BLMK
Integrated Care System

NHS
Bedfordshire, Luton and Milton Keynes
Clinical Commissioning Group

Annual Report and Accounts
2021/22

ANNUAL REPORT AND ACCOUNTS 2021/22

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Foreword

Bringing health and care together – our year in review

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

On 1 April 2021 we merged three separate Clinical Commissioning Groups to become a single organisation – Bedfordshire, Luton and Milton Keynes CCG. This meant that patients could benefit from being part of a larger healthcare system, while retaining services that meet the distinct needs of populations within our four places: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

Change continued through the year as we prepared to become an Integrated Care Board (ICB) as part of the new Integrated Care System (ICS). We have been informally working in this way since 2020 and this formal step is very positive, as it genuinely brings the worlds of health and care together in a way that could have huge benefits for patients.

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

2021 was the second year where we have delivered regular services alongside meeting the challenge of the Coronavirus pandemic.

The work of people from across the healthcare system was truly astonishing in making the vaccine roll-out a success. We are particularly proud of the work to engage with diverse communities, and to share clear information from trusted voices to overcome any vaccine hesitancy from different groups.

During 2021 our community showed how it would care for those less fortunate than ourselves. As part of the evacuation from Afghanistan last summer, scores of families arrived in our area. Through a huge team effort, they received the health support they needed, as well as clothes and shelter so that they could begin new lives here in Britain. In March, the CCG provided support at the humanitarian hub at London Luton Airport for Ukrainian refugees fleeing the conflict in their homeland.

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

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

Felicity Cox, Accountable Officer

Sarah Whiteman, Clinical Chair

Performance overview

This section contains a summary of our performance as an organisation during 2021/22, with detail about some of the more significant projects that took place.

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

From merging our three CCGs into one at the beginning of the 2021/22 year, we are now in the middle of advanced preparations for our move to formally becoming part of an Integrated Care System. This should have tremendous benefits to patients and the wider population.

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

To maximise the impact of our COVID vaccination programme we employed a data-driven population health approach.

We monitored our performance and population uptake of the vaccine by age, underlying health condition, ethnicity and deprivation. This data was mapped at council and ward level, so we were able to easily identify any areas of lower uptake. Working with local authority colleagues we introduced additional accessible and trusted places to deliver vaccines, such as pop-up clinics in mosques, town halls and supermarkets.

Having access to timely data was essential, enabling our delivery teams to be agile. Using feedback from local trusted community leaders we commissioned walk-in services and flexed the offer to our communities to improve uptake.

The balance of delivering care and treatment throughout the pandemic whilst maintaining and delivering our financial duties has been challenging. In spite of these challenges we have met our financial duties.

Our allocation was £1,762m and we finished the year with total expenditure of £1,750m, delivering a surplus of £11.6m against our Revenue Resource Limit.

We continued to develop the Risk Management Framework over the year to identify and understand key risks to the organisation's ability to deliver its strategic objectives. The strategic objectives, to which all risks are aligned, were reviewed by the Board in 2021/22 and are:

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

Details of the risks faced are set out in more detail within the Annual Governance Statement within the Accountability Report (page 38).

In summary, the key risks in 2021/22 were the delivery of NHS constitutional standards, the impact of COVID on delivery of services, financial stability, resource capacity for transformational change versus business as usual and recruitment and staffing across the health and social care system.

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

In primary care, we continued to strive to make available both responsive and accessible appointments for all essential patient services. This included immunisations, cancer screening and conditions needing same-day appointments. We resumed our support to facilitate development of primary care by working

with our 23 Primary Care Networks (PCNs) that operate across the four local authority areas. The transformation of services has been achieved by clinically-led initiatives, such as digitally remote monitoring and consultations, joint GP and community pharmacy services for minor conditions and a more diverse and increased GP workforce through new, innovative clinical roles.

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

Felicity Cox

Accountable Officer

16 June 2022

About us

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

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

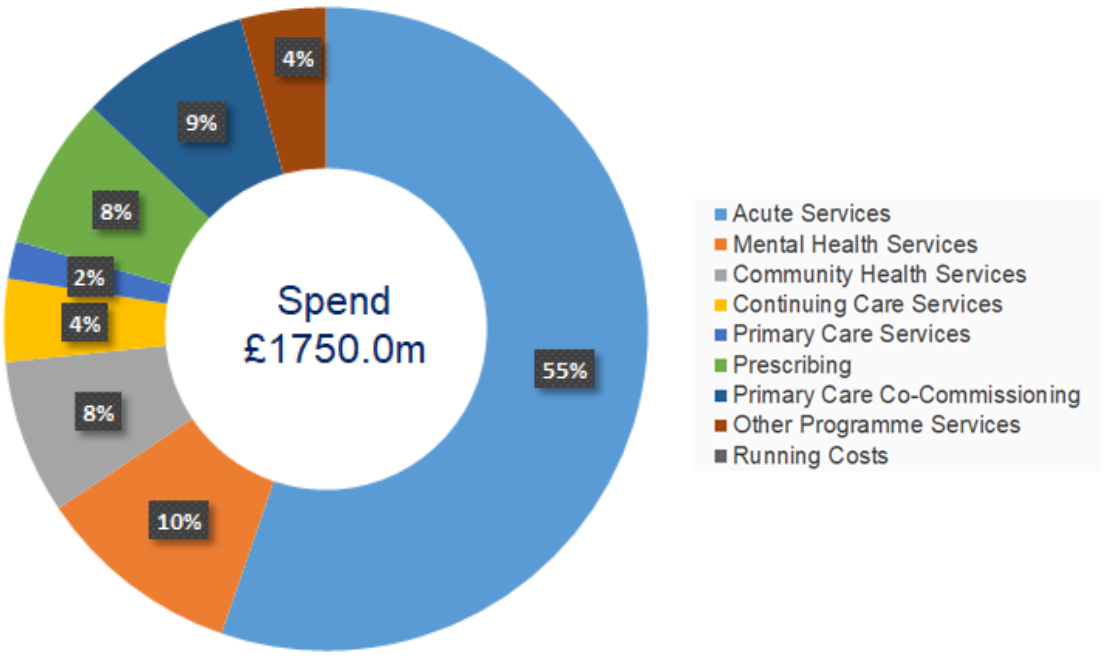
Our local GPs provide our Governing Body with advice and support using their local knowledge and clinical expertise to ensure we can carry out our role successfully.

Our services

We currently commission the following services:

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

How we spent our funding



About the Bedfordshire, Luton and Milton Keynes area

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

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

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

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

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

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

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

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

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

Becoming a single CCG and moving towards an Integrated Care System

Three became one when the Bedfordshire, Luton and Milton Keynes CCGs merged.

The new Bedfordshire, Luton and Milton Keynes CCG was launched on 1 April 2021 with the support of our staff, stakeholders, GP members and the approval of NHS England.

During our first six months, we completed a staff reorganisation, putting a single structure in place. We strengthened our ways of working with our NHS Trusts, GP and local authority partners with a clear

focus on improving outcomes for our whole population and in our four places: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

This work was underpinned by our values:

Co-production:
We work with people and communities as equal partners to achieve better outcomes

Community:
We value our people and our communities

Compassion:
We treat people with respect and compassion

Collaboration:
We develop trusted relationships and embrace partnership working

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

While we recognise the distinct places and people within the new CCG area, there are significant advantages in planning healthcare services for a larger population. It allows us to provide a more joined up service, reduce unnecessary variation in care and spread good practice. It means we can benefit from economies of scale, while cutting duplication and bureaucracy. This annual report showcases these achievements and we will continue to build on this work in 2022/23.

Some of the key benefits of the CCG merger delivered in 2021/22 were:

- reduced unnecessary variations in care by having the same policies for gluten-free food, over-the-counter medication and for in vitro fertilisation (IVF);
- population health management initiatives to provide proactive, preventative support for people in relation to frailty and heart failure;
- an integrated care, treatment and rehabilitation programme for patients who have had a fall rolled-out across Bedfordshire;
- discharge to assess model rolled-out, where patients in hospital are supported to return to their own home for assessment; and
- reducing the CCG's running costs by £2.4m.

Becoming an ICS

The change continues apace. Building on our merger programme experience and following the publication in February 2021of the White Paper *Integration and innovation: working together to improve health and social care for all*, we started the journey towards an integrated care system (ICS). This means that the CCG will transition into a new statutory NHS organisation called the Bedfordshire, Luton and Milton Keynes Integrated Care Board, which is due to launch in July 2022. These changes are part of the implementation of the Government's Health and Care Bill.

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

To deliver these objectives, the ICS Establishment Programme involves all of our system partners and is designed to deliver the following new ways of working:

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

Integrated Care Board – the statutory NHS organisation that will take on the CCG's functions and will have some new functions to deliver plans to realise the strategy set by the Integrated Care Partnership;

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

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

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

The work programme includes all of the activities necessary to transfer the staff, assets and liabilities of the CCG to the ICB, including a robust process of due diligence, supported by Internal Audit. The CCG Governing Body and staff have been fully engaged in this programme.

Strategic objectives

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

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

Performance summary

Key achievements

These are some of our key achievements from the 2021/22 year:

- **Working with communities to protect people against COVID-19**
  A major part of our work in 2021/22 was the continued roll-out of the COVID-19 vaccination programme. This was a complex effort that required significant contributions from many different parts of the population. One example of this was the work to engage with seldom heard groups who may have been hesitant about being vaccinated, and working with trusted voices to boost vaccination rates. Read more on page 30.

- **Helping people fleeing from conflict**
  People affected by conflict were helped in the past year. Families were evacuated from Afghanistan in the summer of 2021 as part of the withdrawal of UK troops. Many were initially put up in hotels in our area and were given the healthcare they needed as part of a big, successful collaborative effort. See page 10.

- **Enabling speedy access to patient data to help improve care**
  Digital technology has continued to transform how we care for patients. We introduced an innovative yellow bracelet to speed access to patient data who receive care. The bracelet contains all of a patient's data and can help them avoid unnecessary hospital attendance and maintain their independence. See page 16.

- **Supporting the health and wellbeing of our healthcare professionals**
  We introduced the ShinyMind app for healthcare professionals across the CCG system to support their health and wellbeing. The app was designed to help NHS workers build resilience and reduce stress. By doing that they are better able to support patients, even in a highly pressurised environment. Read more on page 16.

- **Keeping more older people independent**
  We worked with partners in the third sector to provide additional support to older people during the winter. This support helped hundreds of patients to stay safe at home rather than needing to go to hospital due to the non-medical interventions provided. See page 16.

Primary care

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

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

In addition, our Primary Care Networks (PCNs) have been involved in the COVID-19 vaccination programme. From September 2021 onwards they played a major role in the flu vaccination campaign, giving both vaccines together where possible.

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

Cancer and primary care

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

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

General practice

During the year we worked with our member practices and many other primary care providers.

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

General practice provides over 400,000 appointments per month in Bedfordshire, Luton and Milton Keynes, with three out of five of these face-to-face (based on data from April-August 2021).

CASE STUDY STORY – Helping Afghan refugees

Following the UK Government's evacuation from Afghanistan in August 2021, two resettlement hotels were set up at short notice for families seeking refuge.

This saw around 800 evacuees arrive to Luton and Milton Keynes, in urgent need of help. What followed was a remarkable, co-ordinated effort to make sure the arrivals had what they needed.

"It seemed to unite something and all of a sudden people from all over the country were volunteering to help us over the Bank Holiday weekend in whatever way they could," said CCG Chair Dr Sarah Whiteman.

Two local practices helped to register the families. They provided general medical services as well as health checks, immunisations, screening and COVID-19 vaccinations. A whole system approach to support the families was put in place, including health visitors, mental health, district nursing as well as local charities. As the refugees arrived with few personal belongings, the local community, charities and the CCG collected clothing and toys for them.

While many of the evacuees have now moved to other parts of the country, many remain as part of a community that pulled together to welcome and support them.

Social prescribing

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

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

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

CASE STUDY STORY: 'I've gained my life back thanks to social prescribing'

Jamie's life changed forever when Social Prescriber, Victoria, walked in on an accident at their initial consultation. Since then, the two have worked closely together to save Jamie's life.

Social prescribing is when health professionals refer patients to support in the community to help improve their health and wellbeing. By spending dedicated time with the patient, teams can unpick the things causing concern and help connect them with organisations and activities in their area.

Through this approach, social prescriber Victoria was able to refer Jamie into community lead initiatives to support him to tackle his issue with alcohol and drugs and worked with him to implement daily routines, like bathing, to help him take regular care of himself.

Jamie said: "Thanks to social prescribing, I've gained my life back. Yes, medication helps me manage my life, but social prescribing has helped me to live it."

Urgent care

We focused on commissioning resilient urgent care services during 2021/22.

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

NHS 111 plays a crucial role in directing a patient to the right service. The urgent care system will manage the patient's need in the most appropriate way. This could be done through a remote or face-to-face conversation with a clinician, or advice and guidance given to support self-care. There are over 1,000 calls to 111 each day on average in our CCG area (based on data gathered from 5-18 January 2022). Last year, we provided additional funding to our 111 providers to recruit and train additional call handling staff to manage the growth in calls.

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

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

Improving primary care

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

During 2021/22 we developed the GP Community Pharmacy Consultation Scheme which allows GP practices to refer some patients to be seen at a pharmacy without the need to go to see a GP.

Digital transformation has continued. We updated records, phone systems and provided access to digital capability to see patients virtually where that is the best approach.

We have supported primary care to recruit to new posts to expand their teams. In addition, we have provided access to staff training and wellbeing support.

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

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

Finally, we mobilised additional capacity (in urgent care, the voluntary sector and general practice) during the busy winter period.

Adult Mental Health, Learning Disabilities and Autism

Collaboration has been key to making sure that the mental health system stayed resilient in the face of increased pressures. We saw increases both in numbers of patients and also the severity of their condition over the past year.

There was a rapid rise in crisis admissions to adult inpatient facilities following the end of the first lockdown, and those figures remained high throughout 2021/22. Our mental health providers mobilised quickly to set up isolation facilities and have continued to be flexible to maintain bed capacity.

There was significant investment in mental health last year, both from the CCG and NHS England. This has helped to increase activity and access and to support transformation. We met the Mental Health Investment Standard, working closely with our main providers to allocate funding according to strategic priorities and local need.

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

We established a comprehensive programme, with East London NHS Foundation Trust and our local authorities, to transform ways of working for people supported through Section 117 aftercare. Some 550 people had a review of their care and support needs, to make sure that they are receiving the right level of care to meet their needs, in the right setting.

We made progress on our NHS Long Term Plan commitments. These include transforming community services, improving access to psychological therapies (IAPT) as reported in our performance analysis section on p18, health checks for people with serious mental illness and reduced use of beds outside of our area.

Securing funding has been a critical part of our success in delivering improved outcomes for the people of Bedfordshire, Luton and Milton Keynes. We received funding for a whole range of initiatives, such as delivering health checks, having sensory areas for inpatient facilities and establishing a wellbeing hub for NHS and social staff. In addition, we have been supported to provide crisis alternatives, to support winter pressures, for treating tobacco dependence, and new funding for a rough-sleepers project in Milton Keynes, with continued funding for the project in Luton.

Modernising inpatient mental health care in Bedfordshire and Luton

Plans to modernise mental health services progressed during the 2021/22 year.

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

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

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

The result will be state-of-the-art service provision, with patients benefiting from multi-disciplinary teams at two centres of excellence. In the near future, children's inpatient beds at a temporary home, will be put in place in summer 2022.

Public engagement on the proposals took place during 2021, with very positive feedback. Detailed feedback was given from members of the public on what the buildings should look like, and how to cater for specialist needs such as autistic patients.

This feedback has contributed to the next phase of the project, to develop and refine the clinical strategy. When the proposals are fully developed there will be a statutory engagement process before the plans are finalised.

Improving cancer outcomes

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

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

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

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

- delayed diagnosis and late presentation;
- public and primary care awareness of signs and symptoms of cancer;
- access to services and poorer experience of care;
- lifestyle and risk factors; and
- anecdotally, treatment location, transport mode and distance travelled also have effect on the patient treatment choice and, ultimately, cancer survival outcomes.

Nanmani, a patient from Dunstable, has advanced cervical cancer, and is an example of someone who presented late with symptoms.

She said: "I do not drive. I didn't take part in screening programmes and I didn't want to go to my male GP. By the time my cancer was diagnosed, it was advanced. My husband was unable to take time off from work to drive me 24 miles to Northwood and it was too difficult by public transport, so I was unable to access radiotherapy. I have now been put on the palliative care pathway."

The report outlined three recommendations.

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

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

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

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

Post-COVID Support

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

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

Patient flow and discharge

The Coronavirus pandemic continued to require special focus last year, alongside recovering the elective surgical lists.

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

During a small lull in demand in mid-summer 2021, we rationalised the community bed stock, to make it more manageable and ensure clinical support.

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

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

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

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

Safeguarding

The safeguarding team has continued to work with partners to support children of Afghan refugees who are placed in Luton, ensuring their health needs are recognised and met, and that they are safeguarded.

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

Looked after children

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

Special Educational Needs and Disability (SEND)

Luton Borough and Central Bedfordshire councils worked towards addressing the areas of weakness identified in the SEND written statement of action following the last inspections in 2018/19. A needs assessment was refreshed in 2021 which has informed the SEND Strategy refresh. The next inspections are due in summer autumn 2022.

Children and Adolescent Mental Health Services (CAMHS)

East London NHS Foundation Trust (ELFT) launched its Year of Engagement in 2022 which will see young people hosting a series of creative engagement sessions across Bedfordshire, Luton and Milton Keynes. They will use various social platforms to ensure their voices are heard, involving young people who are interested in talking about emotional health and wellbeing. This will inform and shape priorities for mental health and wellbeing and ensure services are delivered that need the needs of local communities.

Maternity

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

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

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

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

Helping people with diabetes during a pandemic

Diabetes services had to adapt to life during the pandemic during 2021/22.

Our **NHS Diabetes Prevention Programme** supports patients with elevated blood glucose levels to change their lifestyles with the support of an educator moved online.

This meant that services could continue remotely when restrictions did not allow face-to-face contact. Not only did the programme to continue, waiting times were reduced for patients to join following GP referral. It also opens up access for people in different localities and in different languages.

While the programme will continue to be available digitally, face-to-face sessions will be reintroduced during 2022.

One participant in the programme was Rachel.

She said: “The group has helped me to lose weight and remain focused. It’s been really helpful to have the accountability and support from the group and coach. I have been inspired by listening to the progress and challenges of other participants.”

Our **Diabetes Education programmes** also moved online during the pandemic. These programmes, delivered by local providers across the CCG area, help educate those living with diabetes to know how to manage their condition. The programmes were delivered through an accredited web portal, commissioned by the CCG. Again, the programmes will move to a mix of face-to-face and online delivery now that restrictions have been lifted.

A significant success during the year was the **NHS Low Calorie Diet Programme**.

The CCG was part of the first wave of the programme's pilot. It is a behaviour change programme, delivered by specialist dietitians and health coaches. It helps people with type 2 diabetes lose weight, increase physical activity, improve their blood glucose levels and reduce their medication needs.

The programme involves three phases:

1. Total dietary replacement phase – 12 weeks of a low calorie diet consisting of nutritionally complete soups, shakes and bars;
2. Food reintroduction phase – 4 weeks to transition back to regular food;
3. Maintenance phase – support provided for up to 12 months to maintain a healthy lifestyle and weight loss.

Over 260 patients started the programme and at the six-month stage achieved an average weight loss of 13.1kgs. The programme is delivered digitally and so has been unaffected by the pandemic.

During 2022/23 we will work towards using all the 500 places allocated by NHS England on the programme to maximise the benefits to our patients.

Boosting the health and wellbeing of healthcare professionals

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

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

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

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

Yellow bracelet scheme to support better patient care

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

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

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

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

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

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

We worked with Age UK Bedfordshire and Milton Keynes and Age Concern Luton to provide the new service. It gives healthcare professionals, including GPs, nurses and social prescribers, the ability to refer patients to the scheme. They can do this through email and phone, which will be responded to in up to four hours who then make an assessment of the support required. The team from the charities

could then make a variety of non-medical interventions, such as welfare checks, collecting prescriptions and shopping for essential items.

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

In the first three months of the year, data from the third sector providers – but not yet verified by the CCG – showed that there were 542 referrals recorded with at least one intervention provided to the patient.

Performance Analysis

Performance, quality and safety of local healthcare

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

The CCG tracks each indicator against the 2021/22 Planned Constitution Performance, which was developed using the planning framework and technical definitions set out by NHS England. In addition, the Governing Body routinely monitors our performance against these indicators, with oversight from NHS England and NHS Improvement.

The main areas of success in 2021/22 were:

- cancer waiting times - providing cancer drugs within the 31-day target;
- ambulance response times – category 1T, which measures response times of ambulances arriving at the scene of a patient requiring urgent care;
- IAPT (improving access to psychological therapy) recovery, 6- and 18-week wait times; and
- early intervention in psychosis programme.

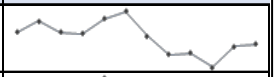
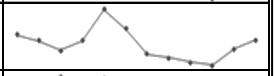
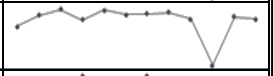
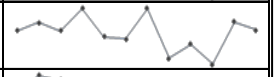
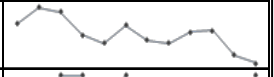
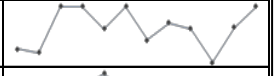
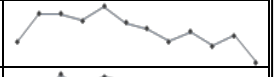
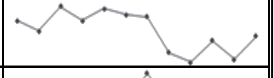
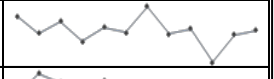
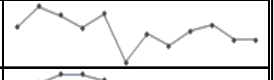
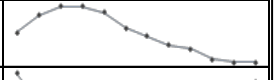
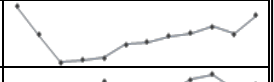
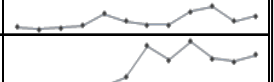
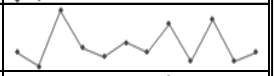
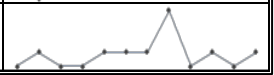
The main areas of challenge were:

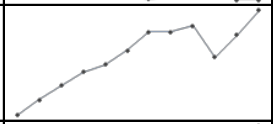
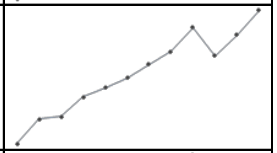
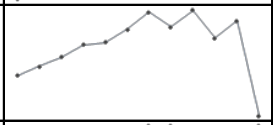
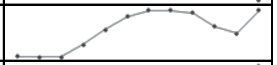
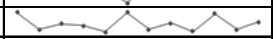
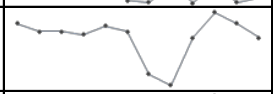
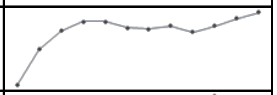
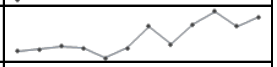
- delivery against a number of cancer waiting times including the two-week wait for cancer and breast symptoms, the 28-day faster diagnosis standard, the 31-day target for surgery and radiotherapy, and the 62-day standards for patients to receive their first treatment following an urgent GP referral and upgrade to a consultant;
- 18 weeks from 'referral to treatment' (RTT) and 52 week-long waits;
- access to diagnostic testing within six weeks;
- clostridium difficile (C-diff) and Methicillin-resistant Staphylococcus Aureus (MRSA) infections;
- ambulance response times – category 1 (e.g. an immediate response to a Life threatening condition) and category 2 (e.g. a serious condition which may require rapid assessment and/or urgent transport) – mean time;
- achievement of the national standards for diagnosis of dementia, IAPT access and the care programme approach (CPA) for 72-hour follow-ups;
- physical health checks carried out for those with serious mental health issues and learning disabilities; and
- children and young people's mental health service access, access to perinatal mental health services children and young people's eating disorder performance for both urgent and routine referrals.

The NHS Oversight Framework was suspended during 2021/22 due to the coronavirus pandemic. The last published ratings for CCGs were in November 2020 for 2019/20.

The ratings were not broken down into domains, but at the time of assessment, our CCG was made up of the three individual CCGs. The overall rating for Bedfordshire CCG remains 'requires improvement', and both Luton and Milton Keynes CCGs were rated 'good'.

NHS Constitution Measures Dashboard

BLMK CCG Performance Dashboard 2021.22		Q1			Q2			Q3			Q4			Trendline
Measure	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Cancer Waiting Times - 2 Week Wait	93.00%	82.34%	84.94%	82.31%	82.06%	85.40%	87.12%	81.52%	77.45%	77.69%	74.60%	79.23%	79.74%	
Cancer Waiting Times - 2 Week Wait (Breast Symptoms)	93.00%	70.86%	67.70%	63.16%	67.92%	82.87%	73.51%	61.68%	59.81%	57.64%	56.32%	63.94%	68.11%	
Cancer Waiting Times - 28 Days Faster Diagnosis Standard	75.00%	69.51%	72.44%	74.06%	71.28%	73.86%	72.55%	72.74%	73.17%	71.51%	59.31%	71.98%	71.47%	
Cancer Waiting Times - 31 Day First Treatment	96.00%	95.55%	96.33%	95.54%	97.56%	95.04%	94.84%	97.61%	93.09%	94.37%	92.54%	96.34%	95.64%	
Cancer Waiting Times - 31 Day Surgery	94.00%	90.67%	94.87%	93.59%	87.80%	85.54%	90.28%	86.36%	85.54%	88.52%	88.89%	82.54%	80.52%	
Cancer Waiting Times - 31 Day Drugs	98.00%	97.67%	97.47%	100.00%	100.00%	98.77%	100.00%	98.15%	99.10%	98.78%	96.94%	98.85%	100.00%	
Cancer Waiting Times - 31 Day Radiotherapy	94.00%	89.76%	96.06%	96.18%	94.55%	97.89%	94.16%	92.75%	89.92%	92.03%	88.89%	91.20%	85.29%	
Cancer Waiting Times - 62 Day GP Referral	85.00%	71.81%	68.69%	75.86%	71.79%	75.12%	73.43%	72.77%	62.63%	59.89%	66.02%	60.78%	67.27%	
Cancer Waiting Times - 62 Day Screening	90.00%	90.63%	81.82%	88.00%	77.42%	84.85%	82.14%	95.83%	81.48%	83.87%	66.67%	81.08%	83.33%	
Cancer Waiting Times - 62 Day Upgrade	90.00%	82.98%	91.49%	87.69%	82.69%	88.37%	68.97%	80.39%	75.44%	81.36%	83.87%	77.97%	77.92%	
RTT Incomplete Pathway - 18 Weeks	92.00%	65.54%	68.68%	70.37%	70.39%	69.26%	66.39%	64.98%	63.34%	62.66%	60.74%	60.27%	60.24%	
RTT Incomplete Pathway - 52 Week Waits	0	4,375	3,772	3,211	3,251	3,299	3,577	3,626	3,750	3804	3950	3801	4182	
Diagnostic Test Waiting Times	1.00%	24.70%	23.69%	24.61%	25.60%	30.95%	27.74%	25.95%	25.72%	32.15%	34.68%	27.43%	30.12%	
Appointments in General Practice - %Did Not Attend	N/A	3.08%	3.09%	3.22%	3.39%	3.35%	3.60%	4.42%	4.05%	4.54%	4.09%	4.01%	4.19%	
Healthcare Acquired Infection Measure (Clostridium Difficile)	131 Total Threshold	12	9	21	13	11	14	12	18	10	19	10	12	
Healthcare Acquired Infection Measure (MRSA)	Zero Threshold	0	1	0	0	1	1	1	4	0	1	0	1	

BLMK CCG Performance Dashboard 2021.22		Q1			Q2			Q3			Q4			Trendline
Measure	**Threshold**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	
A&E 4hr Waits (MKUHT only)	**95%**	91.61%	89.38%	87.93%	85.36%	82.28%	82.07%	80.70%	81.85%	81.53%	83.24%	80.53%	80.54%	
Ambulance Response Times - Category 1 - Mean *(National Data - EEAST - Bedfordshire & Luton; SCAS - Milton Keynes)*	**7:00**	06:36	07:12	07:46	08:19	08:37	09:11	09:54	09:54	10:10	08:54	09:47	10:47	
Ambulance Response Times - Category 1T - 90th Centile *(National Data - EEAST - Bedfordshire & Luton; SCAS - Milton Keynes)*	**30:00**	14:41	16:27	16:40	18:05	18:43	19:27	20:24	21:20	23:04	21:03	22:33	24:20:00	
Ambulance Response Times - Category 2 - Mean *(National Data - EEAST - Bedfordshire & Luton; SCAS - Milton Keynes)*	**18:00**	17:56:00	22:03:00	25:57:00	31:32:00	32:32:00	38:25:00	45:50:00	39:17:00	46:54:00	34:34:00	42:13:00	01:07:54:00	
Estimated Diagnosis rate for people with dementia	**66.70%**	62.36%	62.35%	62.35%	62.68%	63.09%	63.44%	63.60%	63.61%	63.54%	63.16%	62.99%	63.60%	
IAPT Access	**25.00%**	21.37%	20.56%	23.89%	22.92%	20.45%	20.91%	0.2378	24.35%	18.55%	22.57%	24.35%	28.14%	
IAPT Recovery Rate	**50.00%**	51.81%	50.32%	49.48%	50.56%	50.35%	46.24%	0.5159	50.51%	48.00%	50.00%	51.28%	51.46%	
IAPT Waiting Times - 6 weeks	**75.00%**	99.44%	98.82%	99.03%	98.94%	98.71%	99.46%	0.988	99.05%	98.74%	99.41%	98.80%	99.10%	
IAPT Waiting Times - 18 weeks	**95.00%**	100.00%	100.00%	100.00%	100.00%	100.00%	99.46%	0.994	100.00%	99.37%	100.00%	99.40%	99.55%	
Early Intervention in Pyschosis - 1st Treatment within 2 weeks (Rolling 3 months)	**56.00%**	81.00%	78.00%	78.00%	77.00%	80.00%	78.00%	63.00%	59.00%	76.00%	85.00%	81.00%	*76.00%*	
CPA 72-Hour Follow Ups	**80.00%**	85.00%	80.00%	84.00%	78.00%	77.00%	73.00%	85.00%	78.00%	82.00%	89.00%	88.00%	*85.00%*	
Total number of inappropriate Out of Area Placement days that are external - Quarterly Data	**N/A**			185			175			280			490	
SMI Physical Health Checks (Rolling 12 months) Quarterly Data	**60.00%**			28.38%			27.78%			31.12%			43.03%	
Learning Disabilities Health Checks Quarterly Data	**75.00%**			6.67%			16.26%			32.50%			67.00%	
Children and Young People's Mental Health Services Access (Rolling 12 months)	**35.00%**	56.10%	58.51%	59.76%	60.38%	60.38%	60.00%	59.91%	60.09%	59.67%	60.09%	60.59%	61.04%	
Perinatal mental health services - Access (Rolling 12 months)	**7.10%**	5.00%	5.10%	5.30%	5.20%	4.60%	5.20%	6.50%	5.40%	6.60%	7.40%	6.50%	7.05%	
CYP Eating Disorders - Urgent (Rolling 12 months) Quarterly Data	**95.00%**			66.67%			66.67%			70.59%			76.92%	
CYP Eating Disorders - Routine (Rolling 12 months) Quarterly Data	**95.00%**			79.49%			78.95%			80.77%			80.81%	

NHS Constitution measures

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

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

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

Cancer waiting time standards

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

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

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

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

New tests were introduced last year.

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

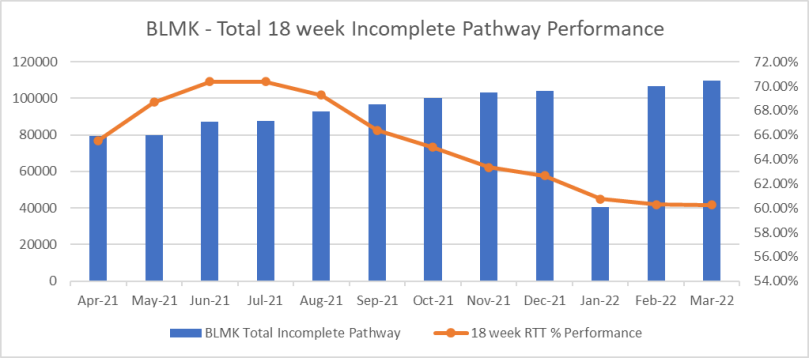
We ran a successful community engagement to encourage participation in national cancer screening programmes. Work on innovation continued with the introduction of genomic tests to identify cancers earlier.

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

Work began to engage with patients and the public on improving access to radiotherapy services, bringing care closer to home. Work also began on consulting with the public on bringing radiotherapy services to Milton Keynes.

“I visited the breast clinic and I wanted to say how great the care was that I received. Everyone I came into contact with was welcoming and made me feel at ease through my appointment. I left feeling very reassured…keep up the great work and thank you.” Patient, October 2021

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



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

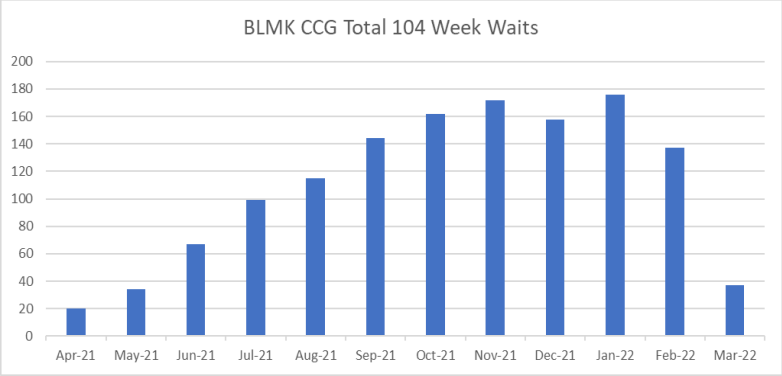
We worked to hold steady performance for patients on the 18-week incomplete pathway over the year. Performance began the year at 65.5% and ended at 60.2%. For most of the year we exceeded regional and England performance. The pathway was managed alongside an increase in GP referrals over the year, peaking in June and September.

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

We implemented work programmes with trusts to:

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

As a result of winter and COVID-19 pressures, we saw an increase in patients who have waited 52 weeks or longer for treatment from the point of referral. Consequently, the number of patients waiting 104 weeks increased significantly over the year.



The CCG worked with providers to start to return 104-week waits to zero. Bedfordshire Hospitals NHS Foundation Trust was allocated £5.9m to help reduce patient waiting lists, while Milton Keynes University NHS Foundation Trust received £3m for enhanced diagnostic capital. A further £4.47m was awarded to the ICS to support patients at home and during their care pathway.

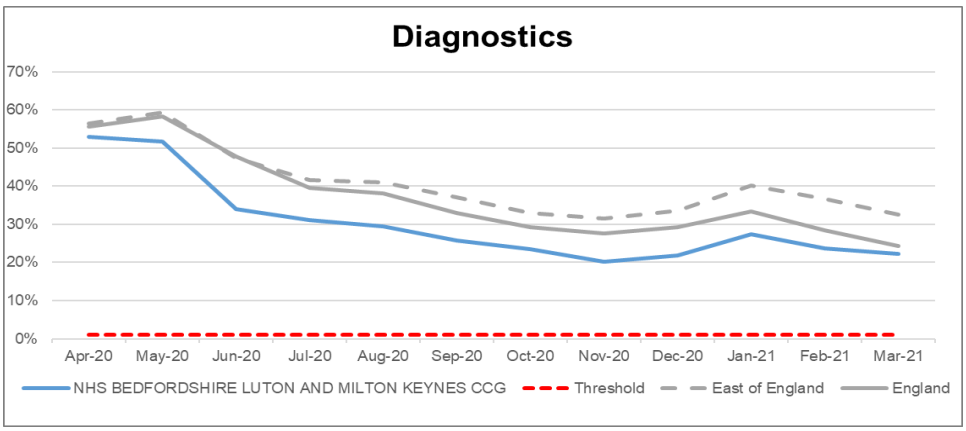
Trusts continued to implement “patient-initiated follow-ups” across different specialities. These allow patients to arrange their own follow-up when they need it. In addition, the rates of virtual consultations increased in line with the target of 25%. This enables the patient to access a consultation via video conferencing technology using their preferred device. We also maximised our advice and guidance service to support primary care by providing specialist clinical advice to clinicians. This allows a patient’s care to be directed to the most appropriate setting and supports the safe reduction of unnecessary outpatient appointments.

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

There was a significant increase in GP use of consultant advice and guidance. This led to more patients being supported to either self-care, receive quicker access to treatments outside of hospital or referred directly into the most appropriate services.

Diagnostic Waits

Diagnostic waits under six weeks (target 1% or below) remained above target throughout the year, peaking in April with 52.8%. Achievement of the national target was impacted by adverse performance within several specialities including magnetic resonance imaging (MRI), cardiology (electrophysiology) and computed tomography (CT) scans. Both trusts have prioritised their imaging waiting lists which should help to improve performance. Trusts worked with provider organisations to secure additional capacity to aid recovery.

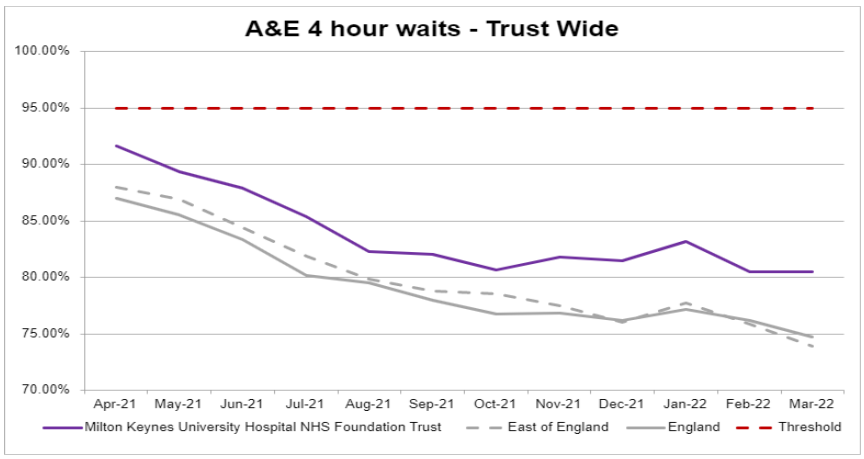


Infection Control

We saw 161 cases of clostridium difficile (C-diff) against a CCG threshold of 131 cases and 10 cases of methicillin-resistant staphylococcus aureus (MRSA) infections, against a threshold of zero. The quality team continued to provide regular infection prevention control training to GP practices, care homes and social care settings.

Accident & Emergency (A&E) 4-hour waits

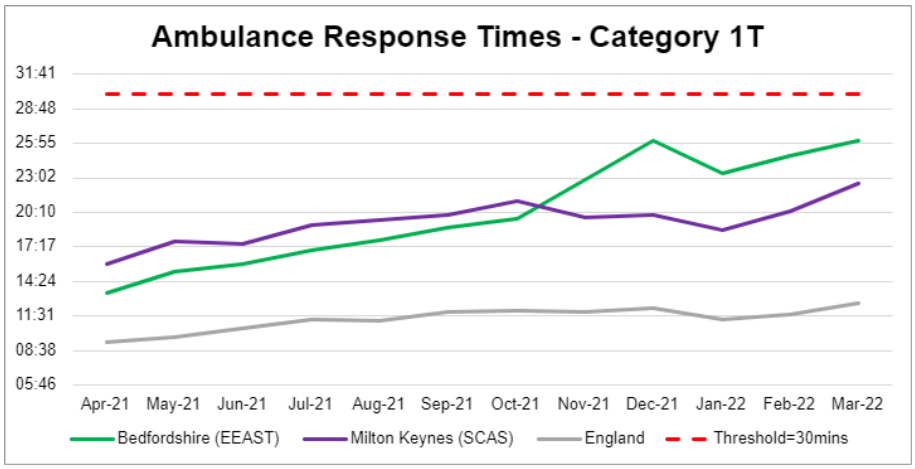
Bedfordshire Hospitals do not have to report the A&E 4-hour measure, due to their participation in the national ‘rapid care measures’ pilot programme. Milton Keynes University Hospital performed above both the England and regional average for this measure throughout the year, with a year-end performance of 80.5% against a 95% target. The Milton Keynes University Hospital Trust consistently performed at third-best in region and ended the year in the top-half of performers in the country.



“I received wonderful care from all the staff in A&E and X-ray. The department was busy as expected but I was triaged, seen by the doctor, had x-rays quickly and was given a walking boot. I am now waiting for a virtual fracture clinic follow up. Thank you to all the staff it’s a busy and tough job you are doing, keep it up.” Patient, June 2021

Ambulance Clinical Quality

There are three measures used to assess the performance of ambulance response times. Category 1 has a 7-minute response threshold, category 1T is 30 minutes and category 2 is 18 minutes. We did not meet the target for categories 1 and 2. Both ambulance providers achieved the category 1T target of below 30-minutes by performing under 19 minutes every month of the year.



“Having been taken to hospital by a very professional ambulance crew…I cannot thank all involved enough.” Patient, October 2021

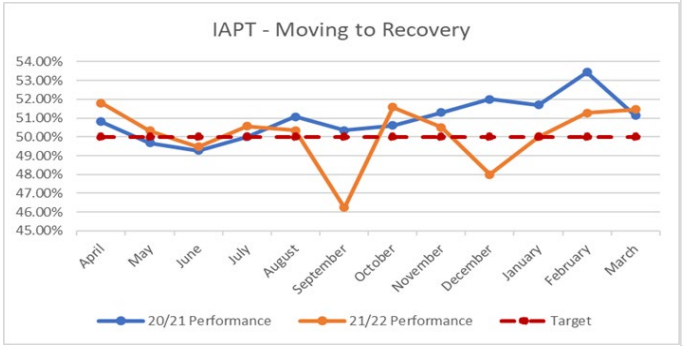
Dementia Diagnosis

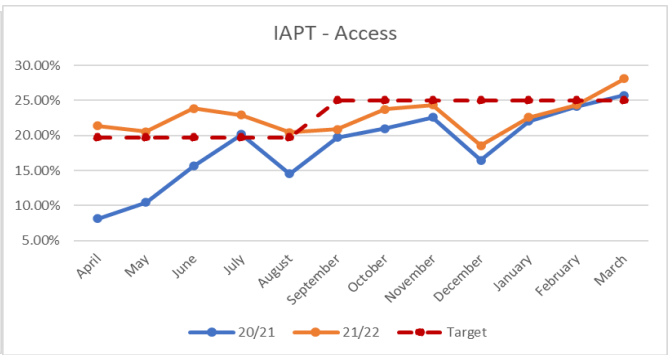
The dementia diagnosis rate improved over the year, exceeding both the regional and the England national average performance. We worked with providers on a local plan and performance trajectory to meet the national target of 66.7%. Our performance consistently met the locally planned trajectory over the year. However, we ended the year at a diagnosis rate of 63.6%, falling short of the end-of-year and national target. We have continued work programmes to improve the level of diagnosis for patients with dementia.

The Improved Access to Psychological Services (IAPT)

The IAPT recovery rate saw largely positive performance over the year, dipping slightly below the national target of 50% three times, with a year average recovery rate of 50%.

The national IAPT access target increased in September from 19.75% to 25%. The measure improved through the year, exceeding the target by March with 28%. This was due to a culmination of workforce issues and referral shortages. We are working with providers to increase referrals through advertising campaigns, webinars, outreach programmes, and linking with local colleges, universities and employers.





IAPT waiting times have consistently achieved targets over the year; this means that most patients have been seen within 18 weeks.

Early intervention for psychosis first treatment

This measure was achieved consistently over the year with a year-average achievement of 76%. This was above both the national target of 56% and the England average performance.

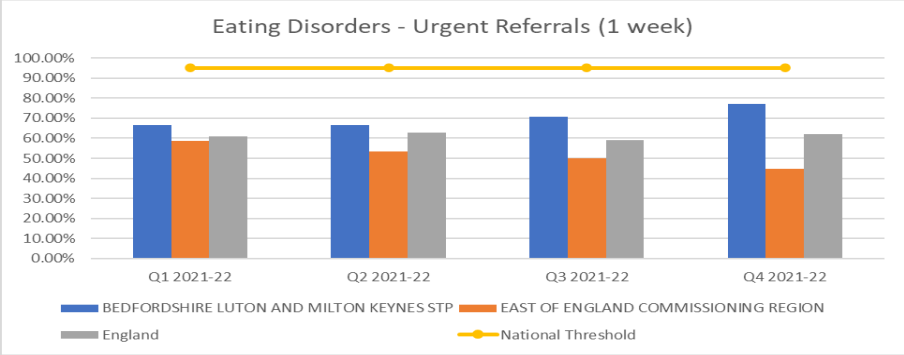
Physical Health Checks

For physical health checks for people with a severe mental illness**,** we have delivered an end-of-year score of 43% against a target of 60%. Health checks for those with a learning disability were below the national target of 75%, achieving an end-of-year position of 67%. We worked with providers to deliver tailored outreach services to people with a severe mental illness and those with a learning disability to increase physical health.

Children, Young People and Maternity

We achieved the children and young people (CYP) mental health access rate with an end-of-year rate of 61% against a 35% target. Commissioners and providers worked together to build further capacity within voluntary sector services. This enabled earlier intervention and support for children and young people, and reduced demand for more acute support. We did not meet the target for perinatal access over the year, achieving an average access rate of 5.7% against a target of 7.1%.

For eating disorders, we exceeded both the England and regional average performance for urgent referrals - to be seen within one week – over the full year. However, we underachieved against the national threshold of 95% with achievement of 76.9% at the end of the year.



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

Sustainable Development

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

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

Key actions were taken during 2021/22 to support progress against these objectives. There was a particular focus on our office bases and how they are used. Agile working arrangements for staff continued, with the majority working from home. Consequently, the amount of travel to and from our offices and to partner organisations for meetings significantly reduced. While this behaviour change will have led to increased utility consumption in colleagues' homes, there will have been a positive net impact in terms of reduced carbon emissions.

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

Measures have been implemented across our estate to help our buildings operate more efficiently. The Bedford office has been closed since 2020, due to the challenges with re-opening in a COVID-secure environment.

The other three offices are leased, and each of the landlords has taken measures to help improve energy efficiency performance.

These include the installation of movement sensors to ensure power is only used when needed. At the Luton office, a Light Emitting Diode (LED) lighting grid was installed, which led to savings of over 5,000 hours of electricity per fitting per year.

At our Capability House office in Silsoe, LED lighting panels for reduced power consumption have been installed, with a proposal to phase the replacement to LED panels for remaining areas. A++ rated electrical heat/cool systems, additional ceiling insultation and double-glazing have been installed across the site. Electric car charging points and cycle racks have been installed to encourage staff to adopt greener travel.

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

Improve Quality

Quality and safety

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

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

The ongoing coronavirus pandemic has provided significant challenge to our health providers. The availability of workers to deliver services has been a particular challenge. However, we have continued to support providers of NHS-funded care to make sure people are treated and cared for in a safe environment and protected from avoidable harm.

Infection prevention and control and coronavirus

Throughout 2021/22, our infection prevention and control (IPC) work was focused on the impact of coronavirus. Working with our team of expert specialist nurses, we prioritised support for care homes who look after some of the most vulnerable elderly people in our population.

We supported the movement of patients across different care sectors, working with public health and local authority partners, in line with national guidance. In addition, our teams of specialist nurses delivered both virtual and physical training and IPC advice to all care homes in our area.

Clinical, nursing, and administrative staff from our quality team were redeployed to provide extra nursing support for our hospital and community healthcare teams. Many of our clinical staff supported the COVID-19 vaccination roll out. They did this at vaccination centres and for vulnerable housebound and care home communities. We also continued to work across the health economy to reduce healthcare associated infections.

Quality visits

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

We worked with our providers and local authority care standards teams to identify areas of concern that required urgent support or quality visits. These visits were carried out virtually where possible but in person where needed, for example to make sure appropriate use of infection, prevention and control standards were in place.

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

Serious incidents

Throughout the pandemic, we continued to be informed of any serious incidents that occurred in our commissioned services. However, some of the usual reporting standards were temporarily paused. Normal reporting processes resumed in 2021/22, and we have continued to work with care providers so that lessons are learned and appropriate action taken.

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

Safeguarding

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

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

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

Throughout 2021/22 we continued in our support of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2009). We maintained our work in support of lawful processes for care packages (via applications to the Court of Protection) where it is recognised that restrictions are in place for an individual and where those restrictions amount to deprivation.

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

Primary care

We continued to support primary care in quality standards and preparation for Care Quality Commission (CQC) inspections. During 2021/22, we have supported practices with vaccination programmes for housebound patients and vulnerable people with learning disabilities needs in care provision.

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

Children and young people

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

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

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

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

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

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

For children and young people with existing mental health problems we invested new transformation funding in additional staff in crisis teams, new home treatment teams and additional support for those with eating disorders. In October 2021, we reviewed progress against the Children and Adolescent Mental Health Services (CAMHS) Transformation Plan, working with partners and young people to prioritise for 2022/23.

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

Mental health and learning disabilities

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

We worked with colleagues across local authorities, the NHS, independent and voluntary sectors so that vulnerable groups received support, especially during periods when their movements were restricted. We oversaw the alignment of mental health and learning disabilities crisis support teams. In addition, we worked with providers to ensure support could be accessed remotely with as few barriers as possible, and supported providers with any concerns about quality of service provision.

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

Engaging people and communities

Our year in engagement has been dominated by the COVID-19 vaccination programme.

There were of course huge benefits to getting as many people in our population vaccinated as possible. In the first phase of the roll-out in early 2021, we made fast progress, but as we entered the spring it was clear that not everyone was taking up the vaccine. We were unclear why this was.

To investigate why, we analysed data which showed that some communities were less likely to have strong vaccine take-up than others. Then we worked with local authorities and community groups to understand any potential barriers for people of different cultures and backgrounds.

We found that some thought the vaccine might be contrary to their religious practice, while others may have had a negative experience around vaccines in the past.

In line with the national 3 Cs – convenience, confidence and complacency – we looked to build confidence in the vaccine. We worked with trusted voices, including our COVID champions, who encouraged people to take the vaccine. They reported back issues, including that some vaccination centres were in relatively difficult-to-access locations. This led to practical solutions, such as the Vaxi Taxi in Luton, a service to drive people to vaccination centres if they didn't have the means to do so themselves.

One trusted voice who worked closely with his community was Bedford-based GP, Dr Vijay Nayar.

He said: "In Bedford, the Sikh temple in Queens Park was chosen as one of the vaccination sites, to help reach the community. To further dispel fears we ran group workshops to help provide reassurance and confidence regarding the safety and efficacy of the vaccines."

We also worked with religious leaders in Luton, where we had a pop-up vaccination centre in a local mosque. This proved successful, so we rolled-out pop-ups in other areas where there was a specific need. In addition, our communications were translated, with videos going out on social media in a variety of languages, such as Urdu and Polish.

A seldom heard group we identified was the homeless. Dr Tayo Kufeji, Clinical Director from The Bridge Primary Care Network, Milton Keynes, was at the forefront of the work to reach out to this part of the community. Dr Kufeji said:

"One of the biggest challenges we faced was vaccinating our homeless population and people in temporary accommodation. We quickly set up a small working group with the CCG, Primary Care Networks, Milton Keynes Homelessness Partnership and the local authority. This group was able to co-ordinate vaccination efforts to this vulnerable group of people with frequent outreach visits to temporary accommodation sites, as well as night shelters and the town's Young Men's Christian Association (YMCA). Over 100 vulnerable people have been successfully vaccinated against Covid through the efforts of this team."

Dr Manraj Barhey, Clinical Director, the Medics PCN, Luton, said:

"In the first phase of the COVID-19 vaccinations, we carried out visits to care homes, housebound patients and held outreach clinics at a local mosque and Sikh temple.

The programme showed just how well the PCN could work in collaboration with multiple stakeholders. Going out to the 'hard to reach' populations also showed it is possible to engage with these groups. We are planning to deliver further health care using the same approach.

The whole experience felt surreal at the time, but the achievements were very rewarding. The statistics showed we made a very real difference in savings lives and hospital admissions."

Consultations

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

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

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

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

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

Internal communications

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

This can mean sharing good news stories, such as one colleague sharing her story about how volunteering had a positive impact on her life. Working with the Equality, Diversity and Inclusion (EDI) Committee, we created content to mark Black History Month in October 2021, as well as International Dyslexia Awareness Day, to raise awareness of our diverse community. We also marked International Women's Day in March 2022.

The transition to an Integrated Care System (ICS) has been a point of focus. We delivered an ICS roadshow that looked at what this transition will mean for staff, supported by information for managers.

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

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

Reducing health inequality

Health is sadly not a level playing field for everyone.

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

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

At Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group, we promote, recognise and value the diverse nature of our communities. We work with our partners to address inequalities for the local population. This work has identified clinical leadership for Looked After Children, people with mental health difficulties, learning disabilities, and other vulnerable groups. We complete equality impact assessments whenever we are considering major service changes. This allows us to understand and be clear how any changes would impact people from all backgrounds in our community.

We work hard to integrate equality into everything we do. We are committed to designing and implementing policies, procedures and commissioning services that meet the diverse needs of our local population and workforce, so that no one is placed at a disadvantage.

We carried out several pieces of work to help reduce health inequalities over the past year.

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

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

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

Reducing health inequality and COVID-19 vaccinations

The Coronavirus vaccination effort highlighted health inequalities which we have worked hard to tackle over the past year.

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

Using this information, our vaccinations, public health and communications teams connected to a network of COVID-19 champions and faith leaders to find out more about the issues. These were related to three Cs – Confidence, Convenience and Complacency – regarding vaccination. Underneath those factors we surfaced many challenges, such as how to use the booking system, the language letters were written in, questions about the vaccine, or the accessibility of a vaccine site.

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

We were also able to offer a local service for the traveller community, working with schools and local leaders. Homeless people supported by the local authority were offered the vaccine as part of a health and wellbeing visit. People with learning disabilities and severe mental illness were supported by a

multidisciplinary team to make informed decisions about having a vaccination in a place where they felt safe and empowered.

Equality, Diversity and Inclusion (EDI) Committee

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

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

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

Since its formation, the committee has:

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

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

Engaging with seldom heard groups

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

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

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

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

During the coronavirus pandemic, we worked closely with community and faith leaders, and organisations including Healthwatch, Age Concern and Access Bedford, so that our communications reached our diverse communities. This included those with English as a second language, people with disabilities, our most vulnerable and those without internet access. We recognise the potential for digital exclusion and working with voluntary sector partners we are piloting community digital health champions to enable people to build their confidence and skills to access digital healthcare.

As part of our engagement on integration to become a single CCG, we produced an 'Easy Read' version of our public engagement document. Working with Access Bedford, we also held a virtual meeting with British sign language signing for the local deaf community.

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

Health and wellbeing strategy

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

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

By working collaboratively through the Health and Wellbeing Boards, we have developed a shared vision for our local communities. This has enabled a co-ordinated response to the roll out of public health campaigns, including flu and programmes to address waiting lists for mental health services, cancer, elective care, and children and young people. It has also enabled the successful roll-out of our COVID-19 response, testing, vaccination programme and long COVID pathways.

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

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

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

Review of financial performance

The 2021/22 financial year was the final full financial year in which Bedfordshire, Luton and Milton Keynes CCG will exist as a separate NHS commissioning entity. This follows the decision to cease the operation of CCGs and establish statutory integrated care systems (ICSs) and integrated care boards (ICBs).

This section sets out a summary of the CCG's financial performance during the 2021/22 year of operation.

The Accounts (from p85) have been prepared under a direction issued by NHS England under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health.

Financial Duties

CCGs have a statutory duty to keep their expenditure within the resources available. There are six separate duties with this regard, although there is some overlap between them and some were not relevant in 2021/22. The duties, their relevance in 2021/22 and the performance of the CCG are set out in the following table. Further details are provided in Note 27 of the accounts, on page 28 of the annual accounts that are attached to this Annual Report.

Duty [and section of 2012 Act]	Relevance in 2021/22	Achievement
Expenditure does not exceed sums allotted to the CCG plus other income received [223H(1)]	Applicable	✔ Underspend of £11,597k
Capital resource use does not exceed the amount specified in Directions [223I(2)]	Not applicable No specified matters in 2021/22	
Revenue resource use does not exceed the amount specified in Directions [223I(3)]	Applicable	✔ Underspend of £11,597k
Capital resource use on specified matter(s) does not exceed the amount specified in Directions [223J(1)]	Not applicable No specified matters in 2021/22	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions [223J(2)]	Not applicable No specified matters in 2021/22	
Revenue administration resource use does not exceed the amount specified in Directions [223J(3)]	Applicable	✔ Underspend of £594k

Impact of coronavirus on CCG finances

The Government, working with NHS England, has provided the NHS with the resources it needed to respond to the pandemic. The changes that remained in place in 2021/22 included:

- suspending the operation of Payment by Results, simplifying how CCGs contract and pay NHS providers;
- maintaining arrangements and funding to facilitate accelerated hospital discharge and avoidance of hospital admissions; and
- providing funding for pandemic-related costs incurred by NHS organisations.

Mental Health Investment Standard

An important planning requirement is the delivery of the Mental Health Investment Standard (MHIS). This means that all CCGs must increase their spending on mental health services by at least the same percentage increase as their programme allocation growth. In 2021/22 the CCG was required to increase its mental health spending by a minimum 4.63%.

The CCG targeted increased investment in delivering the Mental Health Five Year Forward View and other national priorities.

In addition to the requirements of the MHIS, we also received targeted mental health Service Development Funding (SDF) and non-recurrent Spending Review monies to bring forward long term plan requirements. This funding has been used to invest in children and young people's services, physical health checks, community services, suicide prevention, mental health crisis response services and health and wellbeing support to NHS staff because of the pandemic.

Achievement of the Standard is measured by comparing expenditure in 2021/22 to that in the previous financial year. This is after considering any mental health specific recurrent or non-recurrent allocations we 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, although we did invest in the Transforming Care Programme.

CCGs 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 CCG's auditor. This report will be published alongside the CCG's own formal declaration.

2022/23 planning guidance and financial outlook

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

The financial framework arrangements for 2022/23 will 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 has published one-year revenue allocations and three-year capital allocations alongside the 2022/23 planning guidance.

For 2022/23 and beyond, NHS systems are expected to return to making efficiencies and pre-pandemic levels of productivity where the context allows. Systems have been given a 'glidepath' from the 2021/22 system revenues to fair share allocations, assisted by a 'convergence' adjustment to gradually bring systems to their fair share of allocation. To manage within the funding available, while delivering national and local priorities, the ICS will need to deliver a stretching efficiency requirement. The task is made more difficult by the current level of inflation in the economy which is creating additional financial challenges for the NHS and the system to manage.

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

Closing down the CCG

The 2021/22 financial year signalled the final full financial year in which Bedfordshire, Luton and Milton Keynes CCG will exist as a separate NHS commissioning entity. As mentioned above, this follows the decision to cease the operation of CCGs and establish statutory integrated care systems (ICSs) and integrated care boards (ICBs).

It is expected that the CCG will be abolished on 30 June 2022. From 1 July 2022 its functions will be taken on by a new statutory body – Bedfordshire, Luton and Milton Keynes ICB. The closedown of CCGs and the creation of ICBs will require NHS finance staff to undertake a significant number of tasks to enable a smooth transition of people, property and liabilities between organisations. The CCG will also be required to prepare a full set of Accounts for the first quarter of the new financial year.

Felicity Cox

Accountable Officer

16 June 2022

Corporate governance report

Introduction and context

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

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

The CCG 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 local population.

Members' report

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

Dr Sarah Whiteman, Chair

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

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

Felicity Cox, Accountable Officer

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

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

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

Saqhib Ali, Lay Member for Audit and Governance

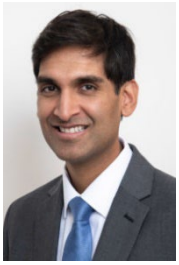
Saqhib Ali is a qualified accountant and holds an Executive MBA from Cranfield University. He currently works for a leading electric vehicle charging post manufacturer and charging network provider in the UK, owned by a major energy company.

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

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

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

Dr Chirag Bakhai, Member Representative



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

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

Dr Anitha Bolanthur, Member Representative

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

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

Anitha has always been passionate about cancer services. While she was Cancer Lead for Luton CCG from 2014 until 2020 she was a vocal advocate for improvements to services.

Her current portfolio also includes providing strategic support to the Elective Collaborative Board.

Alison Borrett, Lay Member for Patient and Public Engagement

Alison has lived in Bedfordshire for 26 years. She has had a successful retail career, having worked in senior leadership positions for Marks and Spencer and the John Lewis Partnership. Her most recent appointment was as Branch Manager for Waitrose's Bedford store.

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

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

Sally England, Lay Member for Finance and Performance

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

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

Dr Sureena Goutam, Member Representative

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

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

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

She is excited to work collaboratively with our system partners to improve our population's health and wellbeing.

Dr Roshan Jayalath, Member Representative

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

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

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

Hilary Jones, Independent Registered Nurse

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

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

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

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

Dr Chris Longstaff, Member Representative

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

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

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

Dr Shankari Mahathmakanthi, Member Representative

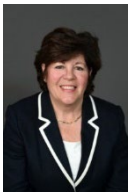
Shankari does clinical triage work for Herts Urgent Care. She is currently the GP Early Careers Strategic Lead and Deputy Chair of the Bedfordshire, Luton and Milton Keynes Primary Care Training Hub.

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

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

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

Anne Murray, Chief Nurse



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

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

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

Dr Linus Onah, Member Representative

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

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

Nicky Poulain, Director of Primary Care

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

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

Dr Edward Sivills, Interim Medical Director

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

Dr Helen Turner, Secondary Care Specialist

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

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

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

Dean Westcott, Chief Finance Officer and ICS Executive Finance Lead

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

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

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

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

Richard Alsop, Director of Commissioning and Contracting

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

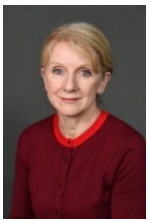
Richard has held a number of Executive Director roles and prior to his current role was Chief Operating Officer for Milton Keynes CCG.

Geraint Davies, Director of Performance and Governance

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

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

Jane Meggitt, Director of Communications and Engagement



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

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

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

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

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

Martha Roberts, Director of People & Organisation Development

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

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

1. Member practices

Bedfordshire, Luton and Milton Keynes CCG was made up of 23 primary care networks (PCNs) during 2021/22. The number of GP member practices within PCNs reduced from 98 to 95 during the year. This was due to a list dispersal and practice mergers.

One GP practice decided not to be a core member of a PCN. However, we worked with this practice so that they became a 'non-core member' of their nearest PCN. Their registered population was served by the PCN as set out in the NHS England Network Contract Directed Enhanced Service. During the year we had a further practice that became a non-core member following a contractual change.

The table below details our member practices and their respective PCNs at place level, our non-core members and any changes that occurred during the year.

Bedford Borough

Caritas

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

East Bedford

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

Unity

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

North Bedford

- De Parys Group

Non-core PCN member
The Village Medical Centre***

*St Johns merged with King Street on 1 April 2021.

** Rothesay Surgery contract ceased on 30 June 2021 with most of the patients dispersed to Goldington Avenue who retain the Rothesay premises.

*** The Village Medical Centre was a non-core member of North Bedford PCN from 1 April-31 October 2021 when a new provider was appointed. The practice is now a non-core member of Caritas PCN.

Central Bedfordshire

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

Ivel Valley North
- Greensands (Potton)
- Ivel Medical Centre
- Saffron Health Partnership
- Sandy Health Centre

Ivel Valley South
- Arlesey Medical Centre*
- Dr Cakebread & Partners
- Larksfield Surgery Medical Partnership
- Dr Collins and Carragher

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

Hillton
- Dr Hughes & Partners
- Greensand Surgery (Ampthill)
- Houghton Close Surgery

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

H is for Health
- Cranfield Surgery
- Flitwick Surgery
- Oliver Street Surgery

*Arlesey Medical Centre became a non-core member of Ivel Valley South PCN on 1 May 2021 due to the existing provider resigning. The new provider is in place on a short-term caretaking agreement while a longer solution is being planned.

Milton Keynes

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

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

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

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

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

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

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

Luton

Medics Network

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

Oasis

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

Hatters Health

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

Eden Network

- Ashcroft Surgery
- Leavale Medical Group
- Larkside Medical Centre

Phoenix Sunrisers

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

*The Medina practice merged on 1 March 2022 with Malzeard Road Surgery.

2. Composition of Governing Body

The CCG has a Governing Body comprised GP members, executive directors, registered clinical specialists and lay members. The Governing Body met regularly during 2021/22 in both public and private sessions. Voting members and their attendance at meetings throughout 2021/22 are detailed in the table below.

Information on the work of the Governing Body during 2020/21 can be found in the papers and minutes of the meetings, that are available on our website www.blmkccg.nhs.net. The Bedfordshire, Luton and Milton Keynes CCG ceased to exist as of 1 July 2022; at the time this report was published its website was in the process of being archived.

		Private	**Public**
Number of meetings held during 2021/22		9	7
Role	**Name**	**Attendance**	
Chair	Sarah Whiteman	6/9	5/7
Accountable Officer	Felicity Cox	9/9	6/7
Lay Member, Audit and Governance (Conflict of Interest Guardian)	Saqhib Ali	9/9	7/7
Member Representative	Chirag Bakhai	9/9	7/7
Member Representative	*Anitha Bolanthur (from 1 July 2021)	5/6	4/5
Lay Member, Patient and Public Engagement (Freedom to Speak up Guardian)	Alison Borrett	9/9	7/7
Lay Member, Finance and Performance	Sally England	8/9	6/7
Member Representative	*Sureena Goutam	7/9	5/7
Member Representative	*Roshan Jayalath	7/9	5/7
Independent Nurse (Registered Nurse)	Hilary Jones	9/9	7/7
Member Representative	*Christopher Longstaff	8/9	6/7
Member Representative	Shankari Mahathmakanthi	8/9	7/7
Acting Chief Finance Officer	Stephen Makin (until 31 May 2021)	3/3	2/2
Director of Nursing and Quality (Chief Nurse)	Anne Murray	7/9	5/7
Member Representative	*Linus Onah	6/9	5/7
Director of Primary Care	Nicky Poulain	7/9	5/7
Chief Finance Officer	Dean Wescott (from 1 June 2021)	6/7	4/5
Member Representative	Nicola Smith (until 6 April 2021)	1/1	1/1
Secondary Care Specialist	Helen Turner	7/9	7/7

**These Member Representatives were asked to support the Covid Medical Delivery Unit (CMDU) so did not attend the 29 March 2022 Governing Body Meeting.*

3. Committee(s), including Audit Committee

The Governing Body is supported by the following statutory committees. Details of these committees, a list of members and their attendance is provided in the Governance Statement starting on page 55.

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

The Governing Body is also supported by the following non-statutory committees. Details of these committees, a list of members and their attendance is provided in the Governance Statement starting on page 58.

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

4. Register of interests

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

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

5. Personal data-related incidents

The CCG informally reported an IG incident to the Information Commissioner's Office (ICO). The ICO thanked the CCG for its openness and confirmed that they did not feel the incident was of a serious level and would not be investigating or taking any other form of action.

6. Statement of disclosure to auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; and
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

7. Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

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

Felicity Cox

Accountable Officer

Date signed: 16 June 2022

Governance statement

Introduction and context

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

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

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

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

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

Highlights of the work of the Governing Body can be found on page 55 of this report, and in the papers and minutes of the meetings that can be accessed through our website, blmkccg.nhs.uk. The Bedfordshire, Luton and Milton Keynes CCG ceased to exist as of 1 July 2022; at the time this report was published its website was in the process of being archived. Membership and attendance records of

Governing Body members can be found in section 2 of the members' report on pages 38-45. A list of member practices can be found in section 1 of the members' report on pages 46-48, and details of the Members Forum and its work can be found below.

The Governing Body is supported by statutory and non-statutory committees, listed in section 3 of the members' report (page 50). Details of these committees of the Governing Body, their purpose, membership and attendance can be found on pages 55-62. Further information about the Remuneration Committee can be found in our Remuneration Report from page 74.

UK Corporate Governance Code

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

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

Governance structure

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

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

Members' Forum

The CCG is a membership organisation made up of 95 member practices. During 2021/22, following feedback from our practices, Members Forums continued to be held in each of the three former CCG geographical areas Bedfordshire, Luton, and Milton Keynes. All the GP practices in BLMK CCG are members and a representative from each practice is invited to the appropriate forum. The main function of the Members Forum is to provide an opportunity for practice members and the CCG clinical and managerial leadership team to come together to review service and developmental priorities involving and impacting primary care but more broadly the forum facilitates practice representatives to:

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

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

Due to the COVID pandemic and the need to focus on vaccinations and same day access some of the events were unfortunately cancelled during 2021/22.

Audit Committee

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

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

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

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

Throughout 2021/22 the committee has:

- approved a detailed internal audit programme of work consistent with the needs of the organisation
- scrutinised the findings from internal audits and recommendations for improvement and monitored progress with the implementation of the recommendations.
- discussed and agreed the nature and scope of external audit as set out in the annual plan, scrutinised the findings of the audit and considered the implications and management responses
- scrutinised external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the clinical commissioning group and the work undertaken outside the annual audit plan
- reviewed and approved a Counter Fraud Workplan and monitored progress with the plan and scrutinised and discussed the outcome of the work

- reviewed 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
- scrutinised of a range of systems, policies and procedures that are in place to manage risk.
- reviewed assurance that the Governing Body Assurance Framework accurately records the CCG's objectives, and those associated risks are identified together with the measures and controls to manage these principle risks
- recommended the Risk Management Plan, Policy & Strategy, the conflicts of Interest & Standards of Business Conduct Policy and the Anti-Fraud and Bribery Policy for approval; and
- in addition, considered emerging themes such as workforce pressures due to COVID, and emergency funding towards beds and other COVID-related services as mandated by Central Government.

Members and their attendance are listed in the table below.

Number of meetings held during 2021/22		6
Role	**Name**	**Attendance**
Chair - Lay Member, Audit and Governance (Conflict of Interest Guardian)	Saqhib Ali	6/6
Deputy Chair - Lay Member, Finance and Performance	Sally England	6/6
Member Representative	Sureena Goutam (from September 2021)	2/2
Member Representative	Shankari Mahathmakanthi (until September 2021)	4/4

Remuneration Committee

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

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

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

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

Members, their roles and attendance are listed in the table below.

Number of meetings held during 2021/22		5
Role	**Name**	**Attendance**
Chair - Lay Member, Finance and Performance	Sally England	5/5
Deputy Chair - Lay Member, Patient and Public Engagement	Alison Borrett	5/5
Independent Nurse (Registered Nurse)	Hilary Jones	5/5
Secondary Care Specialist	Helen Turner	1/5

Primary Care Commissioning Committee

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

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

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

In 2020-21 the Committee carried out the functions relating to the commissioning of primary medical services:

- monitored General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts and resilience of Practices, taking contractual action and providing support to Practices and Primary Care Networks (PCNs) where required;
- assured the delivery of the primary care aspects of the CCG's COVID vaccination programme working with key stakeholders including Local Authorities and support collaborative working of the Primary Care Networks to participate and contribute to the vaccination programme;
- worked with Healthwatch, Local Medical Committees and NHS England (NHSE) to assess local population needs in accessing services to assure delivery of a significant programme of work to support and develop primary care access and ensure equitable access for the population. This included supporting patients to quickly access community pharmacy staff for advice and treatment on minor conditions. In addition, digital transformation to ensure easy access to services to see a primary care service provider; clear communications for patients; a clinical-led forum to improve workflow between hospitals and primary care/GP services. Finally, it contained the Primary Care Workforce Programme support to PCN development, recruitment, retention and professional development. An underpinning principle was to address inequalities in practice populations;
- ensured arrangements in place across the CCG area for practices and PCNs to provide local and directed enhanced services for patient access including services for interpreting and translation, special allocation scheme, long COVID, weight management, severe mental illness health checks, tackling and reducing local health inequalities and cardiovascular disease prevention and diagnosis;
- developed, implemented and approved strategies for primary care estates and premises, workforce development and information management and technology infrastructure to meet current and future need;
- approved approach to support PCNs to identify and progress quick win estates schemes to address need for additional physical space to accommodate Additional Roles Reimbursement Scheme (ARRs), and proposals for new surgeries, smaller premises projects and hub type facilities;
- focused on supporting continued development of PCNs, integrated care delivery, recovery and a wider Population Health Management approach, particularly access for vulnerable groups;
- supported practices to maximise the total number of points, address inequalities and monitor quality under the Quality & Outcome Framework to benchmark and improve outcomes;

- reviewed and monitored risks related to the primary care directorate and digital transformation in primary care and digital first programme;
- approved and managed the annual delegated Primary Care budget;
- reviewed and scrutinised of the financial position of the primary care budgets, financial performance, financial risks to that position and forecast and actions to manage the risks.
- planned for the transfer of remaining primary care services from NHSE in April 2022 and dental, pharmacy and optometry contracts from 2023.

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

Number of meetings held during 2021/22		Private 6	Public 5
Role	**Name**	**Attendance**	**Attendance**
Chair – Lay Member for Patient and Public Engagement (Freedom To Speak Up Guardian)	Alison Borrett	5/6	4/5
Vice Chair – Lay Member, Finance and Performance	Sally England	6/6	5/5
Accountable Officer / Integrated Care System Executive Lead	Felicity Cox	1/6	0/5
Member Representative	Sureena Goutam	5/6	4/5
Member Representative	Shankari Mahathmakanthi	6/6	4/5
Interim Chief Finance Officer	Stephen Makin (until 31 May 2021)	3/3	2/2
Director of Nursing and Quality (Chief Nurse)	Anne Murray	*2/6	*1/5
Member Representative	Linus Onah	6/6	5/5
Director of Primary Care	Nicky Poulain	6/6	5/5
Chief Finance Officer	Dean Westcott (from 1 June 2021)	3/3	3/3
Interim Medical Director	Ed Sivills	5/6	4/5

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

Equality, Diversity and Inclusion Committee

In July 2020, we established a dedicated Equality, Diversity, and Inclusion (EDI) Committee for the CCG area, reporting directly to the Governing Body. Its role includes:

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

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

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

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

Number of meetings held during 2021/22		3
Role	**Name**	**Attendance**
Chair – Member Representative	Roshan Jayalath	2/3
Deputy Chair – Director of Performance & Governance	Geraint Davies	3/3
Emergency Preparedness & Resilience & Risk Integrated Manager	Elaine Baugh	3/3
Joint Special Educational Needs & Disabilities Development Manager	Kulwinder Bola	3/3
Assistant Head of Medicines Optimisation	Tess Dawoud	2/3
Diabetes Project Lead/Commissioning Support Lead	Matin Fahad (until 12 September2021)	0/1
Equality & Human Rights Manager, Arden and Gem	David King	2/3
Commissioning and Operations Manager	Eugena Marshall-Lewis	3/3
Senior Finance Manager	Edna Muraya	3/3
Director of Nursing and Quality (Chief Nurse)	Anne Murray	2/3
Head of Cancer Network	Kathy Nelson	1/3
Programme Manager/Personalised Care operational Lead	Sonia Okoh (from 13 September 2021)	1/1
Commissioning Project Manager	Kamini Patel (until July 2021)	1/2
Transforming Care Programme Manager (Learning Disability & Autism)	Bharti Quinn	1/3
Deputy Director of Quality and Clinical Governance / Safeguarding Representative	Jennie Russell	0/3
Head of People and Development	Emma Richards	2/3
Director of Organisation Development	Martha Roberts (from 1 August 2021)	1/1
Senior Transformation Manager (Adult Mental Health)	Louis Stanford	3/3
Associate Director, Communications and Engagement	Michelle Summers	2/3
One Beds, Luton & Milton Keynes Clinical Commissioning Group Programme Manager	Sandra Vanreyk	1/3
Chair of BLMK CCG (Caldicott and Wellbeing Guardians)	Sarah Whiteman	2/3

Finance and Performance Committee

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

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

The Committee oversaw the following during the 2021/22:

- assured the delivery of statutory financial targets for the year, including review and scrutiny of the forecast financial position on a monthly basis. This included the review of monthly income and expenditure and the balance sheet and cash position of the CCG;
- assured the delivery of statutory performance targets with particular focus on those considered critical during the pandemic and those required to deliver the agreed performance plans, for example elective recovery;
- reviewed delivery against the requirements of the Mental Health Investment Standard (MHIS);
- put in place emergency measures with regard to expenditure on COVID-19-related costs;
- approved the annual budget and budget management arrangements of the CCG;
- review and scrutiny of future financial and operational plans, CCG efficiency plans and delivery;
- the pipeline of procurement activity and associated contracting activity;
- deep dives, where deemed appropriate, on specific areas including continuing healthcare, S117 and mental health;
- review of quarterly information governance reports; and
- review and scrutiny of the risk registers associated with Finance, Contracting, Information Governance and Information Technology.

The committee would usually meet monthly, however due to pandemic pressures during quarter 3 and quarter 4, meetings were held in common with the Quality and Performance Committee from December 2021 onwards. All meetings were quorate and in accordance with its terms of reference. The Committee membership consists of ten members, all of whom are Governing Body members.

Number of meetings held during 2021/22		10
Role	**Name**	**Attendance**
Chair – Lay Member for Finance and Performance	Sally England	9/10
Deputy Chair – Independent Nurse (Registered Nurse)	Hilary Jones	10/10
Director of Commissioning and Contracting	Richard Alsop	9/10
Member Representative	Chirag Bakhai	5/10
Lay Member for Patient and Public Engagement (Freedom To Speak Up Guardian)	Alison Borrett	9/10
Director for Performance and Governance	Geraint Davies	10/10
Acting Chief Finance Officer	Stephen Makin (until 31 May 2021)	2/2
Director of Nursing and Quality (Chief Nurse)	Anne Murray	5/10
Director of Primary Care	Nicky Poulain	7/10
Chief Finance Officer	Dean Westcott (from 1 June 2021)	6/8

Patient and Public Engagement Committee

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

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

Membership of the committee includes a GP Member Representative, Independent Nurse, and the Director of Communications and Engagement. Meetings are also attended by representatives from the four local Healthwatch organisations, voluntary and community sectors, including children and young people. This broad mix encourages robust conversations and recommendations, which have helped ensure the patient voice is being heard and that health inequalities are being addressed.

During the 2021/22 the committee:

- influenced the consultation documents and engagement plans for the public consultation on aligning policies across our area. They provided assurance to the Governing Body that the engagement activity was robust;
- received updates from the commissioners on the modernisation of mental health inpatient services and musculoskeletal services. This provided opportunity to find out about the work being undertaken to redesign these services to make them equitable to patients across our area. They found out how patients and the public were being involved in the redesign process and provided suggestions to strengthen involvement;
- reviewed communication and engagement plans for winter planning, including the flu and COVID vaccination programmes. The committee provided assurance to the Governing Body that the CCG was listening and responding to stakeholder feedback, and that it was working in partnership with local organisations to reach and engage seldom heard communities; and
- offered their views and recommendations on the CCG's approach for engaging on the working with people and communities strategy which will be the foundation for engagement for the new Integrated Care Board.

Number of meetings held during 2021/22		6
Role	**Name**	**Attendance**
Chair – Lay Member for Patient and Public Engagement (Freedom To Speak Up Guardian)	Alison Borrett	6/6
Independent Nurse (Registered Nurse)	Hilary Jones	5/6
Director of Communications and Engagement	Jane Meggitt	6/6
Member Representative	Chris Longstaff	6/6

Quality and Performance Committee

The Quality and Performance Committee was Chaired by Hilary Jones, Independent Nurse (Registered Nurse) who is a member of the Governing Body.

The committee takes on overall responsibility for leading the organisation's quality and safety agenda and reports directly to the Governing Body on these matters. It has an Annual Workplan which supports the delivery of the CCG's work plans and delivers on functions delegated to it under the CCG's Scheme of Reservation and Delegation.

It works to ensure that commissioned services are being delivered in a high quality and safe manner, ensuring that quality and safety sits at the heart of everything the organisation does. It is responsible for providing assurance and information to the Governing Body to fulfil its role and responsibilities in relation to quality and safety.

The committees work during 2021/22 has included:

- subjecting service changes and pathway redesigns to appropriate assessment for quality and safety;
- scrutinising the quality, safety and effectiveness of commissioned services;
- ensuring the CCG fulfils its statutory safeguarding duties;
- undertaking Deep Dives into areas of quality concern in relation to services and overseeing remedial action plans to improve the quality and / or safety of any commissioned service;
- monitoring provider performance to ensure local, national, regulatory and NHS Constitution standards are met;
- review and scrutiny of CCG corporate quality risks and operational quality risks;
- reviewing reports relating to serious incidents, never events and other patient safety or safeguarding incidents;
- approval of the quality and outcomes framework and quality, innovation, productivity and prevention schemes;
- ensured the sharing of learning from incidents, complaints, reviews and patient feedback across the health and social care system;
- ensuring patients and patient experience are integral to the design and delivery of commissioned services;
- overseeing the CCG's complaints process;
- overseeing provider quality account approval; and
- approval of CCG policies relating to quality, clinical effectiveness and safety.

In 2021/22 the Quality Committee received assurance reports into services including the clinical response to the COVID-19 pandemic, the Ockendon Maternity Review, a range of Adult and Children's mental health services, transforming care and learning disability and cancer services. Workforce plans and the impact on commissioned services were also scrutinised. The committee was kept updated with the development of the system quality group which will further strengthen the ability to deliver quality improvements at a system level.

Number of meetings held during 2021/22		10
Role	**Name**	**Attendance**
Chair – Independent Nurse (Registered Nurse)	Hilary Jones	10/10
Deputy Chair – Lay Member for Patient and Public Engagement (Freedom to Speak Up Guardian)	Alison Borrett	9/10
Director of Commissioning and Contracting	Richard Alsop	6/10
Director of Communications and Engagement	Jane Meggitt	7/10
Director of Nursing and Quality (Chief Nurse)	Anne Murray	9/10
Secondary Care Specialist	Helen Turner	8/10

Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the CCG 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 CCG 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 CCG's statutory duties.

Risk management arrangements and effectiveness

We recognise that every activity we undertake or commission brings with it some element of risk. These have the potential to threaten or prevent the achievement of our objectives.

We have responded to this by:

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

During the course of 2021/22, following the formation of the single CCG, we used the transitional Risk Management Framework to manage risk, as agreed the previous year. This was codified as the Bedfordshire, Luton and Milton Keynes CCG Risk Management Strategy in December 2021. The Strategy sets out the organisation's roadmap for management of risk. It also sets out the practical means through which risk is identified and evaluated as well as the control mechanisms through which it is managed.

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

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

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

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

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

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

All recommended actions were closed off during the 2021/22 year. The audit recognised the immense work to migrate existing risks, integrate and embed a new risk management model and system across the CCG in the midst of a pandemic response.

Capacity to handle risk

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

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

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

At the start of 2021/22, the CCG aligned the strategic risks from the previous organisations to the new organisation's strategic priorities and objectives. The BAF was reviewed regularly throughout the year and was received at each meeting of the Audit Committee. The committee provides an assurance to the Governing Body with respect to management of the risks identified within the BAF. In doing so, the committee draws upon the sources of assurance, including the work of the CCG's external auditors and a comprehensive internal audit programme.

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

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

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

Risk assessment

All risks to the CCG are assessed for their consequence and likelihood to give an overall risk rating. The CCG's governance, risk management and internal control frameworks have been subject to constant review so that they remain fit for purpose.

At the start of 2021/22, the merged BAF held 22 strategic risks from the three previous organisations, with 13 high (red) risks and nine medium (amber) risks. The three highest risks are detailed below:

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

All risks on the BAF were subject to review of controls to mitigate risks. Action plans to improve the controls were carried out individually by the Executive Management Team in conjunction with the

appropriate lead. Wherever gaps in controls or assurances were identified, action plans were defined and allocated to a lead director to ensure that the situation was remedied.

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

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

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

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

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

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

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

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

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

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

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

Emergency Preparedness, Resilience and Response (EPRR)

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

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

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

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

We take part in the annual NHS EPRR assurance process and work closely with the main health partners. We do this to make sure that we have appropriate incident response and business continuity plans in place, providing compliance to the requirements of the Civil Contingencies Act (2004), the NHS Act 2006 (as amended) and other NHS England EPRR guidance. In 2021/22, the CCG maintained 'substantial' compliance with the NHS England Core Standards for EPRR.

With the NHS operating at an Incident Level 3 or 4 for most of the year, we had a business continuity plan in place. We had an Incident Control Centre (ICC) covering Bedfordshire, Luton and Milton Keynes providing strategic leadership as well as tactical support to the CCG's system and into the east of England and south-east regions. The ICC supported the COVID-19 response and the vaccination programme. It has also contributed greatly to the dynamic risk management of the pandemic and other concurrent incidents across the system.

During 2021/22, the CCG responded to or supported in the response to the following incidents, while managing the response to the pandemic:

- Operation Marston (death of Captain Sir Tom Moore);
- Operation Forth Bridge (death of HRH Duke of Edinburgh);
- Operation Liven (CBRNe);
- Managed quarantine facilities;
- Operation Highmoor (planned protests);
- Afghan evacuee crisis;
- Beckton Dickerson supply chain disruptions;
- Operation Shrew (planned protests); and
- Covid-19 Omicron surge.

Internal control framework

A system of internal control is the set of processes and procedures in place in the CCG 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 constitution.

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

Internal audit

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

External audit

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

Local counter fraud service

The CCG commissioned BDO's local counter fraud specialist (LCFS) during 2021/22 to establish whether the CCG was compliant with the NHS Counter Fraud Functional Standards, developed to support public sector organisations in implementing appropriate measures to counter fraud, bribery and corruption. A work plan was developed through a fraud risk assessment which identified the key areas of risk at the CCG.

The Audit Committee received regular update reports from the LCFS.

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

Board assurance framework

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

Annual audit of conflicts of interest management

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

To support CCGs to undertake this task, NHS England has published a template audit framework. The organisation received Moderate assurance (significantly meets expectations) for this audit. However, some areas for improvement were identified including ensuring each section of the register of interest is adequately completed, timely review and publication of the register of interest and completion of the conflicts of interest mandatory training module by all staff.

Data quality

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

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

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

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

Commissioning Support Unit carry out validation checks for data completeness and accuracy on all data reports provided to the CCG.

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

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

Information governance

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

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

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

We are undertaking an assessment of our position against the data security and protection toolkit and will perform our submission for 2021/22 by 30 June 2022 (as mandated for CCGs).

Business critical models

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

Third party assurances

Where the CCG relies on third party providers for support services, the contract is overseen by an executive director, with input and operational management provided by subject matter and contracting experts. Regular review meetings are held which receive performance and KPI reports, and which allow discussion of any issues needing resolution. Where services are new or undergoing significant change, this is typically managed through a Mobilisation and Delivery Board structure No significant issues or concerns have been raised during the year.

Control issues

The CCG has no substantial control issues requiring remedial action.

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

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

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

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

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

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

Delegation of functions

The CCG has had responsibility for primary care commissioning since 1 April 2019. It delegated no functions during 2021/22.

Counter fraud arrangements

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

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

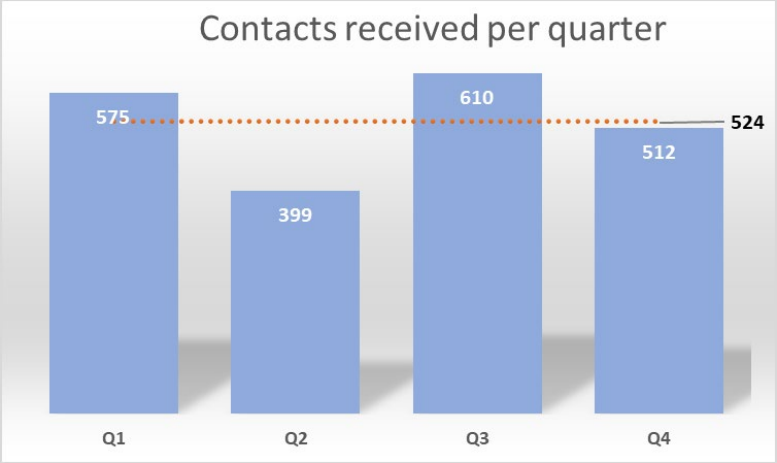
The CCG undertakes comprehensive risk assessments to identify and manage its fraud, bribery and corruption risks, ensuring that counter fraud activities are prioritised and focussed towards areas of greatest risk.

Our Counter Fraud Service is provided by an accredited Local Counter Fraud Specialist (LCFS) – in 2021/22 our counter fraud service was provided by BDO. The LCFS works to a risk-based annual plan which has been agreed by the Chief Finance Officer and the Audit Committee. The plan is designed around the NHS Counter Fraud Authority's Functional Standards , and compliance with these standards is reported to the Audit Committee on an annual basis. The Local Counter Fraud Specialist attends meetings of the Audit Committee to provide updates on progress against the annual work plan and compliance with the Functional Standards.

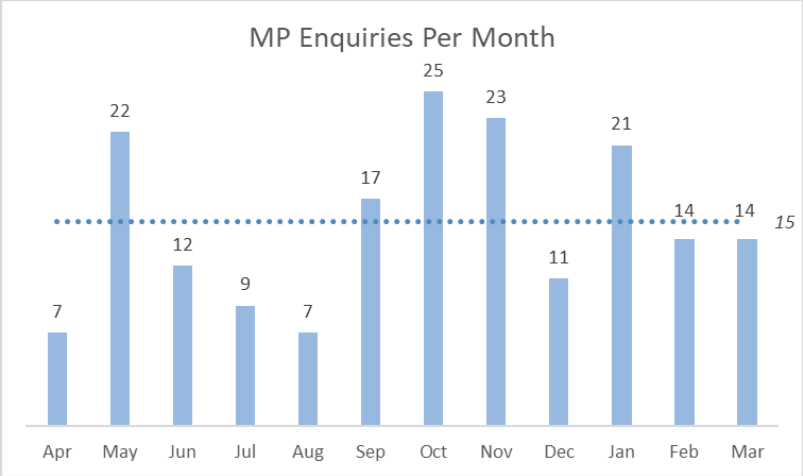
All concerns of fraud, bribery and corruption at the CCG are referred to the Local Counter Fraud Specialist and addressed in accordance with the CCG's fraud, bribery and corruption policy. The Local Counter Fraud Specialist reports annually on all work undertaken, including the outcome of investigations.

Enquiries and Complaints

To provide context, most of the contacts the CCG received were in relation to enquiries and concerns about healthcare matters and, as part of our patient centric culture, we maintained this service throughout the COVID-19 pandemic. For example, this year we received 2096 contacts in total (emails, telephone calls and letters), 788 (38%) related to the COVID-19 pandemic and vaccinations. Our objective is to acknowledge all contacts within three working days, and to resolve any issues arising within 10 working days. On average, we received 524 contacts per quarter.



We received 182 enquiries from MPs (average 15 per month); 87 (48%) were in relation to the COVID-19 pandemic and vaccinations.



The CCG's Complaints Policy explains what constitutes a complaint. The main complaint subjects received were about delays/not responding to funding requests. This year we have submitted nine complaints as part of our KO41A submission to NHS Digital for the national monitoring of complaints. Our key performance indicator (KPI), as set out in the Complaints Policy, is to respond to complaints within 25 working days.

KO41A	Q1	Q2	Q3	Q4
New cases	3	2	3	1
Resolved	3	2	3	1
Upheld	0	0	0	0
Partially upheld	0	0	2	0
Not upheld	3	2	1	1
Carried forward	0	0	0	0

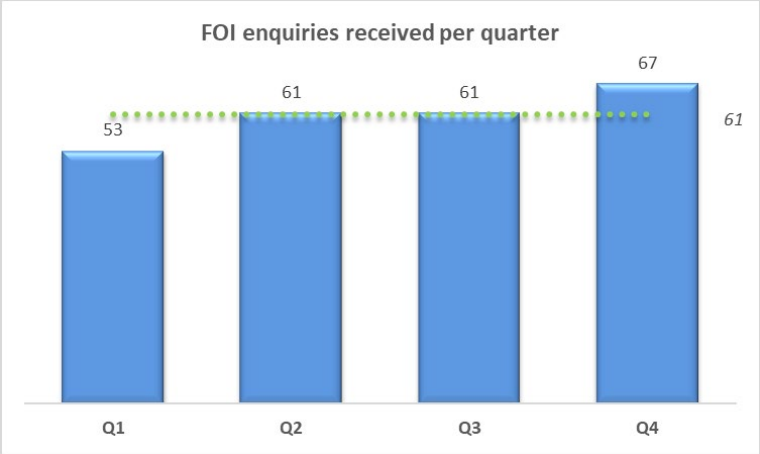
We use the information and data we gather from enquiries and complaints to inform the directorates about emerging themes and trends. For instance, we were able to communicate queries about delays in COVID-19 vaccinations appearing on medical records to the COVID vaccination team, and they were able to update the records with the information we provided, and we triangulated this information to the enquirer and GP.

Freedom of Information requests

The Freedom of Information (FOI) Act 2000 and the Environmental Information Regulations 2004 give members of the public the right to request recorded information held by public authorities. We received on average 61 FOI enquires per quarter.

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

During this financial year we received 242 FOI requests and failed to meet the 20 days' timeframe with 53 (22%) requests. The Information Commissioners Office (ICO) stated that they will take the Covid-19 pandemic national emergency into consideration if asked to review a case due to a timeframe breach.



Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

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

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

Area of Audit	**Level of Assurance** (please refer to legend below for definitions)	
	Design	**Operational Effectiveness**
Conflicts of Interest		
Cyber Security		
Key Financial Systems		
Primary Care Commissioning		
Risk Management Systems		
Section 117		

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 fully effective.	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, that 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.

Outcome of Section 117 internal audit

Section 117 (S117) of the Mental Health Act 1983 (MHA) requires the NHS and local authorities to provide aftercare services, including a care home place if that is needed, for people who have been discharged from hospital having been detained under the MHA. Aftercare is provided in order to reduce the risk of their mental health declining and preventing further admissions to hospital. As at the end of November 2021, the CCG had 658 people entitled to S117 aftercare (both jointly and fully funded by the CCG) across Bedford Borough, Central Bedfordshire and Luton. (S117 mental health functions for Milton Keynes are delegated under contract to Central & North West London NHS Foundation Trust (CNWL) and the CCG does not hold information locally.)

The CCG and local authorities have seen an increase over time of the number of people eligible for S117 aftercare, and increased costs. This has presented a cost pressure to the CCG, and a S117 Transformation Programme commenced in 2021/22 to mitigate that cost pressure and develop new ways of working. An executive-level programme board maintains oversight. The programme has achieved significant outcomes during the year, but key areas such as joint protocols and market shaping require a longer timeframe.

The CCG's internal auditors undertook a review of a random selection of packages of care. Auditors identified a number of areas of good practice. Areas for improvement were a lack of an overarching policy framework across the S117 process, and inconsistency in overall oversight protocols and engagement between stakeholders. As a result, auditors provided an opinion of limited assurance in respect of the design, and moderate assurance over the operational effectiveness of the controls in place in respect of the CCG's S117 aftercare procedures.

An action plan is in place to respond to the recommendations, with target dates within the 2022/3 financial year. Many of the recommendations are already being actioned through the S117 Transformation Programme and are achievable, working with system partners.

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

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

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

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

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

Conclusion

As Accountable Officer, and based on the review processes outlined above, I can confirm that the governance statement is a balanced reflection of the actual controls position. There is an action plan in place to address the findings from the Section 117 audit as detailed in the Head of Internal Audit Opinion.

Felicity Cox

Accountable Officer

Date Signed: 16 June 2022

REMUNERATION AND STAFF REPORT

Remuneration report

Remuneration Committee

We provide appropriate levels of remuneration to attract the right people with the right skills to Bedfordshire, Luton and Milton Keynes. Remuneration is managed in conjunction with the Remuneration Committee, which includes lay members, a secondary care specialist doctor and the Governing Body registered nurse, none of whom is an employee of the organisation. More information is provided on page 56 of this report.

Policy on the remuneration of senior managers

The Remuneration Committee sets salaries and terms and conditions of service for all Governing Body members apart from lay members, which are set by a special remuneration.

All staff are paid either in accordance with 'Agenda for Change' terms, or on very senior manager (VSM) terms and conditions of service, including notice periods. Objectives are set and performance is measured using the objective setting and appraisal process in conjunction with other relevant policies. Remuneration is basic salary, with no awards. All roles in the CCG 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 Play (2011), job evaluation methods and pay guidelines set for chief officers and chief finance officers by NHS England.

Remuneration of very senior managers

The CCG had one senior manager on a VSM contract which provides for a contractual salary of £150,000 or greater per annum. The salary related to the Chief Executive Officer (CEO) who was appointed in February 2021.

As part of the appointment process, the remuneration for the post was reviewed and discussed at the CCG Remuneration Committee to ascertain its reasonableness in line with current salary guidance. Approval for the appointment and salary was sought from NHS England.

Where the salary was greater than £150k, a business case was submitted to HM Treasury seeking approval. Where appointments are made to a salary above the £150k threshold, we follow the above process and gain approval from HM Treasury.

Senior manager remuneration (including salary and pension entitlements)

The remuneration report including salary and pension entitlements is provided from the following page, shown as separate tables for 2021/22 and 2020/21.

Remuneration report 2021/22 (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 Sarah Whiteman	Chair	130-135	0	0	0	0	130-135
Felicity Cox	Accountable Officer	165-170	0	0	0	85-87.5	250-255
Dean Westcott	Chief Finance Officer (from 1 June 2021)	110-115	0	0	0	127.5-130	240-245
Stephen Makin	Acting Chief Finance Officer (to 31 May 2021)	15-20	0	0	0	5-7.5	25-30
Dr Edward Sivills	Interim Medical Director	45-50	0	0	0	0	45-50
Geraint Davies	Director of Performance and Governance	115-120	0	0	0	0	115-120
Richard Alsop	Director of Commissioning and Contracting	130-135	0	0	0	0	130-135
Anne Murray	Director Of Nursing and Quality	120-125	0	0	0	0	120-125
Jane Meggitt	Director of Communication and Engagement	105-110	0	0	0	22.5-25	130-135
Nicky Poulain	Director of Primary Care	120-125	0	0	0	25-27.5	145-150
Martha Roberts	Director of Organisational Development (from 1 August 2021)	60-65	0	0	0	60-62.5	120-125
GP Members							
Dr Roshan Jayalath	Member Representative	80-85	0	0	0	0	80-85
Dr Linus Onah	Member Representative	65-70	0	0	0	0	65-70
Dr Christopher Longstaff	Member Representative	25-30	0	0	0	0	25-30
Dr Chirag Bakhai	Member Representative	155-160	0	0	0	0	155-160
Dr Sureena Goutam	Member Representative	50-55	0	0	0	0	50-55
Dr Shankari Mahathmakanthi	Member Representative	80-85	0	0	0	0	80-85
Dr Anitha Bolanthur	Member Representative	65-70	0	0	0	0	65-70
Dr Helen Turner	Secondary Care Specialist	25-30	0	0	0	37.5-40	60-65
Hilary Jones	Independent Nurse (Registered Nurse)	10-15	0	0	0	0	10-15
Lay Members							
Alison Borrett	Lay Member	25-30	0	0	0	0	25-30
Saqhib Ali	Lay Member	5-10	0	0	0	0	5-10
Sally England	Lay Member	20-25	0	0	0	0	20-25

Notes:

Other remuneration received for duties that are not part of the management role and included in the table above are as follows:

- Dr Sarah Whiteman received £25-30k for her roles as Caldicott and Health and Wellbeing Guardians in 2021/22.

- Dr Roshan Jayalath received £40-45k for his role as Clinical Lead for Mental Health in 2021/22.

- Dr Linus Onah received £25-30k for his role as Clinical Lead for MSK in 2021/22.

- Dr Chirag Bakhai received £115-120k for his roles as NHSE Diabetes Lead and Clinical Lead for Long Term Conditions in 2021/22.

- Dr Sureena Goutam received £10-15k for her role as a Placed Based Clinical Lead in 2021/22.

- Dr Shankari Mahathmakanthi received £40-45k for her roles as GP Early Careers Strategic Lead and Deputy Chair of BLMK ICS Primary Care Training Hub in 2021/22.

- Dr Anitha Bolanthur received £25-30k for her role as a Clinical Lead for Cancer in 2021/22.

Directors' pension entitlements (Subject to audit)

		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
Name	Title	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Felicity Cox	Accountable Officer	5.0-7.5	5.0-7.5	35-40	100-105	752	91	870	-
Dean Westcott	Chief Finance Officer (from 1 June 2021)	5.0-7.5	17.5-20	70-75	215-220	N/A	N/A	N/A	-
Stephen Makin	Acting Chief Finance Officer (to 31 May 2021)	0.0-2.5	0.0-2.5	35-40	70-75	545	0	596	-
Jane Meggitt	Director of Communication and Engagement	0.0-2.5	0.0-2.5	40-45	100-105	882	32	933	-
Nicky Poulain	Director of Primary Care	0.0-2.5	0.0-2.5	50-55	115-120	1,057	37	1,116	-
Dr Helen Turner	Secondary Care Specialist	0.0-2.5	0.0-2.5	10-15	15-20	220	29	254	-
Martha Roberts	Director of Organisational Development (from 1 August 2021)	2.5-5.0	5.0-7.5	25-30	55-60	445	52	542	-

Notes:

- 'Real increase' reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement)
- Lay members do not receive pensionable remuneration, therefore there will be no entries in respect of pensions for them.

Should a director/senior managers retire early, any and all benefits received would be paid in line with current NHS terms and conditions.

Cash equivalent transfer values (CETV)

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

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

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

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

Real increase in CETV

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

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

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

Payments to past directors (subject to audit)

There have been no payments to past directors.

Pay multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the 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 is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director / member in the organisation in the financial year 2021/22 was £167,500. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2021/22	4.3 : 1	3.26 : 1	2.21 : 1

In 2021/22, no employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £17,500 to £167,500.

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.

Staff report

Number of senior managers

At 31 March 2022 Bedfordshire, Luton and Milton Keynes CCG employed 15 very senior managers (VSMs) including Band 9s.

Staff numbers and costs (subject to audit)

Employee benefits	Permanent employees £000s	Other £000s	Total £000s
Salaries and wages	17,090	2,655	19,745
Social security costs	1,911	0	1,911
Employer contributions to NHS pension scheme	2,688	0	2,688
Other pension costs	0	0	0
Apprenticeship levy	46	0	46
Termination benefits	0	0	0
Gross employee benefits expenditure	**21,735**	**2,655**	**24,390**
Employee numbers (rounded to nearest WTE *)	**320 WTE**	**26 WTE**	**346 WTE**

* Whole Time Equivalent (WTE)

Staff composition

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

Male		Female	
Headcount	%	Headcount	%
5	38.46	8	61.54

Senior managers and VSMs, excluding Governing Body.

Male		Female	
Headcount	%	Headcount	%
7	46.67	8	53.33

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

Male		Female	
Headcount	%	Headcount	%
53	14.93	302	85.07

Note: Headcount figures as at 31 March 2022 and exclude off-payroll staff.

Staff turnover percentages

The staff turnover percentage for the CCG, as at 31 March 2022, was 17.25%.

Staff engagement percentages

The annual staff survey results for 2021/22 showed a response rate of 86%, against an average national CCG response rate of 78%. This was a significant improvement on the CCG response rate of 73% for 2020/21 (averaged across the three former CCGs of Bedfordshire, Luton & Milton Keynes). The CCG will analyse the results to identify areas of good performance and points for development.

The CCG recognised it had been a challenging 12 months during 2021/22 and worked hard to provide focused support for staff wellbeing.

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 CCG workforce consisted of 23% BAME and 74% white, 3% not stated at 31 March 2022. Our Governing Body consisted of 46% BAME, 46% white and 8% not stated.

Developing an inclusive and diverse workforce is important to the CCG and we work hard to ensure that our workforce processes and practices support this aim and align to our Equality, Diversity and Inclusion Policy. This approach is enhanced by the establishment of an Equality, Diversity and Inclusion Committee that reports to the Governing Body. We continued to progress the development of a diverse workforce during 2021/22.

Equality and Diversity training is delivered online to all CCG staff, ensuring compliance with the Equality Act 2010. Equality and Diversity training was completed by 83% of CCG staff as at 31 March 2022. This

training helps to enhance the role and importance of diversity within the organisation, supporting respect for and among the workforce.

The CCG is an equal opportunities employer. When recruiting to posts we utilise best practice. We ensure that 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. In 2021/22, 35 members of staff secured an internal transfer or promotion either on a permanent or temporary basis, of which 14% were from our BAME colleagues.

We recognise that staff can develop through partnership with external organisations. Where appropriate the CCG will work with other organisations to arrange secondments. One member of staff secured an external secondment with a local partner and we agreed seven secondments into the CCG with partnership staff.

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, 5.11% have declared a disability. It is not mandatory for staff to declare disabilities.

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.

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

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

All our current workforce policies can be viewed on our website.

Support for staff

We 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.

COVID-19 brought challenges for our staff in 2020/21 which required the use of new initiatives, creative thinking and additional support for staff who were remote working. Our learning from that period continued into 2021/22, focusing our efforts on staff wellbeing by retaining and enhancing existing measures and support available to staff.

These measures were:

- remote working guidance;
- regular communication and contact between managers and staff members;
- quarterly appraisals and wellbeing conversations between managers and staff;
- an internal staff survey to assess staff experiences and wellbeing during the COVID lockdown;
- 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 Accountable Officer to keep staff updated;
- risk assessments undertaken for all staff including BAME and high-risk groups
- DSE assessments for homeworking; and
- recognition of the improved work / life balance available through remote working by formalising the arrangements.

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

We 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.

Sickness absence data

Under guidance issued by NHS England, guidance on Sickness Absence Data Reporting for NHS Bodies 2013–14 (2014), CCGs are required to report on a calendar year. The data in this report reflects a full twelve-month period from 1 January-31 December 2021.

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

The sickness absence data for 2021/22 showed an average 5.5 working days lost per full-time employee. It should be noted that the days lost were attributed to a number of long-term illnesses and a reduced amount of short-term absences. The CCG had minimal absence related to Covid.

Health and safety

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

Consultations

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

Towards the latter part of the year, we consulted on formalising the remote working arrangements we had enforced during the initial COVID-19 lockdown. There was an appetite for a new way of working among staff who valued the improved work / life balance presented by the flexibility of home and office working. Implementation of the outcome of the consultation will take place in 2022/23.

Trade unions

We work in partnership with the recognised unions and, during this reporting period, set up a formal Partnership Forum which has participation from regional and local representatives. The Forum is chaired by our Head of People and Development (formerly Corporate Services and Workforce Lead, to 31 January 2021).

In accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017, public sector organisations are required to report on trade union facility time. As at 31 March 2022 we had three employees who were engaged by trade unions to act as their formal representative.

The CCG has agreed a facilities time policy with the trade unions.

Table 1: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
5	3.43

*There have been 5 different employees acting as representatives throughout the period, with WTE fluctuating between 2.6 – 3.6 WTE

Table 2: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	5
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time

Total cost of facility time	£195,526
Total pay bill	£24,389,950
Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time ÷ total pay bill) x 100	0.8%

Table 4: Paid trade union activities

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

Expenditure on consultancy

Expenditure on consultancy was £694,697

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements as at 31 March 2022, earning £245 per day or greater.

This table shows all off-payroll engagements as of 31 March 2022, earning more than £245 a day.

Number of existing engagements as of 31 March 2022 earning more than £245 a day	28
of which, the number that have existed:	
• for less than 1 year at the time of reporting	28
• for between 1 and 2 years at the time of reporting	0
• for between 2 and 3 years at the time of reporting	0
• for between 3 and 4 years at the time of reporting	0
• for 4 or more years at the time of reporting	0

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

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2022, earning £245 per day or greater.

This table shows all new off-payroll engagements, between 1 April 2021 and 31 March 2022, earning more than £245 a day.

Number of all new engagements between 1 April 2021 and 31 March 2022 earning more than £245 a day.	31
of which...	
Not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	13
Number subject to off-payroll legislation and determined as out-of-scope of IR35	18
Number of engagements reassessed for consistency/assurance purposes during the year	4
Number of engagements that saw a change to IR35 status following the consistency review	0

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

This table shows all off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

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

Exit packages (subject to audit)

Reporting bodies are required to disclose any exit packages agreed in the financial year. This information is disclosed in the below table:

Exit packages agreed in the financial year

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	9,266	1	9,266
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	1	30,229	0	0	1	30,229
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	102,189	0	0	1	102,189
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**132,419**	**1**	**9,266**	**3**	**141,685**

There were no other agreed departures where special payments have been made in 2021-22

Parliamentary Accountability and Audit Report

Bedfordshire, Luton & Milton Keynes CCG 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.

ANNUAL ACCOUNTS

Felicity Cox
Accountable Officer
16 June 2022

Independent auditor's report to the members of the Governing Body of NHS Bedfordshire, Luton and Milton Keynes CCG

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 CCG (the 'CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year 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 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

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

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 24 to the financial statements, which describes that under the Health and Care Act (2022), which received Royal Assent on 28 April 2022, the commissioning functions of NHS Bedfordshire, Luton and Milton Keynes CCG will transfer to Bedfordshire, Luton and Milton Keynes Integrated Care Board. The expected date of the transfer is 01 July 2022.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the CCG 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 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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.

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

In connection with our audit of the financial statements, 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 or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

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

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

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

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

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

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

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. 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.

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.

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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, fraud within revenue recognition which we have rebutted and fraud within expenditure recognition. We determined that the principal risks were in relation to:
  - The risk of management override of controls
  - The risk of fraudulent expenditure recognition in relation to the existence of year end liabilities and the completeness of expenditure
- Our audit procedures involved:
  - evaluating the design effectiveness of management controls over journals;
  - analysing the journals listing and determining the criteria for selecting high risk unusual journals;
  - testing unusual journals made during the year and after the draft accounts stage for appropriateness and corroboration;
  - gaining an understanding of the material accounting estimate in relation to the prescribing accrual and critical judgements applied made by management and considering their reasonableness;
  - evaluating the rationale for any changes in accounting policies, estimates or significant unusual transactions.
  - evaluating the design effectiveness of accrual controls for posting manual accrual journals;
  - inspecting year end manual accrual journals that reduce the level of expenditure recorded to ensure appropriate basis for journal and that it can be agreed to supporting evidence;
  - testing a sample of invoices input to the accounts payable system post period end and confirming that these were correctly accounted for;
  - testing a sample of cash payments made post the period end and confirming that these were correctly accounted for;

  - reviewing the unmatched expenditure and payables balances with NHS bodies (in the DHSC mismatch report), and corroborating the CCG's unmatched balances to supporting evidence; and
  - testing a sample of year end accruals to verify the actual amount paid after year end to assess the accuracy of accruals recorded.
- 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 communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in expenditure recognition, and the significant accounting estimates related to the prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the CCG'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 CCG'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 year ended 31 March 2022.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources 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 December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG 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 CCG 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 the NHS Bedfordshire, Luton and Milton Keynes CCG for the year ended 31 March 2022 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 CCG'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 Governing Body of the CCG, 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 Governing Body of the CCG 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 CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Grady, Key Audit Partner

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

London

16 June 2022

Independent auditor's report to the members of Bedfordshire, Luton and Milton Keynes Integrated Care Board in respect of Bedfordshire, Luton and Milton Keynes CCG

In our auditor's report issued on 16 June 2022, we explained that we could not formally conclude the audit and issue an audit certificate for Bedfordshire, Luton and Milton Keynes CCG (the 'CCG') for the year ended 31 March 2022, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2022 issued on 16 June 2022 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year 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 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

In forming our opinion on the financial statements, we drew attention to note 24 to the financial statements, which describes that under the Health and Care Act (2022), which received Royal Assent on 28 April 2022, the commissioning functions of NHS Bedfordshire, Luton and Milton Keynes CCG will transfer to Bedfordshire, Luton and Milton Keynes Integrated Care Board. The expected date of the transfer is 01 July 2022.

No matters have come to our attention since 16 June 2022 that would have a material impact on the financial statements on which we gave this opinion.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

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

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

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Bedfordshire, Luton and Milton Keynes CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Paul Grady

Paul Grady
Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

16 September 2022

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000
Income from sale of goods and services	2	(1,514)
Other operating income	2	(106)
Total operating income		**(1,620)**
Staff costs	4	24,390
Purchase of goods and services	5	1,723,790
Depreciation and impairment charges	5	216
Provision expense	5	2,286
Other Operating Expenditure	5	804
Total operating expenditure		**1,751,486**
Net Operating Expenditure		**1,749,866**
Finance expense		221
Net expenditure for the Year		**1,750,087**
Net (Gain)/Loss on Transfer by Absorption		125,400
Total Net Expenditure for the Financial Year		**1,875,487**
Comprehensive Expenditure for the year		**1,875,487**

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

Statement of Financial Position as at 31 March 2022

	Note	31-Mar-22 £'000	01-Apr-21 £'000
Non-current assets:			
Property, plant and equipment	10	68	477
Intangible assets	11	0	28
Total non-current assets		68	505
Current assets:			
Inventories	12	67	97
Trade and other receivables	13	19,063	9,609
Cash and cash equivalents	14	(405)	0
Total current assets		**18,725**	9,706
Total assets		**18,793**	10,211
Current liabilities			
Trade and other payables	15	(133,719)	(126,082)
Borrowings	16	(299)	(6,113)
Provisions	17	(4,293)	(3,415)
Total current liabilities		**(138,311)**	(135,611)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(119,518)**	(125,400)
Non-current liabilities			
Provisions	17	(984)	0
Total non-current liabilities		**(984)**	0
Assets less Liabilities		**(120,502)**	(125,400)
Financed by Taxpayers' Equity			
General fund		(120,502)	(125,400)
Total taxpayers' equity:		**(120,502)**	(125,400)

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

The financial statements on pages 1 to 28 were approved by the Governing Body on 14 June 2022 and signed on its behalf by:

Felicity Cox
Accountable Officer
Date: 16-June-2022

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	(1,750,087)	**(1,750,087)**
Transfers by absorption to (from) other bodies	(125,400)	**(125,400)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(1,875,487)**	**(1,875,487)**
Net funding	1,754,985	**1,754,985**
Balance at 31 March 2022	**(120,502)**	**(120,502)**

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

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(1,750,087)
Depreciation and amortisation	5	216
Other Gains & Losses		221
(Increase)/decrease in inventories		30
(Increase)/decrease in trade & other receivables	13	(9,454)
Increase/(decrease) in trade & other payables	15	7,637
Provisions utilised	17	(425)
Increase/(decrease) in provisions	17	2,286
Net Cash Inflow (Outflow) from Operating Activities		**(1,749,576)**
Net Cash Inflow (Outflow) before Financing		**(1,749,576)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		1,754,985
Net Cash Inflow (Outflow) from Financing Activities		**1,754,985**
Net Increase (Decrease) in Cash & Cash Equivalents	14	**5,409**
Cash & Cash Equivalents at the Beginning of the Financial Year		**(6,113)**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(704)**

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 clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

NHS Bedfordshire, Luton and Milton Keynes clinical commissioning group was approved by NHS England to operate from 1 April 2021 and was created from the merger of NHS Bedfordshire CCG, NHS Luton CCG and NHS Milton Keynes CCG. Closing balances from the three predecessor CCGs were transferred to NHS Bedfordshire, Luton and Milton Keynes CCG at 1 April 2021. The transfer of balances is detailed in Note 8 of these accounts. As a result of the merger, other than for the Statement of Financial Position, comparative figures for the previous financial year have not been provided as the CCG did not exist in 2020-21.

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and 141 liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs. Other transfers of assets and liabilities within the Department of Health and Social Care group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

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

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 **Accounting Convention**

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

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

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

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

1.4 **Pooled Budgets**

The clinical commissioning group has entered into pooled budget arrangements with Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Community Equipment, Learning Disabilities and the Better Care Fund and Note 22 to the accounts provides details of the income and expenditure.

Notes to the financial statements

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

1.5 **Operating Segments**

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

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

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

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

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

Notes to the financial statements

1.7.3 **Local Government Pensions**

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

1.8 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 **Grants Payable**

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

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

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

1.10.2 **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.

Notes to the financial statements

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

1.10.3 **Subsequent Expenditure**

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

1.11 **Intangible Assets**

1.11.1 **Recognition**

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

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

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

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

1.11.2 **Measurement**

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

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

1.11.3 **Depreciation, Amortisation & Impairments**

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

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

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

Notes to the financial statements

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

1.12 **Leases**

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

1.12.1 **The Clinical Commissioning Group as Lessee**

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

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

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

1.13 **Inventories**

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

1.14 **Cash & Cash Equivalents**

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

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

1.15 **Provisions**

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

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

• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

Notes to the financial statements

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

1.16 **Clinical Negligence Costs**

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

1.17 **Non-clinical Risk Pooling**

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

1.18 **Contingent liabilities and contingent assets**

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

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

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

1.19 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.19.1 **Financial Assets at Amortised cost**

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

1.20 **Financial Liabilities**

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

1.21 **Value Added Tax**

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

Notes to the financial statements

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

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

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

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

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

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

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

1.25 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

Notes to the financial statements

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

In accord with IAS8 the clinical commissioning group has reviewed the impact of the implementation of IFRS 16 on the Statement of Financial Position and the Statement of Comprehensive Net Expenditure in future financial periods. The impact of the implementation of the IFRS 16 is not considered material by the clinical commissioning group and as such it has chosen not to provide any additional disclosure.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2021-22 Total
	£'000
Income from sale of goods and services (contracts)	
Non-patient care services to other bodies	744
Other Contract income	513
Recoveries in respect of employee benefits	257
Total Income from sale of goods and services	**1,514**
Other operating income	
Charitable and other contributions to revenue expenditure: non-NHS	12
Other non contract revenue	93
Total Other operating income	**106**
Total Operating Income	**1,620**

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

	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits	2021-22 Total
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	522	491	79	1,092
Non NHS	222	22	178	422
Total	**744**	**513**	**257**	**1,514**

	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits	2021-22 Total
	£'000	£'000	£'000	£'000
Timing of Revenue				
Over time	744	513	257	1,514
Total	**744**	**513**	**257**	**1,514**

3.2 Transaction price to remaining contract performance obligations

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

4 Employee benefits and staff numbers

4.1.1 Employee benefits

	Permanent Employees	Other	2021-22 Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	17,090	2,655	19,745
Social security costs	1,911	0	1,911
Employer Contributions to NHS Pension scheme	2,688	0	2,688
Apprenticeship Levy	46	0	46
Gross employee benefits expenditure	**21,735**	**2,655**	**24,390**
Less recoveries in respect of employee benefits (note 4.1.2)	(257)	0	(257)
Net employee benefits excluding capitalised costs	**21,478**	**2,655**	**24,133**

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees	Other	2021-22 Total
	£'000	£'000	£'000
Employee Benefits - Revenue			
Salaries and wages	(236)	0	(236)
Social security costs	(11)	0	(11)
Employer contributions to the NHS Pension Scheme	(10)	0	(10)
Total recoveries in respect of employee benefits	**(257)**	**0**	**(257)**

4.2 Average number of people employed

	Permanent Employees	Other	2021-22 Total
	Number	Number	Number
Total	**320.38**	**26.16**	**346.54**

No people were engaged on capital projects in 2021-22.

4.3 Exit packages agreed in the financial year

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	9,266	1	9,266
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	1	30,229	0	0	1	30,229
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	102,189	0	0	1	102,189
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**132,419**	**1**	**9,266**	**3**	**141,685**

There were no other agreed departures where special payments have been made in 2021-22

Analysis of Other Agreed Departures

	2021-22 Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	1	9,266
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval*	0	0
Total	**1**	**9,266**

The tables above report the number and value of exit packages agreed in the financial year.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook (Agenda for Change).

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

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

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme, and are included in the tables.

Ill-health retirement costs are met by the NHS Pension Scheme and are not included in these tables. In 2021-22 there has been one such payment for £120,712.

4.4 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5 Operating expenses

	2021-22 Total £'000
Purchase of goods and services	
Services from other CCGs and NHS England	6,211
Services from foundation trusts	1,067,266
Services from other NHS trusts	103,842
Purchase of healthcare from non-NHS bodies	239,122
Purchase of social care	368
Prescribing costs	134,756
GPMS/APMS and PCTMS	149,503
Supplies and services – clinical	741
Supplies and services – general	2,538
Consultancy services	151
Establishment	7,623
Transport	7,621
Premises	2,603
Audit fees	124
Other professional fees	405
Legal fees	238
Education, training and conferences	677
Total Purchase of goods and services	**1,723,790**
Depreciation and impairment charges	
Depreciation	199
Amortisation	16
Total Depreciation and impairment charges	**216**
Provision expense	
Provisions	2,286
Total Provision expense	**2,286**
Other Operating Expenditure	
Chair and Non Executive Members	596
Grants to Other bodies	50
Research and development (excluding staff costs)	50
Expected credit loss on receivables	3
Inventories consumed	30
Other expenditure	76
Total Other Operating Expenditure	**804**
Total operating expenses	**1,727,096**

The purchase of healthcare from non-NHS bodies includes grants provided to: Bedford Borough Council £2,672k, Central Bedfordshire Council £4,288k, Luton Borough Council £3,576k and Milton Keynes Council £6,965k. This is in addition to the pooled budget arrangements in place with the local authorities.

These grants are made under Section 256 of the NHS Act 2006. The grants aim to 1) reduce delays in acute discharge, ensuring that more people are supported at home and 2) support the implementation of Population Health Management.

5 Operating expenses contd

5.1 Auditor Liability Limitation Agreement

In accordance with SI2008 no.489, the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, if the clinical commissioning group contract with its auditors provides for a limitation of the auditor's liability, it is required to disclose the principle terms of this limitation.

In the contract the clinical commissioning group holds with its external auditors, the total aggregate liability (whether those liabilities are expressed as an indemnity or otherwise) for each year of this contract shall be:

Liability for all defaults resulting in direct loss or damage to property shall be subject to a limit of £2 million (two million pounds) unless otherwise stipulated by the clinical commissioning group in the letter of appointment.

In respect of all other defaults, claims, losses or damages whether arising from breach of contract, misrepresentation (whether tortious or statutory), tort (including negligence), breach of statutory duty or otherwise shall in no event exceed the greater of the sum of £2 million (two million pounds) or a sum equivalent to 125% (one hundred and twenty-five per cent) of the contract charges paid or payable to the clinical commissioning group in the relevant year of the contract calculated at the date of the event giving rise to the liability (estimated for the full year if the event occurs in the first year of the contract) unless a different aggregate limit or limits is otherwise stipulated by the clinical commissioning group in the letter of appointment following a further competition.

6.1 Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	31,775	401,468
Total Non-NHS Trade Invoices paid within target	30,373	382,993
Percentage of Non-NHS Trade invoices paid within target	**95.59%**	**95.40%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,198	1,197,646
Total NHS Trade Invoices Paid within target	1,120	1,195,373
Percentage of NHS Trade Invoices paid within target	**93.49%**	**99.81%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group incurred £nil during 2021-22 relating to claims made under this legislation.

7 Other gains and losses

	2021-22 £'000
(Gain)/loss on disposal of property, plant and equipment assets other than by sale	221
Total	**221**

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. 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.

	2021-22 £'000
Transfer of property plant and equipment	477
Transfer of intangibles	28
Transfer of inventories	97
Transfer of receivables	9,609
Transfer of payables	(132,196)
Transfer of provisions	(3,415)
Net loss on transfers by absorption	**(125,400)**

9 Operating Leases

9.1 As lessee

The clinical commissioning group occupies Sherwood Place, a building leased by NHS Property Services Limited. Although the clinical commissioning group does not yet have a formal sublease with NHS Property Services Limited, the transactions involved convey a right to use the asset. As such the transaction has been accounted for under IAS 17 and consequently no future minimum lease payments are stated in respect of this arrangement.

In respect of the other properties occupied by the clinical commissioning group, payments are fixed over the term of the contract. The ownership of each property transfers back to the lessor at the end of the lease. Restrictions, where they exist in relation to the property, relate to the use of the property for its permitted use only, not to leave the property continuously unoccupied and not to sleep or permit any persons to reside on the property.

The clinical commissioning group also leases office equipment through renewable leases. There are several separate leases, with the longest term lasting five years, although there are only less than two years left to run.

9.1.1 Payments recognised as an Expense

	Buildings £'000	Other £'000	2021-22 Total £'000
Payments recognised as an expense			
Minimum lease payments	738	12	750
Total	**738**	**12**	**750**

9.1.2 Future minimum lease payments

	Buildings £'000	Other £'000	2021-22 Total £'000
Payable:			
No later than one year	181	5	186
Between one and five years	239	2	241
Total	**420**	**7**	**426**

10. Property, plant and equipment

	Plant & machinery	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000
Cost or valuation at 01 April 2021	47	966	218	1,231
Additions purchased	0	0	0	0
Reclassifications	0	0	0	0
Disposals other than by sale	0	(100)	(218)	(319)
Cost/Valuation at 31 March 2022	**47**	**866**	**0**	**913**
Depreciation 01 April 2021	26	692	37	754
Reclassifications	0	0	0	0
Disposals other than by sale	0	(57)	(52)	(109)
Charged during the year	9	175	15	199
Depreciation at 31 March 2022	**35**	**809**	**0**	**844**
Net Book Value at 31 March 2022	**12**	**57**	**0**	**68**
Purchased	12	57	0	68
Donated	0	0	0	0
Government Granted	0	0	0	0
Total at 31 March 2022	**12**	**57**	**0**	**68**
Asset financing:				
Owned	12	57	0	68
Held on finance lease	0	0	0	0
Total at 31 March 2022	**12**	**57**	**0**	**68**

Revaluation Reserve Balance for Property, Plant & Equipment

No revaluation reserve balance was held for property, plant and equipment at 31 March 2022.

10.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22 £'000
Plant & machinery	14
Information technology	293
Total	**307**

10.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	5	5
Information technology	3	5
Furniture & fittings	25	25

11 Intangible non-current assets

	Computer Software: Purchased	Development Expenditure (internally generated)	Total
	£'000	£'000	£'000
Cost or valuation at 01 April 2021	261	19	**280**
Additions purchased	0	0	**0**
Reclassifications	0	0	**0**
Disposals other than by sale	(33)	0	**(33)**
Cost / Valuation At 31 March 2022	**227**	**19**	**247**
Amortisation 01 April 2021	233	19	**252**
Reclassifications	0	0	**0**
Disposals other than by sale	(22)	0	**(22)**
Charged during the year	16	0	**16**
Amortisation At 31 March 2022	**227**	**19**	**247**
Net Book Value at 31 March 2022	**0**	**0**	**0**
Purchased	0	0	**0**
Donated	0	0	**0**
Government Granted	0	0	**0**
Total at 31 March 2022	**0**	**0**	**0**

Revaluation Reserve Balance for intangible assets

No revaluation reserve balance was held for intangible assets at 31 March 2022.

11.1 Cost or valuation of fully amortised assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22 £'000
Computer software: purchased	247
Total	**247**

11.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	3	5
Development expenditure (internally generated)	3	5

12 Inventories

	Loan Equipment	Total
	£'000	£'000
Balance at 01 April 2021	97	97
Inventories recognised as an expense in the period	(30)	(30)
Balance at 31 March 2022	**67**	**67**

13.1 Trade and other receivables

	Current 2021-22 £'000
NHS receivables: Revenue	4,201
NHS accrued income	936
Non-NHS and Other WGA receivables: Revenue	9,444
Non-NHS and Other WGA prepayments	778
Non-NHS and Other WGA accrued income	2,483
Expected credit loss allowance-receivables	(4)
VAT	1,210
Other receivables and accruals	14
Total Trade & other receivables	**19,063**

The clinical commissioning group did not prepay any pension contributions at 31 March 2022.

13.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	223	8,621
By three to six months	5	28
By more than six months	95	15
Total	**323**	**8,664**

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2022.

13.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 01 April 2020	(1)	**(1)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(3)	**(3)**
Total	**(4)**	**(4)**

14 Cash and cash equivalents

	2021-22 £'000
Balance at 01 April 2021	(6,113)
Net change in year	5,409
Balance at 31 March 2022	**(704)**
Made up of:	
Cash held in Pooled Budget	(405)
Cash and cash equivalents as in statement of financial position	**(405)**
Bank overdraft: Government Banking Service	(299)
Total bank overdrafts	**(299)**
Balance at 31 March 2022	**(704)**

The bank overdraft is a technical overdraft representing the clinical commissioning group's cash book position. The actual bank balance was in credit by £230k.

Included within cash held in Pooled Budget is an overdrawn balance of £406k held on behalf of the clinical commissioning group by Milton Keynes Council for the Integrated Community Equipment Service and Learning Disability Service pooled budgets.

15 Trade and other payables

	Current 2021-22 £'000
NHS payables: Revenue	2,326
NHS accruals	9,059
NHS deferred income	233
Non-NHS and Other WGA payables: Revenue	36,655
Non-NHS and Other WGA accruals	76,859
Non-NHS and Other WGA deferred income	67
Social security costs	292
Tax	257
Payments received on account	6
Other payables and accruals	7,965
Total Trade & Other Payables	**133,719**

16 Borrowings

	Current 2021-22 £'000
Bank overdrafts:	
· Government banking service	299
Total overdrafts	**299**
Total Borrowings	**299**

16.1 Repayment of principal falling due

	Department of Health 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Within one year	0	299	299
Total	**0**	**299**	**299**

17 Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000
Restructuring	784	984
Redundancy	496	0
Legal claims	3	0
Continuing care	846	0
Other	2,164	0
Total	**4,293**	**984**
Total current and non-current	**5,277**	

	Restructuring £'000	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2021	**400**	**267**	**0**	**1,135**	**1,614**	**3,415**
Arising during the year	1,768	496	3	846	550	**3,663**
Utilised during the year	(226)	(132)	0	(66)	0	**(425)**
Reversed unused	(174)	(135)	0	(1,068)	0	**(1,377)**
Unwinding of discount	0	0	0	0	0	0
Balance at 31 March 2022	**1,768**	**496**	**3**	**846**	**2,164**	**5,277**
Expected timing of cash flows:						
Within one year	784	496	3	846	2,164	**4,293**
Between one and five years	984	0	0	0	0	**984**
After five years	0	0	0	0	0	0
Balance at 31 March 2022	**1,768**	**496**	**3**	**846**	**2,164**	**5,277**

Over the last two years, the role and function of the clinical commissioning group's corporate office spaces has changed significantly with a more flexible approach to working from home. The clinical commissioning group's future corporate estates requirements have been re-assessed and also taking account for the requirements of the future Integrated Care Board (ICB) it has been agreed that the office bases across Bedfordshire, Luton and Milton Keynes be rationalised. Several bases will be downscaled. Whilst the clinical commissioning group is attempting to seek additional tenants, the clinical commissioning group will continue to be liable for lease costs for the excess areas until the lease-end/break clause dates in 2025 and 2024 respectively. This restructuring provision £1,768k relates to the ongoing liability for costs of this excess space.

As part of the planned creation of an Integrated Care Board (ICB) from 1 July 2022 there is a requirement to establish a new Integrated Care Board structure. The process to establish the new Integrated Care Board has placed some Executive Directors of the clinical commissioning group at risk. A £496k 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 2021 that are undergoing an appeal process. The clinical commissioning group has assessed the likelihood of a successful appeal based on the outcome of previous appeals and the remaining balance has been reported as a contingent liability in Note 18.

Other provisions are made up of £1,614k provision for liabilities to be concluded with partner organisations following the COVID-19 pandemic response, a legacy £470k employer superannuation liability and £80k for dilapidations on terminating a lease agreement on premises relating to the restructuring of the clinical commissioning group.

18 Contingencies

	2021-22 £'000
Contingent liabilities	
Continuing Healthcare	1,325
Net value of contingent liabilities	**1,325**

The contingent liability for Continuing Health Care relates to cases from April 2013 to March 2021 that are undergoing an appeal process. A provision has been established for the likely cost of successful appeals (see Note 17) with the contingency above reflecting the remainder of the liability should the outcome of the appeals go against the clinical commissioning group.

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group identified £nil during 2021-22 relating to contingent assets.

19 Commitments

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group had £nil capital commitments or other financial commitments.

20 Financial instruments

20.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

20.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

20.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

20.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

20 Financial instruments cont'd

20.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

20.1.5 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.

20.2 Financial assets

	Financial Assets measured at amortised cost	2021-22 Total
	£'000	£'000
Trade and other receivables with NHSE bodies	4,931	4,931
Trade and other receivables with other DHSC group bodies	2,716	2,716
Trade and other receivables with external bodies	9,431	9,431
Cash and cash equivalents	(405)	(405)
Total at 31 March 2022	**16,673**	**16,673**

20.3 Financial liabilities

	Financial Liabilities measured at amortised cost	2021-22 Total
	£'000	£'000
Loans with external bodies	299	299
Trade and other payables with NHSE bodies	1,100	1,100
Trade and other payables with other DHSC group bodies	10,260	10,260
Trade and other payables with external bodies	121,503	121,503
Total at 31 March 2022	**133,162**	**133,162**

20.4 Fair Value

In reporting the value of the financial assets and liabilities in notes 20.2 and 20.3 the clinical commissioning group has assessed that given the nature of its financial assets and liabilities the fair value is equal to the current value and therefore no further disclosure is required.

21 Operating segments

The Clinical Commissioning Group operates as one operating segment and that is to commission healthcare.

22 Pooled budgets

NHS Bedfordshire, Luton and Milton Keynes clinical commissioning group entered in to pooled budgets with Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council.

Under each arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budgets are hosted by the four Councils and are for Community Equipment Services, the Learning Disability Service and Children Service Pools, the Better Care Fund, Winter Funds and Discharge Arrangements, as listed below.

			Amounts recognised in Entities books ONLY 2021-22			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**
Section 75 Agreement	BLMK CCG & Luton Borough Council	Pooling of funds for LD, Children's Services, Community Equipment, BCF, Winter Funds & Hospital Discharge Arrangements	0	0	0	23,985
Section 75 Agreement	BLMK CCG & Milton Keynes Council	Pooling of funds for BCF, Winter Funds & Hospital Discharge Arrangements	0	0	0	21,520
Section 75 Agreement	BLMK CCG & Bedfordshire Borough Council	Pooling of funds for BCF, Winter Funds & Hospital Discharge Arrangements	0	0	0	14,865
Section 75 Agreement	BLMK CCG & Central Bedfordshire Council	Pooling of funds for BCF, Winter Funds & Hospital Discharge Arrangements	0	0	0	24,016
Integrated Community Equipment Store	BLMK CCG, Central Bedfordshire Council & Bedford Borough Council	Loan of Community Medical Equipment	0	0	0	1,447
Learning Disability Pooled Budget	BLMK CCG & Milton Keynes Council	Joint commissioning of learning disability services to support clients in the community	77	-77	0	1,503
Integrated Community Equipment Pooled Budget	BLMK CCG & Milton Keynes Council	Provision and maintenance of equipment in the local community	495	-495	0	853

23 Related party transactions

Individual Governing Body members, having significant influence over the management of the Clinical Commissioning Group, are considered to be related parties. Details of transactions between the CCG and Governing Body members are detailed in the Remuneration Report within the Annual Report.

Entities controlled by Governing Body members, or a close family member, are also considered to be a related party as defined by IAS 24. There were no entities that fell within this definition in 2021/22.

Under IAS 24 entities in the same group as the Department of Health are considered to be related parties.

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group had a number of material transactions with other NHS and other government bodies. Materiality in this context is considered to be over £10m and transactions have been prepared on an accruals basis.

Bedfordshire Hospitals NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Central and North West London NHS Foundation Trust
East London NHS Foundation Trust
East and North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Milton Keynes Hospital NHS Trust
South Central Ambulance Service NHS Foundation Trust
Bedfordshire Borough Council
Central Bedfordshire Council
Luton Borough Council
Milton Keynes Council

24 Events after the end of the reporting period

The Health and Care Act (2022) received Royal Assent on the 28 April 2022, after the end of the reporting period. It introduced significant reforms to the organisation and delivery of health and care services in England. The Act abolishes Clinical Commissioning Groups (CCG) and establishes Integrated Care Boards (ICB). NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board will take on the commissioning function of the CCG and the assets and liabilities of the CCG will transfer to the ICB. The expected date for the transfer is 01 July 2022. It is classified as a non-adjusting event as it is an event that arose after the end of the reporting period and therefore does not result in adjustment to the financial statements. It is disclosed for completeness, to support the users of the financial statements to reach a proper understanding of the financial position of the CCG; the disclosure supplements Note 1.1.

There are no other adjusting events after the reporting period which will have a material effect on the financial statements of NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group.

25 Losses and special payments

25.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Fruitless payments	1	22
Total	**1**	**22**

25.2 Special payments

The clinical commissioning group made no special payments during 2021-22.

26 Third party assets

The clinical commissioning group had £nil third party assets during 2021-22.

27 Financial performance targets

The clinical commissioning group has a number of financial duties under the NHS Act 2006 (as amended).

The clinical commissioning group's performance against those duties was as follows:

	2021-22 Target £'000	2021-22 Performance £'000	2021-22 Variance £'000	Duty Achieved
Expenditure not to exceed income	1,763,304	1,751,707	11,597	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	0	-
Revenue resource use does not exceed the amount specified in Directions	1,761,684	1,750,087	11,597	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	-
Revenue administration resource use does not exceed the amount specified in Directions	19,258	18,664	594	Yes