

Annual Report

1 April 2024 – 31 March 2025



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Foreword from Manjeet Gill

Acting Chair of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

I am pleased and proud to introduce the Annual Report and Accounts for the NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) for 2024/25, and to reflect on the progress we have made as a system over the past 12 months.

This year, we have demonstrated what is possible when all organisations who are responsible for supporting and delivering health and care services work collaboratively and with a shared ambition to increase healthy life expectancy for the just over one million people who live in our four areas – Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

Our commitment to delivering a system-wide, clinically-led Health Service Strategy has given us a clearer vision for the future — one that prioritises integrated high-quality care, reduces inequalities and ensures that every individual in our communities can live a longer, healthier life. The progress we have made in 2024/25 is a testament to the dedication and expertise of our teams across the NHS, local government, voluntary and community organisations and beyond.

During 2024/25, despite significant challenges and pressures, we have significantly improved access to care. We have increased general practice appointments by 7.95% (daily average), helping to ensure that more of our residents receive the support they need when they need it. A key focus this year has been our estate. We are pleased to have delivered 15 primary care estate projects across BLMK, including transforming empty NHS spaces into additional capacity - creating environments that better serve both patients and staff.

We are committed to putting local people at the centre of our work. In 2024/25, we refreshed our Working with People and Communities Strategy and delivered on our commitment to involve residents by engaging with, listening to and understanding more than 2,000 local people, ensuring that resident voices shape our services and inform the decisions we make. Our proud tradition of kicking off every ICB Board meeting by listening to a person resident story remains central to who we are.

We are proud to support our four places and have made good progress in establishing a neighbourhood model of care. The Bletchley Pathfinder, Luton 2040 and Bedfordshire's welcoming spaces initiatives are just some of the remarkable programmes that are creating healthier, more connected communities – all as part of continued efforts to give more people access to care closer to home.

Tackling health inequalities remains a clear priority in an area which is as rich in cultural heritage as ours. We have worked collectively to identify and address the root causes of inequality, applying what we have learned to work towards eliminating preventable diseases such as cardiovascular disease and diabetes among those most at risk. Our System-wide Learning Action Network, which we have established alongside the Institute of Healthcare Improvement, is bringing together local residents with health and care professionals to co-produce community led approaches to tackling preventable conditions which reduce healthy life expectancy in our area. These efforts are already making a difference and I am eager to see how this work progresses.

I am proud of BLMK's continued strong financial stewardship. This includes achieving £106 million in system efficiencies in 2024/25—exceeding our target by more than £3 million and delivering a balanced budget too.

Our achievements in 2024/25 reflect the strength of our partnerships, the dedication of our workforce and the resilience of our system. As we look ahead, we remain focused on delivering high-quality, integrated and sustainable care for everyone across BLMK.

Together, we are shaping a future where every resident has the opportunity to thrive and live a longer, healthier life.

Manjeet Gill

Performance Report

Statement by Felicity Cox, Chief Executive Officer

Welcome to NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) Annual Report and Accounts for 2024/25.

I am proud to lead our ICB, an organisation responsible for supporting more than 1million people from many diverse backgrounds to live long and healthy lives. I am pleased to reflect on the progress we have made alongside our partners and residents to deliver on our ambitious plans.

2024/25 has been a challenging year. We have worked hard to meet ambitious performance targets, reduce waiting times and increase appointments against a backdrop of tight financial controls and industrial action. In the face of these challenges – and many more - we have so much to be proud of as a system.

We have made great strides in transforming how we work to deliver for local people.

- Our innovative unscheduled Care Hub has averted more than 1,800 hospital admissions.
- We have increased primary care appointments – delivering 1,669,754 appointments between September and November 2024, which is a 10.38% increase on the same period in 2023/24
- Pharmacy First consultations were up by 60% in December 2024.
- We have rolled out a huge expansion of self-referral, including for musculoskeletal services.
- We have agreed our Health Services Strategy which underpins our ambition for a more sustainable system.
- We have established two new mental health support teams in schools in Luton and Milton Keynes to provide additional support to school age children.
- Our dementia diagnosis rate has consistently been ranked highest in the East of England Region – and has remained an average of 3.7% above the national average all year.
- We have launched a refreshed transforming care pathway for children with learning disabilities and autism.
- We co-produced with residents a major procurement to re-shape our musculoskeletal service.

The maturity of our partnerships has enabled us to deliver a break-even budget at year end - an achievement that did not look certain at points within the year. This is the third year in a row that we have successfully balanced our books. We remain committed to listening to and delivering for local people and stand ready to rise to the challenge in 2025/26 which promises to be a year of transformation – with the introduction of the 10-Year Plan for Health and Care and a wider focus on improving NHS performance and productivity. These are missions we are already working hard to deliver in BLMK.

Felicity Cox

Accountable Officer

19 June 2025

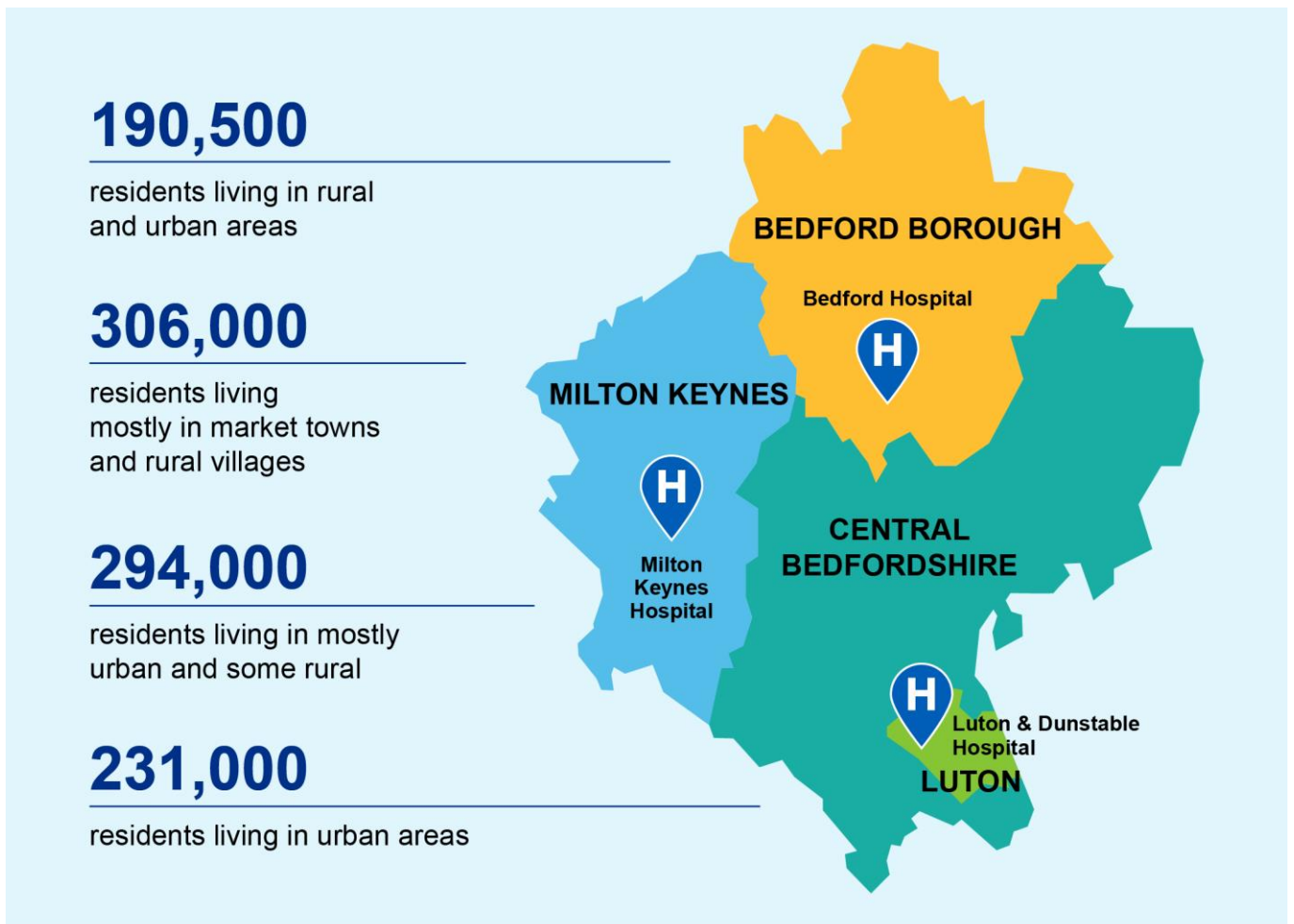
Performance Overview

The performance overview section provides a look at how NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) operates, its structures and strategic priorities and our progress during the period 1 April 2024 to 31 March 2025. It also describes the area in which we work, detailing our four places and the work being done to make sure that services are being delivered in an integrated way as close as possible to where residents live.

Our population

The BLMK area is covered by four local authorities who we work closely with - Bedford Borough Council, Central Bedfordshire Council, Luton Council and Milton Keynes City Council. ¹We are also proud to work with Buckinghamshire Council for the 6,000 residents there who form part of the ICB's geography.

BLMK is a culturally diverse and vibrant population of just over 1 million residents living in urban and rural areas with varying health needs. The most common identified health condition in BLMK is high blood pressure (hypertension).



¹ The area covered by the ICB includes the following Lower Layer Super Output Areas in the County of Buckinghamshire: E01017695, E0107696, E01017669 and E01017670

Forecasts suggest the population of BLMK will grow by 25% between 2023 and 2043. This compares to 15% in the ten years between 2011 and 2021. Forecast growth is highest in Central Bedfordshire at 31%, followed by Bedford Borough (28%) and Milton Keynes (27%), with lowest growth forecast in Luton (14%).

Growth is forecast in nearly all age groups across all areas. Luton is forecast to have lowest growth in working-age groups and will continue to have a younger age profile. The number of people aged 65 and over is forecast to increase by 63% across BLMK overall, with the highest percentage growth in Milton Keynes (70%), followed by Bedford Borough (64%), then Central Bedfordshire (60%), with the lowest percentage growth in Luton (56%).

The ICB is proud to have invested in the development of a Population Health Intelligence Unit (PHIU) in order to develop local analytical capacity and foster data-driven decision making. A core part of the PHIU's initial focus has been on developing our forward planning. The PHIU is currently working on the development of condition-specific forecasts of patient numbers and healthcare needs. This information will help to inform future strategic planning and has been at the centre of our [Health Services Strategy](#).

About the ICB

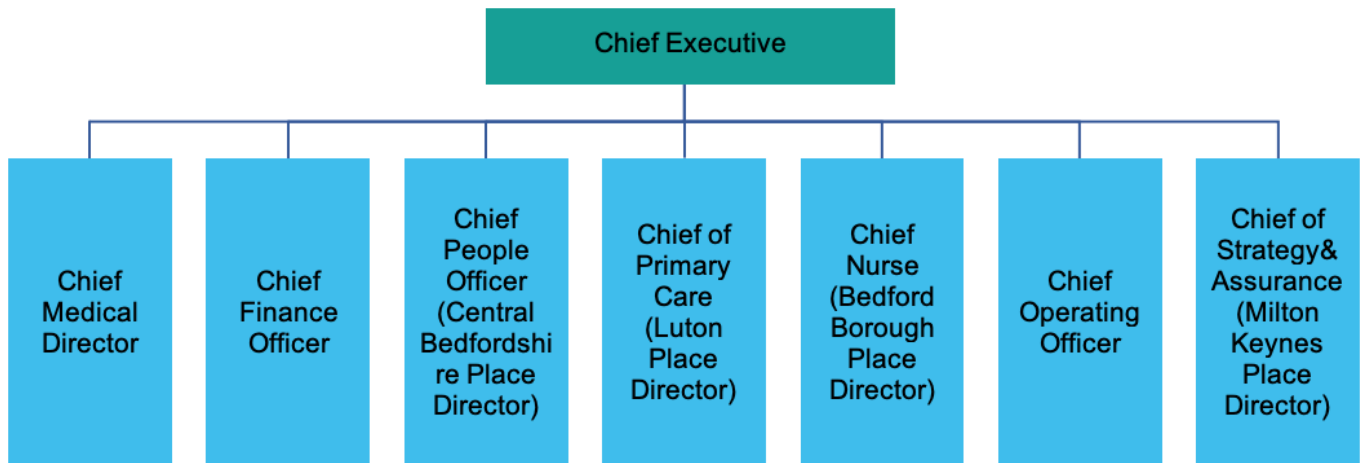
BLMK ICB is a statutory NHS organisation which brings together NHS organisations, local authorities and other service provider partners to work to improve people's health outcomes.

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

The ICB enables and ensures there is effective collaboration between NHS providers, primary care, local councils, hospices, voluntary community and social enterprise (VCSE) organisations and Healthwatch partners across all areas of BLMK.

As shown in the Executive Structure diagram on the next page, we have Place Link Directors (Executive of the ICB) who work with Place Teams and partners to work collaboratively on local priorities. The ICB's work is informed by, responds to and supports, the priorities identified locally and set out in Joint Health and Care Strategies (see page 17).

Executive Structure Diagram

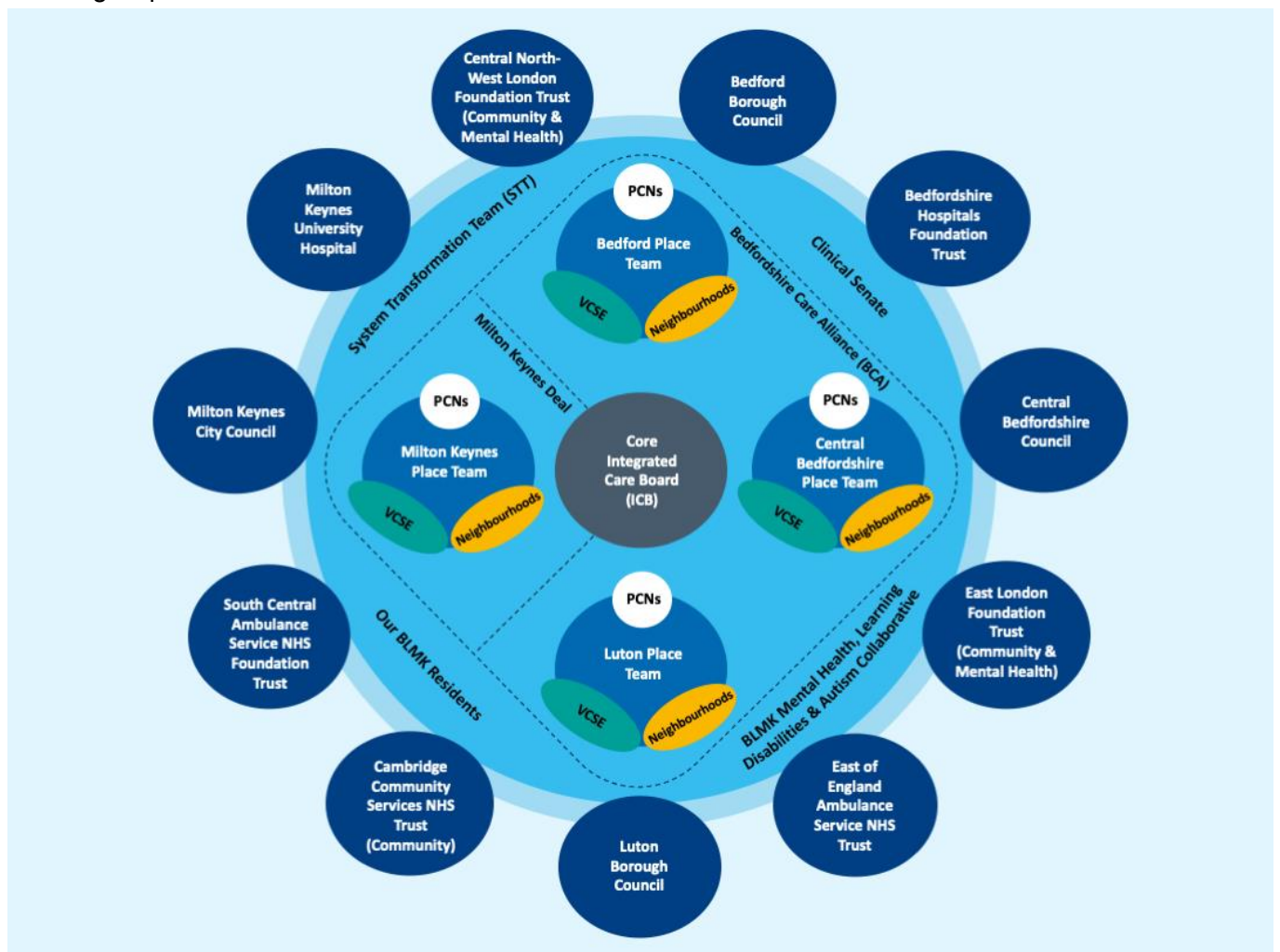


Our Target Operating Model

The ICB's new Target Operating Model (TOM) was introduced from April 2024. It established:

- A core ICB team
- Four place teams working closely with neighbourhoods / Primary Care Networks
- A System Transformation Team

Further evolution in 2025/26 will support continued delivery of system wide strategies and meet the evolving requirements of ICBs.



Our strategic priorities

A key focus of the ICB is to influence effective collaboration among system partners so that complex challenges specific to the BLMK area can be addressed. As a system, we have five strategic priorities (agreed in 2022/23 following discussions with our partners, local people and patient forums). In 2024/25 the ICB remained committed to delivering against these priorities.



These priorities are informed by the strategic objectives of our partner organisations. They aim to improve health and wellbeing and equality in our communities, make the best use of resources and shape the way we work as a system in BLMK. They are supported by our seven cross-cutting 'enablers' (shown in the diagram above). The headline progress made against our five priorities and our seven enablers in 2024/25 can be found on page 17.

Our Board Assurance Framework serves as the central tool for managing strategic risks – those with the potential to impede the ICB's ability to achieve its strategic objectives. These are listed in the table on the next page. Further information on our risk management arrangements can be found on page 103.

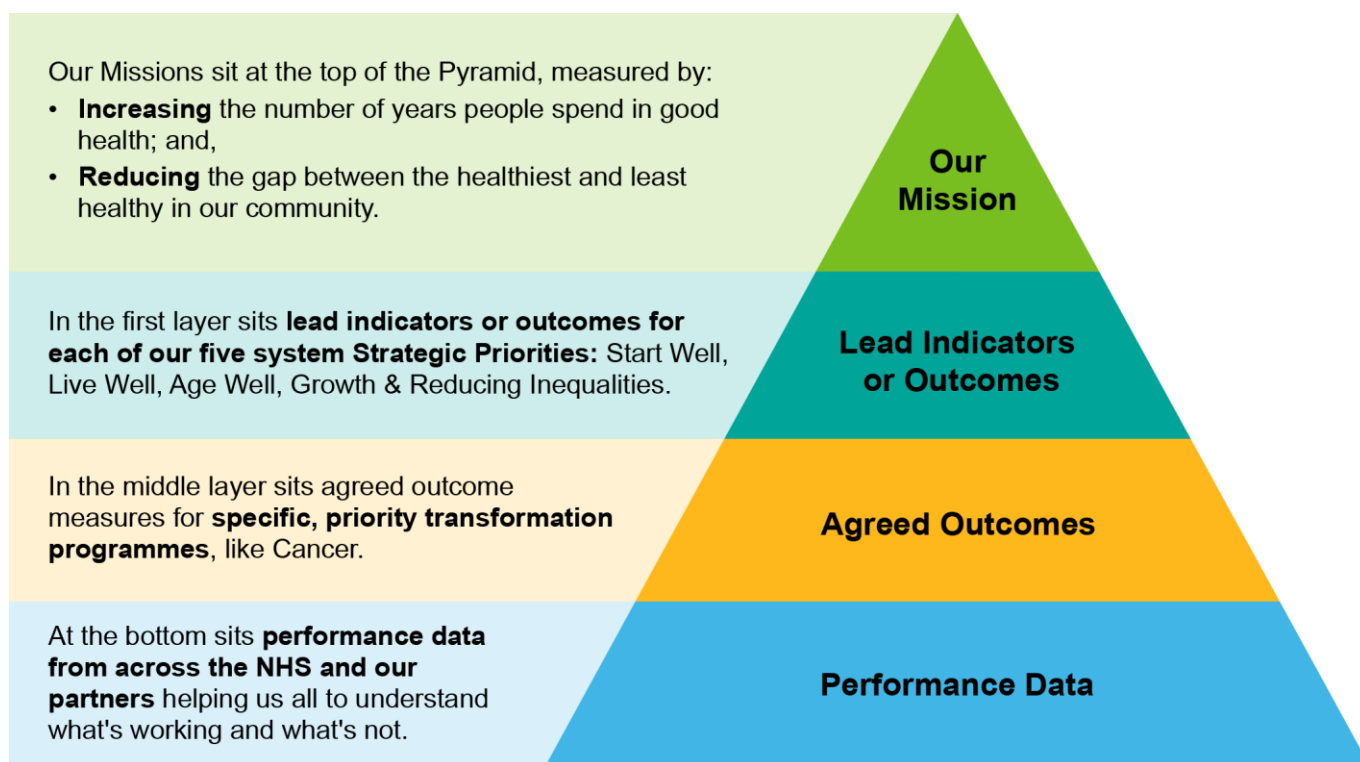
Board Assurance Framework (BAF)

Ref	Risk	Risk Scores as at 31 March 2025
001	Recovery of Elective Services	20
002	Developing suitable workforce	20
003	Pressure on Urgent and Emergency Care (UEC) in the BLMK System	20
004	Widening inequalities	16
005	System Transformation	20
006	Financial Sustainability & Underlying Financial Health	20
007	Climate Change: Health, inequality and healthcare service impacts from Climate Change and environmental degradation and risk of not achieving net zero.	16
008	Impact of Population Growth on Health and Care Services Infrastructure	20
009	Impact of Rising Cost of Living on Residents and Staff Wellbeing	16
010	Partnership working	9
011	Health literacy	16
012	System Collaboration	6
013	VCSE sustainability - Impact on Delivery of ICS Strategic Priorities	16
014	Maternity Services at Bedfordshire Hospitals Foundation Trust	16

Our transformation priorities

At a Board Seminar in January 2025 (see page 92), three transformation priorities were agreed that would have a significant impact on resident outcomes and make services more efficient. Work is underway on the transformation areas of Complex Care, End of Life Care and Admission Avoidance and Discharge Pathways.

BLMK is on a journey to lead the way when it comes to an Integrated Care System (ICS) measuring impacts with a consistent focus on population health. In September 2024, our Board agreed our new Measurement Framework, which we call the 'Data Pyramid'.



Our Impact Statement on page 17 shows the progress made against each of our lead indicators and we are in the process of expanding it to cover our transformation programmes too.

The BLMK Portfolio Report provides a comprehensive overview of progress with our overall portfolio, offering visibility into ongoing changes and fostering collaboration among teams.

We are working alongside the [Institute for Healthcare Improvement](#) (IHI) as part of a three-year partnership to harness the power of improvement in our system. The IHI brings world-leading expertise and broad international experience in data-driven health systems and we are proud to be one of the first ICSs in the country to work with it in this way.

The collaborative approach for this work combines three aspects of IHI strategic guidance in planning and design, implementation support and capacity building to support improvement and transformation. The approach contains three phases of work to build and sustain the work in the ICS over approximately five years, during which time the IHI would transition from co-leadership to coaching and support to ensure local ownership for the long-term sustainability.

- **Phase 1 (12 months 2023-2024): Discovery, Design, and Capacity Building** - The ICS and IHI developed a common understanding of the current systems, opportunities, challenges, resources and gaps to move from isolated impact within an organisation, facility, agency, or subpopulation, to collective impact at regional level. This work concluded in 2024.
- **Phase 2 (Years 2-3 2024-2026/27): Learning and Action Network** - With the foundation built during Phase I, the IHI, BLMK ICS and other community partners are making measurable progress through a 24-month Learning and Action phase. Phase 2 began with the launch of the Learning Action Networks (LANs – see page 39) for priority population workstreams at place, with associated cross-sector improvement teams.
- **Phase 3 (Year 4 and Beyond 2026/27): Diminishing role for IHI & Transition to a Learning Health Network (LHN)** - While year's 1-3 are about developing a mechanism for collective action of the priority areas and using Learning and Action Networks to begin to see improvements at place, the ICS will require a longer-term effort to see substantial reduction in inequities and dramatic improvement in overall outcomes.

The BLMK Portfolio Report provides assurance on the progress of key portfolios, programmes and projects across the BLMK ICS. Produced quarterly for the Chief Executive Officer's Group, Quality and Performance Committee and the Board of the ICB, the report is generated directly from Verto 365, the ICB's Project Management & Collaboration System.

Our Joint Forward Plan

The purpose of this Plan – required to be published by every ICB - is to set out how we will:

- Deliver our Integrated Health and Care Strategy to improve health outcomes and tackle inequalities.
- Deliver our strategic objectives in accordance with the statutory requirements of ICBs, including supporting our partner NHS and Local Authority organisations to deliver their own mandates.
- Deliver the health service's objectives set out by NHS England.
- Provide a medium-term view of how these will be delivered, for a minimum of five years.

Going beyond the NHS five-year requirement, our Joint Forward Plan better aligns with local authority planning timelines and covers the time period up to 2040.

Our [Joint Forward Plan](#) is updated annually and the most recent update was published on 31 March 2025 following approval from the ICB Board.

Our strategies

Our key strategies have been developed in collaboration with our partner organisations.

- **Health and Care Partnership Strategy:** The BLMK Integrated [Health & Care Strategy](#) sets out our overall ambition to tackle inequalities and improve health outcomes for our residents. Progress made in delivering the Health and Care Strategy is provided on page 17.
- **Data Strategy 2021-2025:** The BLMK Integrated Care System (ICS) [Data Strategy](#) seeks to identify the priorities we must tackle to address our four ICS purposes of direct care, case identification, supporting self-care and system redesign. Information on our work in this area is available on page 70.
- **Digital Strategy 2022-2025:** The BLMK Health and Care Partnership [Digital Strategy](#) sets out how digital technology can support us to deliver the best outcomes for our residents and support our teams to work effectively by making the best use of technology. Information on our work in this area is available on page 70.
- **People Strategy:** The BLMK Integrated Care System (ICS) [People Strategy](#) presents six People Strategy workstreams. Information on our work in this area is provided on page 75.
- **Working with People and Communities Strategy 2024-2027:** The BLMK [Working with People and Communities Strategy](#) was produced following extensive engagement and builds on the good practice championed by NHS partners, local authorities, Healthwatch and the VCSE's. Information on our work in this area is available on page 65.
- **Learning Disabilities and Autism Strategy 2023-2026:** The BLMK [Learning Disabilities and Autism Strategy](#) brings partners together to reduce inequalities for people with learning disabilities and autistic people by listening to people and increasing awareness of their needs. Information on our work in this area is available on pages 37 and 55 and page 96.
- **Health Service Strategy 2024-2040:** The BLMK Health and Care Partnership [Health Service Strategy](#) was developed in discussion with NHS providers in BLMK and through the engagement of those who provide publicly funded health services and are key in the delivery of joined up integrated care. It describes how leaders in the provision of health services in BLMK commit to working together over the years ahead.

Working in partnership

We have continued to strengthen our work together with a wide range of partners, including:

Voluntary, community and social enterprises (VCSE): VCSE Partners in BLMK have played a key role in improving healthcare access, enhancing community collaboration and addressing health inequalities through targeted initiatives in 2024/25.

We focused on enhancing partnerships with a range of stakeholders, building cross-sector understanding, and overcoming the challenges of partnership working. Examples include:

- Involvement in place-based partnerships and delivery of place priorities.
- Strengthening of the VCSE Strategy Group and the three VCSE Mental Health Alliances.
- Convening the BLMK ICS Climate and Health Seminar and the Creating a Fairer BLMK – Sharing & Learning Event.
- Attending and contributing at BLMK system planning events including:
 - September 2024 - Winter Planning Workshop
 - October 2024 - BLMK Personalised Care conference
 - January 2025 – Transformation Priorities Workshop
- Supporting winter messaging and facilitated healthcare engagement with community events.

ICB funding has been allocated to enable senior VCSE representatives to participate in strategic NHS planning. This has strengthened VCSE representation at place and system, supporting the development of integrated working and shaping strategic responses in a rapidly changing environment. The VCSE Co-chairs of the BLMK VCSE Strategy Group have become members of the Health and Care Partnership, supported the system risk work on VCSE sustainability and took part in the stakeholder panel for an executive director role within the ICB.

Health Equity Funds have been allocated to strengthen VCSE infrastructure to deliver health and care services that are more efficient and effective. It is helping to build the evidence base for sustainable integration of the VCSE into pathway redesign and delivery of new models of care that improve health outcomes and reduce health inequalities. The funds will support VCSE involvement in the Age Care Technology (ACT) project at Bedford Borough Place and enable VCSE attendance at the NHS Employers Diversity in Healthcare programme.

Over the course of 2024/25, our strategic partnership with the VCSE has strengthened further and will put us on a solid footing for delivering system improvement through 2025/26.

Healthwatch: The ICB and the four local Healthwatch organisations signed a Memorandum of Understanding (MoU) in September 2023. The MoU sets out the details of our commitment to work in partnership to realise shared ambitions to improve the health and wellbeing of the people of BLMK. Healthwatch is represented on the ICB Board and Health and Care Partnership. The ICB convenes a monthly meeting with the CEOs of Healthwatch to shape our work together.

Committees of the Board: In addition to organisations from across the ICS being members or participants of the Board of the ICB, BLMK ICS organisations are also members or attendees on many of the committees of the Board including Bedfordshire Care Alliance Committee, Mental Health Learning Disabilities and Autism Collaborative Committee and the Audit and Risk Assurance Committee. For more information on the committees of the Board please see page 92.

Consultative forums: The Board of the ICB engages with partners to discuss and agree shared strategic direction through the following forums:

- Health and Care Senate (Professional Leadership Group) - provides health and care professional leadership and advice and has a role in ensuring that the health and care professional voice is heard at every level of the ICS.
- Place Based Partnerships - we have worked in partnership with local authorities, NHS Trusts and local organisations to establish place-based working as detailed below.

Health and Wellbeing Boards: Health and wellbeing boards play a leading role in setting strategic direction to improve the health and wellbeing of people locally. The ICB is a partner in five health and wellbeing boards:

- Bedford Borough
- Central Bedfordshire (known as the Joint Leadership Group)
- Luton
- Milton Keynes (known as the Milton Keynes Health and Care Partnership)
- Buckinghamshire

Working at place: We are proud of our work together with local partners in our four places. Place teams play a key role in facilitating collaborative, place-based action to address health and care priorities across the Integrated Care System. Working closely with stakeholders, the teams translate national and system requirements into meaningful improvements for residents.

A short summary on each place is provided below and information on each local authority Health and Wellbeing/Care Strategy can be found on pages 22 to 24.

Further information on achievements at place are provided throughout the Performance Analysis section from page 18.

Bedford Borough: The head of the Bedford Borough place team is a joint post between the ICB and Bedford Borough Council. The Bedford Borough Executive Delivery Group (EDG) is formed of partners from across the council, ICB, community services and health providers. It oversees the Place Based Plan which is currently being redeveloped to include four priority areas - Starting Well, Living Well, Ageing Well and Health Estate.

These priorities see a focus on a range of health-related challenges where outcomes for residents in Bedford Borough are worse than those in wider BLMK or across the country. Work will continue to improve outcomes in the following areas:

- reduce childhood obesity
- improve children's oral health
- increase uptake of antenatal and childhood immunisations
- improve cardiovascular disease prevention and management
- increase the uptake of cervical and breast cancer screening programmes
- support people over 65 to live independently for longer
- improve local health estate

These priorities will be delivered through a range of localised projects at neighbourhood level, as well as wider initiatives led by colleagues from Public Health.

Central Bedfordshire: Key areas of focus for the Central Bedfordshire Place Team during 2024/25 has been the continued development of the Integrated Neighbourhood Working (INW) programme at place and building on existing projects and models of care. The place team has:

- Worked in collaboration with system partners to co-design a plan for Central Bedfordshire that creates a framework for delivering neighbourhood working that supports an evidence-based approach.
- Worked with partners to evaluate and review models of care and agree measures that will evidence the impact for residents in Central Bedfordshire.
- Coordinated a series of meetings and are planning drop-in sessions to continue the development of this work and align to the Neighbourhood Health Guidelines 2025/26 (published by NHS England January 2025).

During 2024/25 the place team established a dementia task and finish group and developed a joint plan with partners to improve performance around dementia diagnosis.

Luton: During 2024/25, the Luton Place team continued to strengthen local partnerships and deliver targeted initiatives that address health inequalities and improve population health outcomes. The focus remained on prevention, early intervention and community engagement, with particular attention to cardiovascular health, integrated neighbourhood working and support for vulnerable groups such as care home residents. While some initiatives began prior to this reporting period, they have matured and delivered meaningful results this year, demonstrating the ongoing impact of place-based working for residents across the borough.

Key achievement include:

- Coordinated a series of neighbourhood events that brought together partners from health, social care, education, employment, and the voluntary sector, fostering greater collaboration and access to local support services.
- Commenced the Hypertension Learning Action Network (see page 39) in November 2024, focusing on early identification of hypertension in Indian and Black African residents aged 40–50. This initiative is addressing known health disparities and has seen increased uptake of preventative checks within these communities.
- The Luton Medicines Management Care Home Team delivered adult social care training to 300 staff members in January 2025, improving medication safety and confidence in clinical practices across local care settings.

Luton has also seen great success following the Luton [NHS App](#) launch in October 2024, which has driven digital engagement and prompted a 20% increase in monthly logins.

Milton Keynes: In Milton Keynes, the ICB has collaborated with MK partners to establish the [MK Deal](#), which aligns with the ICS's strategic priorities and the system's [Joint Forward Plan](#). This initiative focuses on improving system flow, tackling obesity, children's mental health and integrated neighbourhood working through the [Bletchley Pathfinder](#).

Key achievements include:

- Establishment of an Integrated Discharge Hub at Milton Keynes Hospital, featuring a Housing Officer and VCSE roles to connect patients with community resources, reducing the time they spend in hospital.
- The new Care Academy has launched a training program to support Health Care Assistants, reablement workers, and carers in promoting movement and mobility.
- Efforts to tackle obesity include a digital wearable program for Type 2 diabetes, training within primary care and the commissioning of a new service focused on children and families.
- For children and young people, initiatives include appointing a Clinical Psychologist to Child and Adolescent Mental Health Services (CAMHS), multi-professional training on Autism Spectrum Conditions, and commissioning the Crisis Sanctuary service.
- The Bletchley Pathfinder has made notable progress since its launch in October 2024, organising monthly Bletchley Get Togethers, providing support services, health promotion and wellbeing activities. Additionally, funding was provided to over 30 local groups for activities such as gardening, football and bereavement support. Efforts to help families eat well included healthy recipe kits, school fruit and vegetable stalls and budget-friendly cooking sessions.
- We have developed and are testing a multi-disciplinary team (MDT) model through the Bletchley Pathfinder to improve outcomes for children and young people at risk of school exclusion or low attendance due to emotionally based school avoidance or unmet needs. This holistic, family-centred approach aims to enhance access to local health and care services, closely linking with community-based support led by a named support coordinator in a local school.

Performance Analysis

This section of the Annual Report reviews our performance over the past year. We focus on key metrics from the 2024/25 NHSE operational plan and critical service areas such as patient access, wait times, and the quality and safety of care. We also highlight our achievements, our challenges, and our strategies to enhance performance and patient outcomes, ensuring we meet the needs of our local population. Additionally, it provides ongoing initiatives and plans for continued progress in 2025/26.

Health and Care Strategy

BLMK's [Health and Care Strategy](#) (January 2023), agreed by the Health and Care Partnership (see page 95), established five strategic priorities for the BLMK system. These are set out on pages 18 to 21, alongside the headline progress made against each in 2024/25, the seven 'enablers' presented in the same strategy, and the work done to advance each.

We are proud of what our partnership has achieved. We have selected three highlights per priority and enabler but the list is not exhaustive as many more interventions across the BLMK system contribute to the performance changes identified than just those presented in this section.

In 2025, we look forward to refreshing our system strategy with our partners and will incorporate the objectives set out in the NHS 10 Year Plan being published in 2025/26.

Progress against the Health and Care Strategy was reported to the Health and Care Partnership Committee in February 2025 - as shown on pages 18 to 21)



Start Well

Lead Outcome Measure and Performance:

Increasing the % of children who reach a [Good Level of Development \(GLD\)](#) at the end of the Early Years Foundation Stage.

The percentage of children achieving GLD has increased in all four places since 2021/22. The percentage in Luton remains lower than the national average, although shows the greatest increase since 2021/22.

Table shows, school readiness: percentage of children achieving a good level of development at the end of Reception.

Area	Baseline (2021/22)	2023/24	% point change
Bedford	63.8	66.2	2.4
Central Beds	65.5	68.9	3.4
Luton	56.6	62.0	5.4
Milton Keynes	66.7	68.4	1.7
England	65.2	67.7	2.5

Headline initiatives in 2024/25

1. Each place now has a robust multi-agency Local Area Partnership focused on improving outcomes for Children & Young People with Special Education Needs and Disabilities. This means that more children have access to some health services more quickly. A good example is the new self-referral pathway to Speech and Language Therapy advice for under 5s.
2. We have launched a refreshed Transforming Care Pathway for children with Learning Disabilities & Autism at risk of admission to an inpatient [Children and young people's mental health services](#) (CAMHS) provision. The pathway was co-produced with young people and now includes easy to access self-referral, enabling more young people to manage their own long-term needs.
3. Two new Mental Health Support Teams are in place in schools in Luton and MK, meaning that school-age children have more access to mental health support in their school.



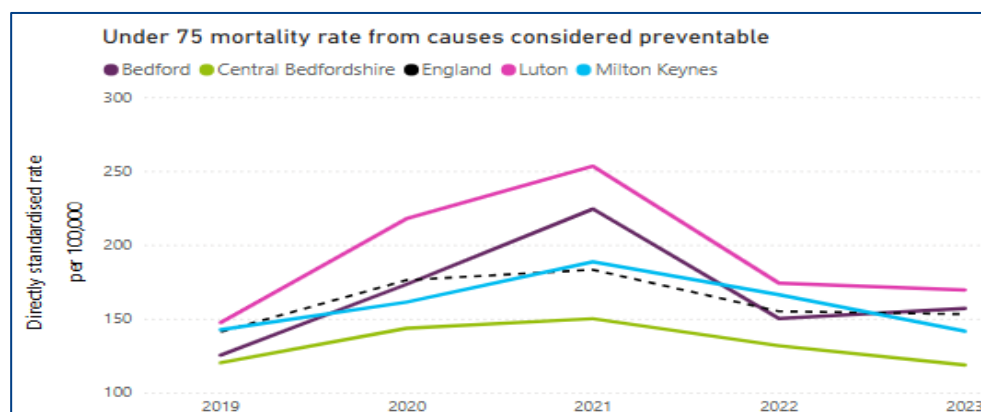
Live Well

Lead Outcome Measure and Performance:

Reducing preventable premature mortality.

Change over time in preventable premature mortality for our four places and England is shown below, starting from the 2019 baseline. All areas saw a large rise over 2020 and 2021 due to COVID-19 with rates then falling in 2022; however in Bedford and in Luton that fall has not continued into 2023 and these areas are still above their 2019 baseline.

Graph showing under 75 mortality rate from causes considered preventable: directly standardised rate per 100,000



Headline initiatives in 2024/25

1. A major musculoskeletal procurement with patient co-production embedded has been launched. From November 2025, everyone in BLMK can self-refer for musculoskeletal support.
2. Established tobacco dependency treatment across BLMK.
3. Launched a diabetes pre-warning dashboard in primary care.



Lead Outcome Measure and Performance:

Reducing emergency admissions for falls.

The rate of admissions for falls in people aged 65+ is significantly lower in 2022/23 than 2019/20 in all four places.

Table shows emergency hospital admissions due to falls in people aged 65 and over. Directly standardised rate per 100,000 population.

Area	Baseline (2019/20)	2022/23	% Change
Bedford	2100	1725	-17.9
Central Beds	2339	1842	-21.3
Luton	2488	1639	-34.1
Milton Keynes	2520	1999	-20.7
England	2256	1933	-14.3

Headline initiatives in 2024/25

1. BLMK has the highest dementia diagnosis rate in the East of England at 69.8% which is 3.1% above the national ambition and 4% above the average.
2. BLMK has exceeded the 80% target for [Digital Social Care Record](#) (DSCR) and met a further stretch target with 85% of care providers now having a DSCR.
3. Nearly 2,000 vulnerable patients supported through the Warm Homes project in Bedford Borough. Rural Communities Charity (Bedfordshire) & Age UK (MK) commissioned to provide enhanced discharge and follow-up support to prevent readmission. Innovative work on frailty led by the Bedfordshire Care Alliance Committee (see page 94).



Growth

Lead Outcome Measure and Performance:

Reducing economic inactivity due to long-term sickness.

The percentage of economically inactive people aged 16-64 who are inactive due to long-term sickness has increased in all places except Bedford since 2019/20. The greatest increases were seen in Central Bedfordshire and Luton.

Table showing percentage of economically inactive people aged 16-64 who are inactive due to long-term sickness. Bedford estimates in 2023-24 are calculated from small group sample sizes and may be unreliable.

Area	Baseline (2019/20)	2023/24	% point change
Bedford	31.7	14.1	-17.6
Central Beds	21.9	31.8	9.9
Luton	17.5	28.9	11.4
Milton Keynes	20.8	22.4	1.6
England	23.3	26.3	3.0

Headline initiatives in 2024/25

1. Launched "Passport to NHSE Careers" across BLMK – a supported employment pathway for residents with lived experience of the care system, unpaid carers and those with neurodiversity.
2. Continued development of the BLMK ICS and University of Bedfordshire Research and Innovation hub. First BLMK ICS research and innovation awards created and funded by the hub in May 2024.
3. Saw a 21% reduction (since 2022) in emissions per inhaler prescribed, the introduction of recycling and re-use schemes for walking aids and a reduced food waste at hospital sites.









Reducing Inequalities


Lead Outcome Measure and Performance:

Reducing Inequality in average age of onset of first Long Term Condition – methodology subject to continued development from BLMK Population Health Intelligence Unit.

Headline initiatives in 2024/25

1. Launch of new Learning and Action Networks across BLMK in Partnership with the Institute for Healthcare Improvement (IHI), aimed at reducing cardiovascular disease in equal partnership with residents.
2. Review of existing Translation and Interpretation services underway across the system with a view to present an options appraisal in Q1 2025/26. Wide-ranging response of all system partners to the Denny Review presented to ICB Board in December 2025.
3. Inaugural BLMK Inequalities Seminar as part of major BLMK inequalities week brought partners together to listen to residents, share progress and agree next steps.

Enabler	Headline Initiatives in 2024/25
 <p>Data and Digital</p>	<ol style="list-style-type: none"> 1. Share for Care use increased, with over 110,000 individual records viewed per month. 2. NHS App Launch days across BLMK have brought together primary care leaders, VCSE organisations and elective representatives to promote the app to residents. 3. Population Health Information Unit (PHIU) established and delivering system-level analytical outputs using healthcare activity and outcome data.
 <p>Workforce</p>	<ol style="list-style-type: none"> 1. BLMK is one of two ICSs piloting implementing digital people transformation – the efficiency and automation of HR process to improve employee experience at work. 2. BLMK is the highest performing system in the East of England for completion of the Oliver McGowan training. 3. Launched expanded Health and Care Academy across the full ICS to encourage 14-18year olds to pursue careers in health & care.
 <p>Ways of Working</p>	<ol style="list-style-type: none"> 1. Our unscheduled care hub in Bedfordshire brings together ambulance, community and acute colleagues so more people can get the most appropriate help more quickly and reduce pressure on A&E. Over 1800 hospital admissions were avoided Jan 2024 – Jan 2025. 2. Integrated Neighbourhood Working – we are taking an asset-based approach to the development of our 19 neighbourhoods in BLMK. The four places are facilitating organic development with several leading examples of progress including the Bletchley Pathfinder in MK and the Bedford Queens Park ‘Be Active’ programme supporting families at risk of diabetes. 3. Launched i) our new Mental Health Learning Disability and Autism Collaborative Committee, and ii) our Portfolio Report providing a transparent and holistic view of transformation activity across the BLMK system.
 <p>Estates</p>	<ol style="list-style-type: none"> 1. We have delivered 15 out of the 23 primary care estates projects prioritised in 2023. This included the new Enhanced Services Centre in Bedford to provide new accommodation for the largest GP practice in BLMK, the De Parys Group. 2. Continued delivery of a variety of schemes on the Milton Keynes Hospital site as enablers for the New Hospitals Programme. Upgrades to the Bedford Hospital Emergency Department (ED), providing a secure Paediatric ED area, additional cubicles and contingency beds and extra waiting room capacity. 3. Completion of an expanded and refurbished emergency department at Luton & Dunstable Hospital, with increased capacity and a new fully segregated Paediatric Department. As per the Luton 2040 Pledge, the ICB has continued to campaign to NHSE to secure funding for a Clinical Diagnostic Centre in Luton Town Centre. New Community Diagnostic Centre opened at Lloyds Court in Milton Keynes.
 <p>Communications</p>	<ol style="list-style-type: none"> 1. We have launched our new System Insights Network, bringing together a wide range of partners and residents to inform our system strategy. 2. Relationships with new partners, in particular faith leaders, are supporting the reach of crucial communications, including for vaccination and immunization. 3. Our Winter 2024/25 campaign was co-produced with system partners, supporting coordinated messaging to keep more people well at home.
 <p>Finance</p>	<ol style="list-style-type: none"> 1. In an increasingly challenged financial environment, BLMK is expecting to deliver a break-even financial position at the end of 2024/25. 2. The system has established significant new infrastructure to oversee delivery of the Financial and Operational Plan for 2025/26. 3. BLMK is exceeding its 6% system efficiencies target and due to breaking even last year received an additional £2.8M capital allocation for our residents.

Enabler	Headline Initiatives in 2024/25
 <p>Operational and Clinical Excellence</p>	<ol style="list-style-type: none"> 1. Our new Health Services Strategy has laid the foundations for a more sustainable healthcare system delivering high quality care over the long term. 2. Appointments in primary care in 2024 + 10.4% vs 2023. 3. Luton Cancer Outcomes Project PCN prostate cancer case finding pilot is identifying Black men with prostate cancer earlier. This project identified 18 men to date with prostate cancer, all with few symptoms.

Whilst the Health and Care Strategy is a system strategy, each local authority has its own distinct plans and priorities which respond to the needs of its population. It is often the cumulative impact of these diverse place-based initiatives which provide a system-level impact in the five strategic priority areas.

The BLMK Health and Care Strategy has been developed from the Health and Care Strategy/Health and Wellbeing Strategy for each local authority which are listed on the next two pages.

Information about working at ‘place’ can be found on pages 14 to 16.

Bedford Borough - [Joint Local Health and Wellbeing Strategy](#)

The Bedford Borough Joint Local Health and Wellbeing Strategy for 2024-2027 aims to reduce differences in health and wellbeing across the borough by strengthening five building blocks of health by:

1. giving every child the best start in life
2. promoting inclusive employment
3. lifelong education and workplace health
4. ensuring we have strong, supportive communities
5. promoting healthy homes and tackling fuel poverty
6. ensuring that we have a sustainable built and natural environment that promotes health and wellbeing for all

Multi-agency implementation groups have been established for the ‘building block’ workstreams. Each group has developed its own action plan and early achievements include the following:

- Achieved universal distribution of toothbrushes and toothpaste to children in Year R and targeted oral health education sessions with toothbrushing packs for schools in the 40% most disadvantaged areas.
- 22 local organisations supported to run a Welcoming Space during the winter months to provide warmth and social activities.
- 755 Warm & Well assessments and 165 home visits completed by Better Housing Better Health, providing a range of support including 143 emergency fuel vouchers, 203 warmth packs, 125 households added to the Priority Services Register and 179 households offered debt or financial advice.
- In response to a locally identified need we established the Beyond Limits programme which aims to deliver high quality physical activity sessions for young people with Special Educational Needs and Disabilities (SEND). Sessions were designed in collaboration with partners and based on feedback from young people and adults with SEND. 17 multi-activity sessions were delivered in the first six months with over 170 attendances.

Actions for next year include work on policies to improve the local food environment, supporting housing association tenants with respiratory conditions in cold or damp homes and promoting access to Bedford Borough’s blue and green spaces for underserved communities.

Central Bedfordshire - [Joint Health and Wellbeing Strategy 2024-29](#)

The Central Bedfordshire Joint Health and Wellbeing Strategy was refreshed in 2024. The overarching vision is to "improve the health and wellbeing of residents in Central Bedfordshire and reduce inequalities now and for future generations".

There are four areas of focus for 2024-29:

1. Giving children in Central Bedfordshire the best start in life with a focus on educational attainment.
2. Tackling social isolation and loneliness across all sectors of society.
3. Making Central Bedfordshire a smoke-free place.
4. Securing improved and integrated health and care outcomes through delivery of our Place Plan.

These areas of focus sit alongside the existing Place Plan priorities for Central Bedfordshire:

- Reducing excess weight in children and adults
- Earlier diagnosis of cancer
- Positive mental health for children and young people
- Improving mental health services and support for people with learning disabilities and autism
- Improving access to primary care and dentistry
- Improving out of hospital service

The place plan deliverables for 2025/26 are being reviewed and updated along with the governance supporting place. The Joint Leadership Group (formally known as Central Bedfordshire Place Board) was reviewed and there has been a change in chair and the terms of reference have been updated.

Luton - [Luton's Population Wellbeing Strategy 2023-28](#)

Luton remains committed to the Luton 2040 vision, working to establish a Marmot Town where all residents can thrive and health inequalities are actively addressed. The [Luton 2040 Progress Report for 2025](#) confirmed that in 2024/25, Luton had 5000 fewer people living in destitution than the previous year.

The Luton 2040 vision is focused on a central mission to tackle poverty and inequality so that everyone can enjoy a good quality of life. This responds directly to the evidence gathered by the Inclusive Growth Commission in 2019, which recognised the scale of poverty in our town and the clear link between this and many other challenges, including education and health inequalities.

Across the 2040 vision there are five key strategic areas. This strategy sets out the ambition and actions that underpin primarily the "improving population wellbeing" priority but also incorporates the priority of "Becoming a Child Friendly Town" and is strongly linked to the priority "Supporting a strong and empowered community" – particularly with regards to the impact that having a fair and equitable community has on health inequalities.

Milton Keynes - [Health and Wellbeing Strategy 2018-2028](#)

The Milton Keynes (MK) Health and Wellbeing Strategy priorities are based on four overarching areas for Lifelong Wellbeing:

- Starting Well
- Living Well
- Aging Well

The priorities which sit under each key area have been shaped by the views and experiences of MK residents, partners and stakeholders and are based on a detailed analysis of an evidence (Joint Strategic Needs Assessment). All partners represented on the MK Health and Wellbeing Board have signed up to addressing these priorities in both their day to day work and through special projects.

Buckinghamshire

In Buckinghamshire, where 6,000 residents are within the ICB footprint, we have prioritised sharing information on services that Buckinghamshire residents' access in Milton Keynes and considering the needs of these residents (through a Joint Strategic Needs Assessment) in the development of the Joint Forward Plan.

Performance, Quality and Safety of local Healthcare

The ICB oversees NHS Constitution measures and operational standards, which define NHS responsibilities and underpin the delivery of high-quality services for BLMK. These are the standards of health care that patients, the public and staff are entitled to. Throughout the year, we remained committed to delivering clinical quality, patient safety and harm reduction across all our commissioned services.

Our performance reports continue to deliver clear, focused insights with strong supporting narratives; a practice that will continue into 2025/26. Reports presented to our Board are published on our [BLMK ICB Website](#) in the interests of transparency and public accessibility.

Over the year we have made positive progress in the following areas:

- Referral to treatment long waits (52 weeks) – we made significant improvements in reducing the number of patients waiting over 52 weeks for treatment with a 55% reduction between April 2024 and March 2025.
- Early-stage cancer diagnosis - we continue to be on-track in meeting our Long-Term Plan of diagnosing cancers earlier. Currently (latest published Q3 data), BLMK are diagnosing 65% of cancers at stage 1 or 2, progressing toward the national target of 75% by 2028 (the national average is 59%).
- General Practice Appointments in Primary Care - we delivered 6,213,398 appointments over 2024/25; a 9% increase on last year.
- Care Programme Approach 72 hours follow up standard - we ended the year above the 80% target with 88% of patients being followed up within 72 hours of discharge from psychiatric inpatient care.
- Dementia Diagnosis - we over-achieved the diagnosis rate in every month of 2024/25. We ended the year with a diagnosis rate of 69.3%, over-achieving against the 66.7% national target and the regional average performance of 64%.
- Early intervention in psychosis (EIP) programme - we exceeded the 60% target in March with 80% of patients seen within 2 weeks of referral.
- Talking therapies (reliable Improvement) - we met and exceeded the 67% target in March with a total of 71.6% patients making reliable improvement.
- Perinatal Access - we exceeded our monthly target for every month in the year with a total of 17,080 women accessing perinatal services within BLMK by the end of March, against our plan of 15,348.
- 2-hour urgent community response - we successfully met and exceeded the 70% target every month this year, with March achievement of 82.7%.
- Learning Disability & Autism Health checks – we incrementally improved our delivery over the year, with a total of 76.3% of patients having had a health check by March (against the 75% target).

Reflecting on our performance over the past year, it is important to recognise the challenges we have faced. Despite our collective efforts and unwavering commitment, we encountered on-going pressures such as rising demand, workforce and capacity constraints, and data quality issues.

Throughout the year we have faced performance challenges in the following areas:

- **Referral to treatment (RTT) long waits (78 and 65 weeks)** - despite an overall reduction, planned waits *over 78 weeks* increased in year, from 93 in April 24, peaking to 174 in January 25, before significantly reducing in March down to 10, achieving a 90% reduction over the year. BLMK waits for planned treatment *over 65 weeks* saw a reduction of 96% over the year, from 1,716 in April 2024 to 65 in March 25, however we underachieved against target (zero by March 2025).
- **Diagnostic 6 week waits** – the ICB made good progress against the 15% target, over the year, ending the year with 31.4% of people waiting 6 weeks or more for a diagnostic test (a reduction of 13.6% in the waiting list over the year).
- **Cancer 28-day faster diagnosis** – performance improved over the year from 65.6% in April 2024, peaking to 77.9% in February, and ending the year with 76.3% in March, falling short of the 77% end of year national target.
- **Cancer 62-day wait times** - we saw similar improvement over the year in wait times for patients to receive their first treatment following an urgent GP referral, from a low of 59.2% in June to 68.1% in March; falling short of the 70% target.
- **A&E 4-hour** - despite our best efforts, we underachieved against the national target of 78% ending the year with at 74.8%.
- **Children and young people mental health services access** - we fell significantly short of the of BLMK 17,612 target, with a year- end achievement of 13,500.

Elective Care, Diagnostics and Cancer care (more information on pages 57 to 59)

BLMK ICB	Threshold / End of Year Target	Q1 June Snapshot Achievement	Q2 September Snapshot Achievement	Q3 December Snapshot Achievement	Q4 March Snapshot Achievement	M12 Regional Average	What does good look like
RTT - % Patients Waiting 18 Weeks or less	92%	51.4%	51.7%	51.5%	52.8%	59.4%	High
RTT - Number of 104+ Week Waits	0	5	4	1	0	1	Low
RTT - Number of 78+ Week Waits	0	98	128	106	10	16	Low
RTT - Number of 65+ Week Waits	0	2,209	1,047	499	65	227	Low
RTT - Number of 52+ Week Waits – BLMK operational plan	5,285	9,289	7,407	5,226	4,305	5,769	Low
Diagnostics Tests - 6 Week Waits	15%	45.8%	44.1%	44.4%	31.4%	25.2%	Low

18 weeks referral to treatment (RTT), and long wait measures

Over the year, we have been working in collaboration with providers to deliver planned treatment within 18 weeks. In March, BLMK achieved 52.8% against the 18-week RTT national target of 92%; this is compared to a regional average performance of 59.4% and a national average achievement of 59.8%. Following significant national challenges in meeting the 92% target, this has been reduced for 2025/26, and BLMK ICB will be working towards 60% achievement by March 2026.

BLMK is committed to reducing long waits for patients, while respecting their choices and allowing for necessary cancellations. However, ongoing challenges in planned care have affected our ability to bring waiting times down as quickly as we would have liked. We have worked towards reducing 78 week waits over the year, which peaked to 174 in January 2025, and then reduced to 10 by the end of March. In the same period, we worked diligently to make a 96% reduction in the number of patients waiting 65+ weeks (from 1,716 in April to 10 patients in March). As we continue working in partnership with our providers, our focus for 2025/26 will be reducing the number of patients waiting 52+ weeks, which we have successfully reduced by 55% this year.

Our most challenged pathways have been Urology, Orthopedics, Ophthalmology and Gynecology. Trusts have supported pressures by establishing additional clinics, cross-site leadership support, capacity planning and outsourcing where appropriate. System-wide discussions have focused on quality of care and reducing any additional harm resulting from extended waiting times. Patients with the most urgent clinical needs continue to be prioritised in accordance with national guidelines.

Outpatient transformation initiatives continue to support performance and demand management, and the ICB are working with Acute Trusts, Community, and Independent Sector providers on several improvement initiatives, see page 58 for more details.

Diagnostics – waits over 6 weeks (more information on page 58)

While the ICB faced considerable challenges in meeting the 6-week wait measure, we have made encouraging progress throughout the year, steadily advancing toward the 15% target. We started the year at 45% and ended with 31.4% of people waiting 6 weeks or more for a diagnostic test (lower is better). Challenges included high volumes of patients on the waiting list, peaking in October with 39,602 and ending in March with 31,139 patients, and between April and March, the ICB made a 20% reduction in the wait list.

Key improvement initiatives include the use of i-Refer (a tool to support clinicians to determine the most appropriate imaging investigation or intervention for patients), waiting list reviews, clinical pathway development and on-going recruitment and the use of agency staff. The ICB implementation of community diagnostic centers (CDCs) across BLMK have increased local diagnostic capacity, supporting performance and improved patient access to tests, closer to home, this will continue into 2025/26.

Cancer waiting time standards (more information on page 55)

BLMK ICB	Threshold /End of Year Target	Q1 June Snapshot Achievement	Q2 September Snapshot Achievement	Q3 December Snapshot Achievement	Q4 March Snapshot Achievement	M12 Regional Average	What does good look like
Cancer - 28 Day Faster Diagnosis Standard	77%	72.2%	68.5%	75.2%	76.3%	76.2%	High
Cancer - 31 Day Combined	96%	91.2%	89.3%	88.9%	87.9%	88.3%	High
Cancer - 62 Day Combined	70%	59.2%	65.1%	68.2%	68.1%	67.7%	High

The 28-Day Faster Diagnosis Standard (FDS) ensures patients with suspected cancer receive a timely diagnosis. By the end of March, the ICB saw a 3.6% increase in referrals (demand) compared to last year and we treated 7.3% more patients that we did last year. The ICB achieved 76.3% in March (0.7% below target). We have good oversight of our most challenged pathways and the ICB is actively working with providers to advance towards the revised national standard of 80% by March 2026.

The 31-day decision to treat standard, following a cancer diagnosis, has a target of 96% and the ICB fell short with 87.9%. Performance has been impacted by surgical and chemotherapy unit capacity and the ICB have aligned funding to support chemotherapy services and waiting list initiatives to improve capacity within the system.

Delivery of the 62-day performance standard has been one of our biggest system challenges this year, and by the end of March, the ICB under-performed against the 70% target with 68%. We saw a 16.5% increase in referrals (demand) compared to last year and we treated a total of 13.3% more patients than we did last year.

Key challenges included high referral volumes, delays to diagnostic tests and the management of complex pathways. Our 2025/26 focus will be on achieving the revised national standard of 75% by making further improvements to the pathway from diagnosis to treatment, including specialist diagnostics tests to support staging and treatment decision making. Further information on Cancer can be found on page 55.

Urgent Emergency Care and Community Care (more information on pages 59 to 61)

BLMK ICB	Threshold / End of Year Target	Q1 June Snapshot Achievement	Q2 September Snapshot Achievement	Q3 December Snapshot Achievement	Q4 March Snapshot Achievement	M12 Regional Average	What does good look like
Ambulance - 30-minute Handover Delays (Daily Average)		40	41	42	30		Low
A&E 4 hour waits	78%	75.9%	75.9%	72.9%	74.7%	73.8%	High
% A&E 12-hour journey time	5%	2.65%	3.03%	4.54%	3.45%		Low
% ED Attendances that result in emergency admission		26.6%	26.3%	27.6%	26.4%	28.4%	High
Virtual Wards Occupancy	80.00%	68.9%	62.4%	75.6%	74.7%	86.2%	High
System Flow - Bed Occupancy (Total Overnight G&A Beds)		95.4%	94.6%	93.0%	92.6%		Low

Ambulance Handovers – 30-minute handover delays (more information on pages 59 to 61)

An ambulance handover is the transfer of patients from ambulance crews to hospital staff. The duration of this process can vary, affecting both patient care and the overall efficiency of ambulance services.

BLMK ICB handovers are recorded as a daily average snapshot and have remained consistent over the first three quarters of the year, with an average of 40 over quarter one, increasing to 42 in quarter three, reflecting well managed services during the peak of winter and then reducing to an average of 30 handover delays over quarter four.

System providers work in collaboration to reduce ambulance handover delays; progress and issues are managed through system-wide meetings and daily operational and escalation discussions with the System Co-ordination Center (SCC). The ICB have been working with our partners to refresh our Ambulance Recovery Plan which will establish revised trajectories and associated actions to meet the new 2025/26 ambulance Handover targets set at 27 minutes.

Accident and Emergency (A&E) 4 hour waits (more information on pages 59 to 61)

A critical performance metric is the time patients spend in A&E before being discharged, admitted, or transferred. Whilst we performed to plan for the first half of the year, BLMK and Trusts under-performed against the end-of-year 78% target with 74.7% for the ICB (71.9% BHT and 74.5% MKUH). Over the year, trust performance has been strong, allowing the ICB to secure a regional ranking of first place out of six ICBs in region, for nine out of 12 months in the year. The ICB reported peak performance in July with 77.3%, BHT achieved 76% in June and July and MKUH a peak of 77.7% in August.

Accident and Emergency (A&E) 12 hour waits “Journey time” (more information on pages 59 to 61)

The 12 hour “journey time” refers to the hours a patient spends in A&E departments between the point when a doctor decides on admitting them and the point until they are admitted. Delays can involve hospital bed availability, staffing shortages, or busy A&E periods (demand). In March, the ICB saw 3.4% of all patients attending the ED breaching 12-hours in the department, against the 5% threshold (lower is better). Collaboration continues within the UEC system to improve mental health services, management, and flow. At the same time, efforts are being made to prevent unnecessary admissions and improve discharges, all aimed at making patient flow through hospitals more efficient.

Emergency Department attendances resulting in an emergency admission

Urgent and emergency services continue to experience strain, seeing growing demand for acute care throughout the year. As a result, total A&E attendances across BLMK in March 2025 have seen a 1.9% increase compared to March 2024 and emergency admissions have seen a 1.6% decrease for the same period. Initiatives are in place to alleviate and manage ongoing system pressures. These will continue to develop into 2025/26 and include:

- “Call before you Convey” which ensures frail and elderly patients are streamed to the most appropriate pathway with a community first approach;
- Virtual Wards, where patients receive hospital level care at home (see below for virtual ward performance), and the
- Unscheduled Care Coordination Hub (UCCH) which hosts a variety of healthcare professionals, to support admission avoidance. Since its launch in January 2024, the UCCH has averted over 1,800 emergency responses across Bedfordshire, with call handlers ensuring patients receive the most appropriate care, closer to home, reducing unnecessary hospital demand.

Virtual Wards

Virtual wards are a way to provide personalised, convenient, and safe hospital level patient care at home. Over the year the ICB has seen improved levels of occupancy against the 80% target, ending the year with 74.7%.

This year, the system have reviewed its virtual ward capacity (following the national direction and incorporating feedback from the [GIRFT](#) programme) to focus on *higher acuity patients* and as of April 2025, the ICB will reduce the number of virtual ward beds to 20-30 per 100,000 population. The system firmly believes that these actions will achieve a greater occupancy rate (in excess of 80%) and will support admission avoidance.

Bed Occupancy

Adult bed occupancy performance across our acute hospitals has fluctuated over the year, with the last two quarters seeing a slight reduction (lower is better). By the end of Q4, ICB performance was 92.6%, with BHT at 95.1% and MKUH at 88.0%. Challenges within Trusts have included high demand and increased patient acuity. Urgent and emergency care (UEC) transformation programmes including admission avoidance and discharge initiatives will continue to support reduced bed occupancy – see more details on pages 59 to 61.

Primary Care (more information on pages 51 to 53)

BLMK ICB	Threshold / Operational Plan	Q1 June Snapshot Achievement	Q2 September Snapshot Achievement	Q3 December Snapshot Achievement	Q4 March Snapshot Achievement	M12 Regional Average	What does good look like
Number of appointments in General Practice	5,804,717	458,021	495,944	496,360	563,047	612,086	High
% same day appointments in General Practice	none	40.7%	40.6%	44.3%	44.8%	43.7%	High
% of appointments With Health Professional Other Than GP	none	51.9%	52.4%	50.2%	55.2%	55.9%	High

Appointments in General Practice (GP)

BLMK ICB are working to implement modern practice access, which is about seeing and signposting the people to the most appropriate form of care.

By March 2025, the ICB had delivered 6,213,348 appointments, this is a 9% increase on the previous year. The ICB continues to deliver a high proportion of same day appointments with a year-end achievement of 44.8%, slightly above the regional average performance of 43.7% and in line with national at 44.2%. We are delivering up to 55.2% of appointments with professionals other than a GP, thereby maximising use of the most appropriate BLMK healthcare practitioner, ensuring a faster and more targeted approach to health care.

Adult Mental Health, Learning Disability and Autism (more information on pages 47 to 50)

BLMK ICB	Threshold / End of Year Target	Q1 June Snapshot Achievement	Q2 September Snapshot Achievement	Q3 December Snapshot Achievement	Q4 March Snapshot Achievement	M12 Regional Average	What does good look like
Mental Health							
CPA 72-Hour Follow Ups	80%	87.0%	89.0%	86.0%	88.0%	57.0%	High
SMI Health checks (Rolling 12 months)	60%	57.3%	55.3%	57.0%	Q4 data not published at time of reporting	58.5%	High
Dementia Diagnosis Rate	66.7%	68.3%	69.4%	69.6%	69.3%	64.0%	High
NHS Talking Therapies - Reliable Recovery	48%	43.4%	47.3%	48.7%	47.2%	49.0%	High
NHS Talking Therapies - Reliable Improvement	67%	66.7%	68.4%	70.9%	71.6%	67.4%	High
Early Intervention in Psychosis (EIP)	60%	Data Quality Issues in Q1	80.0%	79.0%	80.0%	71.3%	High
Inappropriate Out Of Area Placements	0	15	15	20	15	28	Low
Learning Disability & Autism							
Learning Disability Health checks (Cumulative)	76%	14.0%	30.9%	52.9%	76.2%		High

Physical Health Checks for People with a Severe Mental Illness (SMI)

People aged 18+ living with an SMI may be at a higher risk for certain preventable health conditions and regular health checks allow for early identification and treatment. This health check will include blood pressure, weight management and smoking status.

The 2024/25 ambition was that at least 60% of people on SMI registers would receive a full annual physical health check. At the end of Q3, (latest published data) BLMK successfully carried out 4,655 (57%) physical health checks. The ICB are progressing improvement programmes including working with primary care and outreach teams to promote attendance, and with clinicians to ensure accurate recording of those who have attended checks.

Dementia Diagnosis

Dementia prevalence rises with age, and a timely diagnosis is increasingly vital to ensure patients and families have access to appropriate information, care, and support which in turn will improve patient outcomes.

The dementia diagnosis rate for BLMK has shown significant progress during 2024/25. As of March 2025, the dementia diagnosis rate stands at 69.3% (against the national target of 66.7%), which is the highest in the East of England. The ICB continues to display performance variation within BLMK, and work programmes are in place to improve the level of diagnosis for patients with dementia across BLMK, which will continue into 2025/26.

NHS Talking Therapies – Reliable Recovery and Improvement

Talking therapies are evidence-based psychological therapy services, addressing a range of conditions. The ICB under-achieved the target for reliable recovery with 47.2% (48% target) and over-achieved against the target for reliable improvement with 71.6% (67% target).

Throughout 2025/26, the system will continue to improve access and experience strengthened with a focus on reducing inequalities and developing digital opportunities for engagement. These actions will support delivery of the increased targets for recovery (to 50%) and improvement (to 68%).

Learning Disability and Autism Health checks

BLMK ICB delivered a total of 76.2% (3,368) health checks to the LD&A population by the end of the year, against the 76% target. Performance variation within BLMK exists and training will continue with primary care to support identification of patients who have missed checks and subsequently inviting them into practice alongside online videos showing how to record and upload data.

Children, young people (CYP), and maternity (more information on pages 43 to 46 and page 54)

BLMK ICB	Threshold / Operational Plan	Q1 June Snapshot Achievement	Q2 September Snapshot Achievement	Q3 December Snapshot Achievement	Q4 March Snapshot Achievement	M12 Regional Average	What does good look like
Number of CYP accessing mental health services (Rolling 12 months)	17,614	13,375	13,245	13,175	13,500	15,372	High
CYP Eating Disorders - Routine	95.00%	No patients	83.0%	84.0%	56.0%	56.50%	High
Perinatal Mental Health Access (Rolling 12 months)	1,279 p/m	1,455	1,455	1,460	1,375	1,468	High

Children and Young People (CYP) Mental Health Access

Child and Adolescent Mental Health Service ([CAMHS](#)) is a service supporting children and young people with emotional, behavioral, and mental health difficulties. The ICB has under-performed against this metric seeing a total of 13,500 CYP against our target of 17,614 patients. This was 1,872 patients below the regional average, placing the ICB fifth out of six in region. While meeting this target has been challenging, we remain committed and continue to work hard as a system, to drive improvement. Actions taken in year include improvements to data quality (counting and recording on systems) and working closely with schools to improve referrals into the service. We have also offered drop in and foundation offers of support alongside psychoeducation sessions.

Artificial Intelligence is being used to reduce administration burden, alongside streamlining pathways, making it easier to refer patients. Moving into 2025/26, transformation efforts will develop with an NHSE supported review of CAMHS productivity and efficiency and we will be conducting peer to peer learning initiatives.

Perinatal Access

Over 2024/25, at least 66,000 women (nationally) with moderate to severe or complex perinatal mental health needs should have access to specialist care, recognising the vital role perinatal services play in supporting the well-being of new parents. The ICB has consistently exceeded our BLMK monthly target of 1,279 all year, ending the year with a total of 17,080 patients accessing the service (this is 11.3% over our allocated target). ICB performance was comparable to the regional (average) end of year total of 17,049, placing us fourth out of six in region at M12. The ICB is confident we can meet the planned increased level of performance over 2025/26, of 1,440 patients each month (17,280 total revised annual target).

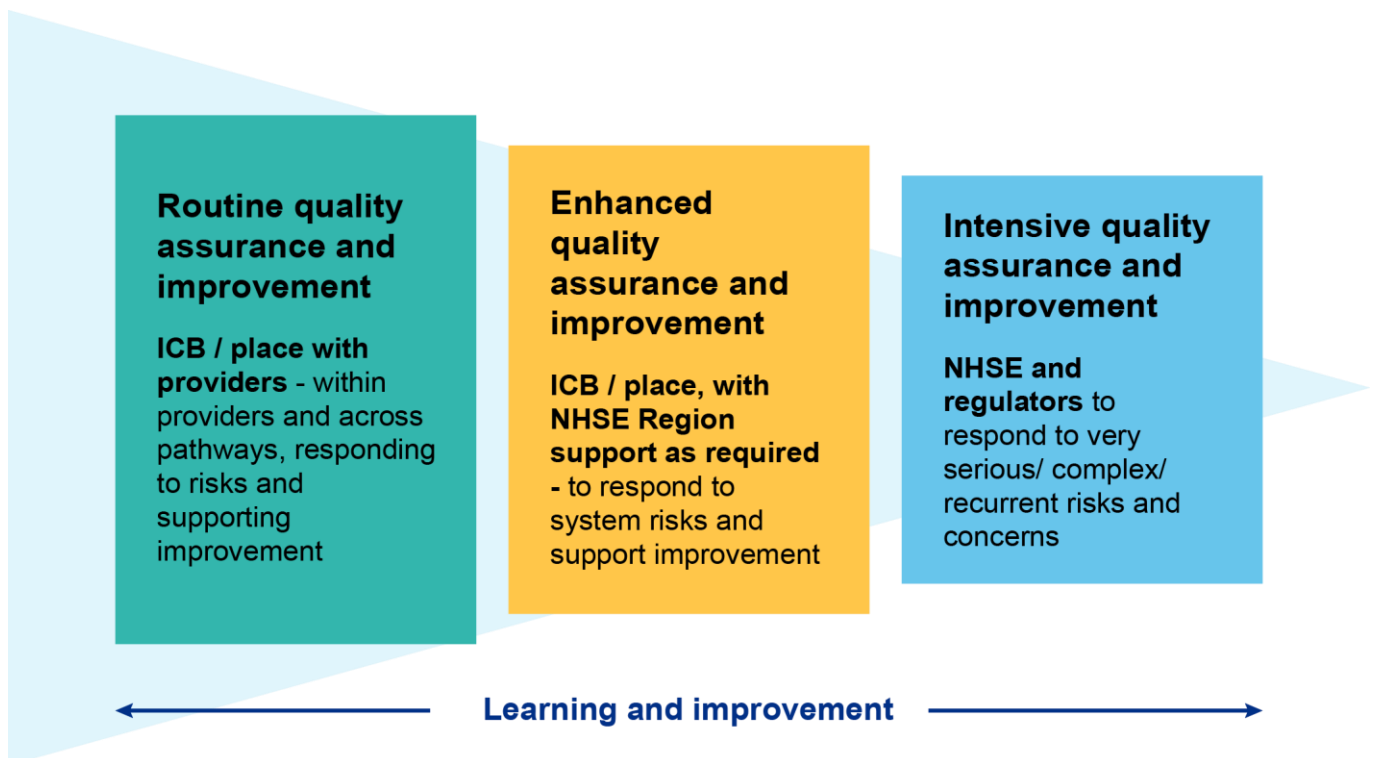
Improve quality

Quality continues to be a priority to improve residents experience of our health and social care system and reaching the ICB's vision for everyone in our city, towns, villages and communities to live a longer, healthier lives.

In line with the [National Quality Board \(NQB\)](#), the ICB has two overarching quality responsibilities:

- To ensure the fundamental standards of quality are delivered – including managing quality and safety risks and addressing inequalities and variation.
- To continually improve quality of services, in a way that makes a real difference to the people who use the services.

Overview of main levels of quality assurance and improvement:



System Quality Groups (SQG) are a requirement of an ICS to monitor and improve quality across the system, as outlined in the NQB. Our SQG (established in 2023/24) is chaired by our Chief Nurse with good engagement across our system including primary care, service providers and voluntary, community & social enterprises (VCSE). The SQG provides joined up quality intelligence, enables improvement and supports a response to system concerns and risks, including escalation. The SQG feeds into Regional Quality Groups which seeks to identify areas for improvement, share best practice and coordinate efforts to improve the overall quality of services delivered.

The SQG also feeds into the ICB's Quality & Performance Committee (see page 98), to review data and information regarding our commissioned services and scrutinises the quality of these services.

Infection Prevention and Control – The ICB's Infection Prevention and Control (IPC) team continue to work with system partners to provide up to date advice and support and continue to monitor system wide healthcare associated infection (HCAI) including clostridium difficile infection (C.Diff). During 2024/25 work has continued with the ICB's emergency preparedness resilience and response team and primary care colleagues in seeking assurance and supporting our system partners in measles outbreak preparedness.

The team have worked closely with the ICB medicines optimisation teams and the medical directorate to develop a system wide antimicrobial resistance forum to look at learning and improvement. This feeds into regional system learning forums while this work currently has an acute lens, the aim in 2025/26 is to expand this across the system community settings including domiciliary care.

As part of the project to standardise the IPC audits in primary care, a two year pilot is running using a web-based Infection Control Audit Tool (ICAT). The pilot has had some success, with some GP practices embedding the tool well. The ICB has continued to offer training to close gaps in knowledge. The project comes to an end in March 2025 with the ICAT tool being available for GP practices to pick up individually.

The ICB has continued to offer IPC training and awareness for primary care and care homes and support the wider quality team with onsite visits to give advice and support including a focus on Care Quality Commission (CQC) inspection readiness.

Patient Safety Incident Response Framework - The [NHS Patient Safety Incident Response Framework](#) (PSIRF) is a key part of the NHS's strategy to improve patient safety and was introduced in 2024. PSIRF replaces the previous Serious Incident Framework and represents a significant shift in how the NHS responds to patient safety incidents. The framework is designed to foster a culture of continuous learning and improvement in patient safety across the NHS.

The key principles of the PSIRF Framework are:

- **Compassionate Engagement:** Involving and supporting those affected by patient safety incidents, including patients, families, and staff.
- **System-Based Learning:** Applying a range of approaches to understand how incidents happen and the factors contributing to them.
- **Proportionate Responses:** Ensuring responses to incidents are considered and appropriate to the severity and impact of the incident.
- **Supportive Oversight:** Strengthening the functioning and improvement of the response system.

PSIRF is mandatory for services provided under an NHS Standard Contract, including acute, ambulance, mental health and community healthcare providers. All our large providers have successfully implemented PSIRF and have a patient safety incident response plan.

Implementation of the [NHS Primary Care Patient Safety Strategy](#) (published in 2024) is encouraged but not mandated at this point. The patient safety team alongside the quality and primary care ICB teams have linked to deliver information sessions for our primary care partners, with a task & finish group being created to support the implementation of the strategy.

The team continue to work with system partners in jointly promoting a shared learning culture across the system, linking in with the regional Patient Safety Team. As a system we have established a Patient Safety Network, which is an effective forum to learn together from incidences as well as creating a supportive environment to identify areas of improvement.

Local Maternity and Neonatal System (LMNS) - The Local Maternity and Neonatal System (LMNS) is the dedicated maternity and neonatal arm of the ICS, focusing on enhancing the quality of services provided to women, babies, and families. Our overarching goal is to create safer, more personalised, and equitable maternity experiences. In alignment with the [NHS Three-Year Delivery Plan for Maternity and Neonatal Services](#) (published in March 2023), the LMNS has embarked on a comprehensive improvement program that targets key areas of service delivery.

Key Initiatives and Improvements:

1. **[NHS Saving Babies' Lives Care Bundle](#)** (SBL) Version 3 and **[Clinical Negligence Scheme for Trusts](#)** (CNST) **[Maternity Incentive Scheme](#)** (MIS):

We have actively supported implementation of these initiatives, which is integral in adhering to evidence-based best practices aimed at reducing perinatal mortality. By monitoring compliance across all trusts, we ensure that the care provided meets high standards.

2. **Data-Driven Improvement:**

The LMNS has developed a robust outcomes dashboard to collect and utilise data for continuous improvement. We have been triangulating this data with the regional dashboard, service user feedback and information on patient safety incidents to facilitate informed decision-making and strategic planning.

3. **Perinatal Transformation Committee:**

The establishment of a Perinatal Improvement Committee demonstrates our commitment to a cohesive approach in quality enhancement. Five dedicated workstreams have been launched, focusing on:

- Translation Services
- Equality and Equity Gaps
- Risk Assessments
- Managing Deterioration
- Induction of Labour Pathway (to be added as currently a regional work stream)

These workstreams are designed to address specific areas of need and foster systemic improvement.

4. **Collaboration on Safety Initiatives:**

In partnership with the regional maternity team, we have engaged in the "*Sixty Supportive Steps to Safety*" initiative. This peer-supportive framework is implemental for ongoing monitoring and improving safety alongside quality outcomes.

Impactful Services for Residents - In addition to the above initiatives, the LMNS has successfully introduced several vital services aimed at enhancing maternal and neonatal health:

- **Maternity-Led Smoking Cessation Services:** Our focused efforts on implementing maternity-led services have led to a notable increase in the number of pregnant women and birthing people quitting smoking by the time of delivery.
- **Pelvic Floor Service:** Recognising the importance of pelvic health, we prioritised funding for a dedicated pelvic floor service for 2024/25 for Bedfordshire hospitals, addressing a crucial aspect of postnatal care and recovery.
- **Genetic Risk Services:** The LMNS has secured funding to enhance our genetic risk services for Bedfordshire hospitals.

- **Preconception Care:** The implementation of preconception care services is imperative for reducing complications during pregnancy and improving the health of our local birthing people. We have allocated funding for this initiative in the coming year to support women before they conceive, ensuring healthier pregnancies. We are also partner to a national research programme collaborative on preconception care. This includes supporting women who are at risk from obesity and its complications. For more information on Preconception Care see page 53.
- **Maternity Neonatal Voices Partnership (MNVP):** To bolster our efforts, we have expanded our team with four MNVP leads and one senior MNVP lead. This enhancement will help to ensure we can provide comprehensive, high-quality care to our families. For more information on Maternity see page 54.

The LMNS is dedicated to fostering an environment of continuous quality improvement within maternity and neonatal services. By focusing on data-driven initiatives and prioritising the needs of our communities, we aim to enhance service delivery, improve health outcomes and ensure equitable access to care.

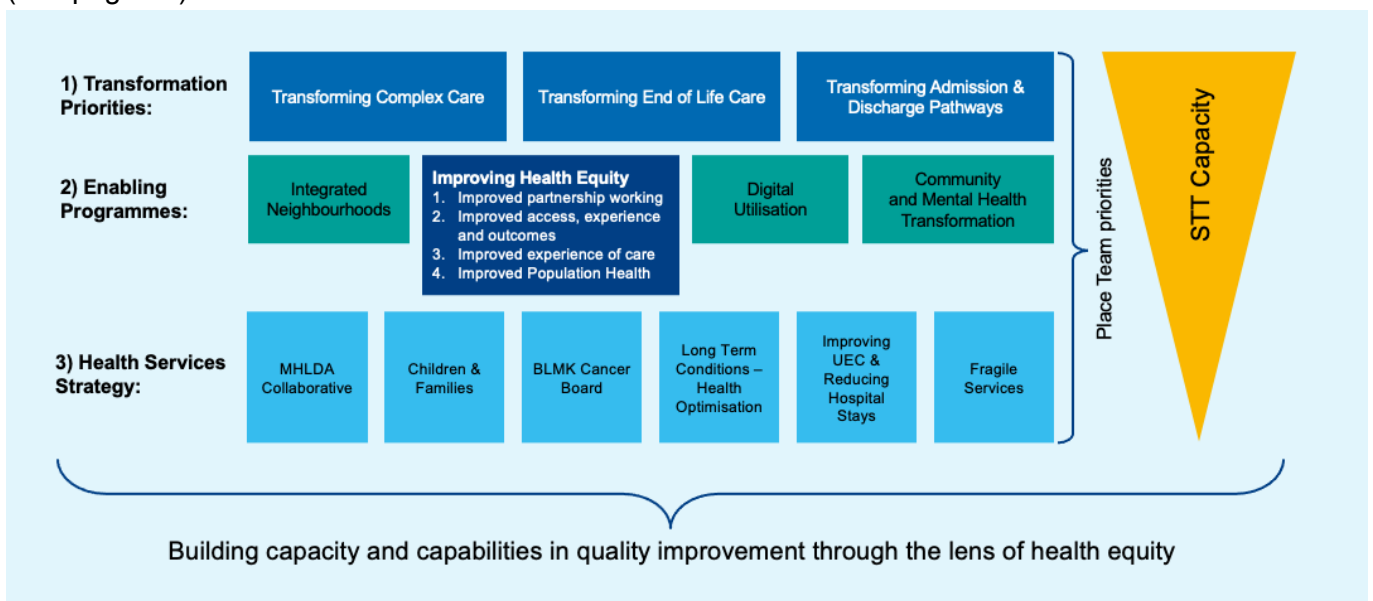
Reducing health inequalities

This section of our Annual Report is supplemented by our Health Inequalities Information Statement (available in the ‘Publications’ section of our [website](#)) which provides further information on our work in this area.

The forming of the Health Equity Programme

In 2024/25, BLMK conducted a comprehensive refresh of its inequalities programme, now known as the “Health Equity Programme”. This initiative serves as the enabling framework for the ICS, establishing four main priorities. These priorities include recommendations from the [Denny Review](#), quality improvement projects, transformation programmes and oversight of major system health equity projects with the Core20+5 being our framework for how we target our populations. Each priority features new leadership accountabilities and timelines, guiding us into 2025 and beyond.

The diagram below illustrates where the health equity programme sits within the transformation priorities (see page 10).



Aligning quality improvement with health equity - We have adopted quality improvement as the primary methodology to address inequalities. The ICB Board has allocated inequalities funding to establish a dedicated quality improvement team and to secure a contract with the Institute of Healthcare Improvement, which includes participation in the Learning and Action Network. This strategic decision underscores the commitment to enhancing healthcare quality and reducing disparities.

Partnership working with our residents - During 2024/25, we ran a series of webinars with residents and our partners to celebrate different cultures and encourage people to share stories and history from their communities:

- In July 2024, black leaders from across BLMK joined together to deliver a series of webinars for black colleagues, which sought to inspire a new generation of black leaders and increase representation in the ICB and our wider partnership.
- In August 2024, we celebrated South Asian Heritage Month, which gave colleagues the opportunity to understand the diverse backgrounds and cultures of people from our vibrant south Asian communities.
- In October 2024, we celebrated Black History Month and listened to leaders from across our region talking about their heritage.
- In February 2025, we celebrated LGBT History Month, listening to colleagues and leaders about their experiences and the reasons why some LGBT people may disconnect from health and care.

As part of this work, a reciprocal mentoring scheme was established and led by ICB's People Team, to encourage the sharing of lived experiences and support people from under-represented backgrounds to access development opportunities. A Black Leaders Network is also being established to give black colleagues a vehicle to make their voice heard and advocate for colleagues and their communities.

During 2024/25 we have also worked with local people to understand their experience of accessing translation and interpretation services and shared their stories with commissioners to help inform service transformation. Healthwatch was commissioned during this period to delve deeper into the challenges around translation and interpretation services in our area and has produced a detailed report which will inform service transformation.

Through our work with [Autism Bedfordshire](#), we have funded videos that have been co-produced by the ICB, clinicians, autistic adults, East London NHS Foundation Trust (ELFT) and Autism Bedfordshire to help autistic people and people with a learning disability better understand what to expect when going to healthcare appointments, screening appointments and different areas of their health.

Learning and Action Network - BLMK is prioritising the improvement of hypertension management.. This programme involves close collaboration with residents who experience the worst outcomes, engaging them as equal partners by recruiting them into our core project teams.

From July 2024 to September 2024, the Institute of Healthcare Improvement (IHI), the Population Health Intelligence Unit (PHIU), Public Health, and the ICB Quality Improvement team supported our four places in identifying the target population.

On 22 November, [The Learning Action Network](#) (LAN), was launched which brought together residents identified from the virtual workshops who experience significant inequalities, from each of our four places. Each team progressed through the journey of improvement, identifying the problem, understanding insights and data, developing a strategy with specific aims, developing change ideas and testing them in a way that allows us to measure improvement. Some of the aim statements developed are:

- Reduce the number of people with unmanaged hypertension by 50% amongst Black African patients aged between 30 and 60 in eQuality PCN and Oasis PCN by June 2025.
- For 60% of Indians aged between 40-50 with a pre-existing medical condition (defined list) to have a recorded blood pressure by June in Medics PCN.
- By the end of the Heart Health project in May 2026, 80% of the Black African population, aged 40-64, who have a diagnosis of hypertension alone, in the Urban South neighbourhood (Cauldwell, Kempston and Kingsbrook wards) and are registered with one of the three practices serving this area (London Road Surgery, Cauldwell Medical Centre and King Street Surgery) will achieve a blood pressure target of below 140/90 mmHg.
- Increase the percentage of Black African residents of all genders aged between 40-64 years with managed blood pressure (below 140/90 mmHg) from the Central Milton Keynes Neighbourhood (covering seven practices) by 10% by end of June 2026.
- Community Support for Children and Young People: Total Wellbeing will support children and young people in accessing non-clinical community support for the Core20 and PLUS groups in the three most deprived PCNs in Luton.

The photograph below show residents and staff at the launch of the Learning Action Network - co-producing community solutions to hypertension as part of the Health Equity Programme



Children and Young People (CYP) safeguarding

BLMK ICB has a statutory duty to have appropriate arrangements in place for safeguarding children, young people and adults.

As outlined in the Safeguarding Children, Young People and Adults at Risk in the NHSE: [Safeguarding Accountability and Assurance Framework](#) (SAAF) revised June 2024, the ICB also has a duty to ensure that all health providers from whom we commission services promote the welfare of children and protect vulnerable adults from abuse or risk of abuse.

Since BLMK became an ICS in 2022, the ICB's Safeguarding Team have supported the reshaping of relationships with safeguarding partnerships including our health colleagues. This has been achieved by working more collaboratively with stronger approaches to integration with health partners in forging a collective voice to support strategy development and delivery.

Safeguarding within the ICB - During 2024/25 the ICB safeguarding team has continued to work on the delivery of statutory safeguarding duties. Following earlier changes to internal processes and definition of workstreams we are now beginning to see clear deliverables particularly around the requirements set out in the SAAF. The safeguarding and vulnerabilities portfolio includes areas such as CYP, Special Educational Needs and Disability (SEND), Frailty, Mental health and Learning Disability and End of Life. Safeguarding is recognised as an ICB 'core function' as well as valuing the place base function which is evident through the safeguarding structure.

As part of monitoring and assuring the ICBs compliance with its statutory function, it self-assesses against the key areas and standards set out in the SAAF, completion of the Safeguarding Commissioning Assurance Tool (S- CAT) takes place quarterly. A summary of the SAAF is captured in the table on the next page with exception reporting statements against the AMBER rating.

Area	Standard	RAG
Leadership and Organisational Accountability	A clear line of accountability for safeguarding, reflected in the ICB governance arrangements, i.e., a named Executive Lead to take overall leadership responsibility for the organisation's safeguarding arrangements. In addition, a team made up of designated professionals for safeguarding children, looked after children, care leavers and adults	
Training	Training all ICB staff to recognise and report safeguarding issues supported by a training strategy and compliance percentage in line with Intercollegiate Documents and national guidance for Prevent.	
Safer Recruitment	Clear policies describing the commitment and approach to safeguarding, including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults, as appropriate	
Interagency working	Effective inter-agency working with Local Authorities, the Police and third sector organisations, including appropriate arrangements to co-operate with Local Authorities in the operation of safeguarding children's partnerships, Corporate Parenting Boards, Safeguarding Adults Boards and Health and Wellbeing Boards.	
Implementation	Appropriately engaged with all safeguarding investigations, multi-agency case reviews or safeguarding practice reviews and that the evidence of learning has been embedded into practice.	
Patient Engagement	Ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding.	
Supervision	Safeguarding supervision is available to staff in line with Intercollegiate Guidance.	
Assurance	As a commissioner of local health services, the ICB must be assured that there are effective safeguarding arrangements in place in the services and gain assurance throughout the year to ensure continuous improvement.	

Exception reporting on AMBER rating:

Implementation: Progress continues to be made across partnership boards new initiatives around sharing learning however, a system learning assurance approach is still to be fully embedded to assess impact.

Our safeguarding achievements in 2024/25 included:

- Safeguarding Processes audit undertaken by the ICB’s Internal Auditors (see page 112) with the outcome of the audit presented to the ICB’ Audit and Risk Assurance Committee (see page 93) and the ICB’s Quality and Performance Committee (see page 98).
- Safeguarding Designated Nurses have strategic portfolios aligned to the NHS Safeguarding Protocols to ensure a system wide overview of ICB responsibilities in delivering statutory duties.
- ICB formally signed up to the [NHS Sexual Safety in Healthcare – Organisational Charter](#) and has established a Domestic Abuse and Sexual Violence Working Group.
- Produced Sexual Safety in the Workplace toolkit to support colleagues in BLMK ICS to discuss and appropriately react to sexual safety of staff in the workplace.
- Child Death Overview Process (CDOP) audit undertaken.
- Review and refresh of [Multi Agency Safeguarding Arrangements](#) (MASA) and published on safeguarding partnership websites – see links below.
- NHS Safeguarding Protocols – the ICB safeguarding and vulnerabilities team are currently working to self-assess against the protocols, including an updated self-assessment against the SAAF for 2025/26

Working in Partnership - The ICB is a statutory partner on the following Safeguarding Partnership boards. The ICB is represented by our designated professionals.

- Bedford Borough Safeguarding Children Partnership
- Central Bedfordshire Safeguarding Children Partnership
- Luton Safeguarding Children Partnership
- Bedford Borough and Central Bedfordshire Safeguarding Adults Board
- Luton Safeguarding Adults Board
- Milton Keynes (Adult and Children) Together Safeguarding Partnership

The ICB’s Chief Nurse attends the partnership board’s executive committee as the ICB’s lead executive for safeguarding.

The ICB is represented on all safeguarding review panels and supports health partners including primary care with their contributions to all statutory learning reviews, adult, children and domestic homicides.

Statutory Review Activity during 2024/25:

Type	Completed	In Progress
Child Safeguarding Practice Reviews (CSPR)	4	2
Safeguarding Adult Reviews (SAR)	1	11
Joint CSPR & SAR	2	0
Domestic Abuse Related Death Reviews (DARDR))	2	8

The ICB contributes to safeguarding partnership annual reports, safeguarding partnership arrangements and published reports which can be accessed using the links provided on the next page.

Central Bedfordshire

[Safeguarding | Central Bedfordshire Council](#)

[Safeguarding Children | Central Bedfordshire Council](#)

Milton Keynes

[Annual Reports | mk-together](#)

Bedford Borough

[Safeguarding Children Partnership | Bedford Borough Council](#)

[Safeguarding Adults Board explained | Bedford Borough Council](#)

Luton

[Safeguarding children \(luton.gov.uk\)](#)

[Safeguarding adults \(luton.gov.uk\)](#)

Children and young people

Local Transformation Plan - In 2024/25 we updated our Children and Young People's Local Transformation Plan ([BLMK CYP Transformation Plan](#)) which outlines what the integrated care system will do to improve outcomes for children and young people's mental health. This sets out 6 key areas for action:

1. Driving transformation as the system comes together in the Mental Health, Learning Disability and Autism Collaborative – see page 96.
2. Optimising the use of resources across the system.
3. Developing the Children and Adolescent Mental Health Service (CAMHS) alternative to admission offer across BLMK.
4. Ensuring that there is robust and integrated early intervention support offer across BLMK.
5. Building the eating disorder offer for those with conditions such as Avoidant Restrictive Food Intake Disorder.
6. Developing the workforce for children's mental health and emotional wellbeing.

Ensuring that there is robust and integrated early intervention support offer across BLMK -

This has been a particular area of progress in the plan. We have continued to build our whole system approach to supporting emotional wellbeing based on the principles of the [THRIVE Framework for system change | i-THRIVE](#) (Wolpert et al 2019), particularly in the "Getting Advice" and "Getting Help" quadrants which provide and promote early intervention.

In Milton Keynes we have introduced an Emotional Wellbeing Service in partnership with the Voluntary Community and Social Enterprise sector which has provided early intervention support for to around 800 children and young people with mild to moderate mental health needs. This service operates alongside School Mental Health Support Teams. Two additional Mental Health Support Teams have commenced training which will result in five teams providing coverage to around 70% of schools in Milton Keynes.

In Bedfordshire and Luton an additional Mental Health Support Team has been added which results in nine teams providing coverage to around 60% of schools in Bedfordshire and Luton. These teams operate as part of a wider CAMHS Access Service with a remit of building a whole system approach to resilience and early intervention and risk prevention for those with mild to moderate mental health needs.

There is also a focus on sharing training opportunities across the system and co-producing services with young people and their families. For example in Luton, CAMHS are mobilising an “Empowering Parents and Empowering Communities” Hub which will train parents to deliver an evidence based parenting programme to other parents, with the aim of ensuring that the needs and emotions of young people can be better understood and supported at home.

Special Educational Needs and Disabilities - National statistics indicate that approximately 20% of children will have additional needs identified as Special Educational Needs and Disabilities (SEND) that make it harder for a child or young person to learn compared to others of the same age. For these children additional help is provided by health, social care, and education services to support their learning and development.

SEND legislation provides guidance and every local authority (LA) area receives an unannounced Local Area Partnership (LAP) inspection where five inspectors across health, education and social care spend three weeks looking at how well children’s needs are assessed and met, and the experiences of children using SEND services.

LAP inspection result in a one of the following ‘judgements’:

- A. typically lead to positive experiences and outcomes
- B. typically lead to inconsistent experiences and outcomes
- C. typically there are widespread and/or systemic failings

During 2024/25 two LAP inspections took place across BLMK:

- [Milton Keynes Local Area Partnership report](#) - outcome judgment B
- [Bedford Local Area Partnership report](#) - outcome judgment A

Positive findings were that many children are identified quickly and receive support for their needs across education, social care and health. Areas that were identified for improvement included strengthening the use of our data and multi-agency working to improve current processes and to address gaps and delays experienced.

Information and support for a child with SEND can be found on the ICB’s [BLMK Healthier Together](#) partnership website which has been developed in partnership with parents and healthcare professionals from across BLMK.

Partnerships for Inclusion of Neurodiversity in Schools - The national Partnerships for Inclusion of Neurodiversity in Schools (PINS) programme is designed to support neurodivergent children in mainstream primary schools.

PINS is funded nationally by the Department for Education (DfE), supported by the Department for Health and Social Care (DHSC) and NHS England (NHSE) with the funding being available until the end of a one year pilot phase ending March 2025.

PINS supports the needs of all children within a primary school setting, recognising the neurodiverse nature of classrooms. It is a partnership that brings together health and education workforces and expert parent carers into mainstream primary schools to:

- Help shape whole school SEND provision
- Provide early interventions at a school level
- Upskill school staff
- Support strengthening of partnerships between schools and parents and carers

In Milton Keynes 40 mainstream primary schools are fully engaged with the PINS programme and are currently receiving five days' worth of specialist support that was agreed collaboratively by the partnership. The newly enhanced commissioned offer will help to further improve outcomes across attainment, attendance, wellbeing and parental confidence.

The Parents and Carers Alliance (PACA) MKK and Parent Carer Forum (PCF) are a key strategic partner in the PINS programme. There are three objectives for parent carer forums taking part in PINS:

1. To work strategically with the ICB and LA partners to develop and deliver the project.
2. To work with schools, and parents and carers of neurodiverse children to strengthen relationships between them.
3. To support the development of improved co-production with families to facilitate service design and delivery.

PACA are working together with schools to deliver coffee mornings for parents and carers. These are enabling a more positive approach and are improving communication by the sharing of information and signposting.

The DfE has commissioned a process and impact evaluation, which will run until end of July 2025. The aim of the evaluation is to understand how PINS has been implemented and to examine the impact of the programme on outcomes of neurodiverse children.

The PINS national team has confirmed that the DfE will be funding a second year of the programme, (2025/26). This funding will deliver PINS to an additional 30 mainstream primary schools and to embed and sustain the 40 schools currently on the programme.

In 2025/26 focus will be on delivering the PINS programme across Bedfordshire.

Support for Children & Young People with Long Term Conditions:

Asthma - Asthma is the most common long-term medical condition in children in the UK, with around one in 11 children and young people living with asthma. It is greatly affected by the wider determinants of health and is associated with generally poorer outcomes for those in the most deprived areas.

Poor housing conditions (such as mould, damp, pollution, and allergens) can have a significant effect on asthma management, so the ICB is working with local authorities to raise awareness of the links between housing and health and initiatives which can support residents to improve their indoor air quality. Training has also been delivered to housing association staff across BLMK in order that the potentially severe health impacts are understood and help to residents can be offered as appropriate.

An average of two students in each school class have asthma. The Asthma Friendly Schools programme is continuing in Luton, ensuring that accredited schools have key provisions in place to support and safeguard their students, such as a register of students with asthma, basic training for staff and emergency medication available in case of an exacerbation. Supplementary online training specific to staff working in educational settings has also been made available to schools across BLMK.

Epilepsy - Living with epilepsy can be a significant challenge for young people and their families, with the potential for anxiety, impact on school attendance and academic attainment, and other limitations of opportunities for young people.

A community Epilepsy Nurse Specialist pilot is continuing in Bedfordshire, working with teams involved in epilepsy care to improve co-ordination and communication and act as a single point of contact for families to reduce anxiety and support school attendance. The role is also being used to develop a community of practice and improve education on epilepsy across the paediatric workforce.

Diabetes - Living with diabetes can be especially challenging for young people as they must learn to manage their condition as they themselves are growing and developing, carrying the burden of diabetes management as they navigate physical, social, and emotional developments.

Adult mental health, learning disabilities and autism

Neurodiversity

Neurodiversity is all about recognising and celebrating the different ways our brains work, including autism and attention deficit hyperactivity disorder (ADHD). Diagnosing neurodiversity means understanding these differences to provide the right support for people to live life and thrive.

During 2024/25, we re-commissioned the autism diagnostic service for Milton Keynes, which is now provided by East London NHS Foundation Trust (ELFT). As there was a significant waiting list in the former Milton Keynes service, we provided additional funding to enable the people on that waiting list to receive assessments with our other commissioned provider, [Psychiatry UK](#). We have also entered into a new contract with Psychiatry UK to provide ADHD assessment for Milton Keynes, with a new funding model that will provide the same quality of service at a lower cost to the ICB. ADHD assessment in Luton and Bedfordshire continues to be provided by ELFT.

Limited resources and capacity have been significant hurdles, along with the need for better understanding and education about neurodiversity. To address these challenges, we are working with our providers, system partners and people with lived experience to develop new pathways that aim to reduce waiting times for autism and ADHD assessments, provide choice for patients, and support pre and post-assessment.

Health checks for people with serious mental illness (SMI)

People who have a serious mental illness (e.g. schizophrenia; bi-polar disorder) are entitled to an annual health check. These checks include blood pressure, blood glucose, body mass index, blood lipids, alcohol consumption and smoking status. A patient's GP will then follow up on any concerns identified.

The 2024/25 ambition was that at least 60% of people on SMI registers would receive a full annual physical health check. At the end of Q3, (latest published data) BLMK successfully carried out 4,655 (57%)

The ICB awarded contracts to two local organisations providing outreach. Evexia is leading the project in Luton, offering home visits and appointments at base clinics, with a core team including a pharmacist, administrator, health care assistant, and paramedic. Bedoc is leading the project in Bedfordshire, focusing on data checking from secondary care and physical health checks.

Challenges in 2024/25 - The main challenges include gaining data access to GP practices for outreach providers, missing elements of the health checks and an increase in the number of declined checks across BLMK. The ICB is working with GP practices, our mental health providers and voluntary organisations to reduce those challenges, improve the offer to our patients and achieve expected performance.

Dementia diagnosis

BLMK consistently exceeded the dementia diagnosis standard of 66.7% every month of the year, ending the year with 69.3%. This puts the ICB 5.3% above the East of England average and 3.7% above the national average.

Several factors have contributed to this success. There has been a strong focus on improving the quality of life, effectiveness of treatment and care for people with dementia. Implementation of dementia care plan reviews has played a crucial role. This approach ensures that patients receive personalised and continuous care, which is essential for managing dementia effectively.

Acute Mental Health Care

The Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan was developed and implemented as part of our transformation programme. In 2024/25 there has been a particular focus on the following area's across BLMK:

- The Culture of Care Programme
- Localising and realigning care
- Reducing restrictive practices

Adult Crisis Services

Work has continued across BLMK to support residents who experience a mental health crisis, including:

- Mobilisation of 24/7 age-appropriate mental health crisis care support, via NHS 111 in Milton Keynes which means there is now 100% coverage across BLMK.
- Quality improvement projects have commenced to reduce attendance to Accident and Emergency (A&E), which is joint working between partner organisations.
- In Bedfordshire and Luton there has been a review of alternative crisis services to A&E and admission to hospital with ELFT developing community assets, working with the Lighthouse, Bedford Beacon and MIND BLMK and implementing changes to crisis lounges.
- Across BLMK there has been the on-going implementation of [Right Care Right Person](#) with partnership working with the Police, Ambulance Services and the Acute Hospitals.
- Work has commenced in Bedfordshire and Luton looking at potentially developing a crisis house and a step down unit.

NHS Talking Therapies Services

In 2024/25 there has been the mobilisation and implementation of employment advisors across the BLMK's Talking Therapies Services. We have also increased the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies.

Central and North West London NHS Foundation Trust (CNWL) in Milton Keynes have been piloting [Wysa](#), an online support application.

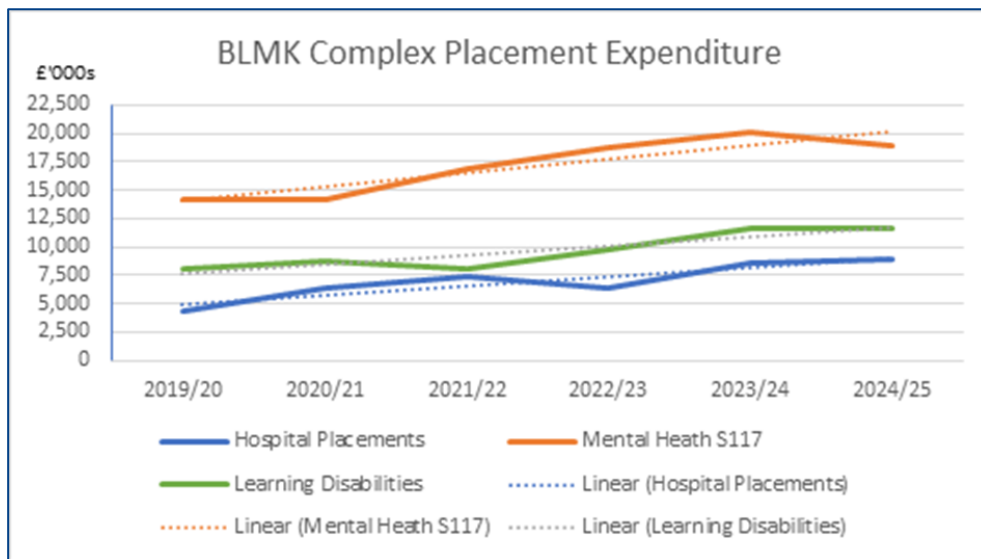
Complex Care

The majority of people receive aftercare through mainstream services such as Community Mental Health Teams. For some people, their mental health needs are more complex and they need a paid package of care, which may involve a supported accommodation or a specialist hospital placement. Section 117 is a statutory duty shared by the NHS and the patient’s local authority with funding for packages of care funded by either party or shared.

During 2024/25, BLMK health and social care partners continued to advance the Complex Care Programme, focusing on three key priorities:

- Enhancing the quality of care for people entitled to Mental Health Act (MHA) Section 117 aftercare and those in specialist hospitals.
- Improving the experience of care for service users and their families.
- Delivering better value for money across the system.

The programme has delivered **cost avoidance of £4.3 million over the past two years**, including **£2.4 million in 2024/25 alone**. However, long-standing systemic pressures continue to impact the overall financial position of complex care. The graph below shows the trend over time of complex care expenditure.



During 2024/25, the ICB agreed complex care as a transformation priority for the system (see page 10). A Mental Health Supported Accommodation Commissioning Plan was agreed during 2024/25 which will improve supported accommodation for adults with mental health needs.

Wider community mental health services developments and achievements during 2024/25 also include:

- The Early Intervention in Psychosis Services across BLMK both achieved level 4 (Top Performing) in the [National Clinical Audit of Psychosis](#).
- The harmful gambling clinic has continued to develop its support for BLMK residents. Luton has been identified as a high need area in the East of England Region.
- The adult eating disorder support service has focused on the medical emergency in eating disorders protocol and first episode rapid early intervention for eating disorders across Bedfordshire and Luton. The Intensive Community Service has been mobilised with work ongoing with the eating disorder VCSE organisation, Caraline, across Bedfordshire and Luton.
- A Service User Network (SUN) has been launched in Bedfordshire and Luton provided by MIND BLMK which is a new, open access, community-based, facilitated peer support service for adults experiencing difficulties with complex emotions often associated with a diagnosis of 'personality disorder'. SUN members are not required to have a formal diagnosis of personality disorder to access the service.
- In Milton Keynes there is a Complex Emotional Needs (CEN) peer group which provides a safe, supportive space for individuals who are experiencing difficulties with emotional regulation and who would benefit from support in a peer group setting.
- The [BLMK Suicide Prevention Action Plan](#) has been refreshed which aims to reduce the rate of suicides in BLMK over the next four years and to provide support for those bereaved by suicide.
- Work has continued with implementing the Patient and Carer Race Equality Framework across all aspects of policy, procedure and practice by the two mental health trusts.
- In December 2024 the Board of the ICB received an assurance report in relation to the provision of an intensive assertive outreach services in BLMK. A further update is due to be provided to the Board in June 2025 following publication of [NHS England » Independent mental health homicide report into the treatment of Valdo Calocane](#).

Mental Health Investment Standards

The Mental Health Investment Standard (MHIS), set by NHSE, requires all ICBs in England to increase their planned spending on mental health services by a greater proportion than their overall increase in recurrent funded allocation each year.

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

Financial Years	2023/24	2024/25
Mental Health Expenditure, £000s	168,876*	180,665
ICB Programme Recurrent Allocation, £000s	1,649,069	1,775,007
Mental Health Expenditure as a proportion of ICB Programme Allocation	10.2%	10.2%

* 2023/24 expenditure value re-stated following NHSE re-categorisation exercise

The key points to note are:

- Recurrent ICB funding from NHSE (Allocation) grew by 7.64% between 2023/24 and 2024/25.
- The recurrent ICB funding from NHSE includes a higher level of growth for targeted hospital discharge and capacity funding in 24/25. If this was excluded the growth in recurrent baseline allocation would be 6.34%.
- Expenditure in scope of the MHIS has grown by 6.98%.

Therefore, subject to independent audit, the ICB has met the requirements of the Mental Health Investment Standard in 2024/25.

Primary Care

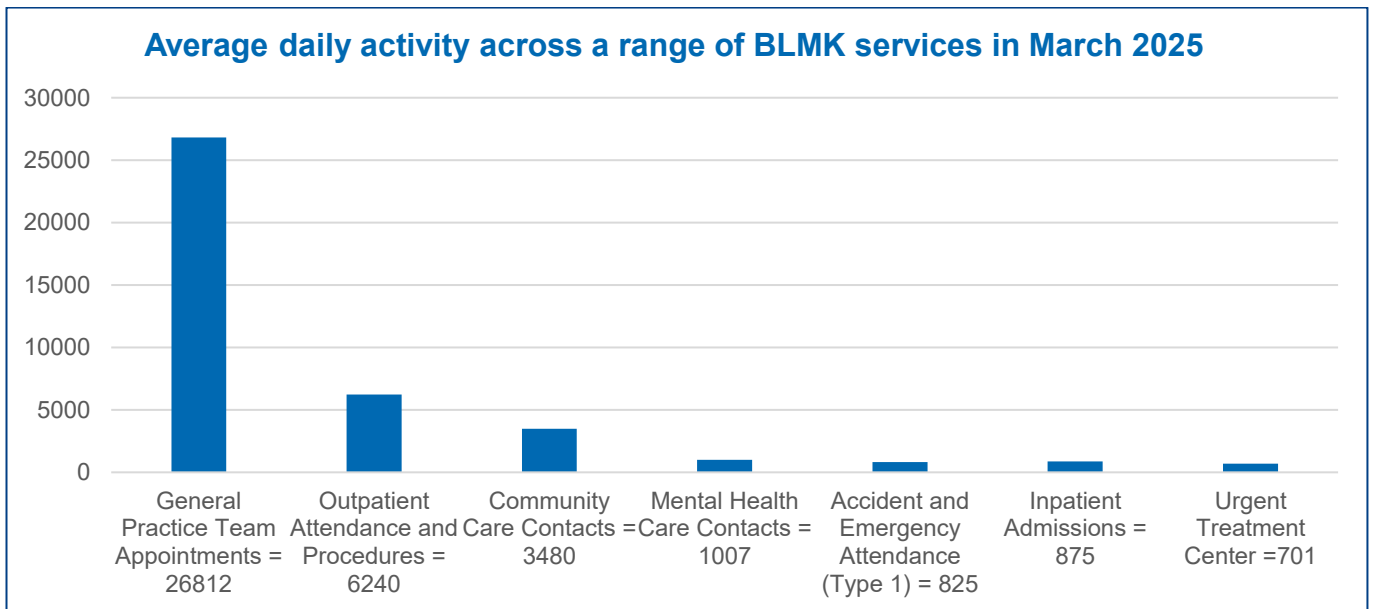
Primary Care includes 111 services, General Practice, Community Pharmacy, Optometry and Dental.

In 2024/25 primary care has made significant progress to transform and integrate. The key national strategies informing the BLMK 'Transformation Plan to Deliver the National Primary Care Strategy' are [Next Steps for Integrating Primary Care: Fuller Stocktake Report](#) (May 2022) and The [Delivery Plan for Recovering Access to Primary Care](#) (May 2023).

General Practice

During 2024/25 there has been an average of 24,372 appointments per working day in general practice on an average weekday compared to 22,578 in the previous year, a daily average appointment increase of 7.95%.

The diagram below shows the contribution general practice makes every day to system activity and access for residents and the average daily activity levels across a selection of BLMK services in January 2025 when general practice provided an average of 24,953 appointments per day.



Cloud based telephony (which uses the internet to improve capacity and capabilities) is now installed in all of BLMK general practices and is supporting Modern General Practice Access delivery.

Modern general practice access is the term used to describe a model of access – usually a triage-based approach, that moves away from appointments being provided on a first come, first served basis (the 8am telephone rush), to a consistent clinical triage approach that facilitates equity of access regardless of the method of contact (walk in, telephone call, or online request).

Over 70% of BLMK practice teams are now offering a full modern general practice access model, which means patients know on the day they contact their practice (either online, via the telephone or by attending their practice) how their need will be responded to e.g. signposted to self-care or an appointment in an appropriate timescale etc.

This multi-disciplinary approach means that the number of patients per clinician (GPs, GPs in training, Practice Nurses and Direct Patient Care staff) is 952 (Jan 2025 data). In addition to these practice-based teams, there are over 580 (full-time equivalent (fte)) multi professional staff working across their Primary Care Network to provide care to the population. ²Personalised Care staff* (172 fte) work with their communities to encourage self-care and self-management, access to digital support and making best use of the resources available to them within their neighbourhood.

Central to our plan to transform primary care is the development of learning organisations, where staff are supported and empowered to work at the top of their licence, learn and train together, skill mix is maximised, and personal and professional development prioritised. Since April 2022 we have increased our GP Educators by 52%, Nurse Educators by 93%, practice learning organisations by 29% and PCN Learning Organisations by 90%.

Pharmacy

97% of community pharmacies in BLMK are now actively providing the [Pharmacy First Service](#), with 63% of GP practices referring patients as of December 2024 compared to 7% in May 2024. Based on February 2025 data a total of 104,979 consultations were completed in community pharmacies in BLMK between January 2024 and February 2025 compared to 31,925 between the same time period in 2023. This not only reflects considerable progress in service uptake but demonstrates the increasing prominence and integration of community pharmacy as a crucial member of the BLMK primary care team.

Residents directly accessing Pharmacy First Services were responsible for more than 50% of the Pharmacy First Service (including the Pharmacy Contraception and Blood Pressure Service) which signifies increasing public awareness of the services in community pharmacy beyond the dispensing of prescriptions.

We have recruited 10 Community Pharmacy / PCN Engagement leads who are actively working to improve local communication between general practice and community pharmacy with innovative approaches to improving the patient referral pathway through active collaboration and co-production with involvement in local learning and sharing of best practice events.

² *Personalised Care staff = Social Prescribing Link Workers, Care Co-ordinators & Health & Wellbeing Coaches.

Dental

2024/25 has seen dental providers (general dentistry) delivering more of their agreed contracted activity. In 2023/24 BLMK ICB dental providers delivered 88% of their agreed units of dental activity (UDA). As of 20 March 2025 for 2024/25 BLMK providers had already delivered 88% of their contracted UDAs. Using the current run rate, dental providers should achieve 92% of their activity by 31 March 2025. However, the full year end (2024/25) reconciliation process will not conclude until September 2025 which includes the final claw back figure but the expectations based on the increased activity is that the dental clawback is likely to be circa £3.2M compared to £5.2M for 2023/24.

The Dental Recruitment Incentive Scheme (DRIS), the offer of incentive 'Golden Hello' payments to support dental practices in the recruitment of dentists, has had a positive impact. The national target for BLMK ICB was to recruit five fte dentists. As of March 2025, 3.4 fte dentists have been recruited with confirmation of 1 further fte pending.

Ophthalmic Services

The commissioning of General Ophthalmic Services (GOS) was delegated to ICBs, along with Community Pharmacy and Dentistry, from the 1 April 2023. GOS is the provision of NHS sight tests. There are 82 contractors delivering sight tests to BLMK residents with costs forecast to increase to £10.228m in 2024/25 from £9.64m in 2023/24.

Preconception and maternity

Preconception care - Non-recurrent funding from the ICB's health inequalities budget was made available for a 12 month period (February 2023 to February 2024) for a dedicated preconception pilot program with a focus on tackling disparities in outcomes in maternity care. The objective of the program was to reach as many women as possible across BLMK who were contemplating pregnancy. Our focus was on reaching communities identified in the national [Core 20 Plus 5 inequalities framework](#). We wanted to update our women with the available information to improve their health, in body and mind before they start on their pregnancy journey. We also wanted to improve more of our mothers to access antenatal care by 10 weeks of pregnancy which is recorded in our monthly maternity dashboard.

BLMK ICB is now part of a national research collaborative with [National Institute of Health and Care Research](#) to develop a national framework to deliver preconception care. This is a national movement to change the dial in addressing national disparities in maternity care. Our systemwide BLMK preconception program is being considered as a blueprint.

As part of this programme a number of pilots with evaluations were introduced in 2024/25 including:

- System wide preconception program mobilised through engagement in community, primary care, women's groups and hospital clinicians. Preconception clinics are in operation in Bedfordshire and Milton Keynes Hospitals. The pilot is being planned for 85 women with complex obesity to undergo intensive therapy with Tier 3 obesity service, specialist dieticians and novel medication.
- Bedford Borough social prescribing link worker who works with midwives to support mothers from diverse and disadvantaged communities with non-clinical social issues that impact on maternal health. A social prescribing link worker has seen 77 women from diverse communities and have supported them for a wide variety of non-clinical reasons such as housing, nutrition, mental health and education.
- Luton & Dunstable Hospital is in the third year of a national genetic risk program to support families who have close relative unions and are at risk of transmitting autosomal recessive conditions. The program promotes awareness and training for midwives, nurses and other front line staff. communities and families who need support have access to genetic testing from our regional genetic centre at Northwick Park.

Maternity - In 2024/25 there was a big focus on reinvigorating BLMK's Local Maternity & Neonatal Service (LMNS) priorities and governance, this has included recruitment to a Chief Midwife to lead on the programme. For more information on LMNS see page 36.

In 2024/25 we have:

- Planned permanent recruitment of Maternity & Neonatal Voices Partnership (MNVP) leads, including one overall LMNS MNVP lead to ensure that patient voices are at the centre of our work.
- Worked closely with Bedfordshire Hospitals to implement an Improvement Board, supporting the Trust to make improvements following the 2024 Care Quality Commission (CQC) outcome.
- Implemented a working group to review escalation of maternity and neonatal beds through a local escalation steering group.
- Developed a working group with our Business Intelligence Team to review available data and how this can be streamlined and automated to support clinical time and regular review of patient outcomes through the correct governance.
- Commissioned a sustainable smoke-free pregnancy pathway which has reduced the number of women who smoke at time of delivery.
- Supported recruitment and retention programmes with Bedfordshire Hospitals and Milton Keynes Hospital to reduce the number of vacant posts across local maternity services.

Improving cancer outcomes

The rates of cancer diagnoses are increasing with cases projected to continue rising over the next 10 years. The focus of our work is to ensure that people are diagnosed as early as possible; to ensure that they are able to access curative treatment and have better chances of living a full and happy life after treatment has been completed.

During 2024/25 we have:

- Increased the number of stage 1 and stage 2 cancer diagnoses being made, overall, 64.9% of our diagnoses are 'early' cancers. This is above the East of England average of 60.3% and ensures that we are able to offer curative treatments and improve outcomes.
- Improved our position against faster diagnosis performance metrics informing an increased number of patients of a diagnosis within the first 28 days of their pathway.
- Promoted uptake of cancer screening campaigns by holding screening saves lives events in Bedford and Milton Keynes that included informative patient videos to explain the purpose of screening and what to expect at their visit. We have also increased the resources available to patients that are eligible for screening to include videos and text messages as well as developed a booklet specific to residents with learning disabilities and autism to encourage attendance.
- Developed our approach to cancer case finding, extending the reach of the Targeted Lung Health Check programme into Milton Keynes and run specific prostate cancer case finding initiatives in at risk groups to support early diagnosis ambitions and ensure that patients have access to treatment as early as possible.
- Continued working with local communities to understand our population and further our understanding of barriers to accessing healthcare. We have held forums to discuss cancer from a faith perspective bringing local faith groups together to share their experiences and ensure that faith leaders are empowered to support their communities. Engaged with communities in 'screening saves lives' events and evaluated the impacts of our community connector programme and the readiness of our communities to engage with cancer related healthcare following initiatives running in Luton.
- Continued efforts to improve the quality of life for residents living with a cancer diagnosis by increasing the number of Level 4 Personal Trainers operating across BLMK and collaborating with Health Innovation East to evaluate our Cancer Pre-hab / Re-hab programme, identifying opportunities to enhance our current provision. We also held a 'Living With and Beyond Cancer' conference that brought together patients and professionals across BLMK to discuss the coordination of services and raise awareness of services available.
- Continued to support our primary and secondary care colleagues through education events to raise awareness of signs and symptoms of cancer, implement unscheduled bleeding on hormone replacement therapy (HRT) pathways and facilitate increased clinical conversations between system partners.
- We showcased the work happening in BLMK with our peers through presentations at the Capsule Sponge Symposium, East of England Cancer Summit and panel representation at the Health Service Journal (HSJ) inequalities forum, Deloitte's and Cancer Research UK webinars focussing on access to screening.

Personalisation of care

Working with people so that care is right for their needs

Shared Decision-Making - A shared decision-making (SDM) conversation gives patients an understanding of their treatment and care options and helps to put them in charge of their healthcare journey. We are increasing SDM in planned care areas including musculoskeletal and dermatology.

SDM and support for advance care planning have become commonplace in primary care so that every individual is able to voice 'what matters to me' rather than thinking 'what is wrong with me.' This is evidenced in personalised care and support plans, as part of the primary care enhanced health in care homes framework. Our multidisciplinary teams also work together to highlight where SDM is needed.

Health Coaching - Health coaching is delivered by Health and Wellbeing Coaches as part of the extended Primary Care Network Team, providing personalised support to service users. Currently there are 25 Health and Wellbeing Coaches across BLMK. These coaches use specialist coaching approaches and behaviour change techniques to empower individuals to take control of their health and wellbeing.

Social prescribing - We know health and wellbeing issues can emerge if a resident's practical, social and emotional needs are not being met. Social prescribing is when a social prescribing link worker works with a patient to identify these individual needs. They then connect them with activities, groups and services in the community. Social prescribing link workers give their clients time, focusing on what matters to them. They co-produce a simple, personalised care and support plan which helps people to take control of their health and wellbeing.

Green Social Prescribing - Green Social Prescribing is "the practice of supporting people to engage in nature-based interventions and activities to improve their wellbeing and mental and physical health."

The ICB has commissioned Bedfordshire Rural Communities Charity to provide this service. The current green social prescribing offer provides support with:

- Mental health
- Social activity
- Physical activity
- Signposting to further support via community referral

The service connects users with nature through well-being walks, conservation work, community gardens and nature-based wellbeing groups.

Green Social Prescribing Case Study – Click on the [link](#) to hear directly from our residents how this year's Rail to Roots project has supported them to access green spaces by bus and rail and have a positive impact on their lives.

Personalised care and support planning - Personalised care and support plans are being used across numerous health and care pathways. These include maternity, continuing health care, cancer and the Enhanced Health in Care Homes framework. The plans involve clinicians and care coordinators working with service users and where appropriate, their carers and families. Together they agree the health and wellbeing outcomes that matter to the patient and how best to deliver the treatment plan.

Enabling choice - We currently provide choice of GP practice. However, if someone is a resident permanently living in a care home, we do encourage them to register with the aligned GP practice responsible for supporting that home, so that they can fully benefit from the Enhanced Health in Care Homes programme. We also provide choice at point of referral and for personal health budgets.

Personal health budgets - The Personal Health Budget (PHB Team) have worked closely with the Continuing Health Care (CHC) Team to improve processes to better provide PHB's to clients.

Personalised Care Lead - This role supports the recruitment, integration, development, and retention of Personalised Care roles across BLMK Primary Care Networks (PCNs) and Practices. This involves delivering peer support forums and learning sessions. A key focus is on improving data and reporting by piloting the Athena dashboard, simplifying reporting processes and tracking impact across PCNs. The role also ensures personalised care teams have access to training, facilitation skills, and data analysis support, helping to address system challenges and drive meaningful change.

Personalised Care Events - Quarterly events have been held across BLMK, working with Place Teams and supporting Personalised Care Roles to embed Personalised Care and adopt an Integrated Neighbourhood Working approach to improve the health and wellbeing of our population, as laid out in [NHS England's Neighbourhood Health Guidelines](#).

Planned care

Elective care services are services that are planned, non-urgent and usually delivered in hospitals. They include tests, scans, surgery and cancer treatment. In 2024/25, the focus continued on 'recovery' of elective care services, particularly for patients waiting the longest for outpatient appointments, diagnostics tests and cancer treatment.

Reducing Long Waits - The objective in 2024/25 was to eliminate all waits for elective care beyond 65 weeks. In May 2024, there were 2130 residents in BLMK waiting more than 65 weeks for their treatment.

Eliminating all 65 week waits presented a significant challenge for our system. Sustained urgent and emergency care pressures, financial constraints and workforce challenges all hindered progress. To offset this, Bedfordshire Hospitals and Milton Keynes Hospital secured additional elective care capacity through insourcing and outsourcing arrangements, alongside improved internal productivity, and efficiencies such as theatre productivity and validation of wait lists. The ICB also commissioned additional Independent Sector capacity to support ongoing demand.

The recovery of long waits was a challenge throughout 2024/25 and additional support was given from NHS England, particularly to Milton Keynes Hospital. By 31 March 2025, the number of residents waiting longer than 65 weeks reduced to 53 with most of these long wait breaches occurring under the care of Milton Keynes Hospital and a small number at independent sector hospitals. Bedfordshire Hospitals treated all patients waiting longer than 65 weeks.

Diagnostics - Demand for diagnostics continued to grow during 2024/25 across BLMK and has been particularly exacerbated by pressures in urgent and emergency care services and improving long waits for elective care and cancer treatment.

Whilst diagnostic waits over six weeks remain above our local target of 15%, there have been some improvements across particular diagnostic modalities (see below) such as Magnetic Resonance Imaging (MRI) and Non-Obstetric Ultrasound (NOUS).

- For MRI, those waiting more than 6 weeks stood at 19% of the total waiting list in April 2024, this reduced to 12.1% by 31 March 2025.
- For NOUS, those waiting more than 6 weeks stood at 43% of the total waiting list in April 2024 and reduced to 27.7% by 31 March 2025

This has been driven through the go live of Community Diagnostic Centres (CDC) at Lloyds Court and Whitehouse Park in Milton Keynes and mobile diagnostics for MRI and Computed Tomography (CT) in Bedfordshire.

Outpatient Transformation and Productivity - The NHS continues to look at improvements in how outpatient services are delivered so that patients can be seen more quickly and can access and interact with services that better suits their needs. We have continued to empower patients to book follow up care when they need it and worked with GPs to enable access to expert advice & guidance as early as possible through the NHS Electronic Referral System (e-RS) and Consultant Connect.

Patient Initiated Follow Up (PIFU) progress has been slow during 2024/25 across our two main hospital Trusts (Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes NHS Foundation Trust) with current utilisation rate in BLMK at 2.4% (as at March 2025). With dedicated resource in place and working directly with both Trusts, a work plan has been developed which ensures the foundations are in place to increase PIFU utilisation. This includes engaging with clinical teams, standardising PIFU processes, PIFU utilisation included in Trust dashboards and revising patient information on PIFU. This will support further progress of PIFU during 2025/26.

For the year ending 31st March 2025, BLMK ICB was within the highest quartile for theatre utilisation at 83.8%. Milton Keynes Hospital achieved 82.1% which is an improvement on 7 April 2024 position of 78.4% theatre utilisation. For Bedfordshire Hospitals, there was an improvement in theatre utilisation from 77.8% in April 2024 to 84.3% by the end of March 2025. (Data source: Model Health System data).

Both Trusts have utilised the [Getting It Right First Time](#) (GIRFT) Further Faster Handbooks and have worked with system perioperative clinical leads to drive productivity improvements. The perioperative leads have focussed on cancellations and postponement, engaging clinicians in the audit process (100% submission from all BLMK sites) and developing improvement plans to reduce cancellations in 2025/26.

In terms of improvements in the number of procedures completed in a day case/outpatient setting, this has remained fairly flat from 83.4% in April 2024 to 83.2% in November 2024. However, peaks were seen in June 2024 and July 2024 at 83.9%.

Patient Choice - The ICB continues to support patients with Right to Choose through accrediting and awarding contracts to providers in 2024/25. During 2024 the ICB has accredited and awarded contracts to two providers covering ophthalmology services and Direct to Test Endoscopy. The ICB is also in the process of reviewing an accreditation request for dermatology services. This will continue to support our elective recovery as well as giving residents a greater choice on who they see for their treatment.

Urgent and emergency care

Throughout 2024/25 the ICB and NHS partners have supported residents to stay well at home by avoiding unnecessary admissions and safely supported discharges following an admission to hospital. Transformation has covered multiple areas with the primary intent of ensuring patient outcomes are optimised through reduced hospital and community bed discharge delays and facilitating more patients to have their care delivered at home.

In Milton Keynes, an Integrated Discharge Hub (IDH) has been created to support patients leaving the hospital to receive tailored support after discharge. The IDH consists of multi-disciplinary professionals from Central North West London (CNWL) NHS Foundation Trust, Milton Keynes City Council (MKCC), Milton Keynes University Hospital (MKUH), and the voluntary sector all co-located.

To further strengthen patient recovery and independence, a joint Care Academy has been introduced in collaboration with CNWL, MKCC, and MKUH. The academy focuses on improving reablement skills across various healthcare roles, equipping professionals with the expertise to support individuals in regaining their independence after a hospital stay. Additionally, a new joint health and social care pathway has been developed to provide adaptable, patient centred care. The pathway ensures that as individuals recover, their needs are met with the right combination of health and social care support.

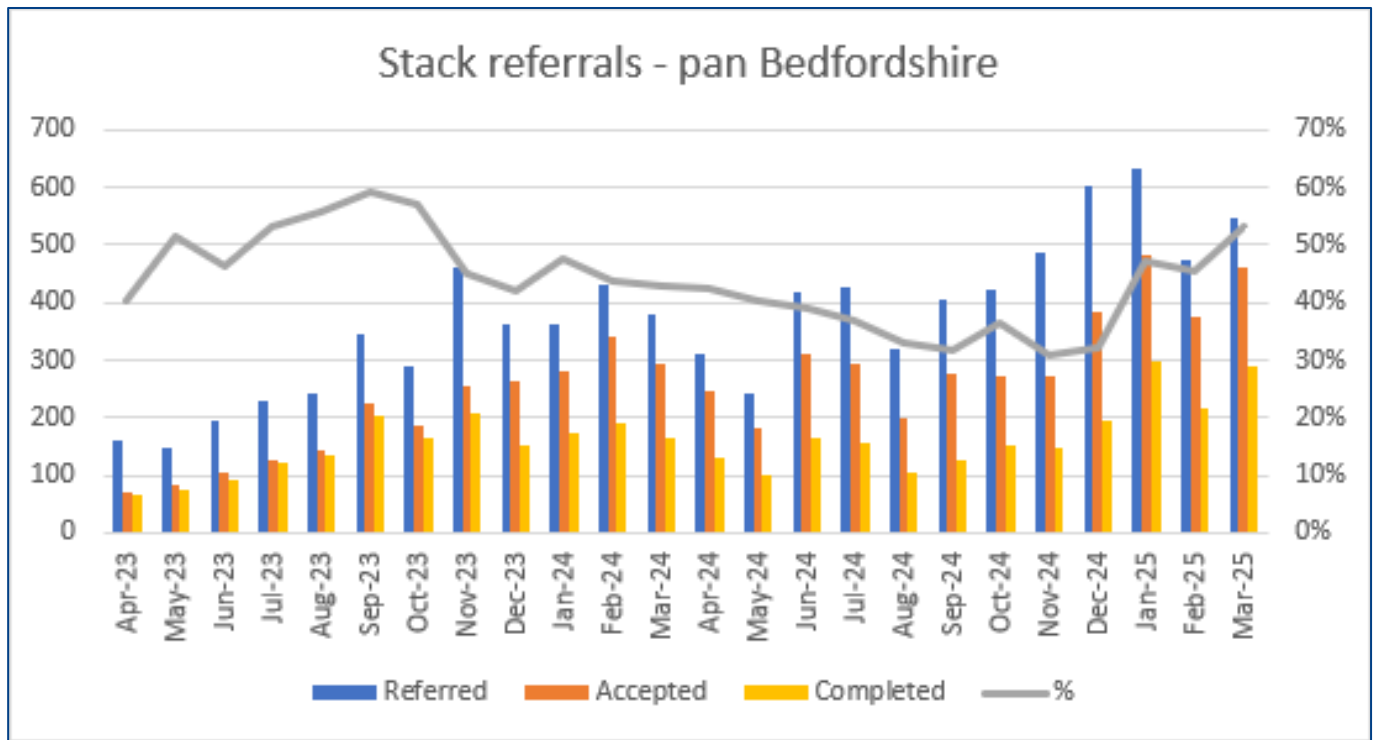
Looking ahead to 2025/26, a High-Intensity User (HIU) Service will be proactively identifying individuals who frequently require emergency care. By addressing the non-medical underlying causes that contribute to repeated Accident and Emergency (A&E) visits, this initiative aims to reduce emergency attendances and subsequent admissions to hospital.

Bedfordshire Unscheduled Care Coordination Hub - Hospital Attendance/Ambulance Conveyance Avoidance

Bedfordshire's Unscheduled Care Coordination Hub (UCCH) commenced in January 2025 with East of England Ambulance Service Trust NHS Trust (EEAST) paramedics, acute consultants, urgent community response teams and frailty teams supporting a single point of access (SPOA) for healthcare clinicians to discuss and arrange support for residents healthcare needs out of hospital. Call before Convey is mandated for care home conveyances, frail/falls patients and those which sit within the urgent community response acceptance criteria.

Since January 2025, the Unscheduled Care Coordination Hub has discussed the care needs of over 1500 residents in Bedfordshire with over 1000 clinical episodes of care accepted into the service. Due to the number of patients accepted into the UCCH, this service now ranks as one of the best in the East of England.

The graph below articulates the number of patients that the Bedfordshire UCCH have removed from the 999-ambulance stack (residents awaiting an ambulance to be sent) by using alternative pathways to ensure residents receive the care they need at home and therefore negate the need for an ambulance and hospital attendance.



Milton Keynes Unscheduled Care Coordination Hub

The UCCH in Milton Keynes has not enjoyed the same success as in Bedfordshire because community clinicians are unable to access to the 999-ambulance stack (a digital platform where all requests for ambulances are logged) and find cases where residents needs could be managed elsewhere. Any transfers of care into the UCCH are therefore dependent on ambulance clinicians having a comprehensive knowledge of what the community services can safely offer whilst the assessing patients clinical needs. Whilst a small number of cases have been referred to community services, Central North West London NHS Foundation Trust (CNWL) and South Central Ambulance Service NHS Foundation Trust (SCAS) continue to work together to develop a UCCH pathway that improves the care for residents and this will be a focus throughout 2025/26.

BLMK Virtual Wards

Virtual Wards are community services that support patients at home as opposed to remaining or being sent to hospital. They can support residents by avoiding an unnecessary hospital stay or facilitating an earlier discharge by continuing their care in the community.

In Milton Keynes there has been capacity to support 75 residents any one time with utilisation rates consistently more than 80%. In Bedfordshire there has been capacity to support 265 residents with utilisation rates variable, but generally above 60%. Whilst utilisation rates have been below the target of 80%, the service has continually engaged with secondary care to try and find suitable patients to support, and this is ongoing.

In 2025/26 the Virtual Wards in Milton and Bedfordshire will reduce their capacity. This is in response to the national drive to focus on more complex care and reduce the virtual ward capacity to 20-30 patients per 100,000 population. Milton Keynes will therefore reduce its capacity at any one time to 50 patients and Bedfordshire to 235. There will be a greater focus on frailty, respiratory and cardiology conditions and the system remains confident it can achieve occupancy rates in excess of 80%

System Coordination Centre (SCC) - Operational System Oversight

BLMK's System Coordination Centre (SCC) has developed throughout 2024/25 and now offer a seven day a week service which support system partners to increase discharges and decompress operational pressures. This ICB led service has provided support and co-ordination throughout the year but in particular has made a positive contribution during challenging winter periods where significant infection and prevention control issues occurred.

The SCC/urgent and emergency care (UEC) team have supported a reduction of out of area delays, specifically in Milton Keynes, and actively supported ELFT's mental health team to improve flow out of acute and community beds. The SCC alongside secondary care providers have reviewed the Same Day Emergency Care (SDEC) services and developed a programme plan which will be implemented in 2025/26 aiming to ensure greater compliance with the national service specification.

Digital improvements have been achieved in 2024/25. An early warning forecasting tool has been developed and is being tested by the SCC. This will hopefully allow the SCC and NHS partners to predict operational pressures allowing proactive action to avoid urgent and emergency pressures and mitigate risks. The Single Health Resilience Early Warning Database (SHREWD) has been embedded in SCC and partner organisations operational processes. This allows all partners to see demand and pressure across the East of England enabling decisions to be made about how care can be managed or supported.

A UEC programme plan has been developed for the Bedfordshire Care Alliance (BCA) and Milton Keynes Together drawing from the alternatives to Accident and Emergency (A&E) review, Better Care Fund analysis and internal plans to enable prioritisation of key improvements to support system flow, admission avoidance and integrated neighbourhood health at place.

Pre-planned decompression events, multi-agency discharge events (MADE) and enhanced patient transfer meetings were scheduled throughout the year demonstrating a robust system approach to support flow by removing barriers and ensure collaborative working. The MADE events are planned to continue throughout 2025/26. In addition, complex multi-disciplinary team meetings have been established to ensure the needs of the patients have been identified early and effectively managed to avoid unnecessary delays and duplication in the patients journey and discharge.

BLMK remains a challenged system with high demand and complexity of care. Despite this we continue to maintain strong performance across a range of urgent and emergency care measures. As an example, BLMK is the only system across the East of England to consistently achieve the 'ambulance handover hours lost fair share' target which helps to release ambulances in a timely manner so they can respond to other medical emergencies. BLMK also perform well in regard to the 60 minute ambulance handover target and 12-hour patient journey time in ED and identified by NHS England as a top performer against the new 45-minute release to respond ambulance target.

BLMK is below the 78% 4-hour performance target with a deteriorated position from 2023/24. However, there are Bedfordshire and Milton Keynes Trust specific improvement plans in place to support achievement of this metric through 2025/26.

Palliative and end of life care

Providing high-quality, coordinated care to individuals at the end of their life is a critical priority both locally and nationally. With the aging population growing rapidly, BLMK faces an increasing demand for effective, community-centred palliative and end-of-life care services. Over the next 15–20 years, the number of residents over 75 is projected to increase by more than 25% (BLMK Joint Forward Plan 2024). In response to this urgent need, in May 2024, BLMK ICB Chief Nurse initiated a review of adult end-of-life services across BLMK.

Families, carers, service users, frontline staff, managers, commissioners, and system leaders from across BLMK all contributed to the review, sharing their challenges and aspirations. Frontline staff played a particularly supportive role, offering their expertise to ensure organisational memory would inform the improvement process. Everyone recognised that this review would serve as a launch pad for sustainable change, leading to measurable, positive outcomes for the population of BLMK.

The review culminated in the "BLMK Dying Well Report," which was presented at a meeting of the Board of BLMK ICB in December 2024 by Sarah Stanley, Chief Nurse of BLMK ICB, and Elaine Tolliday, Clinical Director of Keech Hospice. The Board fully endorsed the recommendations of the review and approved the creation of a new Palliative and End-of-Life Care (PEoLC) Programme Board to oversee the development, implementation, and any necessary business cases. The ICB Board also tasked the PEoLC Programme Board with prioritising objectives for 2025/26 and defining outcome measures.

End of life care is one of the ICB's three transformation priorities. For more information on our Transformation Priorities - see page 10.

During 2024/25 the PEoLC Programme Board was established and is supported by Place-Based End-of-Life working groups in Milton Keynes and Bedfordshire. This enables enhanced integration of the broader system. The first meeting of the PEoLC Programme Board took place in March 2025. The programme has been designed to maximize opportunities for system-wide collaboration, building on developing relationships and arrangements to integrate care.

The Place Based End-of-Life working groups are strategically aligned with the NHSE Ambitions for Palliative and End-of-Life Care, with several key initiatives currently underway, will focus on:

- improving coordination of care,
- expanding access to end-of-life services,
- supporting equitable service delivery across local areas,
- enhancing hospice sustainability through long-term contracts, and
- conducting capacity and demand modelling. This modelling will help ensure that the right resources are deployed in the right place at the right time to improve outcomes for patients, carers, and their families.

Research and innovation

The BLMK ICB Research & Innovation (R&I) programme sets out our vision to grow a thriving system that enables and facilitates innovation and research as key elements of a thriving health and care system. During 2024/25 we have embedded our Research and Innovation programmes across secondary, primary and community care across Bedfordshire, Luton and Milton Keynes to enhance the quality and safety of services accessible to our local population. Through collaborations and partnerships, we aim to develop research and innovation capabilities and infrastructure to positively impact the healthcare landscape.

Developing Research and Innovation Capabilities and Infrastructure

Some examples of the work we have undertaken to support research and innovation in our system to date:

- **Established the BLMK ICS R&I Network:** The BLMK ICB Research & Innovation (R&I) programme has grown in scale and impact across 2024/25, with a focus on tackling health inequalities, building research capacity and embedding innovation in care delivery. Chaired by Professor Sir Keith Willett, the BLMK ICS R&I Network now includes over 100 members across the system, to collectively promote shared learning and establish new ways of working together as a system.
- **R&I Plan:** We delivered two workshops with BLMK R&I ICS Network members to co-produce a two-year R&I which is due to be published in April 2025. The R&I plan will further embed our approach into our whole system research, transformation and innovation.
- **Joint Head of Research Role:** Secured funding from the Regional Research Delivery Network (RRDN) to support a joint Head of Research role within BLMK ICB, which commenced October 2024 to support with embedding research across primary care settings, meeting our statutory requirements to NHS England and reporting against key research metrics.
- **Primary Care Research Capability Development:** We ran a competitive funding call for [National Institute for Health and Care Research](#) (NIHR) Research Capability Funding and awarded at total funding of £30,000 which enabled eight GP practices, many serving high-deprivation areas to upskill staff and deliver research.
- BLMK ICS & University of Bedfordshire Research and Innovation Hub is supporting 17 active research projects aligned with local population health needs and workforce challenges.
- Secured **£45,000 in funding from the NIHR Applied Research Collaborative (ARC)** to support a Knowledge Mobilisation role. This position will facilitate the alignment of research and innovation findings across BLMK networks and workstreams, informing transformation decisions, supporting ICB partners to deepen their understanding of evidence-based practices, and explore avenues for incorporating research and innovation into service design and delivery.

Addressing Health Inequalities through R&I

- **Research Engagement Network (REN) Funding:** BLMK R&I team, in collaboration with Health Innovation East, East London NHS Foundation Trust, the VCSE sector collaborative, and University of Cambridge, secured a second phase of funding from NHSE for our Research Engagement Network which increased the diversity of residents in BLMK getting involved in research, both as participants and in study design.
- **Diabetes:** The Research Engagement Network (REN) programme has actively tackled regional health challenges related to diabetes by establishing community-based research champions. In BLMK, 6.5% of the population has been diagnosed with diabetes, with a disproportionate impact on people from ethnic minority backgrounds and those living in areas of high deprivation. As part of the REN initiative, the Research Champions programme delivered six community roadshows across Luton (Feb–Sept 2024), engaging over 400 residents, primarily from underserved and ethnically diverse communities. Feedback from participants showed that 84% reported an improved understanding of health research, helping to build trust, awareness, and readiness for future diabetes-related research participation.
- **Children and Young People’s Mental Health:** An additional £79,000 in funding was secured to develop Research Champions focused on increasing participation in mental health research among children and young people (CYP) from groups that are typically underserved by research. This project responds directly to BLMK’s system-wide priorities: the rising prevalence of CYP mental health needs, the diverse demographic profile of the local population, and the recognised underrepresentation of these groups in research. The programme included bespoke mental health training, co-designed with CYP and delivered by East London NHS Foundation Trust (ELFT) social prescribing link workers, people participation workers from ELFT, and [CHUMS](#) (mental health and emotional wellbeing service) child welfare practitioners. The training covered not only the mental health needs of CYP but also provided insight into the support needs of their families. In addition, NIHR Research Ready Communities training was delivered to social prescribing and participation workers to build capability in engaging communities in research. The programme has already led to further workshops to co-design research projects shaped by the lived experiences of CYP in Luton who access mental health services, helping to ensure that emerging studies are grounded in the unmet needs of the population.
- **Maternity and Women’s Health**
 - **Maternal Disparities NIHR Collaborative-** BLMK is part of a diverse consortium of organisations which launched in December 2024, having successfully secured funding from the NIHR over 5 years, to support research and capacity building to increase the evidence base to drive actions to reduce maternity inequalities and lead to better outcomes for women and their babies. Disparities in maternity outcomes are heavily influenced by factors before pregnancy and outside healthcare and the risk of dying from pregnancy or birth in the UK has risen since 2000. This consortium aims to address the pre and inter-conception challenges and healthcare disparities experienced by Women across Bedfordshire, Luton and Milton Keynes.
 - **The PARTNER Trial** successfully supported Bedfordshire Hospitals in taking part in the PARTNER Trial. The Trial uses the [TOMMYS](#) (a pregnancy and baby charity) decision tool to enable midwives and doctors to more accurately assess each woman’s needs during pregnancy and to personalise their care, using latest evidence and national clinical guidelines.

- **Innovative Spirometry Project:** In October 2024, BLMK was the only system to successfully bid for **£79,000 in regional NHSE funding**. This project aims to improve early and accurate diagnosis and scale up spirometry, with a focus on addressing health inequalities in Milton Keynes. The four-workstreams included outreach in drug and alcohol services, creation of a spirometry hub in 7 high-deprivation practices with the lowest 20% IMD area, and mentorship for professionals. Early clinics identified undiagnosed chronic obstructive pulmonary disease (COPD) and enabled targeted cessation advice.
- **Automated red cell exchange service (Spectra-Optia) for sickle cell:** Milton Keynes University Hospital NHS Foundation Trust (MKUH) and Bedfordshire Hospitals NHS Foundation Trust (BHFT) have secured recurrent national funding from specialised commissioning to provide this service in BLMK, enabling care closer to home for over 40 residents who currently require red cell exchange. There is predicted growth in need for the service, with Luton having one of the highest numbers of residents with sickle cell in the East of England.
- **GaitSmart Pilot for Fall Prevention: Piloted in four locations across BLMK** to increase physical activity and reduce fall risks. A final evaluation report is expected by April 2025, with regional and national interest in the findings. Interim findings reported 86% of users experienced improvement in their mobility and 34% decrease in those categorised as high concern of falling

The first-ever **BLMK ICS Research & Innovation Awards** were created and funded by the hub, awarding a total of **£45,000** to three local BLMK projects:

- Proactively identifying and meeting the needs of the over-75 population in Milton Keynes.
- Assessing the determinants of unequal cardiovascular disease outcomes in Luton.

[Young Men's Christian Association](#) (YMCA) and MKUH navigator project is part of a public health approach to violence reduction within the community to support vulnerable young people and reduce their re-attendance in Accident and Emergency (A&E) 592 young people took part in the scheme and were paired with a volunteer navigator. 70% of people referred to Hospital Navigator Scheme did not reattend A&E Emergency Departments for the same reason within 12 months of their referral.

Engaging people and communities

Working collaboratively with people and communities is at the heart of everything we do in BLMK. We comply with our legal duty to involve the public and believe that listening to local people, and co-designing approaches not only makes us more accountable but enriches our services and ensures people have opportunity to shape and improve them.

Meeting our legal duty - Our [Working with People and Communities Strategy](#) which was refreshed in 2024/25 sets out our approach to engaging locally, and outlines our commitment to:

- Listening to insight and resident voice and applying what we have heard to inform and shape strategy and policy in our area.
- Embedding co-production approaches – working with people and communities on the issues that are most important to them.
- Learning from our landmark [Denny Review](#), which has been developed into the Health Equity Programme, to help residents feel better supported and that there is a place for them in the NHS.

In accordance with the Health and Care Act, 2022, we have worked to ensure that we continue to meet our legal duties, working with Health Overview and Scrutiny Committees to channel our engagement work and ensure that resident voices are central to decision making.

In 2024/25 we have:

- Drawn on the voices of more than **2,000** people who contributed to the Denny Review to refresh our [Joint Forward Plan](#) and inform our system wide [Health Service Strategy](#).
- Re-engaged with more than **300** people from different communities to test what we heard from the Denny Review and identify new areas of need.
- Worked with Healthwatch to hear the views of **200** people who experience translation and interpretation barriers when accessing health and care.
- Established **deeper** relationships with Gypsy and Roma communities, as well as residents from Caribbean, African and south Asian communities as part of our continued conversations.
- Worked with **174** people as part of a process to re-design and reprocur musculoskeletal services across BLMK.
- Attended 27 events across our area and engaged with more **709** people to provide support and signposting to health and care services.
- Engaged with more than **100** people on the future of the NHS, as part of a new system wide Insight Network, which was established to put insight at the centre of decision making in BLMK.
- Engaged over **500** patients to discuss changes being made to their GP surgeries and the launch of an Enhanced Service Centre in Bedford.
- Reached **640,292** people through our corporate social media accounts and **67,300** people through our corporate websites – encouraging participation.

How we engaged, listening to insights - In 2024/25, we engaged residents, partners, advocates, community and faith leaders to ensure local people were given the opportunity to share their views and shape health and care services.

In May 2024, we held an event to bring together residents, partners and health and care professionals to reflect on what we had heard from the Denny Review and launch a three-year Health Equity programme to create a 'fairer BLMK'. At the event, we launched a Learning Action Network, which brought together representatives from communities known to be 'at risk' of hypertension to increase healthy life expectancy and reduce the prevalence of heart attacks and strokes.

From June 2024 to November 2024, we ran a series of spotlight events in our four places to share what we had heard from local people and ask for their feedback and insights to better understand what we'd missed and how we could bridge the gaps.

From September 2024 to February 2024, we worked with our four local Healthwatch to undertake a quality improvement exercise with people who experience barriers to health and care because of translation and interpretation services. The feedback from the engagement is being used to develop a new approach across BLMK.

From October 2024 to February 2025, we ran an extensive winter engagement campaign (see photo below) – using what we had heard from residents to explain to local people how they can access health and care services without going to Accident and Emergency (A&E).



We applied learning from the Health Equity Programme and co-designed a series of leaflets and videos to support local people and reflect their preference for different and accessible communications.

During 2024/25 we worked to listen to residents about concerns they have about health and care services. We have engaged and listened to residents from Leighton Buzzard, Wixams and Biggleswade, who have expressed concern about the capacity of health and care services in their neighbourhoods, and we have worked with them to share their insights with the Board and seek solutions.

We have also worked closely with members of the Roma community, Autism Bedfordshire, deaf residents and Somali Voices (see photo below) to listen to their concerns and advocate for them within the ICB and across the system.



In the past year, we have also worked with residents and health and care professionals to review translation and interpretation services. Through our engagement work, we heard that many residents drop out of the system, because of challenges in accessing services. We commissioned Local Healthwatch to help us understand this more and in February 2025, the ICB received a report on translation and interpretation services, which is being taken forward as part of our Health Equity Programme. We expect to provide an overview of how this work will benefit residents during the next year.

In addition, we continue to work with residents to listen to their views on the quality of services we deliver and their experience. In the past year, many residents have attended the ICB Board to share their stories, and influence policy decisions undertaken by the organisation. Their stories have led to changes in how we work, for example the story of a deaf resident has prompted us to consider how we engage with deaf communities and ensure that we continue to meet the Accessible Information Standard as a system.

Insight is central to our work in BLMK. In January 2025, we launched the System Insight Network to provide a regular mechanism for listening to insights from residents. The System Insight Network evolved from the Working with People and Communities Committee, allowing for greater sharing and richer insight to be used to inform strategy and policy in our work.

The Insights Network will meet four times per year and give local people the opportunity to share their views on the most important issues facing them – with reports being shared with the Quality and Performance Committee (see page 98), the Board of the ICB, commissioners across the system and residents.

Understanding others - We have heard that a lack of understanding of people and communities often created barriers to access and led to people ‘dropping out’ of the system and poor health outcomes. During 2024/25, we have worked to increase understanding of our population.

From May 2024 to February 2025, we ran a series of webinars and events with partners, advocates and residents to help people understand the different cultures in BLMK. We heard from:

- Gypsy and Roma people about their culture, history and the barriers they face
- Caribbean and African colleagues and residents on Black Leaders Day
- South Asian residents during South Asian Heritage Month and attended community led ‘Chai and Chat’ events
- Caribbean and African colleagues during Black History Month, with people sharing literature, music, history and cuisine,
- Leading historians and lesbian, gay, bisexual and transgender (LGBT) people and advocates during LGBT History Month, and;
- Deaf residents, who shared their stories and stressed the importance of partners adhering to the Accessible Information Standard.

Co-production and working with our communities - Embedding co-production has been a cornerstone of our strategy this year.

In January 2025, the System Insight Network met for the first time and focused on Government’s Change NHS consultation, which is a national conversation to listen to local people’s views on how the NHS could improve to deliver for people and communities in the future. More than 100 residents and partners attended the event, which was held in Central Bedfordshire – and feedback was submitted through the national portal to influence the NHS 10-Year Plan for Health. The insights have also been shared across the ICB and are being considered alongside operational plans for 2025/26.

We have also worked closely with residents in 2024/25 to co-produce and co-design the new musculoskeletal contract for BLMK, which will be mobilised during 2025. Residents have been involved in all stages of this process including evaluation and will be involved in mobilisation as the process moves to the next stage during the next reporting period.

We have advocated strongly for parity of esteem between resident voices and health and care professionals and have contributed development of a new remuneration policy for the ICB, which will allow residents to be paid as ‘experts by experience’ – enabling an equitable residents(s) voice at the table to influence decision-making.

Chair of the Insights Network

“Chairing the Insights network has been an incredible opportunity to ensure that residents voices are not only heard but truly shape the decisions that affect their lives. It’s about enabling and empowering people to take an active role in their communities, and that’s where real change begins”.

Chair, Bedford Borough Health Overview and Scrutiny Committee (HOSC)

“The Bedford Borough Council HOSC has worked with the ICB on a number of issues over the past year, in particular the Committee’s review on primary care services, and thanks the ICB for its support with the review”.

Emma Freda, Chief Executive Healthwatch Bedford Borough

“We appreciate the ICB’s transparency when it comes to difficult decision-making. It helps us to understand the bigger picture and how our work at Healthwatch Bedford Borough contributes to overall ICB goals. Your promptness in addressing concerns is commendable and shows that you genuinely care about both the quality of the work and stakeholder relationships. Thank you for your dedication and support over the past 12 months.”

Diana Blackmun, Chief Executive Healthwatch Central Bedfordshire

“At Healthwatch Central Bedfordshire we have greatly valued working in close partnership with the ICB Engagement & Communications Team, especially on the Denny Review, which has been instrumental in highlighting local health inequalities and driving actionable change. This effective collaboration between healthcare and local Healthwatch is essential to enhancing health outcomes and ensuring services meet local needs. We look forward to continuing our valued partnership to further improve access and provision of healthcare services for our local residents”.

Data and digital

Work has continued during 2024/25 in support of our ICS [Digital Strategy](#) which is aligned to the Government's strategy Data Saves Lives: [Reshaping Health and Social Care with Data](#) (June 2022) and builds on the local strategies and standards, and considerable success that BLMK system partners have already delivered through the innovative use of digital tools and services.

The use of data and digital underpins the work we are doing to improve health and care outcomes for residents. Together they will help us increase choice and provide a digital-first, rather than digital-only approach to more personalised services for residents.

We have enhanced the delivery of the 'Share for Care' programme with more access to data, which enables secure access for health and care professionals providing direct care to the appropriate information they require. This shared information enables care providers to make more personalised, better informed care decisions and improves resident experience as they do not need to repeat their story.

Through close collaboration with our partners we have accelerated the improvements in digital maturity across the ICS, including acute digitisation, better access and choice around how services are accessed in primary care through cloud telephony, online consultations, and messaging via the [NHS App](#). We also expanded the availability of secondary care services via the NHS App, building on this as a quick and convenient option for residents to access a broad range of health services and view their care record. It is already used by 54% of GP registered residents aged 13 and over, and we have held 'NHS App days' in each of our Places to promote increased uptake. These received huge support from partners across Health, Social Care and MP's, and GP staff NHS App awareness sessions are planned to ensure enhanced knowledge to assist the population with queries.

We continue to support our local authorities in bringing digital services into care homes and domiciliary settings: In line with national priorities, digitised resident records are now in place in over 80% of our adult Care Quality Commission (CQC) registered care homes, which enables better recording of resident information in support of their care. This also enables our care providers to meet core standards around data and information, acting as the forerunner for achievement of the required standards included in the Data Use and Access Bill which is expected to gain Royal Assent in 2025.

We have further expanded the use of monitoring technologies that allow care staff to remotely monitor and record vital signs, activity and [National Early Warning Score](#) (NEWS2). These empower our care providers through better availability of information at the point of care to inform decision making, improving information sharing and reducing avoidable GP/111 and ambulance call outs. Additionally, we are using virtual health assistant sensor technology to monitor resident wellbeing and identify early intervention opportunities, supporting our residents to stay safely in their home for longer.

We are also an early adopter of the Federated Data Platform, supporting overall Elective Recovery and System data analytics.

Environmental matters

The Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following 'pillars': Governance, Risk management, and Metrics and targets. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the ARA and in other external publications.

BLMK ICB coordinates a system [ICS Green Plan](#), aiming to reduce the production of healthcare-related greenhouse gas (GHG) emissions in line with the national NHS England goal for the health service to be net zero across all emission Scopes by 2045. In doing so, the ICB expects to minimise the risks of climate change to health and healthcare delivery, and support improved health, reduced inequalities and better value services.

Impact of the ICB on the environment - The ICB's direct impact on the environment is relatively small. It currently occupies four main offices (Milton Keynes, Bedford, Chicksands and Luton), all of which are shared with the local authority. Staff work a minimum of four days per month on face-to-face work duties, reducing the need to commute. The vast majority of the ICB's emissions lie in its directly commissioned services; NHS Trusts are required to have their own Green Plans setting out actions to reduce emissions. For non-NHS organisations, new tenders require suppliers to have Carbon Reduction Plans aligned to the 2045 net-zero target.

The ICB's office space consolidation has continued, following vacation of Sherwood House in Milton Keynes in 2023/24, to reflect the required space for staff on hybrid working patterns. By end of March 2025, it will have reduced its office space at Bedford Borough Hall by three desks and one meeting room. Further ICB office moves are planned for 2025/26, following which the ICB will have reduced its available office space to 108 desks, five meeting rooms/areas (and access to meeting space shared with council colleagues).

Governance - Environmental sustainability and net zero ambitions are contained in the system [ICS Green Plan](#) (2022-2025), and are also integrated into other system strategies, including the [BLMK Health Services Strategy](#) and the [Joint Forward Plan](#).

BLMK ICB convenes an “Environmental Sustainability System Leadership Group” (ESSLG). Chaired by the ICB non-executive green champion and attended by sustainability senior responsible officers from local authorities and NHS Trusts, Green Plan theme leads, voluntary, community and social enterprises (VCSE) and resident representatives, the group oversees the strategic direction and progress against the system Green Plan. The group makes recommendations to the ICB Board.

The ESSLG takes updates and reports from a “Green Plan Working Group” (consisting of sustainability leads from local authorities and NHS Trusts in BLMK), and regular updates on progress against data and thematic workstreams such as medicines, procurement and estates.

Reports on progress with sustainability metrics are also presented quarterly to the Quality and Performance committee – see page 98.

The ICB Board and committees require papers to consider Green Plan impacts. A more comprehensive Environmental and Social Impact Assessment Tool (EaSIA) has been developed and implemented during 2024/25, which is required for all major service changes undertaken by the ICB (as defined by the ICB’s Service Change Policy) to demonstrate qualitatively the expected impact of changes on 20 environmental and social impact categories. In 2025/26, use of this approach will be expanded to cover a wider range of decisions, with potential future developments to include qualitative analysis where appropriate.

The ICB has a “Sustainability and Growth” team consisting of two full time equivalent posts; delivery of environmental sustainability programmes is one of the key responsibilities of this team. The team meets with the two acute Trusts within the ICS (Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes Hospital Trust) on a twice-annual basis to review progress against Trust Green Plans, support resolution of barriers to progress, and seek assurance about compliance with national requirements, horizon scan and discuss potential opportunities

Risk Management - The Audit and Risk Assurance Committee oversees the Board Assurance Framework (BAF) risk on Health and Climate Change (BAF risk 07 – see page 10 and pages 103 to 104 and page 93). The risk description is listed as: “Climate Change: Health, inequality and healthcare service impacts from Climate Change and environmental degradation and the risk of not achieving the net zero target”. The ICS Green Plan is the main control for this risk.

The ICB sustainability team regularly updates the controls, mitigations and progress against the risk via the ICB’s Insights 4Risk platform. A series of organisational and programme risks are also recorded.

Risks are monitored quarterly by the ESSLG.

Metrics and targets - The carbon footprint for the ICB is calculated and reported via NHS England. To ensure progress against local initiatives, the ICB monitors a number of metrics, shown within each area of achievement, listed below.

Notes:

- 1. Some emissions are reported annually after the end of the financial year. Progress below is presented using the latest available data, which may be 2024/25 or 2023/24 data (noted where relevant).*
- 2. Many metrics are measured as a system, taking into account the two hosted acute Trusts (Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes Hospital Trust) or general practice only. The ICB supports action across all healthcare organisations.*

Metric: emissions from volatile anaesthetic gases

- Desflurane, the anaesthetic gas with the highest global warming potential, has been eliminated from use in BLMK (except in exceptional, clinically required circumstances). This is saving 800 tCO₂e per year against the 2019/20 baseline, and approximately 40 tCO₂e less than 2023/24. Nitrous oxide (N₂O) emissions have reduced by 30.1% since the baseline, whilst emissions from use of N₂O / O₂ mix (“gas and air”) have dropped 4.1%. This reduction has plateaued since last financial year. Further work on nitrous oxide manifolds is planned at both acute hospitals, to reduce waste.

Metric: emissions from primary care-prescribed inhalers

- Emissions from primary care-prescribed asthma inhalers have dropped by ~33% since 2019/20, saving 5 ktCO₂e annually, with a fifth of that reduction occurring in the last year. BLMK has improved from the 95th percentile to the 3rd quartile in the two key Green Plan inhaler metrics (emissions per inhaler, and proportion of inhalers prescribed as Metered-Dose inhalers), improving quicker than the national median.

Metric: Emissions from operation of healthcare organisations and services

- **Waste and a circular economy:** at acute sites, waste emissions reduced by 16% overall from 2022/23 to 2023/24 (the latest available data), due predominantly to reductions in clinical and food waste, however domestic landfill rates appear to have increased.
 - Reusable sharps bins have been introduced at an acute Trust, saving 105.78 tCO₂e and 18.2t of plastic waste annually.
 - Food waste has dropped at some hospital sites to 2% overall, with one hospital site reducing waste by 60%. The ICB is working with Trusts to explore how to increase the uptake of lower carbon meals.
 - A walking aid return and reuse scheme, at Milton Keynes Hospital has saved 12 tCO₂e and £2,500. More than 600 office assets were distributed for reuse by the ICB to a hospital, schools and VCSE. Distribution of supplies has been consolidated to reduce travel miles. And clinical teams are switching various consumables from single use to reusable alternatives.
 - The ICB has been trialling an asset-sharing platform called Xsilio. As of March 2025, the system is now operational and will be used to share unused office assets with ICS partners including primary care practices, schools and VCSE.
 - Distribution of medical supplies to primary care practices within Milton Keynes has now moved to a consolidated approach, rather than daily couriers. This will reduce costs, and miles travelled. Evaluation is in progress to understand the final impact.
 - There are several examples within the system of trials of reusable equipment to replace single use. One led by the ICB is that of reusable wraps to support wound care, which is currently being evaluated for further roll-out.

- **Energy efficiency:** installation of renewable and other energy systems at our main hospitals, including securing additional capital funding for various works.
- **Travel and transport:**
 - Both acute Trusts made returns to the annual travel and transport data submission for the first time this year. This demonstrated that 21% of fleet vehicles across the Trusts are higher emission, above the in-year target (10%) but they are also significantly above the target for ultra-low and zero emission fleet vehicles (43% vs. 11%). Both Trusts are looking to meet the national roadmap for fleet replacement.
 - The ICB runs two salary sacrifice schemes – for cars and cycles, the former only offering low emission vehicles. As of March 2025, there are 27 cars on lease, including 23 EVs (85% of the total) and 4 Plug-in Hybrids, and 1 cycle.
- **Digital:**
 - Increased usage of 'Share for Care', a tool which brings together information about a resident's care in one place to support better informed care decisions and care outcomes. There are currently approximately 130k views of Share for Care per month by health and care providers, reducing the need to spend time tracking down records and reducing resident journeys/appointments e.g. for duplicate diagnostic tests.
 - Digitisation of Adult Care Homes - over 80% of the ICS' CQC registered Adult Care Homes have now moved from paper to digital resident care records to support more effective care provision and reduce paper use.
 - All BLMK GP Practices are now on Cloud-Based telephony systems to improve access to services and reduce the need for residents to travel to GP Practices to book appointments.
 - Promotion of NHS App by residents, which enables them to order repeat prescriptions, complete personalised questionnaires etc. without the need for a face-to-face meeting.

Metric: education of workforce in environmental sustainability

- Over 60 staff members (more than 10 in the last year) from the ICB, Trusts, public health teams, and primary care have undertaken forms of enhanced sustainability training, and many others are forming a wider network across sectors (including local authority, and VCSE).
- A further three individuals are currently undertaking a Corporate Responsibility and Sustainability apprenticeship with LDN Apprentices, which started in 2024/25.
- The ICB has recently made basic sustainability training mandatory for all its staff.

Metric: Social Value

- All NHS organisations now include Social Value questions within procurements, with a 10% weighting. The ICB has developed a more-consistent method to evaluate social value submissions and is working with the re-convened system Procurement Practitioners Group to adapt a standard set of social value priorities and metrics, aligned with new procurement notices and place priorities.

Additional activities supporting environmental duties

- **Adaptation:** The ICB commissioned its CSU partner to undertake analysis of past weather and activity trends, and to project potential future impacts of extreme weather, using linear regression analyses to identify potential activity hotspots. Findings will inform further adaptation planning in 2025/26.
- **Supporting local developments:** The ICB provides input as a statutory consultee to various local developments. This includes the impact of environmental impacts on health and healthcare service delivery. This year we have provided input into local plans, including MK2050 and Luton's Local Plan community engagement, through workshops or consultation submissions and have submitted representations to the East West Rail non-statutory consultation and the Universal Studios' UK Project. The ICB seeks to balance the impacts of all wider determinants, aiming to achieve the biggest benefit for the health and wellbeing of the population it serves.

Green Plan and Environmental Policy Refresh - The first ICS Green Plan, published in 2022, runs until 2025. The ICB has undergone extensive engagement with NHS Trusts and primary care, local authorities, universities, VCSEs and members of the public over six months in 2024/25, culminating in a system-wide [Climate and Health seminar](#) in November 2024, and is in the final stages of preparing the next iteration of the ICS Green Plan, due to be published in summer 2025. Alongside this, the ICB's Environmental Policy, which was extended during 2024, is being refreshed to align with the ICS Green Plan.

Workforce – Initiatives and Developments

As an ICB, we collaborate with our ICS partners to deliver against the 10 functions of an ICS People team. Our ICS People Strategy outlines our goals and priorities including:

- Growing and developing talent, skills, and knowledge across health and social care for both the present and future.
- Utilising new technologies to enhance capacity for our workforce.
- Retaining and attracting a supply of residents into roles in health and social care and improving access to employment pathways.
- Promoting equality, diversity and inclusion.
- Protecting the wellbeing of our workforce.
- Developing the 'one workforce' across BLMK

We work collaboratively and proactively with system partners and stakeholders including provider Trusts, social care colleagues, VCSE, Higher Education Institutes, training providers and the BLMK Health and Care Academy to shape the BLMK response to workforce challenges and long-term workforce plans.

Retaining and Attracting A BLMK Workforce:

Local Skills Improvement Plan (LSIP) - BLMK health and care partnership organisations have an important role to play in promoting a strong employment offer to residents and working with partners to ensure there is a workforce supply with the relevant skills needed now and in the future. The workforce team have been engaged with the local chambers of commerce and their (local skills improvement plan) [LSiP](#) work. This allows for learning from sectors other than health and social care and offers a chance to proactively highlight our future workforce needs. Working across the ICS to ensure our strategic Long Term Workforce Plans enable us to have the right staff in the right place with the right skills at the right time.

We have developed and implemented an employment hub which helps to signpost residents to various professional groups across the system for advice and information about career pathways and accessing employment and training opportunities. Since its launch in October 2024, there has been significant interest and use of this tool with c.8,000 views.

Community Targeted Outreach Programme – working with the University of Bedfordshire, young people from our diverse communities have shared why they do and don't want to go into careers in health and social care. A fascinating research project culminating in a play and launch with our communities will support the understanding of how people make decisions about coming and working in our sector. This learning has been put into practice and will be presented at the International Integrated Care Conference in May 2025.

Careers Events and Carousels - Held throughout 2024/25, these have enabled health and social care partners to come together to promote the wide range of careers available. The most recent event in Luton attracted over 1100 residents.

Passport to NHS Careers - We have developed supported employment pathways for our residents to support those furthest from employment into careers and education pathways across health and care. We delivered our first cohort in October 2024, followed by two additional cohorts in early 2025. We have also conducted workshops for the Shaw Trust, Jobs 22, Kings Trust, and teams focused on supporting those with lived experience of the care system. To date, we have successfully supported over 250 residents of BLMK with training, work experience, volunteering, and employment opportunities. Sixteen candidates have gained employment, twenty-six volunteering opportunities and forty-three have accessed further education and development.

Work and Health Integration Stewardship Partnership - This group formed in October 2024 and has over 50 members across BLMK whose focus is on collaboration regarding the work, health and skills agenda. Future work of the group will focus on Mental Health, Neurodiversity, Learning Disabilities, Women's Health and Children and Young People and the development of a BLMK ICS Work, Health and Skills Strategy.

Global Majority Nursing and Midwifery (N & M) 90-day challenge - A national programme aimed to strengthen the career development of nurses and midwives from the Global Majority population. Working collaboratively with our acute Trust partners we created a steering group with Nursing & Midwifery leads, EDI leads and network chairs who developed a series of initiatives. Engagement through questionnaires and focus groups, shaping a series of solution focused career workshops and bitesize inspiring journey webinars which the group delivered across the ICS.

Nursing Placements (Primary Care) - Our primary care digital nursing placement has continued to grow throughout 2024/25 with a further two second-year placement cohorts taking place, along with the addition of a new third-year placement. Plans are underway to adapt this model for paramedic students in Autumn 2025.

Student Pharmacy Summer Placement - The Primary Care Training Hub (PCTH) have been at the forefront of collaborative working, embracing opportunities to share learning and work in partnership with other ICB Training Hubs both regionally and nationally. Our flagship Student Pharmacy Summer Placement has been running for the past five years, providing opportunities for student pharmacists to experience primary care placements during their summer break. Our PCTH has led this programme on behalf of four of the six ICB areas in the region and supported over 100 students to experience working in a primary care setting and attracting them to work in BLMK when they qualify.

Community Pharmacy Leads - As part of the drive towards integrated working 10 community pharmacy leads have been appointed to encourage joint working between our Primary Care Networks (PCN) and community pharmacy colleagues. Building relationships and connections to promote the uptake of the Pharmacy First Service has been pivotal to their role and we have seen great success, particularly in Luton with well-established closer working relationships.

Developing Our Workforce:

Oliver McGowan training roll out - This new national training aims to ensure the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. At the time of writing, over 5000 BLMK NHS and primary care staff have received this training; another 3700 places are already commissioned for 2025/26 to ensure continued priority is given to this training. We are proud that our Oliver McGowan training project manager won the Integrity category at the ICB's staff awards for their care and diligence in rolling out this training whilst keeping the needs of the experts by experience at the forefront of each decision.

Clinical Learning Environment (CLE) - The CLE leads have developed a Healthcare learner toolkit in the form of an application (App) which is a 'one stop shop' for learners to access essential information relating to clinical placements, health and wellbeing, support into work and a wealth of other information available on their phone 24/7.

Festival of Learning - Integrated Neighbourhood Working (INW) has been a key priority for the Primary Care Training Hub (PCTH) throughout 2024/25, and just ahead of the start of the year it hosted the first Festival of Learning in Milton Keynes to kick start the conversation. Over one hundred primary care professionals came together to share local best practice, generate ideas and hear about what is working well in other parts of the country.

Our keynote speaker Nick Downham (Independent Health and Social Care Improvement Specialist) shared his thoughts on the key ingredients for integrated neighbourhood working and challenged our thinking on how we manage demand. Throughout the day participants discussed over twenty hot topics ranging from virtual group consultations at scale, to working with the Fire Service, team coaching, sustainability in healthcare and workforce planning.

GP Educator Training - The Primary Care Training Hub (PCTH) has continued to expand multiprofessional learner capacity across primary care, including GP Educator Training. The cohorts held in June 2024 and October 2024, supported a total of 35 new GP educators who went on to be formally approved by the East of England Primary Care School, and are a pivotal part of the development of our GPs of the future. This is in addition to 15 new nursing educators and the expansion of one of our learning organisation sites to also support placements for students on nursing, paramedic, pharmacy and physician associate programmes. As an exemplar site, our education quality and expansion team has supported a 52% increase in GP Educators, 93% increase in Nurse Educators, 29% increase in practice learning organisations and 900% increase in PCN Learning Organisations since April 2022.

Podcasts - To help our primary care and neighbourhood workforce better understand the concept of Integrated Neighbourhood Working (INW), the Primary Care Workforce Team started a podcast to share learning, examples and best practice of INW.

Personalised Care Conferences - Over the past couple of years, the PCTH has worked to deliver six personalised care conferences aimed at primary care personalised care role holders as well as any staff involved in personalisation. The conferences have aimed to support networking between staff of different PCNs, share best practice and new ways of working, help our personalised care colleagues understand INW and discuss how they can further support the development of neighbourhoods at place. Three conferences took place during 2024/25, the most recent held in November 2024 which brought together 87 people working in personalised care across primary care in BLMK. A survey was conducted to assess the impact of the conferences. 100% of responders reported that the following had improved either a lot or a little: their understanding of INW, their ability to improve population health and health inequalities, their understanding of their role, and the number of quality relationships they had formed. For further information on personalised care, please see pages 56 to 57.

Leadership Development - In recognition of the importance of leadership in the embedding of INW, the PCTH partnered with Unchain Potential to run a leadership development programme designed specifically to support clinicians working in practice. The programme supported nine individuals from a range of professions to develop their skills in self-leadership, emotional intelligence, building relationships and stakeholder management.

A BLMK ICS Leadership brochure has been developed for staff which outlines a range of national, regional and local programmes designed to enhance the leadership capabilities across the ICS.

During 2024, we worked in partnership with Affina Organisational Development (pioneers of team-based working in health and social care), to develop and deliver a pilot leadership programme consisting of four modules for our ICB System Transformation Teams and Place Teams.

BLMK ICB has launched the 'Springboard' leadership programme. Springboard is a world-renowned work and personal development course for women and is open to staff across the ICS footprint, working in all system partners.

Leading Beyond Boundaries Alumni Offer - BLMK now has over 150 change agents who have completed this system leadership programme. To embrace this capacity to support new ways of working and build on skills gained, an alumni offer, including action learning sets; masterclasses; mentoring and shadowing has been developed to continue to grow this cohort of future leaders.

Apprenticeships - Apprenticeships offer an alternative route into careers for BLMK residents; they also offer a way to develop existing staff. During 2024/25, the system met the challenging target for apprenticeships outlined in the Long term Workforce Plan (LTWP) for this year. To support this work, an apprenticeship programme board has been established and an apprenticeship levy transfer system has been put in place to support partners in offering apprenticeships, regardless of size.

Rewards & Recognition

During 2024/25 we have been successful in obtaining several accreditations, which highlight the ICB as an inclusive and supportive employer, these are:

Disability Confident Employer (Level 2) - In November 2024 BLMK ICB completed the next step on our Disability Confident journey and moved from being Disability Confident Committed (Level 1) to a Disability Confident Employer (Level 2). This means we think differently about disability and are taking the core actions to be a Disability Confident employer, to improve how we recruit, retain and develop disabled people in our workforce.

Living Wage - In October 2024, BLMK ICB became the first ICB outside of London, and the second in the country, to be accredited with the Living Wage Foundation. The living wage foundation is a charity formed out of Citizens UK and aims to ensure that people are paid a fair wage for fair work. They independently calculate what the minimum wage should be based on the cost of living and all organisations that then accredit with them are required to pay the living wage.

Lived Experience Charter Award - The award demonstrates the ICBs ambition and commitment to a diverse and inclusive workforce, developing a new talent pool of people from a diverse range of backgrounds with appropriate skills and values, who otherwise might not have considered jobs and careers in health and social care. The Lived Experience Charter has increased our understanding and knowledge providing support and a highly influential approach towards this service development. BLMK ICB is the first ICB to achieve the award.

ICB Staff Awards - In September 2024 the ICB held a staff recognition awards event. It was a celebratory afternoon, attended by 200 staff, with nine awards linked to the ICB values for which 150 staff were nominated. There was also a Chairs' Award and a Chief Executive's Award. We recognised over 1400 years' service in total, with 50 long service awards for aggregated service of 25+ years.

Nursing Times Workforce Awards - ICB staff attended the Nursing Times Workforce Awards Ceremony (see photo below) as the ICB was shortlisted for Best Use of Workplace Technology and Workforce Team of the Year – We were recognised for our innovative and collaborative work with partners on a digital health care support worker recruitment initiative and Legacy Mentoring programme. The judges said

“Fantastic example of multimodal multimedia approach using technologies to deliver a solution to our workforce challenge. Real social movement and example of how ICB’s can bring community and health care systems together”



Protecting the Health and Wellbeing of our Workforce

Staff Wellbeing Festival - The ICB delivered a system wide event aimed to uplift and educate employees by addressing critical aspects of their mental and physical health, whilst equipping staff with tools to manage their wellbeing effectively. The six-week festival spanned October 2024 and November 2024 and attended by 414 people, provided a range of 20 different sessions, including menopause, neurodivergence, stress management, and work-life balance. Each week focused on a particular area of wellbeing: financial, nutrition, women's health, men's health and mental health. The event also incorporated practical resources, access to wellbeing applications (Apps), access to experts, incentives, and expert-led discussions. The feedback survey for the event highlighted a 100% satisfaction rate with an average of 4.7/5 stars for the effectiveness and impact.

Health and Wellbeing Champions - Within the ICB 11 health and wellbeing champions have been appointed to provide a valuable listening and signposting service for staff. The champions will also be representing staff on a Health and Wellbeing Steering Group, feeding into decision making and the creation of a Health and Wellbeing Strategy.

Domestic Abuse and Sexual Violence (DASV) Programme - NHS England launched the Domestic Abuse and Sexual Violence (DASV) programme to enhance safeguarding procedures, improve support for victims, and prioritise early intervention and prevention. The scope of the programme has since been expanded to strengthen the NHS' response to domestic abuse and sexual violence, particularly concerning NHS staff. To drive this initiative a BLMK ICB working group was established. Since its formation, the group has successfully signed up to the Sexual Safety Charter and is implementing its 10 key principles and developed a Sexual Safety Toolkit which is accessible by all staff. The group will be launching Domestic Abuse and Sexual Violence policies to enhance staff support and rolling out staff training to increase DASV understanding during 2025.

Freedom to Speak Up: Raising Concerns (Whistleblowing)

The ICB has a Freedom to Speak Up (FTSU) Policy and process in place to ensure that concerns can be raised without fear of reprisal or victimisation. The ICB actively encourages the reporting of concerns regarding risk, malpractice or wrongdoing, and promotes an open and honest culture.

As well as their line manager, people have the option to raise a concern with the ICB Freedom to Speak Up Guardians who act as independent and impartial sources of advice to staff at any stage of raising a concern. Our Freedom to Speak Up Guardians are supported by Freedom to Speak Up Champions who help staff to follow the process outlined in the ICB FTSU Policy and report outcomes as appropriate.

As part of the programme to enhance and promote good practice in respect to 'Speaking Up' the ICB hosted a system event in March 2025 for BLMK Leaders from health and social care to come together and discuss how we can work together to support 'Speaking Up', enabling best practice and reflecting on learning. Keynote speakers from the National Guardians Office joined the conference, NHS England and legal advisers supported the day.

Financial review

This section of the Annual Report sets out a summary of the ICB's financial performance for the 2024/25 financial year.

The Annual Accounts have been prepared under directions issued by NHS England and the DHSC Group Accounting Manual (GAM). Further details on the ICB's financial performance can be found in the ICB's Accounts at the end of this Annual Report.

Financial Performance

ICBs have a statutory duty to contain expenditure within the limits directed by NHS England, with a requirement to deliver system financial balance. NHS England may make directions about ICB's management or use of financial or other resources. NHS England may also set joint financial objectives for ICBs, and their partner NHS trusts and NHS foundation trusts. ICBs and partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that limits specified by a direction by NHS England are not exceeded.

ICBs have the following statutory financial duties. The performance of the ICB in 2024/25 is set out in the following table. Further details are provided in Note 40 in the Accounts section of this report.

Matter	Target	Actual	Achieved
	£000s	£000s	
Maximum revenue resource use The revenue resource use for each Integrated Care Board in 2024-25 shall not exceed the amount specified.	2,483,315	2,483,149	Yes
Maximum revenue resource attributable to matters relating to administration The revenue resource use for each Integrated Care Board attributable to matters relating to administration in 2024-25 shall not exceed the amount specified.	18,484	18,357	Yes
Maximum capital resource use The capital resource use for each Integrated Care Board in 2024-25 shall not exceed the amount specified.	2,161	2,158	Yes

During the 2024/25 financial period, the ICB received a £2,483 million funding allocation from the Department of Health and Social Care, via NHS England, to commission care services for the local population. The ICB's Control Total, the targeted amount of spending NHS England sets for the ICB, was to deliver breakeven position in 2024/25. The ICB worked within the financial allocations set by NHS England, delivering a small surplus of £175k.

The ICB's other financial duties include controlling the amount of spend on the administration function of the organisation. In 2024/25, the ICB spent £18.4 million in this area, which is within the planned spending target.

Mental Health Investment Standard

An important planning requirement is the delivery of the Mental Health Investment Standard (MHIS). The standard requires Integrated Care Boards to increase investment in mental health services at a higher percentage than their overall rise in allocation from NHS England each year.

Achievement of the Standard is measured by comparing expenditure in 2024/25 to that in the previous financial year. This is after considering any mental health specific recurrent or non-recurrent allocations received in either of these years. These adjustments are made to ensure that changes in spending are not skewed by non-recurrent allocations and are limited to reviewing spending funded from our general allocation. Spending on learning disability and dementia services is currently excluded from the MHIS calculation. ICBs are required to publish a formal declaration as to whether their spending met the Standard. This statement will be subject to a separate audit assurance engagement through the ICB's auditor. This report will be published alongside the ICB's own formal declaration.

In 2024/25 the ICB was required to increase its mental health spending by a minimum 6.89%. Subject to confirmation through independent audit, the ICB has met the Mental Health Investment Standard (MHIS) in 2024/25.

2025/26 Planning Guidance and Financial Outlook

The financial framework arrangements for 2025/26 continues to be based 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 have published one year revenue allocations and one-year capital allocations alongside the 2025/26 planning guidance.

To manage within the funding available, while delivering national and local priorities, the ICS will need to deliver a stretching efficiency requirement, beyond that delivered historically. NHS England analysis shows that NHS organisations will need to reduce their cost base by at least 1% and achieve 4% improvement in productivity, in order to deal with demand growth.

Importantly, NHS England have recently published information about how far each system is over or underfunded in England versus a target fair share. BLMK ICB is the most underfunded in percentage terms in England at 5.8 per cent. It is anticipated that over the coming years systems will be moved towards the fair share target (deemed to be within the range of +/- 2.5%) at an accelerated rate.

From the 1 April 2024, BLMK ICB (and other East of England ICBs) were delegated responsibility for commissioning, contracting and paying for 59 specialised services that were deemed to be suitable and ready for greater ICB leadership - the remaining, predominantly highly specialised, services continued to be commissioned by NHS England in 2024/25. From April 2025, NHS England will delegate responsibility for the commissioning of a further 11 specialised services to ICBs.

On the 13 March 2025, the Secretary of State for Health and Social Care announced the abolition of NHS England – ‘Over the next 2 years, NHS England will be brought into the department entirely’. It is currently unclear what will happen to services that are currently commissioned by NHS England, this includes the remaining highly specialised services, some public health functions including national screening and immunisation programmes, health & justice and armed forces commissioning. It is possible that responsibility for commissioning these services will be delegated to Integrated Care Boards.

ICBs receive an allowance for their day-to-day management and administration costs, known as the running cost allowance. This allowance must cover all ICB management costs including the costs of commissioning support services. ICBs were required to reduce running costs by 20% in 2024/25 in real terms with a further 10% from 2025/26 as part of a wider reduction in administrative costs by NHS England.

Recent announcements from NHS England will require ICBs to make significant further savings in management and administration costs. ICBs have been asked to make 50% cuts to ‘running costs’. The detail of what and how has not yet been set out, but this will likely cover further reductions in day-to-day management and admin costs (the running cost allowance), as well as some wider programme costs. The ICB is working with NHS England, ICS partners and neighboring ICBs to develop plans as to how this can be achieved.

Joint Capital Resource Plan

The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act), requires ICBs and their partner trusts to prepare a plan (the Joint Capital Resource Use Plan (JCRUP)). This must be approved by the Boards of the organisations within the system and must be published on the ICB website.

The published plan aims to provide transparency for local residents, patients, NHS health workers and other NHS stakeholders, on the prioritisation and expenditure of capital funding by BLMK ICB and its partner organisations, to achieve its strategic aims.

[The plan for 2024/25 can be found here.](#)

BLMK ICB both supports and directly delivers elements of the capital and estates plan, in collaboration with its partners. This work includes consulting with patients, Providers, Local Authorities and system committees to ensure the ICB continues to meet the goals of its Joint Forward Plan by living within its financial means and maximising the benefit of the capital available for its residents. Estate is a key enabler to delivering the ICBs strategic priorities, to support the population to start well, live well, age well, maintain sustainable growth and reduce inequalities.

During 2024/25 the internal Capital and Estates team continued to work hard with GP practices, local authorities, NHS Property Services and NHS England to plan and manage the delivery of developments to the primary care estate. This included the development of plans, working with NHSE to gain approval, managing funding sources, project management of schemes and ensuring the governance process is adhered to. Some of this work will come to fruition in future years as the ICB takes a longer-term view of primary care requirements, especially in growth areas given the increasing size of the population.

The internal digital team is essential in the planning, ordering and fitting of GPIT to maintain up to date digital capability within GP practices.

Whilst Trusts deliver capital projects using their own resources, the planning of large capital projects requires joint working together with the BLMK ICB. This approach provides a level of scrutiny, challenge and assurance as business cases develop, to ensure significant projects meet the needs of the population and are clinically and financially viable. Examples of this work where projects progressed or completed in 2024/25 relate to the New Hospital Programme, the Lloyds Court Community Diagnostic Centre (Milton Keynes) and the Gilbert Hitchcock House Community Diagnostic Centre (Bedfordshire).

The ICB has also been working with partners during 2024/25, on the planning process for large capital projects for which build work has not yet begun. This work has included the business case for the Mount Vernon cancer centre and planning work for the national capital allocations announced for 2025/26 including business cases for reopening and adapting mental health beds, creation of a crisis centre, developing a rehabilitation facility, and options to consider the viability of a CDC in south Bedfordshire.

The ICB internal Capital and Estates team undertook significant planning for the additional capital announced for 2025/26 in Primary Care, to create additional capacity and appointments within the existing primary care estate footprint.

BLMK ICB meets monthly with capital and estates colleagues from all its partners to ensure excellent communication across the spectrum of work related to estates. This includes (but is not limited to) discussion of new and upcoming consultations on planning applications across the geography of BLMK, progress and direction of the net zero carbon strategy, government announcements related to capital funding and updates from partners on key capital issues and projects within their organisations.

The ICB developed its own Infrastructure Strategy during 2024/25 which will be taken to the Board to request approval in June 2025.

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Felicity Cox

Accountable Officer

19 June 2025

Corporate Governance Report

The purpose of this report is to explain the composition and organisation of the ICB's governance structures, and how each supports the achievement of objectives.

Members' Report

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

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

ICB Chair - The ICB's former Chair, Rima Makarem, left on 31 December 2024. Her deputy Manjeet Gill has been acting into the role since then.

ICB Chair appointments are public appointments, made by the Secretary of State for Health and Social Care.

The recruitment of the new Chair was supported by Finegreen Ltd, working with NHS England East Regional Director Clare Panniker to ensure a wide, fair, and inclusive search process was run with BLMK ICS.

On 14 January 2025, the shortlisted candidates attended three stakeholder panels comprised of Board members, Health and Care Partnership members and members of the public. This was followed on 22 January by a formal interview panel Chaired by Clare Panniker. The panel has recommended a candidate for the position of ICB Chair. The appointment is being considered by the Secretary of State. It is hoped that the appointment will be confirmed and announced late spring/early summer 2025.

Member profiles - Each member of the Board has a responsibility to ensure that the ICB performs its duties in accordance with the terms of the constitution, with each member bringing a unique perspective that is informed by their individual expertise and experience. Profiles of the ICB Board members can be found on the [ICB website](#).

Composition of the Board - The Board of the ICB is composed of the following Board Members and Board Participants. Their name, role and attendance at meetings of the Board are provided in the table on page 90.

Board Members:

- Independent Non-Executive Chair
- Chief Executive Officer
- Partner Members from:
 - NHS Trusts and Foundation Trusts
 - primary medical services
 - local authorities
- Non-Executive Members
- Chief Finance Officer
- Chief Medical Director
- Chief Nurse.

The Board is supported by the following Board participants:

- ICB Executives:
 - Chief Operating Officer
 - Chief of Primary Care
 - Chief People Officer
 - Chief of Strategy and Assurance
- Directors of Public Health
- Local Healthwatch Representative
- Chair of the Integrated Care Partnership (known as the BLMK Health and Care Partnership)
- Associate Non-Executive Member

The ICB is a unitary board, which means all members are collectively and corporately accountable for organisational performance. The purpose of the Board is to govern effectively and in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands.

The Board is responsible for:

- formulating strategy for the organisation.
- holding the organisation to account for the delivery of the strategy.
- being accountable for ensuring the organisation operates effectively and with openness, transparency and candour.
- seeking assurance that systems of control are robust and reliable.
- shaping a healthy culture for the organisation and the wider ICS partnership

The Board met publicly four times in 2024/25 ([papers available here](#)), with each meeting followed by a private session. Key Focus Areas in 2024/25 included:

Listening to Residents

- Revised the Working with People and Communities Strategy.
- Established the System Insights Network to gather public input to inform decisions.
- Regularly heard resident stories – topics included apprenticeships, Pharmacy First, Autism Bedfordshire, the work Bedford Borough is undertaking to tackle social isolation. There was also a presentation on the Integrated Contraception and Sexual Health service which provides advice and counselling for residents and works with partners to provide support e.g. housing, financial, organising care at home.
- Feedback from the System Insights Network.
- Public questions at each meeting – topics included attention deficit hyperactivity disorder (ADHD) medication, hospice funding, and cardiac rehabilitation.

Strategic Priorities

- Updates on the five strategic priorities: Start Well, Live Well, Age Well, Growth, and Inequalities.
- Developed principles for future system strategies to measure impact and improve accessibility agreeing the data pyramid- approach to impact and outcome measurement.

Strengthening System Work in BLMK

- Oversight and approval of the Joint Forward Plan (updated in March 2024).
- Approved the Health Services Strategy to address population growth, mental health and clinical variations.
- Coordinated reporting with Health and Wellbeing Boards and NHS Trusts for better outcomes for residents.
- Focus on winter planning, elective treatment backlog reduction and financial oversight.

Integrating Health & Care

- Established the Mental Health, Learning Disability & Autism (MHLDA) Collaborative Committee to improve care, quality and tackle inequalities.
- Implemented the Primary Care Transformation Plan, enhancing access via Pharmacy First, Total Triage and additional clinical roles.
- Launched the Health Equity Programme.

Governance Enhancements

- Committees provide 'Advise, Alert, Assure' reports for oversight by the Board.
- April 2024: Responsibility for 59 specialised services delegated to six ICBs in East of England, with BLMK ICB acting as the host.

Two extraordinary private meetings were also held to approve the Musculoskeletal Service Business Case and the Annual Report & Accounts 2023/24.

The table on the following page provides the name, role and attendance of Board members and participants at meetings of the Board of the ICB in public.

Number of meetings in 2024/25: 4

Board Members

Role	Name	Attended
Chair	Dr Rima Makarem (until 31 December 2025)	3/3
Interim Chair	Manjeet Gill (Non-Executive Member acting as Interim Chair from 1 January 2025)	4/4
Chief Executive Officer	Felicity Cox	3/4
Non-Executive Member	Alison Borrett	4/4
Local Authority Partner Member (Chief Executive, Milton Keynes Council)	Michael Bracey	2/4
NHS Trust Partner Member	David Carter	3/4
Local Authority Partner Member	Laura Church	4/4
Local Authority Partner Member	Marcel Coiffait	3/4
NHS Trust Partner Member	Ross Graves	4/4
NHS Trust Partner Member	Joe Harrison	2/4
Primary Medical Services Partner Member	Omotayo Kufeji	2/4
Non-Executive Member	Vineeta Manchanda	4/4
Non-Executive Member	Shirley Pointer	4/4
Local Authority Partner Member	Robin Porter	3/4
Interim Chief Medical Director	Dr Ian Reckless (from 16 April 2024 to 10 March 2025)	3/3
Chief Medical Director	Dr Andrew Rochford (from 10 March 2025)	1/1
Primary Medical Services Partner Member	Mahesh Shah	3/4
Chief Nurse	Sarah Stanley	4/4
Primary Medical Services Partner Member	Sahadev Swain	2/4
Chief Finance Officer	Dean Westcott	4/4
Chief Medical Director	Dr Sarah Whiteman (20 April 2025)	0/1

Board Participant

Role	Name	Attended
Chief Operating Officer	Anne Brierley	1/4
Interim Director of Public Health, Luton Council	Sally Cartwright (Until 31 December 2024)	1/3
Director of Public Health, Bedford Borough, Central Bedfordshire & Milton Keynes	Vicky Head	4/4
Associate Non-Executive Member	Lorraine Mattis	4/4
Chief of Primary Care	Nicky Poulain	4/4
Chief People Officer	Martha Roberts	3/4
Healthwatch	Maxine Taffetani	4/4
Chief of Strategy & Assurance	Maria Wogan	4/4
Luton Borough Council Co Chair, Health and Care Partnership Bedford Borough Council Co Chair, Health and Care Partnership	One of the following is required to attend each meeting: Councillor Khtija Malik Councillor Martin Towler	3/4

Board members and participants make every effort to attend meetings, however on occasions have to give their apologies and it is not permitted in the ICB's Constitution to appoint deputies. The Board meeting in July 2024 had to be rescheduled from June due to the General Election, which impacted some members ability to attend.

Board Seminars - Meetings of the Board were supplemented by a series of Board Seminars – events in which Board Members are joined by wider partners to consider in depth topics central to the delivery of local health and care services.

Four key seminars covered:

- The Power of Place – Place-based health initiatives.
- Insights from NHS Confederation – Leadership discussions.
- NHS Digital Innovations – Artificial Intelligence, NHS App, and digital priorities.
- New Care Models – Learning from Cambridgeshire & Peterborough ICB.
- Urgent & Emergency Care Integration.
- Provider Selection Regime and developing an approach to transformation and procurements.
- Improvement agenda - working with the Institute of Healthcare Improvement to develop a culture of continuous improvement to support improving health outcomes across BLMK;
- [English Devolution White Paper](#) – published by the Government
- Operational Planning for 2024/25 and 2025/26.

Committees of the Board - The Board of the ICB has established the following statutory and non-statutory committees.

- Statutory committees:
 - Audit and Risk Assurance Committee
 - Remuneration Committee
- Non-statutory committees:
 - Bedfordshire Care Alliance Committee
 - Finance and Investment Committee
 - Mental Health Learning Disabilities and Autism Collaborative Committee
 - Primary Care Commissioning and Assurance Committee
 - Quality and Performance Committee
- Non-statutory joint committee:
 - Bedfordshire, Luton and Milton Keynes Health and Care Partnership Committee

A summary of the purpose and work of the statutory and non-statutory committees of the Board is provided below. The full terms of reference for each committee is available in the ICB's [Governance Handbook](#).

Attendance of voting members for each committee is provided at Appendix 1 to this Corporate Governance Report.

Audit and Risk Assurance Committee:

The Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB. It also invites system partners to discuss the management of system risks .

Work of the committee in 2024/25 has included:

- Approval of a detailed internal audit programme of work consistent with the needs of the organisation.
- Scrutinising the findings from internal audits and recommendations for improvement and monitored progress with the implementation of the recommendations.
- Scrutinising external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board of the ICB and the work undertaken outside the annual audit plan.
- Monitoring progress with the Counter Fraud Workplan, discussing the outcome of the work and promoting counter fraud activities within the ICB.
- Reviewing 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.
- Reviewing and challenging assurance reports and updates on areas covered under the Committee terms of reference, including information governance, cyber security, freedom to speak up and emergency preparedness, resilience & response.
- Reviewing and scrutinising the range of systems, policy and procedures that are in place to manage risk within the ICB and wider system.
- Reviewing the ICB's Corporate Risk Register and the Board Assurance Framework/System Risk Register and providing assurance to the Board that they accurately record the strategic risks to the ICB's objectives (Corporate Risk Register) and ICS's strategic priorities (Board Assurance Framework/System Risk Register) with the measures and controls to manage them.
- Partner Audit Chairs, their Risk Leads and relevant subject matter experts are invited to Part 2 of the ICB's Audit and Risk Assurance Committee to support the development of system risk management arrangements to establish a more dynamic and detailed system risk register supported by Key Risk Indicators. The system risk appetite statement and accompanying system risk matrix (approved by the Board of the ICB in March 2024) serves as a guide for system risk management approach.

Remuneration Committee:

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006 – to confirm the ICB Remuneration Policy including adoption of any pay frameworks for all employees including very senior managers/directors (including Board members). The Committee also oversees workforce issues of the ICB which includes:

- Equality, diversity and inclusion,
- employee engagement,
- staff survey responses and subsequent actions,
- the implementation of the Target Operating Model ensuring appropriate governance was implemented regarding restructuring and redundancies.

Bedfordshire Care Alliance Committee:

The Committee brings health and care partners together across Bedfordshire to work collaboratively and hold joint accountability for addressing variation in quality, access and outcomes, design, plan and organise health services integrated with social care provision, standardise services across Bedfordshire and support place priorities with engagement from providers.

In January 2025 to March 2025 an independent review of the BCA and the three Bedfordshire Places was undertaken, led by Carnall Farrar. The aim of the review was to look at the role of Places and the BCA in supporting the ICBs transformation pillars, how we can maximise the benefit of these arrangements, relationships, collaboration and joint working in and across Bedfordshire.

The review output which will be published to the Board in May 2025, will look to identify opportunities for greater system alignment, oversight and improved delivery with an actionable set of final recommendations, helping to accelerate the work and effectiveness of place and collaborative arrangements in Bedfordshire.

Work of the committee in 2024/25 has included:

Focused oversight of the BCA Programme.

- Project 1, Virtual wards. Currently in operation across North and South Bedfordshire the virtual wards project adopts a multi-disciplinary approach to avoidance of unnecessary hospital admissions and discharge support to care for patients in their home. This uses community based teams alongside technological solutions, such as remote monitoring, to ensure that patients are treated and monitored in the most appropriate environment.
- Project 2, Call before you convey. Working in tandem with the virtual wards project and ambulance service colleagues, this aims to divert patients away from unnecessary admission into hospital and ensure that community based support is coordinated at short notice to support patients to remain at home.
- Project 3, Pathway 2 (intermediate beds). This project seeks to optimise the use of intermediate beds within the community to support the discharge of patients under pathway 2. Progress has been made with audit of requirements, but work remains to maximise efficiency of this resource.
- Project 4, End of Life Care. Work to agree an operating model with partners is currently being worked up.
- Project 5, Community project. Services delivered within the community are delivered through a range of providers, including community services, acutes and primary care. This project is at an early stage, with an overall aim to regularise and improve the commissioning of community based services. Progress is currently confined to undertaking a detailed stock take of current needs and provision.
- Project 6, Using data to prevent hospital admissions. This project is at an early stage, with consultation with partners and service providers underway. The project aims to deploy artificial intelligence to analyse data to predict and avoid hospital admission through appropriate alternative action.

Other business:

- Considered the Urgent and Emergency Care (UEC) risk within the BLMK system, and the work undertaken with partners to score, monitor and reduce impact.

Finance and Investment Committee:

The committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes financial performance of the ICB and financial performance of NHS organisations within the ICB footprint.

Work of the committee in 2024/25 has included:

- Receiving ICB and system finance reports with year-end forecasts and risks.
- Presenting the system Medium Term Financial Plan (MTFP).
- Receiving regular updates from the Financial Improvement Group (FIG).
- Discussing and recommending the ICB's 2024/25 Section 75 agreements for approval by the ICB Board.
- Scrutinising and updating current key procurement and contracting issues including the musculoskeletal (which non-conflicted members of the ICB Board were invited to attend), and the community and mental health services transformation.
- Reviewing progress in terms of system transformation and efficiency activities.
- Updating the ICB and system capital plans, including updates on the system capital position, progress against key projects, overseeing the development of the System Infrastructure Strategy which is due to be considered by the ICB Board in early 2025/26.
- The Committee has focused on a number of deep dive areas of strategic focus: Better Care Fund, Workforce and Operational Planning 2025/26.

Health and Care Partnership Committee:

The joint committee's duties include influencing the wider determinants of health, including creating healthier environments and inclusive and sustainable economies, facilitating joint action to improve health and care outcomes and experiences, building a culture of partnership and broad collaborations, and highlighting where coordination is needed on health and care issues.

Work of the committee in 2024/25 has included:

- Reviewing the BLMK Health Services Strategy 2024-2040,
- Considering developments in cancer services across BLMK.
- Reviewing progress on the health equity programme (following May 2024 Seminar – see below).
- Reviewing delivery of the Health and Care Strategy and a look forward to the priorities of the 2026-2029 iteration.
- Reviewing the Green Plan and the work undertaken with partners and residents, (following the November 2024 Seminar – see below)
- Reviewing the plans of local authority partners in response to the HM Government's English Devolution White Paper.

Meetings in 2024/25 were supplemented by the two following Health and Care Partnership Seminars – events in which Health and Care Partnership members are joined by wider partners to consider in depth topics central to the delivery of local health and care services.

- Creating a Fairer BLMK - Sharing & Learning event in May 2024 to review progress made in response to the Denny Review and the wider problem of inequality of outcomes within health and care and setting strategic goals for the year ahead.
- Leading for a Sustainable Health and Care System event in November 2024 to develop the system sustainability agenda for the year ahead and beyond in collaboration with partners and residents; to clearly identify the links between sustainability and healthy living.

Mental Health, Learning Disabilities and Autism Collaborative Committee:

The Committee provides the ICB and NHS and wider partner organisations with the ability to collaboratively direct and oversee the delivery of high quality patient care relating to mental health, learning disabilities and autism (MHLDA) services in BLMK. It also contributes to the overall delivery of ICB objectives, priorities and the Joint Forward Plan.

Work of the committee in 2024/25 has included:

- Establishing a formal committee of the Board with associated governance processes.
- Identifying and agreeing members and attendees from the three organisations, service users, as well as wider local authority, NHS and VCSE partners, as required by the Terms of Reference.
- Developing the MHLDA Collaborative operating model for consultation with staff.
- Discussing the 2024/25 Financial Plan, with particular focus on the Mental Health Investment Standard and Service Development Funds – and continuous monitoring of financial performance in relation to MHLDA.
- Agreeing the four key priorities for the year and receiving performance updates at each meeting.
- Agreeing the Commissioning Strategy for Supported Accommodation.
- Discussing the gap analysis and assurance on Assertive and Intensive Community Outreach services which was then presented to the Board of the ICB. This is being closely monitored by this committee.
- Receiving a presentation on the Inpatient Quality Transformation Plan.
- Discussing winter planning for 2025/26.
- Introducing patient stories to each meeting.
- Establishing a programme for deep dives starting in January 2025 with Adults' Neurodiversity and in March on Children's & Adolescent Mental Health Services (CAMHS).
- Planning for the MHLDA element of the 2025/26 operational and financial plan and for mental health capital planning.
- Reviewing the Health Services Strategy with focus on the MHLDA Priority Work Programme

Primary Care Commissioning and Assurance Committee:

The Committee exists to scrutinise and provide assurance to the ICB Board that there is an effective system of primary care services including medical, community pharmacy, optometry and dental services commissioning that supports it to effectively deliver its statutory and strategic objectives and provide sustainable, high quality primary care.

Work of the committee in 2024/25 has included:

- Approving recommendations made by the Primary Care (Medical services (GP) and Community Pharmacy, Optometry and Dental) Delivery Groups to ensure the ICB met its statutory responsibility for commissioning and overseeing delegated primary care services and functions.
- Approving recommendations from Primary Care Delivery Groups to ensure the ICB meets statutory commissioning responsibilities.
- Confirming assurance on contract commissioning, delivery, monitoring, and necessary contractual actions.
- Receiving assurance that the statutory contractual requirements, patient engagement and patient safety with practice considerations and actions had been followed in all decisions made.
- Approving a two-year extension for translation and interpretation services for all Primary Care contractors.
- Approving a four-year extension for Bedfordshire Hospitals Trust's Occupational Health Services contract.
- Approving the re-procurement programme for Alternative Primary Medical Services contracts and the recommendations from the Delivery Group to award new contracts on completion of procurements.
- Receiving assurance on practice closures, ensuring patient and stakeholder communication and safe care transfer.
- Reviewing assurance from the Pharmaceutical Services Regulatory Committee in relation to community pharmacy services.
- Overseeing Primary Care transformation and integration, including national and ICB delivery plans.
- Ensuring patient and community engagement drives quality improvements in Primary Care.
- Monitoring Pharmacy First Service developments, including blood pressure checks, contraception services, and a BLMK Pharmacy First Toolkit.
- Overseeing progress of the Primary Care Prevention Delivery Plan.
- Monitoring the delivery of the Primary Care Access Plan.
- Recommending the re-procurement of Integrated Urgent Care and Urgent Primary Care Services via direct awards, in accordance with the Provider Selection Regime regulations.
- Endorsing the refresh of the Primary Care Estates Strategy and Primary Care Strategy.
- Reviewing quarterly financial reports, risk registers, and workforce programme updates.
- Monitoring primary care estates, strategy progress, and Section 106 funding.

Quality and Performance Committee:

The Committee gains and provides assurance to the ICB, that there is an effective system of quality governance and system performance management that supports the ICB to effectively deliver its strategic objectives and ensure that sustainable, high quality care is provided to its population.

Work of the committee in 2024/25 has included:

- Receiving assurance and approving the recommendations and next steps on maternity services at Bedfordshire Hospitals Foundation Trust.
- Reviewing quarterly quality improvement and performance reports covering a number of key topics including elective wait times, diagnostics, health checks for people with serious mental illness, Community Diagnostic Centres, HbA1C blood analyser patient safety incident and Child and Adolescent Mental Health Services access performance.
- Receiving and discussing deep dive reports on ICB priorities from Population Health Intelligence Unit colleagues covering Children and Young People's health, Live Well and Ageing Well.
- Receiving assurance through annual reports on key workstreams including the Key Worker Report, Experience and Enquiries Report, Inequalities Report, Learning Disabilities and Mortality Report and the Child Death Overview Panel Report.
- Approving the dissolution of the Working with People and Communities Committee and supporting the establishments of a System Insights Network which will report back to the Committee.
- Overseeing the continued development of the Local Maternity and Neonatal System.
- Reviewing the Committees Terms of Reference and supporting a change to the approval route of evidenced bases policies, which has now been delegated to the ICB Executive.
- Receiving and noting clinical risks in relation to prescribing and supporting the mitigating actions proposed.
- Endorsing the Health Services Strategy's broad commitment and detailed implementation plans.
- Overseeing progress and delivery of the Patient Safety Incident Response Framework.
- Reviewing risk relevant to the Committee's remit on a quarterly basis.
- Reviewing palliative and end of life care across BLMK, acknowledging the significance of dying well work in BLMK, ensuring residents receive appropriate end of life care.
- Receiving and noting the start of the System Insights Network which replaced the Working with Communities ensuring that resident voice is at the heart of all the ICB do.

Effectiveness of the Board and it's committees

The ICB is in the process of undertaking a review of the effectiveness of the Board and the committees of the Board. The outcome of which will be reported to the Board in 2025.

Seeking appropriate advice

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

- Clinical advice to support the prevention, diagnosis or treatment of illness.
- The protection or improvement of public health.

We have three Primary Medical Services (PMS) Partner Member roles, a Chief Medical Director and a Chief Nurse on our Board to ensure the voice of clinicians is heard. The PMS members currently include two GPs and a community pharmacist. Public Health Directors are participant members of our Board. In addition, our Chief Executive is a qualified pharmacist and our Chief of Primary Care is a registered nurse.

Making effective decisions

The Board of the ICB has a number of committees to support it in its functions. These committees are described on page 92. In exercising its functions, the ICB uses a range of sources and intelligence to ensure it makes the most effective decisions possible. These include:

- The Board explicitly includes among its membership representatives from partner organisations, such as NHS providers, local authorities and the voluntary and community sector, so that their views inform decision making.
- The Finance and Investment Committee (see page 95) advises the Board on value for money and effective uses of resources.
- The Quality and Performance Committee (see page 98) advises the Board on service quality and improving patient experience.

Keeping the experience of members of the Board under review

The ICB has a robust appointment process in place to ensure that all Board members have the necessary experience and expertise, taking into account guidance issued by NHS England in August 2023. Members are offered induction sessions on key areas of the ICB's role and functions. In addition, Board seminars are held to help to develop members' knowledge and to support team building and collaborative ways of working.

The Remuneration Committee (see page 93) has responsibility for reviewing the talent on the Board and determining succession planning.

Register of Interests

The ICB maintains a [Register of Interests](#) which is published on the public website.

An extract from the register listing interests of members is presented as part of the meeting papers for meetings of the Board and its committees.

The policy for [Conflicts of Interest Management and Standards of Business Conduct Policy](#) is based on statutory guidance and is available on our public website together with the ICB's register of interests.

Information on the National Fraud Initiative (NFI) data matching exercise led by the Cabinet Office to prevent and detect fraud and identify undeclared interests can be found on page 110.

Personal data related incidents

The ICB is committed to reporting, managing, investigating and learning from all information governance incidents and near-misses. From 1 April 2024 to 31 March 2025, the ICB did not have any personal data-related incidents reported that met the required threshold for notification to the Information Commissioner's Office. Notifiable breaches are those that are likely to result in a high risk to the rights and freedoms of the individual (data subject), as defined by the UK General Data Protection Regulation and the Data Protection Act (2018).

Modern Slavery Act

BLMK ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement is published on our [website](#).

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

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

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

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

Felicity Cox

Accountable Officer

19 June 2025

Governance Statement

Introduction and context

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Between 1 April 2024 and 31 March 2025 the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The Members Report (see page 87) summarises the composition and work of the Board from 1 April 2024 to 31 March 2025.

A description of the purpose and work of the statutory and non-statutory committees established by the Board are provided in the Members Report from pages 90 to 97. The full terms of reference for each committee is available in the ICB's [Governance Handbook](#).

Attendance by voting members of each committee is provided on page 119.

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 NHS Bodies, the ICB considers relevant principles of the Code is considered to be good practice. This governance statement is intended to demonstrate how the ICB had regard to the principles set out in the Code which are considered appropriate for ICBs for this reporting period.

Discharge of Statutory Functions

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

The ICB has established a comprehensive risk management framework to proactively identify, assess, and manage risks across the organisation and the wider BLMK system. This framework outlines practical methods for risk identification, evaluation, and control implementation.

All Directors within the ICB have a clear responsibility and role for the identification and management of risk within their Directorates with risks recorded on Directorate Risk Registers. Where a risk necessitates corporate oversight, it will be recommended for inclusion on the Corporate Risk Register.

The Corporate Risk Register provides comprehensive reporting and assessment of high-level ICB risks, including those with strategic implications, long-term operational or broad impact, delivery of corporate objectives and/or potential effects on the ICB's reputation.

The System Risk Register/Board Assurance Framework (SRR/BAF) serves as the primary risk register for the ICS. The BAF/SRR is a key tool used to document and manage the main risks that could impact the delivery of the system's strategic objectives.

During 2024/25 the ICB has worked with all of its partner organisations to mature its system risk management approach. In alignment with the latest advancements in risk management methodologies, the ICB has been embedding Dynamic Risk Management (DRM) to enhance the System's ability to adapt and respond to an ever-changing risk environment. This approach allows for more flexible, real-time decision-making that reflects current and prospective threats to System objectives and priorities. The ICB's Risk Management Policy was reviewed and updated and approved by the Board of the ICB in September 2024.

Capacity to Handle Risk

As of 31 March 2025, the BAF/SRR has 14 identified and tracked strategic risks, 12 of which are categorised as high risk.

Each risk is overseen for assurance by a relevant committee or board where collaboration between system partners is undertaken to review controls to mitigate these risks and action plans for control improvement are developed.

Expanding the Risk Landscape - Throughout 2024/25, the Board acknowledged two new strategic system risks:

- As a result of challenges with funding and charitable donations, service closure or decommissioning and workforce challenges, the Board agreed that there is a risk to voluntary, community and social enterprises (VCSE) Sustainability as the ICS will not be able to deliver its vision and strategic priorities as the VCSE sector may not be in a position to adequately support the design and delivery of alternative approaches and services to deliver the shift towards prevention and early intervention to the population of BLMK.
- The Board recognised a risk in Maternity Services at Bedfordshire Hospitals NHS Foundation Trust (BHFT), relating to staffing and governance process issues, which could lead to avoidable harm, patient dissatisfaction and increased health and social care costs, jeopardising the delivery of this service.

Risk Assessment

Embedding Dynamic Risk Management (DRM) - DRM integrates continuous risk assessment and mitigation strategies that are designed to evolve as new information emerges and circumstances change. This method is particularly well-suited to managing the complex and interconnected risks faced by healthcare systems today. It enables the ICB to not only react to risks as they manifest but also to anticipate and prepare for potential threats before they fully develop.

A critical component of DRM is the employment of key risk indicators (KRIs) which help in monitoring changes in risk conditions. These indicators provide early warnings of potential problems, allowing the System to manage risks proactively rather than reactively. By focusing on these indicators, the ICB ensures that its strategic and operational planning are informed by real-time data, facilitating more effective and responsive governance.

By implementing DRM, the ICB aims to achieve a higher level of resilience and agility, securing its strategic objectives against a backdrop of uncertainty and change.

As an example, the risk of *'Increasing pressure on Urgent and Emergency Care (UEC) in the BLMK System'* has agreed ICS KRIs, a number of which are monitored via an Urgent and Emergency Care (UEC) Predictive Modelling Tool. The DRM of this system risk informed the development of the ICS Winter Plan.

Emergency Preparedness, Resilience and Response (EPRR)

Building a Robust EPRR Framework - The ICB is a Category One responder under the Civil Contingencies Act 2004, the same category as emergency services and therefore has a statutory requirement to ensure that a risk-based approach is taken to EPRR, that we collaborate and support Local Resilience Forums and the wider community to respond and recover from incidents and we undertake the publication, testing and exercising of plans for critical functions and key services.

In accordance with NHS England EPRR Framework, the ICB Chief of Staff is the Accountable Emergency Officer for the ICB, supported by the Head of Organisational Resilience. The ICB Audit & Risk Assurance Committee provides the assurance to the Board that EPRR requirements are being met, following the annual EPRR assurance process - [NHS England Core Standards for EPRR](#).

In 2024/25, the ICB maintained 'substantial' compliance with the NHS England Core Standards for EPRR, which has been the case for four consecutive years.

The ICB maintains an active programme of engagement with key stakeholders on key strategic and service decisions for EPRR via the Local Health Resilience Partnership (LHRP). This enables assurance that all partners have incident response and business continuity plans in place, providing compliance with the requirements of the Civil Contingencies Act 2004, the NHS Act 2006 (as amended) and NHS England EPRR Framework 2022.

EPRR Development - During 2024/25, a number of plans and policies were reviewed or developed including the EPRR Policy, Adverse Weather Plan, Command and Control Plan, Water Disruption Plan and Widespread Power Outage Plan.

A newly developed EPRR training strategy, ensures that those within the ICB who have a responsibility for leading and participating in the incident preparation and response arrangements, adhere to the National Occupational Standards (NOS) and NHS Core Competencies that have been developed for EPRR staff and responder competency through a structured approach comprising of mandatory regional introductory training and internal training with continuous professional development offered via annual training and exercising opportunities within the ICB and in conjunction with NHS England or the Local Resilience Forum (LRF).

The ICB has developed and facilitated Exercises Jackpot (LRF, Cyber incident), Silver Birch (Health System, National Power Outage), Broken Windows (ICB Executive, Business Continuity / Cyber incident), Dry River (Health System, Water Outage) as well developing health scenarios for LRF exercises.

EPRR Response

The ICB has responded to or supported a wide range of incidents, detailed in the table below, including 2 Major Incidents (one protracted) and a Critical Incident. A debrief process follows all incidents (and exercises) with lessons systematically captured, analysed, and, where relevant, implemented, as well as recording notable good practice. Lessons identified are shared with LHRP and / or LRF partners, as relevant. In undertaking this process, the ICB fosters a culture of continuous improvement, ensuring past mistakes are not repeated and that best practices are adopted.

2024/25 Incident Responses

April 2024	<ul style="list-style-type: none"> • Measles outbreak Preparedness • E-Coli Incident
May 2024	<ul style="list-style-type: none"> • Measles outbreak
June 2024	<ul style="list-style-type: none"> • Potential Just Stop Oil protests. • NHSE Regional Level 3 Incident - 144-hour Junior Doctor Industrial Action • Measles outbreak • Toddington GP Surgery drainage
July 2024	<ul style="list-style-type: none"> • Luton Accident and Emergency (A&E) Cubicle Closure • Measles outbreak • GP Collective Action planning
August 2024	<ul style="list-style-type: none"> • Response to potential civil unrest • GP Collective Action • BHFT HbA1c Analyser Business Continuity response • Mpox Clade 1 preparedness
September 2024	<ul style="list-style-type: none"> • GP Collective Action • BHFT HbA1c (measures blood sugar levels) Analyser Business Continuity response • MAJOR INCIDENT – Flooding in Bedfordshire and Milton Keynes
October 2024	<ul style="list-style-type: none"> • Flooding in Bedfordshire and Milton Keynes • BHFT Information Technology Outage • Bedford Hospital Power Outage • MKUH Endoscopy Business Continuity response • Bedford Renal business continuity response • MAJOR INCIDENT – Cleat Hill Gas Explosion
November 2024	<ul style="list-style-type: none"> • Flooding in Bedfordshire and Milton Keynes (Storm Bert) • Asylum seeker hotels in Milton Keynes • Cleat Hill Gas Explosion
December 2024	<ul style="list-style-type: none"> • Luton and Dunstable Hospital Heating business continuity • Luton and Dunstable Hospital Oxygen Pipe issue • CRITICAL INCIDENT – Bedford Hospital Pressures
January 2025	<ul style="list-style-type: none"> • NHSE Regional Level 3 Incident – Urgent and Emergency Care Pressures • BHFT Lait Test (SARS-CoV-2, Influenza A/B & RSV nucleic acid automated rapid) shortage • Stabbing outside of Luton and Dunstable Hospital
February 2025	<ul style="list-style-type: none"> • 111 system outage • 111 system issues • HCRG Care Group Cyber Security Incident • 111 Internet issues • Luton Town Centre Surgery power outage • Bedford Hospital lifts • Kingsway Health Centre Security system issues
March 2025	<ul style="list-style-type: none"> • South Central Ambulance Service airwaves radio issues

Other sources of assurance

Internal Control Framework

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

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

The system of control in place is set out within the ICB's [Governance Handbook](#) (including the ICB's Standing Financial Instructions) and as described in the following sections of this Accountability Report:

- Composition of the Board of the ICB – see page 88
- Committees of the Board of the ICB – see page 92
- Risk Management/Board Assurance Framework – see pages 9 and 10 and pages 103 to 104.
- Counter Fraud – see pages 110 to 112.
- Internal Audit – see page 112 to 113.

Data Quality

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

All the ICB's contracted providers are contractually obligated to maintain high-quality data that complies with national standards. Recently, the ICB has introduced a data quality policy that strengthens and supports data validation and management processes, ensuring that the data is complete, accurate, relevant, and timely. The mobilisation of the policy has increased the focus on data quality and makes accessible a current log of all known data quality issues and actions. The quality of the data for key providers is managed through formal contract and information monitoring arrangements. The data quality log is reviewed monthly by ICB business intelligence, finance and contracting teams.

Executive leads take responsibility for ensuring that all data presented to the Board is of high quality, accurate and fit for purpose. Performance data is submitted to the ICB executive team monthly and is disseminated through ICB Board and committee papers in line with meeting frequency.

The performance report continues to expand and evolve, providing a system-wide view of performance with support from NHSE and local authority partners. The report now consists of dashboards at different data levels including ICB, place and provider levels. Also included is national and regional benchmarking data where available.

Data presented within the reports includes national data from NHSE which is also available to the public through NHSE websites. This data has a time-lag prior to release to allow for national quality checking and verification. In addition, the ICB's Business Intelligence partner, NHS Arden & GEM Commissioning Support Unit and the ICB's Population Health Intelligence Unit, undertake their own validation checks for data completeness and accuracy.

Many data measures will be subject to change following a period of validation and, as such, annual data tables are refreshed monthly to ensure that the ICB can report against the most accurate, timely and complete data. No concerns have been raised by members of the Board about data quality.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. [The ICB's Information Governance Framework can be found here.](#)

All organisations that have access to NHS patient information must provide assurances that they have the required measures in place to ensure information is kept safe and secure. The way in which we must do this, is to complete the NHSE online self-assessment tool (the Data Security and Protection Toolkit (DSPT)) to measure their performance against the data protection standards. The annual submission provides assurances to NHSE and the ICB that personal information is dealt with legally, securely, efficiently and effectively.

In September 2024, the DSPT was updated to align with the [National Cyber Security Centre's Cyber Assessment Framework](#) (CAF). The scope of the 2024/25 DSPT includes additional cyber and information governance requirements split into 47 contributing outcomes, each of which are supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'.

We undertook an interim assessment in February 2025 of our position against the 2024/25 DSPT, in line with national timeframes. A 'final' submission will take place by the deadline set by NHSE of 30 June 2025. [Further information on our submissions can be found here.](#)

We have mandatory annual data awareness / information governance training for all staff and have processes in place for incident reporting and investigation of serious incidents.

Business Critical Models

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

Third party assurances

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

Control Issues

The ICB had no substantial control issues during 2024/25 requiring remedial action.

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

The Board of the ICB has overarching responsibility for ensuring the organisation has appropriate arrangements in place for exercising its functions economically, efficiently and effectively in the use of its resources and in accordance with the principles of good governance.

It ensures that the organisation has robust financial controls including detailed financial policies, standing financial instructions, agreed expenditure approval limits for staff, a monthly budget holder accountability process and an internal audit function, which focuses its work on the areas of financial control risk, as agreed with the Audit and Risk Assurance Committee.

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

Detailed performance, quality and finance reports, which include the use of comparative analysis to assess performance, are presented at each ICB Board meeting. These reports provide an overview of progress against key indicators and financial objectives and prior to consideration by the Board will have been reviewed in detail by the Finance and Investment and Quality and Performance Committees.

The ICB undertakes a comprehensive range of contract monitoring, benchmarking and budget monitoring to ensure the robust management of resources.

The Audit and Risk Assurance Committee receives opinion from the work of the internal and external auditors and is able to advise the Board on the assurances available with regard to the economic, efficient and effective use of resources.

Senior managers meet with NHSE's Assurance Team to ensure that the ICB is meeting its financial responsibilities in accordance with NHSE's regulations. Regular review meetings take place between NHSE Region and the ICB to provide assurance on the delivery of the ICB's statutory functions and strategic priorities. The ICB's Annual Report and Accounts are audited by external auditors who report to the Audit and Risk Assurance Committee.

Commissioning of delegated specialised services

BLMK ICB signed a delegation agreement (DA) with NHS England and held full commissioning responsibilities for delegated services during the 2024/25 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

Where there were known compliance issues, the ICB leadership collectively with the other ICBs in the Eastern Region (Joint Commissioning Consortium) has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance via the Joint Commissioning Consortium, should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

Our delegation arrangements are set out in our [Governance Handbook](#) which incorporates a Scheme of Reservation and Delegation (SORD). Amendments to the SORD require Board approval. Committees of the Board provide an 'alert, advise, assure' for each meeting of the Board to provide visibility and assurance on matters delegated by the Board. We have an agreed internal audit plan each year that tests internal delegations and controls and no internal control failures have been identified. We have regular performance and risk reporting to provide assurance about the operation of internal delegations.

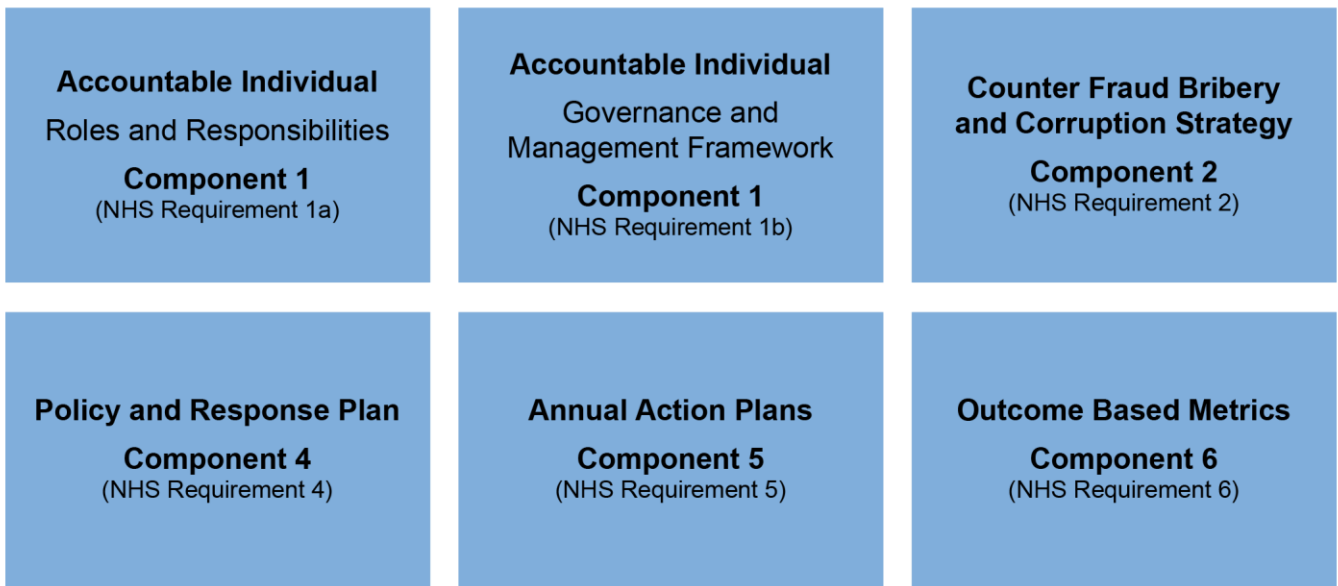
During 2024/25 no issues raised through the whistleblowing/Freedom to Speak Up route have related to delegation arrangements.

Counter fraud arrangements

During 2024/25, the ICB's counter fraud service was provided by a BDO LLP, accredited local counter fraud specialist (LCFS). The ICB's Chief Finance Officer was responsible for ensuring compliance with the Government Functional Standard and the application of the related NHS Counter Fraud Authority (NHSCFA) requirements and the Deputy Chief of Strategy and Assurance, as the ICB's Counter Fraud Champion, continued to support the LCFS by proactively promoting counter fraud activity within the ICB and ensuring the swift internal communication of key messages and alerts.

The LCFS worked to a risk-based annual plan that had been agreed by the Chief Finance Officer and the Audit and Risk Assurance Committee. The plan was designed around the 12 NHS Requirements under the Government Functional Standard for Counter Fraud, Bribery and Corruption (see diagram below), and compliance with these standards was reported to the Audit and Risk Assurance Committee.

Governance



Counter Fraud Bribery and Corruption Practices



The LCFS attended all meetings of the Audit and Risk Assurance Committee to provide updates on progress against the annual work plan. In addition, the LCFS held quarterly catch-up calls with their opposite number at NHS England, to share information on cross-cutting fraud risks and issues.

All concerns of fraud, bribery and corruption at the ICB were referred to the LCFS and addressed in accordance with the ICB's fraud, bribery and corruption policy and NHSCFA Anti-Fraud Manual.

The [National Fraud Initiative](#) (NFI) data matching exercise is currently underway (at the time of writing). This is a Cabinet Office led exercise across the entire public sector, held every two years which helps to prevent and detect fraud and identify undeclared interests by:

- Matching people with payroll assignments in more than one public sector, this is then investigated to establish if arrangements are appropriate.
- Looking for people with public sector payroll assignments who are listed as a director or officer on Companies House data and have conducted business with their public sector employer or associated party.
- Looking at trade and creditor and creditor history matches to identify any patterns of recurring or duplicate matches.

All matches in relation to the ICB will be investigated accordingly by the ICB's CFS.

Head of Internal Audit Opinion

Our internal audit programme adopts a risk-based approach to planning its work, referring to the organisational risk registers in identifying topics for review.

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Overall, we provide Moderate Assurance that there is a sound system of internal controls, designed to meet the ICB's objectives, that controls are being applied consistently across various services.

The table below shows the outcome of the audits carried out during 2024/25.

Area of Audit	Level of Assurance/Opinion (Please refer to legend on next page for definitions)	
	Design	Operational Effectiveness
Cyber Security – supply chain	Moderate	Limited*
IT - Benefits realisation	Substantial	Moderate
Key Financial Systems	Substantial	Substantial
Primary Care Commissioning – Pharmaceutical	Substantial	Substantial

In addition to the audits listed above, BDO carried out advisory reviews on the following:

- Procurement governance and partnership engagement
- Specialist Commissioning
- Data Security & Protection Toolkit 2024/25

**The Cyber Security Supply Chain Audit carried out during this reporting period identified some good practice including, development and running of cyber-attack exercises in conjunction with the ICB's Emergency Preparedness Resilience and Response team. Gaps identified included issues with collection of security certifications and cyber security data from third party providers, risk assessments of all entities along the supply chain, cyber security item on the agenda for meetings with suppliers, ensuring that the contract register is fully updated and timely review of the Network Access Policy. Progress with the implementation of the recommendations to address these gaps has been made with some now closed as completed. Outstanding recommendations will continue to be monitored by the Committee via a progress Update Report from BDO.*

Legend:

Level of Assurance	Design Opinion	Findings from Review	Effectiveness Opinion	Findings from Review
Substantial	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	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	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	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.

Enquiries, Concerns, Freedom of Information

The ICB's Enquiries & Experience Team oversee all enquiries, concerns, Freedom of Information requests and complaints received by BLMK ICB.

The Team also provides advice and support to BLMK ICB residents who have queries or complaints about its provider services, often aiding communication and input from provider organisations to establish a way forward and mutual resolution. Where relationships have broken down, the Team will provide advice regarding options for escalation, which may include a referral to the [Parliamentary and Health Service Ombudsman](#) (PHSO).

From 1 April 2024 to 31 March 2025, the Team received 2751 contacts. General enquiries accounted for just over 80% (2179), 11% of enquiries were concerns.

The majority of concerns related to GP services. A review of themes identified that the main issues raised related to Access to Service, which in turn led to concerns about:

- Delayed follow-up/care following discharge from secondary care
- Consultations needed for ongoing care / treatment / updates
- Follow-up to NHS 111 referrals
- Delayed prescriptions / medication reviews

Residents also report being deferred to online systems which they felt discriminates against those who are unable to use or have access. In addition, residents also report a lack of assistance from front line staff. Of note one resident on limited income reported that waiting for calls to be answered resulted in lost mobile data (minutes) which would not be replenished for 30 days.

Where residents state that attempts to contact a practice have not been successful, the Team will liaise with Primary Care colleagues in the first instance to establish whether there are any issues with the telephone or internet systems. Contact is also made with Practice Managers to highlight residents' concerns so that steps can be taken to improve the situation. The Team will often facilitate communication between the resident and the practice where it is clear that immediate intervention is needed, e.g. medication reviews, prescriptions etc.

Concerns regarding access to dental care and mental health services were also noted. Residents are advised that an increased demand on these services, which has been noted nationally, impacts availability and waiting times. Although the ICB is not able to influence waiting lists due to demand/capacity, residents are provided with safety net advice such as access to NHS111 for mental health support and emergency dental care.

With responsibility for the management of pharmacy, optometry and dental concerns and complaints falling under ICBs since July 2023, residents can approach the ICB and ask for assistance about any of its provider organisations. With a focus on ensuring a timely resolution of issues raised, the Team will liaise with the relevant service/provider organisation, ask that they commission an investigation and provide a response with a view towards establishing a way forward.

During 2024/25 45 formal complaints were received, twelve of which related to access to GP services. To facilitate a response, the Team will liaise with the relevant surgery and ask that they commission an investigation into the issues raised and provide a response which addresses the complaint and any actions and learning as a result.

The ICB received 21 complaints about Continuing Health Care (CHC) in which residents indicated dissatisfaction with the outcome of a CHC assessment. In these circumstances, a review is carried out to determine whether the assessment process was appropriate and reflected in the decision that was reached.

BLMK ICB received 127 MP Contacts during the reporting period. In line with the themes identified in general contacts and concerns, the majority of MP contact related to GP access and questions about the ICB's plans to improve primary care provision in the region.

During 2024/25, 553 FOI requests were received.

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

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

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

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

- The Board
- The Audit and Risk Assurance Committee
- The Finance and Investment Committee
- Internal Audit
- 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 Cyber Security Supply Chain audit as detailed in the Head of Internal Audit Opinion on pages 112 to 113.

APPENDIX 1 -

Attendance at meetings of committees of the Board

The following table provides a list of BLMK ICB Health and Care Partnership Committee and their attendance.

Name	Role	Attended
Cllr Khtija Malik	Co-Chair - Councillor, Luton Borough Council	2/2
Martin Towler	Co-Chair - Chair, Health and Wellbeing Board, Bedford Borough Council	2/2
Manraj Barhey	Primary Care Network Clinical Director, Luton	2/2
Fatima Begum	Portfolio Holder for Population Wellbeing (Adult Social Care), Luton Council	0/2
Diane Blackmun	Chief Executive Officer, Healthwatch, Central Bedfordshire	0/2
Cllr Jane Carr (from 14.2.2025)	Leader of the Liberal Democrat Group, Milton Keynes City Council	1/1
Sally Cartwright (until 31.12.2025)	Director of Public Health, Luton Council	1/1
Simon Chase	Chief Paramedic, East of England Ambulance Service NHS Trust	0/2
Felicity Cox	Chief Executive Officer, ICB	2/2
Mary Elford	Chair, Cambridgeshire Community Services NHS Trust	1/2
Elizabeth Elliott/Nicola Ainsworth (from 14.2.2025)	Joint Directors of Public Health, Luton Council	1/1
Emma Freda	Chief Executive, Healthwatch, Bedford Borough	1/2
Manjeet Gill (from 14.2.2025)	Acting ICB Chair	1/1
Vicky Head	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes	1/2
Tracy Keech	Healthwatch Milton Keynes	2/2
Tom Kibasi (until 19.9.2024)	Chair, Central and North West London NHS Foundation Trust	0/1
Jane Kocen	Primary Care Network Clinical Director, Bedford	2/2
Angela MacPherson	Deputy Leader Buckinghamshire County Council	1/2
Rima Makarem (until 31.12.2025)	ICB Chair	1/1
Peter Marland	Leaders Milton Keynes Council (Chair, Health and Wellbeing Board, Leader, Milton Keynes City Council)	0/2
Sonal Mehta	Voluntary, Community and Social Enterprise (VCSE) Lead	2/2
Navaneetha Rammohan	Primary Care Network Clinical Director, Milton Keynes	1/2
Amanda Rowlatt (from 14.2.2025)	Vice Chair, Central and North West London NHS Foundation Trust	1/1

Name	Role	Attended
Andy Sharp	Director of Social Care, Health and Housing, Central Bedfordshire Council	1/2
Councillor Mark Smith	Executive Member for Adult Social Care and Health, Central Bedfordshire Council	1/2
Richard Summary	Chair, Bedfordshire Hospitals NHS Foundation Trust	2/2
Eileen Taylor	Interim Chair, East London NHS Foundation Trust	1/2
Heidi Travis	Chair, Milton Keynes University Hospital NHS Foundation Trust	2/2
Phil Turner	Chair, Healthwatch Luton	1/2
Kate Walker	Director of Adult services, Bedford Borough Council	0/2
Tom Wootton	Mayor, Bedford Borough	0/2

The table on the following page provides a list of voting members of the following committees of the Board and their attendance:

Statutory committees:

- Audit and Risk Assurance Committee (A&AC)
- Remuneration Committee (RemC)

Non-statutory committees:

- Bedfordshire Care Alliance Committee (BCAC)
- Finance and Investment Committee (F&IC)
- Mental Health Learning Disabilities and Autism Collaborative Committee (MHLDA)
- Primary Care Commissioning and Assurance Committee (PCCAC)
- Quality and Performance Committee (Q&PC)

Name of voting members of the committees of the Board and their attendance.

Name	Role/Job Title (BLMK ICB role unless otherwise stated)	A&RAC	BCA	F&IC	MHLDA	PCCAC	Q&PC	RemC
Dr Manraj Barhey	Primary Care Network Clinical Director - Luton	-	2/2	-	-	-	-	-
Lisa Benn	Service user/carer representative	-	-	-	2/3	-	-	-
Alison Borrett	Non-Executive Member & ICB Senior Independent Director	4/4	-	-	-	4/4	3/4	3/4
Anne Brierley	Chief Operating Officer	-	-	0/1	1/3	-	-	-
David Carter	Chief Executive, Bedfordshire Hospitals NHS Foundation Trust	-	2/2	-	-	-	-	-
Felicity Cox	Chief Executive Officer	-	1/2	-	-	-	-	-
Mark Cox	Service user/carer representative	-	-	-	3/3	-	-	-
Dr Simon Edwards	Medical Director, Central and North West London NHS Foundation Trust	-	-	-	3/3	-	-	-
Mark Fowler	Deputy Chief Executive, Luton Borough Council	-	0/2	-	-	-	-	-
Richard Fradgley	Executive Director of Integrated Care and Deputy Chief Executive, East London NHS Foundation Trust	-	-	-	3/3	-	-	-
Manjeet Gill	Non-Executive Member	3/3	-	4/4	1/2	3/4	-	3/4
Ross Graves	Chief Strategy and Digital Officer, Central & North West London NHS Foundation Trust	-	-	-	3/3	-	-	-
Dr Jane Kocen	Clinical Director (Bedford), Primary Care Network	-	2/2	-	-	-	-	-
Dr Omotayo Kuefji	Primary Medical Services Board Member	-	-	-	-	1/4	-	-
Sophie Lonsdale	Service user/carer representative	-	-	-	3/3	-	-	-
Dr Rima Makarem	Independent Chair	-	-	3/3	1/1	-	-	2/3
Vineeta Manchanda	Non-Executive Member	4/4	-	4/4	3/3	-	2/4	3/4
Claire McKenna	Interim Chief Nurse, East London NHS Foundation Trust	-	-	-	2/3	-	-	-
Claire Murdoch	Chief Executive, Central and North West London NHS Foundation Trust	-	-	-	0/3	-	-	-
Shirley Pointer	Non-Executive Member	-	2/2	-	-	-	4/4	4/4
Nicky Poulain	Chief Primary Care Officer	-	-	1/1	-	4/4	-	-
Dr Ian Reckless	Interim Chief Medical Director	-	-	0/3	-	0/4	4/4	-
Martha Roberts	Chief People Officer	-	-	0/1	-	-	2/4	-
Mahesh Shah	Primary Medical Services Partner Board Member	-	-	-	-	2/4	2/4	-
Andy Sharp	Director of Social Care, Health and Housing, Central Bedfordshire Council	-	0/2	-	-	-	-	-
Sarah Stanley	Chief Nurse	-	-	4/4	3/3	3/4	4/4	-
Lorraine Sunduza	Chief Executive Officer, East London NHS Foundation Trust	-	2/2	-	1/3	-	-	-
Dr Sahadev Swain	Primary Medical Services Partner Board Member	-	-	-	-	-	3/4	-
Kate Walker	Director of Adult Social Care, Bedford Borough Council	-	1/2	-	-	-	-	-
Dean Westcott	Chief Finance Officer	-	-	4/4	1/3	4/4	-	-
Deborah Wheeler	Vice Chair, East London NHS Foundation Trust	-	-	-	2/3	-	-	-
Mathew Winn	Chief Executive, Cambridge Community Services NHS Trust	-	2/2	-	-	-	-	-
Dr Sarah Whiteman	Chief Medical Director	-	-	1/1	-	-	-	-
Maria Wogan	Chief of Strategy and Assurance	-	-	-	2/2	-	3/4	-

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

We provide appropriate levels of remuneration to attract the right people with the right skills to BLMK. Remuneration is approved and assured by the Remuneration Committee. More information can be found on page 93.

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.00%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	4.94%	0%

The salary of the highest paid director has increased by 5.00% compared to 2023/24. At the start of 2024/25 the highest paid director was the ICB Accountable Officer. This is consistent with the highest paid director in 2023/24. The salary is based on and is compliant with guidance issued by NHS England and was approved by both the ICB remuneration committee and NHS England.

The average percentage change in salary for employees of the ICB was 4.94% compared to 2023/24 financial year. The agenda for change pay award for 2024/25, including the introduction of new mid-point pay scales, has been incorporated into this calculation.

No performance pay or bonuses were paid in the financial year 2024/25.

Pay ratio information

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

The banded remuneration of the highest paid director in Bedfordshire Luton & Milton Keynes ICB in the reporting period 1st April 2024 – 31st March 2025 was £197,500 (prior year 2023/24 was £187,500).

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

2024/25	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	39,405	53,400	66,507
Salary component of total remuneration (£)	39,405	53,031	66,507
Pay ratio information	5.01 : 1	3.70 : 1	2.97 : 1

During the reporting period 1st April 2024 – 31st March 2025, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £6,300 to £197,500.

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.

Comparable information for the previous reporting period 1st April 2023 – 31st March 2024 is shown in the table below:

2023/24	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	37,905	52,074	62,305
Salary component of total remuneration (£)	37,654	52,074	62,305
Pay ratio information	5.01 : 1	3.65 : 1	3.05 : 1

The changes in the current financial year's pay ratios compared to the pay ratios of the previous financial year are mainly due to the restructuring of the ICB in order to deliver the required running cost reductions after taking into account the in-year pay award and pay progression affecting the median pay ratio.

Policy on the remuneration of senior managers

NHSE executive pay framework sets Operational Maximum pay levels for ICB Executive Roles. The Remuneration Committee considers national guidance to set salaries and terms and conditions of service for all Board members, any salaries exceeding the NHSE Operational maximum are subject to ministerial approval. All Board members are paid on very senior manager (VSM) terms and conditions of service, including notice periods.

Objectives are set and performance is measured using the objective setting and appraisal process in conjunction with other relevant policies. Remuneration is basic salary, with no awards. All roles in the ICB are subject to job evaluation. In respect of executive remuneration, the committee is guided by the key principles set out in the Hutton Review of Fair Pay (2011), job evaluation methods and pay guidelines set for chief officers and chief finance officers by NHS England.

Remuneration of Very Senior Managers

In March 2025 the ICB had five senior managers on a VSM contract which provided for a contractual salary of £150,000 or greater per annum.

All annual increases to VSM salaries are compliant with guidance from NHS England. Appropriate internal increases for increased accountability are presented and discussed at the ICB Remuneration Committee to determine reasonableness in line with current salary guidance and, where the increase takes the salary above the NHSE threshold, permission is sought from HM Treasury. All pay for VSMs is within the pay thresholds set out by NHS England.

Senior manager remuneration (including salary and pension entitlements)

2024/25 (1st April 2024 – 31st March 2025)

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)
Executive Team		£'000	£	£'000	£'000	£'000	£'000
Felicity Cox	Chief Executive Officer	195 to 200	200	0	0	45 to 47.5	245 to 250
Dr Sarah Whiteman **	Chief Medical Director (to 14th April 2024)	10 to 15	0	0	0	0	10 to 15
Dr Ian Reckless ***	Interim Chief Medical Director (from 16th April 2024 to 10th March 2025)	105 to 110	0	0	0	0	105 to 110
Dr Andrew Rochford **	Chief Medical Director (from 10th March 2025)	5 to 10	0	0	0	0	5 to 10
Dean Westcott **	Chief Finance Officer	170 to 175	300	0	0	0	170 to 175
Nicky Poulain	Chief of Primary Care	145 to 150	1,000	0	0	15 to 17.5	165 to 170
Sarah Stanley	Chief Nurse	150 to 155	0	0	0	45 to 47.5	195 to 200
Anne Brierley	Chief Operating Officer (to 31st March 2025)	150 to 155	5,700	0	0	35 to 37.5	190 to 195
Maria Wogan	Chief of Strategy & Assurance	150 to 155	0	0	0	42.5 to 45	195 to 200
Martha Roberts	Chief People Officer	145 to 150	400	0	0	92.5 to 95	240 to 245
GP Members							
Dr Omotayo Kufeji **	Primary Medical Services Partner Member	35 to 40	0	0	0	0	35 to 40
Mahesh Shah **	Primary Medical Services Partner Member	20 to 25	0	0	0	0	20 to 25
Dr Sahadev Swain	Primary Medical Services Partner Member	15 to 20	0	0	0	5 to 7.5	20 to 25
Lay Members							
Dr Rima Makarem **	Chair (to 31st December 2024)	45 to 50	1,000	0	0	0	45 to 50
Manjeet Gill **	Non-Executive Member (to 31st December 2024) Interim Chair (from 1st January 2025)	25 to 30	1,500	0	0	0	25 to 30
Alison Borrett **	Non-Executive Member	15 to 20	0	0	0	0	15 to 20
Shirley Pointer **	Non-Executive Member	15 to 20	0	0	0	0	15 to 20
Vineeta Manchanda-Singh **	Non-Executive Member	15 to 20	500	0	0	0	15 to 20
Lorraine Mattis **	Associate Non-Executive Member	10 to 15	0	0	0	0	10 to 15

* The taxable benefits are in respect of business mileage and subsistence claims.

** These senior managers are either not members of the NHS Pension Scheme or are drawing on their retirement benefits.

*** This senior manager is off-payroll and was recharged to the ICB from an external partner organisation.

No member received any additional remuneration from the ICB for duties that are not part of the management role.

2023/24 (1st April 2023 – 31st March 2024)

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)
Executive Team		£'000	£	£'000	£'000	£'000	£'000
Felicity Cox **	Chief Executive Officer	185 to 190	1,800	0	0	0	190 to 195
Dr Sarah Whiteman **	Chief Medical Director	155 to 160	0	0	0	0	155 to 160
Dean Westcott **	Chief Finance Officer	160 to 165	500	0	0	0	160 to 165
Nicky Poulain	Chief Primary Care Officer	140 to 145	1,900	0	0	0	140 to 145
Sarah Stanley	Chief Nursing Director	145 to 150	0	0	0	105 to 107.5	250 to 255
Anne Brierley	Chief Transformation Officer	155 to 160	0	0	0	0	155 to 160
Maria Wogan	Chief of System Assurance and Corporate Services	140 to 145	0	0	0	0 to 2.5	140 to 145
Martha Roberts	Chief People Officer	130 to 135	800	0	0	72.5 to 75	200 to 205
GP Members							
Dr Omotayo Kufeji **	Primary Medical Services Partner Member	35 to 40	0	0	0	0	35 to 40
Mahesh Shah **	Primary Medical Services Partner Member	20 to 25	0	0	0	0	20 to 25
Dr Sahadev Swain	Primary Medical Services Partner Member (from 5th June 2023)	15 to 20	0	0	0	2.5 to 5	20 to 25
Lay Members							
Dr Rima Makarem **	Chair	60 to 65	1,600	0	0	0	60 to 65
Alison Borrett **	Non-Executive Member	15 to 20	0	0	0	0	15 to 20
Shirley Pointer **	Non-Executive Member	15 to 20	0	0	0	0	15 to 20
Vineeta Manchanda-Singh **	Non-Executive Member (from 21st July 2023)	10 to 15	400	0	0	0	10 to 15
Manjeet Gill **	Non-Executive Member	15 to 20	600	0	0	0	15 to 20
Lorraine Mattis **	Associate Non-Executive Member	5 to 10	0	0	0	0	5 to 10

* The taxable benefits are in respect of business mileage and subsistence claims.

** These senior managers are either not members of the NHS Pension Scheme or are drawing on their retirement benefits.

No member received any additional remuneration from the ICB for duties that are not part of the management role.

The following members of the ICB Board are representatives of partner organisations and do not receive remuneration from the ICB:

- David Carter, NHS Trust Partner Member, Bedfordshire Hospitals Foundation Trust
- Joe Harrison, NHS Trust Partner Member, Milton Keynes University Hospital Foundation Trust
- Ross Graves, NHS Trust Partner Member, Central and North West London Foundation Trust
- Laura Church, Local Authority Partner Member, Bedford Borough Council
- Marcel Coiffait, Local Authority Partner Member, Central Bedfordshire Council
- Robin Porter, Local Authority Partner Member, Luton Borough Council
- Michael Bracey, Local Authority Partner Member, Milton Keynes City Council
- Vicky Head, Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes
- Sally Cartwright, Director of Public Health, Luton
- Maxine Taffetani, Milton Keynes Healthwatch
- Cllr Khtija Malik, Co-Chair of Bedfordshire, Luton & Milton Keynes, Health and Care Partnership
- Cllr Martin Towler, Co-Chair of Bedfordshire, Luton & Milton Keynes, Health and Care Partnership

Pension benefits

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Felicity Cox	Accountable Officer	2.5 to 5.0	0.0	5 to 10	0	59	38	125	0
Dean Westcott	Chief Finance Officer	0	0.0	0	0	0	0	0	0
Nicky Poulain	Chief Primary Care Officer	0.0 to 2.5	0.0	65 to 70	175 to 180	1,571	0	142	0
Sarah Stanley	Chief Nursing Director	2.5 to 5.0	0.0 to 2.5	50 to 55	135 to 140	1,005	47	1,137	0
Anne Brierley	Chief Transformation Officer	2.5 to 5.0	0.0	45 to 50	105 to 110	852	31	954	0
Maria Wogan	Chief of System Assurance and Corporate Services	2.5 to 5.0	0.0 to 2.5	20 to 25	45 to 50	433	38	519	0
Martha Roberts	Chief People Officer	5.0 to 7.5	7.5 to 10.0	50 to 55	135 to 140	1,042	103	1,248	0
Dr Sahadev Swain	Primary Medical Services Providers Partner Member	0.0 to 2.5	0.0	0 to 5	0	5	5	11	0

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

No payments of this nature were made by the ICB during the reporting period 1st April 2024 – 31st March 2025.

Payments to past directors

No payments were made by the ICB to past directors during the reporting period 1st April 2024 – 31st March 2025.

Staff Report

Number of senior managers

At the end of March 2025 BLMK ICB employed 16 senior managers including very senior managers (VSMs) and Band 9s.

Staff numbers and costs

On average we have employed 376 full-time (FTE) people at a cost of £31,309,000 (of which £15,455,000 is included in running costs).

Staff Numbers	Permanent employees	Other staff	Total
	Average FTE	Average FTE	Average FTE
Administration and estates staff	271.28	19.03	290.31
Medical and dental staff	5.61	0.00	5.61
Nursing, midwifery and health visiting staff	50.60	9.32	59.92
Scientific, therapeutic and technical staff	19.88	0.00	19.88
Totals	347.37	28.35	375.72

Employee benefits	Permanent employees	Other staff	Total
	£000s	£000s	£000s
Salaries and wages	21,856	2,216	24,072
Social security costs	2,513	0	2,513
Employer contributions to NHS pension scheme	4,628	0	4,628
Other pension costs	1	0	1
Apprenticeship levy	95	0	95
Gross employee benefits expenditure	29,092	2,216	31,309

Board members on the ICB payroll, excluding senior executive/senior management members:

Male		Female	
Headcount	%	Headcount	%
2	25	6	75

Senior managers and VSMs, excluding Board of the ICB:

Male		Female	
Headcount	%	Headcount	%
4	25	12	75

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

Male		Female	
Headcount	%	Headcount	%
56	16.14	291	83.86

Gender pay gap reporting

We aim to achieve a gender balance across our workforce, including at the most senior levels. All our job or employment opportunities are advertised internally and career conversations are held as part of appraisals. We have actively looked to fill vacancies with internal talent before seeking external candidates. We are mindful that we must act fairly, and within the law, and act where possible to close or reduce the gender pay gap. We are therefore committed to:

- checking for any gender bias in our recruitment information, appointment and onboarding processes and also rectifying this through training, raising / increasing awareness or other means.
- checking for any gender bias in the uptake of our training offers and other professional, leadership and development programmes.
- monitoring the interpretation and application of policies and procedures, such as flexible working and agile/hybrid working.
- undertaking an analysis of current workforce in relation to specific roles, salary increase requests, and starter salaries to understand any occupational bias.
- ensuring that we respond appropriately to any behavioural concerns arising from feedback mechanisms such as Freedom to Speak Up, staff survey results, our staff networks and staff engagement sessions.
- Review any indicators from staff surveys and/or exit interviews that might increase the understanding of the situation.

We are also committed to eliminating other pay gaps such as ethnicity pay gap as well as disability pay gap. Our pay gap reports are accessible via

<https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-publications/icb-equality/>

Sickness absence data

Under guidance issued by NHS England, guidance on Sickness Absence Data Reporting for NHS Bodies 2013–14 (2014), ICBs are required to report on a calendar year. The data in this report reflects the period from 1st January to 31st December 2024.

We supported employees' health and wellbeing through access to an Occupational Health Service, Employee Assistance Programme, absence management process, as well as wellbeing initiatives throughout the year including but not limited to wellbeing topics included in our staff briefings, wellbeing conversations and access to system-wide wellbeing resources. Recognising the benefits of activity, we have launched a cycle to work scheme for our staff and achieved accreditation as a Menopause Friendly organisation, achieved Lived Experience Charter Status and we have implemented mandatory menopause awareness training complemented by enhanced virtual menopause in the workplace training, access to desk fans at all sites and a supplementary menopause return to work form. We also reinforced an 'open-door' culture, with colleagues encouraged to speak with their line manager or appropriate senior manager regarding any matters of concern, as well as a Freedom to Speak Up Guardian and Freedom to Speak up Champions in place for staff to contact should they wish to.

The sickness absence data for months 1 – 12 of 2024 showed an average 6.0 working days lost per employee. It should be noted that the days lost were attributed to both long-term and short-term illnesses.

Staff turnover percentages

The staff turnover percentage for the ICB for 2024/25 is 13.29% which is a significant reduction from the figure reported for the period 2023/2024 (20.99%). The current figure is above average and it should be noted that this figure reflects the impact following organisational change within the ICB in 2023/2024. The top three reasons for leaving (outside of the organisational change) are attributed to work life balance, retirement and promotion. To support retention, we ensure staff feel supported in their careers, not only through secondment opportunities to help develop skills, but also advertise roles internally to ensure staff have opportunities to progress within the organisation. We have implemented Wellbeing Champions to support staff.

We have continued to offer a hybrid working model and flexible working to our staff to ensure they have an opportunity for good work like balance. No formal flexible working requests have been declined.

We conduct exit interviews where requested so that we can gather more information around the reason for leaving and can therefore take steps to address any concerns raised.

Staff engagement percentages

2024/25 has been a further year of change for the ICB because of the NHS England directive for all ICBs to reduce their running costs by 30%. As part of this we have conducted engagement with our staff on phase two of the target operating model. Engagement within the year includes specific sessions on the new target operating model and the proposal for a new way of working with new teams, All staff briefings, Directorate Sessions, Formal Consultation, support sessions for all staff, NHS Elect training sessions, weekly meetings with Trade Unions, weekly staff communications, FAQs & Intranet resources.

We have also engaged with our staff to understand what they need in respect of development of skills to operate successfully in our new environment. As a consequence, we launched a leadership programme, held topic specific 'bitesize' sessions and implemented practical development days to upskill staff knowledge in respect to project management, quality improvement techniques and IT systems.

Focus groups were held with staff which developed the Talk Listen Act (TLA) plan in relation to the annual staff survey results for 2023-2024. The ICB actively wants to ensure consistency in the work experience of all its employees. Following publication of the WRES & WDES data, engagement sessions were held with these specific groups of staff to understand and enhance their working experience.

Health and wellbeing support

During the reporting period we have continued to offer wellbeing support for our staff and are fully committed to the health and wellbeing of our employees and understand that a healthy and happy workforce is crucial to delivering improvements in patient care.

With the continuation of hybrid working, we have continued to support our staff by retaining and enhancing existing measures. These measures have included:

- hybrid working guidance
- regular communication and contact between managers and staff member
- introduction of a more robust appraisal process using NHSE's scope for growth framework
- provision of a suite of wellbeing advice and tools
- completion of the NHS Wellbeing Diagnostic
- implementation of Wellbeing Champions
- menopause related support sessions
- use of technology in terms of social applications
- fortnightly all staff huddle meetings with our Chief Executive to keep staff updated
- DSE assessments for homeworking and making use of Access to Work to support where applicable

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

We offer an employee assistance programme (EAP), accessed through a free and confidential helpline. We also have access to occupational health services to support staff with health concerns and during the last year have launched a NHS Leaders wellbeing local programme to emphasise the importance of wellbeing for staff and the impact on patient care.

Induction, Onboarding and development

Giving new team members a strong start at BLMK ICB is essential to our commitment to providing a positive and productive work environment for all staff. In a challenging time for the NHS, and while ICBs are still embedding their ways of working in the new target operating model, it is more important than ever to ensure that our plans are robust and that new staff hit the ground running.

During 2024/25 our corporate induction was redesigned to help new employees feel supported and give them the tools and knowledge they need to succeed in their roles. The program covers a wide range of topics including mission, vision and values, governance structure, key stakeholders, contacts, and services, internal processes and expectations for employees. For executive and non-executive members, our development plan expands further covering Establishment & Transition and Strategy, Priorities & ICB Delivery. The People and Development team have worked with line managers to ensure effective use of probationary periods, ensuring initial objectives are set so that all new employees have clarity on the expectations of their roles and feel supported to achieve these.

Developing a diverse workforce

BLMK ICB promotes and cultivates a culture of inclusivity, belonging, and effective leadership at all levels bound together by a passion to serve our communities, being willing and able to challenge professional and organisational paradigms and seeing a future where health and care are better delivered through collaboration. The ICB workforce represents different faith and beliefs, age groups, and socio-economic backgrounds that bring different perspectives.

Public Sector Equality Duty (PSED)

The ICB is committed to the reduction in inequalities in the provision of services in BLMK and within our workforce. There are several mechanisms that are used to assess how well the ICB is progressing in this area. The Public Sector Equality Duty (PSED) is one of those, designed to support ICBs and other organisations to think about equality across our workforce and the work that we do.

The PSED consists of a general duty and specific duties. The general duty requires ICBs to think about how they can prevent discrimination, advance equality and foster good relations. This applies to the services that are provided and commissioned, and to the employment of staff, and their experience in the workplace. The PSED requires a thorough consideration of the needs of people with each protected characteristic and is therefore different to the focus of the health inequalities duty which includes a focus on geographical inequalities and other non-protected characteristic inequalities.

The specific duty requires the ICB to be transparent about our work on equality and to show how we are meeting the requirements of the general duty. Each year we must publish equality information that demonstrates how we are thinking about equality across the services we provide and commission and the employment of staff. The following documentation is published on our [Website](#) meeting our duty as an ICB:

- NHS Workforce Race Equality Standard (WRES) Report
- Workforce Disability Equality Standard (WDES) Report
- Pay Gap reports
 - Gender pay gap
 - Ethnicity pay gap (voluntary)
 - Disability pay gap (voluntary)
- BLMK ICB NHS Equality Delivery System (EDS) Report
 - Domain 1 - Commissioned or provided services
 - Domain 2 - Workforce health and well-being
 - Domain 3 - Inclusive leadership

Diversity in Health and Care Partners Programme

BLMK have participated in the NHS Employers Diversity in Health and Care Partners Programme run by NHS Employers which supports health and care organisations to create more inclusive workplace cultures. This programme provides thought leadership to help put organisations at the forefront of EDI practices. It encourages collaborative working, sharing innovation and best practice and making change happen. This equality, diversity and inclusion work is shaped by three principles: leadership, accountability and equity.

ICB Website development

The ICB invited the Equality and Human Rights Commission to review the EDI work of the ICB. Listening to their feedback, colleagues have worked hard to ensure that EDI information on our website is laid out clearly and is easily retrievable to the public.

Disabled employees

In 2024/25 the ICB gained Disability Confident Level 2 Employer status. 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 ICB.
- we provide training, career development and promotion of disabled people that we employ.

Of our staff, 9.16% have declared a disability which is an increase on the figure reported for 2023/24 (8.10%). It is not mandatory for staff to declare disabilities.

All staff complete online DSE Training and assessments on an annual basis and new joiners complete these as part of their induction. Staff are supported to purchase any DSE equipment needed, and support is in place for staff with disabilities who may require specialist equipment.

Staff policies

As a statutory body, we ensure that we have robust employment policies that are compliant with current employment legislation, best practice and reflect our culture and values.

During the year where changes to legislation have been made, we have reviewed and updated our policies working alongside our trade union representatives, who have an active part in this process.

All new policies have been developed in conjunction with relevant groups and Trade unions and signed-off by the appropriate bodies before implementation.

All our current workforce policies are available to staff through our intranet. During the year our HR team has worked with managers to ensure understanding of our policies. We have developed a training programme, which includes a focus on key policies. This is available to all our organisational managers taking into consideration those who are new to management and those who are more experienced but would like to refresh their knowledge.

Trade Union Facility Time Reporting Requirements

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

There have been 4 different employees acting as representatives throughout the period.

Table 1: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
4	4.00

Table 2: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	4
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time

Total cost of facility time	£71,882
Total pay bill	£31,308,516
Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time ÷ total pay bill) x 100%	0.23%

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%	2%
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Other employee matters

All other matters relating to staff can be found at the workforce section on pages 75 to 81.

Expenditure on consultancy

Expenditure on consultancy was £389,815.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2025, for more than £245* per day:

Number of existing engagements as of 31 March 2025	11
<i>Of which, the number that have existed:</i>	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	5
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 to 31 March 2025, for more than £245⁽¹⁾ per day:

No. of temporary off-payroll workers engaged between 1 April 2024 to 31 March 2025	6
<i>Of which:</i>	
No. not subject to off-payroll legislation⁽²⁾	0
No. subject to off-payroll legislation and determined as in-scope of IR35⁽²⁾	1
No. subject to off-payroll legislation and determined as out of scope of IR35⁽²⁾	5
the number of engagements reassessed for compliance or assurance purposes during the year	5
Of which: no. of engagements that saw a change to IR35 status following review	0

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2024 to 31 March 2025:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	19

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	2	42,000	0	0	2	42,000	0	0
£25,001 - £50,000	1	26,696	0	0	1	26,696	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	1	108,944	0	0	1	108,944	0	0
£150,001 – £200,000	2	329,933	0	0	2	329,933	0	0
>£200,001	0	0	0	0	0	0	0	0
TOTALS	6	507,573	0	0	6	507,573	0	0

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

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Table 2: Analysis of Other Departures

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

**Any non-contractual payments in lieu of notice are disclosed under "Non-contractual payments requiring HMT approval".*

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

Parliamentary Accountability and Audit Report

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

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

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (the 'ICB') for the year ended 31 March 2025, 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 material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 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 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

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

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

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

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in November 2024 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 requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

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

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

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accountable Officer

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit and risk assurance committee, concerning the ICB's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit and risk assurance committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
 - Journals with a specific focus on those which altered the financial performance of the ICB for the year
 - significant accounting estimates related to the prescribing accrual
- Our audit procedures involved:
 - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - journal entry testing, with a focus
 - journals posted by senior finance officers
 - journals that are self-approved
 - large value journals
 - journals posted in March and post period-end that might relate to advance payments
 - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals;
 - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from

error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the accrual. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
 - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
 - knowledge of the health sector and economy in which the ICB operates
 - understanding of the legal and regulatory requirements specific to the ICB including:
 - the provisions of the applicable legislation
 - NHS England's rules and related guidance
 - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
 - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
 - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

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

Responsibilities of the Accountable Officer

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

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

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

We 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 November 2024. This guidance sets out the arrangements that fall within the scope of

'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

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

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

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

We cannot formally conclude the audit and issue an audit certificate for NHS Bedfordshire, Luton And Milton Keynes Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

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

Helen Lillington

Helen Lillington, Key Audit Partner

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

Birmingham
20 June 2025

Annual Accounts

Felicity Cox

Accountable Officer

19 June 2025

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	2	(30,486)	(24,078)
Other operating income	2	(1,127)	(330)
Total operating income		(31,613)	(24,408)
Staff costs	4	31,308	29,765
Purchase of goods and services	5	2,482,289	2,107,917
Depreciation and impairment charges	5	181	272
Provision expense	5	753	860
Other operating expenditure	5	227	218
Total operating expenditure		2,514,758	2,139,032
Net Operating Expenditure		2,483,145	2,114,623
Finance expense	1	4	6
Other Gains & Losses	9	-	6
Net expenditure for the Year		2,483,149	2,114,636
Comprehensive Expenditure for the year		2,483,149	2,114,636

Statement of Financial Position as at 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Right-of-use assets	10	357	538
Trade and other receivables	17	-	-
Total non-current assets		357	538
Current assets:			
Inventories	11	40	83
Trade and other receivables	17	15,010	11,734
Cash and cash equivalents	13	41	(698)
Total current assets		15,091	11,118
Total current assets		15,091	11,118
Total assets		15,448	11,657
Current liabilities			
Trade and other payables	14	(113,351)	(107,515)
Lease liabilities	13.2	(161)	(6)
Borrowings	26	-	(213)
Provisions	16	(2,240)	(2,293)
Total current liabilities		(115,752)	(110,028)
Non-Current Assets plus/less Net Current Assets/Liabilities		(100,303)	(98,371)
Non-current liabilities			
Lease liabilities	13.2	(197)	(534)
Total non-current liabilities		(197)	(534)
Assets less Liabilities		(100,501)	(98,906)
Financed by Taxpayers' Equity			
General fund		(100,501)	(98,906)
Total taxpayers' equity:		(100,501)	(98,906)

The notes on pages 150 to 170 form part of this statement

The financial statements on pages 146 to 170 were approved by the Governing Body on 18 June 2025 and signed on its behalf by:

Felicity Cox

Chief Accountable Officer

Date: 18 June 2025

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(98,906)	(98,906)
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(2,483,149)	(2,483,149)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	(2,483,149)	(2,483,149)
Net funding	2,481,554	2,481,554
Balance at 31 March 2025	(100,501)	(100,501)

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 01 April 2023	(109,755)	(109,755)
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating costs for the financial year	(2,114,636)	(2,114,636)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	(2,114,636)	(2,114,636)
Net funding	2,125,486	2,125,486
Balance at 31 March 2024	(98,906)	(98,906)

The notes on pages 150 to 170 form part of this statement

Statement of Cash Flows for the year ended 31 March 2025

	2024-25	2023-24
Note	£'000	£'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	(2,483,149)	(2,114,630)
Depreciation and amortisation	5. 181	272
Interest paid / received	4	-
Other Gains & Losses	-	6
(Increase)/decrease in inventories	43	24
(Increase)/decrease in trade & other receivables	17 (3,277)	4,481
Increase/(decrease) in trade & other payables	14 5,836	(5,664)
Provisions utilised	16 (806)	(977)
Increase/(decrease) in provisions	16 753	860
Net Cash Inflow (Outflow) from Operating Activities	(2,480,415)	(2,115,629)
Net Cash Inflow (Outflow) before Financing	(2,480,415)	(2,115,629)
Cash Flows from Financing Activities		
Grant in Aid Funding Received	2,481,554	2,125,486
Repayment of lease liabilities	(186)	(266)
Net Cash Inflow (Outflow) from Financing Activities	2,481,368	2,125,219
Net Increase (Decrease) in Cash & Cash Equivalents	13 952	9,591
Cash & Cash Equivalents at the Beginning of the Financial Year	(912)	(10,502)
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	41	(912)

The notes on pages 150 to 170 form part of this statement

1 Notes to the financial statements

1.1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Going Concern

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

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged. - Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.3 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.

1.4 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.

1.5 Pooled Budgets

The ICB has entered into pooled budget arrangements with Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council and Milton Keynes Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Community Equipment Services, the Learning Disability Service and Children Service Pools, the Better Care Fund and Discharge Funds with Note 21 to the accounts providing the detail of the income and expenditure.

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

1.6 Operating Segments

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

1.7 Revenue

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

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

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

1.8 Employee Benefits

1.9.1 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 Notes to the financial statements

1.9.2 Retirement Benefit Costs

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

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

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

1.10 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.11 Grants Payable

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

1.12 Property, Plant & Equipment

1.12.1 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 ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost. Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.12.2 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 and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use. IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.12.3 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.

1.13 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use

1 Notes to the financial statements

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.14 Inventories

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

1.15 Cash & Cash Equivalents

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

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

1.16 Provisions

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

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

- A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.07% (2023-24: 4.03%) 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 4.81% (2023-24: 4.72%) 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 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.17 Clinical Negligence Costs

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

1.18 Non-clinical Risk Pooling

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

1.19 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 nonoccurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1.20 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.20.1 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.

1.21 Financial Liabilities

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

1 Notes to the financial statements

1.22 Value Added Tax

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

1.23 Third Party Assets

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

1.24 Losses & Special Payments

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

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

1.25 Critical accounting judgements and key sources of estimation uncertainty

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

The ICB had no critical accounting judgements in 2024-25.

1.26 Sources of estimation uncertainty

These are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Where key estimations have been made by management in the process of applying the ICB's accounting policies, that have the most significant effect on the amounts recognised in the financial statements, details are provided in the relevant notes to the accounts.

The ICB had no material key sources of estimation uncertainty in 2024-25.

1.27 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.

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

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

2 Other Operating Revenue

	2024-25	2023-24
	Total	Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	4,499	-
Non-patient care services to other bodies	3,494	2,076
Prescription fees and charges	10,311	9,837
Dental fees and charges	11,200	11,195
Other Contract income	205	19
Recoveries in respect of employee benefits	777	951
Total Income from sale of goods and services	30,486	24,078
Other operating income		
Other non contract revenue	1,127	330
Total Other operating income	1,127	330
Total Operating Income	31,613	24,408

Education, training and research income shown above under 2024-25 represents both the in year receipt and income deferred from the previous year for workforce development across the Bedfordshire, Luton and Milton Keynes Integrated Care System, hence no comparator income for 2023-24.

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

	Education, training and research £'000	Non- patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue						
NHS	653	2,633	-	-	-	488
Non NHS	3,846	861	10,311	11,200	205	289
Total	4,499	3,494	10,311	11,200	205	777

	Education, training and research £'000	Non- patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue						
Point in time	-	-	10,311	11,200	-	-
Over time	4,499	3,494	-	-	205	777
Total	4,499	3,494	10,311	11,200	205	777

3.2 Transaction price to remaining contract performance obligations

NHS Bedfordshire, Luton and Milton Keynes ICB had no contract revenue expected to be recognised in future periods relating to contract performance

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2024-25
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	21,856	2,216	24,072
Social security costs	2,513	-	2,513
Employer Contributions to NHS Pension scheme	4,628	-	4,628
Other pension costs	1	-	1
Apprenticeship Levy	95	-	95
Gross employee benefits expenditure	29,092	2,216	31,308
Less recoveries in respect of employee benefits (note 4.1.2)	(777)	-	(777)
Total - Net admin employee benefits including capitalised costs	28,315	2,216	30,531
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	28,315	2,216	30,531

4.1.1 Employee benefits

	Total		2023-24
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	21,169	2,044	23,213
Social security costs	2,263	-	2,263
Employer Contributions to NHS Pension scheme	3,945	-	3,945
Other pension costs	17	-	17
Apprenticeship Levy	88	-	88
Termination benefits	240	-	240
Gross employee benefits expenditure	27,721	2,044	29,765
Less recoveries in respect of employee benefits (note 4.1.2)	(951)	-	(951)
Total - Net admin employee benefits including capitalised costs	26,770	2,044	28,813
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	26,770	2,044	28,813

4.1.2 Recoveries in respect of employee benefits

	2024-25			2023-24
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(741)	-	(741)	(913)
Social security costs	(17)	-	(17)	(17)
Employer contributions to the NHS Pension Scheme	(19)	-	(19)	(21)
Total recoveries in respect of employee benefits	(777)	-	(777)	(951)

4.2 Average number of people employed

	2023-24			2023-24		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	347.37	28.35	375.72	362.88	23.92	386.80

Of the above:

Number of whole time equivalent people engaged on capital projects

No people were engaged on capital projects in the period from 01 April 2024 to 31 March 2025 (nil in the period 01 April 2023 to 31 March 2024)

4.4 Exit packages agreed in the financial year

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	2	42,000	-	-	2	42,000
£25,001 to £50,000	1	26,696	-	-	1	26,696
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	108,944	-	-	1	108,944
£150,001 to £200,000	2	329,933	-	-	2	329,933
Over £200,001	-	-	-	-	-	-
Total	6	507,573	-	-	6	507,573

	2023-24 Compulsory redundancies		2023-24 Other agreed departures		2023-24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	1	24,026	4	67,184	5	91,210
£25,001 to £50,000	2	90,454	3	101,121	5	191,575
£50,001 to £100,000	-	-	1	67,862	1	67,862
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	3	114,480	8	236,167	11	350,647

Analysis of Other Agreed Departures

	2024-25 Other agreed departures		2023-24 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	8	236,167
Total	-	-	8	236,167

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.

Where the ICB has agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

Ill-health retirement costs are met by the NHS Pension Scheme and are not included in these tables. In 2024-25 there has been one such payment and the information was not available at the time of producing these accounts.

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

4.5 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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.

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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.

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5. Operating expenses

	2024-25	2023-24
	Total	Total
	£'000	£'000
Services from other ICBs and NHS England	331	357
Services from foundation trusts	1,478,351	1,219,839
Services from other NHS trusts	181,968	130,831
Purchase of healthcare from non-NHS bodies	317,526	277,888
General Dental services and personal dental services	60,916	55,081
Prescribing costs	165,601	164,261
Pharmaceutical services	30,267	27,967
General Ophthalmic services	10,253	9,640
GPMS/APMS and PCTMS	201,152	185,393
Supplies and services – clinical	341	737
Supplies and services – general	12,551	12,698
Consultancy services	390	188
Establishment	5,433	7,586
Transport	10,779	9,574
Premises	3,803	4,155
Audit fees	228	216
Other services	51	48
Other professional fees	1,423	1,095
Legal fees	473	273
Education, training and conferences	450	88
Total Purchase of goods and services	2,482,289	2,107,917
Depreciation and impairment charges		
Depreciation	181	272
Total Depreciation and impairment charges	181	272
Provision expense		
Provisions	753	860
Total Provision expense	753	860
Other Operating Expenditure		
Chair and Non Executive Members	135	138
Research and development (excluding staff costs)	-	40
Expected credit loss on receivables	10	14
Inventories consumed	43	24
Other expenditure	39	4
Total Other Operating Expenditure	227	218
Total operating expenditure	2,483,450	2,109,267

The supplies and services - general includes grants provided to: Healthwatch Milton Keynes £48k and Community Action MK £35k. This is in addition to the pooled budget arrangements in place with the local authorities.

Other Audit fees represent the fees for validating the delivery of the Mental Health Investment Standard. **5.1**

Auditors Liability Statement

In accordance with SI2008 no.489, the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, if the ICB contract with its auditors provides for a limitation of the auditor's liability, it is required to disclose the principle terms of this limitation.

In the contract the ICB holds with its external auditors, the total aggregate liability (whether those liabilities are expressed as an indemnity or otherwise) for each year of this contract shall be:

Liability for all defaults resulting in direct loss or damage to property shall be subject to a limit of £2 million (two million pounds) unless otherwise stipulated by the ICB in the letter of appointment.

In respect of all other defaults, claims, losses or damages whether arising from breach of contract, misrepresentation (whether tortious or statutory), tort (including negligence), breach of statutory duty or otherwise shall in no event exceed the greater of the sum of £2 million (two million pounds) or a sum equivalent to 125% (one hundred and twenty-five per cent) of the contract charges paid or payable to the ICB in the relevant year of the contract calculated at the date of the event giving rise to the liability (estimated for the full year if the event occurs in the first year of the contract) unless a different aggregate limit or limits is otherwise stipulated by the ICB in the letter of appointment following a further competition.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	25,247	448,919	26,350	426,881
Total Non-NHS Trade Invoices paid within target	24,137	423,314	25,047	420,071
Percentage of Non-NHS Trade invoices paid within target	95.06%	94.30%	95.06%	98.40%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,685	1,686,386	2,029	1,388,055
Total NHS Trade Invoices Paid within target	2,630	1,685,374	1,915	1,387,299
Percentage of NHS Trade Invoices paid within target	97.95%	99.94%	94.38%	99.95%

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The ICB incurred £nil in the period from 1 April 2024 to 31 March 2025 relating to claims made under this legislation.

7. Other gains and losses

	2024-25 £'000	2023-24 £'000
(Gain)/loss on disposal of property, plant and equipment assets other than by sale	-	6
Total other gains and losses	-	6

8 Finance costs

	2024-25 £'000	2023-24 £'000
Interest		
Interest on lease liabilities	4	6
Total interest	4	6
Total finance costs	-	-

9 Property, plant and equipment

	2024-25 Plant & machinery £'000	2024-25 Information technology £'000	2024-25 Total £'000
Cost or valuation at 01 April 2024	33	75	108
Cost/Valuation at 31 March 2024	33	75	108
Depreciation 01 April 2024	33	75	108
Depreciation at 31 March 2025	33	75	108
Net Book Value at 31 March 2025	-	-	-
Total at 31 March 2024	-	-	-

Revaluation Reserve Balance for Property, Plant & Equipment

No revaluation reserve balance was held for property, plant and equipment in the period 01 April 2024 to 31 March 2025.

9.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2024-25 £'000	2023-24 £'000
Plant & machinery	33	33
Information technology	75	106
Total	108	139

9.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	5	5
Information technology	3	5

10 Leases

10.1 Right-of-use assets

2024-25	Buildings excluding dwellings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 01 April 2024	1,020	1,020	159
Disposals on expiry of lease term	(159)	(159)	(159)
Cost/Valuation at 31 March 2025	861	861	-
Depreciation 01 April 2024	482	482	159
Charged during the year	181	181	-
Disposals on expiry of lease term	(159)	(159)	(159)
Depreciation at 31 March 2025	504	504	-
Net Book Value at 31 March 2025	357	357	-
	2024-25 £'000	2023-24 £000	
NBV by counterparty			
Leased from DHSC	-	-	
Leased externally	357	538	
Net Book Value at 31 March 2025	357	538	

10.2 Lease liabilities

	2024-25 £'000	2023-24 £'000
Lease liabilities at 01 April 2024	(540)	(801)
Interest expense relating to lease liabilities	(4)	(6)
Repayment of lease liabilities (including interest)	186	266
Lease liabilities at 31 March 2025	(358)	(540)

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25 £'000	Of which: leased from DHSC group bodies £000	2023-24 £000	Of which: leased from DHSC group bodies £000
Within one year	(161)	-	(186)	-
Between one and five years	(201)	-	(361)	-
After five years	-	-	-	-
Balance at 31 March 2025	(362)	-	(548)	-
	2024-25 £000	2023-24 £000		
Balance by counterparty				
Leased from DHSC	-	-		
Leased externally	(362)	(548)		
Balance as at 31 March 2025	(362)	(548)		

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2024-25 £'000	2023-24 £'000
Depreciation expense on right-of-use assets	181	261
Interest expense on lease liabilities	4	6
Expense relating to short-term leases	-	(21)

10.5 Amounts recognised in Statement of Cash Flows

	2024-25 £'000	2023-24 £'000
Total cash outflow on leases under IFRS 16	186	266

10.6 Nature of lessee's leasing activities

	2024-25 £'000	2023-24 £'000
Prevalence of extension and termination options	231	231

11 Inventories

	Loan Equipment £'000	Total £'000
Balance at 01 April 2024	83	83
Inventories recognised as an expense in the period	(43)	(43)
Balance at 31 March 2025	40	40

12 Trade and other receivables

	Current 2024-25 £'000	Current 2023-24 £'000
NHS receivables: Revenue	4,902	5,057
NHS prepayments	129	30
NHS accrued income	217	518
Non-NHS and Other WGA receivables: Revenue	4,056	2,125
Non-NHS and Other WGA prepayments	500	266
Non-NHS and Other WGA accrued income	4,112	3,280
Expected credit loss allowance-receivables	(5)	(15)
VAT	1,087	466
Other receivables and accruals	12	7
Total Trade & other receivables	15,010	11,734
Total current and non current	15,010	11,734

12.1 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000
By up to three months	312	2650	219	1701
By three to six months	8	5	308	84
By more than six months	1	112	38	46
Total	321	2,767	565	1,831

12.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2024	(15)	-	(15)
Lifetime expected credit losses on trade and other receivables-Stage 2	(10)	-	(10)
Amounts written off	21	-	21
Other changes	(1)	-	(1)
Total	(5)	-	(5)

13 Cash and cash equivalents

	2024-25 £'000	2023-24 £'000
Balance at 01 April 2024	(912)	(10,502)
Net change in year	952	9,591
Balance at 31 March 2025	41	(912)
Made up of:		
Cash with the Government Banking Service	722	0
Cash in hand	(682)	(698)
Cash and cash equivalents as in statement of financial position	41	(698)
Bank overdraft: Government Banking Service	-	(213)
Total bank overdrafts	-	(213)
Balance at 31 March 2025	41	(912)
Patients' money held by the integrated care board, not included above	-	-

Included within cash held in Pooled Budget is an overdrawn balance of £682k held on behalf of the ICB by Milton Keynes Council for the Integrated Community Equipment Service and Learning Disability Service pooled budgets.

14 Trade and other payables

	Current 2024-25 £'000	Current 2023-24 £'000
NHS payables: Revenue	1,318	2,228
NHS accruals	15,927	9,305
NHS deferred income	-	157
Non-NHS and Other WGA payables: Revenue	9,669	8,995
Non-NHS and Other WGA accruals	80,117	74,830
Non-NHS and Other WGA deferred income	3,045	7,391
Social security costs	296	295
Tax	344	313
Other payables and accruals	2,634	4,001
Total Trade & Other Payables	113,351	107,515
Total current and non-current	113,351	107,515

Other payables include £406k outstanding pension contributions at 31 March 2024.

15 Borrowings

	Current 2024-25 £'000	Current 2023-24 £'000
Bank overdrafts:		
• Government banking service	-	213
• Commercial banks	-	-
Total overdrafts	-	213
Total Borrowings	-	213
Total current and non-current	-	213

16 Provisions

	Current 2024-25 £'000	Current 2023-24 £'000
Restructuring	24	450
Redundancy	232	535
Legal claims	329	3
Continuing care	1,115	689
Other	540	616
Total	2,240	2,293
Total current and non-current	2,240	2,293

	Restructuring £'000	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2024	450	535	3	689	616	2,293
Arising during the year	-	232	326	867	70	1,495
Utilised during the year	(183)	(508)	-	(116)	-	(806)
Reversed unused	(243)	(28)	-	(324)	(146)	(741)
Balance at 31 March 2025	24	232	329	1,115	540	2,240
Expected timing of cash flows:						
Within one year	24	232	329	1,115	540	2,240
Balance at 31 March 2025	24	232	329	1,115	540	2,240

Over recent years, the role and function of corporate office spaces has changed significantly with a more flexible approach to working from home. The Integrated Care Board's future corporate estates requirements has therefore been re-assessed and it was agreed that the office bases across Bedfordshire, Luton and Milton Keynes be rationalised. Several bases have therefore been downscaled however the Integrated Care Board will continue to be liable for the lease costs of the excess office space until the lease-end/break clause dates. The lease for the Milton Keynes site was terminated in April 2024 and a break clause has now been exercised on the lease for the Luton site terminating the contract in June 2025. The restructuring provision of £24k relates to the liability for the ongoing costs of this excess space.

As part of the Integrated Care Board's ongoing transition a review of workforce requirements has been undertaken during the year. This process has placed some staff within the Integrated Care Board at risk. A £232k redundancy provision reflects an estimate of the financial risk associated with this.

The legal claims provision consists of two elements. The first relates to the number of claims currently lodged with NHS Resolution and the probabilities provided by them. The ICB's exposure on these claims totals £6k. In addition, an unsuccessful bidder commenced legal proceedings in December 2024 challenging the contract award decision regarding a joint procurement with twenty three other ICBs for a Primary Care Clinical Waste Collection and Disposal contract. The probability of success by the Claimant has been assessed by the ICB and a provision of £323k has been established to cover legal fees and estimated damages. The remaining liability not covered by the provision has been classified as a contingent liability in Note 18.

The provision for Continuing Health Care relates to cases from 1 April 2013 to 31 March 2025 that are undergoing an appeal process. The Integrated Care Board has assessed the likelihood of a successful appeal based on the outcome of previous appeals and the remaining balance has been reported as a contingent liability in Note 18.

Other provisions reflects a legacy £470k employer superannuation liability relating to previous clinical commissioning groups and the impact of dilapidations for non rights of use assets of £70k following an assessment in year.

17 Contingencies

	2024-25 £'000	2023-24 £'000
Contingent liabilities		
Continuing Healthcare	2,323	1,656
Legal Claim - challenge against joint procurement contract decision	323	-
Net value of contingent liabilities	2,646	1,656

The contingent liability for Continuing Health Care relates to cases from April 2013 to March 2025 that are undergoing an appeal process. A provision has been established for the likely cost of successful appeals (see Note 16) with the contingency above reflecting the remainder of the liability should the outcome of the appeals go against the ICB.

The contingent liability for the Legal Claim relates to a challenge from an unsuccessful bidder against the contract award decision regarding a joint procurement with twenty three other ICBs for a Primary Care Clinical Waste Collection and Disposal contract. A provision has been established for the partial cost of a successful claim against the ICB (see Note 16) with the contingency above reflecting the remainder of the liability should the outcome of the claim go against the ICB.

NHS Bedfordshire, Luton and Milton Keynes ICB identified £nil in the period from 1 April 2024 to 31 March 2025 relating to contingent assets.

18 Commitments

NHS Bedfordshire, Luton and Milton Keynes ICB had £nil capital commitments or other financial commitments.

19 Financial instruments**19.1 Financial risk management**

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS integrated care board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS integrated care board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS integrated care board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS integrated care board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS integrated care board and internal auditors.

19.1.1 Currency risk

The NHS integrated care board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS integrated care board has no overseas operations and therefore has low exposure to currency rate fluctuations.

19.1.2 Interest rate risk

The NHS integrated care board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS integrated care board therefore has low exposure to interest rate fluctuations.

19.1.3 Credit risk

Because the majority of the NHS integrated care board revenue comes parliamentary funding, NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

19.1.4 Liquidity risk

NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

19.1.5 Financial Instruments

As the cash requirements of NHS integrated care board 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 integrated care board's expected purchase and usage requirements and NHS integrated care board is therefore exposed to little credit, liquidity or market risk.

19 Financial instruments cont'd

19.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £'000	Total 2024-25 £'000	Financial Assets measured at amortised cost 2023-24 £'000	Total 2023-24 £'000
Trade and other receivables with NHSE bodies	1,745	1,745	3,246	3,246
Trade and other receivables with other DHSC group bodies	3,375	3,375	5,487	5,487
Trade and other receivables with external bodies	8,180	8,180	2,253	2,253
Cash and cash equivalents	41	41	(698)	(698)
Total at 31 March 2025	13,341	13,341	10,289	10,289

19.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £'000	Total 2024-25 £'000	Financial Liabilities measured at 2023-24 £'000	Total 2023-24 £'000
Loans with external bodies	-	-	213	213
Trade and other payables with NHSE bodies	232	232	1,129	1,129
Trade and other payables with other DHSC group bodies	18,599	18,599	12,597	12,597
Trade and other payables with external bodies	90,836	90,836	86,174	86,174
Private Finance Initiative and finance lease obligations	358	358	-	-
Total at 31 March 2025	110,024	110,024	100,114	100,114

20 Operating segments

The ICB operates as one operating segment and that is to commission healthcare.

22 Related party transactions

Individual ICB Board members, having significant influence over the management of the ICB, are considered to be related parties. Details of transactions between the ICB and ICB Board members are detailed in the Remuneration Report within the Annual Report.

Entities controlled by the ICB Board members, or a close family member, are also considered to be a related party as defined by IAS 24. There were no entities that fell within this definition in 2024/25.

Under IAS 24 entities in the same group as the Department of Health are considered to be related parties.

NHS Bedfordshire, Luton and Milton Keynes ICB had a number of material transactions with other NHS and other government bodies. Materiality in this context is considered to be over £10m and transactions have been prepared on an accruals basis.

Bedford Unitary Authority
 Bedfordshire Hospitals NHS Foundation Trust
 Buckinghamshire Healthcare NHS Trust
 Cambridge University Hospitals NHS Foundation Trust
 Cambridgeshire Community Services NHS Trust
 Central & North West London NHS Foundation Trust
 Central Bedfordshire Unitary Authority
 East & North Hertfordshire NHS Trust
 East London NHS Foundation Trust
 East of England Ambulance Service NHS Trust
 Great Ormond Street Hospital for Children NHS Foundation Trust
 Guy's & St Thomas' NHS Foundation Trust
 Luton Borough Council
 Milton Keynes Council
 Milton Keynes University Hospital NHS Foundation Trust
 Oxford University Hospitals NHS Foundation Trust
 Royal Papworth Hospital NHS Foundation Trust
 South Central Ambulance Service NHS Foundation Trust
 University College London Hospitals NHS Foundation Trust

23 Events after the end of the reporting period

From the 1 April 2025, BLMK ICB have been delegated responsibility for commissioning, contracting and paying for 11 additional specialised services that were deemed to be suitable and ready for greater ICB leadership, bringing the total to 70 - the remaining, predominantly highly specialised, services will continue to be commissioned by NHS England in 2025/26.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

There are no adjusting events after the reporting period which will have a material effect on the financial statements of NHS Bedfordshire, Luton and Milton Keynes ICB.

24 Third party assets

The ICB had £nil third party assets in the period from 1 April 2024 to 31 March 2025.

25 Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).

NHS Integrated Care Board performance against those duties was as follows:

	2024-25 Target	2024-25 Performance	2023-24 Target	2023-24 Performance
Expenditure not to exceed income	2,514,928	2,514,763	2,139,189	2,139,044
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	2,483,315	2,483,149	2,114,781	2,114,636
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	18,484	18,357	20,721	19,053

26 Losses and special payments

26.1 Losses

The total number of NHS integrated care board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Administrative write-offs	8	21	-	-
Fruitless payments	1	32	-	-
Book Keeping Losses	9	3	-	-
Total	18	56	-	-

27 Employee benefits and staff numbers

27.1 Employee benefits

	Admin			Programme			Total			2024-25
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	
Employee Benefits										
Salaries and wages	10,474	467	10,941	11,382	1,750	13,131	21,856	2,216	24,072	
Social security costs	1,236	-	1,236	1,277	-	1,277	2,513	-	2,513	
Employer contributions to the NHS Pension Scheme	3,183	-	3,183	1,445	0	1,445	4,628	0	4,628	
Other pension costs	-	-	-	1	-	1	1	-	1	
Apprenticeship Levy	95	-	95	-	-	-	95	-	95	
Gross employee benefits expenditure	14,988	467	15,455	14,104	1,750	15,854	29,092	2,216	31,308	
Less recoveries in respect of employee benefits (note 4.1.2)	(168)	-	(168)	(609)	-	(609)	(777)	-	(777)	
Total - Net admin employee benefits including capitalised costs	14,820	467	15,287	13,495	1,750	15,245	28,315	2,216	30,531	
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-	
Net employee benefits excluding capitalised costs	14,820	467	15,287	13,495	1,750	15,245	28,315	2,216	30,531	

	Admin			Programme			Total			2023-24
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	
Salaries and wages	10,715	460	11,175	10,454	1,583	12,037	21,169	2,044	23,213	
Social security costs	1,093	-	1,093	1,170	-	1,170	2,263	-	2,263	
Employer contributions to the NHS Pension Scheme	2,576	-	2,576	1,368	-	1,368	3,945	-	3,945	
Other pension costs	3	-	3	14	-	14	17	-	17	
Apprenticeship Levy	88	-	88	-	-	-	88	-	88	
Termination benefits	238	-	238	2	-	2	240	-	240	
Gross employee benefits expenditure	14,713	460	15,173	13,008	1,583	14,591	27,721	2,044	29,765	
Less recoveries in respect of employee benefits (note 4.1.2)	(231)	-	(231)	(721)	-	(721)	(951)	-	(951)	
Total - Net admin employee benefits including capitalised costs	14,482	460	14,943	12,287	1,583	13,871	26,770	2,044	28,813	
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-	
Net employee benefits excluding capitalised costs	14,482	460	14,943	12,287	1,583	13,871	26,770	2,044	28,813	