and promoting prevention and positive behaviours. More information about working at place on pages 11-18.

Diagnostics – waits over 6 weeks (More information on page 39)

The ICB did not achieve the less than 1% target for patients waiting over 6-weeks for a diagnostic test. The ICB improved its position from September with 36% to 28% by March 2023. Challenging pathways over the year included magnetic resonance imaging (MRI), cardiology (electrophysiology) and computed tomography (CT) scans. ICB work plans to support diagnostic capacity include the development of community diagnostic centres (CDC's) across BLMK over 2023/24.

Cancer care (More information on pages 23, and 38-43)

Area	BLMK ICB	Threshold	Q2 - September Snapshot Achievement	Q3 - December Snapshot Achievement	Q4 - March Snsapshot Achievement	Total Year Performance	What does good look like
Cancer Care	Cancer - 2 Week Waits Standard	93%	83%	87%	83%	83%	High
	Cancer - 28 Day Faster Diagnosis Standard	75%	71%	72%	71%	71%	High
	Cancer - 62 Day GP Referral	85%	59%	66%	60%	61%	High
	Cancer - 104+ day waits	0	39	35	42	NA	Low

Cancer waiting time standards

Cancer standards have underperformed against national targets but have remained steady over quarters two to four. This has been due to several on-going challenges including an increase in monthly referrals and demand (an increase of 4% of 2w referrals and 7% of 62-day referrals this year compared to last year), a growing backlog and waiting list, and workforce / capacity issues, all against a backdrop of reduced screening and diagnostic capacity. We worked closely as a system, with the acute Trusts and the East of England Cancer Alliance to understand and mitigate these challenges.

The ICS Cancer Programme, alongside our regional Cancer Alliance, continued to focus on delivery of the Long-Term Plan ambitions for cancer to improve earlier and faster diagnosis, and cancer has remained a prioritised service over the year, including over the period of industrial action, to give all patients fair and timely access to diagnostics and treatment.

One of our biggest challenge areas over the year was the level of the 62-day backlog across BLMK due to factors including increase in demand, winter pressures, COVID-19, and annual leave / sickness. This was a particular concern for Bedfordshire Hospital Trust (BHT), who featured in the national relative cancer backlog list for tier one. This is a national list where all trusts are ranked by the proportion of patients on the waiting list, waiting more than 62 days. BHT were placed within Tier one of this group for a short period over the year. At our peak in January, there were 732 total BLMK patients waiting over 62 days for treatment, and as of March, there were 464 (37% reduction). System partners have worked closely to monitor and manage the total BLMK backlog over the year, and this continues to be a priority. As a result, BHT were removed from Tier one and placed into tier two as of Quarter four this year.

The BLMK ambition to reduce waiting times and the 63-day backlog continues with two-week wait priority bookings and pathway trackers in place to improve list validation, this is supported by regular ICB, provider and Cancer Alliance meetings to focus on overall performance, specific challenging pathways, and service level improvement plans.

System partners together with oversight from our Cancer Board worked to improve the patient pathways and support recovery and restoration of cancer services by implementing national best practice pathways for specific types of cancer. Despite the continued challenges with COVID-19, our hospitals implemented and maintained new pathways for prostate cancer, upper gastrointestinal (GI) oesophageal cancer, lower GI colorectal cancer and lung cancer.

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 use cytosponge tests. For Milton Keynes and Bedfordshire patients who display symptoms that could indicate cancer, such as fatigue of vague abdominal pain, there is a new way to identify if they have the disease (non-specific symptoms pathway).

We successfully ran a community engagement survey to better understand the barriers facing cervical screening access. The findings included a misperception of this screening as a sexual health test only, lack of access to primary care and a requirement to improve staff cultural sensitivity. The ICB worked to address these concerns by participating in national cancer screening programmes by using digital screens in supermarkets and bus stops to promote breast, bowel, and cervical cancer screening, supporting PCNs to develop action plans at a local level to increase screening uptake and we have implemented a two-day training course which was well attended and delivered in May 2023. We also worked towards improving access to appointments in primary care and increasing training for sample takers to be more sensitive towards cultural and personal barriers impacting those coming forward.

Further developments include upgraded technology used by the breast screening unit; they now use higher quality images to identify the disease. We also used a new oncotype test to improve treatment of breast cancer patients and upgraded technology at the breast screening unit for enhanced imaging and innovation continued with the introduction of genomic tests for early identification of cancers.

We worked to expand the targeted lung health check outcomes programme into Central Bedfordshire and completed over 4,600 lung checks and this successfully identified several lung cancers at an early stage. This was a crucial piece of early identification work as lung cancers are traditionally diagnosed

at stages 3 or 4 which has an impact on treatment options available and cancer outcomes. There are plans to roll this programme out to the rest of BLMK over 2023/24.

We have a diverse population and health inequalities within cancer have been further exposed post COVID-19, with variation identified in cancer outcomes, service provision, access, and patient experience. There are inequalities in the presentation of cancer, as some cancers affect different age groups and ethnicities. There are also preventable cancers which are impacted by wider determinants such as where people live and work and lifestyle factors. BLMK ICB are working with partners and our communities to deliver our caner inequalities action plan alongside several projects to support reduction in inequalities, these include:

The Luton Cancer outcomes project – where we work in partnership with the community to understand and address poor cancer outcomes;

Work to understand barriers – we are undertaking several initiatives to fully understand the barriers our population face around access, poor uptake, screening, and presentation;

Implementing the Core20PLUS5 national programme – we are working with our PCNs to raise awareness, support access to appointments and to support screening follow ups. We continue to use social media, digital screens, and community engagement to improve awareness of cancer signs and symptoms and screening programme uptake;

Recovery and restoration – work is ongoing to monitor access to services and review monthly equity data; and

Patient experience – we have several initiatives to understand variation in experience within the communities we service; working in partnership with Macmillan and BAME communities.

In addition, place-based priorities aim to support overall improvements which will contribute to cancer care, with Central Bedfordshire working towards improvements in diagnosis and outcomes, and both Luton and Bedford Borough towards tackling inequalities, with Bedford Borough focusing on prevention of ill health and promoting positive behaviours which will further support our aim to reduce preventable cancers.

Urgent Emergency Care and Primary Care (More information on pages 24-29)

Area	BLMK ICB	Threshold	Q2 - September Snapshot Achievement	Q3 - December Snapshot Achievement	Q4 - March Snapshot Achievement	Total Year Performance	What does good look like
Urgent Emergency Care	Ambulance - 30 minute Handover Delays (Daily Average)		25	49.96	27.07	24.60	Low
	% ED Attendances that result in emergency admission		25%	25%	27%	27%	High
Primary Care	Appointments in GP Practice - % Face to Face	75%	78%	79%	81%	78%	High

Ambulance Handovers – 30 minute handover delays

Ambulance handovers over 30 minutes remained within threshold for quarter two and four, only exceeding the national target of 30 minutes in quarter three, due to the peak winter pressure period. A whole system approach is being taken to reduce ambulance handover delays which is reviewed at both ICB system-wide and daily operational meetings, improvement initiatives include intelligent conveyancing (management of the number of ambulances arriving each hour at each emergency department), batching of ambulances (grouping similar calls), and development of a 999 to 111 workstream across Bedfordshire and Luton to free up frontline ambulance resources and improve response times.

Emergency Department attendances resulting in an emergency admission

Urgent and emergency services have seen a rise in demand across acute services and providers have been under significant pressure over the year (total A&E attendances across BLMK in March 2023 have seen a 7% when compared to the same time in 2022 and total emergency admissions have seen a 14% increase for the same month last year). Several initiatives are in place to support and mitigate system pressures including the new Same Day Emergency Care unit at MKUH. Milton Keynes place is supporting urgent and emergency care through their priority "improving system flow" which will focus on services for older and frail people and providing more joined up care for our residents, complementing the work of Central Bedfordshire who are working towards a "one team" approach to intermediate care services.

Primary Care – appointments in GP Practice

Demand for general practice has continued to increase over the year, with practice appointments above pre-pandemic levels (508,718 General Practice appointments offered across BLMK in March 2023 compared to 486,886 in March 2022 - an increase of 4.5%. The proportion of face-to-face activity also remains above the national target. The 2022 GP Patient survey showed that 38% of patients found it "very or fairly easy" to get through on the phone, and telephony (patients being able to get through on the phone) is cited at place as a significant issue alongside, workforce and estates. The ICB is working towards developing a clear plan to support practices with the most significant access challenges, we are aligning the ICB digital strategy and digital offer with new telephony across practices to improve patient access. To consolidate efforts at place, Bedford Borough are working towards transforming primary care with input and support from voluntary, charity and social enterprise sector (VCSE) and Central Bedfordshire who are prioritising primary care access, including dentistry.

Adult Mental Health, Learning Disability and Autism (More information on pages 29-34)

Area	BLMK ICB	Threshold	Q2 - September Snapshot Achievement	Q3 - December Snapshot Achievement	Q4 - March Snapshot Achievement	Total Year Performance	What does good look like
Adult Mental Health	CPA 72-Hour Follow Ups	80%	*See below data note 1	78%	82%	82%	High
	SMI Healthchecks (Rolling 12 months)	5,392 (local)	4,239	4,731	5,353	5,353	High
	Dementia Diagnosis Rate	66.71%	64%	64%	67%	64%	High
	IAPT Access	2,331 (local)	*See below data note 1	1,510	2,210	24,960	High
	IAPT Moving to Recovery	50%		50%	48%	49%	High
	Early Intervention in Psychosis (EIP)	60%		83%	75%	76%	High
	Inappropriate Out Of Area Bed Days		265	935	980	2,180	Low
Learning Disability & Autism	Learning Disability Healthchecks (Cumulative)	75%	28.00%	48%	75%	75%	High

Note* - Adjustments to the national Mental Health Services Monthly Statistics to support reporting under the new commissioning structures meant that it has not been possible to include ICB level breakdowns for July - September. This affects metrics: CPA 72-hour follow up, IAPT Access and Moving to recovery and EIP.

Physical health checks

For physical health checks for people with a severe mental illness (SMI), we delivered an end-of-quarter four number of 5,353 checks just short of the quarter four plan of 5,392. Health checks for those with a learning disability over-achieved against our locally agreed target of 31% with an end-of-quarter four total of 59%. We worked providers to deliver tailored outreach services to people with a severe mental illness and those with a learning disability to improve physical health, more information on page 24.

Dementia diagnosis

The dementia diagnosis rate has remained steady over the year with a total year acheivement of 64%. At the end of March-23 the ICB successfully achieved 66.8% and we were the only ICB in the East of England to exceed against the national target of 66.7%. There continues to be variation of acheivement within BLMK and we have work programmes in place to improve the level of diagnosis for patients with dementia across BLMK, over 2023/24. These include setting up a new specialist dementia diagnosis service for care home residents in Central Bedfordshire as part of a national NHS pilot.

Improved access to psychological services (IAPT)

The proportion of people moving to recovery at the end of quarter four, fell below the target with 48%. This was due to a culmination of an increase in demand, workforce issues and data quality which has impacted capacity and recording. Data quality is reviewed and monitored monthly.

Mental health services have seen unprecedented levels of demand which is in turn impacting on acute services (we have had 5.5% more people accessing IAPT services over the year compared to 2021/22. To support flow through the system, private acute and step-down beds have been procured. Further mitigating actions include ongoing community outreach and drop-in clinics for the IAPT service.

We are working with providers to on a BLMK wide recruitment, retention and wellbeing improvement programme which aims to improve staff wellbeing, reward, and development across IAPT services.

Early Intervention for Psychosis (EIP) first treatment

We saw 75% of patients for EIP first treatment at the end of quarter four. Performance has consistently been above both the national target of 60% and the England performance of 71% in March. Central Bedfordshire will be supporting improvements in care with a focus on mental health, learning disability and autism for all ages.

Children, Young People and Maternity (More information on pages 34-37)

Area	BLMK ICB	Threshold	Q2 - September Snapshot Achievement	Q3 - December Snapshot Achievement	Q4 - March Snapshot Achievement	Total Year Performance	What does good look like
Children and Young People (CYP) & Maternity	Number of CYP accessing mental health services (Rolling 12 months)	16,475 (local)	*See below data note 1	17,335	13,085	17,570 (Feb)	High
	CYP Eating Disorders - Routine	95%	**See below data note 2	82%	83%	83%	High
	CYP Eating Disorders - Urgent	95%		75%	69%	74%	High
	Perinatal Mental Health Access (Cumulative)	1,280 (local)	630	820	1,000	1,000	High

Data Note* - CYP Mental Health Access metric - adjustments to the national Mental Health Services Monthly Statistics to support reporting under the new commissioning structures meant that it has not been possible to include ICB level breakdowns for July - September. This also impacted the total end of year figure so total is shown to February 2023.

Data Note ** - CYP Eating Disorders - Urgent and Routine data for Q2 not available to due to a cyber-attack.

Children, young people and maternity – mental health access

We over-achieved against the children and young people (CYP) mental health access. By the end of quarter four (February position), 17,570 patients had accessed these services against a quarter four plan of 16,458. Commissioners and providers worked to build further capacity within voluntary sector services. This enabled earlier intervention and support for children and young people, and reduced demand for support in hospitals.

The BLMK system is seeing a significant increase in the number of children and young people with either mental health or a learning disability / autism presenting to acute hospitals as a safe place when their placements have broken down. These young people often present with challenging behaviours but do not always meet the criteria for a mental health in patient bed and often spend time in acute hospital paediatric beds. This is not the right or safest place for these young people. In addition to strengthening multi-disciplinary responses for these young people when they present at A&E, BLMK has opened the Evergreen Tier 4 children and adult mental health services in-patient facility in Luton and have plans to increase training to the acute workforce through a bespoke train the trainer programmes. The ICB is also developing a CYP community eating disorder service and an intensive outreach and home treatment to offer alternatives to admission and crisis services.

For eating disorders, over quarter four we exceeded the regional average performance for both urgent (to be seen within one week) and routine referrals (to be seen within four weeks) by 4% and 11% respectively, however we did not achieve the national threshold of 95% for either urgent or routine referrals; achieving 69% for urgent and 83% for routine referrals. Medical management of eating disorders is a focus for the BLMK CYP Clinical Reference Group with work programmes in place to support improved outcomes for both measures. Work has started to expand Body Project and Spotting the Signs training across BLMK alongside a virtual day service for children with eating disorders with oversight from a dedicated clinical reference group.

The number of women accessing perinatal mental health services fell short of the target but has grown steadily over the year from 630 in quarter two, to 1,000 as at March against a target of 1,280. There has been excellent user feedback from people accessing perinatal mental health services across BLMK, and whilst the Milton Keynes service has been fully recruited since April, recruitment and retention of staff continues to impact on capacity in the Bedfordshire service. The ICB is accessing support through the regional team, who are mobilising workforce planners across ICBs to support current and future workforce planning.

We recognise the importance of promoting children and young people's emotional and mental health, as well as their overall health and wellbeing, and offering evidence-based interventions in a timely way is imperative for children and young people to become resilient adults. This is recognised at each place within BLMK. Central Bedfordshire has identified children's mental health and emotional wellbeing as a priority. Luton's vision includes giving every child the best start in life, with focus on supporting early years and attainment supporting growing capabilities in adults. Milton Keynes Health and Care partnership has identified children and young people's mental health as well as complex care (with a focus on children and young people) as two of their priorities delivered via the "MK Deal" on behalf of the ICB.

Community services

Area	BLMK ICB	Threshold	Q2 - September Snapshot Achievement	Q3 - December Snapshot Achievement	Q4 - March Snapshot Achievement	Total Year Performance	What does good look like
Community Services	Childrens Wheelchairs - % received in 18 weeks	74% (local)	74%	61%	54%	66%	High

Children's wheelchairs

The ICB has not been able to achieve the 74% standard for delivering children's wheelchairs over quarters two to four, with a total year performance of 66%. This is primarily due to the challenge of lasting supply chain issues from the COVID-19 pandemic, with "lead in" wait times having increased to up to double pre-pandemic wait times in some cases. Whilst there has been improvement with the supply of most items, waiting times for equipment remain longer than the 18-week RTT pathway allows. All new referrals are triaged and prioritised daily based on a RAG rating and the existing waiting list management continues to mitigate demand and risk by prioritisation based on clinical risk. In addition, the referrals administration team has a robust process for tracking and chasing equipment orders and all children are prioritised; any additional internal capacity is used to expedite access for lower priority clients.s

Quality and Safety

Area	BLMK ICB	Threshold	Q2 - September Snapshot Achievement	Q3 - December Snapshot Achievement	Q4 - March Snapshot Achievement	Total Year Performance	What does good look like
Quality & Safety	Serious Incidents	0	25	18	13	261	Low
	Infection Control - C-Difficile	149	22	11	20	187	Low
	Infection Control - MRSA	0	2	0	1	23	Low

Clostridium Difficile (C-diff) and Methicillin-Resistant Staphylococcus Aureus (MRSA)

In March 2023, we recorded 20 cases of C-diff, this is above the monthly threshold of 13; there were 187 total cases for the year, 26% above the annual threshold of 148 cases. There were zero cases of MRSA infections in March, against a threshold of zero; there were 23 total cases for the year. The quality team provided regular infection prevention control training to GP practices, care homes and social care settings.

Mental Health

The table below sets out expenditure within scope of the Mental Health Investment Standard.

Financial year	2021/22	2022/23
Mental health spend, £000s	145,329	156,042
ICB Core Programme Recurrent Allocation, £000s	1,433,092	1,492,777
Mental health Spend as a proportion of ICB Programme Allocation, %	10.1%	10.4%

Subject to independent audit, the ICB has met the requirements of the Mental Health Investment Standard.

Children and Young People (CYP) and adults safeguarding

Safeguarding

We have a statutory duty to have appropriate arrangements for safeguarding children and adults who are at risk.

Safeguarding means protecting a resident's health, wellbeing and human rights. It enables them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care.

We are making sure our internal safeguarding arrangements are robust, and that safeguarding is embedded in everything we do, across all commissioned services.

Safeguarding within the Integrated Care Board

The Associate Director of Quality and Safeguarding has reviewed the structure of the safeguarding team to ensure it can deliver the ICB's statutory responsibilities.

This included appointing a Head of Safeguarding, a named GP and specialist nurse roles. The specialist safeguarding nurses make sure support is offered across primary care, local authorities, including safeguarding hubs, and children in care.

In May 2022, we hosted a safeguarding workshop. This brought together safeguarding leads from health, local authority, police, and education. They heard from national and regional colleagues and our safeguarding model was discussed.

In December 2022, our safeguarding team developed and launched a joint annual GP audit toolkit. The purpose of the safeguarding toolkit is to support and enable best practice. It sets out the roles and responsibilities of GPs and their staff, in the recognition and referral of situations that indicate that a child, unborn child, or adult may be at risk of significant harm.

Local safeguarding partnership boards

We work closely with our local council colleagues, healthcare providers and the police to deliver on agreed safeguarding priorities.

We are a statutory partner on the safeguarding adults and children partnership boards. We are represented on the board's executive committees by the Executive Lead for Safeguarding, the Chief Nurse, and at the safeguarding partnership boards by our designated professionals.

We play an active role on the safeguarding partnership boards. We have taken a lead on various groups, including reviews into child safeguarding practice and safeguarding adults. We have also been involved in many other activities, including joint learning and development groups, domestic violence and suicide prevention partnerships, the voice of the child, and child death reviews.

We host child death overview panels and have two designated doctors to support in this area. They are responsible for the child death process and in fulfilling the statutory requirements, as outlined in the Child Death Review Statutory Guidance (2018). This includes the preparation of an annual report, which feeds into local workstreams.

The designated professionals provide strategic leadership, support and advice across the local health economy. They inform and advise on commissioning arrangements as required and are members of the partnership boards.

During 2022/23 three child safeguarding practice reviews and two safeguarding adult reviews were independently commissioned and published by the safeguarding partnership boards.

Each agency has a responsibility for sharing the learning from each of the reviews and to develop an action plan and monitoring its progress.

Regional NHS England safeguarding programme

The NHS England safeguarding accountability and assurance framework was refreshed in July 2022.

It outlines the NHS commitment to the safeguarding of children, young people, and adults. It also sets out the safeguarding roles and responsibilities of all individuals in providers of NHS- funded care settings and NHS commissioning organisations.

The SAAF governance process replicates ICB guidance and the ICB Executive Chief Nurse is accountable for the statutory commissioning assurance functions of NHS Safeguarding. These programmes will include:

- CP-IS - Child Protection – Information Sharing
- FGM - Female genital mutilation
- Working Together
- Prevent
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Liberty Protection Safeguards

Our designated professionals self-assessed against several standards included in the assurance framework. They will be using this to prioritise outcomes and develop a safeguarding strategy.

The East of England regional safeguarding team are working with the six ICBs across the region. They are bringing together safeguarding professionals to share best practice and monitor the ICBs' delivery of their responsibilities.

We submit quarterly data which monitors how each ICB is delivering against several standards.

We have developed our current top five risks and concerns in safeguarding children and adults. We have also identified our top five lessons from our reviews to inform the regional support plan for 2023/24.

Our safeguarding achievements 2022/23

- ICB has participated in listening events with Children in Care Council
- Co-production with service users around LGBTQ issues
- Introduction of GP audit tool
- Development of Safeguarding Supervision model and framework
- Introduction of the ICON programme – Babies Cry, You Can Cope
- Strengthened ICB Safeguarding relationships at place
- Supporting front line health practitioners to identify and tackle neglect issues at the earliest opportunity by using the Graded Care Profile assessment tool
- Continued development of policies and procedures

Safeguarding Partnership Reports

Our safeguarding partnership annual reports and partnership arrangements can be accessed using the links below.

Central Bedfordshire Safeguarding Children's Partnership

CB SCP Annual Report 2021-22 MASA

Milton Keynes

Annual Reports | mk-together (mktogether.co.uk) **Bedford Borough**
https://www.bedford.gov.uk/media/5402/download?inline https://www.bedford.gov.uk/media/5469

Luton – not currently available online

Environmental matters

How we are working towards a healthier, more sustainable environment

Climate change is an issue which affects us all and has a significant impact on our health.

It is caused by emissions from fossil fuels, such as oil and gas, and other sources including many healthcare activities. Society needs to move to an economy which has net zero carbon emissions, meaning society no longer pollutes the atmosphere and reduces the associated risks to health.

As an Integrated Care System (ICS), we aim to reach net zero by 2035 for emissions for which the system is directly responsible. Emissions can be due to use of buildings, energy transport, equipment, waste and water use, and through use of medicines. The NHS also has an ambition to reduce to net zero the emissions associated with its supply chain by 2045.

These are ambitious goals. Our system's ICS Green Plan, published in April 2022, describes how we will reach these goals.

Progress towards net zero

The ICB has governance in place to oversee the delivery of the Green Plan. We also support hospital trusts to deliver their own plans, and work with other system partners to achieve their own sustainability goals.

The ICB funds and supports small-scale initiatives for partners to trial or implement with the aim of reducing emissions. For example, air quality monitoring, assessing estate efficiency, travel planning, skills development, and supporting people at risk of cold homes.

Inhalers containing hydrofluorocarbon propellants for conditions such as asthma cause some of our emissions. The ICB has worked with primary care to shift inhaler prescriptions away from those with the highest emissions. This work has helped the system to move from one of the worst-performing areas for these emissions from inhalers, to a mid-range performer. We improved from the 95th percentile to the 57th by November 2022 for average carbon emissions per inhaler. We have also started to see a drop in the proportion of Metered Dose Inhalers prescribed – dropping beneath the 90th percentile for the first time since April 2019.

Staff transport remains a factor in our overall emissions. The ICB offers a salary sacrifice car leasing scheme that only offers low-emission or ultra-low emission vehicles for staff.

Many staff have continued to work from home for most of their working hours after the pandemic. The effect of this is difficult to quantify, but studies[1] suggest that home-working is likely to be more carbon-efficient over the course of a year, particularly if commuting distance is greater than six kilometres[2] .

In support of our hybrid working arrangements, we have rationalised and relocated some of our offices, so that three of our four offices are now co-located with our local authority partners. In addition to helping strengthen our relationships at Place level and the positive environmental

[1] https://iopscience.iop.org/article/10.1088/1748-9326/ab8a84/pdf;

https://www.carbontrust.com/our-work-and-impact/guides-reports-and-tools/the-carbon-savings-potential- of-homeworking-in-europe

[2] https://www.iea.org/commentaries/working-from-home-can-save-energy-and-reduce-emisssions-but-how- much

impact of a reduced footprint, we are benefiting from the efforts being made by our Council landlords to reduce energy use and their buildings' carbon impact.

For the wider health service, remote consultations, online and video, have reduced the need for people to travel to appointments. It has also enabled our services to be more responsive, at times which suit a person's availability.

The joining up of health and care in single clinical records has many benefits. It saves time, improves patient safety by having the right information available, reduces duplication, saves resources and increases productivity.

Case study: Bedford warm homes project

Bedford Borough residents with long-term health conditions were able to receive free support to help keep their households warm during the winter.

Warm Homes Bedford Borough was set up by Bedford Borough Council and the Integrated Care Board. It was in partnership with the National Energy Foundation's warmth and wellbeing service, Better Housing, Better Health.

Over 1,600 residents with health conditions that can be made worse by living in cold or damp home were identified from GP records. Eligible residents received a letter inviting them to contact Better Housing, Better Health with information on how they can apply for free support.

Support included, energy saving advice, draught-proofing, loft and wall insulation, and smart heating controls.

Procurement

The way that the ICB procures services is a way of building in factors around climate change or broader social value into contracts.

The ICB incorporates social value questions in all procurement tenders. This asks potential suppliers to demonstrate how they will work with us to fight climate change. It also includes factors such as combating economic inequality, COVID-19 recovery, equal opportunities and wellbeing. This element usually makes up 10% of an overall score to make a procurement decision, but in some cases this may be increased to reflect the requirements of the service and the strategic aims of the tender. We continue to work to strengthen and modify these questions in order to best improve the local environment and the wellbeing of those living within it.

Suppliers with contracts of over £5m have been identified so the NHS can engage with them and ensure they have carbon reduction plans in place from April 2023 onwards.

Climate change and risks to health and delivery of services

The effects of climate change are one of the strategic risks identified by the Integrated Care Board. This is due to the potential risk to health and wellbeing, as well as service delivery.

The ICB held a deep-dive discussion on the climate change risk in December 2022 as part of our Audit and Risk Assurance Committee. We agreed with our partners to work together on adaptation plans. These make sure the risk of climate change to populations and services are minimised.

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The ICB operates an Emergency Preparedness, Risk and Resilience team and has a business continuity plan in place. There is a Severe Weather Plan which frames the preparedness and response to serious weather events and takes into account climate risk. Business continuity plans will make reference to supply chain risks, which are sometimes as knock-on impacts of serious weather events globally.

There are interdependent plans developed in partnership with the Local Resilience Forums, such as utility failure plans and flood plans, which are sometimes triggered in response to a serious weather event and developed in response to specific risks. A more resilient organisation is considered as the main opportunity deriving from climate action. Therefore, this is being built into future and ongoing plans.

The ICB is also an active partner in local resilience work. A discussion on adaptation was held at the Local Health Resilience Partnership group in November 2022.

In December 2022, the ICB published a green plan health impact assessment. It looked at the Green Plan ambitions and how to prevent impacts to health and wellbeing. Recommendations were approved by the Board on 27 January 2023. The work plan from this report will be taken forward in 2023/24.

Carbon literacy is the term used to describe people having an awareness of issues around fossil fuel emissions. It is one of the most important factors which will help us reach net zero. Several engagement presentations have been made to ICB staff during 2023, alongside delivering seminars and presentations at partner events. The e-learning course, Building a Net Zero NHS was available to staff. The ICB also procured training for staff during 2023.

The ICB requires all Board papers to detail the impact of the proposal on delivery of the ICS Green Plan. At present the ICB does not have a structured way to embed consideration of climate resilience within clinical governance structures or within clinical transformation work. However, one of the themes within the Green Plan is to consider how to make models of care more sustainable. This, including implementation of a sustainability impact assessment checklist as part of service improvement and transformation processes, will be part of the work plan for 2023/24.

Improve quality

Quality and safety

Quality issues are very important to the experience of residents across our health and care system.

These issues are overseen by the quality and performance committee. It meets quarterly to review the data and information available on commissioned health services.

The committee provides scrutiny to help make sure services are of the right quality.

The pandemic and industrial action has been a big challenge to our health providers. It has sometimes reduced the availability of staff members to deliver services in a timely way. We have worked NHS care providers to support these challenges and to make sure people are cared for in a safe environment and protected from avoidable harm.

We are aware that any disruption to provision of clinical services is likely to have an impact directly on patient care , however at time of writing we do not have any specific evidence to demonstrate impact of Industrial Action. For more on the issue of industrial action go to page 38.

For information on how we are reducing inequalities, go to page 79.

Quality improvement

Quality improvement involves multiple providers across our health and care system and requires a collaborative approach.

We work in partnership to make sure that insights from across the system are shared in a timely fashion and turned into opportunities for learning and improvement. We ensure issues are escalated so that statutory duties are being met and; concerns and risks are addressed; and improvement plans are making a positive difference.

We also make sure there is confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight and learning. This includes confidence that inequalities and unwarranted variation of care are being addressed and deliver against our strategic priorities.

Infection prevention and control

Throughout the last year, our infection prevention and control work has continued to focus on Coronavirus. We also had a new strain of influenza impacting delivery of care services. This has made it difficult to discharge vulnerable people safely from hospital. Alongside this, we worked across the health and care system to reduce healthcare associated infections.

With our team of specialist nurses, we prioritised support for providers. This was particularly true in care homes looking after our most vulnerable elderly population. We have worked with social care and public health colleagues to provide advice and guidance on safe discharges and infection prevention and control.

In addition, our teams of specialist nurses continued to deliver both virtual and physical infection prevention and control training and advice to all care homes.

Quality visits

Our new Integrated Care Board structure for quality has identified senior leads to work with each of our four places. They are working to understand the geography, population health needs and any associated quality challenges in their place.

We worked with our providers and local authority care standards teams to spot areas of concern that needed urgent support or quality visits.

Clinical quality nurse teams were established last year. They focus on quality improvement in care homes. We have individuals supporting homes in each specific place aligned with our four local authority areas. These teams have been delivering infection prevention and control work, care home training on pressure area prevention, end of life care and nutrition. In addition, they have supported digitalisation projects and care homes using NHS mail services.

Patient safety incident response framework

We need to learn from incidents involving patient safety so that we can improve services.

The Patient Safety Incident Response Framework (PSIRF) 2022 helps us to do that. It sets out how to develop and maintain effective systems for responding to patient safety incidents for the purpose of learning and improving patient safety.

Since publication of guidance in August 2022, we have been working with system partners in planning for implementation in autumn 2023.

We are working with partners about the right approach to responding to patient safety incidents. A consideration is making sure that we strike the right balance between resources for learning and delivering improvements.

This is a fundamental shift in approach. This work will identify our system safety priorities and areas for quality improvement. It will also support our work around inequalities.

Throughout 2022/23 we continued to receive information regarding Never Events, which are serious incidents requiring investigation. We have started, where possible, working in a systematic, multi-agency way to review incidents involving two or more providers.

Patient safety specialists (including the Lead ICB patient safety specialist - Deputy Chief Nurse, and Place Safety Specialists - Heads of quality), contributed to the development of patient safety plans used by our providers. They have worked with patients, their families and NHS staff and are fundamental to bring about safety improvements.

Mental health and learning disabilities

There has been a focus on people with a learning disability or a mental health condition during the last year.

We worked closely with colleagues across local authorities, the NHS, independent and voluntary sectors to ensure these vulnerable groups received appropriate support, especially during periods when their movements were restricted.

As commissioner we successfully and safely supported the closure and safe reallocation of a 40-bed learning disabilities hospital. We worked with placing commissioners, families and patients from all over the UK to do this.

We have and continue to work closely with our mental health providers on safety in mental health patient wards. We have looked at culture and leadership to improve outcomes.

We brought together the work of the mental health and learning disabilities crisis support teams. 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. We implemented one-stop clinics for flu and COVID vaccinations and health checks. We also ensured carers for these groups were on GP and primary care registers.

Special Educational Needs and Disability (SEND)

The ICB works across partnership structures with each of our local authorities of strategy and plans for improvements for our SEND populations. Jointly we have oversight and assurance group meetings with NHS England and NHS Improvement and external stakeholders where ongoing concerns are discussed, and the improvement plan is monitored.

Across our footprints our SEND partnership boards enable improved governance systems and established joint commissioning framework which and direct plans associated with reviews of services that Ofsted/CQC suggest areas for further development.

We worked in partnership with our local authorities and children's services to develop integrated roles. We focused on improving children and young people's mental health provision, changing the neurodevelopmental pathway and therapy provision.

Local maternity and neonatal system

The ICB is responsible for overseeing the local maternity and neonatal system.

We work in partnership with our maternity units and regional leads to deliver service improvements to meet the needs of local people.

Improvements over the last year include introducing the midwifery continuity of carer as a default model for all women. This is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy.

We also gave personalised care and support plans for all women, as well as equity and equality for women, babies and staff in maternity and neonatal services.

We implemented the immediate and essential actions from an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, published in March 2022. These actions are to improve care and safety in maternity services across England.

We supported women to stop smoking during pregnancy, with our smoke-free pregnancy work.

In addition, we used the Saving Babies' Lives Care Bundle to reduce perinatal mortality, across England. Perinatal mortality refers to deaths in the weeks before or just after birth.

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing four elements of care together:

- Reducing smoking in pregnancy;
- Risk assessment and surveillance for fetal growth restriction;
- Raising awareness of reduced fetal movement; and
- Effective fetal monitoring during labour.

The package was developed by groups brought together by NHS England, including midwives, obstetricians and representatives from stillbirth charities.

Lastly, we have worked with community hubs, to bringing a range of antenatal and postnatal care services together in one setting closer to home.

Research and innovation

The ICB is committed to increasing participation in research across the Bedfordshire, Luton and Milton Keynes system. It is the ICB's ambition to support our workforce to increase their research skills. We are exploring ways in which we build this infrastructure across the ICS.

We are establishing a Research and Innovation Board. It will explore how we can develop a framework for use across the system so that the workforce can access and develop a culture of embedding research and innovation irrespective of sector, place or organisation. It will give direction and focus of our research and innovation to optimise the health and wellbeing of our residents.

Research is essential so that we can provide an evidenced-based practice and continuous improvement to the care we provide. Stronger relationships are being formed with universities and other academic organisations such as the National Institute for Health and Care Research.

The ICS and University of Bedfordshire Research and Innovation Hub was launched in September 2022. It was created following £3 million investment from NHS England, with an aim of focusing on health and social care inequalities.

Making innovation a priority

Innovation is a priority to drive advances in health and social care.

We have been working with both the Eastern and Oxford Academic Health Science Networks in their duty to promote innovation. A new jointly funded post between the ICB and the AHSNs was created in 2022. It will link up innovation to our system priorities and support its spread and adoption.

Technologies that have proven to be effective, cost saving and affordable, according to the MedTech Funding Mandate, have been implemented across our system.

Examples include less invasive procedures for urology and new non-drug treatment for migraines and cluster headaches.

Work is currently underway to review the care for people with sickle cell and the access they have to Spectra Optia Apheresis. This is a platform which is a way of collecting and processing cells so that clinicians have more time to spend with patients.

In 2022, we successfully bid for funding for NHS England's Innovation for Healthcare Inequalities Programme. This funding will support better self-management and treatment of cardiovascular disease. It will allow proactive patient outreach in GP practices and therapies that reduce the body's fatty acids.

Helping residents to stay independent

Using new technologies can have huge benefits, both for residents and health workers.

New social care technology is helping people to stay independent and improve their wellbeing. It is also helping the health and social care workforce to be better supported.

Innovations have focused on three key areas of greatest need:

1. Health monitoring.
2. Falls prevention; and
3. Digital records.

How technology is transforming our care homes

Since the ICB was established, we have been working to bring new technology and innovations into the area to improve care and the experience of our health and care workforce.

We have introduced new technology including Whzan Blue Boxes, which monitor blood pressure, heart rate, oxygen levels and the temperature of a person, so any changes can be identified early and shared with GP records.

The device provides staff with question prompts for assessments. It also advises whether residents need to go to hospital, helping to avoid unnecessary ambulance transfers and hospital admissions. Staff at the care home say they feel empowered and reassured through the easy-to-use device.

Acoustic monitoring has also been introduced in care homes in our area. This is a monitoring system where a sound detecting device non-obtrusively listens to sleeping residents and triggers an alert for staff to respond if a resident is disturbed or is trying to get out of bed. When sound exceeds or falls below an individual's normal noise level alerts are raised. The new system has improved the quality of care being delivered to residents in care homes. In Milton Keynes alone, the acoustic monitoring system has led to a 50% reduction in the number of night time falls and received positive feedback from both staff and the families of residents, who feel more assured that their loved ones are receiving good quality care through the night.

Jean, the wife of a resident in a care home in Bedford said: "It gives me peace of mind knowing that he'll get help when I'm not there".

The introduction of the Raizer II chair has also been a real game-changer for care home staff and residents.

It is an emergency lifting chair which can help raise an uninjured person from the floor after a fall, acting as a replacement for the traditional hoist.

For example, it was used in a care home to help a female resident who fell within a small, enclosed space in the bathroom. The size of the space would have made it impossible to use the traditional hoist device effectively, but the Raizer chair was assembled around the lady easily and

was able to lift her off the floor. The chair is not only good for care home staff and residents – it also helps to alleviate pressure on the emergency services.

In Milton Keynes, the Raizer chair has:

- Reduced the number of emergency admissions by 65%,
- Reduced ambulance calls by 24%,
- Reduced the number of journeys to hospital with a patient after a fall by 53%
- Reduced the number of emergency admissions by 67%

MiiCare is also being rolled out this year across our area in people's own homes, with funding for 142 units.

The digital tool uses sensors to monitor different aspects of the individual's environment or check for movement and falls. This supports a person to stay safely, living independently in their own home for as long as possible, with the reassurance that issues can be detected and investigated.

The benefits of innovations are monitored and evaluated to ensure value for money and improvements to the health and well-being for the residents, carers and staff.

Data and digital

Use of data and digital underpin much of the work we are doing to improve health and care outcomes for residents. They will help us to provide a more personalised service for residents, based on what the data tells us, and the opportunities that digital approaches provide.

Digital

The ICB has agreed a Digital Strategy for 2022-2025, in July 22. It details five key themes:

- A resident-first approach – ensuring we place the needs of our residents at the heart of our strategy;
- Digital as an enabler – using digital to provide better care across our ICS;
- Putting data at the heart of decision making: Using our data ethically and securely to make better decisions;
- Personalised care – discovering and implementing new ways of bringing care closer to our residents; and
- Supporting collaboration and innovation – working together as a partnership to continually improve the health and care we provide.

Data

The Digital Strategy is closely linked to the Data strategy. They have been co-produced with partners across Bedfordshire, Luton and Milton Keynes.

Our system is adopting a digital-first, rather than digital-only, approach. This will ensure that everyone has a choice in how they participate in their care journey. We recognise that not all residents have access to technology and may not be able to use it for a variety of reasons. They will not be excluded from receiving good care because of this.

We will co-design new services with our partners and residents, so that services meet users' needs. This includes ensuring that services are culturally appropriate and accessible.

We will introduce different ways for our residents to communicate with care providers, so they can jointly agree on the right services for them.

Care services are transforming as new approaches to technology are embraced. Throughout the pandemic we saw new, technology-enabled ways of collaboration and how data enabled us to target care where it was most needed.

In the future, data and digital will continue to serve as an enabler for change and improvement across our system. We will stay current with new, proven technologies. Where appropriate, we will choose low-waste, low-carbon footprint, repairable and upgradable technologies.

Our residents expect that health and care organisations share information when they are working together to provide care to an individual. A move to system working will present an opportunity for partners to consolidate our investment in digital products and services, standardising our digital offer around services which support good practice. This will reduce unwarranted variation, improve outcomes, and deliver better value for the technology we are purchasing.

Collaboration and Innovation

We will work in partnership with relevant institutions. These include universities, academic science networks, public health observatories, the Local Government Association and others to review emerging technologies and models of care.

We will evaluate the potential for Trusted Research Environments. This is NHS Digital's service to provide approved researchers with access to health data to answer research questions. We will collectively adopt established national data standards, allowing our teams and residents to connect to national programmes.

Workforce

Working as a system

The ICB People Board oversees all workforce initiatives to support, train and develop staff across Bedfordshire, Luton and Milton Keynes. It is supported by an education partnership sub-group which brings together representatives from all health, care, and voluntary organisations. We have a duty to promote education and training for our staff across Bedfordshire, Luton and Milton Keynes.

The group takes a system-wide view of education and training opportunities. These are promoted so that to training and development takes place together, with learning and best practice shared. It has focused on rotational apprenticeship posts, system-wide training, improving partners' placement capacity and standardising volunteer training.

The ICB's People Plan identifies two focus areas for education and training:

1. Ensure sufficient supply and retention of trained and engaged workforce to provide services to our population; and
2. Making sure careers in health and care are accessible, fair, and equal and support people with their own mental and physical health.

Through the achievement of these objectives, we will support economic growth in our area. We will also reduce inequalities for residents and people who work in our system.

The 2023 People Strategy identifies a focus on the education needs for new roles, liaising with Higher and Further Education institutions to commission education places and apprenticeships and harmonising and developing new system wide training.

Pathways into careers are a priority for us. We have made improvements across a range of areas to help improve access to careers in the health and care system.

We have boosted outreach to education institutions, innovated how we recruit, increased placement capacity, improved pastoral support for new starters and maximised use of the apprenticeship levy.

Our workforce development academy and primary care training hub are fully integrated within the ICB. The teams work in partnership to promote education and training to all staff across the system within primary, social, community and acute care.

Workforce is key to achieving the ICB strategic priorities. To realise these strategic goals and the overarching aim of improving population health outcomes and reducing inequalities, the ICB has developed a Joint Forward Plan and People Strategy. Current system vacancy levels of 13.7%, turnover of 14.9% and sickness absence of 4.8%.

The Joint Forward Plan is the primary strategic driver of delivery for the system-level five-year workforce plan, which will engender integrated care between NHS providers, social care, the voluntary and community sector, and other relevant partners such as fire and police services who support our strategic goals.

There are a range of programmes and initiatives taking place across our area that support organisations in offering flexible working, a variety of roles, and comprehensive support packages to their workforce. The care that our workforce provides to the ICS's population will be improved

through familiarity with and everyday usage of digital systems, within a psychologically safe environment that is free from bullying, harassment, and discrimination. Staff will operate under a 'One Workforce' approach that will enable place and neighbourhood multidisciplinary teams, which will comprise staff from multiple organisations. Staff will have careers that span both health and social care, and in so doing, will gain a broad understanding of how we can work differently as a system to deliver integrated services.

Building on the work of the 2022/23 BLMK ICS People Plan, the following priorities have been identified:

- Development of an integrated workforce planning approach linked to the ICS strategic plan, utilising accurate and timely workforce data;
- Ensuring a sustainable supply of suitably trained workforce;
- Support our population to enter the workforce and have rewarding and varied careers;
- Empowering staff to look after their own wellbeing; and
- Develop organisational development capacity to support service changes and re- design.

The ICB is working to develop new roles within the system. An example is the rotational Health Care Support Worker Post, enabling candidates to undertake the Healthcare support worker (HCSW) level 2 and level 3 apprenticeships. The post will rotate across Social Care, NHS Trust and a local hospice. The system is due to start seven rotational apprentices in September 2023.

The ICB has conducted engagement sessions with health and care partners and has identified the following four priorities for the system People Board and People Strategy:

1. Make the ICS a welcoming place for all people to learn, work and volunteer. We will do this by reducing health inequalities in staff experience across health and care, creating clear and diverse career pathways, recruiting diverse candidates, improving workforce flexibility and wellbeing, improving inclusivity, and increasing understanding of our workforce.
2. Make working across organisations, systems, and specialities the norm. We will do this by embedding system values in leadership training, making CPD activities team- based (not organisation-based), improving OD capacity and co-production for transformation, and creating new roles, placements and apprenticeships across health and care.
3. Provide a system-wide framework to enable integrated care and empower place and neighbourhood teams. We will do this by reducing barriers to integration by introducing digital staff passports, facilitating cross-organisational recognition of statutory/mandatory training and CPD, facilitating temporary staffing and role profiles, and producing guidance on MDT set-up and management.
4. Doing things together and at scale that benefit staff and populations. We will make best use of international recruitment, integrated workforce planning, Robotic Process Automation (RPA), careers outreach and attraction to the system, talent management, sustainability, workforce transformation, and creating new apprenticeship and degree pathways to support the new ways of working and creation of new roles.

Within the People Board there are currently six provider-led workstreams, each with multiple programmes, projects and initiatives, that are pivotal to transformation activity taking place across the ICS at place and organisation level.

We are currently piloting two innovative digital projects within Primary Care focussed on student placement expansion, staff health & wellbeing and patient empowerment for self-care.

The Shine Project which has been shortlisted for a HSJ Digital Award is a digital training programme that fully immerses Primary Care staff in the understanding of a digital App designed by a leading Psychotherapist to support with health, wellbeing & resilience. The App is evidence-based and has been co-produced with NHS staff across the country. These staff groups are able to share the benefits of the App with their colleagues and teams but also through a bespoke prescribing platform prescribe the App to specific patient groups to support with their mental health. The App has a sophisticated nudge technology built in so clinicians can send personal behavioural nudge messages to their patients to.

BLMK has embraced the implementation of Trainee Nurse Associates with 111 planned for 2023 across our NHS Partners and Primary Care. We currently have a total of 23 Trainee Nurse Associates undertaking their apprenticeship within general practices across BLMK. 8 of those are due to qualify this year.

We have piloted a digital student nurse placement project across 9 practices within BLMK which provided students with a blend of online learning and face to face learning in practice. Feedback from both the students and practices has been excellent and we are now scoping how we increase the number of digital placements and extend into other professions such as physiotherapists and paramedic students.

Starting in February the National Association of Primary Care (NAPC) team ran a 6-week 30-minute lunchtime wellbeing session. The sessions provided a space for staff to concentrate on self-care and their own wellbeing and resilience. It provided a half hour out just for staff and gives an understanding and tools to support taking back control and thriving. Easy relaxation skills are built on week by week so that attendees become comfortable with the format.

The sessions were attended by 30-40 people. The feedback was overwhelmingly positive with comments on how relaxed and positive attendees.

With the financial pressures facing all staff, a cost of living support signposting document was created in Winter of 2022, with the aim to help staff in the BLMK system to be aware of support, services and resources available to support the cost of living, both nationally and locally. It is not exhaustive but illustrates the range of support available.

The ICB as an employer

The ICB is committed to training and personal development of our staff and in addition to all staff completing Mandatory training, external training related to their roles and professional registration requirement, we also have annual membership with NHS Elect. NHS Elect is hosted by Imperial Colleague Healthcare NHS Trust and they provide a wide range of training and development services plus an extensive library of online courses including:

- Business and system development;
- Coaching and personal development;
- Customer care and patient engagement;
- Leadership and organisational development;
- Marketing, communication and branding; and
- Quality improvement and measurement.

During quarter two of 2022/23 we undertook the annual appraisal process for all staff. As an organisation we know that Appraisals are important not only for staff but also for ourselves, as they ensure that staff benefit from valuable feedback, recognition and discussions relating to their future career aspirations, as well as contributing to contribute to succession planning and wider organisational development plans.

As part of our appraisal process we included a health and wellbeing conversation. These conversations are intended to be supportive one-to-one coaching-style conversations that focus on people's wellbeing. The conversations aim to consider the whole wellbeing of an individual, to identify any areas of their life where further support may be required. The appraisal meeting is a good forum to hold one of these conversations.

Although we are not obliged to as an ICB, to continue our committee to listening to our staff between September and November we took part in the National NHS Staff Survey. We received a response rate of 86% which was in line with the response for 2021 but above the average. We were also ranked 3rd for the most improved positive scored and moved up to 11th in the rankings out of the 27th ICBs who took part. Although this was a positive year in terms of the results, we continue to look for areas for improvement and are working with staff across the organisation to set action plans for the coming year to address these areas.

Engaging people and communities

Involving residents in decisions that matter

We are ambitious for the people who live in Bedfordshire, Luton and Milton Keynes. We want everyone in our city, towns, villages and communities to live longer lives in good health and we know that working with and empowering local people is central to helping us achieve that.

Our population is culturally diverse – there are more than 100 different languages spoken in just one of our towns. The people that live in our four local authority areas come from a range of different backgrounds and ethnicities, making ours one of the most vibrant areas in the country.

This means that there is no one size fits all approach. With significant health inequalities experienced by local people, it has never been more important to refresh how we engage. This helps us to break down barriers, improve access, support local people to make healthy life choices and work together to shape the health and care services that residents want.

In 2022, following the establishment of the Integrated Care Board, we undertook an extensive engagement process with health and care partners and members of the public to better understand:

- How health and care organisations engage;
- What has worked well;
- How residents want to be communicated with; and
- How we can build trust within local communities.

This work, together with the learnings from the pandemic, resulted in the publication of the Working with People and Communities Strategy. It set out the principles which all organisations in the system agreed to adopt.

The ICB has committed to increasing community involvement and embedding the principles of co-production across the partnership. A Working with People and Communities policy was developed

and included in the Constitution of the ICB to ensure that everyone across the organisation and the system recognised the importance of resident involvement, participation and co-production.

In the first year of the Integrated Care Board and in this reporting period, we set out to:

- Listen to the experiences of local people;
- Develop new community connectors;
- Develop a culture of partnership-working and co-production;
- Roll out a workforce development programme;
- Establish a governance process to provide assurance; and
- Develop an evaluation and monitoring process to track progress and reputation.

Implementing our work

Listening to local people

Building on what we've heard so far – As part of the establishment of the Integrated Care Board, we developed a series of strategies and plans, including the Health and Care Strategy and the Joint Forward Plan.

We made sure that local voices were considered in their development, we analysed feedback since 2019. We also used insights from Healthwatch and other community organisations from during and after the pandemic. Work with children and young people and victims of abuse was also informed the strategies.

Listening to people with disabilities – We engaged with people with sensory needs, such as sight loss and hearing disabilities as part of the development of the digital strategy.

This engagement helped us to better understand the needs of residents living with a disability and how much they rely on digital technology for access to health and care services.

Listening to seldom asked people – During the pandemic, Reverend Lloyd Denny, a local pastor from Luton, was commissioned by the Clinical Commissioning Group to undertake an in-depth review of local people's experience of health inequality. This helped us to understand how the pandemic had impacted some communities more than others

As part of the review, Healthwatch and the Voluntary, Community and Social Enterprise (VCSE) sector were commissioned as trusted advocates to work with community connectors and engage with:

- Gypsy/Roma Traveller communities;
- LGBTQI+ people;
- People who live in areas of high deprivation;
- Homeless people;
- People with physical and learning disabilities; and
- Women who had experienced violence, including forced marriage and female genital mutilation (FGM).

The engagement, which took six months, provided insights into how health and care partners could improve access and break down barriers locally, to help people with health inequalities live longer lives in good health.

Working with Patient Participation Groups – we have also worked closely with patient groups in this reporting period, to understand the challenges they face in accessing primary care and the concerns they have around capacity, in light of population and housing growth.

Establishing a governance process and creating a culture of partnership

Governance - The Working with People and Communities Committee was established in July 2022, as a formal sub-committee of the Integrated Care Board. The committee provides assurance that the Working with People and Communities Strategy is being implemented routinely and effectively.

The committee comprises representatives from local authorities, primary care, the VCSE and Healthwatch. It scrutinises the organisation's engagement and consultation plans and advises how the ICB's statutory duty to involve could be discharged effectively.

A work plan has been developed for the committee to ensure members have visibility of all engagement work planned for the year ahead.

In addition to the formal committee structure, a forum has been established to help create a culture of partnership across the system. The monthly forum includes engagement and co-production leads from all ICS partners. It is working to agree principles and processes across the system to ensure that the lived experiences of local people are shared. The aim is to create a 'tell us once' approach and reduce engagement fatigue from residents who are often asked by multiple agencies to share their views and experience.

Since it was established in August 2022, the forum has worked in partnership to:

- Co-design the chapter on co-production for the Working with People and Communities Strategy;
- Develop a programme of co-production training with the Consultation Institute;
- Develop a co-production framework; and
- Collaborate on developing a draft policy for remunerating residents and service users, learning from best practice from across the country.

The group plans to deliver more in 2023/24, including the establishment of a participation network, which will see experts by experience shared across the system to provide first-hand insights to support decision-making.

In addition, work has been undertaken to establish strategic partnerships with Healthwatch and the VCSE. Memorandums of Understanding have been developed during this reporting period to help put these important relationships on a firm footing to support co-production and involvement in the years ahead.

The collaborative has been instrumental in the ongoing discussions about how we ensure that patients with lived experience bring a voice to our committees.

Establishing a co-production approach and rolling out a development programme

Development training – In October, the ICB commissioned co-production training, which explains how health and care professionals and residents should work together as equal partners to find solutions to some of the biggest health and care challenges we face and design local services for

local people. Led by the Consultation Institute, the training was rolled out to commissioners, practice managers, GPs and the VCSE across Bedfordshire, Luton and Milton Keynes. More than 250 people had received co-production training from January to March 2023.

Bi-monthly community of practice webinars have also been established. They help commissioners see best practice examples and hear from people who have been through the process who can share tips and lessons learned.

A co-production framework, or checklist, has been co-designed with partners and people with lived experience to support the transition from consultation to co-production.

Evaluation and monitoring to track reputation

Monitoring – We commissioned external support to engage with a representative sample of residents to benchmark perceptions in this first year of the Integrated Care Board. Field work will begin during the next financial year period and will report annually.

You said, we're doing - putting words into action

From listening to local people in this important first year of the ICB, we know continuous conversations are important. Also, playing back to residents how their feedback has made a difference is key to building trust and increasing participation.

From the engagement we have undertaken during this reporting period, we have already started to act on feedback, as follows:

You said	We're doing
We feel outed as transgender people every time we enter a health care facility, especially in primary care	Delivered a programme of transgender training for health and care professionals across Bedfordshire, Luton and Milton Keynes. Delivered by experts by experience, the training was delivered virtually and face to face – to give health and care professionals an understanding of transgender issues and confidence in using appropriate language to make the experience of accessing care easier for transgender people.
As deaf people, we struggle to access health services because of the lack of effective digital technology and a lack of understanding from health and care practitioners.	We are delivering a programme of deaf awareness training courses for primary care staff across the area. We are also working with our digital team to provide insights from the community to develop solutions which will support access for people who are deaf or hearing impaired.
As young people, we want to have a role in shaping the tools we use to support diagnosis for ADHD and autism.	Through Cambridge Community Services, young people have worked to co-produce a diagnostic tool – designed for young people with ADHD and autism.

We want to have a say in how mental health services are rolled out across Bedfordshire, Luton and Milton Keynes.	We have undertaken a number of mental health events, including the Mental Health Summit, led by East London Foundation Trust in March 2023, to give people the opportunity to share their experiences and shape mental health services.
We struggle to access the website because of our learning disability or because it's not in our language	We have implemented a new accessibility tool to our website called Recite Me. It translates all content on the website to all community languages and provides support for people who are visually impaired or have dyslexia.

Further work is being undertaken on the Denny Review into health inequalities to co-produce solutions to the challenges outlined, to break down barriers and improve access for everyone in our area – regardless of their background.

Personalisation of care

Working with people so that care is right for their needs

Shared decision-making is increasingly playing a central role in the way we involve patients in their care.

It is being used for planned care in areas such as Musculo-skeletal and dermatology. A shared decision-making conversation gives patients an understanding of their treatment and care options. It helps to put people in charge of their healthcare journey.

It is increasingly used within primary care, where the pandemic highlighted the importance of shared decision-making and advance care planning. It has been encouraged through several initiatives so that all care can be person-centred.

Multi-disciplinary teams

Multi-disciplinary team meetings are becoming standard practice. They help to form relationships with health care and other professionals and carers involved in an individual's care. These meetings highlight where shared decision-making is needed.

Shared decision-making and support for advance care planning have become commonplace in primary care so that every individual is able to voice 'what matters to me' rather than 'what is wrong with me'. This is evidenced by the rise in personalised care and support plans, in particular as part of the primary care enhanced health in care homes framework.

Health coaching

Health coaching is provided by the health and wellbeing coaches, part of the extended Primary Care Network team. There are currently 19 (17.2 whole time equivalent) across our area, using specialist coaching and behaviour change techniques to support service users.

Connecting people to their community

We know health and wellbeing issues can emerge if a resident's practical, social and emotional needs are not being met.

That's why we have something called social prescribing. This is when a health professional works with a patient to identify their needs. Then they connect them with activities, groups and services in the community to meet these needs.

Link workers give residents time, focusing on what matters to them. They co-produce a simple, personalised care and support plan. This helps people to take control of their health and wellbeing.

We have developed a vibrant and varied ways of linking people to the services they need. Link workers are central to this, employed in local practices or Primary Care Networks and commissioned from a range of partners.

Case Study: AGE UK Milton Keynes 'Live Life Service'

Pamela, a resident of Fenny Stratford near Milton Keynes, felt socially isolated from her community, which impacted her health and wellbeing

Age UK Milton Keynes provides a free service for adults living in the city, commissioned by the Integrated Care Board, so that they are better connected to a range of services.

Pamela was referred to Social Prescribing, Live Life as she was feeling bored and unable to go out as often as she needed to. This was having an impact on how she felt. She was "very down" when she started using the service.

Pamela met Lucy, a link worker. They talked through her health and wellbeing, what is important to her and what she would like to achieve. Pamela's goals were to go out, using affordable transport, to meet other people.

Since meeting Lucy, Pamela has applied and received a disabled bus pass, registered for the MK connect service. She now enjoys being independent, feeling safe to go out. Lucy supported Pamela for the initial trip, ensuring Pamela felt confident using the app to book transport.

Pamela says:

"I am going to bed at night and actually sleeping…instead of sitting up all night thinking what am I going to do tomorrow…everything is totally different, how I am dressing, going out all over the place. There's all sorts of things that can help."

Case study: Bedfordshire Rural Communities Charity

A resident who had mild / moderate depression, fatigue and muscle aches was referred to the community wellbeing champion by their GP.

From the assessment it was identified this patient was lonely, felt isolated and didn't access green spaces.

The resident engaged with the community wellbeing champion and are now attending wellbeing walks, joined a conservation group and a community garden and have been on a mindfulness course.

After taking part in these activities, the resident has reduced their dependency on medication.

Personalised care and support planning

Personalised care and support plans are being used across numerous health and care pathways.

These include maternity, continuing health care, cancer and the Enhanced Health in Care Homes framework. The plans involve clinicians and care coordinators working with service users and, where appropriate, their carers and families. Together they agree the health and wellbeing outcomes that matter to the patient and how best to provide the treatment plan.

Personal Health Budgets

A personal health budget is an amount of money to support a person's health and wellbeing needs. It is planned and agreed between a resident, or someone who represents them, and a local NHS team. Personal Health Budgets are available in children's continuing care, continuing health care and personal wheelchair budgets. Work is currently underway to include the process for people in receipt of Section 117 after care, which is when someone comes out of hospital after a mental health problem.

Case study: Helping a young person sleep better and reduce stress

"Lucy" – name changed to protect her identity – is a young person from Luton with a diagnosis of autism and global development delay. She also has problems sleeping. She attends a local children with special educational needs and disabilities (SEND) school which enables her to have specialist one-to-one support.

The ICB commissioned Autism Bedfordshire to manage the personal health budgets for children and young people in the area. These budgets can improve people's quality of life and their experience of care by helping them to have more choices about how their healthcare needs are met.

Using her personal health budget, Lucy was provided with a brand-new bed to promote good sleep hygiene and reduce dysregulation, which is where a person is not always able to regulate their emotional responses.

The support enabled Lucy to improve her health with improved sleep. It gave her the opportunity to relax, de-stress and regulate emotions in her own space.

Lucy's parents said:

"The bed was important as Lucy cannot share a room with her two sisters due to her needs during the night. You have supported us during the most difficult time we normally face as a family when there is no school."

Enabling choice

We currently provide choice of GP practice, choice at point of referral and for personal health budgets.

Personal health budgets

2022/23 saw the ICB further consolidate its Personal Health Budget (PHB) offer. We have reviewed our data capture process enabling us to better record the PHB's we have provided. We have also seen an increase in use of PHBs across the year.

We worked closely with our Continuing Health Care team to formalise the PHB process to ensure that notional PHBs are the default offer for people in receipt of care in their own home.

The ICB also undertook a limited pilot offering small PHBs for people with learning disabilities, which will be evaluated in 2023/24.

GP choice

All residents have a choice as to which GP practice they register with, providing the GP covers the area in which they live (some practices take out-of-area patients, but most have defined boundaries). However, if someone is a resident permanently living in a care home, we do encourage them to register with the aligned GP practice responsible for supporting that home so that they can fully benefit from the Enhanced Health in Care Homes programme.

Reducing inequalities

Making health and care fairer for everyone

We know that not everyone enjoys the same good health and opportunity across their lives. The pandemic also shone a light on some of the health and wider inequalities that persist in our society.

Health inequalities are avoidable, unfair or systematic differences in health between different groups of people.

Since coming together as an Integrated Care System, we have been building a programme of work so that tackling inequalities is at the heart of everything we do. This includes building system leadership on inequalities, hardwiring action on inequalities across all of our programmes. It means distributing national funding for specific projects to tackle inequalities at a place and system level.

Delivering the national inequalities programme

Our programme is designed to deliver the five national healthcare inequalities programme and is built around the national Core20PLUS5 framework.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at a national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies five focus clinical areas requiring accelerated improvement.

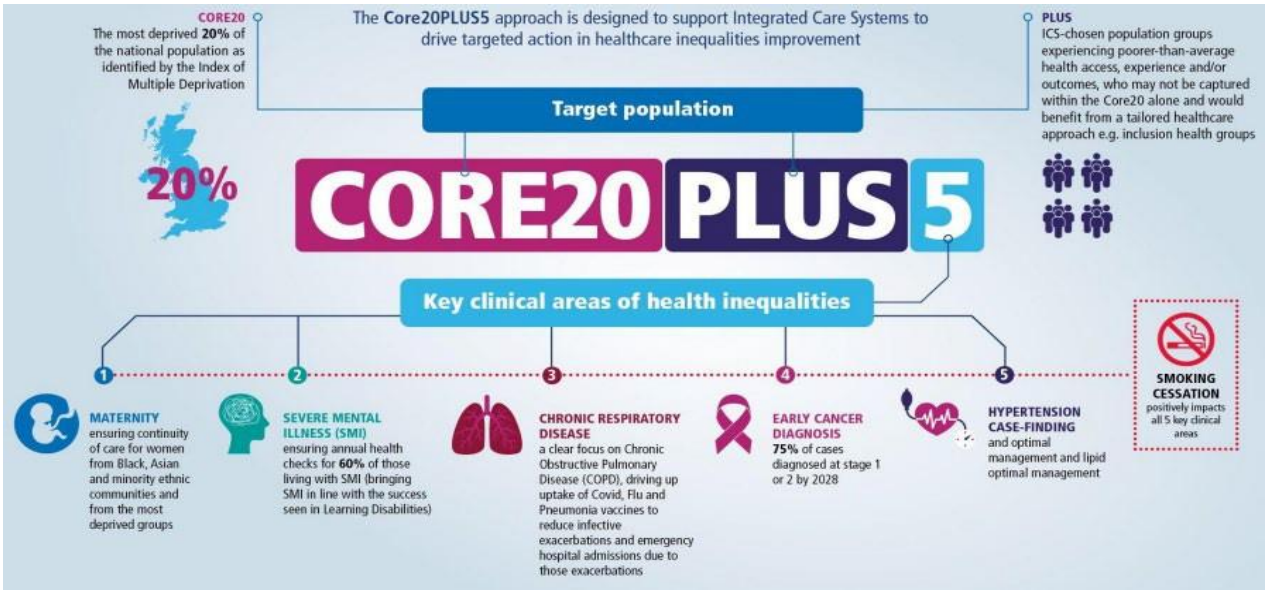
Core20+5 (see graphic 1 and 2)

The NHS Long Term Plan place tackling inequalities at the heart of NHS goals for this decade. The evidence based Core20 PLUS 5 framework defines key population groups and clinical focus areas for accelerated improvement in healthcare inequalities.

The national healthcare inequalities programme has identified five priorities:

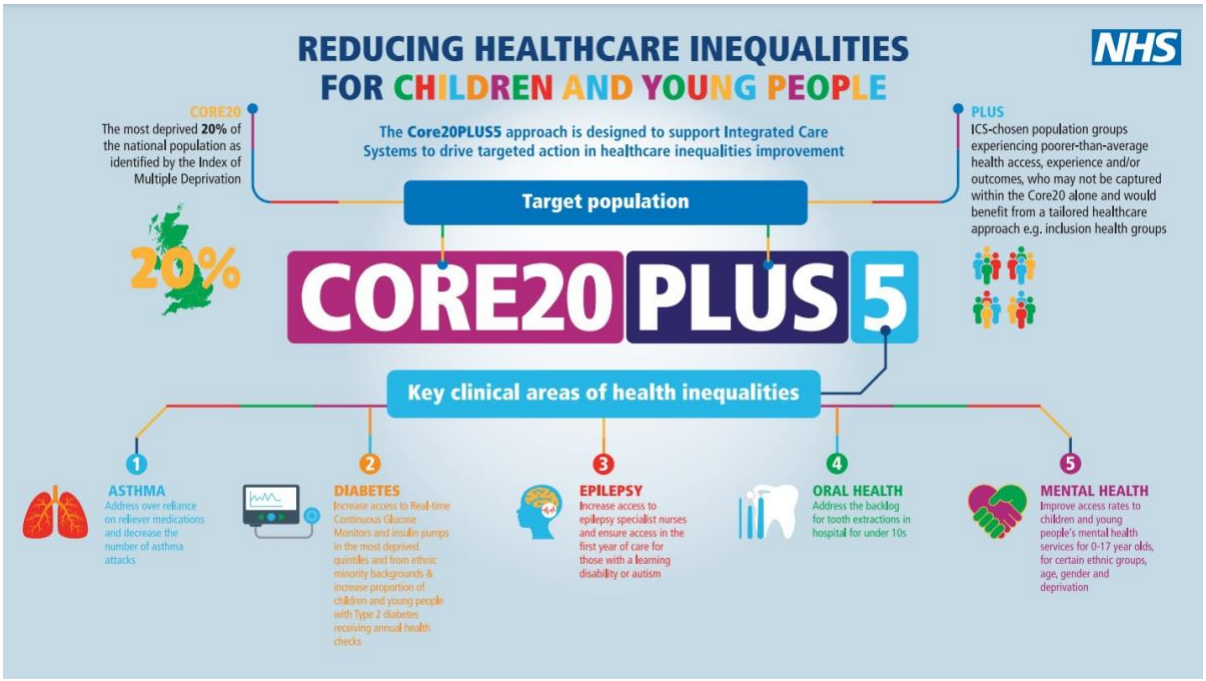
1. Restoring NHS services inclusively,
2. Mitigating against digital exclusion
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes
5. Strengthening leadership and accountability

Core 20 + 5 for adults



https://www.england.nhs.uk/wp-content/uploads/2021/11/Reducing-healthcare-inequalities-Core20PLUS-infographic.pdf

Core 20 + 5 for children and young people



https://www.england.nhs.uk/wp-content/uploads/2022/11/core20plus5-cyp-infographic-v2.pdf

Across Bedfordshire, Luton and Milton Keynes we are focusing on the following areas against the Core20+5

Core20		PLUS			
Tackling inequalities in: • Still birth • Infant mortality • Neonatal mortality • Maternal mortality	Improving healthy life expectancy at birth in the 20% most deprived population and the rest.	People of all ages with mental health issues including children with low emotional resilience	People living with learning disabilities	Health inclusion groups	People who have survived COVID 19 infections, including black, Asian and minority ethnic (BAME) and other diverse communities
5 National Areas of Focus					
Maternity	Severe Mental Illness (SMI)	Chronic Respiratory Disease	Early Cancer Diagnosis	Hypertension Case-Finding	
Ensuring continuity of care for 75% of women from BAME communities and deprived groups	Delivering annual health checks for three out of every five of those living with severe mental illness	Driving uptake of COVID, flu and pneumonia vaccines for people with chronic obstructive pulmonary disease (COPD) to reduce the chances of the disease getting worse and emergency hospital admission	Diagnosing three out of every four cancer cases at stage 1 or 2 by 2028	Identifying people with hypertension and delivering interventions to minimise the risk of heart attack and stroke	

Health inequalities in our area

We have made assessments of health inequalities in our area and looked at population health data.

This work made it clear that the 20% most deprived are more likely to have long-term conditions than the least deprived. Circulatory diseases, which are conditions which are related to problems with the flow of blood around the body, are a common cause of ill health and premature mortality in our most deprived population.

People with mental health conditions are almost twice as likely to have long-term conditions, and other co-morbidities, than the rest of the population. People with learning difficulties are more likely to have diabetes and obesity than others, as well as being more at risk from stroke and dementia.

Looking at the population of Bedfordshire, Luton and Milton Keynes, we have identified inclusion health groups. Inclusion health is a term the NHS uses to describe groups associated with poor health outcomes when compared with the rest of the population. These include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, and victims of modern slavery. Our data and work undertaken during the pandemic has delivered insight into the health needs of these groups.

COVID-19 infections have also disproportionately affected people from diverse communities. Analysis continues to show that people from a black ethnic background are at a greater risk of death involving COVID-19 than other ethnic groups.

Taking action on inequalities

Good data is at the heart of our systematic efforts to tackle inequalities. We are working to deliver against our Population Health Management Strategy, and have published population health data packs at place, and Primary Care Network level. These packs aim to support system partners to identify key inequalities within their area and drive planning and prioritisation. We have developed a health inequalities dashboard, bringing together key metrics to identify and assure progress against tackling inequalities.

Spotlight on health inequalities in Bedfordshire, Luton and Milton Keynes

- **Premature mortality** and difference in life **years lived in good health** or without disability in our area is **higher than in other systems**.
- In Luton, **death rates from COVID-19** were proportionally one of **the highest in the country** between March 2020 and April 2021.
- In Bedford, the **difference in life expectancy** between the most and least deprived is
- **8.2 years** for women and **10.3 years** for men.
- Around 50,000 people in our area are living in the most deprived parts of England. **24%** of children living in Central Bedfordshire, **31%** of children in Milton Keynes and Bedford Borough, and **46%** of children in Luton live in **poverty.**

We have been working to build a quality improvement offer. This involves upskilling system partners and our staff so that they tackle inequalities in a consistent and evidence-based way. Our approach aims to build capabilities to spot inequalities and priority populations for action. Then we design, deliver and evaluate inequalities projects to see the difference they made.

We have created a learning network around our inequalities work. This network shares learning and the best ways to tackle inequalities.

We have developed coaching for people so that they can deliver projects to a high standard. This has been done in areas such hypertension, maternity, and children and young people programmes. We intend to roll-out more such coaching projects in 2023/24.

In October 2022, we held an inequalities event with system partners, experts by experience and residents. This identified five key themes to consider in our inequalities strategy and plan:

1. Collecting, sharing and simplifying data to identify, tackle and assure progress in addressing health inequalities
2. Building culturally appropriate services for residents, supported through workforce training and education
3. Creating a culture of mutual respect and trust and focus on prevention
4. Sharing resources and improving expertise in tackling inequalities
5. Collaboration and co-production with people with lived experience.

The ICB uses EDS2, the equality delivery system for the NHS. It helps us deliver health inequalities work with the aim of improving the services we provide, and the experience people have while using them. It should also ensure better working environments free of discrimination for NHS workers.

The Integrated Care Board will analyse our performance against the agreed outcomes set within the EDS2 for each population group. This work is overseen by our inequalities working group which includes a wide range of stakeholders.

The inequalities team is made up of people with lived experience, improvement advisors and programme leads. The team works with each of the clinical teams to develop inequalities strategies and create improved, more equitable services for residents.

This involves setting up new steering groups with partners and using data to focus on the population groups of interest. An example of this is the new learning disabilities steering group. The improvement advisor takes the steering group through the improvements, which are data- led and co-produced.

The quality improvement and population health approach of the ICB is embedded within our Children and Young Persons Core20+5. We focus on the population and how to improve access, experience and outcomes rather than looking at different clinical pathways separately.

A community connectors strategy group has been developed, headed by our inequalities lead. Community connectors are supported by inequalities funding and VCSE. They work with our communities to understand what priorities matter most to them. As an example, Community Action MK is working with an estate listed within the 20% most deprived in Milton Keynes to find out what the community needs. The group then works with clinical programme leads and VCSE groups to tailor an approach for that community.

Funding for health inequalities projects

We allocated over £3m of national funding for health inequalities projects in 2022/23.

This funding was targeted to develop resource and engagement to build the inequalities programme. It was linked to place and system priorities.

It has been directed to support community connectors. These are people who provide representation from communities who are often not well supported by existing services or experience health inequalities. They then help us to design better services, based on the five Core20PLUS5 priority areas and other local priorities.

In addition, funding has also been spread across six priority areas of cancer, maternity, mental health, hypertension, learning disabilities and immunisation.

	Projects supported
Cancer	Extensions to the Luton Outcomes Project, to improve awareness and screening uptake, cultural literacy training for staff and support for people to attend treatment.
Maternity	Work with the voluntary sector to develop community-based champions. They then promote preconception advice with a focus on diverse and deprived communities.
Mental health	Peer support workers to provide support for people with dementia. Outreach to improve physical health for adults with severe mental health conditions. Personalised support to help children and young people manage their health and wellbeing and improve access to services.
Hypertension	Funding for GPs to support the diagnosis and treatment of people with hypertension who might otherwise not have been diagnosed.
Learning disabilities	Support for staff to identify and serve the needs of people with learning disabilities. Also, a new way helps people with learning disabilities manage their disabilities through a media platform.
Immunisation	Immunisation support for people from the 20% most deprived practices to increase uptake in MMR, flu and COVID vaccinations.

How we are helping to reduce health inequalities across our area

Community support to improve mental health

Community connectors are part of mental health teams across Bedford Borough. They support people with emotional, social and practical needs.

They have an in-depth knowledge of local charity and community services. The community connectors help people access services to improve confidence, social inclusion and independence. These services look at the building blocks of good health, and specific mental health needs.

Tackling inequality in outcomes from heart disease

High blood pressure can increase the risk of heart attack and stroke. Caught early, hypertension is easy to treat, but detection rates are much lower in some populations.

GPs across Milton Keynes are working with pharmacies to identify people at risk of hypertension but who may not be coming forward for treatment.

Supporting people with the cost of living crisis

With more people reporting increases in the cost of living having a negative impact on their health, we are working to find ways to support our residents.

Councils in our area are using ICB funding to work with local organisations to provide warm spaces, where residents can get a hot drink and join in activities. Volunteers are also on hand to advise on issues from managing bills to homelessness and loneliness.

In Bedford Borough, GP services have invited over 1,500 people with health conditions that could be made worse by living in cold or damp houses to access advice and support from their local Better Housing Better Health scheme.

Reducing health inequalities engagement work

Tackling health inequalities is one of our overarching priorities.

But to reduce inequalities we need to understand what causes them.

For this reason, we commissioned the Denny Review in 2022 to explain the barriers to good health for people who experience health inequality. It was led by Reverend Lloyd Denny, a Luton-based pastor and former lay member of Luton Clinical Commissioning Group Board.

A steering group was established, which commissioned a literature review by the University of Sheffield to assess the evidence and understand the most difficult issues. The literature review was followed by listening to lived experiences of seldom heard residents. This work was undertaken by Healthwatch and VCSE partners from August–December 2022.

The literature review highlighted that the people who experience the greatest health inequalities were:

- Gypsy, Roma, Traveller communities.
- People from ethnic minorities living in deprived areas.
- People with a learning or physical disability living in deprived areas.
- Homeless people.
- Migrants; and the
- LGBTQI+ community.

One of the important things it highlighted was the need to not just look at these groups in isolation, but where they were in combination.

Barriers that were repeated in the literature review included health literacy, diversity of community languages, disabilities and access, cultural barriers, race and religion. For all groups a lack of understanding of how the NHS works was an issue.

The engagement work largely validated the literature review. The good news was that there are some quick fixes raised by the review. In the longer term, we have some work to do to rebuild the trust with people, who think that there won't be substantive change based on their experience.

In February 2023, we agreed to:

1. Invest in VCSE and Healthwatch through projects such as community connectors, to build trust.
2. Address immediate recommendations, using co-production to design and implement solution; and
3. Meet face-to-face to build strategy collaboratively.

A face-to-face workshop was held with the steering group in March to review the findings and agree the above as an appropriate way forward.

Health and wellbeing strategy

Health and Wellbeing Boards play a leading role in setting strategic direction to improve the health and wellbeing of people locally.

The ICB is a partner in five Health and Wellbeing Boards:

- Bedford Borough;
- Central Bedfordshire;
- Luton;
- Milton Keynes (known as the MK Health and Care Partnership); and
- Buckinghamshire.

Set out below is a summary of how the ICB has worked together with Health and Wellbeing Boards to improve health outcomes for residents in 2022/23, and where priorities that Health and Wellbeing Boards have set have informed the ICB's work.

Some of this work has been at 'system' level and therefore a priority across Bedfordshire, Luton and Milton Keynes – this is summarised below.

Where work with Health and Wellbeing Boards has been more place-specific to address the health and care needs of a local population, this is reflected in the Our Action at Place in 2022/23 section below.

Our Health and Wellbeing Boards were made aware of their role in contributing to the ICB's annual review and agreed that the following reports would be completed in discussion with the chairs of our Health and Wellbeing Boards and approved by them as accurate representations of the work we have together undertaken over the reporting period for the benefit of our residents.

Action across our health and care system in 2022/23

Across Bedfordshire, Luton and Milton Keynes the ICB has worked with Health and Wellbeing Boards to deliver on agreed priorities.

This has shaped the delivery of the following work.

- Publishing a **BLMK Health and Wellbeing Strategy –** the Strategy, based upon local Health and Wellbeing Strategies, was approved by the BLMK Health and Care Partnership in December 2022. In summary, the Strategy:
    a. Reflects five priorities: Start Well, Live Well, Age Well, Support Growth and Tackle Inequalities;
    b. Is committed to subsidiarity to place, with a focus on planning, decision- making and delivery as close to the resident as possible;
    c. Emphasises the need to further build our partnerships to support residents to live longer, healthier lives, and the central role of VCSE in achieving this; and,
    d. Speaks to real examples that make a difference to local people;
- Delivering the transformative **Digitalising Social Care Programme**, which is supporting more people to live independently at home, and dedicated care staff to be able to access the right information at the right time. New and innovative technology introduced in care settings across BLMK is reducing the prevalence of falls and supporting care users to take the right medication at the right time;
- Widening **access to quality Musculoskeletal (MSK) support** – we have listened to people in BLMK to understand more about their experience of MSK care and what really makes a difference. We will be working together with Places in 2023/24 to use this insight to inform our procurement of services. Increased awareness of self-referral into MSK and expansion of MSK clinicians in Primary Care is providing quicker access to support.
- Improving **Access to Primary Care,** where we've been supporting recruitment and retention of GPs across BLMK and encouraging the development of a more diverse primary care workforce through the Additional Roles Reimbursement Scheme (ARRS) so that more patients can access the most appropriate expert support as soon as possible. More information on this can be found on page 24-28.
- Deliver **Improved Mental Health Services**. We've been working with an unprecedented level of collaboration, which has been crucial to making sure that the mental health system is resilient in the face of continued pressures. We've invested in local services, with a focus on Long Term Plan ambitions, despite seeing increases in crisis and inpatient services, both in numbers of patients and severity, over the past year. We have been developing a Mental Health, Learning Disabilities and Autism Collaborative with CNWL and ELFT which will develop a new service offer for the population;

- **Tackling health inequalities** – we've focused on gathering intelligence into the range of inequalities that exist across BLMK. The Denny Review is providing us with the valuable insights we need to understand how poor experiences of health and care can create barriers to access in each of our Places. We're proud to be investing £300,000 in Community Connectors - people who work in communities and are trusted to engage with residents to represent local views and inform service design.

- Working with **people and communities** – following in-depth engagement with partners from the four local authority areas and the Chairs of Health and Wellbeing Boards, the Working with People and Communities Strategy was approved. This ensures the voices of local people and their experiences are heard at every level across the Integrated Care System. The Health and Care Partnership, which includes the Chairs of the Health and Wellbeing Boards, has continued to guide the implementation of the Strategy in 2023/24.

Action at place in 2022/23

In each of our places, the ICB has worked with the local Health and Wellbeing Board.

In **Bedford Borough** - the ICB has worked with the Health and Wellbeing Board to provide additional support to residents struggling with the rising cost of living, with a specific focus on tackling fuel poverty and preventing deteriorating health conditions and hospital admissions. The Bedford Borough Warm Homes programme has helped over 200 residents to heat their homes more affordably by providing advice, referrals and energy efficiency interventions.

More than 30 organisations have signed up to be part of the Borough's Warm Spaces network, providing somewhere warm and welcoming for thousands of residents this winter. Through the Better Care Fund the Councils has worked with the ICB and voluntary sector to deliver a number of schemes including expansion of the Red Cross service to prevent admission and speed-up discharge, partnering with Age UK to make follow-up calls and provide low-level support to prevent re-admission, and working with Carers in Beds to prevent carer breakdown.

Crisis cafes have been established in partnership with BLMK Mind and the East London NHS Foundation Trust to support people in times of need. Work between the ICB and the Deaf Community in Bedford Borough is supporting access to and experience of primary care.

In **Central Bedfordshire –** the ICB has provided funding to Bedfordshire Rural Communities Charity to help people in rural areas access digital support and equipment to connect with others and reduce social isolation. Work has also been funded through the British Red Cross to help vulnerable people who have been discharged from hospital.

In **Luton –** the ICB has focussed on supporting the development of Luton 2040, which aims to create a "Marmot Town" – one where everyone thrives, and no-one is living in poverty. The Chief Executive of the ICB spoke at the Luton 2040 conference about the ICB's support for this agenda, whilst other ICB representatives ran workshops for attendees focussed on sustainability in health and care. Support for Young People in Luton has been a particular focus, including working with young people with ADHD to help them manage their own health and wellbeing and empowering them to be more actively involved in their own treatment and care.

In **Milton Keynes** – the ICB has worked with MK partners to agree the 'MK Deal' which targets ICB support and resources towards four local priorities of improving system flow, tackling obesity, children's mental health and supporting people with complex needs. Work on the priorities is starting in phases with the first three priorities having commenced in the current year. In 2022, the Place Link Director and the ICB's Head of MK Improvement Action Team became members of the Joint Leadership Team to support delivery of this work programme.

In **Buckinghamshire,** where 6,000 residents are within the ICB footprint, we have prioritised sharing information on services that Buckinghamshire residents' access in Milton Keynes, and considering the needs of these residents (through a Joint Strategic Needs Assessment) in the development of the Joint Forward Plan.

Looking forward to 2023/24**, the ICB will continue to work closely with Health and Wellbeing Boards. The Joint Forward Plan** is due to be published in June 2023. It will set out a framework for how the ICB and partners intend to arrange and/or provide services to meet our population's physical and mental health needs. ICBs are working with Health and Wellbeing Boards in preparing the Joint Forward Plan. This work will intensify during April to June 2023. This includes sharing a draft with each relevant Health and Wellbeing Board (HWB) and consulting as to whether the plan takes proper account of each relevant local health and wellbeing strategy.

Financial Review

The closedown of the CCG and the establishment of the ICB

Bedfordshire, Luton and Milton Keynes CCG was abolished on 30 June 2022. On 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 CCG and ICB finance staff to undertake a significant number of tasks to enable a smooth transition of people, property and liabilities between organisations.

Financial Performance

With the passing of the 2022 Health & Care Act, ICBs have a statutory duty to contain expenditure within the limits directed by NHS England, with a requirement to deliver system financial balance. NHS England may make directions about ICBs' management or use of financial or other resources. NHS England may also set joint financial objectives for ICBs, and their partner NHS trusts and NHS foundation trusts. ICBs and partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that limits specified by a direction by NHS England are not exceeded.

ICBs have the following statutory financial duties. The performance of the ICB in 2022/23 is set out in the following table. Further details are provided in Note [24] of the Accounts, on page [27].

Matter	Target	Actual	Achieved
	£000s	£000s	
Maximum revenue resource use The revenue resource use for each Integrated Care Board in 2022-23 shall not exceed the amount spsecified.	1,405,980	1,405,712	**Yes**
Maximum capital resource use The capital resource use for each Integrated Care Board in 2022-23 shall not exceed the amount specified.	785	785	**Yes**
Maximum revenue resource attributable to matters relating to administration The revenue resource use for each Integrated Care Board attributable to matters relating to administration in 2022-23 shall not exceed the amount specified.	16,354	14,922	**Yes**

Mental Health Investment Standard

An important planning requirement is the delivery of the Mental Health Investment Standard (MHIS). The standard requires Integrated Care Boards to increase investment in mental health services at a higher percentage than their overall rise in allocation from NHS England each year.

Achievement of the Standard is measured by comparing expenditure in 2022/23 to that in the previous financial year. This is after considering any mental health specific recurrent or non-recurrent allocations received in either of these years. These adjustments are made to ensure that changes in spending are not skewed by non-recurrent allocations and are limited to reviewing spending funded from our general allocation. Spending on learning disability and dementia services is currently excluded from the MHIS calculation.

ICBs are required to publish a formal declaration as to whether their spending met the Standard. This statement will be subject to a separate audit assurance engagement through the ICB's auditor. This report will be published alongside the ICB's own formal declaration.

In 2022/23 the legacy BLMK CCG and ICB was required to increase its mental health spending by a minimum 7%. Subject to confirmation through independent audit, the ICB has met the Mental Health Investment Standard (MHIS) in 2022/23.

2023/24 planning guidance and financial outlook

The impact of COVID-19 on the NHS has been significant and continues to shape priorities we set for the use of our collective resources going forward.

Since 2021/22, NHS allocations have been made at a system (or ICS) level. This was originally via a lead CCG, and combined both recurrent funding, and funds for non-recurrent expenditure such as COVID-19 and elective activity recovery. This principle of system wide allocations helps ensure that funding is distributed to meet agreed priorities. Capital monies are also allocated at system level.

The financial framework arrangements for 2023/24 continue to 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 two- year revenue allocations and one-year capital allocations alongside the 2023/24 planning guidance.

For 2023/24 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. In spite of this, the ICB has set a breakeven financial plan for the 2023/24.

From 1 April 2023, the ICB has been delegated responsibility for commissioning and paying for Dental, Pharmacy and Optometry services from NHS England.

At present, ICBs are not responsible for commissioning or paying for national or regional specialised services – these are commissioned by NHS England. However, from April 2023, a joint

committee to oversee the commissioning of specialised services has been established between NHSE and ICBs, with a view to potential future delegation of specialised services delegation to ICBs.

ICBs receive an allowance for their day-to-day management and administration costs, known as the running cost allowance. This allowance must cover all ICB management costs including the costs of commissioning support services. As well as covering the costs directly associated with commissioning, the allowance covers the costs of the chief executive, chief finance officer, internal and external audit, and counter fraud services. ICBs have been notified that they are required to reduce running costs by 30% from 2025/26 as part of a wider reduction in administrative costs by NHS England. The ICB will need to work out how to deliver this efficiency locally. Delivering the reduction in running costs will be challenging.

Capital resource plan for 2023/24

The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act) sets out that an ICB and its partner NHS trusts and foundation trusts must prepare and publish a plan setting out their planned capital resource use.

As an Integrated Care System, BLMK has an ambitious set of estates plans, and a strong track record of delivery of key enabling capital programmes across our partner organisations.

The BLMK ICS capital plan comprises those organisations that form part of the financial control total, namely BLMK ICB, Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes

University Hospital NHS Foundation Trust. The capital funding available to BLMK for 2023/24 includes annual capital allocations from NHS England, Trust-generated capital, and specific funding secured towards national priorities. This joint plan sets out how this funding will support delivery of local system priorities, including redevelopment of our acute hospital sites, delivery of a new Primary Care facilities in North Bedford, the Grove View Integrated Health & Care Hub in Dunstable and community diagnostic centre provision at a number of sites across BLMK.

The Capital resource plan does not describe the entirety of our system estates plans. There are significant primary care, community and mental health services schemes which will be delivered via revenue investment (third party capital investment) within Bedfordshire, Luton and Milton Keynes which are not covered in this plan as they are not dependent on NHS capital funding. Also, our NHS mental health and community providers are based outside of Bedfordshire, Luton and Milton Keynes, and as such their plans form part of their host system capital programme.

ACCOUNTABILITY REPORT

Felicity Cox
Accountable Officer
27th June 2023

Accountability Report

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

It comprises three sections:

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

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

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

Corporate Governance Report

Members' report

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) was established on 1 July 2022, by order made by NHS England under powers in the Health & Social Care 2006 Act (the 2006 Act as amended).

The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

The main powers and duties of the ICB to commission certain health services are set out in Sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

Board member profiles

Dr Rima Makarem – Independent Non-executive Chair

Rima trained as a scientist before going on to hold senior roles within the global pharmaceutical sector. She has 15 years' experience working at board level in the NHS. She has been the Independent Chair for the Bedfordshire, Luton and Milton Keynes Integrated Care System since June 2020. Rima is also Chair of the Sue Ryder charity, Chair of Queen Square Enterprises Ltd, an independent healthcare provider based in London, and a Lay Council member for the General Pharmaceutical Council. Previous recent roles included Senior Independent Director & Audit Chair of the National Institute for Health and Care Excellence (NICE), and Audit Chair and External Commissioner at the House of Commons Commission, working closely with the Speaker and the Leader of the House.

Felicity Cox – Chief Executive

Felicity was appointed as Executive Lead for the Integrated Care System (ICS) in September 2020. In November 2021 she was appointed Chief Executive (Designate) for the new Integrated Care Board, of which she is also Accountable Officer.

Felicity is a qualified pharmacist and maintains her clinical roots through her continuing professional development. Previously 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 other Chief Executive Officer roles and Director of Commissioning Operations for NHS England.

Dean Westcott – Chief Finance Officer

Dean previously held the Chief Finance Officer role at the Clinical Commissioning Group and is Executive Finance Lead for the Integrated Care System. He was previously Director of Capital Planning and Estates for Herts and West Essex ICS and has held Director of Finance roles within the NHS for a number of years.

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

Sarah Stanley – Chief Nursing Director

Sarah trained as a nurse at the Royal Free in London and has spent time working at hospitals in London and Australia. She has worked as an Interim Director of Nursing and a Director of Improvement.

Sarah was previously Divisional Medical Director for Medicine and Urgent Care at the Royal Free in London and spent half her time working clinically as a Consultant Nurse in critical care and resuscitation.

Dr Sarah Whiteman – Chief Medical Director

Sarah is focused on improving quality and addressing health inequalities in our area, particularly those relating to ethnicity. She is a Milton Keynes-based GP and was previously Clinical Chair of the Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group. She has previously held a range of leadership positions including Medical Director for Primary Care at NHS England Hertfordshire and Associate Medical Director for NHS Improvement.

Andrew Blakeman – Non-Executive Member (resigned February 2023)

Andrew is currently Chief Financial Officer of Stryde Group, part of British Telecom (BT) and has held a variety of financial leadership roles within the British Petroleum (BP) Group. A chartered accountant, he is also a lecturer in corporate finance at London Business School and has held several non-executive roles in the NHS, including Deputy Chair of Milton Keynes University Hospital and Audit Committee Chair of NHS Blood and Transplant.

Shirley Pointer – Non-Executive Member

Shirley is a Non-Executive Director of bpha, a housing association providing social housing across the Oxford to Cambridge Arc. She has also held non-executive roles at Cambridge University Hospitals and the Whitehall and Industry Group.

A Milton Keynes resident, Shirley's career has been as a people and change professional working initially in financial services before joining the civil service, where she held senior leadership positions in several government departments, including the Department for Communities and Local Government and the Department of Health.

Alison Borrett - Non-Executive Member

Alison has lived in Bedford for over 25 years and has had a long career in retail. She worked at Marks and Spencer and more recently for John Lewis Partnership as Retail Manager at Waitrose's Bedford store.

Alison was Vice Chair of the Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group's Governing Body, and chaired the Patient and Public Engagement and Primary Care Commissioning committees.

Manjeet Gill - Non-Executive Member

Social justice and improving inequalities have been the golden thread in Manjeet's career. She has served as an NHS non-executive director in both mental health and acute trusts and currently she chairs the People Culture and Improvement Committee at Sherwood Forest Hospitals NHS Foundation Trust. Prior to this Manjeet has been a chief executive in local government and served on the West Berkshire Integrated Care Board in 2017.

In her local government career, Manjeet developed neighbourhood working and multidisciplinary teams in Lincolnshire, Nottingham and Northampton. This work included strengthening the voluntary sector voice, with sustainable funding and infrastructure strategies. Manjeet has also been a national advisor to government on housing, social justice, health and care policies.

David Carter – NHS Trusts Partner Member

David is the Chief Executive Officer (CEO) of Bedfordshire Hospitals NHS Foundation Trust. He has over 25 years' experience as a Board director in the NHS for mental health, community and primary care Trusts as well as the acute sector.

David's background is in finance and before joining the NHS worked in audit and consultancy for KPMG.

Professor Joe Harrison – NHS Trusts Partner Member

Joe joined Milton Keynes University Hospital in 2013, transforming its quality, performance and finances. Under his leadership the Trust gained teaching hospital status and pioneered digital advances revolutionising patient care and experience. Joe champions innovation, leading in supporting health and wellbeing initiatives to improve working lives.

Joe is Vice Chair of the University of Buckingham, Chair of NHS Confederation Employers Policy Board, and is a Trustee of the NHS Confederation.

Ross Graves – NHS Trust Partner Member

Ross is a Board Director and is Chief Strategy and Digital Officer at Central and Northwest London NHS Foundation Trust. He is also the Executive Lead for the Trust's services in Bedfordshire, Luton and Milton Keynes.

Ross' career has spanned strategy and transformation roles across healthcare providers and commissioners as well as the private sector. He is a partner member of the Bedfordshire, Luton and Milton Keynes Integrated Care Board bringing the perspective of the community and mental health sectors.

Dr Tayo Kufeji – Primary Medical Services Partner Member

Tayo is an enthusiastic and innovative GP partner at Newport Pagnell Medical Centre, where he has worked for 17 years. He is a Primary Care Network (PCN) Clinical Director for The Bridge PCN in Milton Keynes and has previously served as a GP board member and Director of Primary Care Clinical Transformation for Milton Keynes. He is an active member of PCN network of the NHS Confederation Primary Care Network and is also a member of the National Association of Primary Care council.

Mahesh Shah – Primary Medical Services Partner Member

Mahesh is a qualified pharmacist with over 45 years' experience in NHS community pharmacy.

Mahesh has previously held several board director positions as Chairman, Chief Executive Officer and Non-Executive director in various companies including Personalised Medicine, Diagnostics, Med Tech, Pharmacy, Telematics and other sectors.

Laura Church – Local Authority Partner Member

Laura was appointed as Chief Executive for Bedford Borough Council in October 2021. She has over 30 years' experience in working in Bedfordshire.

As a qualified town planner, she has a background in place-related responsibilities with a particular focus on town centres, neighbourhood regeneration and economic development. She also had responsibility for adult social care, public health and housing during the pandemic.

Marcel Coiffait – Local Authority Partner Member

Marcel has been the Chief Executive of Central Bedfordshire Council since November 2020. He was the Council's Director of Place and Communities for the previous seven years. Alongside his experience in local authorities, he has worked in a range of roles throughout the UK and abroad, in the private sector and for government agencies.

Robin Porter – Local Authority Partner Member

Robin has worked at Luton Council for the past 14 years and has been Chief Executive for the past three. He leads a team of more than 2,700 staff delivering over 730 services for Luton's diverse 225,000 population. Robin is also the shareholder representative for all of the Council-owned companies, including the airport company. Before joining Luton, Robin worked as a senior manager in the private sector in the project finance industry.

Michael Bracey – Local Authority Partner Member

Michael was appointed Chief Executive of Milton Keynes City Council in 2018. He joined Milton Keynes Council in 2009. Previously Michael was the director responsible for children's services and adult social care.

Michael's professional background is in youth work. He has worked within the voluntary sector, for Ofsted and on secondment to government. He has served on the boards of national charities and is currently a board member of Milton Keynes Development Partnership and Milton Keynes University.

Vacancy – Primary Medical Services Partner Member

Board Participant Profiles:

Nicky Poulain – Chief Primary Care Officer

Formerly a nurse, midwife and community specialist practitioner, Nicky held several director roles across the NHS in Hertfordshire before moving to Luton Clinical Commissioning Group in 2014. Following the creation of the Bedfordshire, Luton and Milton Keynes CCG in April 2021, she was made Director of Primary Care. Nicky was the Associate Dean for Primary Education in Hertfordshire and Barnet between 1999 and 2003.

Anne Brierley – Chief Transformation Officer

Anne has held several senior leadership positions throughout her career across community, mental health and hospital settings. She has developed strong partnerships with local authorities and primary care partners and developed multi-agency frailty units and hospital at home. She has delivered clinical and operational collaborations and worked as an acute provider collaborative director – across 16 clinical networks, procurement, pharmacy and recruitment. With an MBA in Business Administration and NHS Transformation, Anne was the Chief Operating Officer at St George's University Hospitals NHS Foundation Trust, where she worked throughout the COVID-19 pandemic.

Maria Wogan – Chief of System Assurance and Corporate Services

Maria has a background in the NHS and local government and has over 15 years' board-level experience. She has worked as a Director in the Bedfordshire, Luton and Milton Keynes system for over 12 years and has experience in corporate governance, strategy and communications. Her Integrated Care Board role includes performance, governance, sustainability and working with people and communities.

Martha Roberts – Chief People Officer

Martha has a strong track record of working in organisation development and people. She has been Director of People and Organisational Development for the Bedfordshire, Luton, and Milton Keynes Clinical Commissioning Group (CCG) and the Integrated Care System.

During this time, Martha supported the development of the new integrated care partnership and the transition of the CCG team into the new Integrated Care Board.

Prior to this, Martha led the health and wellbeing and staff engagement work for the East of England NHS region and held senior people and organisation development roles across the NHS. Martha is a Chartered Fellow, CIPD.

Lorraine Mattis – Associate Non-Executive Member

Lorraine has a background in healthcare. A board director with over 20 years' experience in the NHS and voluntary, community, social enterprise sector (VCSE), she is working currently in dentistry and leads on transformation. Lorraine brings a wealth of senior leadership experiences within healthcare in the acute sector, community services and primary care.

Vicky Head - Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes

Vicky has a background in analytics and demographics and has 20 years' experience across a range of local authority and NHS roles. She has spent the last five years working in public health roles within Bedfordshire, Luton and Milton Keynes. She has been Director of Public Health for Bedford Borough, Central Bedfordshire and Milton Keynes for the past two years. As Director of Public Health, Vicky works with partners to improve population health outcomes and reduce health inequalities.

Sally Cartwright - Director of Public Health, Luton Council

Sally trained in public health in the East of England, finishing training in 2018. She worked as a consultant in public health in Harrow before coming to Luton and has been Director of Public Health since June 2021.

Maxine Taffetani - Milton Keynes Healthwatch

Maxine has led Healthwatch Milton Keynes since 2017 and was appointed as a Participant Member of the ICB in 2023 for local Healthwatch under a collaborative agreement with Healthwatch Bedford Borough, Healthwatch Central Bedfordshire, Healthwatch Luton and Healthwatch Milton Keynes.

Maxine has worked in leadership roles in healthcare related charities for fifteen years championing the involvement and participation of people who use health and care services.

Cllr Tracey Stock – Chair of Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Tracey was Councillor for Sandy, Beeston and Blunham from 2015 until May 2023. She was the Executive Member for Health, Wellbeing and Communities. She chaired the Central Bedfordshire Health and Wellbeing Board working with local agencies, including the NHS, to improve health and care services for residents. Tracey was appointed as the Chair of the Health and Care Partnership by partnership members and served in this role until May 2023.

Composition of the Board of the ICB

The Board of the ICB is composed of the following Board Members and Board Participants. Board Members:

- Independent Non-Executive Chair
- Chief Executive Officer
- Partner Members from:
    - NHS trusts and foundation trusts
    - primary medical services
    - local authorities
- Non-Executive Members
- Chief Finance Officer
- Chief Medical Director
- Chief Nursing Director.

The Board is supported by the following Board participants:

- ICB Executives:
  - Chief Transformation Officer
  - Chief Primary Care Officer
  - Chief People Officer
  - Chief of System Assurance and Corporate Services
- Directors of Public Health
- Local Healthwatch Representatives
- Chair of the Integrated Care Partnership (known as The Bedfordshire, Luton and Milton Keynes Health and Care Partnership)
- Associate Non-Executive Member.

The ICB is a unitary board, which means all members are collectively and corporately accountable for organisational performance. The purpose of the Board is to govern effectively and in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands.

The Board is responsible for:

- formulating strategy for the organisation.
- holding the organisation to account for the delivery of the strategy; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable; and
- shaping a healthy culture for the organisation and the wider ICS partnership.

The Board met regularly between 1 July 2022 and 31 March 2023 in both public and private sessions.

The Board has, during this period, formally met on six occasions, including five of which moved into a private session. This has been supplemented by a series of Board Seminars – these are events in which Board Members are joined by wider partners to consider in depth broader topics central to the delivery of local health and care services. These have included how to address strategic risks with a focus on the workforce risk, how to respond to BLMK's rapidly growing population and how to design integrated neighbourhood teams in primary care.

The Board have focussed on delivering the following:

Listening to the experience of residents to inform decision making

- The Board is focussed on delivering improved services for BLMK residents. To do this well, it has prioritised listening to and learning from the real-world experiences of those who use local health and care services.
- Recent examples include hearing directly the experiences of a transgender resident to inform the ICB's approach to tackling health inequalities and listening to a resident with complex musculoskeletal issues about her journey through the health and care system to bring to life the ICB's approach to the re-procurement of MSK services.
- The Board responds to all questions submitted by members of the public, with recent examples setting out how the ICB is improving primary care access and estates, incentivising a healthy diet and working to advance employment prospects and raise incomes as a wider determinant of health.

Working with people and communities

- Approving the landmark Working with People and Communities Strategy, putting residents at the centre of the ICB's transformation agenda by setting out how we will work together with local people and community leaders to address health inequalities, give a voice to all and create an effective framework for co-production and partnership working.
- Approving a Memorandum of Understanding (MOU) with the Voluntary, Community & Social Enterprise (VCSE) sector, delivering agreed principles and ways of working on which to build a relationship in which the ICB and VCSE are equal partners.

Integrating health and care at system, place and neighbourhood

- Responding to the Fuller Review of Integrated Care, setting direction for how Places can establish integrated neighbourhood teams in primary care so that more residents get the right support from the right professional at the right time;
- Approving the 'Milton Keynes (MK) Deal' to support MK health and care partners to come together and deliver improvements for their residents across four priority areas
- Supporting the development of a BLMK Mental Health, Learning Disability and Autism Collaborative to spread best practice and make the best use of our workforce to improve outcomes for our residents.
- Reviewed and supported the work of the Bedfordshire Care Alliance.

Strengthening our work as a system in Bedfordshire, Luton and Milton Keynes

- Providing oversight and strategic direction on the development of the ICB's Joint Forward Plan and the 2023/24 Operational Plan. The BLMK Joint Forward Plan that will guide the delivery of NHS services over the next five years and beyond.
- Reviewing, shaping and approving the system's People Strategy and People Plan, including a Board Seminar Deep Dive to consider the strategic workforce risks and mitigating actions, and the opportunities to spread innovative ways of working to make BLMK a great place to work in health and care.
- Approving the ICS Digital Strategy and 'What Good Looks Like' delivery plan for 2022/23 to maximise the benefits of digital technology to integrate and improve services for residents.
- Supporting the work of the ICB Capital & Estates Oversight Group to review the utilisation of the BLMK estate, in preparation for a larger piece of work to update the ICB Estates/Infrastructure Strategy in the context of BLMK's rapidly growing population;
- Approving the governance arrangements for the ICB, its Committees and Place Based Boards, updated terms of reference of committees in the light of experience and received regular reports from the Committees and place based boards.
- Confirming the formal and thorough quality review process underway in BLMK to learn lessons from the **'**Maternity and neonatal services in East Kent University NHS Foundation Trust conducted by Dr Bill Kirkup and published in October 2022: 'Reading the signals' report and the Ockenden Report March 2022 and approving the Local Maternity and Neonatal System Equity & Equality 5-Year Action Plan.
- Considering quality and performance across the system, including a focus on winter planning and performance and the reduction of the number of people waiting a long time for elective treatment.
- Approving the ICB 2022/23 budget and overseeing delivery against the financial plan.

Our Constitution requires Board Members to attend 75% of board meetings per year. Attendance by members and participants in this reporting period are listed in the table below.

Number of meetings held between 1 July 2021 and 31 March 2023	6

Board Members		
Role	**Name**	**Attended**
Chair	Dr Rima Makarem	6/6
Chief Executive Officer	Felicity Cox	6/6
Non-Executive Member	Andrew Blakeman[3] (Until 28 February 2023)	2/5
Non-Executive Member	Alison Borrett	6/6

[3] Andrew Blakeman - low attendance due to illness

Role	Name	Attended
Local Authority Partner Member (Chief Executive, Milton Keynes Council)	Michael Bracey	4/6
NHS Trust Partner Member	David Carter	5/6
Local Authority Partner Member	Laura Church	6/6
Local Authority Partner Member	Marcel Coiffait	5/6
Non-Executive Member	Manjeet Gill (From 30 August 2022)	3/4
NHS Trust Partner Member	Ross Graves	6/6
NHS Trust Partner Member	Joe Harrison	5/6
Primary Medical Services Partner Member	Omotayo Kufeji	5/6
Non-Executive Member	Shirley Pointer	6/6
Local Authority Partner Member,	Robin Porter	6/6
Primary Medical Services Partner Member	Mahesh Shah	5/6
Chief Nursing Director	Sarah Stanley[4] (From 12 September 2022)	4/4
Chief Finance Officer	Dean Westcott	6/6
Chief Medical Officer	Dr Sarah Whiteman	5/6
Board Participant		
Chief Transformation Officer	Anne Brierley (From 30 September 2022)	4/4
Interim Director of Public Health, Luton Council	Sally Cartwright	4/6
Director of Public Health, Bedford Borough, Central Bedfordshire & Milton Keynes	Vicky Head	5/6
Associate Non-Executive Member	Lorraine Mattis (From 1 September 2022)	4/4
Chief Primary Care Officer	Nicky Poulain	5/6
Chief People Officer	Martha Roberts	6/6
Chair of Bedfordshire, Luton and Milton Keynes Health and Care Partnership	Cllr Tracey Stock	2/6
Healthwatch	Maxine Taffetani	5/6
Chief System Assurance and Corporate Services	Maria Wogan	5/6

[4] Anne Murray acted as Interim Chief Nursing Director and attended meetings until the Chief Nursing Director commenced with the ICB on 12 September 2022

Committees of the Board

The Board of the ICB has established the following statutory and non-statutory committees. Details of these committees, a list of members and their attendance is provided in the Governance Statement starting on page 111.

Statutory committees:

- Audit and Risk Assurance Committee;
- Quality and Performance Committee; and
- Remuneration Committee.

Non-statutory Committees:

- Finance and Investment Committee;
- Primary Care Commissioning and Assurance Committee;
- Working with People and Communities Committee; and
- Bedfordshire Care Alliance.

Joint Committees:

The Bedfordshire, Luton and Milton Keynes Health and Care Partnership is BLMK's Integrated Care Partnership.

This committee is a joint committee established by the Board of the ICB and five local authorities.

The Board of the ICB engages with its partners to discuss and agree shared strategic direction together through the following forums. These forums inform and align decisions by relevant statutory bodies in an advisory role, unless specific ICB functions have been delegated to them.

- Health and Care Senate
- Place Based Partnerships:
    - Bedford Borough Health and Wellbeing Board;
    - Central Bedfordshire Place Board;
    - Luton At Place Board; and
    - Milton Keynes Health and Care Partnership.

Register of Interests

The ICB maintains a register of interests that is presented as part of the meeting papers for meetings of the Board and it's committees.

The policy for managing conflicts of interest and standards of business conduct is based on statutory guidance and is available on our public website together with the ICB's register of interest.

Personal data related incidents

The ICB has not reported any Information Governance Serious Untoward Incidents to the Information Commissioner's Office in 2022/23.

Modern Slavery Act 2015

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking statement for the period ending 31 March 2023 is published on our website.

ACCOUNTABILITY REPORT

Statement of Accountable Officer's Responsibilities

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

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

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

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

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board's assets (and hence for taking reasonable steps for

the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board'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.

Felicity Cox
Accountable Officer
27th June 2023

Governance Statement

Introduction and context

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board's (ICB) statutory functions are set out under the National Health Service Act 2006 (as amended).

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

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

Scope of responsibility

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

I am responsible for ensuring that the NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board of the ICB is to ensure that it 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.

In exercising its functions, the ICB uses a range of sources and intelligence to ensure it makes the most effective decisions possible. These include the following:

- The Board explicitly includes amongst its membership representatives from partner organisations, such as NHS providers, local authorities and the voluntary, social and community enterprise (VCSE) sector, to ensure that the views from those partners are heard and inform decision-making;
- The Finance and Investment Committee advises the Board on value for money and effective uses of resources;
- The Quality and Performance Committee advises the Board on the quality of services delivered to patients and in improving patient experience;
- The Audit and Risk Assurance Committee provides assurance to the Board by reviewing overall governance arrangements including the risk management framework;
- The Working with People and Communities Committee provides assurance to the Board that citizens are involved decisions on the planning and delivery of health and care services in all four places in Bedfordshire, Luton & Milton Keynes;
- There are strong and growing relationships between the four places in BLMK and the ICB Board. Regular reports on the work of the ICB are presented to the place boards and place boards are encouraged to raise any issues they have with the ICB Board;
- For policies, programmes, projects or savings schemes, a two-stage Quality Impact Assessment (QIA) is undertaken. This includes screening the proposal and then, if quality implications are identified, reviewing it from safety, clinical effectiveness and patient and wider population experience and involvement perspectives, seeking mitigations where patient quality may be impacted. The QIA is signed off by either the Chief Nursing Director or Chief Medical Director prior to a decision being made;
- The use of a standard cover template for Board reports for authors to demonstrate which of the ICB's strategic priorities the report addresses and
- The template also requires authors to describe how the report will address inequalities and the Green Plan commitments and identify any financial implications;

As a new organisation, arrangements for Board succession and the development of individual board members are still to be fully established, but the following activities have already taken place:

- A robust appointment process was undertaken to ensure that all Board members (including those from partner organisations) have the necessary experience and expertise;
- All Board members are subject to the Fit and Proper Persons (FPP) Regulations and make a declaration upon appointment stating that they comply with FPP;
- Board seminars have been held to help to impart knowledge to Board members, and also to support team building and collaborative ways of working; and
- The Remuneration Committee has responsibility for reviewing the talent on the Board and determining succession planning.

Highlights of the work of the Board of the ICB can be found on page 23 of this report, and in the papers and minutes of the Board Meetings that can be accessed through our website.

Membership and attendance records of Board Members and Board Participants can be found in section 2 of the members' report on pages 105 and 106.

The Board of the ICB has established the statutory and non-statutory committees, listed in the members' report (page 107). Details of these committees of the Board, their purpose, membership and attendance can be found from page 114 to page 127. Further information about the Remuneration Committee can be found in our Remuneration Report from page 153.

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

Committee Effectiveness

Each committee includes a standing item on each agenda to discuss the effectiveness of the meeting. In addition, committees will review their overall effectiveness on an annual basis by reviewing their terms of reference, key topics covered throughout the year, attendance of members and the reflections raised at each meeting. The Audit and Risk Assurance Committee will then review a collation of the feedback from all the committees in order to provide assurance to the Board about the effectiveness of the committee structure as a whole.

Audit and Risk Assurance Committee

The Audit and Risk Assurance Committee is a non-executive statutory committee of the Board.

This Committee is accountable to the Board of the ICB and provides an independent and objective view of the ICB's compliance with its statutory responsibilities, including risk management. The Committee is responsible for arranging appropriate Internal and External Audit.

The purpose of the committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB and within the wider Bedfordshire, Luton and Milton Keynes system, such that the Committee can provide assurance to the Board that its objectives are likely to be met and risks are effectively managed.

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.

The Committee meets in two parts:

- Part 1: to deal with internal ICB audit and risk business; and
- Part 2: to deal with system risk business, taking an overview of all system risks and having a particular deep dive focus on specific risks.

The work of the Committee during this reporting period has included:

- Approval of a detailed internal audit programme of work consistent with the needs of the organisation;
- Scrutinising the findings from internal audits and recommendations for improvement and monitored progress with the implementation of the recommendations;
- Scrutinising external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board of the ICB and the work undertaken outside the annual audit plan;
- Monitoring progress with the Counter Fraud Workplan and discussing the outcome of the work;
- Review of the annual report and financial statements prior to submission with particular focus on changes in and compliance with accounting policies, practices and estimation techniques and significant adjustments resulting from audit;
- Review and scrutiny a range of systems, policies and procedures that are in place to manage risk;
- Reviewing the ICB's Corporate Risk Register and the Board Assurance Framework and providing assurance to the Board that it accurately records the strategic risks to the ICB's objectives with the measures and controls to manage them;
- Reviewed and challenged assurance reports and updates on areas covered under the Committee terms of reference, including information governance, cyber security and freedom to speak up;
- Scrutinising assurance and due diligence reports and updates on the planned delegation of podiatry, ophthalmology and dentistry contracts to the ICB on 1 April 2023 and the proposed delegation of Specialised Commissioning from 1 April 2024; and
- The Committee and system partners have co-designed with a mechanism for involving system partners in discussions on system risks which includes deep dives into strategic risks in the Audit Committee, Board seminars and relevant Board Committees. The Committee has overseen and shaped the developed the approach to system risk management during the reporting period. This has included a deep dive into the climate change risk with health and social care partners which has helped shape the system's approach to adaptation planning.

Members and their attendance are listed in the table below.

		Part 1	Part 2
Number of meetings between 1 July 2022 and 31 March 2023		4	3
Role	**Name**	**Attended**	**Attended**
Chair – Non-Executive Member	Andrew Blakeman[5] (Until 28 February 2023)	2/4	1/3
Deputy Chair – Non-Executive Member	Alison Borrett	4/4	3/3
Non-Executive Member	Shirley Pointer	4/4	3/3
Non-Executive Member	Manjeet Gill (From 3 March 2023)	1/1	1/1

Quality and Performance Committee

The Quality and Performance Committee is a statutory committee of the Board.

The committee is accountable to the Board of the ICB for matters relating to the improvement in the quality of services, against each of the dimensions of quality set out in the NHS Quality Board: Shared Commitment to Quality (refreshed).

The purpose of the committee is to provide the Board with assurance that it is delivering its functions in relation to the Bedfordshire Luton and Milton Keynes system in a way that secures continuous improvement in the quality and effectiveness of services provided to ssthe population of Bedfordshire Luton and Milton Keynes, against each of the dimensions of quality set out in the NHS Quality Board: Shared Commitment to Quality (safe, effective, positive experience, well-led, equitable and sustainably resourced) and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Committee scrutinises the robustness of, and gains and provides assurance to the Board, that there is an effective system of quality governance and system performance management that supports it to effectively deliver its strategic objectives and ensure that sustainable, high quality care is provided to its population.

[5] Andrew Blakeman - low attendance due to illness

The work of the Committee during this reporting period has included:

- Discussion on and oversight of the implementation of the new Patient Safety Incident Response Framework (PSIRF) introduced by NHS England, which was welcomed by the Committee for its system-based quality improvement approach. Regular reports on implementation of PSIRF has been received including feedback from the first PSIRF approach to system learning from an incident. In parallel as the new system is implemented, the Committee has continued to receive regular Serious Incidents and Never Event reports;
- Received performance reports from across the system, which enabled the Committee to review how acute, community, mental health and primary care providers across the system are performing and how performance and quality concerns are being addressed. The Committee is focussed on improving the quality of performance reports to enable ICB decision-making to focus on the 'so what?' question and improving outcomes for our population. This included a review and lessons learned report on performance across the system over winter to support planning for next winter. The Committee also received a detailed report on the recovery plan for patients waiting a long time for ophthalmology appointments and actions being taken to mitigate harm. The Committee will continue to focus on recovery of long waiting times for BLMK residents;
- Held a deep dive with NHS and social care partners into care for Children and Young People with mental health needs and reviewed system plans to drive improved outcomes in this area;
- Received assurance reports on the maternity and neonatal system, transforming care programme, and serious incident themes;
- Received a comprehensive overview of the BLMK Health Inequalities Programme and agreed the population health approach to this work;
- Received a Looked After Children Annual Report and a comprehensive overview on Child Death Overview Panel reports which confirmed that work is underway to identify themes and trends in child deaths across BLMK, which will inform strategies for 2022/23;
- Received a Section 117 Update and assurance that an assurance framework is being strengthened and further developed to ensure oversight and safeguarding of BLMK Section 117 placements; and
- Considered and supported the review and update of clinical policies.

Members and their attendance are listed in the table below.

Number of meetings between 1 July 2022 and 31 March 2023		4
Role	Name	Attended
Chair - Non-Executive Member	Andrew Blakeman[6] (Until 28 February 2023)	3/3
Deputy Chair – Primary Medical Services Partner Member	Mahesh Shah	3/4
Associate Non-Executive Member	Lorraine Mattis (From 1 September 2022)	2/2
Non-Executive Member	Shirley Pointer (From March 2023)	1/1
Chief People Officer	Martha Roberts	3/4
Chief Nursing Director	Sarah Stanley[7] (From 12 September 2022)	2/2
Chief Medical Director	Sarah Whiteman[8]	3/4
Chief of System Assurance & Corporate Services	Maria Wogan	4/4

[6] Non-Executive Member Shirley Pointer Chaired the March 23 meeting.

[7] Anne Murray acted as Interim Chief Nursing Director and attended meetings until the Chief Nursing Director commenced with the ICB on 12 September 2022

[8] Sarah Whiteman - following approval from the Board of the ICB on 27 January 2023, in addition to attending in her role as Medical Director, Sarah attended as Interim Representative for Health & Care Senate.

Remuneration Committee

The Remuneration Committee is a non-executive statutory committee of the Board.

This Committee is accountable to the Board of the ICB for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary - Confirm the ICB Remuneration Policy including adoption of any pay frameworks for all employees including senior managers / Directors (including Board members) and Non-Executive Members. Members and their attendance are listed in the table below.

Number of meetings between 1 July 2022 and 31 March 2023		4
Role	Name	Attended
Chair - Non-Executive Member	Shirley Pointer	4/4
Deputy Chair – Non-Executive Member	Manjeet Gill (From 30 August 2022)	2/3
Non-Executive Member	Andrew Blakeman[9] (Until 28 February 2023)	2/3
Non-Executive Member	Alison Borrett	3/4
Independent Chair of the ICB	Rima Makarem	3/4

Finance and Investment Committee

The Finance and Investment Committee is a non-statutory executive Committee of the Board. The Committee is accountable to the Board of the ICB and is authorised by the Board to investigate any activity within its terms of reference and to seek the information required to do so, commission any reports it deems necessary to help fulfil its obligations and obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions.

The purpose of the committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- Financial performance of the ICB.
- Financial performance of NHS organisations within the ICB footprint.

[9] Andrew Blakeman - low attendance due to illness

The work of the committee during this reporting period has included:

- Receipt of ICB and system finance reports with year end forecasts;
- Scrutinising presentations on the system medium term financial plan;
- Discussed and recommended the ICB's 2022/23 Section 75 agreements for approval by the Board of the ICB;
- Review of an update on the planned procurement approach for the ICB strategic data platform and the governance processes and approved the procurement of a strategic development partner;
- Discussions on updates on current key procurement and contracting issues and on the system capital position and progress of key projects;
- Review of and discussion on draft business cases and in particular how they can be designed to support the key ICB objective of reducing health inequalities going forwards;
- Reviewing progress in terms of system transformation and efficiency activities;
- Reviewing capital updates and plans;
- Reviewing updates in terms of digital activities and plans; and
- Review of the finance risk register.

Members and their attendance are listed in the table below.

Number of meetings between 1 July 2022 and 31 March 2023		4
Role	**Name**	**Attended**
Chair	Rima Makarem	4/4
Non-Executive Member	Alison Borrett	1/3
Chief Transformation Officer	Anne Brierley[10] (From 30 September 2022)	3/3
Non-Executive Member	Manjeet Gill (From 30 August 2022)	3/3
Chief Primary Care Officer	Nicky Poulain	2/4
Chief People Officer	Martha Roberts	3/4
Chief Nursing Director	Sarah Stanley[11] (From 12 September 2022)	3/3
Chief Finance Officer	Dean Westcott	3/4
Chief Medical Director	Sarah Whiteman	3/4

[10] Richard Alsop acted as Interim Chief Transformation Officer and attended meetings until the Chief Transformation Officer commenced with the ICB on 30 September 2022.

[11] Anne Murray acted as Interim Chief Nursing Director and attended meetings until the Chief Nursing Director commenced with the ICB on 12 September 2022

Primary Care Commissioning and Assurance Committee

The Primary Care Commissioning and Assurance Committee is a non-statutory committee of the Board.

Committee is accountable to the Board of the ICB and reports to the Board on how it discharges its delegated primary care commissioning functions for primary medical services. The Committee has been established in accordance with statutory provisions to enable the members to, for example, make collective decisions on the review, planning and procurement of primary medical services in Bedfordshire, Luton and Milton Keynes under delegated authority from NHS England.

The role of the Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the current NHS Act.

The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

The purpose of the committee is to scrutinise and provide assurance to the ICB that there is an effective system of primary medical services commissioning that supports it to effectively deliver its statutory and strategic objectives and provide sustainable, high quality primary care.

The work of the committee during this reporting period has included:

- Discussed and reviewed the safe delegation checklist and ongoing work to progress the delegation of community pharmacy, optometry and dental contracts to the ICB from 1 April 2023;
- Review of payment and cashflow issues for practices and outlined actions taken by ICB;
- Discussed and assurance provided for primacy care access to refugees, evacuees and asylum seekers placed in BLMK;
- Received assurance that risks relating to the primary care directorate are being identified and managed appropriately;
- Discussed digital and estates risks and received assurance that these are being monitored;
- Received regular primary care estates reports including on the estates prioritisation process and the process, criteria and timeline agreed by the Estates Working Group and agreed the prioritisation of primary care estates schemes;
- Received an update on the progress against the primary care workforce programme strategic workstreams;
- Endorsed progress on relocation of the De Parys Group practice;
- Endorsed the proposed BLMK Fuller Programme to implement national recommendations; supported the approach for the principle of subsidiarity;
- Received primary care transformation plans and updates to drive the integration of primary care within the health and care system;
- Held an extraordinary meeting to review the outcome of the primary care estates prioritisation process as it relates to the primary care revenue budget and for the Committee to decide how best to take this work going forward. The meeting was well- attended with over 80 members of the public in attendance. The process for prioritisation and the outcomes of the process were explained and it was noted that the limited budget currently available to the ICB means that some schemes cannot currently be supported. The Committee:

- Approved the recommended indicative budget of £1.95m to invest recurrently in primary care estates. £1.54m of this cost relates to schemes already committed / operational;
- Supported the alternative funding approach for the £1m revenue shortfall for the schemes as outlined by the Chief Financial Officer in the meeting and that primary care budget will be spent on primary care;
- Approved the recommended list of schemes to be supported in principle, including the schemes with marginal revenue impact, even though the scores for some of these were lower than others, noting that individual business cases are required for final approval to be given and should the revenue impact become higher than expected it may not be possible to ultimately approve the business case for these schemes;
- Noted that these proposals enable circa £468k and £472.5k of the business as usual capital to be directed towards primary care estates in 2022/23 and 2023/24, respectively (but note the risk that delays to concluding the prioritisation process may cause some slippage with capital spend between years);
- Requested the Board and Finance and Investment Committee of the ICB to consider making additional revenue available for primary care estates as part of the 2023/24 resource allocation process, noting that a Board seminar on primary care and the development of Fuller neighbourhoods will include discussion of primary care estates as an enabler of neighbourhood working and is planned for 24 February 2023; and
- Recognised that there are other primary care providers with estates needs who are not within the 23. We are committed to working with them and system partners on their needs. We welcome the support and interest from all our partners on this issue and commit to working with all partners at a system and place level and we will continue to escalate the need for additional funding for primary care nationally.

Members and their attendance are listed in the table below.

Number of meetings between 1 July 2022 and 31 March 2023		4
Role	**Name**	**Attended**
Chair - ICB Non-Executive Member	Alison Borrett	4/4
Deputy Chair - Primary Medical Services Providers Partner Member	Mahesh Shah	2/4
Chief Executive Officer	Felicity Cox	2/4
Non-Executive Member	Manjeet Gill (From 30 August 2022)	3/4
Primary Medical Services Providers Partner Member	Dr Omotayo Kufeji	3/4
Chief Primary Care Officer	Nicky Poulain	4/4
Chief Nursing Director	Sarah Stanley[12] (From 12 September 2022)	3/4
Chief Finance Officer	Dean Westcott[13]	3/4
Chief Medical Director	Dr Sarah Whiteman	3/4

Working with People and Communities

The Working with People and Communities Committee is a non-statutory Committee of the Board of the ICB.

The committee is accountable to the Board of the ICB in providing advice and assurance that there is an appropriate ICB work plan which shows that citizens will be involved in decisions on the planning and delivery of health and care services in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, in line with the Working with People and Communities policy in order to deliver the ICS core purposes of:

a. Improving outcomes in population health and healthcare;

b. Tackle inequalities in outcomes, experiences and access;

c. Enhance productivity and value for money; and

d. Help the NHS support broader economic development.

The purpose of the committee is to oversee the delivery and evaluation of the work plan and report to the ICB on the outcomes of citizen engagement. Work with Integrated Care System partners to ensure citizens are engaged with, listened to and co-design health and care services at ICS, Place and Care Alliance. Provide assurance to the ICB on planning, delivery, outcome and evaluation of statutory consultation.

[12] Anne Murray acted as Interim Chief Nursing Director and attended meetings until the Chief Nursing Director commenced with the ICB on 12 September 2022

[13] Dean Westcott was deputised by Deputy Chief Finance Officer Stephen Makin at 8 July 2022 meeting in private.

The work of the committee during this reporting period has focussed on making sure residents and their communities are at the heart of the ICB's decision making. This has included:

- Ensuring that the committee is as inclusive as possible in its membership, creating equal partnerships between the ICB and the communities we serve;
- Shaping and recommending to the Board the ICB's landmark Working with People and Communities Strategy that establishes how the ICB will put residents at the centre of our work to transform health and care for local people, leaning lessons from our experiences during the pandemic;
- Reviewing, supporting and agreeing the development of the draft BLMK ICB and Voluntary, Community & Social Enterprise (VCSE) sector Memorandum of Understanding (MoU) which strengthens the connection between the VCSE Strategy Group and the ICB and establishes a strong foundation for all future work;
- Supporting the development of a Memorandum of Understanding (MoU) between the ICB and valued Healthwatch partners;
- Shaping the ICB's engagement activity undertaken in support of the Musculoskeletal (MSK) service re-design and procurement, ensuring the patient voice is heard throughout the procurement, mobilisation period and implementation of new services;
- Designing the co-production training plan for the system and overseeing the delivering of the ICB's ambitious coproduction training agenda, undertaken by almost 250 people across the system so far to put residents at the heart of what we do;
- Influencing the BLMK Integrated Health and Care Strategy to improve its accessibility to residents and recognition of the contribution of the work of the VCSE;
- Driving the agenda to bring resident voice to the Integrated Care Board through resident participation and, in particular, the inclusion of a resident story relevant to the agenda for the meeting;
- Listening to the feedback from the Denny Review which focuses on building our understanding of how our communities experience health inequalities in BLMK, including traveller communities, lesbian, gay, bisexual, transgender, queer (or questioning), and intersex (LGBTQI) people, homeless people and victims of abuse, and using these insights to shape the ICB's work programme;
- Driving plans to conduct innovative sentiment benchmarking activity which will help us to understand what our stakeholders and residents think of us and how we can do better;
- Adopting a clear "you said, we did" philosophy to ensure it is clear to the committee how the ICB is building on previous engagement and responding to residents' concerns;
- Reviewing the system's winter communications plan and providing expert advice on its impact for residents and in communities;
- Supporting the development of a system-wide engagement community of practice to enable better co-ordination and sharing of resources and insights;
- Using interactive workshops to interrogate barriers to good engagement, and who our engagement is failing to reach, how we can do better to involve these seldom heard communities, how residents want to be communicated with and how we can encourage people to manage their own health and care.

Members and their attendance are listed in the table below.

Number of meetings between 1 July 2022 and 31 March 2023		**4**
Role	**Name**	**Attended**
Chair - Non-Executive Member	Manjeet Gill (Chair From 30 August 2022)	3/3
Deputy Chair - Associate Non-Executive Member	Lorraine Mattis (From 1 September 2022)	2/3
Non-Executive Member	Alison Borrett (Chair member until 30 Chair and August 2022)	1/1
Chief Transformation Officer	Anne Brierley (From 30 September 2022)	2/3
Local Authority Partner Member - Chief Executive, Bedford Borough Council	Laura Church (From October 2022)	3/3
Partner member - Executive Director Central & North West London NHS Foundation Trust	Ross Graves (From December 2022)	2/2
Partnerships Director, Transitions UK	Karen Ironside (Until October 2022)	1/2
Primary Medical Services Partner Member	Mahesh Shah	3/4
Director, Citizens Advice, Milton Keynes	Ben Thomas (From December 2022)	2/2
Chief Medical Officer	Sarah Whiteman (From December 2022)	2/2
Chief of System Assurance & Corporate Services	Maria Wogan	4/4
Healthwatch Chief Executive Officers[14]	**Name**	**Collective Attendance**
Central Bedfordshire	Diane Blackmun	
Role	**Name**	**Attended**
Luton	Lucy Nicholson	44
Milton Keynes	Maxine Taffetani	
Bedford Borough	Helen Terry (until December 2023)	
Bedford Borough	Elizabeth Learoyd (From March 2023)	

[14] At least one Healthwatch Chief Executive Officer is required to attend each meeting

Bedfordshire Care Alliance

The Bedfordshire Care Alliance (BCA) is a non-statutory committee.

The Committee is accountable to the Board of the ICB and reports through governance structures in partner organisations. It is responsible for making decisions on matters that have been delegated to it by the Board of the ICB or other constituent partner members.

The overall aims of the Committee are to bring health and care partners across Bedfordshire together to work collaboratively and hold joint accountability for:

- Addressing unwarranted variation in quality, access and outcomes that people experience in different parts of Bedfordshire;
- Designing, planning and organising health services integrated with social care provision in Bedfordshire – making sure resources are in the right place for the best outcomes;
- Focussing on the things we need to do once across Bedfordshire – standardise where we can, and it makes sense to do so; and
- Supporting place priorities with coherent engagement from providers covering larger footprint and tailoring where particular place population need requires it.

The work of the committee during this reporting period has included discussing the health and care priorities for Bedfordshire and reviewing in detail the progress of the major projects in the BCA work plan.

The BCA programme has been reviewed to take account of the evolving governance of programmes of work across the wider BLMK system and within places.

The following workstreams have been agreed as the priorities for 2023/24:

- Supported discharge;
- Admission avoidance;
- Workforce development to enable integration of services; and
- Digital as an enabler of integrated care.

The BCA plays a key role in co-ordinating quality and improvement plans across all health and local authority partners in Bedfordshire in urgent and emergency care and rehabilitation and reablement.

The aims are to support people with frailty or complex long-term conditions requiring acute intervention to be treated at home wherever clinically appropriate. Also, to have joined-up co-ordination of care on discharge to optimise recovery following admission to acute health settings.

Using learning from the challenges of maintaining services during winter 2022/23, the overarching plan for winter 2023/24 has been agreed. The BCA will oversee the implementation of pathway improvements and optimisation with a view to managing the pressures of the demand for health and care services this coming winter.

Members and their attendance are listed in the table below.

Number of meetings between 1 July 2022 and 31 March 2023		3
Role	**Name**	**Attended**
Chair - Non-Executive Member	Shirley Pointer	3/3
Primary Care Network (PCN) Clinical Director Luton	Manraj Barhey	2/3
Chief Executive Officer, East London NHS Foundation Trust	Paul Calaminus	2/3
Chief Executive Officer, Bedfordshire Hospitals NHS Foundation Trust	David Carter	3/3
Chief Executive Officer, BLMK ICB	Felicity Cox	2/3
Primary Care Network (PCN) Clinical Director Central Bedfordshire	Belinda Ekuban (From November 2022)	2/2
Corporate Director, Population Wellbeing, Luton Borough Council	Mark Fowler[15]	1/3
Primary Care Network (PCN) Clinical Director Bedford Borough	Jane Kocen	3/3
Director of Housing and Adult social care, Central Beds Council	Julie Ogley	2/3
Director of Housing and Adult social care, Central Bedfordshire Council	Andy Sharp (From March 2023)	0/1
Role	**Name**	**Attended**
Director of Adult Social Care, Bedford Borough Council	Kate Walker	2/3
Chief Executive Officer Cambridgeshire Community Services	Mathew Winn	3/3

[15] Mark Fowler – Deputised at November 2022 meeting by Maud O'Leary, Head of Adult Social Care, Luton Borough Council

Health and Care Partnership

The Bedfordshire, Luton and Milton Keynes Health and Care Partnership is BLMK's Integrated Care Partnership.

This committee is a joint committee established by the Board of the ICB and five local authorities.

Duties of the committee includes developing and monitoring the implementation of the Integrated Population Health Strategy for Bedfordshire, Luton and Milton Keynes based on the joint strategic needs assessments, health and wellbeing strategies, place plans, and the voice of people with lived experience.

In fulfilling its statutory duty, the Joint Committee's role is to:

- Facilitate joint action to improve health and care outcomes and experiences;
- Influence the wider determinants of health, including creating healthier environments and inclusive and sustainable economies;
- Create a dedicated forum to enhance relationships between the leaders across the health and social care system;
- Build a culture of partnership and broad collaborations to promote and support holistic care; and
- Highlight where coordination is needed on health and care issues and challenges partners to deliver the actions required.

The Health and Care Partnership has a wide membership that includes BLMK ICB, local authorities, NHS Trusts, ambulance services, primary care, Healthwatch and Voluntary, Community and Social Enterprise. Wider stakeholders including Police and Fire Authorities are also invited to meetings. The Health and Care Partnership is Chaired by Councillor Tracey Stock and Rima Makarem, the ICB Chair, is the Deputy Chair.

The Partnership has met four times and considered the following items:

1. **Health and Care Strategy** agreed in December 2022, which:
    - reflects the 5 strategic priorities (Start Well, Live Well, Age Well, Growth and Tackling Inequalities)
    - is committed to subsidiarity (to Place), with a focus on planning, decision-making and delivery as close to the resident as possible
    - emphasises the need to further use our partnerships to support residents to live longer, healthier lives, and the central role of VCSE in achieving this; and,
    - speaks to real examples that make a difference to local people

2. **Fuller Neighbourhoods** – a briefing was provided on the findings of a review undertaken by Dr Claire Fuller of integrated primary care and highlighted the action being taken under the following four pillars of the programme:
    - The development of neighbourhood teams aligned to local communities
    - The provision of streamlined and flexible access for people who require same day urgent care
    - The provision of proactive personalised care and support for people with complex needs and co-morbidities
    - An ambitious and joined up approach to prevention;
3. **Delegation of dentistry, optometry and community pharmacy** – an update on the delegation of responsibility from 1 April 2023 to the ICB of dentistry, optometry and community pharmacy was provided;
4. **Mental Health, learning disability and autism collaboration** – an update on the establishment of a collaborative and the feedback from service users which was being used to shape future work was received; and
5. **Community Engagement** - the new approach of pooling partner resources to avoid engagement duplication, agreeing co-production principles and highlighted areas of work.

Members and their attendance are listed in the table below

Number of meetings between 1 July 2022 and 31 March 2023		4
Role	**Name**	**Attended**
Chair – Councillor Central Bedfordshire Council	Cllr Tracey Stock	4/4
Primary Care Network Clinical Director, Luton	Manraj Barhey	4/4
Chief Executive Officer, Healthwatch, Central Bedfordshire	Diane Blackmun	0/4
Councillor, Milton Keynes Council	Cllr Robin Bradburn (From September 2022)	1/3
Director of Public Health, Luton Council	Sally Cartwright	3/4
Chief Executive Officer, Central Bedfordshire Council	Marcel Coiffait (Until September 2022)	0/2
Chief Executive Officer, ICB	Felicity Cox	4/4
Chair, Milton Keynes University Hospital NHS Trust	Alison Davis	4/4
Director of Corporate Affairs and Performance, East of England Ambulance	Emma De-Carteret	2/4
Primary Care Network, Clinical Director Central Bedfordshire	Belinda Ekuban (From December 2022)	2/2
Chair, Cambridgeshire Community Services NHS Trust	Mary Elford	3/4
Chair, Central and North West London NHS Foundation Trust	Dorothy Griffiths	2/4
Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes	Vicky Head	2/4
Mayor, Bedford Borough Council	David Hodgson (From March 2023)	1/1
Councillor, Milton Keynes Council	Cllr David Hopkins (From September 2022)	2/3
Councillor, Luton Borough Council	Cllr Javed Hussain	4/4
Chair, Bedford Borough Health and Wellbeing Board	Louise Jackson	3/4
Healthwatch Milton Keynes	Tracy Keech	3/4
Primary Care Network Clinical Director, Bedford	Jane Kocen	3/4
Chair, Bedfordshire University Hospitals NHS Foundation Trust	Simon Linnett	1/4
Deputy Leader Buckinghamshire County Council	Angela MacPherson	0/4
Chair of the Board of the ICB	Rima Makarem	3/4
Councillor, Luton Borough Council	Cllr Khtija Malik	3/4

Role	Name	Attended
Leaders Milton Keynes Council	Peter Marland	3/4
Voluntary, Community and Social Enterprise (VCSE) Lead	Sonal Mehta	4/4
Executive Director, South Central Ambulance Service NHS Foundation Trust	Mike Murphy	2/4
Healthwatch, Luton	Lucy Nicholson	3/4
Director of Adult services, Central Bedfordshire	Julie Ogley	4/4
Primary Care Network Clinical Director, Milton Keynes	Navaneetha Rammohan	4/4
Leader Luton Borough Council	Hazel Simmons	1/4
Interim Chair, East London NHS Foundation Trust	Eileen Taylor	4/4
Healthwatch, Bedford Borough	Helen Terry (Until December 2022)	3/3
Director of Adult services, Bedford Borough Council	Kate Walker	4/4
Representative from ICBs Health and Care Senate	Vacancy	Vacancy

Partnership Forums

The Board of the ICB engages with its partners to discuss and agree shared strategic direction together through the following forums. These forums inform and align decisions by relevant statutory bodies in an advisory role, unless specific ICB functions have been delegated to them.

These are:

- The Health and Care Senate;
- Place-based partnerships:
    - Bedford Borough Health and Wellbeing Board;
    - Central Bedfordshire Place Board;
    - Luton at Place Board; and
    - Milton Keynes Health and Care Partnership.

Health and Care Senate

The Health and Care Senate is a forum which provides health and care professional leadership and advice to the ICB and the Health and Care Partnership. It has a role in ensuring that the voice of the health and care professional is heard at every level of the Integrated Care System.

The Health and Care Senate reports to the Quality and Performance Committee and to the ICB Board.

Purpose and functions of the Senate are to:

- Provide impartial health and care advice to the ICB and the partnership, such as on the development of the system population health and care strategy and plans;
- Draw on the skills of its members from diverse health and care backgrounds, independently of the organisational base;
- Identify system health and care priorities to inform place and care alliance work plans;
- Provide links to wider health and care structures, including the East of England NHS and national clinical and professional bodies. This helps to consider local application of external work, drive innovation and apply research; and
- Support the development of the system health and care professional leadership framework and implementation plan.

Place-based partnerships

We are committed to providing services as close to residents as possible to meet their local needs. In order to do this, we have worked in partnership with local authorities, NHS Trusts and local organisations to establish place-based working in the Council geographical areas of Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. The local priorities for each place are detailed from page 11.

UK Corporate Governance Code

While the detailed provisions of the UK Corporate Governance Code are not mandatory for NHS Bodies, the ICB considers relevant principles of the Code is considered to be good practice. This governance statement is intended to demonstrate how the ICB had regard to the principles set out in the Code which are considered appropriate for ICBs for the reporting period 1 July 2022 to 31 March 2023.

Discharge of Statutory Functions

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk Management

Risk management arrangements and effectiveness

The ICB recognises that every activity it undertakes or commission brings with it some element of risk. These have the potential to threaten or prevent the achievement of our objectives in managing the health and care risks facing our residents.

- The ICB has responded to this by:
- Encouraging a dynamic risk management culture where risk management is viewed as a daily activity. Risk management is the responsibility of all our staff. It is being embedded into operational activity and strategy at all levels of the organisation;
- Having structures, policies and processes in place to support the assessment and management of risks; and
- Assuring the ICB Board, the public and patients that we manage risk effectively.

The ICB's risk management strategy sets out our roadmap for management of risk as an organisation and a system together with partners. It outlines the ways in 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 all partners to:

- Identify and control risks which may negatively affect the achievement of our strategic priorities, without being too risk-averse;
- Consistently compare and prioritise risks using defined 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.

The ICB maintains a risk register through a cloud-based electronic reporting system which can be made accessible to all partners. Risks are systematically reviewed at the ICB Executive meeting, System Oversight and Assurance Group, the ICB's Audit and Risk Assurance Committee, at other relevant committees of the Board and by the Board itself at each meeting. They are also reviewed by directorates, senior managers and individual risk owners.

The risk register allows us to assess the impact and likelihood of inherent and residual risks. It tracks the progress of risks over time through a standardised grading matrix. Risks that increase in rating and have a broad, deep, organisational or system impact are subject to additional scrutiny and review.

The ICB continued to develop its work on strategic risk management. This is linked to the development of the system's integrated health and care strategy and joint forward plan. Working with system partners, key strategic risks have been identified on our Board Assurance Framework (BAF).

The ICB makes sure all decisions are taken with due consideration to the management of risks. There are clearly defined accountability and responsibility for risk management within the ICB's structure.

Our Chief Executive has overall responsibility for risk management. The Chief of System Assurance and Corporate Services has delegated responsibility for the day-to-day management of our risk management process and system. The specific responsibilities of other committees, senior officers, non-executive members and all other staff are set out in our risk management strategy.

The Audit and Risk Assurance Committee reviews the establishment and maintenance of an effective system of governance, risk management and internal control that supports the

achievement of the ICB's objectives. Representatives from hospital trusts and local authorities have reviewed the BAF and have taken part in deep dives into the most relevant risks to the health and care of residents in Board committees and in the meetings of the System Oversight and Assurance Group.

In November 2022, the Board reflected on the strengths of risk management at system level and how that was supportive of addressing complex risks. A collaborative deep dive into the workforce risk was also carried out, facilitated by Chief People Officer. The deep dive supported system partners to think about the risk across the health and care spectrum and reflect risk mitigations that not only work at system level, taking advantage of the scale of the system but also work at place.

We formed a community of practice of risk leads from across the system to support in the development of movement model with the aim of ensuring that system risks are able to move through the system as appropriate to the BAF where a collaborative approach to strategic management and risk reduction is employed. This risk movement model ensures subsidiarity of risk with Trusts, Place and Neighbourhoods.

The Audit and Risk Assurance Committee also maintains oversight of the ICB's operational risks by reviewing the corporate risk register. It provides assurance to the Board with respect to the control mechanisms for risk. The other Board committees receive and review risks related to their areas of responsibility at committee meetings.

The Board and its Quality and Performance Committee continued to maintain rigorous oversight of our performance.

Risk Assessment and Performance

A new Risk Management Framework and Strategy was agreed for the ICB to support the framework for managing risk within the ICB and across the BLMK system.

At the start of 2022/23, we aligned strategic risks from the BLMK CCG to the ICS's agreed priorities and objectives, in preparation for the establishment of the ICB on 1st July 2022. The BAF was reviewed throughout the year and was presented to each Audit and Risk Assurance Committee meeting. The Committee provides an assurance to the Board with respect to management of the risks identified within the BAF.

The key risks in 2022/23 were:

- The rising cost of living for staff and residents;
- The impact of climate change on our population;
- Financial sustainability;
- Recovery of cancer and elective services;
- System resilience due to system pressures from staff sickness and increased demand
- Resource capacity for transformational change versus business as usual;
- Widening inequalities;
- Recruitment and staffing across the health and social care system; and
- Pressure on system infrastructure from rapid population growth and demographic changes.

On 1 July 2022, the newly developed BAF held six strategic risks approved by the Board, all being high (red) risks.

Risk Title	Risk Description	Current Risk Rating
Recovery of Services	There is a risk that the NHS is unable to recover services and waiting times to pre-pandemic levels due to Covid related pressures, or demand led pressures. This may lead to poorer patient outcomes and reputational damage.	16
Developing suitable workforce	If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened.	20
System Pressure & Resilience	As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the system which threatens delivery of services across BLMK	16
Widening inequalities	There is a risk that inequalities in the system widen due to a range of factors leading to compromise to population health and increases in system pressure in the most deprived areas.	16
System Transformation	There is a risk that as a result of significant operational pressures, there will be decreased capacity to focus on strategic transformational change to deliver improved outcomes for our population.	16
Financial Sustainability and Underlying Financial Health	As a result of increased inflation, significant operational pressures, elective recovery and the enduring financial implications of the covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties.	15

All risks on the BAF were subject to review of controls to mitigate risks. Action plans to improve the controls were carried out working with system partners and the ICB executive management team. Wherever gaps in controls or assurances were identified, action plans were defined and allocated as appropriate to remedy the situation so that risks to delivery of objectives were mitigated.

Strategic risks do not tend to change much over a three-to-five-year period. However, we saw increases to three risks during the reporting period. These were rising cost of living as a result of rapid rises in inflation, population growth as a result of migration and immigration, and system transformation due to winter pressures and industrial action.

During the year, the Board agreed three new strategic system risks added to the BAF, which are described below.

A) **Climate change** was added to the BAF as a significant risk to health and care, as it can have a range of direct and indirect impacts on health. Overall, climate change is a significant risk to health and care, with the potential to impact everything from the availability and quality of healthcare resources to the spread of infectious diseases and the prevalence of chronic conditions.

B) The Board agreed **population growth** was a risk to the system. This was due to the fact that as the population grows and its demography changes, demand for health and care services increases and changes, which can strain existing systems and resources. This can lead to longer wait times, decreased quality of care, and reduced patient satisfaction. It can also exacerbate existing health disparities, particularly in low-income or marginalized communities, thereby exacerbating existing inequities and leading to poorer health outcomes.

C) **Rising cost of living** was agreed as a strategic risk to the system as it potentially can also contribute to the development or exacerbation of chronic health conditions, particularly for individuals who may be forced to make trade-offs between healthcare and other basic necessities. It also has a health and care workforce impact.

As part of our commitment to risk management across the system, we work with partners to ensure that risk mitigations not only reduce present risks but also influence ongoing performance and future plans, as illustrated by the graphics below.

Risk Management and Emergency Preparedness, Resilience and Response (EPRR)

The ICB is a Category One responder under the Civil Contingencies Act 2004. This is the same category as the emergency services. We are statutorily required to ensure that a risk- based approach is taken to Emergency Planning, Resilience and Response (EPRR).

The ICB maintained an active programme of engagement with residents and other key stakeholders on key strategic and service decisions. In addition, the ICB considered our plans so that resilient control mechanisms are put in place.

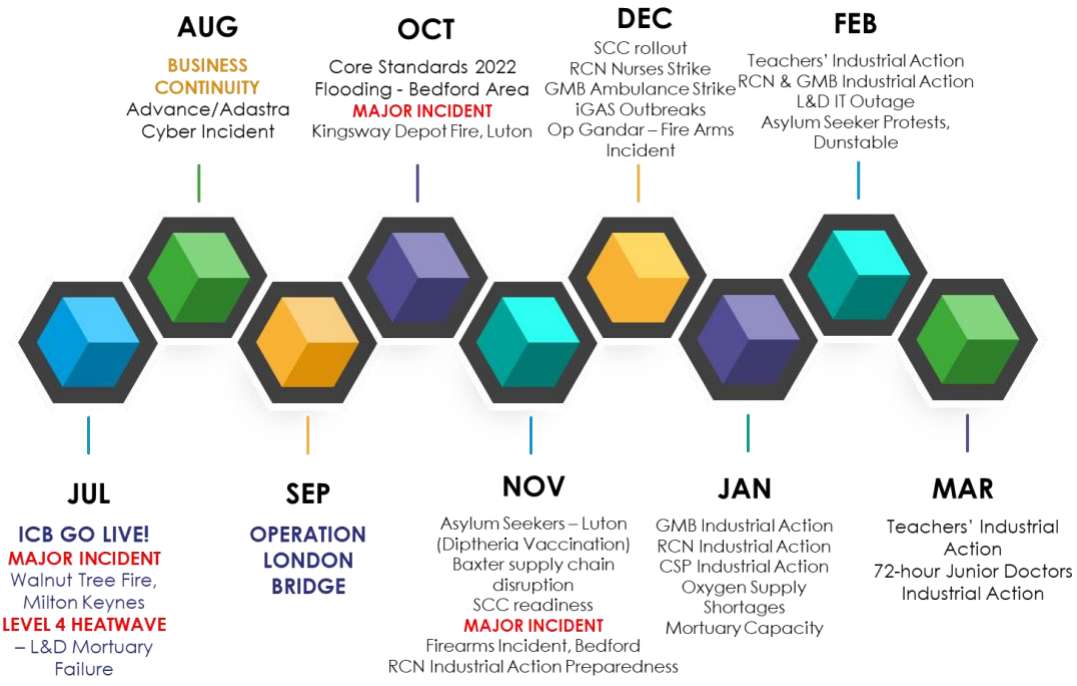
Bringing together EPRR and business continuity with risk management means that resilience becomes inbuilt into organisational risk assessments. In accordance with NHS England guidance, our chief of staff is our accountable emergency officer, supported by the head of organisational resilience.

Risks are managed across organisational boundaries. This is because often the highest risks exist at the interface between organisations. Only by working collaboratively with partner organisations can risk areas be identified, managed and prioritised within risk action plans.

The ICB has an overarching incident response plan in place, as well as a business continuity plan. The ICB maintains a health economy escalation framework in line with the NHS EPRR framework 2022 and the NHS England core standards for EPRR.

The ICB takes part in the annual NHS EPRR assurance process and work closely with the main health partners. This is so we have the right incident response and business continuity plans in place, providing compliance with the requirements of the Civil Contingencies Act 2004, the NHS Act 2006 (as amended) and NHS England EPRR guidance. In 2022/23, we maintained 'substantial' compliance with the NHS England Core Standards for EPRR, which has been the case for three consecutive years.

The timeline below illustrates the incidents/activities the ICB responded to or supported in the response during the reporting period:



Impact of existing and future risks on service delivery

Both existing and future risks can have a significant impact on the performance and delivery of healthcare plans in future years. Risks can arise from a variety of sources, including changes in patient needs, evolving regulatory requirements, shifts in funding or resources, and unexpected events or emergencies such as flooding, heatwaves or pandemics.

Our existing risks can impact the ability of health and care providers to meet our current goals and objectives. Future risks, on the other hand, can impact our ability to achieve our long-term goals and objectives. In both cases, risks can impact the performance and delivery of health and care plans in future years by creating uncertainty and disruption. This can lead to delays in the implementation of new initiatives, decreased quality of care, and reduced patient satisfaction. The public sector industrial action from December 2022, which is ongoing into 2023/24, is one such risk, which has been assessed and will continue to be managed and monitored through the internal risk management and EPRR systems.

To mitigate these risks, the ICB must remain vigilant and proactive in identifying potential threats and developing strategies to address them. This may involve investing in contingency planning, strengthening partnerships with existing stakeholders, and exploring new partnerships with other institutions. By taking a strategic and proactive approach to risk management, the ICB can help to ensure that it is well positioned to meet the evolving needs of patients and our communities in future years.

Other sources of assurance

Internal Control Framework

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

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

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 Governance Handbook.

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. 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 and on the establishment of the ICB, the contract novated to the ICB. A work plan was developed in line with the NHS Counter Fraud Functional Standards, which was approved by the Audit and Risk Assurance Committee.

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

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The ICB'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 (published June 2016) requires the ICB to undertake an annual internal audit of conflicts of interest management.

To support ICBs to undertake this task, NHS England has published a template audit framework.

We received Moderate assurance for this audit, which was conducted early 2023. Internal Auditors reported that the ICB has 'sound controls to manage and monitor conflicts of interests through clear guidance set by the policies and committee meeting discussions. However, some declaration forms in relation to procurement were not sufficiently completed, and the register of procurement decisions was not uploaded on the ICB's website.'

Data Quality

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

In addition, the ICB 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 Board is of high quality, accurate and fit for purpose.

Performance data is submitted to the ICB executive team monthly and is disseminated through ICB Board and committee papers in line with meeting frequency.

Data presented within the reports includes national data from NHS England (NHSE) which is also available to the public through NHSE websites. This data has a time-lag prior to release to allow for national quality checking and verification. In addition, the ICB's Business Intelligence partner, NHS Arden & GEM Commissioning Support Unit, undertake its own validation checks for data completeness and accuracy.

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 ICB can report against the most accurate, timely and complete data. No concerns have been raised by members of the Board about data quality.

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 a Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We undertook an assessment of our position against the DSPT and submitted a 'baseline' submission. A 'final' submission will take place by the deadline set by NHS England of 30 June 2023.

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

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.

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 ICB 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 key performance indicator 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.

Freedom to Speak Up: Raising Concerns (Whistleblowing)

BLMK ICB have a Freedom to Speak Up Policy and process in place to ensure that concerns can be raised without fear of reprisal or victimisation. The ICB actively encourages the reporting of concerns regarding risk, malpractice or wrongdoing, and will promote an open and honest culture and ensure employees raising a genuine concern in good faith will not suffer any detriment.

As well as their line manager, people have the option to raise a concern with our Freedom to Speak Up Guardian, who acts as an independent and impartial source of advice to staff at any stage of raising a concern and will follow the process as outlined in our Freedom to Speak Up Policy and report outcomes as appropriate.

Alongside continuing to have a Freedom to Speak Up Guardian, in quarter one of 2023/24, we will be launching a programme to have Freedom to Speak Up Champions within the organisation.

Control Issues

The ICB has no substantial control issues requiring remedial action.

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

The Board of the ICB 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 and Risk Assurance Committee.

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

We produce finance reports, which are reviewed by the Finance and Investment Committee prior to reporting to the Board of the ICB. The Audit and Risk Assurance Committee receives opinion from the work of the internal and external auditors and is able to advise the Board 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 ICB is meeting its financial responsibilities in accordance with NHS England's regulations.

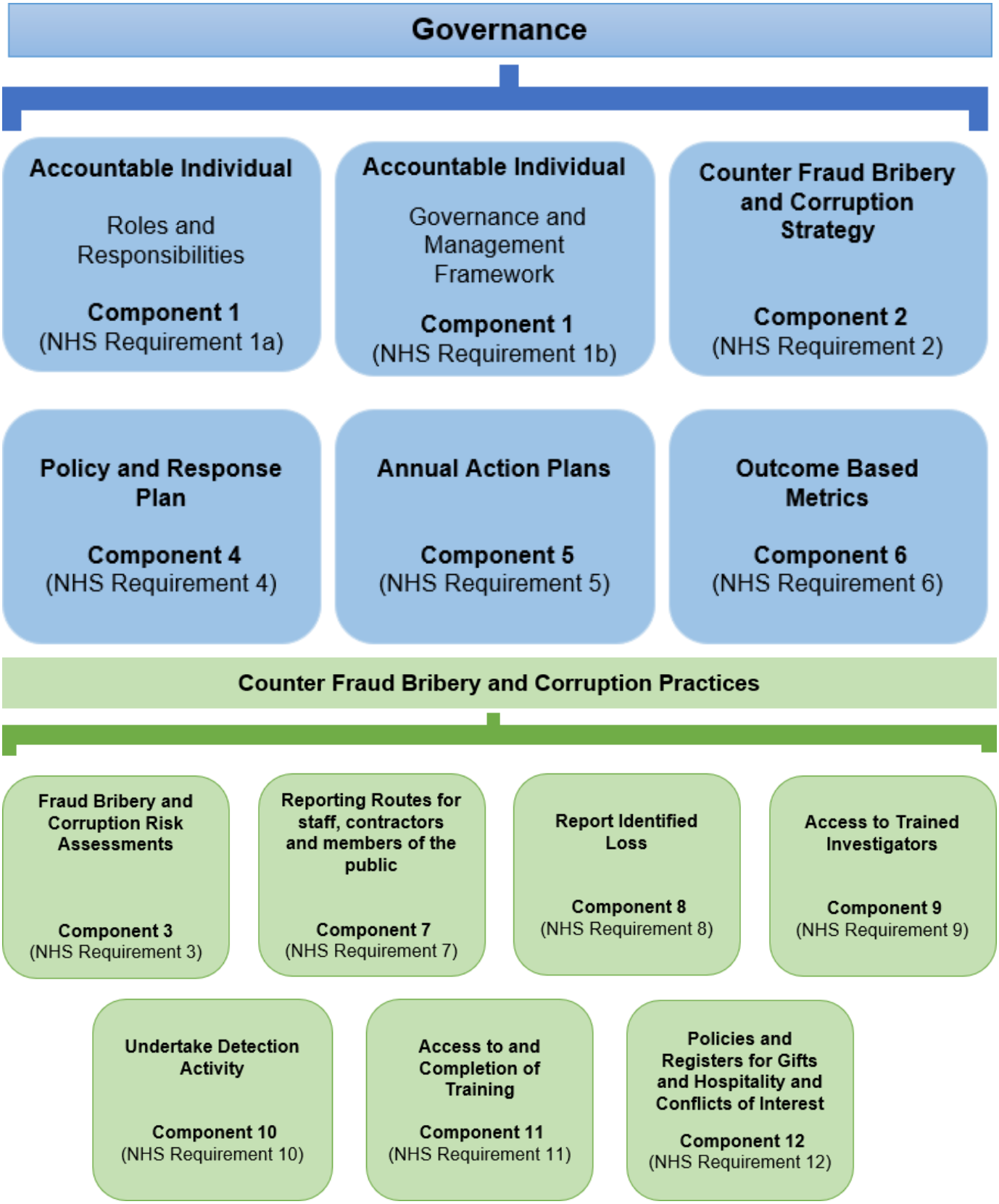
Furthermore, the organisation's Annual Report and Accounts are audited by external auditors who report to the Audit and Risk Assurance Committee.

Delegation of functions

The ICB delegated no functions during this reporting period.

Counter fraud arrangements

The Local Counter Fraud Specialist (LCFS) undertook a work plan to enable the organisation to demonstrate its compliance with the Government Functional Standard for Counter Fraud, Bribery and Corruption and its 12 component NHS Requirements, as set out below:



The Chief Finance Officer was responsible for ensuring compliance with the Government Functional Standard and the application of the related NHS Counter Fraud Authority (NHSCFA) requirements.

The ICB 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 ICB's Counter Fraud Service was provided by an accredited LCFS; during the period this counter fraud service was provided by BDO LLP. The LCFS worked to a risk-based annual plan that had been agreed by the Chief Finance Officer and the Audit and Risk Assurance Committee. As stated above, the plan is designed around the 12 NHS Requirements under the Government Functional Standard, and compliance with these standards is reported to the Audit and Risk Assurance Committee on an annual basis.

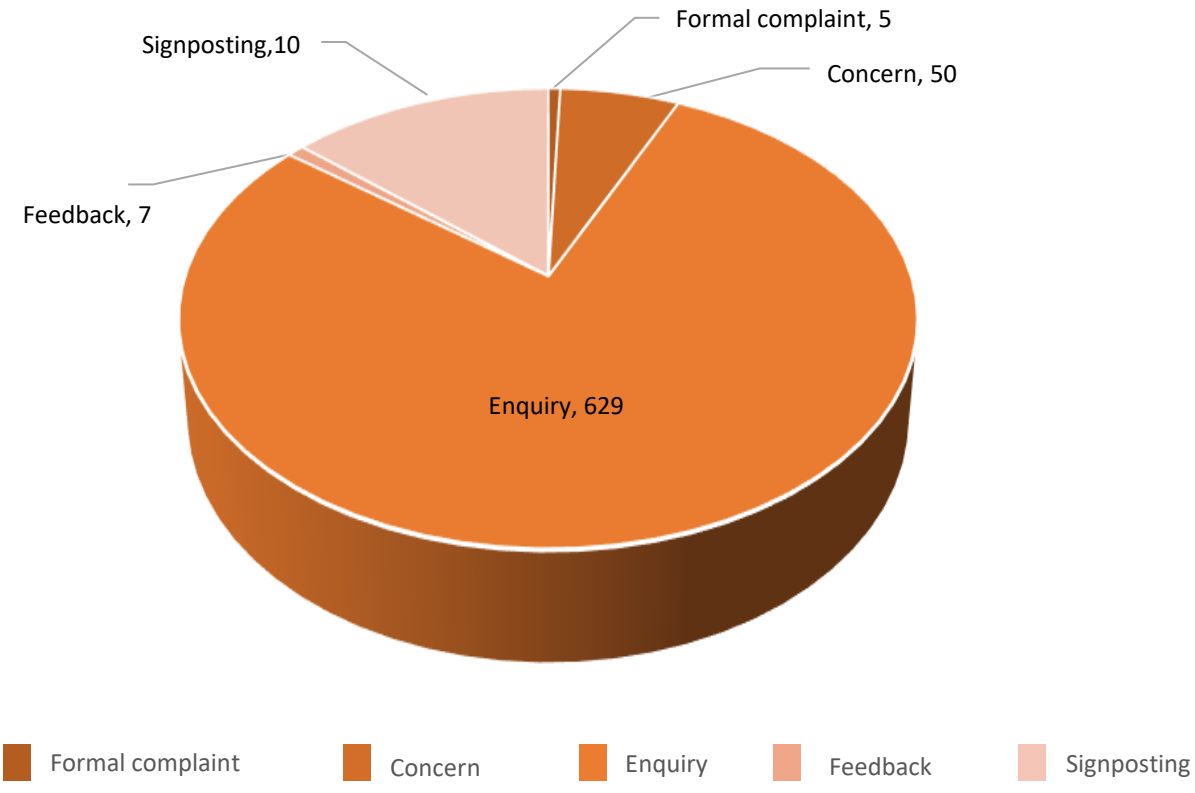
The LCFS attended meetings of the Audit and Risk Assurance Committee to provide updates on progress against the annual work plan.

All concerns of fraud, bribery and corruption at the ICB were referred to the LCFS and addressed in accordance with the ICB's fraud, bribery and corruption policy and NHSCFA Anti-Fraud Manual.

Enquiries and Complaints

General Enquiries

For this reporting period the ICB received 796 contacts, 79% (629) of which were general enquiries.

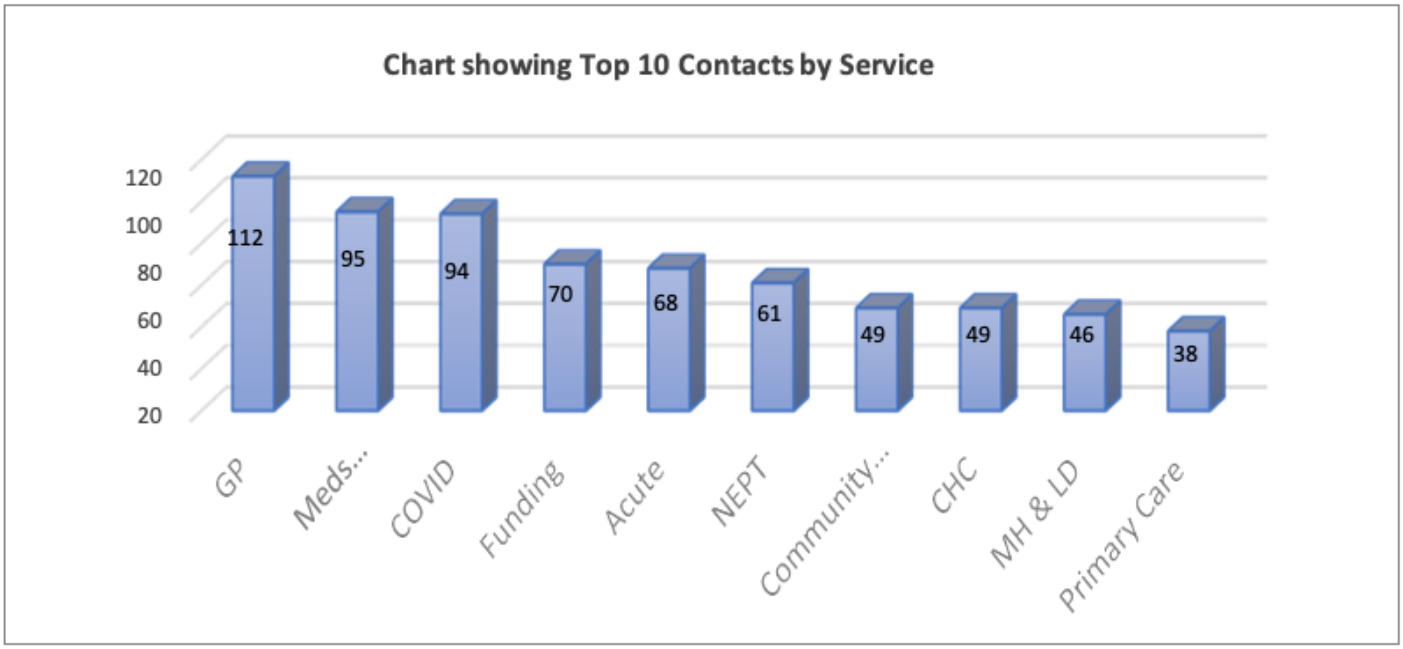


The chart below shows the top ten contacts by service and that 18% (112) GP/primary care related enquiries were received. These included enquiries around proposed plans for additional GP provision in areas which had seen or were due to see an increase in population. The ICB confirmed that additional investment had been secured and a prioritisation scheme was in place. Enquirers were also assured that the ICB continues to work with its partners to explore opportunities to progress primary care estates schemes.

Access to GP practices and delayed referrals to secondary or community services concerns were also received. Concerns of this nature were referred to primary care colleagues to assist with clarifying pathways and waiting times.

Enquiries about the availability of medication, either generally in terms of stocks or by prescription were raised in 95 instances, with some residents unhappy at not being able to obtain products as before. The ICB was able to confirm that following a review of clinical and cost effectiveness some changes had been made.

The ICB recognises the value of the lived experiences of its residents and the importance of listening to their voices.



Complaints

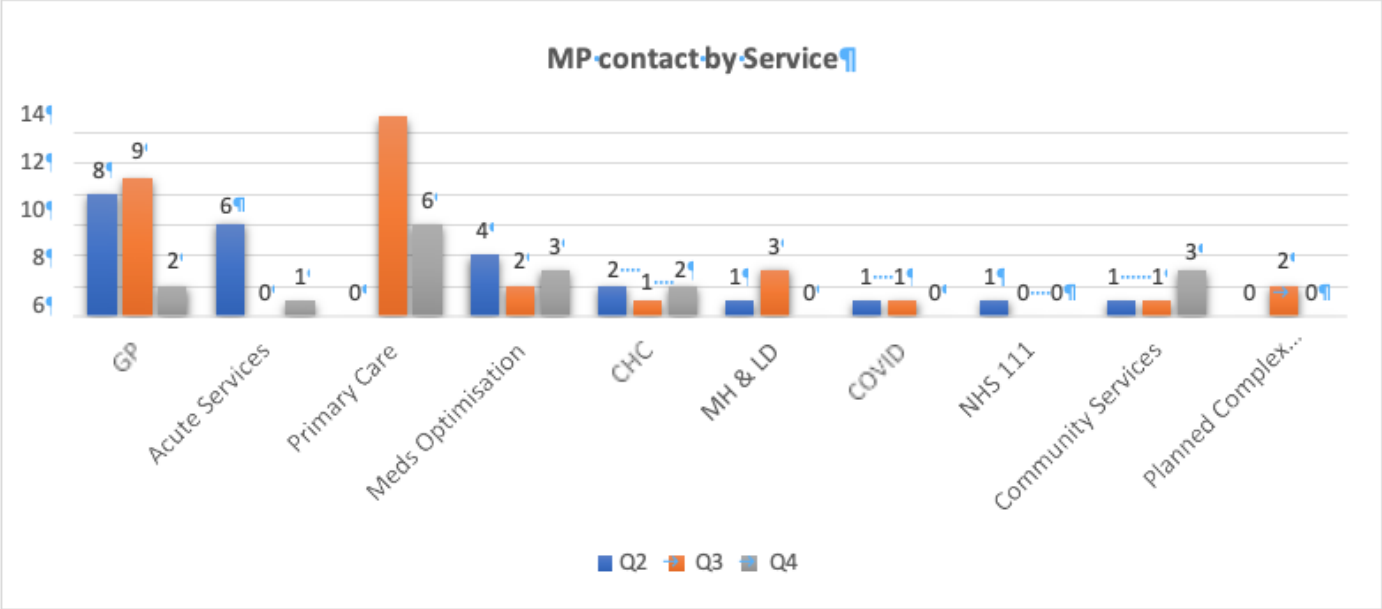
The ICB received five formal complaints:

- Communication x two (delays and administration process)
- Care and/or treatment x three (Children Continuing Health care) Complaint outcomes:

Two complaint investigations were concluded and upheld. The ICB acknowledged that poor administration and communication contributed towards a delay in providing a complaint response and that changes to a child's package of care should have been handled differently.

MP enquiries and contacts

The ICB received a total of 89 enquiries from MPs. The chart below shows the top ten enquiries by service type. Of the enquiries received, 38 concerned primary care and GP provision and the ICB was asked to clarify its plans for the BLMK region. Some enquiries were raised on behalf of constituents who believed the ICB had reneged on a promise to invest. The ICB provided assurance that there was additional funding in place and that it would continue to explore opportunities and develop relationships to benefit the health and wellbeing of the whole community.



Freedom of Information requests

The ICB received 244 Freedom of Information (FOI) requests, 15 of which exceeded the 20 working day deadline for responding to requests as outlined in the FOI Act 2000. The ICB received one breach notice from the Information Commissioners Office (ICO) which it responded to on the day of receipt. No further action was taken by the ICO. No themes were identified. Request subjects included contract information, contact details and expenditure.

Head of Internal Audit Opinion

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

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

Overall, subject to the outcome of the audits not yet complete for 2022/23, we provide moderate assurance that there is a sound system of internal control designed to meet the ICB's objectives and that controls are being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

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

Area of Audit	**Level of Assurance** (Please refer to legend below for definitions)	
	Design	**Operational Effectiveness**
Continuing Health Care		
Primary Care Commissioning		
Key Financial Systems		
Conflicts of Interest		

Legend:

Level of assurance	Design of internal control framework		Operational effectiveness of controls	
	Findings from review	Design opinion	Findings from review	Effectiveness opinion
Substantial assurance	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
Moderate assurance	In the main, there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fullyeffective.	Generally, a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non-compliance with some controls, which may put some of the system objectives at risk.
Limited assurance	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in- year.	Non-compliance with key procedures and controls places the system objectives at risk.
No assurance	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in- year affects the quality of the organisation's overall internal control framework.	Non-compliance and/or compliance with inadequate controls.

The Continuing Health Care Internal Audit carried out during this reporting period identified weaknesses in the areas of financial reporting and processes.

As a result of joint working between the ICB and IT system suppliers these issues are being resolved as follows:

- Work is almost complete on bespoke financial reporting ready for use in 2023/24.
- Payment processes have been mapped and are currently being trialled. Following the trial period, a departmental audit will be undertaken to assess how effective the new processes are, and amendments made if applicable. These processes will continue to be reviewed on an ongoing basis.

Due to the significant work undertaken to date the ICBs Internal Auditors feel that the current position reflects ‘moderate’ assurance with identified actions to reduce further.

In addition to the audits listed above, BDO carried out the following management reviews:

- BLMK CCG Closedown and ICB Readiness (Part 2)
- Healthcare Financial Management Association (HFMA) Financial Sustainability
- Primary Care Commissioning (readiness for delegation)
- ICB Governance
- Equality, Diversity & Inclusion Maturity

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

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

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

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

- Board;
- Audit and Risk Assurance Committee;
- Quality & Performance Committee;
- Finance & Investment 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. There is an action plan in place to address the findings from the Continuing Health Care audit as detailed in the Head of Internal Audit Opinion.

Felicity Cox
Accountable Officer
27th 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. More information can be found on page 118.

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 in Bedfordshire Luton & Milton Keynes ICB in the reporting period 1st July 2022 – 31st March 2023 was £182,500.

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

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	38,939	48,993	65,729
Salary component of total remuneration (£)	38,579	48,993	65,729
Pay ratio information	4.69:1	3.73:1	2.78:1

During the reporting period 1st July 2022 – 31st March 2023, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £6,250 to £182,500

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

Policy on the remuneration of senior managers

The Remuneration Committee sets salaries and terms and conditions of service for all Board members apart from Non-Executive 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 ICB are 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 Pay (2011), job evaluation methods and pay guidelines set for chief officers and chief finance officers by NHS England.

Remuneration of Very Senior Managers

The ICB had 3 senior managers on a VSM contract which provided for a contractual salary of £150,000 or greater per annum. As part of the appointment process, the remuneration for the each post was reviewed and discussed at the ICB 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 (subject to audit)

Name	Title	Salary (bands of £5,000)	Taxable benefits (total to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000
Executive Team							
Dr Rima Makarem	Chair	45-50	600	0	0	0	45-50
Felicity Cox	Accountable Officer	135-140	1,300	0	0	85-87.5	220-225
Dr Sarah Whiteman	Chief Medical Director	110-115	0	0	0	0	110-115
Dean Westcott	Chief Finance Officer	115-120	0	0	0	160-162.5	275-280
Nicky Poulain	Chief Primary Care Officer	100-105	0	0	0	65-67.5	165-170
Sarah Stanley	Chief Nursing Director (from 12th September 2022)	75-80	0	0	0	97.5-100	175-180
Anne Brierley	Chief Transformation Officer (from 20th September 2022)	75-80	0	0	0	2.5-5	75-80
Maria Wogan	Chief of System Assurance and Corporate Services (from 30th September 2022)	100-105	0	0	0	17.5-20	120-125
Martha Roberts	Chief People Officer	85-90	0	0	0	95-97.5	180-185
GP Members							
Dr Tayo Kufeji	Primary Medical Services Provider Partner Member	25-30	0	0	0	0	25-30
Mahesh Shah	Primary Medical Services Provider Partner Member	0-5	0	0	0	0	0-5
Lay Members							
Alison Borrett	Non Executive Member	10-15	0	0	0	0	10-15
Andrew Blakeman	Non Executive Member & Audit & Risk	10-15	0	0	0	0	10-15
Shirley Pointer	Non Executive Member & Remuneration Chair	10-15	0	0	0	0	10-15
Manjeet Gill	Non Executive Member (from 30th August 2022)	5-10	0	0	0	0	5-10
Lorraine Mattis	Non Executive Member (from 1st September 2022)	0-5	0	0	0	0	0-5

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

No member received any additional remuneration from the ICB for duties that are not part of the management role. Full year equivalent salary (bands of £5,000) for each of the senior mangers above is as follows:

Dr Rima Makarem - £60,000-£65,000
Felicity Cox - £180,000 - £185,000
Dr Sarah Whiteman - £145,000 - £150,000
Dean Westcott - £150,000 - £155,000
Nicky Poulain - £135,000 - £140,000
Sarah Stanley - £135,000 - £140,000
Anne Brierley - £150,000 - £155,000

Maria Wogan - £135,000 - £140,000
Martha Roberts - £115,000 - £120,000
Dr Tayo Kufeji - £35,000 - £40,000
Mahesh Shah - £20,000 - £25,000
Alison Borrett - £15,000 - £20,000
Andrew Blakeman - £15,000 - £20,000
Shirley Pointer - £15,000 - £20,000
Manjeet Gill - £15,000 - £20,000
Lorraine Mattis - £5,000 - £10,000

The following members of the ICB Board are representatives of partner organisations and do not receive remuneration from the ICB:

David Carter, NHS Trust Partner Member, Bedfordshire Hospitals Foundation Trust

Joe Harrison, NHS Trust Partner Member, Milton Keynes University Hospital Foundation Trust

Ross Graves, NHS Trust Partner Member, Central and North West London Foundation Trust Laura Church. Local Authority Partner Member, Bedford Borough Council

Marcel Coiffait, Local Authority Partner Member, Central Bedfordshire Council Robin Porter, Local Authority Partner Member, Luton Borough Council Michael Bracey, Local Authority Partner Member, Milton Keynes City Council

Vicky Head, Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes Sally Cartwright, Director of Public Health, Luton

Maxine Taffetani, Milton Keynes Healthwatch

Cllr Tracy Stock, Chair of Bedfordshire, Luton & Milton Keynes, Health and Care Partnership

Pension benefits (subject to audit)

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023(bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2022*	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Felicity Cox	Accountable Officer	2.5-5	2.5-5	40-45	105-110	685	0	126	0
Dean Westcott	Chief Finance Officer	7.5-10	15-17.5	80-85	245-250	12	22	50	0
Nicky Poulain	Chief Primary Care Officer	2.5-5	5-7.5	55-60	125-130	1,155	77	1,273	0
Sarah Stanley	Chief Nursing Director	2.5-5	10-12.5	35-40	70-75	507	80	639	0
Anne Brierley	Chief Transformation Officer	0-2.5	0	35-40	60-65	586	2	616	0
Maria Wogan	Chief of System Assurance and Corporate Services	0-2.5	0-2.5	15-20	20-25	259	14	302	0
Martha Roberts	Chief People Officer	5-7.5	10-12.5	35-40	70-75	583	89	706	0

*CETV value at 1st July 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.

Cash equivalent transfer values

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

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

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

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.

Real increase in CETV

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

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

No payments of this nature were made by the ICB during the reporting period 1st July 2022 – 31st March 2023.

Payments to past directors (subject to audit)

No payments were made by the ICB to past directors during the reporting period 1st July 2022 – 31st March 2023.

Staff Report

Number of senior managers

At the end of March 2023 Bedfordshire, Luton and Milton Keynes ICB employed 23 very senior managers (VSMs) including Band 9s.

Staff numbers and costs (subject to audit)

We employ 379 people at a cost of £22,080,000 (of which £11,983,000 is included in running costs).

Employee benefits	Permanent employees	Other	Total
	£000s	£000s	£000s
Salaries and wages	15,368	2,186	17,553
Social security costs	1,842	0	1,842
Employer contributions to NHS pension scheme	2,579	0	2,579
Other pension costs	0	0	0
Apprenticeship levy	65	0	65
Termination benefits	43	0	43
Gross employee benefits expenditure	**19,895**	**2,186**	**22,080**

Note: 379 is the average whole time equivalent staff including agency staff.

Staff composition

Board members on the ICB payroll, excluding senior executive/senior management members

Male		Female	
Headcount	%	Headcount	%
4	0.99%	12	2.96%

Senior managers and VSMs, excluding Board of the ICB

Male		Female	
Headcount	%	Headcount	%
4	23.53%	13	76.47%

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

Male		Female	
Headcount	%	Headcount	%
63	16.94%	309	83.06%

Note: Headcount figures as at the end of month 12 for 22/23 and exclude off-payroll staff.

Gender pay gap reporting

We aim to achieve a gender balance across our workforce, as a whole, including at the most senior levels.

All our opportunities are advertised internally and career conversations are held as part of appraisals. We have actively looked to fill vacancies with internal talent before seeking external candidates.

When we set up the ICB we:

- promoted opportunities to communities and those who may not have thought of a career in the NHS.
- ensured the recruitment process for ICB senior roles went through procurement exercises that tested the mechanism's commitment to equality of opportunity.

We are mindful that we must act fairly, and within the law, and act where possible to reduce the gender pay gap. Therefore, we are committed to:

- check for any gender bias in our recruitment information and appointment processes and rectifying this through training or other means
- check for any gender bias in the uptake of its training offers and other development processes
- Ensuring our recruitment strategy has a focus on attracting men to the NHS in all grades. It needs to appeal to all genders as an attractive career path
- monitor the application policies and procedures, such as flexible working
- carrying out an analysis of current workforce in relation to specific roles, salary increase requests, and starter salaries to understand any occupational bias

- ensure that we respond to any behavioural concerns arising from feedback mechanisms such as Freedom to Speak Up
- and in future years, check for any indicators from staff surveys and or exit interviews that might increase the understanding of the situation.

Sickness absence data

Under guidance issued by NHS England, guidance on Sickness Absence Data Reporting for NHS Bodies 2013–14 (2014), ICBs are required to report on a calendar year. The data in this report reflects a full twelve-month period from January 22-December 22

We supported employees' health and wellbeing through access to an Occupational Health Service, Employee Assistance Programme, absence management process, as well as wellbeing initiatives throughout the year including but not limited to fitness sessions, wellbeing topics included in our staff briefings and wellbeing conversations including as part of our appraisal 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, as well as a Freedom to Speak Up Guardian in place for staff to contact should they wish to.

The sickness absence data for 2022 showed an average 5.2 working days lost per full-time employee. It should be noted that the days lost were attributed to both long-term and short- term illnesses.

Staff turnover percentages

The staff turnover percentage for the ICB for quarters 2-4 of 2022/23 is 10.95% per headcount. The top three reasons for leaving are attributed to Retirement, work life balance and promotion. To support retention, we ensure staff feel supported in their careers, not only through secondment opportunities to help develop skills, but also advertise roles internally to ensure staff have opportunities to progress within the organisation. We have continued to offer a hybrid working model and flexible working to our staff to ensure they an opportunity for good work like balance. We conduct exit interviews both online and face to face, so that we can gather more information around the reason for leaving and can therefore take steps to address any concerns raised.

Staff engagement percentages

During the year we have held engagement sessions for our leadership group within the ICB part of which was to refresh their thinking on what their role is as leaders of the ICB is during the year of transition.

In quarter three we held two all staff engagement days with our staff. This was to enable us to work together to develop our approach system working to enable us to deliver improved outcomes for our residents at system, collaborative, place and neighbourhood levels. As well has keynote speakers from our senior team and provider colleagues the days also involved workshops for staff to explore the work going on within the ICB and wider to help develop shared understanding of how we can work as an ICB to be a full part of how our system.

Health and wellbeing support

During the reporting period we have continued to offer wellbeing support for our staff and are 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.

With the continuation of hybrid working, we have continued to support our staff by retaining and enhancing existing measures. These measures have included:

- remote working guidance;
- regular communication and contact between managers and staff members;
- appraisals and wellbeing conversations between managers and staff;
- provision of a suite of wellbeing advice and tools
- regular staff sessions on topics such as stress awareness and resilience;
- use of technology in terms of social applications;
- fortnightly MS Teams meetings with our Chief Officer to keep staff updated;
- DSE assessments for homeworking and making use of Access to Work to support where applicable 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 offer an employee assistance programme (EAP), accessed through a free and confidential helpline. We also have access to occupational health services, to support staff with health concerns and during the last year have introduced additional online apps in the form of the Peppy Menopause App and Shiny Mind.

During the Autumn of 2022 the BLMK ICB Book Club was established by the Primary Care Training Wellbeing team. It was created in response to the need for colleagues to connect to

others outside their immediate team and discuss things other than work. There is often between 5-10 people that join each month and the team have promoted the idea of other groups setting up a book club themselves.

Developing our workforce

We have created a competency framework with the aim of creating a blueprint for the skills and behaviours that enable our People to successfully operate within an Integrated Care System whilst fulfilling the NHS People Promise and delivering the BLMK ICS vision. These are integrated into the employee lifecycle from employee attraction, selection, recruitment, onboarding and development. The competencies cover five key themes – working smarter, Service Improvement & Transformation, Co-Production, Project & Programme Management and Line Management.

We began by socialising these competencies to staff during directorate days in July, then embedding these competencies as part of our annual appraisal process and moved on to hosting a Festival of Learning during the summer which included roadshows including socialising the competencies and finishing with a development plan being derived from training needs analysis from the Appraisal process.

Induction, Onboarding and development

Giving new team members a strong start at BLMK ICB is essential to our commitment to providing a positive and productive work environment for all staff. In a challenging time for the NHS, and while ICBs are still new, it is more important than ever to ensure that our plans are robust and that new staff hit the ground running. Our induction, onboarding and development plan is designed to help new employees feel welcome and supported, get up to speed quickly and effectively, and give them the tools and knowledge, they need to succeed in their roles. The program covers a wide range of topics including: mission, vision and values, governance structure, key stakeholders, contacts, and services, internal processes, and expectations for employees. For executive and non-executive members, our development plan expands further covering Establishment & Transition and Strategy, Priorities & ICB Delivery and many more.

Developing a diverse workforce

We are committed to providing a safe and thriving environment for all of our colleagues.

This means making sure that our workplace is free from discrimination and racism, and actively promoting opportunities for all staff, regardless of background, race, ethnicity or disability. The ICB consists of a diverse workforce, 21.73% of whom were from a BAME background and 71.85% white, 2.47% not stated as at the end of month 12 for 22/23. Of our workforce, our Board consisted of 0.49% BAME, 3.21% white and 0.25% not stated.

Developing an inclusive and diverse workforce is important to the ICB and we work hard to ensure that our workforce processes and practices support this aim and align to our Equality, Diversity and Inclusion Policy. We have continued to progress the development of a diverse workforce during July 2022 to March 2023. During this period, online refresher Equality and Diversity training has been delivered to all ICB staff, ensuring compliance with the Equality Act 2010. This training helps to enhance the role and importance of diversity within the organisation, supporting respect for and among the workforce. Equality, Diversity, Inclusion and belonging (EDIB) have also formed part of the recruitment and selection masterclasses that have been held. Equality impact assessment (EQIAs) training has also been offered and delivered to staff who are involved in producing EQIAs.

As part of our continued approach to support EDIB we have started work on launching Staff Networks and an EDI Forum within the organisation.

The ICB is an equal opportunities employer. When recruiting to posts we utilise best practice. We use TRAC as our recruitment system and all vacancies are 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 utilise other advertising mechanisms including jobsites, online media, newspapers and forums.

In addition to new hires, we seek to develop and promote staff internally to vacant positions. All opportunities are promoted internally as standard. We also seek to other channels for development, this includes training, mentoring, coaching and secondments. We recognise that staff can develop through partnership with external organisations. Where appropriate the ICB will work with other organisations to arrange secondments.

Disabled employees

We strive to be an inclusive employer and our policy on disabled persons ensures that:

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

Of our staff, 6.65% have declared a disability. It is not mandatory for staff to declare disabilities.

All staff complete online DSE Training and assessments on an annual basis and new joiners complete these as part of their induction. Staff are supported to purchase any DSE equipment needed and support is in place for staff with disabilities who may require specialist equipment.

Staff policies

As a statutory body, we ensure that we have robust employment policies that are compliant with current employment legislation, best practice and reflect our culture and values.

During the year where changes to legislation have been made, we have reviewed and updated our policies working alongside our trade union representatives, who have an active part in this process.

All new policies were reviewed by our Senior Leadership Group, Executives and through the appropriate board committee, before implementation.

All our current workforce policies can be viewed on our website and are available to staff through our intranet. During the year training had commenced for line managers and staff on key workforce policies and this will continue into 23/24.

Trade Union Facility Time Reporting Requirements

The ICB has agreed a facilities time policy with the trade unions.

*There have been 3 different employees acting as representatives throughout the period, with WTE fluctuating between 2.8 – 3.0 WTE

Table 1: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
3	2.12

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	£112,965
Total pay bill	£22,271,517
Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time ÷ total pay bill) x 100	0.51%

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	4%

Other employee matters

All other matters relating to staff can be found at the workforce section on page 159.

Expenditure on consultancy

Expenditure on consultancy was £127,000.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

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

	Number
Number of existing engagements as of 31st March 2023	12
Of which, the number that have existed:	
for less than one year at the time of reporting	10
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	1

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

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

Table 2: Off-payroll workers engaged at any point during the financial year

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

	Number
No. of temporary off-payroll workers engaged between 1/7/2022 and 31/3/23	
Of which:	
No. not subject to off-payroll legislation(2)	
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	15
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	27
the number of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	0

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

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

Table 3: Off-payroll engagements / senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	0

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

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies WHOLE NUMBERS ONLY	Cost of compulsory redundancies £s	Number of other departures agreed WHOLE NUMBERS ONLY	Cost of other departures agreed £s	Total number of exit packages WHOLE NUMBERS ONLY	Total cost of exit packages £s	Number of departures where special payments have been made WHOLE NUMBERS ONLY	Cost of special payment element included in exit packages £s
Less than £10,000	0	0	0	0	0	0	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	0
£100,001 - £150,000	1	105,298	0	0	1	105,298	0	0
£150,001 –£200,000	1	177,940	0	0	1	177,940	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**2**	**283,238**	**0**	**0**	**2**	**283,238**	**0**	**0**

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.

Parliamentary Accountability and Audit Report

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

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 Integrated Care Board (the 'ICB') for the period ended 31 March 2023, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

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

Basis for opinion

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

Conclusions relating to going concern

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

such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

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

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

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

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

Other information

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

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

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

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

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 109 to 110, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls.

We determined that the principal risks were in relation to high risk journals including consideration of closing entries, entries posted after year end, manual journals and journals that have a material impact on

reported outturn along with a number of other risk factors. We considered whether there was any potential management bias in accounting estimates or any significant transactions with related parties which could give rise to an indication of management override. Our audit procedures involved:

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

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

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

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

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

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

A further description of our responsibilities for the audit of the financial statements is located on the

Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

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

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

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

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

Responsibilities of the Accountable Officer

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

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

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

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

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

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

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

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

Use of our report

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

Joanne Brown
Joanne Brown, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

Date: 30 June 2023

ANNUAL ACCOUNTS

Felicity Cox

Accountable Officer

27th June 2023

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2023

	Note	01 July 2022 - 31 March 2023 £'000
Income from sale of goods and services	2	(2,068)
Other operating income	2	(77)
Total operating income		**(2,145)**
Staff costs	4	22,080
Purchase of goods and services	5	1,384,983
Depreciation and impairment charges	5	232
Provision expense	5	124
Other Operating Expenditure	5	430
Total operating expenditure		**1,407,851**
Net Operating Expenditure		**1,405,706**
Finance expense		6
Net expenditure for the Year		**1,405,712**
Comprehensive Expenditure for the year		**1,405,712**

The Health and Care Act (2022) received Royal Assent on the 28 April 2022. It introduced significant reforms to the organisation and delivery of health and care services in England. The Act abolished Clinical Commissioning Groups (CCG) and established Integrated Care Boards (ICB). NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board took on the commissioning function of the CCG and the assets and liabilities of the CCG transferred to the ICB. This transfer occurred on the 01 July 2022.

In view of these changes there are no prior year comparators for the Statement of Comprehensive Net Expenditure, the Statement of Cash Flows nor the Statement of Changes in Taxpayers Equity. Prior year comparators are included in the Statement of Financial Position and associated notes; this is due to the transfer of assets and liabilities into the ICB.

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

Statement of Financial Position as at 31 March 2023

	Note	01 July 2022 - 31 March 2023 £'000	01 April 2022 - 30 June 2022 £'000
Non-current assets:			
Property, plant and equipment	9	18	55
Right-of-use assets	9a	799	209
Total non-current assets		**817**	264
Current assets:			
Inventories	10	106	94
Trade and other receivables	11	16,214	13,543
Cash and cash equivalents	12	(524)	(406)
Total current assets		**15,797**	**13,231**
Total current assets		**15,797**	13,231
Total assets		**16,613**	13,495
Current liabilities			
Trade and other payables	13	(113,179)	(91,476)
Lease liabilities	9a.2	(266)	(209)
Borrowings	14	(9,978)	(12,830)
Provisions	15	(2,053)	(2,344)
Total current liabilities		**(125,477)**	(106,859)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(108,864)**	(93,364)
Non-current liabilities			
Lease liabilities	9a.2	(534)	-
Provisions	15	(357)	(812)
Total non-current liabilities		**(892)**	**(812)**
Assets less Liabilities		**(109,755)**	(94,176)
Financed by Taxpayers' Equity			
General fund		(109,755)	(94,176)
Total taxpayers' equity:		**(109,755)**	(94,176)

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

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

Felicity Cox
Chief Accountable Officer
Date: 27 June 2023

Statement of Changes In Taxpayers Equity for the year ended 31 March 2023

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 01 July 2022 - 31 March 2023		
Changes in NHS Integrated Care Board taxpayers' equity for 01 July 2022 - 31 March 2023		
Net operating expenditure for the financial year	(1,405,712)	**(1,405,712)**
Transfers by absorption to (from) other bodies	(94,468)	(94,468)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(1,500,180)**	**(1,500,180)**
Net funding	1,390,425	**1,390,425**
Balance at 31 March 2023	**(109,755)**	**(109,755)**

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

Statement of Cash Flows for the year ended 31 March 2023

	Note	01 July 2022 - 31 March 2023 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(1,405,706)
Depreciation and amortisation	5	232
Movement due to transfer by Modified Absorption		(91,367)
(Increase)/decrease in inventories		(106)
(Increase)/decrease in trade & other receivables	11	(16,214)
Increase/(decrease) in trade & other payables	13	113,179
Provisions utilised	15	(869)
Increase/(decrease) in provisions	15	124
Net Cash Inflow (Outflow) from Operating Activities		**(1,400,727)**
Net Cash Inflow (Outflow) before Financing		**(1,400,727)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		1,390,425
Repayment of lease liabilities		(200)
Net Cash Inflow (Outflow) from Financing Activities		**1,390,225**
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(10,502)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(10,502)**

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

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB 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.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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

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

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

1.2 Accounting Convention

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

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

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

1.4 Pooled Budgets

The ICB 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 19 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 ICB makes contributions to the pool, which are then used to purchase healthcare services. The ICB 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

Notes to the financial statements

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 ICB.

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 ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

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 ICB'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 ICB 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
- 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 single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit,

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

1.10.2 Measurement

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

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

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

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

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.

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 Leases

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

1.11.1 The ICB as Lessee

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

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

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

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

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

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

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

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

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

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

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

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

1.12 Inventories

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

1.13 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 ICB's cash management.

1.14 Provisions

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

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

• A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

A restructuring provision is recognised when the ICB 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.

1.15 Clinical Negligence Costs

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

1.16 Non-clinical Risk Pooling

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

1.17 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 ICB, 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 ICB. 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.

1.18 Financial Assets

Financial assets are recognised when the ICB 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.

1.18.1 Financial Assets at Amortised cost

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

1.19 Financial Liabilities

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

1.20 Value Added Tax

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

1.21 Third Party Assets

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

1.22 Losses & Special Payments

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

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

1.23 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB'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.

1.23.1 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 ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The ICB 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 ICB accounts. Having reviewed the terms of the partnership agreement and the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care, the ICB has accounted for its share of the assets, liabilities, income and expenditure as described in Note 1.4 above.

1.23.2 Sources of estimation uncertainty

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

1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

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

2 Other Operating Revenue

	01 July 2022 - 31 March 2023 Admin £'000	01 July 2022 - 31 March 2023 Programme £'000	01 July 2022 - 31 March 2023 Total £'000
Income from sale of goods and services (contracts)			
Education, training and research	-	1,024	**1,024**
Non-patient care services to other bodies	-	747	**747**
Other Contract income	0	3	**3**
Recoveries in respect of employee benefits	11	283	**294**
Total Income from sale of goods and services	**11**	**2,057**	**2,068**
Other operating income			
Other non contract revenue	-	77	**77**
Total Other operating income	**-**	**77**	**77**
Total Operating Income	**11**	**2,134**	**2,145**

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

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000	01 July 2022 31 March 2023 £'000
Source of Revenue					
NHS	1,024	602	-	275	1,901
Non NHS	-	145	3	19	167
Total	**1,024**	**747**	**3**	**294**	**2,068**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000	01 July 2022 31 March 2023 £'000
Timing of Revenue					
Over time	1024	747	**3**	294	2068
Total	**1,024**	**747**	**3**	**294**	**2,068**

3.2 Transaction price to remaining contract performance obligations

NHS Bedfordshire, Luton and Milton Keynes ICB had no contract revenue expected to be recognised in future periods relating to contract performance.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	01 July 2022 - 31 March 2023		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	15,368	2,186	**17,553**
Social security costs	1,842	-	**1,842**
Employer Contributions to NHS Pension scheme	2,579	-	**2,579**
Apprenticeship Levy	65	-	**65**
Termination benefits	43	-	**43**
Gross employee benefits expenditure	**19,895**	**2,186**	**22,080**
Less recoveries in respect of employee benefits (note 4.1.2)	(294)	-	**(294)**
Total - Net admin employee benefits including capitalised costs	**19,601**	**2,186**	**21,787**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**19,601**	**2,186**	**21,787**

4.1.2 Recoveries in respect of employee benefits

	01 July 2022 - 31 March 2023		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits - Revenue			
Salaries and wages	(225)	-	(225)
Social security costs	(31)	-	(31)
Employer contributions to the NHS Pension Scheme	(37)	-	(37)
Total recoveries in respect of employee benefits	**(294)**	**-**	**(294)**

4.2 Average number of people employed

	01 July 2022 - 31 March 2023		
	Permanently employed Number	Other Number	Total Number
Total	349	29	379
Of the above:			
Number of whole time equivalent people engaged on capital projects	-	-	-

No people were engaged on capital projects in the period from 01 July 2022 to 31 March 2023 (nil in the period 1 April 2022 to 30 June 2022).

4.3 Exit packages agreed in the financial year

	01 July 2022 - 31 March 2023		01 July 2022 - 31 March 2023	
	Compulsory redundancies		Total	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	1	105,298	1	105,298
£150,001 to £200,000	1	177,940	1	177,940
Over £200,001	-	-	-	-
Total	**2**	**283,238**	**2**	**283,238**

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

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).

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

Where the ICB has agreed early retirements, the additional costs are met by the ICB and not by the NHS Pension Scheme, and are included in the tables.

Where the ICB has agreed early retirements, the additional costs are met by NHS Entities 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 the tables.

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

4.5 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	01 July 2022 - 31 March 2023 Total £'000
Purchase of goods and services	
Services from other ICBs, CCGs and NHS England	3,756
Services from foundation trusts	827,273
Services from other NHS trusts	93,308
Purchase of healthcare from non-NHS bodies	193,051
Prescribing costs	114,387
GPMS/APMS and PCTMS	124,987
Supplies and services – clinical	476
Supplies and services – general	11,398
Consultancy services	127
Establishment	3,728
Transport	7,081
Premises	2,373
Audit fees	175
Other services	30
Other professional fees	520
Legal fees	167
Education, training and conferences	2,147
Total Purchase of goods and services	**1,384,983**
Depreciation and impairment charges	
Depreciation	232
Total Depreciation and impairment charges	**232**
Provision expense	
Provisions	124
Total Provision expense	**124**
Other Operating Expenditure	
Chair and Non Executive Members	168
Grants to Other bodies	177
Expected credit loss on receivables	(0)
Other expenditure	86
Total Other Operating Expenditure	**430**
Total operating expenditure	**1,385,770**

The supplies and services - general includes grants provided to: Bedford Borough Council £3,300k, Central Bedfordshire Council £300k, Luton Borough Council £300k and Milton Keynes Council £600k. This is in addition to the pooled budget arrangements in place with the local authorities.

Other Audit fees represent the fees for validating the delivery of the Mental Health Investment Standard.

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 ICB 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 ICB 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 ICB 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 ICB 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 ICB in the letter of appointment following a further competition.

6 Better Payment Practice Code

Measure of compliance	01 July 2022 - 31 March 2023 Number	01 July 2022 - 31 March 2023 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	15,469	269,442
Total Non-NHS Trade Invoices paid within target	14,616	230,849
Percentage of Non-NHS Trade invoices paid within target	**94.49%**	**85.68%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,305	934,708
Total NHS Trade Invoices Paid within target	1,233	932,296
Percentage of NHS Trade Invoices paid within target	**94.48%**	**99.74%**

6.1 The Late Payment of Commercial Debts (Interest) Act 1998

The ICB incurred £nil in the period from 1 July 2022 to 31 March 2023 (nil in the period from 1 April 2022 to 30 June 2022) relating to claims made under this legislation.

7 Finance costs

	01 July 2022 - 31 March 2023 £'000
Interest on lease liabilities	6
Total interest	**6**
Other finance costs	-
Provisions: unwinding of discount	-
Total finance costs	**6**

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

	01 July 2022 - 31 March 2023 £'000
Transfer of property plant and equipment	55
Transfer of Right of Use assets	209
Transfer of inventories	94
Transfer of cash and cash equivalents	(406)
Transfer of receivables	13,543
Transfer of payables	(91,476)
Transfer of provisions	(3,156)
Transfer of Right Of Use liabilities	(209)
Transfer of borrowings	(12,830)
Transfer of PUPOC liability	(293)
Net loss on transfers by absorption	**(94,468)**

9 Property, plant and equipment

	01 July 2022 - 31 March 2023	01 July 2022 - 31 March 2023	01 July 2022 - 31 March 2023		01 April 2022 - 30 June 2022	01 April 2022 - 30 June 2022	01 April 2022 - 30 June 2022
	Plant & machinery	Information technology	Total		Plant & machinery	Information technology	Total
	£'000	£'000	£'000		£'000	£'000	£'000
Cost or valuation at 01 July 2022	-	-	-	**Cost or valuation at 01 April 2022**	47	866	913
Additions purchased	-	-	-	Additions purchased	-	-	-
Reclassifications	-	-	-	Reclassifications	-	-	-
Disposals other than by sale	-	-	-	Disposals other than by sale	(14)	(760)	(773)
Transfer (to)/from other public sector body	33	106	139	Transfer (to)/from other public sector body	-	-	-
Cost/Valuation at 31 March 2023	**33**	**106**	**139**	**Cost/Valuation at 30 June 2022**	**33**	**106**	**139**
Depreciation 01 July 2022	-	-	-	**Depreciation 01 April 2022**	35	809	844
Reclassifications	-	-	-	Reclassifications	-	-	-
Disposals other than by sale	-	-	-	Disposals other than by sale	(14)	(760)	(773)
Charged during the year	5	32	37	Charged during the year	2	12	13
Transfer (to)/from other public sector body	23	61	84	Transfer (to)/from other public sector body	-	-	-
Depreciation at 31 March 2023	**28**	**93**	**121**	**Depreciation at 30 June 2022**	**23**	**61**	**84**
Net Book Value at 31 March 2023	**5**	**13**	**18**	**Net Book Value at 30 June 2022**	**10**	**45**	**55**
Purchased	5	13	18	Purchased	10	45	55
Total at 31 March 2023	**5**	**13**	**18**	**Total at 30 June 2022**	**10**	**45**	**55**
Asset financing:				**Asset financing:**			
Owned	5	13	18	Owned	10	45	55
Total at 31 March 2023	**5**	**13**	**18**	**Total at 30 June 2022**	**10**	**45**	**55**

Revaluation Reserve Balance for Property, Plant & Equipment

No revaluation reserve balance was held for property, plant and equipment in the period 01 July 2022 to 31 March 2023

9.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	01 July 2022 - 31 March 2023	01 April 2022 - 30 June 2022
	£'000	£'000
Plant & machinery	-	-
Information technology	62	-
Total	**62**	**-**

9.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Transport equipment	5	5
Furniture & fittings	3	5

9a Leases

9a.1 Right-of-use assets

01 July 2022 - 31 March 2023	01 July 2022 - 31 March 2023	01 July 2022 - 31 March 2023	01 April 2022 - 30 June 2022	01 April 2022 - 30 June 2022	01 April 2022 - 30 June 2022
£'000	£'000	£'000	£'000	£'000	£'000
Buildings excluding dwellings	Total	Of which: leased from DHSC group bodies	Buildings excluding dwellings	Total	Of which: leased from DHSC group bodies
£'000	£'000	£000	£'000	£'000	£000
Cost or valuation at 01 July 2022	-	-		-	-
IFRS 16 Transition Adjustment	-	-		235	235	159
Additions	785	785	-	-	-	-
Transfer (to) from other public sector body	235	235	159	-	-	-
Cost/Valuation at 31 March 2023	**1,020**	**1,020**	**159**	**235**	**235**	**159**
Depreciation 01 July 2022	-	-		-	-	-
Charged during the year	195	195	59	26	26	20
Transfer (to) from other public sector body	26	26	20	-	-	-
Depreciation at 31 March 2023	**221**	**221**	**79**	**26**	**26**	**20**
Net Book Value at 31 March 2023	**799**	**799**	**80**	**209**	**209**	**139**

NBV by counterparty	
Leased from other group bodies	80	139
Leased externally	719	70
Net Book Value at 31 March 2023	**799**	**209**

9a Leases cont'd

9a.2 Lease liabilities

01 July 2022 - 31 March 2023	01 July 2022 - 31 March 2023 £'000	01 April 2022 - 30 June 2022 £'000
Lease liabilities at 01 July 2022	-	-
IFRS 16 Transition Adjustment	-	(235)
Additions purchased	(785)	-
Interest expense relating to lease liabilities	(6)	(1)
Repayment of lease liabilities (including interest)	200	26
Transfer (to) from other public sector body	(209)	-
Lease liabilities at 31 March 2023	**(801)**	**(209)**

9a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	01 July 2022 - 31 March 2023	Of which: leased from DHSC group bodies	01 April 2022 - 30 June 2022	Of which: leased from DHSC group bodies
	£'000	£000	£'000	£000
Within one year	(266)	(80)	(106)	(80)
Between one and five years	(548)	-	(105)	(59)
Balance at 31 March 2023	**(814)**	**(80)**	**(211)**	**(139)**

	01 July 2022 - 31 March 2023 £'000	01 April 2022 - 30 June 2022 £'000
Balance by counterparty		
Leased from other group bodies	(80)	**(139)**
Leased externally	(734)	**(72)**
Balance as at 31 March 2023	**(814)**	**(211)**

9a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	01 July 2022 - 31 March 2023 £'000
Depreciation expense on right-of-use assets	195
Interest expense on lease liabilities	6
Expense relating to short-term leases	14
Total	**215**

9a.5 Amounts recognised in Statement of Cash Flows

	01 July 2022 - 31 March 2023 £'000
Total cash outflow on leases under IFRS 16	200
Total cash outflow for lease payments not included within the meas	-
Total	**200**

9a.6 Nature of lessee's leasing activities

Future cash outflows to which the lessee is potentially exposed that are not reflected in the measurement of lease liabilities. This includes exposure arising from:

	01 July 2022 - 31 March 2023 £'000
Prevalence of extension and termination options	126
Total	**126**

10 Inventories

	01 July 2022 - 31 March 2023 £'000
Balance at 01 July 2022	-
Additions	12
Transfer (to) from -Goods for resale	94
Balance at 31 March 2023	**106**

11.1 Trade and other receivables

	Current 01 July 2022 - 31 March 2023 £'000	Current 01 April 2022 - 30 June 2022 £'000
NHS receivables: Revenue	2,071	1,705
NHS prepayments	12	2,177
NHS accrued income	1,801	257
Non-NHS and Other WGA receivables: Revenue	8,347	3,602
Non-NHS and Other WGA prepayments	191	1,830
Non-NHS and Other WGA accrued income	3,517	3,008
Expected credit loss allowance-receivables	(2)	(2)
VAT	269	953
Other receivables and accruals	9	12
Total Trade & other receivables	**16,214**	**13,543**
Total current receivables	**16,214**	**13,543**
Included above:		
Prepaid pensions contributions	-	-

11.2 Receivables past their due date but not impaired

	01 July 2022 - 31 March 2023 DHSC Group Bodies £'000	01 July 2022 - 31 March 2023 Non DHSC Group Bodies £'000	01 April 2022 - 30 June 2022 DHSC Group Bodies £'000	01 April 2022 - 30 June 2022 Non DHSC Group Bodies £'000
By up to three months	234	3,041	223	8,621
By three to six months	5	198	5	28
By more than six months	(3)	137	95	15
Total	**236**	**3,377**	**323**	**8,664**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 01 April 2022	-	-
Transfer by Absorption from other entity	(2)	(2)
Total	**(2)**	**(2)**

12 Cash and cash equivalents

	01 July 2022 - 31 March 2023 £'000	01 April 2022 - 30 June 2022 £'000
Balance at 01 July 2022	-	(705)
Net change in year	(10,502)	(12,531)
Balance at 31 March 2023	**(10,502)**	**(13,236)**
Made up of:		
Cash held in Pooled Budget	(524)	(406)
Cash and cash equivalents as in statement of financial po	**(524)**	**(406)**
Bank overdraft: Government Banking Service	(9,978)	(12,830)
Total bank overdrafts	**(9,978)**	**(12,830)**
Balance at 31 March 2023	**(10,502)**	**(13,236)**

The bank overdraft is a technical overdraft representing the ICB's cash book position. The actual bank balance was in credit by £801k

Included within cash held in Pooled Budget is an overdrawn balance of £524k held on behalf of the ICB by Milton Keynes Council for the Integrated Community Equipment Service and Learning Disability Service pooled budgets.

13 Trade and other payables	Current 01 July 2022 - 31 March 2023 £'000	Current 01 April 2022 - 30 June 2022 £'000
NHS payables: Revenue	4,366	3,043
NHS accruals	11,126	10,147
NHS deferred income	248	270
Non-NHS and Other WGA payables: Revenue	16,723	3,399
Non-NHS and Other WGA accruals	69,985	68,525
Non-NHS and Other WGA deferred income	5,125	78
Social security costs	450	298
Tax	341	259
Other payables and accruals	4,816	5,458
Total Trade & Other Payables	**113,179**	**91,476**

Other payables include £1335 outstanding pension contributions at 31 March 2023

14 Borrowings

	Current 01 July 2022 - 31 March 2023 £'000	Current 01 April 2022 - 30 June 2022 £'000
Bank overdrafts:		
Government banking service	9,978	12,830
Total overdrafts	**9,978**	**12,830**
Total Borrowings	**9,978**	**12,830**

14.1 Repayment of principal falling due

	Department of Health 01 July 2022 - 31 March 2023 £'000	Other 01 July 2022 - 31 March 2023 £'000	Total 01 July 2022 - 31 March 2023 £'000	Department of Health 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Within one year	-	9,978	9,978	0	12,830	12,830
Total	**-**	**9,978**	**9,978**	**0**	**12,830**	**12,830**

15 Provisions

	Current 01 July 2022 - 31 March 2023 £'000	Non-current 01 July 2022 - 31 March 2023 £'000	Current 01 April 2022 30 June 2022 £'000	Non-current 01 April 2022 - 30 June 2022 £'000
Restructuring	784	357	784	812
Redundancy	111	-	255	-
Legal claims	15	-	3	-
Continuing care	674	-	752	-
Other	470	-	550	-
Total	**2,053**	**357**	**2,344**	**812**
Total current and non-current	**2,411**		**3,156**	

	Restructuring £'000	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 July 2022	**-**	**-**	**-**	**-**	**-**	**-**
Arising during the year	-	96	12	290	-	**398**
Utilised during the year	(455)	(241)	-	(103)	(71)	**(869)**
Reversed unused	-	-	-	(265)	(9)	**(274)**
Transfer (to) from other public sector body under absorption	1,596	255	3	752	550	**3,156**
Balance at 31 March 2023	**1,141**	**111**	**15**	**674**	**470**	**2,411**
Expected timing of cash flows:						
Within one year	784	111	15	674	470	**2,053**
Between one and five years	357	-	-	-	-	**357**
Balance at 31 March 2023	**1,141**	**111**	**15**	**674**	**470**	**2,411**

Over the last three years, the role and function of corporate office spaces has changed significantly with a more flexible approach to working from home. The Integrated Care Board's future corporate estates requirements has therefore been re-assessed and it was agreed that the office bases across Bedfordshire, Luton and Milton Keynes be rationalised. Several bases have therefore been downscaled and, whilst the Integrated Care Board is attempting to seek additional tenants, it will continue to be liable for the lease costs of the excess office space until the lease-end/break clause dates in Milton Keynes (April 2024) and Luton (June 2025). The restructuring provision of £1,141k relates to the liability for the ongoing costs of this excess space.

As part of the Integrated Care Board's ongoing transition there is a requirement to review the roles of very senior managers within its structure. This process has placed some Directors within the Integrated Care Board at risk. A £111k redundancy provision 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 2023 that are undergoing an appeal process. The Integrated Care Board 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 16.

Other provisions reflects a legacy £470k employer superannuation liability relating to previous clinical commissioning groups.

16 Contingencies

	01 July 2022 - 31 March 2023 £'000
Contingent liabilities	
Continuing Healthcare	1,316
Net value of contingent liabilities	**1,316**

The contingent liability for Continuing Health Care relates to cases from April 2013 to March 2023 that are undergoing an appeal process. A provision has been established for the likely cost of successful appeals (see Note 15) with the contingency above reflecting the remainder of the liability should the outcome of the appeals go against the ICB.

NHS Bedfordshire, Luton and Milton Keynes ICB identified £nil in the period from 1 July 2022 to 31 March 2023 relating to contingent assets.

17 Commitments

NHS Bedfordshire, Luton and Milton Keynes ICB had £nil capital commitments or other financial commitments.

18 Financial instruments

18.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS integrated care board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The integrated care board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS integrated care board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS integrated care board and internal auditors.

18.1.1 Currency risk

The NHS integrated care board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS integrated care board has no overseas operations. The NHS integrated care board therefore has low exposure to currency rate fluctuations.

18.1.2 Interest rate risk

The integrated care board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The integrated care board therefore has low exposure to interest rate fluctuations.

18.1.3 Credit risk

Because the majority of the NHS integrated care board and revenue comes parliamentary funding, NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

18.1.4 Liquidity risk

NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

18.1.5 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.

18 Financial instruments cont'd

18.2 Financial assets

	Financial Assets measured at amortised cost	Total
	01 July 2022 - 31 March 2023 £'000	01 July 2022 - 31 March 2023 £'000
Trade and other receivables with NHSE bodies	3,796	3,796
Trade and other receivables with other DHSC group bodies	3,439	3,439
Trade and other receivables with external bodies	8,510	8,510
Cash and cash equivalents	(524)	(524)
Total at 31 March 2023	**15,221**	**15,221**

18.3 Financial liabilities

	Financial Liabilities measured at amortised cost	Total
	01 July 2022 - 31 March 2023 £'000	01 July 2022 - 31 March 2023 £'000
Loans with external bodies	9,978	**9,978**
Trade and other payables with NHSE bodies	718	**718**
Trade and other payables with other DHSC group bodies	15,129	**15,129**
Trade and other payables with external bodies	91,969	**91,969**
Total at 31 March 2023	**117,795**	**117,795**

19 Operating segments

The ICB operates as one operating segment and that is to commission healthcare.

20 Pooled Budgets

NHS Bedfordshire, Luton and Milton Keynes ICB The ICB 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.

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, Adult Social Care Discharge Funds & Hospital Discharge Funds, as listed below.

20.1 Joint operations

Bedford Borough Locality Arrangement	Total £'000	Better Care Fund £'000	Hospital Discharge Fund £'000	Community Equipment * £'000	Childrens Services £'000	Learning Disabilities £'000
Contribution						
Bedford Borough Council	6,153	5,292	517	344	-	-
Bedfordshire, Luton & Milton Keynes ICB	5,732	4,227	902	603	-	-
Total Funding	**11,885**	**9,519**	**1,419**	**947**	**-**	**-**
Expenditure						
Bedford Borough Council	6,153	5,292	517	344	-	-
Bedfordshire, Luton & Milton Keynes ICB	5,679	4,227	902	550	-	-
Total Expenditure	**11,832**	**9,519**	**1,419**	**894**	**-**	**-**
Net Overspend / (Underspend)						
Bedford Borough Council	-	-	-	-	-	-
Bedfordshire, Luton & Milton Keynes ICB	(52)	-	-	(52)	-	-
Total Overspend / (Underspend)	**(52)**	**-**	**-**	**(52)**	**-**	**-**

* The community equipment funds are pooled with Central Bedfordshire Council and Milton Keynes ICB in a three way agreement as below

Central Bedfordshire Locality Arrangement	Total £'000	Better Care Fund £'000	Hospital Discharge Fund £'000	Community Equipment * £'000	Childrens Services £'000	Learning Disabilities £'000
Contribution						
Central Bedfordshire Council	7,365	6,114	722	529	-	-
Bedfordshire, Luton & Milton Keynes ICB	11,433	8,988	1,519	926	-	-
Total Funding	**18,798**	**15,102**	**2,240**	**1,455**	**-**	**-**
Expenditure						
Central Bedfordshire Council	7,365	6,114	722	529	-	-
Bedfordshire, Luton & Milton Keynes ICB	11,353	8,988	1,519	846	-	-
Total Expenditure	**18,717**	**15,102**	**2,240**	**1,375**	**-**	**-**
Net Overspend / (Underspend)						
Central Bedfordshire Council	-	-	-	-	-	-
Bedfordshire, Luton & Milton Keynes ICB	(81)	-	-	(81)	-	-
Total Overspend / (Underspend)	**(81)**	**-**	**-**	**(81)**	**-**	**-**

* The community equipment funds are pooled with Bedford Borough Council and Milton Keynes ICB in a three way agreement as above

Luton Borough Locality Arrangement	Total £'000	Better Care Fund £'000	Hospital Discharge Fund £'000	Community Equipment * £'000	Childrens Services £'000	Learning Disabilities £'000
Contribution						
Luton Borough Council	13,401	5,635	943	605	1,707	4,512
Bedfordshire, Luton & Milton Keynes ICB	13,564	6,639	1,895	589	809	3,632
Total Funding	**26,965**	**12,274**	**2,838**	**1,194**	**2,515**	**8,144**
Expenditure						
Luton Borough Council	13,694	5,928	943	605	1,707	4,512
Bedfordshire, Luton & Milton Keynes ICB	13,271	6,346	1,895	589	809	3,632
Total Expenditure	**26,965**	**12,274**	**2,838**	**1,194**	**2,515**	**8,144**
Net Overspend / (Underspend)						
Luton Borough Council	293	293	-	-	-	-
Bedfordshire, Luton & Milton Keynes ICB	(293)	(293)	-	-	-	-
Total Overspend / (Underspend)	**0**	**0**	**-**	**-**	**-**	**-**

Milton Keynes Locality Arrangement	Total £'000	Better Care Fund £'000	Hospital Discharge Fund £'000	Community Equipment * £'000	Childrens Services £'000	Learning Disabilities £'000
Contribution						
Milton Keynes Council	28,701	5,571	757	563	-	21,810
Bedfordshire, Luton & Milton Keynes ICB	11,524	8,370	1,395	593	-	1,165
Other Grant Funds	335	-	-	335	-	-
Total Funding	**40,560**	**13,941**	**2,152**	**1,492**	**-**	**22,975**
Expenditure						
Milton Keynes Council	27,263	5,571	757	730	-	20,205
Bedfordshire, Luton & Milton Keynes ICB	11,279	8,370	1,395	445	-	1,068
Total Expenditure	**38,542**	**13,941**	**2,152**	**1,175**	**-**	**21,273**
Net Overspend / (Underspend)						
Milton Keynes Council	(1,438)	-	-	(168)	-	(1,605)
Bedfordshire, Luton & Milton Keynes ICB	(245)	-	-	(148)	-	(97)
Total Overspend / (Underspend)	**(1,683)**	**-**	**-**	**(316)**	**-**	**(1,702)**

21 Related party transactions

Individual ICB Board members, having significant influence over the management of the ICB, are considered to be related parties. Details of transactions between the ICB and ICB Board members are detailed in the Remuneration Report within the Annual Report.

Entities controlled by the ICB Board 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 2022/23.

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 ICB had a number of material transactions with other NHS and other government bodies. Materiality in this context is considered to be over £7.5m and transactions have been prepared on an accruals basis.

Bedford Unitary Authority
Bedfordshire Hospitals NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Central & North West London NHS Foundation Trust
Central Bedfordshire Unitary Authority
East & North Hertfordshire NHS Trust
East London NHS Foundation Trust
East of England Ambulance Service NHS Trust
Luton Borough Council
Milton Keynes Council
Milton Keynes University Hospital NHS Foundation Trust
Oxford University Hospitals NHS Foundation Trust
South Central Ambulance Service NHS Foundation Trust

22 Events after the end of the reporting period

On the 1st April 2023 Bedfordshire, Luton & Milton Keynes Integrated Care Board was delegated responsibility from NHSE for the commissioning of pharmacy, ophthalmology, and dentistry (POD) services. The impact of POD delegation has no impact on the 2022/23 financial statements or the going concern status of the ICB.

There are no adjusting events after the reporting period which will have a material effect on the financial statements of NHS Bedfordshire, Luton and Milton Keynes ICB.

23 Third party assets

The ICB had £nil third party assets in the period from 1 July 2022 to 31 March 2023.

24 Financial performance targets

NHS ICB have a number of financial duties under the NHS Act 2006 (as amended).
NHS ICB performance against those duties was as follows:

	01 July 2022 - 31 March 2023 Target	01 July 2022 - 31 March 2023 Performance	01 July 2022 - 31 March 2023 Variance	Duty Achieved
Expenditure not to exceed income	1,408,125	1,407,857	268	Yes
Capital resource use does not exceed the amount specified in Directions	785	785	-	Yes
Revenue resource use does not exceed the amount specified in Directions	1,405,980	1,405,712	268	Yes
Revenue administration resource use does not exceed the amount specified in Directions	16,354	14,916	1,438	Yes

25 Losses and special payments

25.1 Losses

There have not been any losses in the period from 1 July 2022 to 31 March 2023.

25.2 Special payments

	Total Number of Cases 01 July 2022 - 31 March 2023 Number	Total Value of Cases 01 July 2022 - 31 March 2023 £'000
Compensation payments	1	83
Ex Gratia Payments	1	3
Total	**2**	**86**

26. Accountability - Staff

	Admin			Programme			Total		01 July 2022 - 31 March 2023
	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	8,491	618	**9,109**	6,876	1,568	**8,444**	15,368	2,186	**17,553**
Social security costs	1,055	-	**1,055**	787	-	**787**	1,842	-	**1,842**
Employer contributions to the NHS Pension Scheme	1,712	-	**1,712**	866	-	**866**	2,579	-	**2,579**
Apprenticeship Levy	65	-	**65**	-	-	**-**	65	-	**65**
Termination benefits	43	-	**43**	-	-	**-**	43	-	**43**
Gross employee benefits expenditure	**11,366**	**618**	**11,983**	**8,529**	**1,568**	**10,097**	**19,895**	**2,186**	**22,080**
Less recoveries in respect of employee benefits (note 4.1.2)	(11)	-	**(11)**	(283)	-	**(283)**	(294)	-	**(294)**
Total - Net admin employee benefits including capitalised costs	**11,355**	**618**	**11,973**	**8,246**	**1,568**	**9,814**	**19,601**	**2,186**	**21,787**
Net employee benefits excluding capitalised costs	**11,355**	**618**	**11,973**	**8,246**	**1,568**	**9,814**	**19,601**	**2,186**	**21,787**

For more information

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