



**Bedfordshire, Luton
and Milton Keynes**
Integrated Care Board

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Annual Report

1 April 2025 – 31 March 2026

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PERFORMANCE REPORT

Statement by Jan Thomas and Robin Porter

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

Welcome to our 2025/26 Annual Report.

The past year has brought significant challenges, alongside steady progress. Demand for services remained high, and we also worked through major organisational change, including plans to reduce running costs and reshape how we operate. Throughout this period, teams across the system stayed focused on supporting our population.

Over the year, the ICB made progress against key transformation priorities, particularly in complex care, end of life care, and admission avoidance and discharge pathways. Strong collaboration across the system helped more people receive care closer to home and avoid unnecessary hospital admissions, easing pressure on acute services.

The ICB continued to develop community-based support for people most at risk of unplanned admissions, particularly those who are older and frailer. Services such as virtual wards, falls response teams and the use of new technologies helped more people remain well and independent at home. As a result, emergency admissions for falls reduced by 22% over the last two years.

Partnership working also supported a stronger focus on prevention. Through work with the Institute for Healthcare Improvement, the ICB expanded activity to detect and treat high blood pressure earlier and introduced an early-warning dashboard for diabetes, helping to better identify and support people most at risk.

Improving access to primary care remained a key priority. GP practices delivered more than 6.2 million appointments during the year, a 9% increase on the previous year. This was supported by new ways of managing demand, including online triage, helping more people get the care they need. We also made over 6,000 additional urgent dental appointments available to support patients requiring immediate treatment.

Earlier cancer diagnosis continued to improve, with local performance exceeding the regional average. Services continue to work towards national targets despite rising referral numbers. However, challenges remain, including ongoing pressure on urgent and emergency care, diagnostics, and patient flow across the system.

Some mental health services performed strongly, exceeding national targets in areas such as dementia diagnosis and early intervention in psychosis. However, demand for mental health and wellbeing support, particularly for children and young people, continues to grow, and improving access remains a clear priority.

All of this has taken place during a period of significant change for colleagues across our organisations. We would like to thank staff for their professionalism, resilience and commitment throughout the year.

During 2025/26, work progressed to establish Central East Integrated Care Board, bringing together Bedfordshire, Luton and Milton Keynes with neighbouring systems as part of a new, larger ICB. This marks an important transition from the organisation reflected in this report.

From 1 April, we move forward as part of Central East, serving 3.5 million people. Guided by a clear purpose – to do what best serves our population – and supported by our strategy, *Our Way*, this creates an opportunity to take a more focused and joined-up approach to improving outcomes, experience, and sustainability for the communities we serve.

Jan Thomas
Chief Executive

Robin Porter
Chair

17 June 2026

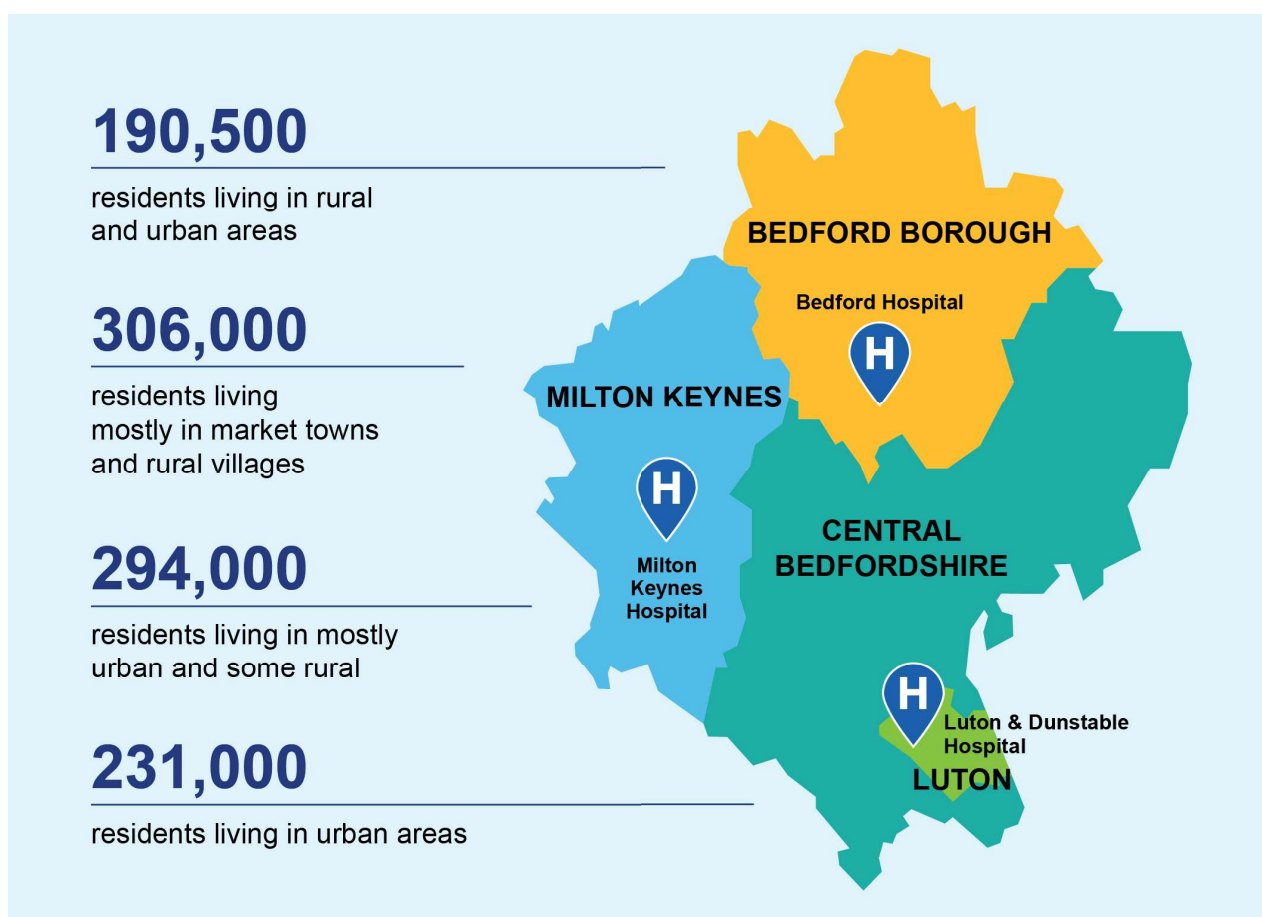
17 June 2026

Performance Overview

The performance overview section provides a look at how Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) operates, its structures and strategic priorities, and our progress during the period 1 April 2025 to 31 March 2026. It also describes the area in which we work, detailing our 4 places, and the work being done to make sure that services are delivered in a joined-up, integrated way, as close as possible to where residents live.

Our population

The BLMK area is covered by 4 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.



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

BLMK is a culturally diverse and vibrant population of just over 1 million residents living in urban and rural areas with varying health needs. Forecasts suggest the population of BLMK will grow by 25% between 2023 and 2043. This compares to 15% in the 10 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%).

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 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. The ICBs Place/Neighbourhood Directors 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 18.

Details of the ICBs organisational structures during this reporting period are available in our [Constitution and Governance Handbook](#).

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 5 strategic priorities (agreed in 2022/23 following discussions with our partners, local people and patient forums).



These priorities are informed by the strategic objectives of our partner organisations. They aim to improve health, wellbeing and equality in our communities, and to make the best use of resources and shape the way we work as a system in BLMK. They are supported by our 7 cross-cutting 'enablers' (shown in the diagram above).

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 together with our risk management arrangements in the Risk section on pages 86 to 89.

Our transformation priorities

At a Board Seminar in January 2025 (see page 79), 3 transformation priorities were agreed that would have a significant impact on resident outcomes and make services more efficient - Complex Care, End of Life Care and Admission Avoidance and Discharge Pathways. Work on these priorities has continued during 2025/26 – see pages 16 to 18.

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 5 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.

During 2025/26 a light review was undertaken of our [Joint Forward Plan](#).

Our strategies

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

- **Data Strategy:** The BLMK Integrated Care System (ICS) [Data Strategy](#) seeks to identify the priorities we must tackle to address our 4 ICS purposes of direct care, case identification, supporting self-care and system redesign. Information on our work in this area is available on pages 59 and 94.
- **Digital Strategy:** 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 pages 58 to 59.
- **People Strategy:** The BLMK Integrated Care System (ICS) [People Strategy](#) presents 6 People Strategy workstreams. Information on our work in this area is provided on pages 67 to 71.
- **Working with People and Communities Strategy:** 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 pages 57 to 58.
- **Learning Disabilities and Autism Strategy:** 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 page 37.
- **Health Service Strategy:** 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.
- **Health and Care Partnership Strategy:** The BLMK Integrated [Health and Care Strategy](#) sets out our overall ambition to tackle inequalities and improve health outcomes for our residents. Information on our work in this area is available on page 18.

Local Authority Health and Care Strategy/Health and Wellbeing Strategy

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 below.

- **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 5 building blocks of health.
- **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".
- **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 vision is focused on a central mission to tackle poverty and inequality so that everyone can enjoy a good quality of life.
- **Milton Keynes** - [Health and Wellbeing Strategy 2018-2028](#)
The Milton Keynes (MK) Health and Wellbeing Strategy priorities is based on 4 overarching areas for Lifelong Wellbeing - Starting Well, Living Well and Aging Well.
- **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](#).

Examples of the delivery of actions from Local Authority Health and Care Strategy/Health and Wellbeing Strategy are provided in the Working at Place section from pages 11 to 15.

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 continued to strengthen collaboration amongst the sector and with system partners over the course of 2025/26. ICB funding has been allocated to continue developing a VCSE Alliance in BLMK, enhance strategic engagement of the VCSE sector with ICB priorities, and influence the development of neighbourhood working.

Informing the Age Care Technology (ACT) in Bedford Borough has brought about significant learning regarding the impact of VCSE organisations in enhancing access to services in communities more likely to experience health inequalities. As a result, a version of the ACT assessment tool has been made available free of charge to VCSE organisations to continue developing the evidence base.

Further examples of collaboration include:

- Engagement with the community and mental health services transformation programme - see page 58.
- Securing VCSE representation in the Palliative and End of Life Care programme - see page 17.
- Mobilising the VCSE sector in supporting the development and delivery of the Green Plan – see pages 59 to 66.
- Understanding joint working opportunities with local anchor institutions in areas such as procurement and social value
- Exploring provider models that are led by or integrated with the VCSE sector that have been established in other areas of the country

In the latter half of the year, much of the focus has been on contributing to the development of a strategic partnership to prepare for the establishment of Central East ICB. This has involved working with the respective Alliances in Cambridgeshire and Hertfordshire to enable the creation of an overarching Central East partnership with the VCSE sector, through strengthening the foundation of existing assets. This structure ensures the VCSE sector can influence strategic developments across a larger geography while remaining embedded within BLMK plans for neighbourhood working.

As a result, the co-chairs of BLMK VCSE Strategy Group are included in the membership for the BLMK Neighbourhood Delivery Committee and the partnership with the VCSE sector is on a stronger footing to build on collaboration during 2025/26.

- **Healthwatch:** The ICB and the 4 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 was represented on the ICB Board and Health and Care Partnership during 2025/26.
- **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 5 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

The Chair for the Health and Wellbeing Boards of Bedford Borough, Central Bedfordshire, Luton and Milton Keynes were consulted on relevant sections of this Annual Report.

- **Working at place:** We are proud of our work together with local partners in our 4 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 page 9.

Bedford Borough

The Bedford Borough Place Team continued to strengthen its work in 2025/26, deepening local relationships and connections, delivering projects to test and learn approaches to reducing health inequalities, working closely to improve the primary care estate, and developing a stronger, more collaborative commissioning approach between health and social care.

Key achievements include:

- Working with the ICB and housing estates teams to secure £6.9 million in capital funding for a new primary care facility in Wixams, and £750,000 towards a new GP surgery in Great Barford. Business cases to develop new GP surgeries in Great Barford, Wootton and Wixams were approved by Bedford Borough Council.
- Embedding an improved joint governance structure between the ICB and the Council for the Better Care Fund (BCF), strengthening shared processes and conducting an extensive review of locally funded schemes in preparation for the expected 2026/27 BCF reform.
- Finalising the 2025-2030 Place-Based Plan with a focus on starting well, living well, ageing well, mental health, learning disabilities and neurodiversity, and estates, which was signed off by the Health and Wellbeing Board in early 2026.
- Enhancing the maternity social prescriber offer through a new steering group, building a partnership with Family Hubs to develop a new evaluation method. In early 2026 Family Hubs committed three-years of funding (2026–2029), replacing the previous reliance on annual one-off funding.
- Delivering an extensive co-produced project with residents, community leaders and primary care clinicians through the Learning and Action Network, demonstrating improved hypertension management for Black African and Black Caribbean residents in Bedford Borough through community engagement, targeted publicity at local events and on the radio, strengthened NHS processes, and collaboration with local pharmacies, all contributing to a potential new hypertension management strategy.
- Gained insights into the health of older residents through working with three GP surgeries to embed a new social prescribing tool in partnership with Age Care Technology.
- Continued strong collaboration with the VCSE sector through regular Integrated Neighbourhood Working Steering Group meetings, involving around 90 members from approximately 50 organisations, with 25–30 attendees at each meeting.

- Established a new Joint Neighbourhood Health and Care Taskforce for clinical leads from primary and secondary care, supported by data colleagues, to work collaboratively on frailty using risk-stratification tools.

Central Bedfordshire

During 2025/26, the Central Bedfordshire Place Team has continued to progress the development of Integrated Neighbourhood Working (INW), strengthening the foundations laid in previous years and aligning activity with the emerging national neighbourhood health model set out in NHS England's Neighbourhood Health Guidelines 2025/26. We have:

- Worked collaboratively with system partners to refine and implement an approach to Neighbourhood Working for Central Bedfordshire, ensuring it reflects an evidence-based, place-led methodology and supports the shift towards more integrated, proactive and preventative neighbourhood care.
- Reviewed and evaluated key models of care, agreeing outcome measures that will demonstrate the impact of neighbourhood-level initiatives for local residents and inform continuous improvement across services.
- Co-ordinated structured engagement with partners, including a programme of meetings and planned drop-in sessions to maintain momentum, strengthen multidisciplinary collaboration, and ensure alignment with the national expectations for 2025/26, including scaling innovation and strengthening evaluation.
- Worked jointly with the council and Health and Wellbeing Board to develop, agree, and deliver Better Care Fund (BCF) plans that support national objectives, shifting from sickness to prevention and enabling people to live independently at home. This includes collaboratively planning integrated health and social care services, aligning BCF priorities with neighbourhood health developments, setting and meeting local goals for reducing non-elective admissions and delayed discharges, improving reablement outcomes, and ensuring compliance with funding conditions such as maintaining the NHS minimum contribution to adult social care.
- Participated in national and regional oversight processes and ensured robust governance, performance monitoring, and integration with wider strategic commissioning and local system priorities.
- Co-produced a Learning Action Network (LAN) with residents and partners, in collaboration with the Institute for Healthcare Improvement (IHI), to improve hypertension outcomes and reduce inequalities in the Gypsy, Roma and Traveler community.

Luton

During 2025/26, the Luton Place team continued to strengthen partnership working across the borough, delivering targeted initiatives to reduce health inequalities, improve prevention and early identification, and support the development of integrated neighbourhood working. Progress this year included embedding a neighbourhood-based approach, strengthening the use of population health intelligence, and expanding community engagement to improve access to preventative health services.

Strengthening Neighbourhood Working - Partners progressed the development of a systematic neighbourhood working programme, informed by Luton's population health intelligence. This work defined 4 neighbourhoods across the borough and established a working group to provide strategic oversight and co-ordination of neighbourhood delivery.

A cross-system workshop in July 2025 brought together partners from health, local government and the voluntary sector to develop recommendations on neighbourhood governance, shared intelligence, community engagement, service redesign, digital enablement and sustainable funding. Work was briefly paused to align with the [National Neighbourhood Implementation Plan](#), after which neighbourhood structures were confirmed and implementation activity resumed.

Community-Based Health Improvement - A programme of neighbourhood events improved access to preventative health checks and strengthened engagement with local communities.

The "Know Your Numbers" family fun days delivered 239 blood pressure and general health checks, identifying residents requiring follow-up care. The events also engaged approximately 300 children in wellbeing activities promoting healthy lifestyles.

Partnership working with local faith organisations enabled pop-up hypertension checks at community events, including the Inspire Eid Festival, helping to reach communities that may experience barriers to accessing traditional healthcare settings.

The annual Luton HealthFest, held in July 2025, attracted significant community participation and delivered 294 blood glucose tests, with 16% showing elevated levels and 400 blood pressure checks, with 18.5% identified as high

Residents also accessed information and support on long-term conditions, women's health and healthy lifestyle choices.

Targeted Prevention and Support for Vulnerable Groups - The Hypertension Learning Action Network supported early identification of hypertension among Indian and Black African residents aged 40–50, addressing known disparities in cardiovascular risk and promoting earlier intervention.

The Medicines Management Care Home Team delivered training to 300 adult social care staff, strengthening medication safety and improving confidence in medicines management across local care settings.

Digital Engagement - The Luton Place team worked with NHS England, Community Interest Luton, primary care and community partners to pilot an approach to increase participation in the [NHS Digital Weight Management Programme](#). The pilot tested the use of trusted community voices – including GPs, pharmacists and faith leaders – to encourage residents to enrol in the programme. Early results indicated a 50% increase in referrals when patients were encouraged to participate through trusted community channels.

Milton Keynes

In Milton Keynes (MK), 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, a multi-agency initiative aimed at improving the ways our health and care services work together.

Key achievements include:

- Continued to strengthen joint working with the local authority through a genuinely place-based approach in MK. Through the MK Deal and the Better Care Fund, the NHS, Milton Keynes City Council and partners have worked together to jointly plan, commission and deliver integrated services that support people to remain independent, avoid unnecessary hospital admissions, and return home quickly and safely when they do need hospital care. Our shared governance, pooled funding and integrated teams have improved system flow, reduced delays, and ensured that health and social care decisions are made together, around the needs of local residents rather than organisational boundaries.
- Efforts to tackle obesity include a digital wearable program for type 2 diabetes. An app is being developed to help motivate patients in this cohort to become more active to help manage their condition, with plans to recruit 760 patients onto the programme over the next 18 months. The programme will be evaluated to see if it proves to be effective.
- The RENEW programme pilot was commissioned to support children and their families living with obesity. The programme is taking an innovative approach by using an MDT model, this includes providing wrap around care and support provided by a team including, GP, paediatric consultant, clinical psychologist, dietitian and a family support worker. The model is being evaluated with the support of Public Health to assess its effectiveness and if it provides a scalable model for tackling childhood obesity.
- 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 established a family help panel, providing multi-agency support for children with low school attendance and unmet health and care needs. Consideration is now being given to expanding this model beyond Bletchley.
- A range of programmes to support healthy eating were tested, working in collaboration with schools, the MK Foodbank and Family Centres to increase access to fresh fruit and vegetables for families.

- A wide-ranging programme of community engagement strengthened partnerships with more than 50 organisations, supported residents to access local services and wellbeing activities, and provided seed funding through the Bletchley Clubs programme to enable 67 community groups to deliver activities reaching over 3,800 residents.

Performance analysis

This section of the Annual Report reviews our performance over the past year. We focus on key metrics from the 2025/26 NHSE operational plan and critical service areas such as patient access, wait times, the quality and safety of care, our achievements and our challenges.

Transformation Priorities

Progress made against the ICBs 3 transformation priorities - Complex Care, End of Life Care and Admission Avoidance and Discharge Pathways during 2025/26 is summarised below.

- **Complex Care**

The 4 local authorities and the ICB have been working together to identify up to 10 children in each local authority area (Central Bedfordshire, Bedford Borough, Luton and Milton Keynes) who are most affected by childhood trauma but who do not meet the criteria for support under the Mental Health Act 1983 or Continuing Health Care. These are children for whom either the local authority or the ICB feel that current health and social care support may not be fully meeting their needs. Some of these children may be in care, while others are on the edge of care.

The aim of this work is to gently strengthen multi-agency responses for children with complex needs arising from childhood trauma. The intention is to support a calmer, more co-ordinated system-wide recovery model that helps children remain local and stay in education, where they can feel safe, understood, and supported. This includes exploring earlier, more appropriate forms of help to reduce the need for high-intensity services, while making thoughtful and effective use of resources across the BLMK system.

System trauma panel meetings are now established in each local authority, bringing together senior leaders from both the local authority and the ICB. These meetings offer a space for careful review, shared recommendations, and supportive strategies for children who are experiencing, or have experienced, trauma-related challenges. The panels help to enhance the quality of care and intervention planning, ensuring a co-ordinated approach that involves children, families, and professionals across health and social care. The focus is on helping children receive the right support at the right time.

Early indications so far, show signs of encouraging benefits, including improved planning, greater placement stability, successful step-downs from high-cost care, and increased stabilisation for a highly complex group of children. There have also been reductions in missing episodes and acute escalation.

Overall, the programme highlights a meaningful opportunity for the NHS and local authorities to continue working together to improve outcomes and create value across the system. Work is now underway to consider the future direction of the model.

- **Palliative and End of Life Care**

In 2025/26, the Palliative and End of Life Care (PEoLC) Transformation Programme made strong progress in developing a more coordinated, equitable and sustainable system across BLMK. Work has focused on improving early identification, strengthening care coordination and reducing reliance on unplanned hospital care.

A key development was the implementation of the Bedfordshire Palliative Co-ordination Service, providing a single, integrated point of access for patients, carers and professionals. The service delivers consistent triage, holistic assessments and personalised care planning, reducing variation and improving system responsiveness.

In Milton Keynes, partners continued to advance a unified PEoLC model through structured system workshops and multi-agency working groups. Building on the work undertaken locally, and further informed by insights from Bedfordshire, this work is helping to shape future coordination arrangements and strengthen specialist palliative care, clinical leadership and digital infrastructure.

The programme also prioritised workforce development, introducing new training resources and undertaking capability assessments to support consistent delivery of advance care planning and high-quality end of life conversations. Resident engagement, supported by Healthwatch, has informed communication materials, helping to strengthen public understanding of palliative and end of life care services and contribute to normalising conversations about death and dying.

Strong collaboration across hospices, NHS Trusts, primary care, and system partners continues to drive systemwide improvement, ensuring a compassionate and high-quality PEoLC offer for BLMK residents.

- **Admission avoidance**

In 2025/26 admission avoidance and discharge were 2 key priorities under the unplanned and emergency care programme. Priorities were agreed and led by the Improved System Flow programme in Milton Keynes and the Bedfordshire Care Alliance in Bedfordshire and were brought together and overseen by the Urgent and Emergency Health and Care Board.

Strong collaborative working is evident across partners; however, delivery remains dependent on system enablers including workforce availability, procurement timelines, commissioning governance and access to shared digital systems.

Bedfordshire focussed on admission avoidance through the strengthening of the Unscheduled Care Co-ordination Hub and community services accessing and supporting patients on the ambulance stack. To reduce the delay between discharge ready date and date of discharge; pathways and staffing has been reviewed to increase the number of patients discharged home on pathway one and improved communication and earlier identification of patient need to identify appropriate P2 beds has been the focus in Bedfordshire – the commissioning of 10 dementia beds did add additional capacity and under-utilised P2 beds were also decommissioned.

In Milton Keynes admission avoidance and prevention initiatives, are aligned to addressing non-medical drivers of demand and reducing pressures on urgent and emergency care. Discharge and intermediate care transformation remain central to delivery, with the Integrated Discharge Hub (IDH) demonstrating improved flow and reduced bed days for complex cohorts, and pathway 2 redesign progressing from agreed models into implementation.

Further information on Urgent and Emergency Care can be found on pages 48 to 52.

Health and care strategy

During 2025/6, the ICB continued to make strong progress against both the [Joint Forward Plan](#) and the [Health and Care Strategy](#), contributing to improved outcomes across early years, long-term conditions, inequalities, and neighbourhood-level integration. The [Joint Forward Plan](#) provided the medium-term framework for aligning NHS and local authority priorities, while delivery against the [Health and Care Strategy](#) saw tangible improvements including higher school-readiness outcomes, strengthened Special Educational Needs and Disability (SEND) partnerships, wider tobacco dependency treatment, enhanced digital and data capability, reductions in falls admissions, and progress on inequalities through initiatives such as Learning and Action Networks and the first system-wide Inequalities Seminar.

These achievements reflect a system that has matured its collaborative working, delivering prevention, earlier intervention, improved access, and more consistent support for residents. Digital social care record adoption exceeded national stretch targets, Musculoskeletal (MSK) and diabetes pathways strengthened, dementia diagnosis rates reached the highest levels in the region, and neighbourhood-based initiatives such as proactive outreach, VCSE partnerships, and place-based programmes continued to develop. Collectively, these efforts demonstrate that the ICB has meaningfully had regard to the [Joint Forward Plan](#) and [Health and Care Strategy](#) in discharging its statutory responsibilities, improving outcomes while strengthening system capability.

As we moved through 2025/26, the [Joint Forward Plan](#) and [Health and Care Strategy](#) were superseded by the planned creation of a new statutory commissioning body. NHS Bedfordshire, Luton and Milton Keynes ICB, together with NHS Cambridgeshire and Peterborough ICB and NHS Hertfordshire and West Essex ICB, were scheduled for disestablishment on 31 March 2026, with the new Central East ICB due to be established on 1 April 2026 in their place. This organisational change required a refreshed strategic framework reflecting the wider geography, larger population, and expanded responsibilities of the new body. The shift from 3 local Integrated Care Boards to a single, larger Strategic Commissioning organisation meant that earlier strategies—while still valuable—no longer provided the level of commissioning focus, discipline or system-wide perspective needed. The Central East [‘Our Way’](#) strategy was therefore developed to set out a unified approach to commissioning, measurable outcomes, neighbourhood-based delivery, and clearer accountability across the wider system. In doing so, it carried forward the intent of earlier strategies but strengthened and updated them to reflect the new statutory context, the broader population footprint, and the organisation’s enhanced role as a Strategic Commissioner focused on improving outcomes at scale.

Performance, Quality and Safety of local Healthcare

The ICB is accountable for monitoring compliance with NHS Constitution pledges and national operational performance standards. These standards set out the core obligations of the NHS, forming the foundation for safe, effective service delivery across BLMK. They define the level of care that patients, the public and NHS staff should expect and receive. During the year, we maintained a consistent focus on assuring clinical excellence, safeguarding patient safety, and minimising avoidable harm across the services we commission.

ICB performance reports continue to deliver clear, focused insights with strong supporting narratives, and our Board reports are published on our [BLMK ICB Website](#) in the interests of transparency and public accessibility.

Over the course of the year, we have delivered measurable improvements across the following priority areas:

Referral to treatment long waits (52 weeks) – we improved long waits over the year, reducing the number of patients waiting over 52 weeks for treatment to 1,396 (a reduction of 67%) between April 2024 and March 2025.

Early-stage cancer diagnosis - latest data published in Q4, shows that BLMK diagnosed 63% of cancers at stage 1 or 2, progressing toward the national target of 75% by 2028 (the regional and England average is 61% and 60%, respectively). The ICB is on track towards meeting our Long-Term Plan of diagnosing cancer earlier.

General Practice Appointments in Primary Care - we delivered 7,077,698 appointments over 2025/26; a 14% increase on last year.

Care Programme Approach 72 hours follow up standard – The ICB has performed above the 80% target all year, ending M12 with 88% of patients followed up within 72 hours of discharge from psychiatric inpatient care.

Dementia Diagnosis – The ICB continues to overachieve the diagnosis rate every month of 2025/26. We ended the year with a diagnosis rate of 70%, over-achieving against the 66.7% national target and the regional average performance of 65%.

Talking therapies (Reliable Improvement) – The ICB over-achieved against the 68% target in March with a total of 68.7% of patients making reliable improvement whilst undertaking talking therapies.

Early intervention in psychosis (EIP) programme – The ICB has exceeded the 60% target every month this year, ending with 100% of patients seen within 2 weeks of referral.

Perinatal Access - we exceeded the monthly target for the last 8 months of the year with a total of 18,490 women accessing perinatal services within BLMK by the end of March, against our plan of 17,280.

2-hour urgent community response - we successfully met and exceeded the 70% target every month this year, with March achievement of 92%, maintaining an average of 88% over the year.

Learning Disability and Autism Health checks – The ICB incrementally improved delivery over the year, with a total of 77% of patients having had a health check by March (against the 75% target).

A review of performance over the past year highlights the significant operational pressures experienced across the system. While we sustained collective effort and strong organisational commitment, services have continued to operate in a challenging environment characterised by increasing demand, workforce and capacity constraints, 3 periods of industrial action, and data quality challenges. Against this backdrop, performance has remained challenged in the following areas:

- **Referral to treatment (RTT) long waits (78 and 65 weeks)** – BLMK 78w waits saw a reduction of 50% over the year, starting with 12 in April 25, peaking in August, before reducing to 6 in March 2026. Similarly, waits for planned treatment over 65 weeks saw a 65% reduction over the year with from 108 in April 2025 to 38 in March 26.
- **Diagnostic 6 week waits** – The ICB has seen variable performance over the year, remaining adversely above the 15% target, starting the year with 32.3% of people waiting 6 weeks or more for a diagnostic test. and ending in March with an improved 30.4%.
- **Cancer 28-day faster diagnosis** – performance has improved over the year from 76.7% in April 2025, peaking above target with 80.7% in February, and ending the year with 78.4% in March, falling short of the 80% end of year national target.
- **Cancer 62-day wait times** – the ICB saw variation over the year in wait times for patients to receive their first treatment following an urgent GP referral, from a low of 61.2% in May to 67% in March; falling short of the 70% target.
- **A&E 4-hour** – Through sustained system-wide collaboration and shared commitment across partners, the ICB exceeded the national target of 78%, achieving 81% by year-end and ranking 2nd regionally out of six systems.
- **Talking therapies (Reliable Recovery)** – The ICB underachieved against the 50% target in March with a total of 46.6% patients making reliable recovery whilst undertaking talking therapies.
- **Children and young people mental health services access** - we fell significantly short of the BLMK 15,982 target, with a year- end achievement of 14,000.

Elective Care, Diagnostics and Cancer care (more information on pages 52, 53 and 45 to 46)

BLMK ICB	Threshold / End of Year Target	Q1 - June Snapshot	Q2 - September Snapshot	Q3 - December Snapshot	Q4 - March Snapshot	Regional M12 Average	What does good look like
RTT - % Patients Waiting 18 Weeks or less	60%	58.2%	58.8%	59.8%	63.1%	61.3%	High
RTT - Number of 104+ Week Waits	0	0	0	0	0		Low
RTT - Number of 78+ Week Waits	0	12	21	11	6	114	Low
RTT - Number of 65+ Week Waits	0	174	195	73	38	376	Low
RTT - Number of 52+ Week Waits	1,878	3,953	3,392	2,422	1,396	3,476	Low
Diagnostics Tests - 6 Week Waits	15%	31.5%	31.3%	33.9%	30.4%	29.9%	Low

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

BLMK ICB worked collaboratively with system partners to deliver planned treatment within 18 weeks. In March, the ICB achieved 63.1% against the revised 18-week RTT national threshold of 60%; this is compared to a regional average performance of 61.3% and a national average achievement of 65.3%. Moving into 2026/27, the ICB will be working towards 67% achievement by March 2027.

BLMK is dedicated to reducing long waits, while respecting patient choices and unavoidable cancellations. Ongoing challenges within planned care over the year have impacted on our targeted efforts in reducing waiting times as rapidly as we would have liked; this included 3 periods of industrial action in July, October, and December. We worked to reduce 78 week waits over the year, peaking in August 2025 to 22, and then reduced to 6 by the end of March. Simultaneously, Partners worked relentlessly to reduce the number of patients waiting 65+ weeks, which saw a larger reduction from 108 in April to 38 patients in March. The ICB continues in joint efforts with our providers over 2026/27 to decrease the number of patients waiting 52+ weeks; this year saw a successful reduction of 67% (2,867 patients) ending the year with 1,396 patients.

Over the year, our most challenging pathways across all providers have been Ear, Nose and Throat (ENT), Gynecology, Trauma and Orthopedics (T&O) and Ophthalmology. To improve performance and where appropriate, trusts have employed waiting list validation, sourcing additional theatre capacity and outpatient clinics, and in and outsourcing where it has been affordable. Further mitigation has come from accreditation of new independent sector providers, specifically within ophthalmology, dermatology, and ENT. Provider recovery meetings continue with NHSE and ICB support. Discussions around harm reduction and clinical risk reviews have continued with a focus on quality of care and reducing additional harm from prolonged waits. Patients are prioritised by urgent clinical need and in accordance with national guidelines.

Diagnostics – waits over 6 weeks (more information on page 53)

The ICB has faced considerable challenges in meeting the 6-week wait measure. Although progress remains limited over the year, partners across the system remain actively committed to delivering improvement and advancing toward the 15% target. Performance varied across the system, with MKUH making significant strides, reaching their lowest waits in November with 21% (lower is better).

The ICB started the year at 32.3% and ended the year with 30.4% of people waiting 6 weeks or more for a diagnostic test; BHT achieved 32.4%. Challenges have included high volumes of patients on the waiting list, ending in March with 33,124 patients, and a 2% improvement in performance. Our most challenged pathways have included Audiology, Cystoscopy and Non-obstetric ultrasound services (NOUS). As we move into 2026/27, our focus will remain on managing demand, strengthening recruitment, and addressing workforce skills shortages. We will continue to improve audiology services in line with the recommendations of the Kingdon Review of children's hearing services, taking account of forthcoming NHS guidance and the workforce pressures currently impacting delivery.

Cancer waiting time standards (more information on pages 45 to 46)

BLMK ICB	Threshold / End of Year Target	Q1 - June Snapshot	Q2 - September Snapshot	Q3 - December Snapshot	Q4 - March Snapshot	Regional M12 Average	What does good look like
Cancer – 28 Day Faster Diagnosis Standard	80%	77.1%	72.8%	78.6%	78.4%	77.2%	High
Cancer – 31 Day Combined	96%	86.7%	88.6%	89.7%	89.0%	90.7%	High
Cancer – 62 Day Combined	75%	69.1%	67.0%	69.3%	67.0%	68.4%	High

The 28-Day Faster Diagnosis Standard (FDS) ensures patients with suspected cancer receive a timely diagnosis. By the end of March, the ICB achieved 78.4% (1.6% below target); BHT achieved just below target with 79.9% in March and MKUH achieved 77.5% (the national average was 79.4%). Over the year, the ICB have had good understanding of our most challenged pathways and the ICB continues to actively work with providers to achieve the national standard of 80% by March 2027 – this target remains for the next 3 years.

The 31-day decision to treat standard, following a cancer diagnosis, has a target of 96% and the ICB fell short of this in March with 89%. Performance has been impacted by seasonal and pathway pressures and in-year local theatre refurbishment work limiting capacity. Additionally, ICB performance is specifically impacted by high volumes and pathway activity delivered by tertiary and acute providers outside the BLMK footprint, despite positive delivery within our local trusts (BHT met the target with 96.2% as did MKUH with 96.7%). Due to National challenge in meeting the 96% target (national England average in March 2026 was 92.8%), for 2026/27, NHSE has reduced this to 92%.

Delivery of the 62-day performance standard remains one of our biggest system challenges this year, and in March, the ICB underperformed against the 75% target with 67% (BHT underachieved with 69.8% and MKUH with 58%). Performance challenges over the year have been driven by capacity pressures across staging scans, outpatient appointments, complex pre-treatment workups (e.g., genomic sampling), and reliance on tertiary providers. Workforce constraints in high volume pathways also extended pathway length. The ICB have targeted improvement plans in place, reviewed monthly with providers. Further improvement actions include; behaviour change projects to reduce delays and alignment of available Cancer funding to high impact specialties alongside workforce recruitment and training. Further information on Cancer can be found on page 45 to 46.

Urgent Emergency Care (more information on pages 48 to 52)

BLMK ICB	Threshold / End of Year Target	Q1 - June Snapshot	Q2 - September Snapshot	Q3 - December Snapshot	Q4 - March Snapshot	Regional M12 Average	What does good look like
Ambulance – 30-minute Handover Delays (Daily Average)		22	21	24	19		Low
A&E 4 hour waits	78% by March	75.7%	76.5%	78. %	81.0%	76.7%	High
% A&E 12-hour journey time	5%	2.3%	2.5%	2.9%	2.0%		Low
% ED Attendances resulting in an emergency admission		26.3%	27.6%	30.4%	29.7%	29.7%	High

Ambulance Handovers – 30-minute handover delays (more information on pages 48 to 52)

Ambulance handovers involve transferring patient care to hospital staff. The time this takes impacts both patient outcomes and emergency service efficiency. BLMK ICB 30-minute handover delays are recorded as a daily average snapshot and have remained comparable over the first 3 quarters of the year, with an average of 22 over Quarter 1 (a 45% reduction in delays on the same period last year), then increasing slightly to 24 in Quarter 3 (a reduction of 42% on the same period last year), reflecting well-managed services during the seasonal peak of winter. Handovers reduced further to an average of 19 handover delays over Quarter 4 (a 36% reduction on the same period last year).

Handovers vary in terms of speed and process which directly impacts patient care and overall ambulance service efficiency. To support overall performance, system providers collaborate to reduce these delays. Progress and issues are managed through daily operational meetings and System Co-ordination Centre (SCC) escalations.

Accident and Emergency (A&E) 4 hour wait (more information on pages 48 to 52)

The time patients spend in A&E before being discharged, admitted, or transferred is a critical performance metric. In addition to exceeding the national 78% target in March, the ICB performed above both the regional and national average performance for 11 out of 12 months in the year. The ICB ended the year with 81%; our highest performance of the year. BHT exceeded the target with 80% and MKUH was slightly below with 79.3%. As a result of our robust performance in March, the ICB was able to secure second place out of six in regional ranking.

Accident and Emergency (A&E) 12 hour waits “Journey time” (more information on pages 48 to 52).

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 be attributed to hospital bed availability, staffing shortages, or busy A&E periods (demand). The ICB has remained below the 5% threshold (lower is better) over the full year, ending in March with 2% of all patients attending the ED breaching 12 hours in the department.

Efforts continue across the UEC system to improve services within mental health, demand management, and patient flow. To mitigate and support pressures, trusts are implementing recommendations from NHS audits, including continued embedding of Criteria to Admit within their ED departments, provision of a stream nurse in the MKUH emergency department and implementation of their same day emergency care service (SDEC) at BHT.

Community Care

BLMK ICB	Threshold / End of Year Target	Q1 - June Snapshot	Q2 - September Snapshot	Q3 - December Snapshot	Q4 - March Snapshot	Regional M12 Average	What does good look like
Urgent Community Response - 2-hour Standard	70.00%	89.0%	88.2%	84.9%	92.0%		High
Virtual Wards Occupancy	80.00%	62.1%	50.6%	73.6%	73.2%	82.4%	High

Urgent Community Response (UCR) 2-Hour Standard

UCR services provide rapid, multidisciplinary care within two hours to support people experiencing a health crisis at home, helping to avoid unnecessary hospital admissions and improve patient outcomes. Over 2025/26, the ICB performed over the 70% target every month, peaking in and ending the year in March with 92%.

Virtual Wards

Virtual wards provide personalised, convenient, and safe hospital level patient care at home. This year the ICB has seen fluctuating levels of occupancy against the 80% target, ending the year below target with 73.2%. The ICB continues to see increased level of acute referrals. The virtual ward acuity tool is now in use across BLMK; this is a digital, technology enabled system that monitors patient vital signs remotely such as oxygen levels, heart rate, and temperature. This tool allows hospital level care at home, supporting clinicians in tracking patient condition in real time thereby facilitating early intervention, reducing hospital readmissions, and supporting early discharge.

Primary Care (more information on pages 39 to 42)

BLMK ICB	Q1 - June Snapshot	Q2 - September Snapshot	Q3 - December Snapshot	Q4 - March Snapshot	Regional M12 Average	What does good look like
Number of appts. in General Practice	555,609	596,233	595,667	653,158	674,129	High
% same day appts. in General Practice	44.6%	43.9%	47.4%	47.2%	45.1%	High
% of appts. with Health Professional Other Than GP	55.5%	56.3%	56.1%	56.3%	56.0%	High

Access in General Practice (GP)

By March 2026, BLMK ICB delivered 7,077,698 appointments over 2025/26, this is a 14% increase on 2024/25, equating to approximately 27,975 appointments per working day. We continue to deliver a high proportion of same day appointments with a year-end achievement of 47.2%, above the regional and England average performance, both at 45%. We delivered up to 56.3% of appointments with professionals other than a GP, thereby we continue to maximise use of the most appropriate BLMK healthcare practitioner, ensuring a more efficient and targeted approach to health care.

Adult Mental Health, Learning Disability and Autism (more information on page 37)

BLMK ICB	Threshold / End of Year Target	Q1 - June Snapshot	Q2 - September Snapshot	Q3 - December Snapshot	Q4 - March Snapshot	Regional M12 Average	What does good look like
CPA 72-Hour Follow Ups	80%	87.0%	85.0%	83.0%	88.0%	77.4%	High
SMI Health checks (Rolling 12 months)	60.00%	60.2%	57.9%	57.7%	62%	64%	High
Dementia Diagnosis Rate	67%	69.3%	69.7%	69.9%	70.0%	64.9%	High
NHS Talking Therapies - Reliable Recovery	50%	47.8%	43.2%	41.5%	46.6%	49.2%	High
NHS Talking Therapies - Reliable Improvement	68%	69.7%	67.7%	65.9%	68.7%	68.8%	High
Early Intervention in Psychosis (EIP)	60%	96.0%	82.0%	84.0%	100%	76.38%	High
Inappropriate Out Of Area Placements	0	20	10	20	20	21	Low
LD Health checks (Cumulative)	75%	12.6%	32.7%	54.0%	77.0%		High

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

Annual health checks are vital for adults over 18 with an SMI, as they face higher risks for preventable, long-term conditions. Regular, proactive checks can allow for early detection and intervention. Checks include a focus on cardiovascular health and blood sugar management. The 2025/26 ambition was that at least 60% of people on SMI registers would receive a full annual physical health check. At the end of Quarter 4, BLMK successfully carried out 5,240 (62%) physical health checks (1.4% more checks than last year, alongside a 5.6% growth in the SMI register). The ICB continues to implement improvement programmes such as commissioning to work with GP practices who have patients on their SMI register who are hard to engage; this support offer includes out-of-hours health checks and home visits to facilitate uptake.

Dementia Diagnosis

As dementia prevalence rises, prompt diagnosis is key to accessing essential support, optimising care, and ensuring a better quality of life for patients and families. The dementia diagnosis rate for BLMK has remained above the national standard of 66.7% every month this year. As of March 2026, the dementia diagnosis rate stands at 70%, giving us first place ranking out of six within the East of England region (M12 regional average 64.9%; England average 66.3%). The ICB continues to experience 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 2026/27.

NHS Talking Therapies – Reliable Recovery and Improvement

Talking therapies are evidence-based psychological therapy services, addressing a range of conditions. The ICB underachieved the target for reliable recovery with 46.6% (50% target), however, we over-achieved against the target for reliable improvement with 68.7% (68% target).

Over 2026/27, the ICB will continue to improve access and experience strengthened with a focus on reducing inequalities and increasing opportunities for engagement.

Inappropriate Out of Area (OOA) Placements

BLMK continues to experience high demand and bed capacity shortage leading to reliance on private out of area provision. This is a fluid figure and is subject to daily change and at the end of Q4, the ICB had 20 OOA placements. Over the year and into 2026/27, the ICB will remain focused on systemwide priorities including avoiding admissions, improving discharge pathways, and reducing OOA placements. Key actions over 2026/27 include capacity expansion of 21 local beds, admission reviews, supported discharge, and addressing waiters, and bottlenecks. Providers are reviewing their accommodation strategies alongside working with local authorities to improve protocols, and strengthening development of a sustainable supported housing market aligned to population need.

Learning Disability and Autism (LD&A) Health checks

BLMK ICB delivered a total of 77% (4,440) health checks to the LD&A population by the end of the year (M12), against the 76% target (this is 5.7% more health checks carried out than by M12 last year). Performance variation continues to exist within BLMK and primary care training will continue to support identification of patients who have missed checks and inviting them into practices, alongside online guides showing staff how to record and upload data to improve recording quality.

Children, young people (CYP), and Maternity (more information on pages 16, 37 and 43 to 45)

BLMK ICB	Threshold / End of Year Target	Q1 - June Snapshot	Q2 - September Snapshot	Q3 - December Snapshot	Q4 - March Snapshot	Regional M12 Average	What does good look like
Number of CYP accessing mental health services (Rolling 12m)	15,982	13,580	13,505	14,000	15,160	16,258	High
Perinatal Mental Health Access (Rolling 12m)	1,440	1,400	1,575	1,650	1,690	1,510	High

Children and Young People (CYP) Mental Health Access

Child and Adolescent Mental Health Service (CAMHS) supports children and young people with emotional, behavioural, and mental health difficulties. The ICB has under-performed against this metric with a total of 15,160 CYP contacts over a 12-month period (based on rolling activity data), against our target of 15,982. This was 822 contacts below target, placing the ICB fourth out of six in region.

Meeting this target has been challenging over the year, however we remain committed and continue to work hard as a system, to drive improvement; the ICB delivered consistent month-on-month improvement from August 2025 (rolling 12m figure of 13,415), with performance increasing by 19% by M12. To strengthen delivery, a system-wide improvement programme is in place. This includes maximising the use of MH Support Teams, improving digital clinical solutions and data quality, as well as self-referral promotion, streamlined processes, and a single point of access. In parallel, the ICB are working with the voluntary sector to expand early intervention offers across BLMK. A dedicated task and finish group continues to monitor progress and drive sustained improvement.

Perinatal Access

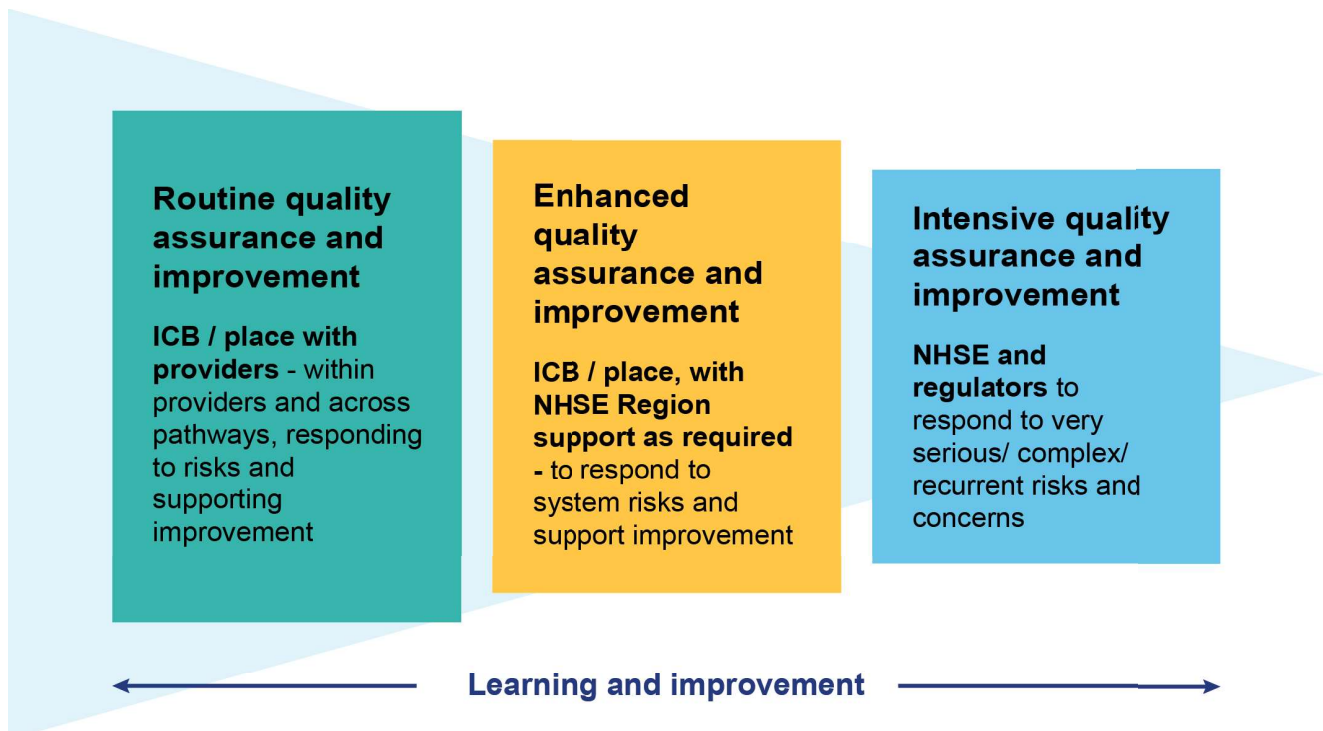
Over 2025/26, at least 66,000 women (nationally) with moderate to severe or complex perinatal mental health needs should have access to specialist care, recognising the vital role perinatal services play in supporting the well-being of new parents. The ICB exceeded our monthly target of 1,440 contacts over the year, averaging 1,541 per month equating to a total of 18,490 (this is 4,990 more contacts than last year and 7% over our allocated target of 17,280). The ICB exceeded the regional end-of-year average by 3%, giving us a ranking of third out of six systems across the region.

Improve quality

Quality remains a core priority for the ICB, underpinning our commitment to improving residents' experience of health care services and delivering our vision for residents across our city, towns, villages and communities to live longer, healthier lives.

In line with the [National Quality Board](#) (NQB), the ICB has 2 overarching responsibilities in relation to quality:

- To ensure that fundamental standards of quality are delivered, including effective management of quality and safety risks and the reduction of inequalities and unwarranted variation; and
- To drive continuous improvement in the quality of services, in ways that deliver meaningful improvements in experience and outcomes for people who use services



In line with NQB expectations the ICBs quality team works closely with providers across the system to support effective quality assurance and quality improvement.

The quality team interfaces routinely with primary care, provider organisations and voluntary, community and social enterprise (VCSE) partners to bring together system-wide quality intelligence, identify emerging risks and support improvement activity. This approach enables a co-ordinated and proportionate response to quality concerns and risks, including escalation where required through established governance routes.

The quality team continues to feed into the Regional Quality Group, supporting shared learning, identification of improvement opportunities and co-ordinated action to improve the overall quality of services delivered across the region.

Locally, quality intelligence and assurance derived from this work informs the ICB's Quality and Performance (from October 2025, Utilisation Management and Quality Improvement) Committees, supporting effective scrutiny of commissioned services and oversight of quality and performance.

Infection Prevention and Control – The year has seen investment to the ICB's Infection Prevention and Control (IPC) team structure, strengthening leadership, oversight and assurances allowing essential work to flourish with system partners to provide up to date advice and support, whilst continuing to monitor system wide healthcare associated infection (HCAI). This includes but is not limited to clostridioides difficile infection (C. diff), Methicillin Resistant Staphylococcus Aureus (MRSA), and Escherichia coli (E. coli). Collaborative working alongside the ICB's emergency preparedness resilience and response team (see page 89) and primary care colleagues has fostered assurance and support of our system partners in outbreak avoidance/containment measures e.g. measles and monkey pox.

The IPC team is recognised for its input with system partners ICB Medicines Optimisation and the Medical Directorate in establishing a system-wide Antimicrobial Resistance Forum focused on shared learning and improved antimicrobial stewardship. The main thrust of work has shifted across the year from acute settings to incorporate community services, including domiciliary care. Output from this work feeds into regional learning forums.

The ICB has continued to deliver IPC training and awareness sessions for primary care, home care and care homes and has supported the wider Quality Team with onsite visits to offer advice, guidance, and support, including a focus on Care Quality Commission (CQC) inspection readiness.

Overall, the strengthened IPC function has enhanced system assurance, partnership working and continuous improvement across the ICB footprint.

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 late 2022 with a deadline for implementation in Autumn 2023.

The key principles of the PSRIF 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, community healthcare providers as well as small providers and independent providers.

All our large providers have successfully implemented PSRIF and have a patient safety incident response plan, with some provider's plan being updated as part of their review.

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 and finish group being created to support the implementation of the strategy. There is a focus on supporting the uptake of the Learning From Patient Safety Events (LFPSE) across Primary Care.

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 incidents, and the wider [NHS England NHS Patient Safety Strategy](#), as well as creating a safe, supportive environment to identify areas of improvement.

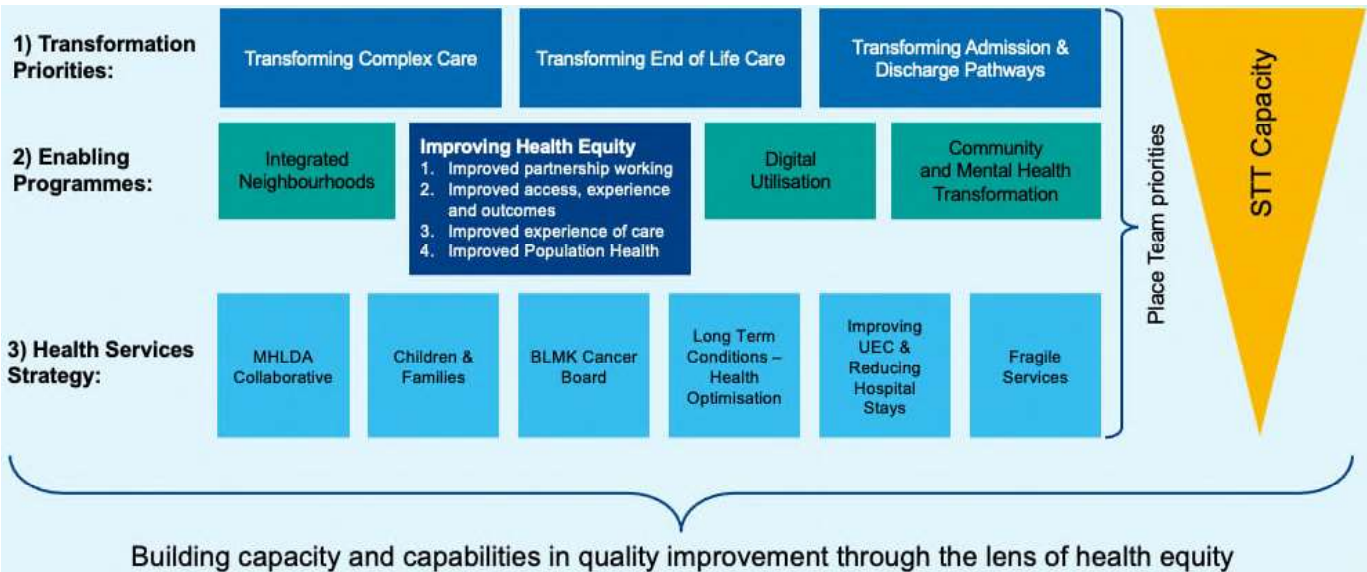
Reducing health inequalities

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.

In 2025/26 the ICB has continued to work on its’ “Health Equity Programme” which was developed in 2024/25. This initiative serves as the enabling framework for the ICS, establishing 4 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 2026 and beyond.

The diagram below illustrates where the health equity programme sits within the BLMK transformation priorities.



The ICB has continued to work with the [Institute for Healthcare Improvement](#) (IHI) to embed quality improvement as the primary methodology to address inequalities. The quality improvement team within the ICB has rolled out a training programme delivered across all staff and some of our smaller providers, such as primary care, which has included an introduction to quality improvement and the model of improvement.

In response to the Denny Review recommendations which was commissioned by the ICB in 2019, work has been taken forward to strengthen Translation and Interpretation (T&I) services across BLMK. Insights from Healthwatch's evaluation, wider system analysis, primary care activity reviews, interpreter usage data and quality improvement tools highlighted opportunities to improve consistency, increase awareness of available support and further embed the [Accessible Information Standard](#).

Drawing on this learning, a set of improvement options has been developed and shared with the Health Equity Forum. As the ICB transitions to the Central East footprint, these options will be used to inform opportunities across the wider system, supporting the adoption of best practice and contributing to a more consistent and accessible communication support offer across settings.

Through our work with [Autism Bedfordshire](#), we have funded videos that have been co-produced by autistic adults, Autism Bedfordshire, clinicians from Bedfordshire Hospitals NHS Foundation Trust, Milton Keynes University Hospital and East London NHS Foundation Trust alongside ICB colleagues to assist autistic people and people with a learning disability to understand what to expect when going to healthcare and screening appointments and different areas of their health. To date we have covered 18 topics working with different healthcare teams to produce videos which explain clearly what to expect when attending an appointment. Topics include type 2 diabetes, X-Rays, Triple AAA screening, visiting the dentist and cancer screening.

For each topic we have worked with autistic adults and those with a learning disability to make sure the result is fit for purpose and as good as it can be. This has included some editing and re-filming in some cases.

Learning and Action Network – Launched in November 2024 our Learning and Action Network (LAN) is a programme focusing on the management of hypertension and involves close collaboration with residents who experience the worst outcomes, engaging them as equal partners by recruiting them into our core project teams.

Throughout 2025/26 each team has continued through the journey of improvement, developing change ideas and testing them through Plan, Do, Study, Act cycles (PDSA) to drive changes against the original aim statements for each area project:

- 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 2026.
- For 60% of Indians aged between 40-50 with a pre-existing medical condition (defined list) to have a recorded blood pressure by June 2026 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 1 of the 3 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 7 practices) by 10% by end of June 2026.
- To raise awareness of the dangers of high blood pressure, encourage the Gypsy, Roma and Traveller (GRT) community to have their blood pressure checked, and improve access by using a health passport. To ensure 5 GRT identifying people use health passport in Ivel Valley PCN by June 2026

These projects are due to come to an end in June 2026.

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



Safeguarding

BLMK ICB has a statutory duty to have appropriate arrangements in place for safeguarding children, young people, and adults. Our work is underpinned by statutory legislation and guidance: Children Act 2004, Children and Social Work Act 2017, Working Together to Safeguard Children (2023), Mental Capacity Act 2005, Care Act 2014, Domestic Abuse Act 2021, Serious Violence Duty 2021, and the Prevent Duty 2023.

The Safeguarding Accountability and Assurance Framework (SAAF) 2024 identifies core duties for individuals working in providers of NHS-funded care settings and NHS commissioning organisations which the ICB is compliant with. The ICB has contractual arrangements via schedule 32 of the NHS Standard Contract and assurance processes for safeguarding with all its providers, and the executive board ensure the discharge and compliance of statutory functions. The NHS England Safeguarding Integrated Data Dashboard (SIDD), Safeguarding Case Review Tracker (SCRT) and Safeguarding Clinical Assurance Tool (S-CAT) have been fully embedded within 2025/26.

Safeguarding within the ICB - During 2025/26 the ICB safeguarding team have continued to be active and effective partners across local safeguarding arrangements, contributing to local priorities including neglect, child sexual abuse, exploitation, mental health and violence against women and girls. The safeguarding team have continued to work closely with partners across the system to ensure statutory compliance, strengthen assurance and improve outcomes across the ICS. This is achieved by:

- Full participation in Domestic Homicides Reviews; Child Safeguarding Practice Reviews; Safeguarding Adult Reviews; Joint Local Reviews, Care Leaver Death reviews and Child Death Reviews.
- The Designated professionals support the multiagency sub-group activities, including Task and Finish groups as members and sub-group Chairs. To ensure that policies and processes are robust, multiagency audits are completed and a system of learning and developments to implement lessons learnt.
- Development of and contribution to strategic direction and priorities, datasets, training, and policy development
- Maintains oversight of commissioned services through attendance at safeguarding boards and committees.

Safeguarding Practice and System Collaboration - Designated professional roles have been restructured to strengthen an all-age approach improving transition models in practice and embed a whole-family focus. This has supported a more robust safeguarding supervision offer to all age continuing healthcare team contributing to smoother transitions to adulthood for children.

The safeguarding team provided GP safeguarding support visits, using the ICB's GP Safeguarding Audit and Assurance Tool to drive improvements in practice.

There have been strengthened links and integrated working with the quality and primary care teams to support early identification of, and response to risk.

The Designated Clinicians team has also strengthened system learning by delivering targeted improvement actions following reviews.

The team has established a thriving Community of Practice for health safeguarding leads and continues to run a forum for lead safeguarding GPs. These forums support sharing knowledge and best practice as well as a positive peer support.

Child Voice and Participation - The ICB has continued to strengthen its Child Voice Strategy through participation in corporate parenting; co-production in service development, including the Dynamic Support Register for children and young people with a learning disability or autism; commissioned interpreting services to support equitable engagement; and ensuring children and young people helped to shape the refreshed Local Transformation Plan, including priorities for crisis support, home treatment, eating disorders and digital access.

Child Protection – Information Sharing (CP-IS) Phase 2 - Working alongside Primary Care colleagues and NHS Digital Leads, the safeguarding team co-ordinated the NHS England priority to launch CP-IS Phase 2 from March 2025 and remains on target.

Statutory Reviews - The ICB Safeguarding Team reports quarterly to NHSE on statutory review themes. Designated professionals act as panel members or panel chairs across Domestic Abuse Related Death Reviews (DARDRs), Safeguarding Adult Reviews (SARs), Child Safeguarding Practice Reviews (CSPRs), and Rapid Reviews.

Significant work has been undertaken to strengthen co-ordination and assurance of these reviews, including new tracking systems and learning briefings to ensure learning is captured and embedded across the system.

Partnership Boards - The ICB is represented at all levels of the partnership boards. It is a testimony to the high regard that agencies have for safeguarding that they continue to prioritise the protection of children, young people and adults in our area and strive to work in partnership to protect and improve outcomes for our population.

Links to Annual Safeguarding Partnership Reports

- Central Bedfordshire – [cbscp annual report 2024-2025](#)
- Bedford Borough – [Bedford Borough Safeguarding Partnership Impact Report](#)
- Safeguarding Adults Board Central Bedfordshire and Bedford Borough - [Safeguarding Adults Board Annual Report 2024-2025](#)
- Luton – [luton lscp yearly report 2024-25](#) and [lsab annual report 2024-25 final](#)
- Milton Keynes – [MK Together Safeguarding Partnership Annual Report 2024-25](#)

Mental Health, Learning Disabilities and Autism

During 2025/26 there have been the following developments across Bedfordshire, Luton and Milton Keynes:

- There has continued to be the development of employment advisors in NHS Talking Therapies Services across BLMK.
- BLMK colleagues have been involved in working with NHS East of England colleagues to progress with mobilising a crisis text service.
- Work is on-going to develop intensive and assertive community treatment for people with severe mental health problems mental health care across BLMK.
- There has been an increase in children and young people accessing mental health services.
- There has been the mobilisation of 2 additional Mental Health Support Teams for children and young people.
- There has been the expansion of the Individual Placement and Support Services so that more people with severe mental illness can be supported into employment.
- There has been a focus on increasing the number of people completing treatment and improving peoples recovery who receive support through NHS Talking Therapies Services.
- Work has commenced to explore the opportunities to develop 24/7 Neighbourhood Mental Health Centres in BLMK.
- Work has progressed to develop a community forensic service in Bedfordshire and Luton.
- Work is progressing to improve the urgent and emergency mental health care pathway across BLMK as well as focusing on the mental health crisis care waiting times ambitions. In Bedfordshire and Luton there has been a focus on setting up an additional 9 acute mental health in-patient beds.
- Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme - There has been a focus on improving the quality of mental health in-patient care which includes eliminating inappropriate out of area placements, reducing the use of restrictive practice and reducing the average length of stay.

There are a number of areas where performance has been good:

- Children and young people accessing Mental Health Support Teams is the second highest in the East of England Region (Access is 4235 at January 2026)
- Early Intervention in Psychosis waiting times standard - Currently at 87% (In January 2026) which is the joint highest in the East of England Region
- Meeting the dementia diagnosis rate - Currently at 69.7% (In January 2026) which is the highest in the East of England Region
- Access to community mental health services - Currently at 13420 (In January 2026) which is the second highest in the East of England Region
- 6 and 18 week waiting times standards for NHS Talking Therapies Services are currently at 94% and 99%
- Meeting the perinatal mental health service access ambition (Currently as 1635 at January 2026)

Mental Health expenditure

An important planning requirement is the delivery of the Mental Health Investment Standard (MHIS). The MHIS requires ICBs to ensure that investment in mental health services increases at least in line with the ICB's overall allocation growth from NHS England each year.

Achievement of the Standard is measured by comparing expenditure in 2025/26 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.

In 2025/26 the ICB was required to increase its mental health spending to at least £206,242k. Subject to confirmation through independent audit, the ICB has spent £206,441k on services in scope of the MHIS in 2025/26 and has therefore met the Mental Health Investment Standard.

Disclosure is shown Note 27 of the Accounts and in the table below.

Financial Years	Current Year (2025/26) £000s	Prior Year (2024/25) £000s
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	206,242	180,384
Eligible mental health expenditure (actuals)	206,441	180,397
Mental health expenditure above / (below) minimum investment required	199	13
Mental health expenditure as a proportion of total expenditure*	7.7%	7.3%

**Expenditure reflects Expenditure in Note 5 of the ICB Accounts*

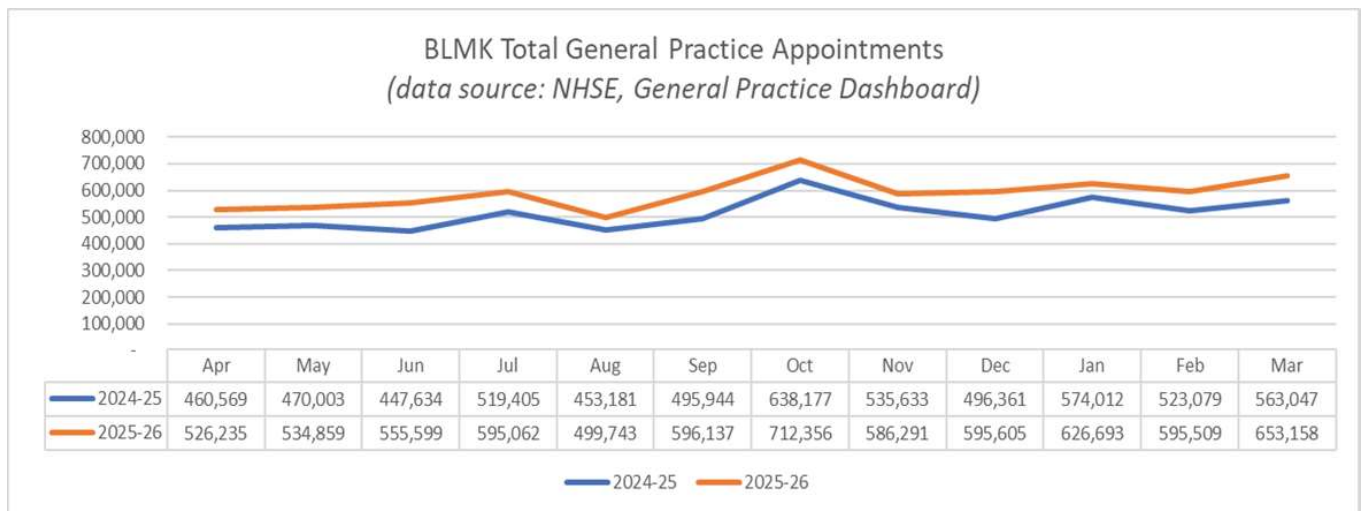
Primary Care (GP, Pharmacy, Optometry and Dentistry)

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

General Practice

There has been an overall increase of 900,202 general practice appointments (13%) between Apr 2025 to March 2026 compared to the same period the previous year across BLMK (this equates to an average increase of 70,017 appointments per month).

The spikes seen in Oct 2024 and 2025 can be attributed to flu and covid vaccinations being delivered within practices and PCNs.

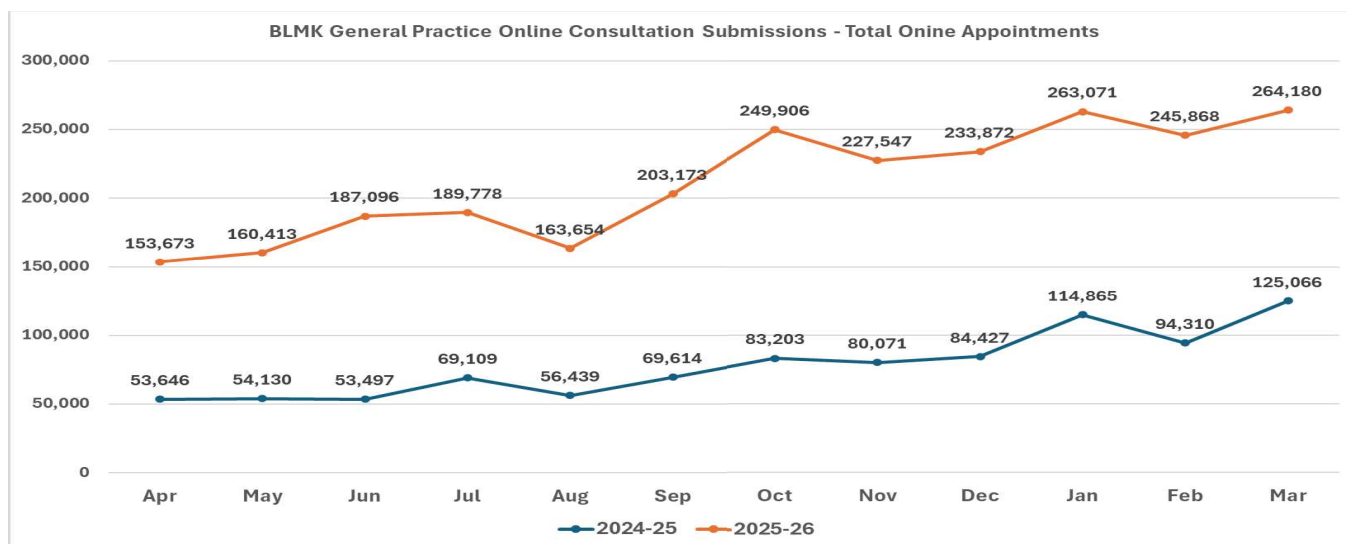


Practices in BLMK continue to deliver the national contract changes for patient access through their use of cloud-based telephony and offering online consultations to deliver a modern practice access model.

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).

During the 2024/25 financial year (Apr 24 – Mar 25), in BLMK there were 938,377 General Practice Online Consultation Submissions. During the 2025.26 financial year (Apr 25 – Mar 26), in BLMK there were 2,542,231 General Practice Online Consultation Submissions (an increase of 171%) – This significant increase is due to this metric becoming mandated in the national Direct Enhanced Services GP contract in October 2025. This significant increase is attributable to the new 25/26 contract requirements in relation to the availability of Online Consultation systems.

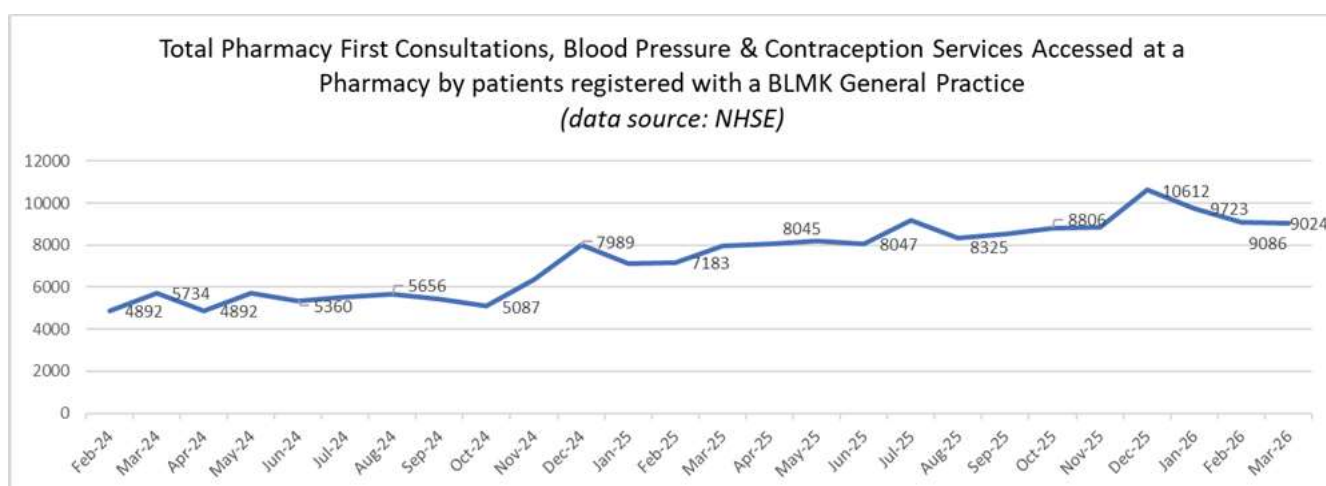
The BLMK Rate of Online Consultations per 1,000 Registered Patients grew from 103 patients in March 2025, to 218 patients in March 2026; with an increase of 111%, BLMK exceeded the national level of growth. The National Rate of Online Consultations per 1,000 Registered Patients grew from 65 patients in March 2025, to 130 patients in March 2026 (an increase of 100%).



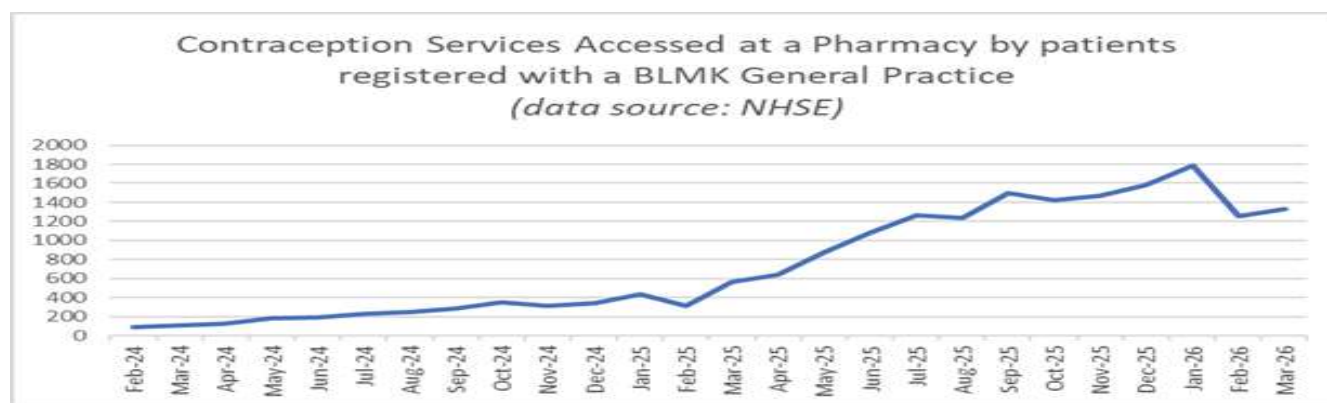
Community Pharmacy

We continue to have the benefit of 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.

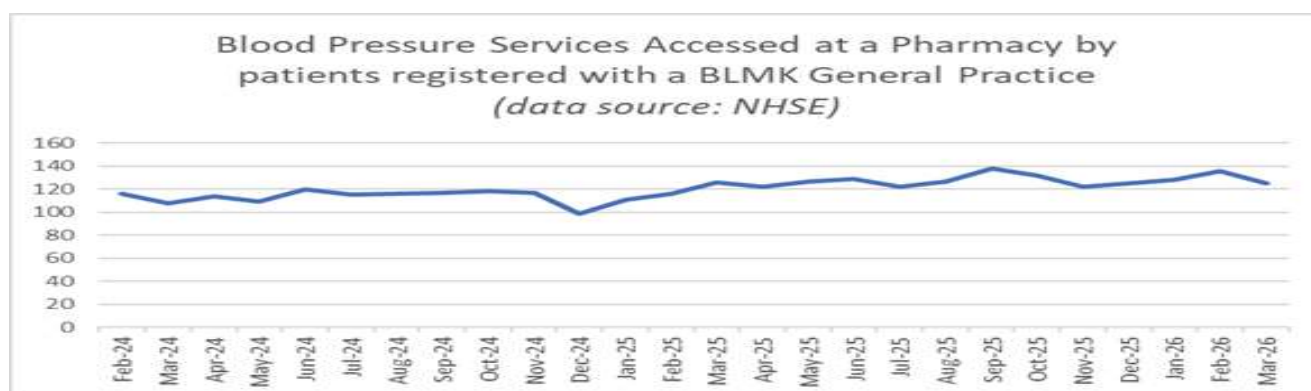
Pharmacy First Service - The Pharmacy First Service launched on 1 Feb 2024 and enables community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways. From April 2025 to March 2026, there was a **22% increase (20,086)** in the number of Pharmacy First consultations compared to the same period the previous year. The graph below demonstrates the continual growth in activity.



Contraception Services - This service launched in Apr 2023, and BLMK has seen an increase of 11,800 consultations from April 2025 to March 2026 compared to the same period the previous year. During Quarter 1 2025/26 the BLMK Community Pharmacy Engagement leads began promoting this service with the impact shown in the months following with a sudden increase in this service being accessed by patients.



Blood Pressure Services - This service launched in Apr 2021, with a 13% increase (175) from Apr 2025 – March 2026 compared to the same period the previous year.



Dental

2025/26 has seen dental providers (general dentistry) delivering more of their agreed contracted activity. Performance reports from 31 March 2026 show BLMK ICB dental providers have increased activity when compared to a similar period in 2024/2025, with an average achievement of circa 92.45% of delivered contracted activity across our 85 contractors. The table below demonstrates delivery across BLMK of contracted activity (compared to the previous month):

Place Base	Number of units of dental activity delivered (UDA) 25/26 indicative (31/03/2026)	Average % of contracted activity delivered 25/26 indicative (31/03/2026)
Bedford (22 Practices)	(200,338) 246,838	(75.55%) 92.50%
Central Bedfordshire (29 Practices)	(267,006) 328,047.20	(74.41%) 91.31%
Luton (14 Practices)	(199,104) 235,265.80	(79.22%) 91.11%
Milton Keynes (20 Practices)	(247,259) 297,858	(78.41%) 94.86%
TOTAL	(913,707) 1,108,009	

On 25 Sept 2025, NHS England launched the new urgent dental care incentive scheme (which accounts for the sudden increase seen in the graph below in the number of appointments available in Oct 2025). This scheme includes unplanned urgent and non-urgent dental conditions requiring clinical care within 24 hours or 7 days respectively, unless the condition worsens. Access to these appointments is via NHS 111 telephony.

A total of 4,197 urgent dental appointments were made available from Jul 2025 to Jan 2026 across BLMK with a utilisation rate of 53% for this period (2,206 attendances)

There was a 5% DNA rate across this period (205 appointments) which have not been included in the utilisation rate.

Ophthalmic Services

Following the delegation of General Ophthalmic Services (GOS) by NHS England to Integrated Care Boards (ICBs) on 1 April 2023 a single Pharmacy and Optometry Contracting Team (P&O Team), manage the GOS contracting function on behalf of the 6 ICBs in the East of England.

GOS contracting is in summary, the provision of NHS sight tests to eligible patients either from a fixed premises (mandatory services contract) or from a patient's usual place of residence or at a Day Centre (additional services contract). BLMK, as at quarter three, had the follow GOS contracts operating:

- 73 mandatory
- 29 additional service contractors

Contractor numbers fluctuate throughout the year as contracts commence or end.

Preconception Care and Maternity

The 2025/26 reporting year marks the final year of operation for the Local Maternity and Neonatal System (LMNS). Significant progress has been made across all 4 themes of the national [Three-Year Delivery Plan for Maternity and Neonatal Services](#). As of 31 March 2026, the LMNS will be formally dissolved, with all ongoing responsibilities transitioning to the NHS England Regional Maternity and Neonatal Team and the respective NHS Trusts. Appropriate governance, risk management, and programme handover arrangements are in place to ensure safe continuation of work. Below is an overview of preconception care and perinatal services.

Preconception care - Targeted preconception care is being undertaken in women who have Epilepsy, Diabetes and those who are known to be part of close relative unions and are at risk of pregnancies affected by Autosomal Recessive Conditions.

The ICB is 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 considered as a blueprint. This program will commence in June 26 with dedicated research to study delivery of preconception care in corner stones in society such as educational institutions, family hubs and other community provision.

Preconception clinics are in operation in Bedfordshire and Milton Keynes Hospitals. The Pregnancy Planning and Metabolic Optimisation pilot is in progress in Luton and Dunstable hospital where 85 women with complex obesity to undergo intensive therapy with Tier 3 obesity service, specialist dieticians and novel medication. 65 women have been recruited and are undergoing treatment.

Luton and Dunstable Hospital is in the fourth 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.

Post natal contraception pathways are available in both maternity units across BLMK which ensures new mothers can get contraception support and advice within their maternity units after babies are born and before mothers can go home. This pathway will improve inter-conception care.

Perinatal Care - The LMNS has delivered substantial progress during 2025/26, focusing on the three-year delivery plan actions, to strengthen workforce and culture initiatives, and supporting both trusts through significant transformation. While Milton Keynes University Hospital (MKUH) demonstrates strong stability, Bedfordshire Hospital Foundation Trust (BHFT) continues to require enhanced oversight and support, which will be maintained through the Improvement Board and the Maternity and Neonatal Improvement Support Team programme.

In 2025/26 we have:

- Strengthened mechanisms for service-user voice through the recruitment of Maternity and Neonatal Voices Partnership (MNVP) Leads and a Senior MNVP Lead.
- Delivery of the MNVP Action Plan, ensuring co-production is embedded across service improvement.
- Consistent involvement of women and families in pathway redesign, safety reviews, and quality improvement initiatives.

Workforce challenges remain variable across the system:

- MKUH - Fully recruited in both midwifery and obstetric staffing. Stable workforce position with improved retention and reduced reliance on temporary staffing. Ongoing challenges in converting student midwives into substantive posts, due to no staffing vacancies.
- BHFT - Persistent midwifery and obstetric staffing funding gaps, which the Trust Board have now agreed to fund. Recruitment and retention remain a key risk area and are being monitored through the Improvement Board and regional oversight going forward.

Culture improvement work - Both trusts continue to engage in culture-improvement programmes, including partnership with Health Innovation to support leadership, team culture, and psychological safety.

Embedding the [Patient Safety Incident Response Framework](#) (PSIRF) across maternity and neonatal services is ongoing. Monthly 'Learning from Incidents' meetings held jointly between trusts to share learning, strengthen governance, and support cross-organisational improvement.

Digital maternity and interoperability:

- BHFT – Plan in place to implement Electronic Patient Record (EPR) and BadgerNet, which will enable personalised, patient-facing access to maternity records – planned for Oct/Nov 26.
- MKUH already has EPR patient facing access to maternity records systems in place.

A key outstanding risk remains the interoperability between Trust EPR systems and SystemOne in primary care, which may impact continuity of information flow. Mitigations to be reviewed following the implementation of Central East.

Quality, Safety and Regulatory Position

- BHFT – Remains an area of concern: imposed conditions under section 31 of the Health and Social Care Act (HSCA) 2008 on the registration of maternity services at BHFT, following the [Care Quality Commission](#) (CQC) Visit in July 2025. An Improvement Board is in place, providing oversight and support. A Maternity and Neonatal Improvement Support Team (IST) programme commenced in January 2026, running for 12 months.
- MKUH maternity services - stable quality and safety position with no regulatory escalations.

Service transformation and pathway development - Mutual Aid and Perinatal Escalation - Work has begun to transition mutual aid arrangements and perinatal escalation processes to Trust and regional oversight as part of LMNS dissolution.

Pathway development - Key pathways developed or enhanced this year include, midwife-led medication supply pathway, supporting safe and timely access to medicines, and Personalised Care Plans and Enhanced Continuity of Care scoping exercise commenced, with recommendations for future implementation.

Commissioned services - Commissioned maternity services continue to support improved outcomes, including, Smoke-Free Pregnancy, Maternal Medicine Network, Genetic Risk and [TOMMYs](#) research Midwife

Contract variations to the Maternity System Development Fund to include, preterm birth clinic, bereavement midwife provision, pelvic floor health and maternal mental health services

LMNS Dissolution and Handover Arrangements - The LMNS will be formally dissolved on 31 March 26. A structured handover plan is in place to ensure safe continuation of all workstreams.

- The regional maternity team will assume responsibility for maternity and neonatal quality oversight, assurance against national standards, monitoring of BHFT improvement progress and system-wide maternity transformation programs.
- Trusts will take responsibility for local maternity transformation work, digital maternity implementation, and pathway development and operational delivery.

Improving Cancer Outcomes

The rates of cancer diagnoses are increasing with cases projected to continue rising over the next 10 years and beyond. The focus of the cancer work programme is to ensure that people are diagnosed as early as possible; to ensure that people are able to access curative treatments and are able to access support for their needs ensuring better chances of living a full and happy life once treatment has been completed.

During 2025/26 we have:

- Continued efforts to diagnose cancers earlier, 63.8% of cancers across BLMK were diagnosed at stage 1 and stage 2. This is above the East of England average of 61.3% and ensures that we are able to offer curative treatments and improve outcomes.
- Supported performance improvement programmes with our secondary care providers to focus on key challenge areas ensuring that actions are identified and tasks completed.
- Continued work to improve the uptake of screening across BLMK through local awareness campaigns aligned to the national screening programmes, supporting roll out of the Lung Screening Pathway and attended events with local community groups to discuss cancer screening, promote local health services and charitable organisations that can provide support. We have also supported primary care to run local projects to target inequalities, promote screening or complete case finding.

- 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, we have also held Living With and Beyond Cancer Market Place events to bring service providers, patients and charitable organisations together. The Market Place events ensured that all cohorts have an awareness of each other and were able to promote each other's services, make appropriate referrals and that patients were able to self-refer for support if needed.
- 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.
- Showcased the work happening in BLMK with our peers through attendance at the Health Service Journal (HSJ) awards, regional and national meetings supporting overall delivery of the cancer programme.

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. SDM in planned care areas including musculoskeletal and dermatology have increased.

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-changing 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 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 Wellbeing Directory – A [directory](#) is now in place with listings to enable residents to find local opportunities to access groups and activities in green spaces. There are currently 111 listings on the directory and is widely used by Social Prescribing Teams and other signposting organisations.

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 GP 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.

Integrated Neighbourhood Working – The ICB has been 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](#).

My Directory of Services (MiDoS) - An online service directory has been developed locally by BLMK ICB and contains a wide range of local and national services across health, social care, community, mental health and the voluntary sector with the main benefit being that these services are listed in one central place.

Within the MiDoS platform there is the functionality to create different user views and across BLMK there is a 'professional' user view and a 'public' user view and the contents shown under each is tailored accordingly. Professional users can use the tool to find alternative services to signpost patients/service users to which may be able to meet their need.

BLMK residents have access to the public facing view and are able to use the tool to search for local services for themselves or for their relatives, friends or dependents. MiDoS supports Personalised Care and is a key enabler to the Integrated Neighbourhood Working programme across BLMK, the Primary Care Transformation Plan to support residents with self-care and prevention and also supports with admission avoidance.

Urgent and Emergency Care (UEC)

Throughout 2025/26 the ICB and NHS partners have successfully collaborated to support more residents to stay well at home by avoiding unnecessary ambulance conveyances, hospital admissions and safely supported discharges following 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.

Demand through our emergency departments (ED) has been high with patients displaying complex health needs and social requirements which has led to an increase in patients' length of stay. These are appropriately managed by partners through weekly length of stay reviews across BLMK and pre-planned multi-agency discharge events (MADE) at peak surge times. Daily focus of pathway zero patients is embedded across all acute hospitals and is robustly supported by senior operational teams.

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. MKUH have recently completed a 'time to care' and 'criteria to admit' audit supported by NHSE improvement team. This has provided recommendations for improving flow and Milton Keynes Transformation team will be taking this forward. Criteria to admit from the ED is critical to improve 4-hour performance. Through 2026, MKUH is focusing on the introduction of Ambient Voice Technology in the ED to reduce the time clinicians spend on manual notetaking, improve documentation quality, and free up clinical capacity for direct patient care, dedicated surgical presence in ED during peak times and embedding a consistent 'Every Minute Matters' rhythm across the trust inclusive of the fundamental quality of care across nursing and therapy staff.

Across Bedfordshire Hospitals NHS Foundations Trust, significant improvements have been made to strengthen the Integrated Discharge Teams inclusive of clinical roles for the Luton and Dunstable Hospital. This is reducing delays with triage of patient's pathways and onward referrals to partners and allows for daily review across all pathways to ensure discharges are mapped, discharge ready dates embedded, and delays minimised. Complex care multi-disciplinary meetings are also established for high health and social care needs patients to ensure discharge planning is proactive and timely.

BLMK ICB has a system wide winter plan which incorporates all elements of UEC alongside the BLMK ICB 2025/26 Operational Plan which includes aspects of UEC. 1 of the 3 ICB strategic priorities for 2025/26 is Admission Avoidance and Discharge Planning. This is underpinned by the acute trusts internal UEC plans.

Bedfordshire Unscheduled Care Co-ordination Hub - Hospital Attendance/Ambulance

Conveyance Avoidance/Call before Convey - Launched on 10 March 2025, the UCCH brings together Geriatricians, A&E consultants, frailty ACPs, EEAST paramedics, and rapid response nursing teams in a single, co-located hub. The team operates with shared protocols, direct access to diagnostics, prescribing, and escalation pathways, enabling complex interventions such as IV therapy and senior frailty assessment to be delivered safely at home. The pre-existing virtual ward model has been fully embedded within the UCCH, creating a seamless end-to-end pathway from initial triage and clinical assessment through to ongoing monitoring, treatment, and step-down support.

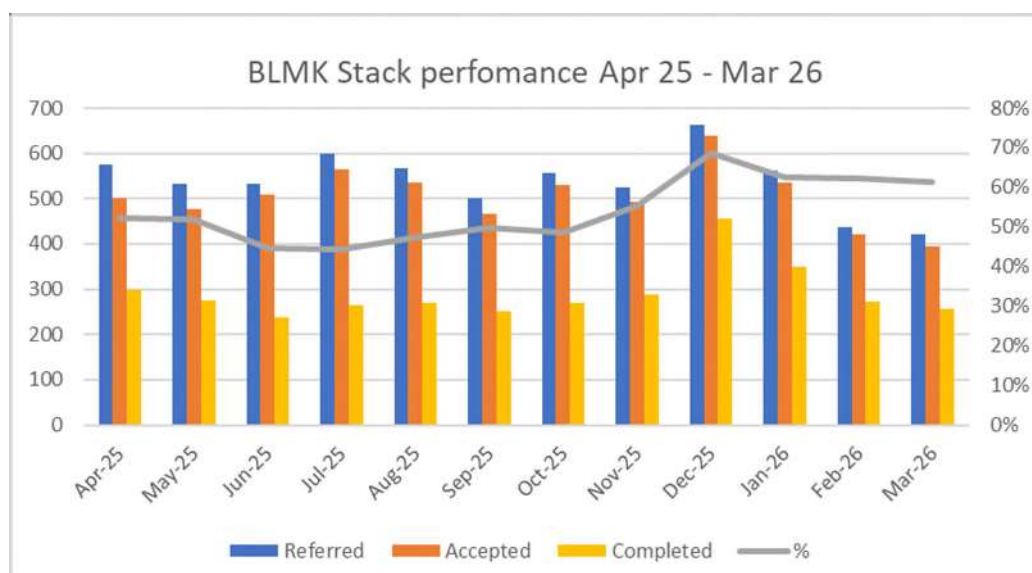
The transition to the UCCH model has led to a significant surge in clinical throughput and hospital avoidance. Overall 6600 calls were taken in 2025/26 with 57.1% (4003) averted an A&E attendance. Following an extension of operating hours in December 2025, call volumes rose by 40% to 800 per month.



The extension of consultant hours has provided an opportunity for EEAST Ambulance Service to implement a mandated CB4C pathway for patients residing within residential and nursing homes and would not be possible without a consistent operating model in respect of opening times. With ongoing extension of the consultant hours, mandating other pathways would be possible.

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 demonstrates similar increases in the number of patients that the Bedfordshire UCCH have removed from the 999-ambulance stack (residents waiting for 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. The completion percentage improved from October onwards and was maintained through to the end of the year.



Overall, the contribution of taking patients from the ambulance stack and the UCCH conveyance avoidance has had a significant impact on the hospital. It is important to remember that 3 years ago neither of these services existed and although the system is currently challenged it would be in a significantly worse place if it was not for these services operating at this level.

Milton Keynes Unscheduled Care Co-ordination Hub - The UCCH in Milton Keynes has not enjoyed the same success as in Bedfordshire because community clinicians are unable to access 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 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 onwards.

BLMK Virtual Wards - Virtual Wards are community services that support patients at home as opposed to remaining or being sent to hospital. They have helped reduce ambulance conveyances, A&E presentations and avoidable admissions by providing timely healthcare interventions, allowing patients to remain in their homes while receiving necessary care. This not only prevents the escalation of medical issues but also supports a smoother transition from hospital to home, minimising the chances of re-admission. They have helped workforce development through rotational roles between acute and community settings, enabling staff to broaden their clinical skillsets, build confidence in managing higher-acuity patients at home, and develop a shared understanding of pathways across the system.

In Milton Keynes there has been capacity to support 50 residents at any one time with utilisation rates of 80% or more the majority of the time. In Bedfordshire there has been capacity to support 185 residents with variable utilisation rates, 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 Keynes and Bedfordshire reduced their capacity. This was 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 with a greater focus on frailty, respiratory and cardiology conditions. A paediatric pathway is also in place, supporting patients across Bedfordshire.

System Co-ordination Centre (SCC) - Operational System Oversight - BLMK's System Co-ordination Centre (SCC) has continued to develop and offers a 7 day a week service to support system partners to improve flow, 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 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, and the SCC now distributes forecasting data which predicts operational pressures allowing for early proactive interventions, daily pulse checks against key performance areas and a review of the past week to identify challenged areas, good practice and support improvements across our partners and all pathways.

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. BLMK remains the only system to meet its planned average handover time every week this financial year and remains the best in the region for Cat 2 response times, ambulance handover times and hours lost inclusive of handover delays less than 45 minutes and 12-hour waits.

There are Bedfordshire and Milton Keynes Trust specific improvement plans in place to support sustainability of the 4-hour ED metric through 2025/26.

Planned care

Elective care services are services that are planned, non-urgent and usually delivered by hospitals. They include tests, scans, surgery and cancer treatment. The focus in 2025/26 continued the 'recovery' of elective care services, particularly for patients waiting the longest for outpatient appointments, diagnostics tests and cancer treatment.

Referral to Treatment (RTT) – In 2025/26 the national priorities focused on:

1. Improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally, with all trusts expected to deliver a minimum 5% improvement.
2. Improving the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally, with all trusts expected to deliver a minimum 5% improvement, and
3. Reducing the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list.

Table 1. 25/26 Performance– Referral to Treatment:

Metric	Bedfordshire Hospitals NHS Foundation Trust		Milton Keynes Hospital NHS Foundation Trust	
	Plan	Latest Performance	Plan	Latest Performance
1. Improving the percentage of patients waiting no longer than 18 weeks for elective treatment	60.70%	62.1% (March 26)	60%	62.6% (March 26)
2. Improving the percentage of patients waiting no longer than 18 weeks for a first appointment	67%	65.3% (end of March 26)	67%	67.4% (end of March 26)
3. Reducing the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list	25 by March 26 >1%	453, 0.54% (March 26)	975 (by March 26)	878, 2.3% (March 26)

Long waits – Eliminating all 65+ week waits continued in 2025/26 with hospital trusts expected to deliver zero patients waiting 65 weeks by the end of the year. This remained a significant challenge for our system against continued and sustained urgent and emergency care pressures, financial constraints and workforce challenges, including industrial action. To offset this, both hospitals 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.

Additional support was given from NHS England to both Milton Keynes Hospital and Bedfordshire Hospitals during 2025/26. By 31 March 2026, the number of residents waiting longer than 65 weeks reduced to 31 (from 102 in April 2025) with 14 of these long wait breaches occurring under Milton Keynes Hospital and 17 at Bedfordshire Hospitals.

Diagnostics - Demand for diagnostics continued to grow during 2025/26 (from 29,022 open pathways in April 25 to 32,580 open pathways in February 2026) 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 diagnostics waits wasn't a national priority, both hospitals continued to work on developing and improving diagnostic services.

Bedfordshire Hospitals opened the North Bedfordshire Community Diagnostics Centre (CDC) in October 25, providing MRI, DEXA scans, CT, Non-Obstetric Ultrasound Scan, Echocardiography and Electrocardiography. Bedfordshire Hospitals also received approval to build a CDC in Luton which is expected to be open to patients January/February 2027. This means that there will be CDC services available to BLMK residents in Bedfordshire Luton and Milton Keynes.

In Milton Keynes there were continued developments to both CDCs in 25/26:

- The new MRI building was completed and started seeing patients in September at Whitehouse Park CDC
- Phlebotomy and Ophthalmology assessment services commenced at Lloyds Court CDC.

Both Lloyds Court and North Bedfordshire CDC's received additional funding to develop CDC pathways for unscheduled bleeding following HRT. These pathways are now live and supporting patients to access faster diagnostic testing.

Outpatient Transformation and Productivity - The NHS continues to look at improvements in how outpatient services are delivered and the demand for outpatient services so that patients can be seen more quickly and can access and interact with services that better suit their needs.

Patient Initiated Follow Up (PIFU) progress has been slow during 2025/26 as our two main hospital Trusts (Bedfordshire Hospitals NHS Foundation Trust and Milton Keynes NHS Foundation Trust) focused on long waits and RTT. Due to this both trusts did not achieve their planned PIFU utilisation rate of 5% by the end of the financial year:

Trust	Plan (January 2026)	Actual (March 2026)
Bedfordshire Hospitals	5.0%	2.5%
Milton Keynes Hospital	34.4%	2.9%

At the end of March 2026, **theatre utilisation** (the number of elective operations within the planned theatre session duration) was at 80.2% with Milton Keynes Hospital at 82.1% and Bedfordshire Hospitals at 78.5%. (Data source: Model Health System data).

In terms of improvements in the number of **procedures completed in a day case/outpatient setting**, this has been a slight improvement from 81.6% in April 25 to 83% in January 2026.

In April 2025, there was a national drive to increase the use of **Advice & Guidance (A&G)** prior to a planned care referral (excluding suspected cancer) in primary care, with a view to reducing the demand for outpatient services. In BLMK, GPs access A&G through the national electronic referral system and through Consultant Connect. The ICB developed a programme of work in 25/26 to support this which included promoting A&G in primary care, clinician to clinician discussion around response times for A&G and specialty discussions where A&G utilization is high.

Between April and January 2024/25 and April and January 2025/26, an 18% increase was seen in the number of A&G requests in BLMK. In terms of A&G requests resulting in a diversion (does not convert to a referral to hospital), there was an increase on 25/26 compared to 24/25. Between April-February 24/25 there were 24,998 diverted requests and in the same period in 25/26, there were 30,340 diverted requests.

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 Ear Nose and Throat and Dermatology. This process continues to support our elective recovery as well as giving residents a greater choice on who they see for their treatment.

Research and Innovation

The BLMK ICB Research and Innovation (R&I) programme continues to play a central role in supporting improved outcomes, reduced inequalities, and sustainable services across the BLMK Integrated Care System (ICS). In 2025/26, we have strengthened system-wide collaboration, bringing together partners from healthcare, academia, local authorities and the voluntary and community sector to create a shared, connected research culture. Investment secured through national funding streams has enabled increased community engagement with research, robust evaluation, innovation and learning aligned to local population health priorities and workforce challenges.

Developing Research and Innovation Capabilities and Infrastructure - Some examples of the work we have undertaken to support research and innovation in our system in 2025/26:

- **Continued to grow the BLMK ICS R&I Network:** The BLMK ICS R&I Network has expanded, with over 140 members from across the system. Chaired by Professor Sir Keith Willett, presentations have been shared by representatives from primary care, secondary care, universities, local authorities, and East Genomics. An example of feedback received from network members: “I feel part of a wider community and have learnt about the depth and breadth of research opportunities across BLMK”
- **Evaluating the Johns Hopkins Adjusted Clinical Groups (ACG) Risk Stratification tool** - £27,473.80 [National Institute for Health and Care Research](#) (NIHR) Research Capability Funding was secured for an evaluation by the University of Cambridge of the Johns Hopkins ACG tool in BLMK general practice. This aims to understand experiences of using the tool, current pathways, which population groups are identified, what continuity of care means to these groups, and map priority areas for future research.
- **BLMK ICS and University of Bedfordshire Research and Innovation Hub** is supporting 17 active research projects within 4 pillars aligned with ICB strategic priorities: Inclusive Workforce and Building Resilience; New Ways of Working and Embracing Innovation; Safeguarding Children and Adults with Complex Needs; and Strengthening Research Capacity. All 17 studies are on track to complete on time by November 2026. Hub researchers and ICB colleagues attended the International Conference in Integrated Care in Lisbon in May 2025, where The Hub's work was recognised internationally, winning the Patient and Caregiver Award 2025 from the International Foundation of Integrated Care.
- **The Knowledge Mobilisation Lead role** commenced in April 2025, using funding from the NIHR Applied Research Collaboration (NIHR ARC) and has facilitated sharing of knowledge and research findings across the BLMK system by coordinating the BLMK ICS R&I Network, supported the BLMK Research Engagement Network programme, gathering impact case studies from the 2024/25 Research Capability Funding, and completing a comprehensive literature search to support the Johns Hopkins ACG evaluation.

Addressing Health Inequalities through R&I

- **Research Engagement Network (REN) Funding:** The BLMK R&I team, together with Health Innovation East, East London NHS Foundation Trust (ELFT), and Voluntary, Community and Social Enterprise (VCSE) sector partners, secured £30,000 continuity funding from NHSE for the REN programme. This supports the Community Research Champions program across VCSE partners and ELFT to facilitate co-designed research promotion activities at community events and youth settings. Current efforts focus on 3 studies: [Youth Loneliness Study](#), [D-CYPHR](#), and [Genes and Health](#).
- **Innovative Spirometry Project:** In October 2024, BLMK was the only system to successfully bid for £79,000 in regional NHSE funding. The project has seen 194 patients for spirometry, with 20 further appointments due to take place, resulting in identification of undiagnosed chronic obstructive pulmonary disease (COPD) and asthma in some of the most marginalized communities. 9 clinicians have been supported in the spirometry certification assessment process and a spirometry update webinar was delivered to 28 clinicians. The project evaluation report is forthcoming.
- **The GaitSmart Pilot for Fall Prevention** was implemented in 4 locations across BLMK, to increase physical activity and reduce fall risks. The Final Evaluation report, published in April 2025, shows a positive impact, with 90% of patients improving in at least 1 clinical outcome and 48% improving across all 4 measures (overall GaitSmart score, gait speed, stride duration and joint angle). Based on gait speed data, the proportion of patients at risk of adverse health outcomes reduced from 60% at baseline to 50% by final test. Staff experience was variable, with 50% overall wishing to continue using GaitSmart. Patient experience was strongly positive, with 92% recommending GaitSmart and 76% reporting improvements in mobility.
- **The Innovation for Healthcare Inequalities Programme (InHIP)** is a nationwide initiative, bringing together the Accelerated Access Collaborative, National Healthcare Inequalities Improvement Programme, and the Health Innovation Network to pilot new strategies that accelerate access to National Institute for Health and Care Excellence (NICE)-approved innovations. In BLMK, the program was delivered by Whaddon Healthcare Primary Care Network in partnership with BLMK ICB, aligning with both [Denny Review](#) recommendations and BLMK ICS strategic priorities. The project focused on identifying patients diagnosed with heart failure with preserved ejection fraction who had not been prescribed a Sodium-glucose cotransporter-2 (SGLT2) inhibitor, such as Dapagliflozin. Across 12 GP practices serving high-need populations, clinicians reviewed 180 patient records. Of these, 60 patients were invited for assessment, and 52 attended appointments. As a result, 35 patients began Dapagliflozin treatment in line with national guidelines, a step that has been shown to improve clinical outcomes and reduce hospital admissions.

BLMK ICS Research and Innovation Awards: Established and funded by the hub in 2024/25, the BLMK ICS Research and Innovation Awards allocated a total of **£45,000** to 3 local projects, which have made the following progress over the past year.

- **Proactively identifying and meeting the needs of the over-75 population in Milton Keynes:** Of 781 people identified and invited to participate, 453 completed a needs assessment. Unmet needs were identified in 34% of participants, who were signposted to services or received a home visit. This proactive approach will be embedded into routine practice and further evaluation will be undertaken to measure the impact of intervention.
- **Assessing the determinants of unequal cardiovascular disease outcomes in Luton:** as Luton is a regional outlier in premature preventable cardiovascular mortality, this project aims to understand the characteristics and experiences of patients presenting at Bedfordshire Hospitals NHS Trust, and links to cardiac outcomes. Patient data analysis and qualitative interviews with staff and patients are in progress.
- **Young Men's Christian Association ([YMCA](#)) and MKUH navigator project:** working with children and young people admitted to A&E as a result of abuse, violence or mental health challenges, completed and reported findings in 2024/25.

Engaging people and communities

People and communities remain at the heart of everything we do as an ICB. The ICB is committed to fulfilling its legal duty to involve residents and to ensuring that local people have meaningful opportunities to help shape and improve services. This helps ensure that services remain responsive to the needs of those who use them.

Our work continues to be guided by the principles set out in our [Working with People and Communities Strategy](#). In line with the Health and Care Act 2022, we have also met our statutory responsibilities by working closely with Health Overview and Scrutiny Committees ensuring that engagement activities inform decision-making and that residents' voices remain central to the development of services. During the year, this has included the following areas of work:

Primary Care Engagement - We have supported engagement and communication with patients across several GP practices where service changes have taken place. These changes are often linked to contract renewals but may also relate to other developments that practices wish to discuss with their patient populations. Our role has been to ensure that patients are kept informed and have opportunities to share their views on proposed changes.

Winter Communications Campaign - As in previous years, from October we delivered an extensive winter communications campaign in partnership with NHS Cambridgeshire and Peterborough ICB and NHS Hertfordshire and West Essex ICB. The campaign encouraged residents to take up their flu vaccinations and provided advice on where to seek health support and guidance during the winter period.

Key Engagement Programmes - 2 of the most significant engagement programmes we supported in this reporting period were:

- **Mount Vernon Cancer Centre Review**

From January to March 2026, we supported NHS England in delivering the Mount Vernon Cancer Centre consultation by increasing awareness, accessibility and participation among local residents and stakeholders. The consultation focused on proposals to improve the long-term sustainability and quality of specialist cancer services, including plans to relocate the centre and explore options for a second unit closer to patients' homes.

Working closely with NHS England, local authorities, Healthwatch, voluntary and community sector organisations and Integrated Care Boards across the region, we co-ordinated a wide range of engagement activities. This included supporting local public events, promoting the public consultation survey and helping to publicise opportunities for community organisations to apply for grants to host local conversations and engage communities who do not always take part in consultations.

Our involvement helped maximise awareness and accessibility of the consultation, ensuring that a broad range of voices from local communities and partners across the health and care system could contribute to shaping the future of cancer services.

- **Community and Mental Health Services (CMHS) Transformation Programme**

Working closely with residents, service users, carers, staff and system partners we sought to understand what matters most in relation to community and mental health services, in order to develop a robust Case for Change to support service transformation.

To build a strong evidence base, a comprehensive programme of engagement was undertaken using a wide range of methods. This began with a desktop review of existing reports and insights held by the ICB and our partners. This was followed by a system insights event bringing together residents, stakeholders and providers, alongside in-depth lived experience interviews.

Building on these early insights, we worked with partners to carry out further engagement through focus groups and surveys. Together, these activities generated rich insight, providing a clear view of what communities and partners feel works well within current services and where improvements are needed, together these insights were key in shaping the published case for change.

Data and Digital

Work has continued during 2025/26 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 continued 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 improvements in digital maturity across the ICS have progressed, including acute digitisation, and better access and choice around how services are accessed in primary care through online consultations and the [NHS App](#). We also expanded the availability of secondary care services via the NHS App, building on this as an option for residents to access a broad range of health services and view their care record.

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 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.

Environmental matters

(Incorporating the Task-Force for Climate-Related Financial Disclosures)

The DHSC GAM set out a phased approach to incorporating the recommended 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.

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

Compliance Statement - BLMK ICB considers Climate Change to be a material risk to the achievement of the organisation's function and objectives. 2 risks relating to this are included on the ICB's Board Assurance Framework risk register, outlining the risk to health, health inequality, and health service delivery from climate change-related impacts, and the risk of not achieving Net Zero greenhouse gas emissions from the healthcare service in BLMK by the NHS's statutory goals for 2040 (for controllable emissions) and 2045 (for influenceable emissions).

BLMK ICB had an active programme and governance, encapsulated and described in the BLMK Green Plan and ICB Environmental Policy, to support healthcare services to increase resilience through climate adaptation, reduce greenhouse gas emissions, and minimise the risks to health, inequalities and service delivery.

The ICB is partially compliant with TCFD requirements: it has a governance structure, risk management, a programme of activities being carried out, and key metrics being monitored; additionally, its main strategy and [Joint Forward Plan](#) incorporated environmental sustainability as a driver and core programme. However, there are some gaps in compliance:

- the ICB was not directly quantifying its own corporate contributions to global warming and environmental degradation, although it was carrying out activities to reduce its impact. NHS England advises individual NHS organisations not to calculate their own carbon footprints.
- supporting ICB plans, strategies, and policies have not yet been updated to specifically incorporate risks to the business and its intended outcomes from climate change. This was due to the announcement, in March 2025, that ICBs were to reduce in size and change function, and the subsequent decision to create the new Central East ICB.

Rectifying both non-compliance issues has been included as a goal within the latest iteration of the BLMK Green Plan², and are considered as recommendations for the successor organisation, Central East ICB.

Governance - Climate risks to health and health services are governed through the same process that oversees all risks on the ICB risk registers and Board Assurance Framework.

Progress against the health system Green Plan, which includes actions specific to the ICB, is overseen by an Executive-level Senior Responsible Officer (SRO), which for 2025/26 was the Chief Financial Officer.

² <https://blmkhealthandcarepartnership.org/wp-content/uploads/2025/07/The-BLMK-ICS-Green-Plan-2025-2032-published-July-2025.pdf>

The governance structure in place ensures both risks and delivery of the Green Plan are considered by the business.

Governance body	Climate-specific function	Climate Reporting Frequency
BLMK ICB Board	Ensures the risks to health, equality and health services from environmental issues are minimised.	Annual or as risks arise
Board committees: Quality and Performance (Q&P) Committee and Audit and Risk-Assurance (ARAC) Committee	Oversee progress of the Green Plan, monitoring metrics (Q&P) and risk management (ARAC)	Quarterly
Green Plan Leadership Group (GPLG)	Chaired by the Non-Executive Green Champion and Executive SRO, ensures the system Green Plan is progressing. Oversees metrics, risk management, and progress against actions, including holding local trusts to account for progress against their own green plan activities. Makes recommendations to the Board and its sub-committees.	Quarterly
Green Plan Operational Working Group (GPOWG)	Working group with ICB and Trust sustainability leads and Green Plan project leads, to maintain momentum with Green Plan delivery, and consider shared challenges and opportunities.	Monthly

Governance mechanisms include:

- Green Plan 2025-2032 (approved by Board in June 2025) and its precursor, detailing health system actions to reduce its contribution to climate change and adapt to the risks of a changing climate
- Environmental and Social Impact Assessment (EaSIA), introduced in 2024/25 to support change programmes to identify risks relating to climate change, and assess and reduce the impact on environmental and social issues.
- All Board papers include a section assessing how the paper affects (positively or negatively) the progress of the system Green Plan.
- All procurements appropriately consider supplier compliance with Procurement Act 2023 (including prior convictions for environmental pollution), Carbon Reduction Plans / Net Zero Commitments (PPN006/25) and Social Value (PPN002/25).
- Some themes and activities within the Green Plan are incorporated into other directorate and governance structures, including:
 - Reducing emissions from inhalers, included within the Primary Care Incentive Scheme
 - Sustainability as a standing item on the Capital and Estates Oversight Group agenda.

Due to the changing function and footprint of the ICB, effectively embedding accountability for green plan delivery across different directorates within the ICB remains incomplete. Reviewing the effectiveness of this is a recommendation for the successor ICB and NHS Trusts.

Strategy - The BLMK ICB's strategy to reduce the impact of health services on climate change and environmental degradation is encapsulated in the BLMK Green Plan 2025-2032, approved by the ICB board in June 2025. Building on the previous Green Plan (2022-2025), it sets out 3 vision statements:

People: we will improve health and wellbeing while reducing health inequalities

Places: we will reduce pollution and support nature regeneration

Planet: we will reduce greenhouse gas emissions and achieve net zero by 2045

These vision statements were underpinned by over 100 actions grouped under 4 themes:

- **Culture:** enabling environmentally sustainable health and care through the right leadership behaviours, information and story-telling, skills and data.
- **Adaptation:** creating more-resilience communities and infrastructure
- **Resources:** reducing resource use and moving towards a circular economy
- **Environmental Sustainability:** designing services to focus on prevention, self-care, efficacy and efficiency, and with low carbon processes and consumables.

The Green Plan was published on the webpages of the BLMK Health and Care Partnership:

<https://blmkhealthandcarepartnership.org/wp-content/uploads/2025/07/The-BLMK-ICS-Green-Plan-2025-2032-published-July-2025.pdf>

Risk Management - All climate-related risks fall under 1 of the 2 BAF risks, overseen by the Board. Originally considered as a single risk item, the Audit and Risk Assurance Committee recommended in 2025 that they be monitored as separate risks.

Risks are identified and captured by the ICB's Sustainability team, managed by the Green Plan Leadership Group (GPLG), and escalated to ARAC when required.

BAF risks are supported by underpinning risks, controls, mitigations and key risk indicators (KRIs; where they exist). These are recorded within a risk register and uploaded into the ICB's Insights4Risk web-based platform. As of March 2026, there were 17 risks recorded (including the 2 BAF items).

BAF Risk	Key Controls / Mitigations	KRIs
BAF0007 Health Inequality and Healthcare Service Impacts from Climate Change and Environmental Degradation	• Delivery of Green Plans and supporting governance • Adverse and Severe Weather Plans • Local Resilience Forum • Risk management, including impact on health, services and demand • Impact Assessment ("EaSIA") and incorporation of outputs in strategy and planning. • Communications and skills development	• Overheating and flood occurrences, and other climate-related major incidents • Local weather profiles
BAF0022 Achieving Net Zero	• Delivery of Green Plans • Carbon footprinting for Trusts.	• Carbon emission data for energy, waste, fugitive gases, travel. • Progress against planned activities

Underpinning risks identified and rated highly include:

- Resource to deliver (dedicated time, finance, activated staff)
- Timeliness and completeness of data (see below section on Metrics and Targets)
- Awareness and preconceptions delaying progress
- Increasing healthcare activity driving higher emissions
- Gap in climate adaptation planning

The refreshed Green Plan 2025-2032 captures many mitigations yet to be implemented as actions to be completed. A review of all climate-change-related risks commenced in February 2026 to ensure mitigating actions were attributed to specific organisations within the BLMK system and clearly linked to specific activities within the Green Plan.

The KRIs need further development, to incorporate metrics of health linked to climate change and extreme weather (such as demand from specific patient cohorts for urgent and emergency services), and those measuring consumable use and supply chain emissions.

The Emergency Preparedness, Risk and Resilience (EPRR) team manages business continuity as risks emerge, working with the Local Resilience Forum and considering climate change and other environmental risks. EPRR cascades heat-health, cold weather, and flooding alerts, activating Adverse and Severe Weather plans as required.

A risk assessment to support climate adaptation planning for the BLMK system commenced in 2025, including the risk to the ICB as a business. Whilst this has not yet been fully completed or approved, a summary is provided below:

[Shading indicates relative level of risk – deeper shading = higher risk]	Climate, weather and atmospheric events	Natural resources and ecosystems	Human Factors
	Extreme temperatures Storm, flood and wildfire Air Quality	Water and food quality, access / supply Biodiversity Disease vectors and Allergens	Climate migration Tourism Climate Activism
Human morbidity and mortality	Discomfort, distress, deterioration, illness and isolation	Disease; dehydration; malnutrition; allergenic response; mental wellbeing	Changing disease prevalence, demographics and demand Risk of increasing activism.
Social infrastructure	Deterioration of greenspace; damage to buildings; Isolation; fuel poverty	Quality of and access to outdoor spaces; cost of living; mental wellbeing; livelihoods	Disruption to social networks and public spaces Demand for all public services
Socio-economic	Outdoor workers; access to cool / warm / green spaces; loss of earnings	Greater inequality, including vaccination rates	Social cohesion and wellbeing
Physical infrastructure (incl. transport)	Equipment failure; travel network disruption; overheating; flood; equipment loss and failure; use of A/C; indoor air quality;	On-site greenspace quality.	Increasing pressure on infrastructure
Operational delivery (including staff)	Increasing healthcare usage; staff absence; cost of living; supply chain disruption; power loss	Loss of water supply; workforce absence; increased demand; patient deterioration; pandemic	Increasing pressure on services; burnout; disruption
Medicine and equipment	Loss of stock; disruption / shortages; higher costs	Competition for medicine supply	Medicine supply vs demand; disruption

Development of improved KRIs and completing the Climate Change Risk Assessment are 2 elements will be taken forward as recommendations for Central East ICB.

Metrics and Targets - A set of 54 metrics are used to oversee delivery of the system Green Plan, and as KRIs. These cover NHS Trust data for energy, waste, fugitive gases, travel and transport, water emissions, and project-level progress metrics such as LED lighting coverage, EV charging points, and walking aid reuse. Overheating and flood occurrences are used to identify risks, as are some health data points which may be vulnerable to climate change.

These metrics are reviewed quarterly by GPLG and used to support trusts to deliver against emissions-reducing actions. Selected metrics are used to provide assurance to Q&P Committee, quarterly, along with a narrative update. NHS England calculates an estimated carbon footprint for NHS trusts on an annual basis. The target is to reach 80% reduction, relative to 1990 levels, by 2032 for controllable emissions, on the way to a 100% reduction by 2040. For all other emissions the target is 80% reduction relative to 1990 levels by 2039, with 100% reduction by 2045. The Trust 2019/20 baseline for controllable emissions was 62% lower than 1990 levels, and 2023/24 emissions were 66% lower.

Key indicators for carbon emissions <i>Data to 2024/25 (last full year)</i>		% change since 2019/20	% change since 2023/24
BLMK-hosted NHS Trusts*	Energy emissions	+9.7% ↑	+19% ↑
	Energy emissions intensity**	-1.8% ⇄	+16% ↑
	Waste emissions	-1.5% ⇄	+0.08% ⇄
	Waste emissions intensity**	-12% ↓	-2.2% ⇄
	Volatile Anaesthetic Gases used in surgery	-81% ↓	+1.5% ⇄
	Volatile Anaesthetic Gases emissions intensity**	-83% ↓	-26% ↓
	Nitrous Oxide (N ₂ O)*** emissions	-25% ↓	-0.35% ⇄
	Nitrous Oxide (N ₂ O)*** emissions intensity*	-33% ↓	-2.7% ⇄
Primary Care	Inhaler emissions	-34% ↓	-8.2% ↓
	Inhaler intensity (per inhaler)	-31% ↓	-8.4% ↓

* Milton Keynes University Hospital and Bedfordshire Hospitals

** per m² occupied estate

*** includes N₂O / O₂ mix

Extrapolating inhaler emissions from April to October 2025 to 2025/26 full year suggests a further 26% drop in emissions against last year (5% drop in emissions per inhaler).

There are gaps in the metrics monitored by the ICB:

- Full emissions data for 2024/25 and 2025/26 have yet to be published by NHS England.
- NHS England has not provided organisational-level emissions for supply chains since the 2019/20 baseline.
- NHS England does not share emissions totals for individual ICBs as organisations. For BLMK ICB, energy and waste are part of service contracts held with landlords of the ICB's office estate, and the ICB has not yet undertaken an assessment of travel, transport or commuting emissions, nor supply chain emissions.
- Some Key Risk Indicators either:
 - o monitor events that are insufficiently frequent (for example, flooding events, overheating events);
 - o are not suitable to disaggregate causation (for example, emergency hospital admissions from respiratory disease); or
 - o are not produced in a timely way (for example, emissions data for energy and waste).

Further metrics are being developed from a selection of over 90 additional possible items to begin to address these gaps, and this work will be a recommended activity for Central East ICB and NHS trusts in BLMK.

ICB Activities and Progress - A summary of ICB activities in 2025/26 is given below.

Governance and Planning	The Green Plan was refreshed, including engaging over 160 people in its co-design. Board-approved in June 2025, including signatories from all NHS trusts and all but 1 local authority.
	A Health Impact Assessment rapid review was carried out, confirming the new Green Plan responds to the recommendations from a previous BLMK report.
	EaSIA assessments were carried out for major clinical service transformation work including the Mount Vernon cancer services and Community and Mental Health services.
	A Primary Care Green Plan was written to support primary care organisations to decarbonise their practices (awaiting approval)
Supply chain and procurement	All tenders include questions on breaches of environmental waste and pollution regulations, Carbon Reduction Plans and Net Zero Commitments (PPN006/25), and set questions for Social Value commitments that always include an environmental consideration.
	tenders were completed in 2025/26, in accordance with Procurement Act 2023 and Provider Selection Regime requirements.
	The ICB convenes a bimonthly Community of Practice (Procurement Practitioners Group) to share learning and identify opportunities for joint work.
	The ICB, funded by Luton Borough Council, trialled the Xsilio asset-sharing platform. By reusing office assets through the platform, the system avoided £75k and 45 tCO ₂ e in new purchases / waste disposal.
Knowledge and skills development	The ICB and the 2 acute trusts in BLMK were Corporate Partners with the Institute of Sustainability and Environmental Professionals (ISEP) for the year to February 2026. This provided 12 affiliate memberships, one fully-funded Foundation Certificate of Sustainability and Environmental Management course, and access to ISEP's Educate and Elevate series of webinars. The ICB facilitated ISEP's deputy chief executive to hold a board development session for Milton Keynes University Hospital.
	The ICB facilitated 2 ICB staff and 1 local trust staff member to undertake LDN's Corporate Responsibility and Sustainability apprenticeship.
	The ICB made the online short course Building a Net Zero NHS mandatory for all staff. More than 78% completed the course.
	13 training and awareness sessions on sustainable healthcare were delivered, to 225 people.
	2 ICB staff members undertook interviews for MK College, encouraging students to consider careers in sustainability
	The ICB included Sustainability as an award category for its annual staff awards in September 2025
	The ICB regularly shared information for staff and public linked to national environmental awareness days, the Green Plan, and activities to live more sustainably (such as promoting car sharing, recycling, reducing use of consumables, switching off equipment), including on its website
ICB activities	19 Electric Vehicles and 2 Plug-In Electric Hybrid cars with active salary sacrifice scheme car contracts
	The ICB further consolidated its office footprint, relinquishing space in Bedford Borough council and Milton Keynes council.
	Ongoing advice, support, check and challenge to trusts and Primary Care organisations to progress sustainability projects, including walking aid reuse at Bedfordshire Hospitals, Green Endoscopy, Plant-First menus, adaptation planning,

Workforce (Education and Training)

As an ICB, we collaborate with our ICS partners to deliver against the 10 functions of an ICS People team. The BLMK Integrated Care System (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 - BLMK has implemented a strong supported employment pathways offer to residents. The main offers, to those who may be furthest from employment, are:

- **Kings Trust Co-location Partnership:** After winning a joint tender with Bedfordshire Hospitals Foundation Trust in March 25, the team became co-location partners for the Kings Trust Health and Care Employability Programme, helping young people move into jobs. Our support includes the BLMK Passport to NHS Careers and programmes for those aged 18 to 30 through the BLMK Health and Care Academy.
- **Passport to Health and Care Careers Programme:** Since the programme's launch in October 24, over 300 individuals have accessed employment, further training, work experience, or volunteering opportunities. Of these, 74 have secured positions with Bedfordshire Hospitals Foundation Trust.
- **Department of Health and Social Care Widening Access Demonstrator:** BLMK ICB was selected as 1 of 10 Integrated Care Boards to lead a national initiative. We are running pre-employment programmes for 100 young people and individuals from deprived communities to help them secure entry-level roles or training in local health and care providers, with paths for advancement. This supports government efforts to boost employment, address workforce gaps in health and social care, and promote economic growth by positioning health organisations as anchor institutions.

- Our general **youth attraction offer** is led by partners at the [BLMK Health and Care Academy](#), hosted on behalf of the system by Bedfordshire Hospitals NHS Trust. Over the last year, the BLMK Health and Care Academy has expanded its offer to include innovative programmes, enhanced digital platforms, and strengthened partnerships with local organisations. The latest cohort, which started in November, has attracted 532 students from 70 different education providers.
- **Clinical Learning Environment:** Over the past 3 years we have increased practice placements utilised each year for Nurses, Midwives and Allied Health Professionals (AHP). The variety of practice placements have grown to enable a wider experience. Implemented the purple flag initiative in all acute, community and mental health trusts.
- **SIM suite at the University of Bedfordshire:** In September 25, the University of Bedfordshire successfully integrated Simulated Practice Learning (SPL) into its nursing curricula. This enhanced student preparedness and confidence before entering clinical placements. This initiative reflects our commitment to innovative education and workforce development within BLMK. Simulation-based learning has been widely praised by students for: Building confidence and competence; fostering a sense of community and enhancing readiness for real-world practice.



Developing Our Workforce:

- **People Digital agenda:** To support development of the People Digital agenda, NHS England selected BLMK as 1 of 2 initial ICB's to participate in a pilot to be people digital exemplars to enable learning to be shared more widely. A governance structure that consists of a People Digital Board and a Community of Practice Working Group have been established to support this work.
- **People Digital programme:** BLMK ICB received the RLDatix Collaborative Excellence in Integrated and System-wide Care Award for its People Digital programme, recognising innovative system-wide collaboration and digital transformation in workforce practices. This achievement highlights BLMK's leadership within system-wide working, digital HR, and staff experience, setting a benchmark for excellence and inspiring future progress across the health and care sector.
- **People Digital – People Digital Leadership Course:** The initial BLMK cohort of 13 learners launched in 2025 and is set to complete all modules by March 2026, with ambitions to expand nationally through NHSE collaboration, linking to the NHS People Services Target Operating Model.

- **Transfer of Apprenticeship Levy.** During 2025/26, £111,000 was transferred, from local authorities, NHS trusts and a BLMK HEI to General Practice and 1 dental practice. This supports equity of access to apprenticeship for those staff employed in organisations too small to pay into the levy fund themselves. By transferring or 'gifting' their unutilised levy, our larger providers ensure that the funding is not lost but rather it contributes to the development of our BLMK workforce.
- **Stepping in my Shoes:** A significant achievement has been the promotion and expansion of the programme across partner organisations. Engagement with Luton Borough Council resulted in strong support and the provision of multiple shadowing opportunities. This endorsement from a key local authority partner has enhanced the credibility and reach of the programme. A total of 26 learners were successfully matched with a sharer, and every learner completed a shadowing experience, either face-to-face or virtually. This programme has demonstrated clear success through high learner participation, effective adaptation to challenges, strengthened VCSE relationships, positive participant feedback, and increased organisational buy-in. These achievements highlight the programme's value and its potential for continued growth and long-term impact.

Leadership Development – 2025/26 saw the continuation and embedding of the BLMK ICS Leadership programme. This was developed for staff and outlines a range of national, regional and local programmes designed to enhance the leadership capabilities across the ICS. This includes, but is not limited to, the 'Springboard' leadership programme, Leading Beyond Boundaries Alumni Offer and Apprenticeships.

GP Educator Training - The Primary Care Training Hub (PCTH) has continued to expand the learning capacity in general practice through new educator training, development and retention. We have trained 26 new GP educators, approved 2 new learning sites and reapproved over 50 existing GP Educators and learning organisations. During the past year we have increased our GP educator numbers from 181 to 202 (11.6%), with an increase of 56% since 2021.

The PCTH delivered a 12-month development programme open to 171 educators to support embedding into new roles and refreshing existing skills. Early evaluation is positive and a second programme has been developed for delivery in 2026-27.

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 5 years, providing opportunities for student pharmacists to experience primary care placements during their summer break. Leading on behalf of 4 of the 6 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.

Continuing Professional Development - A comprehensive Continual Professional Development programme has been delivered to support Nursing and Allied Health Professional staff to maintain and develop vital clinical skills such as immunisations, women's health, Long Term Condition management and group consultations, supporting improved access for patients. By the end of the programme, at least 480 training places will have been offered.

Inspire Innovative Student Placements - Inspire innovative Nursing Student places are now fully embedded and 8 cohorts have been completed, supporting a total of 90 students since 2023. The innovative digital model provides focused practical learning for part of the placement and dedicated theory days managed by the ICB Training Hub.

We have taken the learning from this model and have developed a Paramedic programme with our first cohort expected in Spring 26.

A pilot providing digital placements for first year nurses has led us to go on to develop an in-reach teaching programme enabling us to teach Primary Care skills to whole year group through modern simulation learning suites. We will have reached over 100 first year nursing students through February and March. This has also helped promote General Practice Nursing as a first destination career. Quality Mark awarded for our clinical preceptorship programme last year, we have delivered a new programme of lunch and learn sessions covering a range of clinical and non-clinical skills.

Group Consultation Training - Primary Care teams in General practice are undergoing Group Consultation Training. The multi-professional teams and will work together to improve access for patients, improve QOF achievement, support patients to make health-related decisions and overcome some of the estate barriers to improving care. The programme provides 12-months expert support with learning sessions, coaching, simulation sessions and peer support.

Primary Care Leadership Development Programme - Launched in September 2025 and delivered by our Training Hub team our 6-month Primary Care Leadership Programme combines leadership thinking with practical skills for colleagues to lead on service design and delivery across BLMK PCNs. 34 participants from general practice, pharmacy and dental colleagues took part in the programme. The diversity of attendees ensured creative thinking and shared learning was taken back to practice. Feedback was exceptional and we will plan further programmes.

Our highly successful New to Practice Fellowship Programme has supported 30+ Fellows to understand the evolving landscape of primary care, identify how to have a positive impact on improving health inequalities and patient access within their practices and PCNs. Evaluation of the programme reports a significant improvement in their leadership and influencing skills, understanding of PCNs and population health management. Fellows also reported that they were more likely to stay working in general practice due to their time on the fellowship programme.

Protecting the Health and Wellbeing of our Workforce:

- **Staff Wellbeing Festival** – Following the success of its inaugural wellbeing festival in 2024, 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 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.
- **Health and Wellbeing Champions** – Following the appointment of 11 health and wellbeing champions within the ICB in 2024, the work has continued to embed the service. It provides a valuable listening and signposting service for staff. The champions also represent staff on a Health and Wellbeing Steering Group, feeding into decision making. This has been especially important and valued at this time of organisational change.
- **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.
- **Organisational Change Support** – The ICB is presently in a period of significant organisational change. The ICB has instigated a programme of support and initiatives to support its staff during this period. This includes skills and knowledge development via NHS Elect, Coaching, Talent Hub and CV and interview skills. Wellbeing is protected through focused career transition workshops, listening circles, Employee Assistance Programmes and external providers and regular communications via a variety of briefing mechanisms. Managers are supported to lead teams through additional support with managers training and activity packs. Trade Union Partner contact details are also promoted to staff.

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 its ongoing commitment to fostering best practices in 'Speaking Up', the ICB continues to require all staff to undergo training on raising concerns. Furthermore, the ICB acknowledges that it is currently undergoing a substantial period of change. To support employees and address potential issues, the ICB has promoted the Freedom to Speak Up service, implemented comprehensive communication strategies, and offered various forms of assistance focused on both skill development and staff wellbeing.

Financial review

This section of the Annual Report sets out a summary of the ICB's financial performance for the 2025/26 financial year.

The Annual Accounts have been prepared under directions issued by NHS England and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM). Further details on the ICB's financial performance can be found in the 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 foundation trusts. ICBs and partner NHS trusts and 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 2025/26 is set out in the following table. Further details are provided in Note 42 of the Accounts.

Matter	Target	Actual	Achieved
	£000s	£000s	
Maximum revenue resource use The revenue resource use for each Integrated Care Board in 2025/26 shall not exceed the amount specified.	2,719,818	2,707,863	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 2025/26 shall not exceed the amount specified.	21,357	20,850	Yes

During the 2025/26 financial period, the ICB received a £2719.8 million funding allocation from the DHSC, 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 2025/26. The ICB worked within the financial allocations set by NHS England, delivering a surplus of £11,955k.

The ICB's other financial duties include controlling the amount of spend on the administration function of the organisation. In 2025/26, the ICB spent £20.9 million in this area, which is within the planned spending target.

2026/27 Planning Guidance and Financial Outlook

NHS England has shifted from annual cycles to a multi-year planning framework covering 2026/27 to 2028/29, with aligned capital guidance to 2029/30. This is anchored in the 10-Year Health Plan and the move toward prevention, digital transformation and community-based care. The move from single-year planning to a medium-term approach has been enabled by the 3-year revenue settlement from the Spending Review 2025, and 4-year capital settlement. As part of this, revenue spending will increase by 3% in real terms over the course of the spending review period to 2028/29. However, to manage within the funding available, while delivering national and local priorities, the ICB will need to deliver stretching efficiency and productivity requirements.

From 2026/27 both ICBs and NHS trusts and foundation trusts will be required to deliver a breakeven revenue position as individual bodies, which reflects a change from the 2025/26 business rules where ICBs and NHS trusts were required to support the delivery of breakeven in aggregate across the system. However, ICBs and trusts must continue to collaborate to support the delivery of locally agreed priorities. As part of this, ICBs and trusts will be required to work together to agree plans that address the healthcare needs of the populations they serve, in accordance with national and local priorities, and ensure that resources are used effectively and efficiently in support of this. This includes each organisation taking proactive steps to ensure that plans are mutually aligned.

The financial duties of ICBs for the next three financial years are set out below:

Duty or Requirement	Description of Duty
ICB breakeven duty	Statutory duty to act with a view to ensuring expenditure does not exceed funding received. Deficit support funding will be removed by the end of the planning period, except in exceptional circumstances (where agreed by NHS England).
ICB revenue resource use limit	Statutory duty to comply with the limit set by NHS England.
ICB administration limit	Statutory duty to comply with the limit set by NHS England (referred to as ICB running cost allowance).
Better Care Fund (BCF)	Requirement to comply with the ICB funding conditions set by DHSC.
Mental Health Investment Standard (MHIS)	Requirement to comply with the ICB MHIS values set by NHS England.
Dental services ringfence	Requirement to comply with the ICB dental services ringfence values set by NHS England.

Payment System Reform

Work is underway to deconstruct block contracts with NHS providers and reform the NHS Payment Scheme. For 2026/27, a new payment model is being introduced for urgent and emergency care (UEC) comprising a fixed element (based on price x activity) and a variable element (roughly 20% of total payment).

New best practice tariffs on day cases, outpatients and more efficient ways of working will also be proposed as part of the 2026/27 NHS Payment Scheme. The UEC payment model will be further developed to incentivise shifting more care out of hospitals and into community settings, to be trialed with pilot sites in 2026/27.

A Fairer Distribution of Funding

A review of the NHS funding formula is underway which will seek to return system allocations to their corresponding fair share of resources. The pace of implementation will be balanced with ensuring finances are not destabilised in the short term.

NHS England are also reviewing the Carr-Hill formula for GP funding - another major component of NHS resource distribution. This review is intended to improve fairness by ensuring resource allocation reflects deprivation, population need and workload.

Organisational Change

During 2025/26 the ICB operated within a period of significant national restructuring, culminating in the confirmed abolition of NHS Bedfordshire, Luton and Milton Keynes ICB with effect from 1 April 2026 and establishment of the NHS Central East ICB which will assume all commissioning functions across Hertfordshire, Bedfordshire, Luton, Milton Keynes, Cambridgeshire and Peterborough. The ICB has focused significant capacity during the year on transition planning, ensuring continuity of commissioning, safe transfer of financial and contractual obligations and maintaining organisational stability during a period of unprecedented structural change. The assets and liabilities of the BLMK ICB will transfer to the new Central East ICB as a transfer by absorption.

In 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’. Commissioning responsibility for vaccination and screening will move to ICBs, likely from April 2027, subject to the passage of legislation. In 2026/27, NHS England will develop a commissioning and contracting framework covering these new responsibilities.

It is currently unclear what will happen to the remaining 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 and justice and armed forces commissioning. It is possible that responsibility for commissioning these services will be delegated to Integrated Care Boards in the future.

Joint Capital Resource Plan

As required under the National Health Service Act 2006 (as amended by the Health and Care Act 2022), Central East ICB has, in partnership with its NHS trusts and foundation trusts, prepared a [Joint Capital Resource Plan \(JCRP\)](#) ahead of the 2026/27 financial year. This plan sets out the system's agreed approach to capital resource use, ensuring alignment with the multi-year capital framework introduced through the Spending Review 2025 and the wider 10-Year Health Plan, which emphasises a more transparent, devolved and integrated model of capital planning across the NHS.

The JCRP supports strategic investment decisions that underpin local priorities, including modernisation of estate, digital transformation, diagnostics capacity and community-based service developments, while operating within the national Capital Departmental Expenditure Limit (CDEL). In line with statutory requirements, the plan will be shared with the local Health and Wellbeing Boards and NHS England, and the ICB will report progress against it.

The ICB is allocated an indicative GPIT and ICB BAU capital allocation by NHSE which it can bid for throughout the year and is subject to review and approval by NHSE. This capital allocation is intended to be utilised to cover any estates and GPIT requirements across Primary Care and the ICB (including IFRS16).

The ICB was also awarded a national capital allocation for Primary Care referred to as the Modernisation and Utilisation fund in 2025-26. This was intended to support primary care to expand capacity in its existing estate and within its current footprint. Practices submitted bids for small projects and following this a prioritisation process was undertaken by the ICB before awarding an allocation to successful practices.

Capital expenditure does not have revenue consequences for the ICB, as the asset is held by NHSE and depreciated through NHSE accounts. The ICB publishes an annual Joint Capital Resource Use plan which sets out the Integrated Care System plans for indicative and committed capital allocations published to each System Trust and the ICB at the beginning of the financial year. Indicative allocations are all subject to a business case process and approval by NHSE for Trusts or a PID process as set out above for the ICB. Trusts hold the capital awarded as an asset in their accounts and need to account for the revenue consequences of this capital in line with their depreciation policy. The plan for 2025/26 can be found at <https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-publications/plans-1/>

Delivery against the capital plan has been monitored through the ICB Finance and Investment Committee and Board. Providers also report delivery against their capital plans through their own governance arrangements. For 2026/27 ICBs are responsible for working with Regions to develop planned use of capital that aligns with ICB Strategic Commissioning Plans. They will need to lead the development of each case and ensure proposals are clinically led, contributing to delivery against NHS constitutional standards.

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 3 sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026 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.

Jan Thomas
Accountable Officer
17 June 2026

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.

Member's 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.

From 1 October 2025 to 31 March 2026 the ICB, working in partnership with NHS Cambridge and Peterborough ICB and NHS Herts and West Essex ICB, operated transitional governance arrangements which were approved by the Boards of all 3 organisations. The arrangements required changes to both the ICB's Constitution, which was approved by NHS England, and the ICB's [Governance Handbook](#) which was approved by the ICB Board.

These changes brought together the ICB Boards and Committees of each ICB, whilst maintaining the statutory obligations as independent legal entities. From October 2025, we operated Boards and Committees in Common or as Joint Committees. Whilst statutory Committees were retained, the Board established a number of new Joint Committees. These transitional arrangements have been reflected within this report.

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 - Name and role of Members of the Board of the ICB are set out in Appendix B to this section of the Annual Report.

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 ICB Board met 7 times during 2025/26 as follows:

2 May 2025

27 June 2025

26 September 2025

17 October 2025 (in Common)

28 November 2025 (in Common)

6 February 2026 (in Common)

27 March 2026 (in Common)

There was good attendance from all ICB Board Members. Attendance is recorded within the minutes for each meeting. The agenda, reports minutes of the meetings held in public are available on the ICB website [here](#) for 1 April 2025 to 30 September 2025 and [here](#) for 1 October 2025 to 31 March 2026.

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 (see page 80) are held to help to develop members' knowledge and to support team building and collaborative ways of working. The Remuneration Committee (see page 82) has responsibility for reviewing the talent on the Board and determining succession planning.

Seeking appropriate advice - As an ICB we have a duty to seek appropriate advice to work as effectively as possible, we seek advice in 2 main areas, clinical advice to support the prevention, diagnosis or treatment of illness and the protection or improvement of public health. We have clinically registered professionals on our Board to ensure the voice of clinicians is heard.

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 80 to 83. In exercising its functions, the ICB uses a range of sources and intelligence to ensure it makes the most effective decisions possible.

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.

Seminars held between April 25 and September 25 covered the following subject areas:

- Mount Vernon Cancer Centre Consultation and ICB/ICP Preliminary Position Statement
- Community and Mental Health Services, Ambitions
- Infrastructure Strategy
- Reconfiguration of the ICB
- 10 Year Health Plan
- Hospital Opportunities Assessment

Integrated Care Partnership - Each Integrated Care System is comprised of an Integrated Care Board (ICB) working with an Integrated Care Partnership (ICP) committee formed between health and care organisations, local government, and voluntary sector partners. ICPs are not statutory bodies. The role of the ICP Committee is to ensure that, within the resources available, local people experience the best possible care and are supported to access the services that best meet their needs. The ICP Committee will seek to use its position to influence the decisions of the ICB in endeavour to ensure that decisions are made in the best interests of the people living in Luton, Bedfordshire and Milton Keynes. The committee focuses on the person, rather than organisation and works with the ICB to protect those interests and promote co-production and collaboration as a core values.

Committees of the Board - The ICB Board was served by the following Committees throughout 2025/26. Following each meeting, these Committees produce 'Alert, Advise, Assure' reports for presentation at the meetings of the Board of the ICB. Copies of these reports are available on our public website [here](#) for 1 April 2025 to 30 September 2025 and [here](#) for 1 October 2025 to 31 March 2026.

The name and role of Members of Committees of the Board is set out in Appendix B to this section of the Annual Report.

There was good attendance at committee meetings which is recorded within the minutes of each meeting.

From 1 April 2025 to 30 September 2025

Audit and Risk Assurance Committee (Statutory) – Chaired by a Non-Executive Member. 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 .

Bedfordshire Care Alliance Committee (Non-Statutory) – Chaired by a Non-Executive Member. 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.

Following an independent review in early 2025 led by Carnall Farrar and following approval by the Board of the ICB the Committee was disbanded as an entity and Committee of the Board.

Finance and Investment Committee (Non-Statutory) – Chaired by a Non-Executive Member. 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.

Health and Care Partnership Committee (Non-Statutory) – Chaired by a local authority portfolio Holder.

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 co-ordination is needed on health and care issues.

Mental Health, Learning Disabilities and Autism Collaborative Committee (Non-Statutory) – Chaired by Non-Executive Member.

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](#).

Primary Care Commissioning and Assurance Committee (Non-Statutory) – Chaired by a Non-Executive Member.

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.

Quality and Performance Committee (Non-Statutory) – Chaired by a Non-Executive Member.

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.

Remuneration Committee (Statutory) – Chaired by a Non-Executive Member.

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).

1 October 2025 to 31 March 2026

Audit and Risk Committee (Statutory) – Chaired by a Non-Executive Member.

The Committee's purpose is to provide independent assurance on governance, risk management, internal control, and financial reporting. Key responsibilities of the Committee are to oversee internal and external audit processes; monitor risk management frameworks including deep dives on system-wide risks; review financial statements and governance reports; ensure compliance with statutory and regulatory requirements [Information Governance, Cyber Security, EPRR, Annual Report and Annual Accounts including Annual Governance Statement, Freedom to Speak Up], provide Integrated Care Partnership assurance.

Remuneration and Workforce Committee (Statutory) – Chaired by a Non-Executive Member.

The Committee's purpose is to oversee Executive and Director (VSM) pay, performance, and workforce strategy aligned with NHS People Plan. Key responsibilities of the Committee are to set remuneration and terms for senior executives; monitor workforce planning, recruitment, and wellbeing; compliance with the Fit and Proper Persons Test (FPPT); promote equality, diversity and inclusion and compliance with Workforce Race Equality Standards (WRES)/Workforce Disability Equality Standard (WDES).

Finance Planning and Payer Function Committee (Non-Statutory) – Chaired by a Non-Executive Member.

The Committee's purpose is to ensure financial sustainability and value-based commissioning aligned with population health needs. Key responsibilities of the Committee are to oversee the payer function; oversee financial planning, budget setting and monitoring financial performance; approve major investments and business cases; monitor commissioning outcomes and contract performance; align resources with strategic priorities; approve Health Care Partnership assurance investment; oversee utilisation of research opportunities.

Bedfordshire, Luton and Milton Keynes Neighbourhood Health Delivery Committee – Chaired by a local authority representative and **Cambridge and Peterborough (C&P) Neighbourhood Health Delivery Committee** – Chaired by a non-executive.

The Committee's act as the Integrated Care Partnership Committees of the BLMK and C&P Boards during the transitional arrangements and are responsible for delivering care closer to home; Responding to local priorities; Improving health equity and Enhancing accountability and transparency in how services are planned and delivered.

Utilisation Management and Quality Improvement Committee (Non-Statutory) – Chaired by a Non-Executive Member.

The Joint Committee's purpose is to provide assurance on the quality, safety, and performance of commissioned services. The Committee's key responsibilities are to monitor clinical effectiveness, patient safety, and patient experience across all ICB Commissioned services including primary care; oversee safeguarding, serious incidents, utilisation management and quality improvement; review outcomes against NHS constitutional standards; assure Equality impact and consideration of population health risk of ICB commissioned services; review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, safety, effectiveness, access, equity, acceptability, and relevance.

Management Executive Committee:

The Joint Committee's purpose is to be responsible for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective co-ordination across executive functions and supports the CEO in discharging their responsibilities to the Board. The Committee provides executive leadership and oversight of day-to-day operations including performance, finance, workforce, and quality metrics; ensures delivery of the ICB's strategic and operational plans; co-ordinates cross-functional initiatives and transformation programmes; supports the development of Committee/Board papers and assurance reports; oversees the Board Assurance Framework and Corporate Risk Register and ensures alignment with NHS priorities and statutory obligations.

Register of Interests

The ICB maintains a [Register of Interests](#) which is published on the public website. 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 pages 93 to 94.

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 2025 to 31 March 2026, 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 (BLMK ICB) and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

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

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of BLMK ICB. 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 BLMK ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that BLMK ICB'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.

Jan Thomas, Accountable Officer
17 June 2026

Governance Statement

Introduction and context

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

The ICB'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 2025 and 31 March 2026 the ICB 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 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 the 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 the ICB 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 (from page 77) details the composition of the Board. A description of the purpose of the statutory and non-statutory committees established by the Board are provided in the Members Report from pages 80 to 83. The full terms of reference for each committee is available in the ICB's [Governance Handbooks](#). A list of voting members of each committee is provided as Appendix A to the Accountability Section of this Annual Report.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. Whilst the detailed provisions of the UK corporate governance code are not mandatory for public sector bodies, compliance is considered good practice.

In line with the UK corporate governance code, we conducted a Board and Statutory Committee Effectiveness Survey in Quarter 4 of 2025/26. This was based on the transitional governance arrangements described above which were in place from 1 October 2025. Key themes from the survey are set out below:

- Strategic focus and leadership – Boards and Statutory Committees demonstrate strong strategic intent and leadership, with recognised need for sufficient time to explore complex and high-risk issues in depth.
- Governance roles and clarity – Governance arrangements are broadly understood, with some ongoing need for clarity around roles, responsibilities as decision-making arrangements continue to evolve.
- Papers and agenda management – The volume timing and length of papers can limit effective scrutiny across Boards and Committees with members seeking more concise, purpose-drive reporting.
- Culture, challenges, and relationships – Culture is generally seen as open and respectful, though the size of meetings held in common and the pace of changes can affect consistent participation and challenge.
- Governance development and maturity – There is strong support for structured development to build shared understanding, role clarity and effective challenge as arrangements move forward to a single ICB.

The outcomes of the effectiveness survey were reported to the ICB Boards in Common at the end of March 26. A small number of actions were proposed as a result of the Survey and these will be taken forward by the new Central East ICB.

Regular review of the new Governance Framework and continuing effectiveness monitoring will continue to be a priority for Central East ICB. Board Development will be incorporated into the overall Organisational Development Programme. The Organisational Development & Delivery Team will be responsible for building organisational capability, culture and performance structures to keep promises and sustain delivery and will be responsible for taking forward the ICB's organisational development programme, including Board Development.

Specific focus for the Board will include ensuring mandatory Board training is undertaken, recognising statutory responsibilities, as well Board oversight and involvement on the delivery of Central East ICBs Strategy 'Our Way'. There will be strong focus on effective appraisals for all staff, Executive and Non-Executive Directors. The new ICB will also embark on a series of Orientation Days. These will commence in May/June 2026.

Discharge of Statutory Functions

The 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 are 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

Risk management arrangements and effectiveness

During 2025/26, the ICB continued to strengthen and modernise its approach to risk management, embedding risk governance aligned with national expectations and preparing for the major organisational and functional changes planned for April 2026 under the national ICB reform programme.

The ICB's risk management framework provides a consistent and structured approach to identifying, assessing, escalating, and mitigating risks across the organisation and wider Integrated Care System (ICS). It sets out clear processes for risk capture, evaluation, and control design, enabling Directorates and system partners to identify and act on emerging threats, including those arising from pressures on system finances, workforce, operational performance and changes to national policy.

Every Director remains responsible for ensuring that risks within their areas are actively managed and recorded on Directorate or Programme risk registers, with escalation to the Corporate Risk Register (CRR) or System Risk Register/Board Assurance Framework (SRR/BAF) where risks carry strategic, cross-ICB, or statutory implications. The CRR provides organisational oversight of high-impact risks, while the BAF/SRR captures the principal risks capable of affecting delivery of the ICB's long-term strategic objectives.

In 2025/26, the risk management processes were further refined to reflect updated national NHS governance requirements, including:

- **The 2025/26 NHS Oversight Framework**, which introduced a revised approach to how NHS England assesses ICBs and providers, emphasising financial sustainability, productivity, and operational recovery while suspending formal ICB segmentation ratings for the year.
- **National ICB reform and boundary changes**, with mergers and structural adjustments scheduled to take effect from **1 April 2026**, requiring the ICB to plan for changes in accountability, governance, and the redistribution of certain commissioning and assurance functions.
- **The Model ICB Blueprint (2025)**, which clarified the future role of ICBs as streamlined strategic commissioners, requiring a shift in functions, workforce, and governance arrangements.

In response to these changes, BLMK ICB undertook preparatory alignment of internal processes, governance cycles and committee oversight functions, ensuring that risk management remained robust, proportionate and capable of supporting the transition to the new operating environment from 2026/27.

Capacity to Handle Risk

The full BAF/SRR is reported to each meeting of the Board of the ICB and available on our public website [here](#) for 1 April 2025 to 30 September 2025 and [here](#) for 1 October 2025 to 31 March 2026.

The last BAF/SRR report to the Board of the ICB for the 2025/26 reporting period is available [here](#) and provides details of controls, mitigations and actions taken throughout the 2025/26 reporting period. As of 31 March 2026, the BAF/SRR contained **19 strategic risks**, of which **16** were rated high (see table below). This profile reflects both ongoing system pressures and risks from national reform requirements.

Risk Ref	Risk Title	Current Risk Rating
BAF0001	Recovery of Elective Services	20
BAF0002	Developing suitable workforce	12
BAF0003	Pressure on Urgent and Emergency Care (UEC) in the BLMK System	12
BAF0004	Widening Inequalities	16
BAF0005	System Transformation	20
BAF0006	Financial Sustainability & Underlying Financial Health	20
BAF0007	Climate Change: Health, inequality and healthcare service impacts from Climate Change and environmental degradation	16
BAF0008	Impact of Population Growth on Health and Care Services Infrastructure	20
BAF0009	Impact of Rising Cost of Living on Residents and Staff Wellbeing	16
BAF0010	Partnership Working	9
BAF0011	Health literacy - Denny Review	16
BAF0012	System Collaboration	9
BAF0013	VCSE sustainability	16
BAF0014	Maternity Services at BHFT	16
BAF0015	Failure to Deliver the Operational and Financial Plan	16
BAF0016	ICB Reconfiguration and potential destabilisation of BLMKs ICB's delivery and impact on statutory function delivery	20
BAF0017	Data Security Breach within or impacting BLMK	20
BAF0021	Estates & Infrastructure	9
BAF0022	Achieving Net Zero	12

Each strategic risk is overseen by a designated committee of the Board. Committee oversight includes regular review of control effectiveness, assurance levels, and progress against agreed action plans.

Throughout 2025/26, the ICB strengthened its capability to manage risk through:

- Improved analytical insight supporting Key Risk Indicators (KRIs) and the predictive identification of deteriorating risk conditions
- Strengthened cross-ICB collaboration in response to system pressures
- Early preparation for structural and functional changes associated with the 2026 ICB merger/boundary adjustments
- Continued focus on risks associated with financial balance, as required by the national mandate for systems to deliver a breakeven or surplus position in 2025/26

Expanding the Risk Landscape - During 2025/26, new and emerging risks were recognised at system level in response to both external and internal pressures:

1. Organisational Change and ICB Boundary Reform - National changes to ICB footprints, mergers and boundary adjustments taking effect from April 2026 introduced a significant risk relating to governance continuity, leadership capacity, accountability arrangements and operational stability during transition. These changes will redefine local commissioning responsibilities, necessitate new governance structures, and require the ICB to manage workforce, financial and functional transfers safely.

2. Strategic Commissioning Transition (Model ICB) - The publication of the Model ICB Blueprint and the new Strategic Commissioning Framework clarified that from 2026/27 ICBs will become streamlined strategic commissioners, with many operational functions transferring to providers or regional teams. This created new strategic risks relating to:

- functional transfers
- workforce redesign and capacity gaps
- assurance changes
- market management capability

3. Financial Sustainability and Productivity - The 2025/26 national mandate and oversight framework placed a renewed emphasis on productivity, cost reduction, and financial balance, increasing the risk around achieving required efficiencies and the ability to sustain service quality and transformation.

4. Quality of Care (National Risk Shift) - National risk assessments highlighted an improvement in the impact score for the strategic risk relating to quality of care at NHS England level, affirming local work with system partners to improve quality governance and patient flows. However, while improvements have been made local system level pressures persisted, particularly in urgent and emergency care, maternity, mental health, and primary care, which continued to shape BLMK's own risk landscape.

Risk Assessment

Dynamic Risk Management (DRM)

The ICB continued to advance its use of Dynamic Risk Management (DRM) as a central operating principle. DRM enables continuous assessment of risk conditions and supports rapid, real-time responses to emerging challenges across the system. It incorporates horizon scanning, KRIs, and predictive modelling techniques.

A key example in 2025/26 was the use of urgent and emergency care KRIs, supported by a predictive modelling tool, which informed the development of the winter and resilience plans.

The adoption of DRM also aligned with national expectations on more agile and data-driven approaches to risk management, including enhanced requirements to link risk assessments to cyber-security and information governance controls as part of the 2025/26 Data Security and Protection Toolkit/ Cyber Assessment Framework transition.

Summary

The 2025/26 year was one of significant change for the ICB, both operationally and strategically. Against a backdrop of national NHS reform, financial constraints and increased oversight expectations, BLMK ICB continued to strengthen risk governance, embed dynamic risk management, and prepare for the forthcoming transition to the new strategic commissioning model and revised ICB arrangements from April 26.

The ICB remains committed to further enhancing its risk management maturity, ensuring the system can respond effectively to uncertainty and maintain its focus on improved outcomes for the population it serves.

Emergency Preparedness response and Resilience (EPRR)

The ICB has responded to or supported a wide range of incidents during the 2025/26 reporting period. 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 Local Health Resilience Partnership and / or Local Resilience Forum 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.

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](#) and as described in the following sections of this Accountability Report:

- Composition of the Board – see pages 80 to 83
- Composition and purpose of Committees of the Board of the ICB – see pages 80 to 83.
- System Risk Management/Board Assurance Framework – see pages 87 to 90.
- Internal Audit – see pages 91 to 93.
- Counter Fraud – see pages 93 to 94.

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 2025 to 31 March 2026 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:

'Generally Satisfactory with improvements required in some areas....Overall, the controls in the areas we examined were found to be suitably Design and operating effectively to achieve the specific risk management, control and governance arrangements and value for money. However, there are some areas where weaknesses and/or non-compliance were identified and, therefore, may put the achievement of objectives at risk. Where weaknesses have been identified, improvements are required to enhance the design and/or effectiveness of risk management, control and governance arrangements.'

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

Area of Audit		Level of Assurance/Opinion (see legend of page 93)	
		Design	Operational Effectiveness
*Section 117 and Specialised Hospital Beds		Limited 	Limited 
IT Benefits Realisation		Moderate 	Moderate 
Key Financial Systems	³ ISFE1	Substantial 	Substantial 
	ISFE2	Moderate 	Moderate 
Data Security and Protection Toolkit		Substantial 	Substantial 
ICB Transition - Contracts		Moderate 	Moderate 
Population Health Inequalities		Moderate 	Moderate 

*On 20 February the Audit and Risk Committee was presented with a S117 and Specialist Hospital Beds Progress Report. This report provided the Committee with assurance that work has and continues to be undertaken to address the findings of the audit, including the need for sensitive discussions with local authority partners.

³ Integrated System Finance Environment 1 and 2

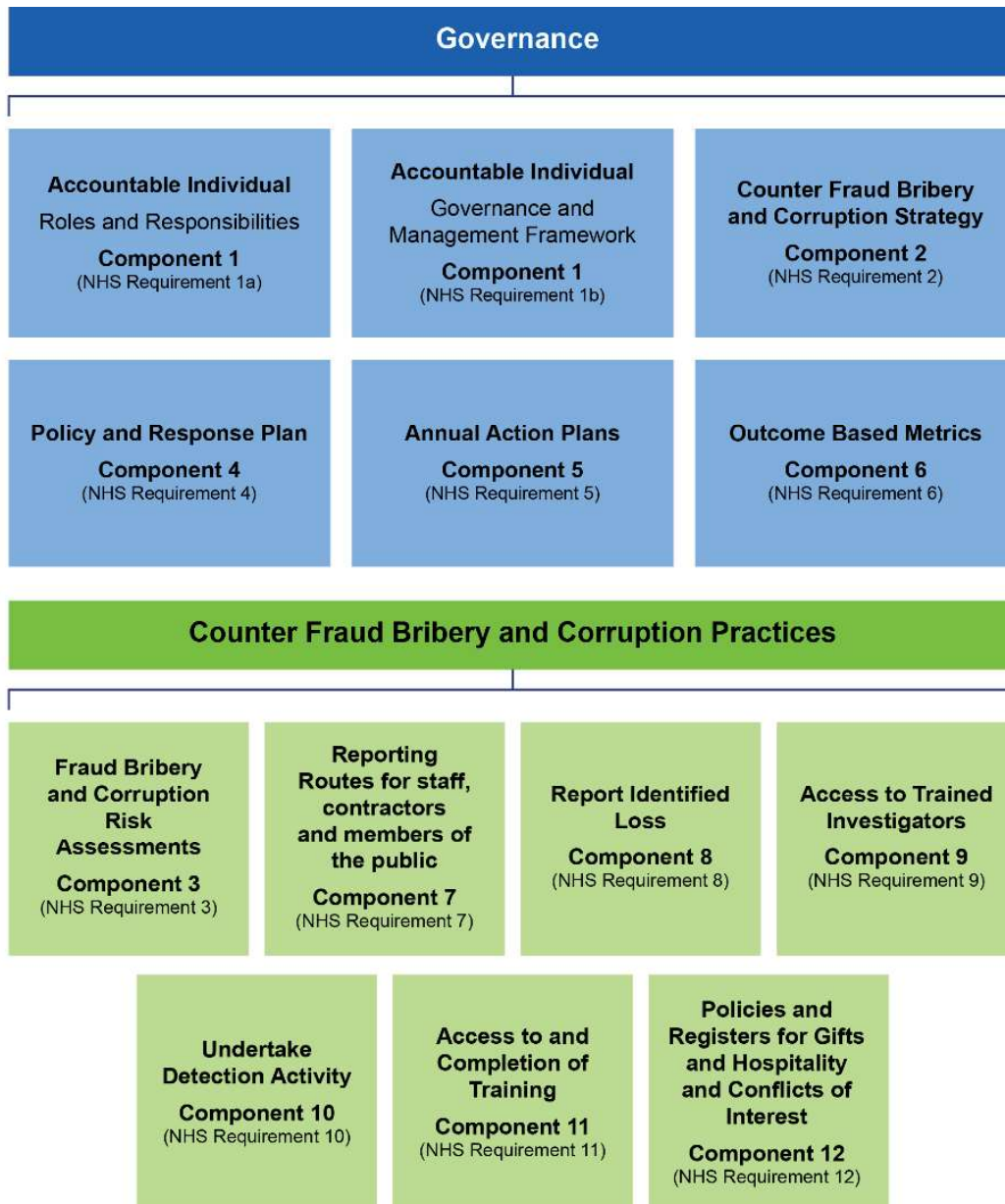
Legend:

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.

Counter Fraud Arrangements

During 2025/26, 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 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 Committee.



The LCFS attended all meetings of the Audit and Risk 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 is a Cabinet Office led exercise across the entire public sector, held every 2 years which helps to prevent and detect fraud and identify undeclared interests by matching people with payroll assignments in more than 1 public sector role; 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 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 were investigated accordingly by the ICB's LCFS.

Data Quality

The BLMK ICB's mobilisation of its new data quality policy in 2024/25 has been pivotal for ensuring effective commissioning and high-quality patient care. The policy, which mandates contracted providers to uphold national data quality standards, has enhanced data validation and management processes so that information remains complete, accurate, relevant, and timely. This has enabled the ICB to fulfil statutory, legal, and financial obligations and improved oversight of providers through contractual mechanisms.

During 2025/26, data quality queries, primarily concerning coding and completeness were actively tracked and addressed. The ICB's governance structure, including multidisciplinary team meetings and provider level reviews, ensured ongoing monitoring and resolution of issues. Risk assessments indicate most concerns were medium or low risk, with no high-risk issues identified.

The policy's mobilisation is supported by contract Schedule 6B Data Quality Improvement Plans (DQIPs), which are tailored to address specific areas identified in data quality logs, respond to new legislative and local requirements, and manage provider system changes. Progress is monitored via dashboards and discussed at data quality and contract review meetings, ensuring continuous improvement and accountability.

Confidence in data quality is highest among NHS providers, who benefit from mature digital systems. Independent sector and non-acute providers are making progress, aided by collaborative efforts between the ICB, and providers. The mobilisation of the new data quality policy has established robust foundations for accurate reporting, effective waiting list management, and invoice validation, supporting the ICB's strategic objectives and compliance requirements.

Information Governance

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

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

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

All organisations with 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 information governance toolkit, known as the [Data Security and Protection Toolkit](#) (DSPT) is an online self-assessment tool to measure performance against the [National Cyber Security Centre's Cyber Assessment Framework](#) (CAF). The DSPT requirements are reviewed and updated as the data security standards evolve. The scope of the 2025/26 DSPT includes 10 cyber security and information governance requirements split into 72 contributing outcomes, each of which are supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'.

An internal audit of the ICB's position against the 2025/26 DSPT was undertaken in February / March 2026. The outcome of this audit concluded 'Risk Level' as 'Low' and 'Confidence Level' as 'High.'

In line with the timeline mandated by NHS England the ICB performed a final submission of the 2025/26 DSPT in March 26 with overall level of achievement as 'Standards Met'. Further information on our submissions can be found [here](#)

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

Set out in the table below are the significant control issues and pressures that were identified by the ICB within the Month 9 Governance Statement submitted in January 2026, together with the remedial action that has been undertaken or is in progress. An update on progress is included.

Control Issue	Month 9 Position (31 December 2025)	Position at 31 March 2026
Finance, Governance and Control – Finance and Procurement	The transition to the new NHS financial system (ISFE2) in Autumn 2025 has been challenging. BLMK ICB, in common with other ICBs, have experienced a challenging go-live period. The ICB has experienced payment issues impacting providers (with potential Better Payment Practice Code (BPPC) compliance impacts) and issues with some ISFE2 functionality and reporting. The ICB is working with NHS Shared Business Services (SBS) to support improvements.	The transition to the new NHS financial system (ISFE2) in Autumn 2025 was challenging. BLMK ICB, in common with other ICBs, experienced a difficult go live period. The ICB experienced delays in making payments to Providers and issues with some ISFE2 functionality and reporting. Although some improvements have been seen, there remain a number of issues still to be resolved. The ICB continues to work with NHS SBS and NHS England to support improvements.
Finance, Governance and Control - Other	The ICB has been asked to reduce its running costs to £19 per head of population from April 2026. Accordingly, the ICB is currently undertaking both voluntary and compulsory redundancy schemes. This will result in a significant number of staff leaving the organisation in the coming months. The ICB considers there is a risk as due to the number of staff leaving in a short space of time and the impact this could have on the business of the ICB, whilst all staff are re-organised. The ICB has mitigations in place with regard to this risk which include clear timelines and handover processes for staff who are leaving. The ICB also has its senior management team in place who are not affected by this change, having already been re-organised during 2025.	As of 31 March 2026 and the dissolution of BLMK ICB, the organisational reconfiguration continues into the new Central East ICB. The ICB is currently continuing to recruit to the new structure, with slotting in finalised and interviews for competitive slot ins concluding over the next few weeks. An Assessment Centre is in place to manage to the next stages of the reconfiguration. Voluntary redundancy arrangements have been finalised. The ICB will be in a better position to understand the number of compulsory redundancies that will be required by the end of Quarter 1 (2026/27). The new Central East ICB will continue to have mitigations in place to manage the business which includes clear timelines and handover processes for staff that are leaving.

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

The Board of the ICB has overarching responsibility for ensuring the organisation has appropriate arrangements in place 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 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 (from October 2025, Finance Payer and Performance) and Quality and Performance (from October 2025, Utilisation Management and Quality Improvement) 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 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 Committee.

Commissioning of delegated services (primary care services and specialised services)

The ICB has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating [either directly or via multi-ICB working arrangements where relevant] 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.

On 22 March 2024 the Board of the ICB agreed to delegate certain functions to the Primary Care Delivery Group. An assurance report will be provided from the Primary Care Delivery Group to Primary Care Commissioning and Assurance Committee at every meeting. In October 2025 the functions of the Primary Care Delivery Group and Primary Care Commissioning and Assurance Committee were combined to the BLMK Primary Care Commissioning and Assurance Programme Board. This reports to the Neighbourhood Health Delivery Committee BLMK.

During 2025/26 no issues raised through the whistleblowing/Freedom to Speak Up route have related to delegation arrangements.

Enquiries, Concerns, Freedom of Information

The ICB's Enquiries & Experience Team oversees all enquiries, concerns, complaints, and Freedom of Information (FOI) requests, this is in addition to providing advice and support to residents who have queries or complaints about NHS commissioned provider services, including GP, dental, pharmacy, acute and community services.

Enquiries and Concerns - 2,221 general enquiries, including general information requests and signposting, accounted for just over 58% (1,284), while 42% (937) were recorded as concerns. Review of the contacts received during the reporting period identified the following 5 recurring themes:

- Primary care access (GP services and registration)
- NHS dental access
- Vaccinations, particularly COVID-19 for housebound patients
- Medication and prescribing issues
- Mental health pathways (ADHD and autism)

Members of Parliament Enquiries - 137 enquiries were received, the majority related to GP access and queries regarding the ICB's plans to improve primary care provision across the area. These concerns closely mirrored the themes identified through enquiries and complaints, particularly access to GP services, delays, and communication issues.

Complaints – 93 formal complaints were received, of which 40 related to GP services and 25 to Continuing Healthcare (CHC).

Freedom of Information Requests - 364 FOI requests were received, reflecting continued public interest in the ICB's commissioning activity, governance, and decision-making processes.

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
- Committees of the Board, including Audit and Risk 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 Section 117 and Specialised Hospital Beds audit as detailed in the Head of Internal Audit Opinion section – see pages 91 to 93.

2025/26 has also been the year when the ICB has been asked to reduce its running costs to £19 per head of population in preparation for 1 April 2026. Accordingly, the ICB embarked on a significant reconfiguration programme during this year, and as we move into the new financial year, and the creation of a new Central East ICB, we are concluding the outcomes of the staff consultation and the creation of a new Organisational Structure. This has/will resulted in a significant number of staff leaving the organisation as we conclude the end of the financial year and move into 2026/2027. The ICB considers there is a risk as due to the number of staff leaving in a short space of time and the impact this could have on the business of the ICB, whilst all staff are re-organised. The ICB has mitigations in place with regard to this risk which include clear timelines and handover processes for staff who are leaving. The ICB also has its Executive Management Team in place who are not affected by this change, having already been re-organised during 2025.

As I conclude our Annual Governance Statement for 2025/26, I recognise that this will be the last 1 for BLMK ICB. During times of significant change, staff have continued to maintain focus on maintaining effective governance arrangements and ensuring the local health and care system partnership remains responsive to the needs of our local population.

Appendix A

The following table provides a list of Voting Members of the Board from 1 April 2025 to 30 September 2025.

Where relevant, 'until' dates have been provided for individuals whose BLMK ICB Board Membership ended between 1 April 2025 and 30 September 2025.

Name	Role (BLMK ICB role unless otherwise stated)
Robin Porter	Non-Executive Chair
Felicity Cox ⁴	Chief Executive Officer (Until 30.9.25)
Alison Borrett	Non-Executive Member
Michael Bracey	Local Authority Partner Member (Chief Executive, Milton Keynes Council) (Until 30.9.25)
David Carter	NHS Trust Partner Member (Chief Executive, Bedfordshire Hospitals NHS Foundation Trust) (Until 30.9.25)
Laura Church	Local Authority Partner Member (Chief Executive, Bedford Borough Council) (Until 30.9.25)
Marcel Coiffait	Local Authority Partner Member (Chief Executive, Central Bedfordshire Council) (Until 30.9.25)
Mark Fowler	Local Authority Partner Member (Chief Executive, Luton Borough Council) (Until 30.9.25)
Manjeet Gill ⁵	Non-Executive Member and Deputy Chair (Until 30.9.25)
Ross Graves	NHS Trust Partner Member (Chief Strategy and Digital Officer at Central and North West London NHS Foundation Trust) (Until 30.9.25)
Prof. Joe Harrison	NHS Trust Partner Member (Chief Executive Milton Keynes University Hospital)
Omotayo Kufeji	Primary Medical Services Partner Member
Vineeta Manchanda	Non-Executive Member
Shirley Pointer ⁶	Non-Executive Member (Until 30.9.25)
Dr Andrew Rochford	Chief Medical Director (Until 30.9.25)
Mahesh Shah	Primary Medical Services Partner Member (Until 30.6.25)
Sarah Stanley	Chief Nurse
Sahadev Swain	Primary Medical Services Partner Member (Until 30.9.25)
Dean Westcott ⁷	Chief Finance Officer (Until 30.9.25)

⁴ Felicity Cox – employment with BLMK ICB ended on 31.12.25

⁵ Manjeet Gill – non executive membership for BLMK ICB ended on 31.12.25

⁶ Shirley Pointer - non executive membership of BLMK ICB ended on 3.12.25

⁷ Dean Westcott – employment with BLMK ICB ended on 31.1.26

From 1 April 2025 to 30 September 2025 the Board was supported by the following non-voting Board Participants:

Name	Role
Elizabeth Elliot	Interim Director of Public Health, Luton Council (Until 1.8.25)
Vicky Head	Director of Public Health, Borough, Central Bedfordshire and Milton Keynes (Until 30.9.25)
Lorraine Mattis	Associate Non-Executive Member (Until 30.9.25)
Kelly O'Neill	Director of Public Health, Luton Council (From 1.8.25 to 30.9.25)
Nicky Poulain ⁸	Chief Primary Care Officer (until 30.4.25)
Martha Roberts ⁹	Chief People Officer Until (Until 30.9.25)
Maxine Taffetani	Healthwatch (Until 30.9.25)
Maria Wogan	Chief of Strategy and Assurance (Until 30.9.25)
Councillor Khtija Malik or Councillor Martin Towler	Luton Borough Council Co Chair, Health and Care Partnership (Until 30.9.25) Bedford Borough Council Co Chair, Health and Care Partnership (Until 30.9.25)

⁸ Nicky Poulain – employment with BLMK ICB ended on 30.4.25

⁹ Martha Roberts – employment with BLMK ICB ceased on 16.4.2026

The following table provides a list of Members of the Board from 1 October 2025 to 31 March 2026.

Name	Role (ICB role unless otherwise stated)
Robin Porter*	Non-Executive Chair
Jan Thomas*	Chief Executive
Karen Barker*	Transition Director and Executive Director of Corporate Services
Alison Borrett**	Non-Executive Member
Michael Bracey	Local Authority Partner Member (Chief Executive, Milton Keynes Council)
David Carter	NHS Trust Partner Member (Chief Executive, Bedfordshire Hospitals NHS Foundation Trust)
Dorothy Gregson**	Non-Executive Member
Sarah Griffiths*	Executive Director of Finance, Resources and Contracting
Prof Joe Harrison	NHS Trust Partner Member (Chief Executive Milton Keynes University Hospital)
Dr Fiona Head*	Executive Clinical Director Utilisation Management (Medical Director)
Sarah Hughes**	Non-Executive Member
Louis Kamfer*	Executive Director of Strategy, Planning and Evaluation
Omotayo Kufeji	GP, Primary Medical Services Partner Member
Vineeta Manchanda**	Non-Executive Member
Prof. Gurch Randhawa**	Non-Executive Member
Sarah Stanley*	Executive Clinical Director Total Quality Management
Kate Vaughton*	Executive Director for Neighbourhood Health, Place and Partnerships

*Joint appointment with C&P ICB and H&WE ICB

**Joint appointment with C&P ICB

Appendix B

The table on the next page provides a list of Members of the following Committees of the Board from 1 April 2025 to 30 September 2025.

- Audit and Risk Assurance Committee (A&A)
- Bedfordshire Care Alliance Committee (BCA)
- Finance and Investment Committee (F&I)
- Mental Health Learning Disabilities and Autism Collaborative Committee (MHLDA)
- Primary Care Commissioning and Assurance Committee (PCCA)
- Quality and Performance Committee (Q&P)
- Remuneration Committee (REM)

Name	Role/Job Title	A&RA	BCA	F&I	MHLDA	PCCA	Q&P	REM
Lisa Benn	Service user/carers representative				✓			
Alison Borrett	Non-Executive Member	✓				✓	✓	✓
Jill Britton	Director of Adult Services, Luton Borough Council		✓					
David Carter	Chief Executive, Bedfordshire Hospitals NHS FT		✓					
Laura Church	Chief Executive, Bedford Borough Council		✓					
Marcel Coiffait	Chief Executive, Bedford Borough Council		✓					
Felicity Cox ¹⁰	Chief Executive Officer (until 30.9.25)		✓					
Mark Cox	Service user/carers representative				✓			
Dr Simon Edwards	Medical Director, Central and North West London NHS FT				✓			
Mark Fowler	Deputy Chief Executive, Luton Borough Council		✓					
Richard Fradgley	Executive Director of Integrated Care and Deputy Chief Executive, East London NHS Foundation Trust				✓			
Manjeet Gill ¹¹	Non-Executive Member (until 30.9.25)	✓		✓		✓		✓
Ross Graves	Chief Strategy and Digital Officer, Central and North West London NHS Foundation Trust				✓			
Dr Omotayo Kuefji	Primary Medical Services Board Member					✓		
Sophie Lonsdale	Service user/carers representative				✓			
Vineeta Manchanda	Non-Executive Member	✓			✓		✓	✓
Claire McKenna	Interim Chief Nurse, East London NHS FT				✓			
Claire Murdoch	Chief Executive, Central and North West London NHS FT				✓			
Shirley Pointer ¹²	Non-Executive Member (until 30.9.25)		✓				✓	✓
Nicky Poulian ¹³	Chief Primary Care Officer (until 30.4.25)					✓	✓	
Robin Porter	Chair of the ICB			✓	✓			✓
Dr Andrew Rochford	Chief Medical Director and Caldicott Guardian (until 30.9.25)			✓	✓	✓	✓	
Martha Roberts ¹⁴	Chief People Officer (until 30.9.25)						✓	
Mahesh Shah	Primary Medical Services Board Member (until 30.6.25)					✓	✓	
Sarah Stanley	Chief Nurse			✓	✓	✓	✓	
Lorraine Sunduza	Chief Executive Officer, East London NHS FT		✓		✓			
Dr Sahadev Swain	Primary Medical Services Board Member (until 30.9.25)						✓	
Kate Walker	Director of Adult Social Care, Bedford Borough Council		✓					
Dean Westcott ¹⁵	Chief Finance Officer (until 30.9.25)			✓	✓	✓		
Deborah Wheeler	Vice Chair, East London NHS FT				✓			
Mathew Winn	Chief Executive, Cambridge Community Services NHS Trust		✓					
Maria Wogan	Chief of Strategy and Assurance				✓		✓	

¹⁰ Felicity Cox – employment with BLMK ICB ended on 31.12.25

¹¹ Manjeet Gill – non executive membership for BLMK ICB ended on 31.12.25

¹² Shirley Pointer - non executive membership of BLMK ICB ended on 3.12.25

¹³ Nicky Poulain – employment with BLMK ICB ended on 30.4.25

¹⁴ Martha Roberts – employment with BLMK ICB ceased on 16.4.26

¹⁵ Dean Westcott – employment with BLMK ICB ended on 31.1.26

The table on the next page provides a list of Members of the following Committees of the Board from 1 October 2025 to 31 March 2026.

- Audit and Risk Committee (A&R)
- Finance Planning and Payer Function Committee (FPPF)
- Management Executive Committee (ME)
- Neighbourhood Health Delivery Committee BLMK (BLMK NHD)
- Neighbourhood Health Delivery Committee Cambridge & Peterborough (C&P NHD)
- Remuneration and Workforce Committee (REM)
- Utilisation Management and Quality Improvement Committee (UMQI)

Name	Role/Job Title/Organisation (ICB Roles unless otherwise stated)	A&R	FPPF	ME	BLMK NHD	C&P NHD	REM	UMQI
Karen Barker*	Transition Director and Executive Director of Corporate Services		✓	✓				
Alison Borrett**	Non-Executive Member	✓	✓		✓		✓	
Michael Bracey	Chief Executive, Milton Keynes Council				✓			
David Carter	Chief Executive, Bedfordshire Hospitals NHS FT				✓			
Laura Church	Chief Executive, Bedford Borough Council				✓			
Stacie Coburn*	Director of Contracts and Performance			✓				
Marcel Coffait	Chief Executive, Central Bedfordshire Council				✓			
Elizabeth Disney*	Director of Strategic Planning and Commissioning (From 2.3.26)			✓				
Beverly Flowers*	Director of Strategic Planning and Commissioning (Until 31.12.25)			✓				
Mark Fowler	Interim Chief Executive / Corporate Director, Population Wellbeing, Luton Council				✓			
Ross Graves	Chief Strategy and Digital Officer, Central North West London NHS FT				✓			
Pam Green*	Director of Neighbourhood Health Places and Partnerships for Cambridge and Peterborough			✓		✓		
Dorothy Gregson**	Non-Executive Member	✓	✓					
Sarah Griffiths*	Executive Director of Finance, Resources and Contracting		✓	✓				
Prof Natalie Hammond*	Director of Safeguarding and Complex Care (Until 22.3.26)			✓				✓
Joe Harrison	Chief Executive, Milton Keynes University Hospital NHS Trust				✓			
Dr Fiona Head*	Executive Clinical Director Utilisation Management (Medical Director) and Caldicott Guardian		✓	✓				✓
Sarah Hughes**	Non-Executive Member						✓	✓
Louis Kamfer*	Executive Director of Strategy, Planning and Evaluation		✓	✓				✓
Ed Knowles*	Director of Neighbourhood, Place and Partnerships for Hertfordshire (From 18.2.26)			✓				
Emma Kriehn-Morris*	Director of Finance			✓				
Dr Omotayo Kufeki	GP (Primary Medical Services)				✓			
Vineeta Manchanda**	Non-Executive Member	✓						✓
Tania Marcus*	Director of People and Culture			✓				
Andrew Palmer*	Director of Population Health, Analytics and Evaluation			✓				
Robin Porter*	Chair, BLMK ICB						✓	
Prof Gurch Randhawa*	Non-Executive Member		✓					✓
Sarah Stanley*	Executive Director Total Quality Management (Nursing Director)		✓	✓				✓
Dr Sahadev Swain	GP (Primary Medical Services)				✓			

*Joint appointment with C&P ICB and H&WE ICB

**Joint appointment with C&P ICB

Name	Role/Job Title/Organisation (ICB Roles unless otherwise stated)	A&R	FPPF	ME	BLMK NHD	C&P NHD	REM	UMQI
Jan Thomas*	Chief Executive Officer, BLMK ICB		✓	✓				
Poi Toner*	Director of Safeguarding and Complex Care (From 2.3.26)			✓				✓
Kate Vaughton*	Executive Director Neighbourhood Health, Places and Partnerships		✓	✓	✓	✓		
Maria Wogan*	Director of Neighbourhood Health Places and Partnerships BLMK			✓	✓			

**Joint appointment with C&P ICB and H&WE ICB*

***Joint appointment with C&P ICB*

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 pages 80 to 83.

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

	2025/26		2024/25	
	Salary and allowances	Performance pay and bonuses	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	3.25%	0%	5.00%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.83%	0%	4.94%	0%

The salary of the highest paid director has increased by 3.25% compared to 2024/25. The highest paid director in 2025/26 was the ICB's former Chief Executive Officer and this is consistent with the highest paid director in 2024/25. 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 increase reflects the pay award for very senior managers in 2025/26 agreed by the ICB's Remuneration Committee.

The average percentage change in salary for employees of the ICB was 3.83% compared to 2024/25 financial year. The increase reflects the agenda for change pay award in 2025/26 as well as the cost of incremental drift as employees move up the agenda for changes pay scales.

No performance pay or bonuses were paid in the financial year 2025/26.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. The banded remuneration of the highest paid director in NHS Bedfordshire Luton & Milton Keynes ICB in the reporting period 1st April 2025 – 31st March 2026 was £207,500 (prior year 2024/25 was £197,500).

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

2025/26	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	41,474	54,710	68,631
Salary component of total remuneration (£)	41,474	54,710	68,631
Pay ratio information	5.00 : 1	3.79 : 1	3.02 : 1

During the reporting period 1st April 2025 – 31st March 2026, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £6,800 to £207,500.

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 2024 – 31st March 2025 is shown in the table below:

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

The change in the current financial year's pay ratios compared to the pay ratios of the previous financial year are minimal. The pay ratio to the highest paid director has improved very slightly in the lower quartile, whereas the pay ratios in the median and upper quartile have slightly worsened. The change has not been significant enough to draw any conclusions from the year-on-year change. The cost impact of the compulsory and voluntary redundancies has not been included in remuneration above.

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 2026 the ICB had eleven senior managers on a contractual salary of £150,000 or greater per annum. Eight of these contracts are currently held by NHS Cambridgeshire & Peterborough ICB as part of the joint Executive / Board arrangement in place for the second six months of the financial year of 2025/26.

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 (subject to audit)

2025/26 (1st April 2025 – 31st March 2026)

Name	Title	Salary (bands of £5,000)	Taxable benefits * (total to nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000
Executive Team							
Felicity Cox	Chief Executive Officer (to 30th September 2025)	100 to 105	600	0	0	112.5 to 115	215 to 220
Jan Thomas ***	Joint Chief Executive Officer (from 1st October 2025)	45 to 50	0	0	0	10 to 12.5	55 to 60
Dr Andrew Rochford **	Chief Medical Officer (to 30th September 2025)	65 to 70	100	0	0	122.5 to 125	190 to 195
Dr Fiona Head ***	Joint Executive Clinical Director Utilisation Management (from 1st October 2025)	15 to 20	0	0	0	32.5 to 35	50 to 55
Dean Westcott **	Chief Finance Officer (to 30th September 2025)	85 to 90	400	0	0	0	85 to 90
Sarah Griffiths ***	Joint Executive Director Finances, Resources and Contracts (from 1st October 2025)	25 to 30	0	0	0	5 to 7.5	35 to 40
Nicky Poulain **	Chief of Primary Care (to 30th April 2025)	10 to 15	300	0	0	0	10 to 15
Kate Vaughton ***	Joint Executive Director Neighbourhood Health Place & Partnerships (from 1st October 2025)	25 to 30	0	0	0	12.5 to 15	40 to 45
Sarah Stanley	Chief Nurse (to 30th September 2025) Joint Executive Clinical Director Total Quality Management (from 1st October 2025)	105 to 110	0	0	0	0	105 to 110
Maria Wogan	Chief of Strategy & Assurance (to 30th September 2025)	75 to 80	0	0	0	2.5 to 5	80 to 85
Louis Kamfer ***	Joint Executive Director Strategy Planning and Evaluation (from 1st October 2025)	25 to 30	0	0	0	5 to 7.5	35 to 40
Martha Roberts	Chief People Officer (to 30th September 2025)	75 to 80	900	0	0	20 to 22.5	95 to 100
Karen Barker ***	Joint Executive Director - Corporate Services (from 1st October 2025)	25 to 30	0	0	0	15 to 17.5	40 to 45

GP Members									
Dr Omotayo Kufeki **	Primary Medical Services Partner Member	35 to 40	0	0	0	0	0	0	35 to 40
Maresh Shah **	Primary Medical Services Partner Member (to 30th June 2025)	5 to 10	0	0	0	0	0	0	5 to 10
Dr Sahadev Swain	Primary Medical Services Partner Member	15 to 20	0	0	0	0	0	5 to 7.5	20 to 25
Lay Members									
Manjeet Gill **	Interim Chair (to 30th April 2025) Non-Executive Member (from 1st May 2025 to 31st December 2025)	15 to 20	1,800	0	0	0	0	0	15 to 20
Robin Porter	Chair (from 1st May 2025 to 30th September 2025) Joint Chair (from 1st October 2025)	35 to 40	500	0	0	0	0	7.5 to 10	45 to 50
Alison Borrett **	Non-Executive Member	15 to 20	0	0	0	0	0	0	15 to 20
Shirley Pointer **	Non-Executive Member (to 3rd December 2025)	10 to 15	0	0	0	0	0	0	10 to 15
Vineeta Manchanda-Singh **	Non-Executive Member	15 to 20	500	0	0	0	0	0	15 to 20
Lorraine Mattis **	Associate Non-Executive Member (to 31st December 2025)	5 to 10	0	0	0	0	0	0	5 to 10

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

** The senior manager is either not a member of the NHS Pension Scheme or is drawing on their retirement benefits.

*** The senior manager is part of a Joint Executive team where the salary from 1st October 2025 to 31st March 2026 is shared equally across three partner organisations: NHS Bedfordshire, Luton & Milton Keynes ICB, NHS Hertfordshire & West Essex ICB and NHS Cambridgeshire & Peterborough ICB.

In 2025/26, no member received any additional remuneration from the ICB for duties that are not part of the management role.

The full year equivalent salary for each senior manager is as follows:

Name	Title	Full Year Equivalent Salary (bands of £5,000)
		£'000
Executive Team		
Felicity Cox	Chief Executive Officer (to 30th September 2025)	205 to 210
Jan Thomas *	Joint Chief Executive Officer (from 1st October 2025)	90 to 95
Dr Andrew Rochford	Chief Medical Officer (to 30th September 2025)	135 to 140
Dr Fiona Head *	Joint Executive Clinical Director Utilisation Management (from 1st October 2025)	40 to 45
Dean Westcott	Chief Finance Officer (to 30th September 2025)	175 to 180
Sarah Griffiths *	Joint Executive Director Finances, Resources and Contracts (from 1st October 2025)	50 to 55
Nicky Poulain	Chief of Primary Care (to 30th April 2025)	145 to 150
Kate Vaughton *	Joint Executive Director Neighbourhood Health Place & Partnerships (from 1st October 2025)	50 to 55
Sarah Stanley	Chief Nurse (to 30th September 2025) Joint Executive Clinical Director Total Quality Management (from 1st October 2025)	170 to 175
Maria Wogan	Chief of Strategy & Assurance (to 30th September 2025)	155 to 160
Louis Kamfer *	Joint Executive Director Strategy Planning and Evaluation (from 1st October 2025)	55 to 60
Martha Roberts	Chief People Officer (to 30th September 2025)	150 to 155
Karen Barker *	Joint Executive Director - Corporate Services (from 1st October 2025)	50 to 55
GP Members		
Dr Omotayo Kufeggi	Primary Medical Services Partner Member	35 to 40
Mahesh Shah	Primary Medical Services Partner Member (to 30th June 2025)	20 to 25
Dr Sahadev Swain	Primary Medical Services Partner Member	15 to 20

Lay Members		
Manjeet Gill	Interim Chair (to 30th April 2025) Non-Executive Member (from 1st May 2025 to 31st December 2025)	15 to 20
Robin Porter	Chair (from 1st May 2025 to 30th September 2025) Joint Chair (from 1st October 2025)	80 to 85
Alison Borrett	Non-Executive Member	15 to 20
Shirley Pointer	Non-Executive Member (to 3rd December 2025)	15 to 20
Vineeta Manchanda-Singh	Non-Executive Member	15 to 20
Lorraine Mattis	Associate Non-Executive Member (to 31st December 2025)	5 to 10

* *The senior manager is part of a Joint Executive team where the salary is shared equally across three partner organisations: NHS Bedfordshire, Luton & Milton Keynes ICB, NHS Hertfordshire & West Essex ICB and NHS Cambridgeshire & Peterborough ICB. The full year equivalent salary is therefore only one third of the individual's overall salary.*

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)
		£'000	£	£'000	£'000	£'000	£'000
Executive Team							
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.

** The senior manager is either not a member of the NHS Pension Scheme or is drawing on their retirement benefits.

*** The senior manager is off-payroll (recharged to the ICB from an external partner organisation).

In 2024/25, no member received any additional remuneration from the ICB for duties that are not part of the management role.

The following are members of the ICB Board who 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
- Michael Bracey, Local Authority Partner Member, Milton Keynes City Council

The following were members of the ICB Board until 30th September 2025 who are representatives of partner organisations and do not receive remuneration from the ICB:

- 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
- Mark Fowler, Local Authority Partner Member, Luton Borough Council
- Vicky Head, Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes
- Elizabeth Elliot, Interim Director of Public Health, Luton (to 30th July 2025)
- Kelly O'Neill, Director of Public Health, Luton (from 1st August 2025)
- 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 (subject to audit)

		Real increase in pension age (bands of £2,500)	Real increase in pension age (bands of £2,500)	Real increase in pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employers Contribution to partnership pension
Name	Title	£000	£000	£000	£000	£000	£000	£000	£000	£000
Felicity Cox	Chief Executive Officer (to 30th September 2025)	5.0 to 7.5	0	20 to 25	0	0	125	100	350	0
Jan Thomas *	Joint Chief Executive Officer (from 1st October 2025)	0 to 2.5	0 to 2.5	45 to 50	25 to 30	25 to 30	690	26	784	0
Dean Westcott	Chief Finance Officer (to 30th September 2025)	0	0	0	0	0	0	0	0	0
Sarah Griffiths *	Joint Executive Director Finances, Resources and Contracts (from 1st October 2025)	0 to 2.5	0	10 to 15	0	0	123	9	163	0
Dr Andrew Rochford	Chief Medical Officer (to 30th September 2025)	5.0 to 7.5	10.0 to 12.5	50 to 55	125 to 130	125 to 130	915	98	1,142	0
Dr Fiona Head *	Joint Executive Clinical Director Utilisation Management (from 1st October 2025)	2.5 to 5.0	10.0 to 12.5	60 to 65	155 to 160	155 to 160	1,225	113	1,489	0
Nicky Poulain	Chief of Primary Care (to 30th April 2025)	0	0	65 to 70	175 to 180	175 to 180	142	0	157	0
Kate Vaughton *	Joint Executive Director Neighbourhood Health Place & Partnerships (from 1st October 2025)	0 to 2.5	0 to 2.5	45 to 50	110 to 115	110 to 115	874	33	974	0
Sarah Stanley	Chief Nurse (to 30th September 2025)	0 to 2.5	0	50 to 55	130 to 135	130 to 135	1,137	0	1,170	0
	Joint Executive Clinical Director Total Quality Management (from 1st October 2025)									
Maria Wogan	Chief of Strategy & Assurance (to 30th September 2025)	0 to 2.5	0	25 to 30	45 to 50	45 to 50	519	2	568	0
Louis Kamfer *	Joint Executive Director Strategy Planning and Evaluation (from 1st October 2025)	0 to 2.5	0	35 to 40	0	0	466	17	529	0
Martha Roberts	Chief People Officer (to 30th September 2025)	0 to 2.5	0 to 2.5	55 to 60	140 to 145	140 to 145	1,248	25	1,353	0
Karen Barker *	Joint Executive Director - Corporate Services (from 1st October 2025)	2.5 to 5.0	0	35 to 40	0	0	412	31	503	0
Robin Porter **	Chair (from 1st May 2025 to 30th September 2025)	0 to 2.5	0	0 to 5	0	0	0	9	18	0
	Joint Chair (from 1st October 2025)									
Dr Sahadev Swain	Primary Medical Services Providers Partner Member	0 to 2.5	0	0 to 5	0	0	11	5	18	0

* The accrued pension, lump sum and cash equivalent transfer values are disclosed in full, however, from the 1st October 2025 the employer's pension contributions for these managers have been shared equally with NHS Cambridgeshire & Peterborough ICB and NHS Hertfordshire & West Essex ICB as part of a Joint Board arrangement. As with the other disclosures, the real increase in accrued pension, lump sum and cash equivalent transfer value is time apportioned so only reflects the period where the individual was a senior manager.

** During the year, an error was identified in the classification of the ICB Chair's pension status. The Chair had been incorrectly treated as pensionable within the NHS Pension Scheme, resulting in an overstatement of pension contributions. The role is non pensionable. Due to system and processing constraints, the ICB was unable to fully correct the error within the 2025/26 financial year. The required adjustment will therefore be processed in 2026/27.

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 (subject to audit)

No payments of this nature were made by the ICB during the reporting period 1 April 2025 – 31 March 2026.

Payments to past directors (subject to audit)

No payments were made by the ICB to past directors during the reporting period 1 April 2025 – 31 March 2026.

Staff Report

Number of senior managers

At the end of March 2026 BLMK ICB employed 33 senior managers including very senior managers (VSMs) and Band 9s.

Staff numbers and costs (subject to audit)

On average we have employed 358 people at a cost of £31,351,000 (of which £13,871,000 is included in running costs). In addition to this, the cost of exit packages for 132 people leaving the ICB because of organisational change is expected to total £16,333,000, resulting in total staff costs for the year of £47,684,000.

Staff Numbers	Permanent employees Average FTE *	Other staff Average FTE *	Total Average FTE *
Administration and estates staff	259.38	11.27	270.65
Medical and dental staff	7.38	0.00	7.38
Nursing, midwifery and health visiting staff	55.83	6.52	62.35
Scientific, therapeutic and technical staff	17.77	0.00	17.77
Totals	340.36	17.79	358.15

* Full-time equivalent

Employee benefits	Permanent employees £000s	Other staff £000s	Total £000s
Salaries and wages	22,354	1,251	23,605
Social security costs	3,036	0	3,036
Employer contributions to NHS pension scheme	4,614	0	4,614
Other pension costs	1	0	1
Apprenticeship levy	95	0	95
Subtotal	30,100	1,251	31,351
Termination benefits	16,333	0	16,333
Gross employee benefits expenditure	46,433	1,251	47,684

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/>

Staff composition

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

Male		Female	
Headcount	%	Headcount	%
3	60	2	40

Senior managers and VSMs, excluding Board of the ICB:

Male		Female	
Headcount	%	Headcount	%
10	29	25	71

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

Male		Female	
Headcount	%	Headcount	%
54	18	247	82

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 2025.

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 impact organisational change can have for colleagues, we implemented specific support for staff including Listening Circles and CV writing and interview skills. In addition we recruited, trained and launched Wellbeing Champions who could support staff across a variety of specialist areas including Mental Health First Aider qualifications.

The sickness absence data for months 1 – 12 of 2025 showed an average 7.0 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 2025/26 is 17.86%. The current figure is above average and it should be noted that this figure reflects the impact following organisational change within the ICB between 2023 - 2025. The top three reasons for leaving (outside of the organisational change) are attributed to Voluntary resignation, End of Fixed Term Contract and Retirement. 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 life 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

2025/26 has been a further year of change for the ICB. We conducted engagement with our staff to finalise phase two of the target operating model to reduce ICB running costs by 30% and, in addition, we have commenced a programme of change related to the government requirement to reduce costs to £19 per head of population which has resulted in a proposed merger with Cambridge and Peterborough ICB and Hertfordshire and West Essex ICB. Engagement within the year included a formal consultation regarding organisational structure change, specific sessions on 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 have delivered a number of skills development sessions including, but not limited to, coaching as a management style and compassionate leadership through change. We have also implemented a policy around Domestic Abuse and Sexual Violence and promoted information and training on Neurodiversity. We have continued to embed our line management programme.

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
- embedding of a more robust appraisal process using NHSE's scope for growth framework
- provision of a suite of wellbeing advice and tools
- 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
- development of a system-wide Wellbeing festival
- establishment of a Freedom to Speak Up conference and community of practice

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.

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)

Disabled employees

The ICB holds Disability Confident Level 2 Employer status. In 2025/26, 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, 8.93% have declared a disability which is marginally lower than the figure reported for 2024/25 (9.16%). 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. In 2024/25 we developed a training programme, which included a focus on key policies. We have continued to roll out and embed this learning in the last financial year. 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 8 different employees acting as representatives throughout the period, equating to 6.46 WTE.

Table 1: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
8	6.46

Table 2: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	8
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time

Total cost of facility time	£137,106
Total pay bill	£31,350,825
Percentage of the total pay bill spent on facility time, calculated as (total cost of facility time ÷ total pay bill) x 100%	0.44%

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%	3%
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Other employee matters

All other matters relating to staff can be found at the workforce section on pages 67 to 71.

Expenditure on consultancy

Expenditure on consultancy was £1,138,622

Off-payroll engagements

For all off-payroll engagements as at 31 March 2026, for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2026	9
<i>Of which, the number that have existed:</i>	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	3
for 4 or more years at the time of reporting	

*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 2025 to 31 March 2026, for more than £245⁽¹⁾ per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026	6
<i>Of which:</i>	
No. not subject to off-payroll legislation ⁽²⁾	2
No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽²⁾	
No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽²⁾	4
the number of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	

⁽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 2025 to 31 March 2026:

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.	8

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

Table 1: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies WHOLE NUMBERS ONLY	Cost of compulsory redundancies £s	Number of other departures agreed WHOLE NUMBERS ONLY	Cost of other departures agreed £s	Total number of exit packages WHOLE NUMBERS ONLY	Total cost of exit packages £s	Number of departures where special payments have been made WHOLE NUMBERS ONLY	Cost of special payment element included in exit packages £s
Less than £10,000	1	2,076	3	22,514	4	24,590	0	0
£10,000 - £25,000	2	30,544	16	283,684	18	314,228	0	0
£25,001 - £50,000	4	153,559	22	826,712	26	980,270	0	0
£50,001 - £100,000	3	237,989	27	2,047,269	30	2,285,258	0	0
£100,001 - £150,000	3	344,000	26	3,181,727	29	3,525,727	0	0
£150,001 – £200,000	2	335,943	23	3,886,520	25	4,222,462	0	0
>£200,001	0	0	0	0	0	0	0	0
TOTALS	15	1,104,111	117	10,248,426	132	11,352,536	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
	Number	£s
Voluntary redundancies including early retirement contractual costs	115	10,155,863
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	2	92,563
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
TOTAL	117	10,248,426

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

As a single exit package can be made up of several components each of which will be counted separately in the tables above, the total number above will not necessarily match the total numbers in Note 4.3 of the Annual Accounts which will be the number of individuals.

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 Central East Integrated Care Board in respect 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 (the 'ICB') for the year ended 31 March 2026, 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 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 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 2025-26; 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.

Emphasis of Matter

We draw attention to note 23 Events after the end of the reporting period to the financial statements, which describes the abolition of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board, 1 April 2026. The functions, assets and liabilities of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board transferred to the newly formed NHS Central East Integrated Care Board from that date. Our opinion is not modified in this respect.

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 2025-26 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 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 2025-26 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 2025-26; 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 2025-26).
- We enquired of management and the audit and risk 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 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 and fraud in expenditure recognition. 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
 - Fraud in expenditure recognition with respect to payables, specifically the completeness of accrued expenditure.
- 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
 - Credits to expenditure from March onwards.
 - large value journals around year end
 - Income accrued from March onwards
 - 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 expenditure recognition, and the significant accounting estimates related to the prescribing 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 2026.

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 March 2026. 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 for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until 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 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the members of the Governing Body of NHS Central East Integrated Care Board (in respect of NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board) 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
17 June 2026

ANNUAL ACCOUNTS

Jan Thomas

Accountable Officer

17 June 2026

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**Statement of Comprehensive Net Expenditure for the year ended
31 March 2026**

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(27,598)	(30,486)
Other operating income	2	(1,633)	(1,127)
Total operating income		(29,231)	(31,613)
Staff costs	4	47,683	31,309
Purchase of goods and services	5	2,683,486	2,482,289
Depreciation and impairment charges	5	156	181
Provision expense	5	5,446	753
Other operating expenditure	5	317	227
Total operating expenditure		2,737,088	2,514,758
Net Operating Expenditure		2,707,857	2,483,145
Finance expense	8	2	4
Other Gains & Losses	7	4	-
Net expenditure for the Year		2,707,863	2,483,149
Total Net Expenditure for the Financial Year		2,707,863	2,483,149
Comprehensive Expenditure for the year		2,707,863	2,483,149

**Statement of Financial Position as at
31 March 2026**

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Right-of-use assets	10	122	357
Total non-current assets		122	357
Current assets:			
Inventories	11	28	40
Trade and other receivables	12	19,642	15,010
Cash and cash equivalents	13	(693)	41
Total current assets		18,976	15,091
Total current assets		18,976	15,091
Total assets		19,098	15,448
Current liabilities			
Trade and other payables	14	(149,543)	(113,351)
Lease liabilities	10	(100)	(161)
Borrowings	15	(2,076)	-
Provisions	16	(6,891)	(2,240)
Total current liabilities		(158,610)	(115,752)
Non-Current Assets plus/less Net Current Assets/Liabilities		(139,512)	(100,303)
Non-current liabilities			
Lease liabilities	10	(24)	(197)
Total non-current liabilities		(24)	(197)
Assets less Liabilities		(139,536)	(100,501)
Financed by Taxpayers' Equity			
General fund		(139,536)	(100,501)
Total taxpayers' equity:		(139,536)	(100,501)

The notes on pages 6 to 26 form part of this statement

The financial statements on pages 2 to 26 were approved by the Governing Body on 16 June 2026 and signed on its behalf by:

Jan Thomas
Date: 17 June 2026

**Statement of Changes In Taxpayers' Equity for the year ended
31 March 2026**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	(100,501)	(100,501)
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Net expenditure for the financial year	(2,707,863)	(2,707,863)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	(2,707,863)	(2,707,863)
Net funding	2,668,827	2,668,827
Balance at 31 March 2026	(139,536)	(139,536)

	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 costs 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)

The notes on pages 6 to 26 form part of this statement

**Statement of Cash Flows for the year ended
31 March 2026**

	Note	2025-26 £'000	2024-25 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(2,707,863)	(2,483,149)
Depreciation and amortisation	5	156	181
Interest paid / received		2	4
Other Gains & Losses		4	-
(Increase)/decrease in inventories		12	43
(Increase)/decrease in trade & other receivables	12	(4,632)	(3,277)
Increase/(decrease) in trade & other payables	14	36,192	5,836
Provisions utilised	16	(795)	(806)
Increase/(decrease) in provisions	16	5,446	753
Net Cash Inflow (Outflow) from Operating Activities		(2,671,477)	(2,480,415)
Net Cash Inflow (Outflow) before Financing		(2,671,477)	(2,480,415)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,668,827	2,481,554
Repayment of lease liabilities	10	(161)	(186)
Net Cash Inflow (Outflow) from Financing Activities		2,668,667	2,481,368
Net Increase (Decrease) in Cash & Cash Equivalents	13	(2,810)	952
Cash & Cash Equivalents at the Beginning of the Financial Year	13	41	(912)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		(2,769)	41

The notes on pages 6 to 26 form part of this statement

Notes to the financial statements

1.0 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 2025-26 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.

1.1 Going Concern

The Accounts of Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) have been prepared on a Going Concern basis. Public sector bodies are presumed to be going concerns where the continuation of services is anticipated, supported by statutory funding and reflected in published financial plans.

NHS England required all Integrated Care Boards (ICBs) to reduce running costs by up to 50% from 2026/27. As part of the national response, Bedfordshire, Luton & Milton Keynes ICB, Cambridgeshire & Peterborough ICB, and Hertfordshire & West Essex ICB worked together to establish a new organisation. This resulted in the creation of Central East ICB, which formally came into existence on 1 April 2026, replacing the three predecessor statutory bodies.

BLMK ICB ceased to exist as a statutory entity on 31 March 2026, with its functions, assets and liabilities transferring to Central East ICB. This change represents a nationally mandated structural reorganisation rather than a cessation of services. Service delivery has continued uninterrupted under the successor body, supported by ongoing statutory funding arrangements.

Management has considered the implications of this transition in assessing the going concern basis. The merger does not reflect any intention to discontinue services or reduce operational activity, but rather a continuation of statutory functions within a new organisational structure. In forming this judgement, management has taken into account the operational and strategic context, financial performance and medium-term financial plans, published allocations and expected cash flows, and the continuity of responsibilities within Central East ICB.

No material uncertainties have been identified that cast significant doubt on the ability of services previously delivered by BLMK ICB to continue within Central East ICB. Management is therefore satisfied that BLMK ICB had sufficient resources, statutory authority and operational capacity to meet its obligations up to 31 March 2026, and that services continue to be delivered by the successor organisation thereafter.

Accordingly, the 2025/26 Annual Accounts of BLMK ICB are prepared on a going concern basis.

1.2 Accounting Convention

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

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

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

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

1.4 Pooled Budgets

The 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 and the Better Care Fund 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.

1.5 Operating Segments

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

1.6 Revenue

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

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FRoM 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.

Notes to the financial statements

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

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

1.7.2 Retirement Benefit Costs

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

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

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

1.8 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.

1.9 Grants Payable

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

1.10 Property, Plant & Equipment

1.10.1 Recognition

Property, plant and equipment is capitalised if:

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

1.10.2 Measurement

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

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

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees 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.

1.10.3 Subsequent Expenditure

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

1.11 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.11.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

Notes to the financial statements

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.12 Inventories

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

1.13 Cash & Cash Equivalents

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

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

1.14 Provisions

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

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

- A nominal short-term rate of 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.22% (2024-25: 4.07%) 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 5.32% (2024-25: 4.81%) 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 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.15 Clinical Negligence Costs

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

1.16 Non-clinical Risk Pooling

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

1.17 Contingent liabilities and contingent assets

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

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

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

1.18 Financial Assets

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

Financial assets are classified into the following categories:

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

Notes to the financial statements

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

1.19 Financial Liabilities

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

1.20 Value Added Tax

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

1.21 Third Party Assets

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

1.22 Losses & Special Payments

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

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

1.23 Critical accounting judgements and key sources of estimation uncertainty

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

The ICB had no critical accounting judgements in 2025-26.

1.24 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 2025-26.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

The ICB does not expect the adoption of this standard to have a material impact on the financial statements.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective

for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

The ICB does not expect the adoption of this standard to have a material impact on the financial statements.

2 Other Operating Revenue

	2025-26	2024-25
	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	3,411	3,494
Prescription fees and charges	10,584	10,311
Dental fees and charges	12,600	11,200
Other Contract income	-	205
Recoveries in respect of employee benefits	1,004	777
Total Income from sale of goods and services	27,598	30,486
Other operating income		
Other non contract revenue	1,633	1,127
Total Other operating income	1,633	1,127
Total Operating Income	29,231	31,613

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

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	2,414	-	-	61
Non NHS	997	10,584	12,600	943
Total	3,411	10,584	12,600	1,004
Timing of Revenue				
Point in time	-	10,584	12,600	-
Over time	3,411	-	-	1,004
Total	3,411	10,584	12,600	1,004

3.1 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		2025-26
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	22,354	1,251	23,605
Social security costs	3,035	-	3,035
Employer Contributions to NHS Pension scheme	4,614	-	4,614
Other pension costs	1	-	1
Apprenticeship Levy	95	-	95
Termination benefits	16,333	-	16,333
Gross employee benefits expenditure	46,433	1,251	47,683
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Total - Net admin employee benefits including capitalised costs	46,433	1,251	47,683
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	46,433	1,251	47,683

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	0	4,628
Other pension costs	1	-	1
Apprenticeship Levy	95	-	95
Gross employee benefits expenditure	29,092	2,216	31,309
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

4.1.2 Recoveries in respect of employee benefits

	2025-26		2024-25
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	-	-	(741)
Social security costs	-	-	(17)
Employer contributions to the NHS Pension Scheme	-	-	(19)
Total recoveries in respect of employee benefits	-	-	(777)

4.2 Average number of people employed

	2025-26			2024-25		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	340.36	17.79	358.15	347.37	28.35	375.72
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-	-

4.3 Exit packages agreed in the financial year

	2025-26		2025-26		2025-26	
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	2,076	3	22,514	4	24,590
£10,001 to £25,000	2	30,544	16	283,684	18	314,228
£25,001 to £50,000	4	153,559	22	826,712	26	980,270
£50,001 to £100,000	3	237,989	27	2,047,269	30	2,285,258
£100,001 to £150,000	3	344,000	26	3,181,727	29	3,525,727
£150,001 to £200,000	2	335,943	23	3,886,520	25	4,222,462
Total	15	1,104,111	117	10,248,426	132	11,352,536

	2024-25		2024-25		2024-25	
	Compulsory redundancies		Other agreed departures		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
£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

Analysis of Other Agreed Departures

	2025-26		2024-25	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual co	115	10,155,863	-	-
Contractual payments in lieu of notice	2	92,563	-	-
Total	117	10,248,426	-	-

The compulsory redundancy amount of £1.104m includes £396k of costs shared with the following organisations:

Hertfordshire and West Essex ICB
Cambridge and Peterborough ICB
Mid and South East Essex ICB
Norfolk and Waveney ICB
Suffolk and North East Essex ICB

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Ill-health retirement costs are met by the NHS Pension Scheme and are not included in these tables. In 2025-26 there has been one such payment for £964k for one staff member.

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

4.4 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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

4.4.1 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5. Operating expenses

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	568	331
Services from foundation trusts	1,616,029	1,478,351
Services from other NHS trusts	188,440	181,968
Purchase of healthcare from non-NHS bodies	340,950	317,526
General Dental services and personal dental services	66,788	60,916
Prescribing costs	174,855	165,601
Pharmaceutical services	34,208	30,267
General Ophthalmic services	10,322	10,253
GPMS/APMS and PCTMS	218,420	201,152
Supplies and services – clinical	243	341
Supplies and services – general	10,473	12,551
Consultancy services	1,139	390
Establishment	4,167	5,433
Transport	11,507	10,779
Premises	2,904	3,803
Audit fees	249	228
Other non statutory audit expenditure		
Other services	-	51
Other professional fees	901	1,423
Legal fees	715	473
Education, training and conferences	606	450
Total Purchase of goods and services	2,683,486	2,482,289
Depreciation and impairment charges		
Depreciation	156	181
Total Depreciation and impairment charges	156	181
Provision expense		
Provisions	5,446	753
Total Provision expense	5,446	753
Other Operating Expenditure		
Chair and Non Executive Members	117	135
Grants to Other bodies	150	-
Expected credit loss on receivables	7	10
Inventories consumed	12	43
Other expenditure	31	39
Total Other Operating Expenditure	317	227
Total operating expenditure	2,689,405	2,483,450

The audit fee disclosed above represents the statutory audit fee excluding VAT, in accordance with 2025-26 GAM (Group Accounting Manual).

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	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	23,307	463,779	25,247	448,919
Total Non-NHS Trade Invoices paid within target	21,713	460,507	24,137	423,314
Percentage of Non-NHS Trade invoices paid within target	93.2%	99.3%	24,137	423,314
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,690	1,824,214	2,685	1,686,386
Total NHS Trade Invoices Paid within target	2,659	1,825,817	2,630	1,685,374
Percentage of NHS Trade Invoices paid within target	98.8%	100.1%	98.0%	99.9%

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The ICB incurred £nil in the period from 1 April 2025 to 31 March 2026 relating to claims made under this legislation.

7. Other gains and losses

	2025-26 £'000	2024-25 £'000
Gain/(loss) on disposal of right-of-use assets other than by sale	4	-
Total	4	-

8 Finance costs

	2025-26 £'000	2024-25 £'000
Interest on lease liabilities	2	4
Total interest	2	4
Total finance costs	2	4

9 Property, plant and equipment

	Plant & machinery	Information technology	Total
2025-26	£'000	£'000	£'000
Cost or valuation at 01 April 2025	33	75	108
Cost/Valuation at 31 March 2026	33	75	108
Depreciation 01 April 2025	33	75	108
Depreciation at 31 March 2026	33	75	108
Net Book Value at 31 March 2026	-	-	-

9.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2025-26 £'000	2024-25 £'000
Plant & machinery	33	33
Information technology	75	75
Total	108	108

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**

	Buildings excluding dwellings	Total	Of which: leased from DHSC group bodies £000
2025-26	£'000	£'000	
Cost or valuation at 01 April 2025	861	861	
Disposals on expiry of lease term	(235)	(235)	(159)
Derecognition for early terminations	(297)	(297)	-
Cost/Valuation at 31 March 2026	329	329	(159)
Depreciation 01 April 2025	504	504	
Charged during the year	156	156	-
Disposals on expiry of lease term	(235)	(235)	(159)
Derecognition for early terminations	(218)	(218)	-
Depreciation at 31 March 2026	207	207	(159)
Net Book Value at 31 March 2026	122	122	-
NBV by counterparty			
Leased from DHSC	-	-	
Leased externally	122	357	
Net Book Value at 31 March 2026	122	357	

10.2 Lease liabilities

2025-26	2025-26	2024-25
£'000	£'000	£'000
Lease liabilities at 01 April 2025	(358)	(540)
Interest expense relating to lease liabilities	(2)	(4)
Repayment of lease liabilities (including interest)	161	186
Derecognition for early terminations	76	-
Lease liabilities at 31 March 2026	(124)	(358)

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26	Of which: leased from DHSC group bodies £000	2024-25	Of which: leased from DHSC group bodies £000
	£'000	£000	£'000	£000
Within one year	(100)	-	(161)	-
Between one and five years	(24)	-	(201)	-
After five years	-	-	-	-
Balance at 31 March 2026	(125)	-	(362)	-
Balance by counterparty				
Leased from DHSC		-		-
Leased externally		(125)		(362)
Balance as at 31 March 2026		(125)		(362)

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025-26	2024-25
	£'000	£'000
Depreciation expense on right-of-use assets	156	181
Interest expense on lease liabilities	2	4
Expense relating to short-term leases	69	-

10.5 Amounts recognised in Statement of Cash Flows

	2025-26	2024-25
	£'000	£'000
Total cash outflow on leases under IFRS 16	161	186

11 Inventories

	Loan Equipment £'000	Total £'000
Balance at 01 April 2025	40	40
Inventories recognised as an expense in the period	(12)	(12)
Balance at 31 March 2026	<u>28</u>	<u>28</u>

12 Trade and other receivables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue	1,131	4,902
NHS prepayments	102	129
NHS accrued income	240	217
Non-NHS and Other WGA receivables: Revenue	7,957	4,056
Non-NHS and Other WGA prepayments	6,655	500
Non-NHS and Other WGA accrued income	2,992	4,112
Expected credit loss allowance-receivables	(9)	(5)
VAT	527	1,087
Other receivables and accruals	47	12
Total Trade & other receivables	<u>19,642</u>	<u>15,010</u>
Total current and non current	<u>19,642</u>	<u>15,010</u>

12.1 Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £'000	2025-26 Non DHSC Group Bodies £'000	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000
By up to three months	-	4,180	312	2,650
By three to six months	-	(122)	8	5
By more than six months	75	72	1	112
Total	<u>75</u>	<u>4,130</u>	<u>321</u>	<u>2,767</u>

12.2 Loss allowance on asset classes

	2025-26 Trade and other receivables - Non DHSC Group Bodies £'000	2025-26 Total £'000	2024-25 Trade and other receivables - Non DHSC Group Bodies £'000	2024-25 Total £'000
Balance at 01 April 2025	(5)	(5)	(15)	(15)
Lifetime expected credit losses on trade and other receivables-Stage 2	(7)	(7)	(10)	(10)
Amounts written off	2	2	21	21
Other changes	-	-	(1)	(1)
Total	<u>(9)</u>	<u>(9)</u>	<u>(5)</u>	<u>(5)</u>

13 Cash and cash equivalents

	2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	41	(912)
Net change in year	(2,810)	952
Balance at 31 March 2026	<u>(2,769)</u>	<u>41</u>
Made up of:		
Cash with the Government Banking Service	-	722
Cash in hand	(693)	(682)
Cash and cash equivalents as in statement of financial position	<u>(693)</u>	<u>41</u>
Bank overdraft: Government Banking Service	(2,076)	-
Total bank overdrafts	<u>(2,076)</u>	<u>-</u>
Balance at 31 March 2026	<u>(2,769)</u>	<u>41</u>

Included within cash held in Pooled Budget is an overdrawn balance of £693k held on behalf of the ICB by Milton Keynes Council for the Integrated Community Equipment Service and Learning Disability Service pooled budgets.

The bank overdraft is a technical overdraft representing the ICB's cash book position. The actual bank balance was in credit by £888k.

14 Trade and other payables	Current 2025-26 £'000	Current 2024-25 £'000
NHS payables: Revenue	2,049	1,318
NHS accruals	22,146	15,927
Non-NHS and Other WGA payables: Revenue	9,851	9,669
Non-NHS and Other WGA accruals	92,950	80,117
Non-NHS and Other WGA deferred income	3,467	3,045
Social security costs	317	296
Tax	311	344
Other payables and accruals	18,452	2,634
Total Trade & Other Payables	149,543	113,351

Other payables includes £10.155m for voluntary redundancies and £5.78m for compulsory redundancies relating to ICB organisational change process. It also includes £1.561m of outstanding pension contributions at 31 March 2026.

15 Borrowings	Current 2025-26 £'000	Current 2024-25 £'000
Bank overdrafts:		
· Government banking service	2,076	-
Total overdrafts	2,076	-
Total Borrowings	2,076	-

16 Provisions

	Current 2025-26 £'000	Current 2024-25 £'000
Restructuring	183	24
Redundancy	0	232
Legal claims	839	329
Continuing care	3,066	1,115
Other	2,803	540
Total	6,891	2,240
Total current and non-current	6,891	2,240

	Restructuring £'000	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2025	24	232	329	1,115	540	2,240
Arising during the year	183	481	511	2,200	2,263	5,638
Utilised during the year	(24)	(708)	-	(62)	-	(795)
Reversed unused	-	(6)	-	(186)	-	(192)
Balance at 31 March 2026	183	0	839	3,066	2,803	6,891
Within one year	183	0	839	3,066	2,803	6,891
Balance at 31 March 2026	183	0	839	3,066	2,803	6,891

Restructuring

During the year, the Integrated Care Board recognised a provision in respect of anticipated stranded costs arising from changes to commissioning support arrangements provided by a Commissioning Support Unit (CSU). The timing and final amount of the costs remain uncertain and will depend on the final resolution of contractual and staffing matters. The provision will be reviewed and updated as appropriate at future reporting dates.

Legal Claims

The legal claims provision comprises three elements:

The first relates to a number of claims currently lodged with NHS Resolution. The provision has been calculated based on the probabilities of settlement provided by NHS Resolution. The Integrated Care Board's estimated exposure in respect of these claims totalled £6k at 31 March 2026.

The second element relates to legal proceedings commenced in December 2024 by an unsuccessful bidder challenging a contract award decision arising from a joint procurement undertaken with other Integrated Care Boards for specific primary care services. Based on management's assessment of the likelihood of an adverse outcome, a provision has been recognised in respect of expected legal costs. Any potential liability in excess of the amount provided has been disclosed as a contingent liability in Note 17.

Finally, during the year the Integrated Care Board recognised a provision in respect of a dispute with a former supplier of services. The provision has been recognised in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets and represents management's best estimate of the expenditure required at 31 March 2026. The timing and final amount of any settlement remain uncertain. The provision will be reviewed at each reporting date and adjusted as appropriate.

Continuing Healthcare

At the reporting date, the ICB has recognised a provision in respect of potential liabilities arising from Continuing Healthcare (CHC) eligibility appeals relating to 1 April 2013 to 31 March 2026. The provision has been recognised where management considers it probable that an outflow of resources will be required to settle appeals currently under review. The provision represents management's best estimate of the expenditure required to meet the obligation at 31 March 2026, based on known appeal volumes, historical outcomes, and information available at the reporting date. The remaining balance has been reported as a contingent liability in Note 17. The timing and final value of settlements remain uncertain. The provision will be reviewed and updated as appropriate in future periods.

Other

During the year, the ICB recognised a provision in respect of a joint commissioning arrangement with a local authority partner. The provision has been recognised in accordance with IAS 37 and represents Management's best estimate of the expenditure required to settle the obligation at the reporting date. The timing and final amount of any settlement remain uncertain. The provision will be reviewed and updated as appropriate at future reporting dates.

Finally, the Integrated Care Board has also recognised a provision in respect of potential VAT liabilities associated with contracted wheelchair services. The provision represents Management's best estimate of the obligation at the reporting date. It is subject to ongoing review with HMRC and our VAT advisors.

17 Contingencies

	2025-26	2024-25
	£'000	£'000
Contingent liabilities		
Continuing Healthcare	6,389	2,323
Legal Claim - challenge against joint procurement contract decision	324	323
VAT liabilities associated with contracted wheelchair services	581	-
Joint commissioning arrangement with a local authority partner	1,682	-
Legal Claim - contract challenge from a former supplier of services	510	-
Net value of contingent liabilities	9,485	2,646

Continuing Health Care (CHC)

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.

Legal Claim – Joint Procurement

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 specific Primary Care services. 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.

Wheelchair VAT

The contingent liability for the Wheelchair VAT relates to potential VAT liabilities associated with contracted wheelchair services. 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 go against the ICB.

Joint Commissioning Arrangement

A contingent liability in respect of a joint commissioning arrangement with a local authority partner has been disclosed. A provision has been recognised for the portion of the costs relating to a potential successful claim against the ICB where an outflow is considered probable and can be reliably estimated (see Note 16). The contingent liability reflects the remaining potential exposure, being the balance of the liability that would crystallise should the outcome of the matter be unfavourable to the ICB.

Contract Challenge – Former Supplier

The contingent liability disclosed relates to a contract challenge from a former supplier of services. A provision has been recognised for the portion of the costs relating to a potential successful claim against the ICB where an outflow is considered probable and can be reliably estimated (see Note 16). The contingent liability reflects the remaining potential exposure, representing the balance of the liability that would arise should the outcome of the challenge be unfavourable to the ICB.

The timing and final outcome of these matters remain uncertain. All positions will continue to be reviewed and updated as appropriate at future reporting dates.

NHS Bedfordshire, Luton and Milton Keynes ICB identified £nil in the period from 1 April 2025 to 31 March 2026 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.

19.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	Total 2025-26 £'000	Financial Assets measured at amortised cost 2024-25 £'000	Total 2024-25 £'000
Trade and other receivables with NHSE bodies	1,275	1,275	1,745	1,745
Trade and other receivables with other DHSC group bodies	96	96	3,375	3,375
Trade and other receivables with external bodies	10,997	10,997	8,180	8,180
Cash and cash equivalents	(693)	(693)	41	41
Total at 31 March 2026	11,674	11,674	13,341	13,341

19.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	Total 2025-26 £'000	Financial Assets measured at amortised cost 2024-25 £'000	Total 2024-25 £'000
Loans with external bodies	2,076	2,076	-	-
Trade and other payables with NHSE bodies	919	919	232	232
Trade and other payables with other DHSC group bodies	23,276	23,276	18,599	18,599
Trade and other payables with external bodies	121,253	121,253	90,836	90,836
Private Finance Initiative and finance lease obligations	124	124	358	358
Total at 31 March 2026	147,649	147,649	110,024	110,024

20 Operating segments

The ICB operates as one operating segment and that is to commission healthcare.

21 Pooled Budgets

NHS Bedfordshire, Luton and Milton Keynes ICB has entered into four separate partnership agreements and pooled budgets with the four local authorities: Bedford Borough Council, Luton Borough Council and Milton Keynes Council. Under each arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budgets are hosted by the four Councils and are for Community Equipment Services, the Learning Disability Service and Children Service Pools and the Better Care Fund as listed below.

2025-26										2024-25									
Bedford Borough Locality Arrangement					Milton Keynes Locality Arrangement					Bedford Borough Locality Arrangement					Milton Keynes Locality Arrangement				
Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities	Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities	Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities	Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contribution					Contribution					Contribution					Contribution				
Bedfordshire, Luton & Milton Keynes ICB	15,889	15,889	-	-	Bedfordshire, Luton & Milton Keynes ICB	15,889	15,889	-	-	Bedfordshire, Luton & Milton Keynes ICB	15,638	14,169	1,470	-	Bedfordshire, Luton & Milton Keynes ICB	15,638	14,169	1,470	-
Total Funding	15,889	15,889	-	-	Total Funding	15,889	15,889	-	-	Total Funding	15,638	14,169	1,470	-	Total Funding	15,638	14,169	1,470	-
Expenditure					Expenditure					Expenditure					Expenditure				
Bedford Borough Council	7,712	7,712	-	-	Bedford Borough Council	7,712	7,712	-	-	Bedford Borough Council	7,850	7,850	-	-	Bedford Borough Council	7,850	7,850	-	-
Bedfordshire, Luton & Milton Keynes ICB	8,178	8,178	-	-	Bedfordshire, Luton & Milton Keynes ICB	8,178	8,178	-	-	Bedfordshire, Luton & Milton Keynes ICB	7,788	6,318	1,470	-	Bedfordshire, Luton & Milton Keynes ICB	7,788	6,318	1,470	-
Total Expenditure	15,889	15,889	-	-	Total Expenditure	15,889	15,889	-	-	Total Expenditure	15,638	14,169	1,470	-	Total Expenditure	15,638	14,169	1,470	-
Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)				
Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-
Total Overspend / (Underspend)	-	-	-	-	Total Overspend / (Underspend)	-	-	-	-	Total Overspend / (Underspend)	-	-	-	-	Total Overspend / (Underspend)	-	-	-	-
Central Bedfordshire Locality Arrangement					Central Bedfordshire Locality Arrangement					Central Bedfordshire Locality Arrangement					Central Bedfordshire Locality Arrangement				
Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities	Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities	Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities	Total	Better Care Fund	Discharge Fund	Community Equipment	Learning Disabilities
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contribution					Contribution					Contribution					Contribution				
Bedfordshire, Luton & Milton Keynes ICB	25,297	25,297	-	-	Bedfordshire, Luton & Milton Keynes ICB	25,297	25,297	-	-	Bedfordshire, Luton & Milton Keynes ICB	25,079	22,605	2,474	-	Bedfordshire, Luton & Milton Keynes ICB	25,079	22,605	2,474	-
Total Funding	25,297	25,297	-	-	Total Funding	25,297	25,297	-	-	Total Funding	25,079	22,605	2,474	-	Total Funding	25,079	22,605	2,474	-
Expenditure					Expenditure					Expenditure					Expenditure				
Central Bedfordshire Council	9,066	9,066	-	-	Central Bedfordshire Council	9,066	9,066	-	-	Central Bedfordshire Council	8,723	8,723	-	-	Central Bedfordshire Council	8,723	8,723	-	-
Bedfordshire, Luton & Milton Keynes ICB	16,231	16,231	-	-	Bedfordshire, Luton & Milton Keynes ICB	16,231	16,231	-	-	Bedfordshire, Luton & Milton Keynes ICB	16,356	13,882	2,474	-	Bedfordshire, Luton & Milton Keynes ICB	16,356	13,882	2,474	-
Total Expenditure	25,297	25,297	-	-	Total Expenditure	25,297	25,297	-	-	Total Expenditure	25,079	22,605	2,474	-	Total Expenditure	25,079	22,605	2,474	-
Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)				
Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-	Bedfordshire, Luton & Milton Keynes ICB	-	-	-	-
Total Overspend / (Underspend)	-	-	-	-	Total Overspend / (Underspend)	-	-	-	-	Total Overspend / (Underspend)	-	-	-	-	Total Overspend / (Underspend)	-	-	-	-
Luton Borough Locality Arrangement					Luton Borough Locality Arrangement					Luton Borough Locality Arrangement					Luton Borough Locality Arrangement				
Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services	Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services	Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services	Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contribution					Contribution					Contribution					Contribution				
Bedfordshire, Luton & Milton Keynes ICB	28,345	18,936	-	751	Bedfordshire, Luton & Milton Keynes ICB	28,345	18,936	-	751	Bedfordshire, Luton & Milton Keynes ICB	26,580	18,817	1,796	727	Bedfordshire, Luton & Milton Keynes ICB	26,580	18,817	1,796	727
Total Funding	28,345	18,936	-	751	Total Funding	28,345	18,936	-	751	Total Funding	26,580	18,817	1,796	727	Total Funding	26,580	18,817	1,796	727
Expenditure					Expenditure					Expenditure					Expenditure				
Luton Borough Council	7,923	7,923	-	-	Luton Borough Council	7,923	7,923	-	-	Luton Borough Council	7,620	7,620	-	-	Luton Borough Council	7,620	7,620	-	-
Bedfordshire, Luton & Milton Keynes ICB	20,173	11,013	-	822	Bedfordshire, Luton & Milton Keynes ICB	20,173	11,013	-	822	Bedfordshire, Luton & Milton Keynes ICB	19,566	9,197	1,796	681	Bedfordshire, Luton & Milton Keynes ICB	19,566	9,197	1,796	681
Total Expenditure	28,096	18,936	-	822	Total Expenditure	28,096	18,936	-	822	Total Expenditure	27,186	18,817	1,796	681	Total Expenditure	27,186	18,817	1,796	681
Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)				
Bedfordshire, Luton & Milton Keynes ICB	(249)	0	-	70	Bedfordshire, Luton & Milton Keynes ICB	(249)	0	-	70	Bedfordshire, Luton & Milton Keynes ICB	606	0	-	(46)	Bedfordshire, Luton & Milton Keynes ICB	606	0	-	(46)
Total Overspend / (Underspend)	(249)	0	-	70	Total Overspend / (Underspend)	(249)	0	-	70	Total Overspend / (Underspend)	606	0	-	(46)	Total Overspend / (Underspend)	606	0	-	(46)
Milton Keynes Locality Arrangement					Milton Keynes Locality Arrangement					Milton Keynes Locality Arrangement					Milton Keynes Locality Arrangement				
Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services	Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services	Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services	Total	Better Care Fund	Discharge Fund	Community Equipment	Children Services
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contribution					Contribution					Contribution					Contribution				
Bedfordshire, Luton & Milton Keynes ICB	25,961	23,347	-	914	Bedfordshire, Luton & Milton Keynes ICB	25,961	23,347	-	914	Bedfordshire, Luton & Milton Keynes ICB	25,509	20,752	2,273	830	Bedfordshire, Luton & Milton Keynes ICB	25,509	20,752	2,273	830
Total Funding	25,961	23,347	-	914	Total Funding	25,961	23,347	-	914	Total Funding	25,509	20,752	2,273	830	Total Funding	25,509	20,752	2,273	830
Expenditure					Expenditure					Expenditure					Expenditure				
Milton Keynes Council	9,527	9,527	-	-	Milton Keynes Council	9,527	9,527	-	-	Milton Keynes Council	8,349	8,349	-	-	Milton Keynes Council	8,349	8,349	-	-
Bedfordshire, Luton & Milton Keynes ICB	16,050	13,820	-	557	Bedfordshire, Luton & Milton Keynes ICB	16,050	13,820	-	557	Bedfordshire, Luton & Milton Keynes ICB	17,484	12,404	2,273	1,193	Bedfordshire, Luton & Milton Keynes ICB	17,484	12,404	2,273	1,193
Total Expenditure	25,577	23,347	-	557	Total Expenditure	25,577	23,347	-	557	Total Expenditure	25,832	20,752	2,273	1,193	Total Expenditure	25,832	20,752	2,273	1,193
Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)					Net Overspend / (Underspend)				
Bedfordshire, Luton & Milton Keynes ICB	(384)	-	-	(357)	Bedfordshire, Luton & Milton Keynes ICB	(384)	-	-	(357)	Bedfordshire, Luton & Milton Keynes ICB	323	-	-	364	Bedfordshire, Luton & Milton Keynes ICB	323	-	-	364
Total Overspend / (Underspend)	(384)	-	-	(357)	Total Overspend / (Underspend)	(384)	-	-	(357)	Total Overspend / (Underspend)	323	-	-	364	Total Overspend / (Underspend)	323	-	-	364

Notes:

Discharge Funds have transferred into the main Better Care Fund in 25/26.

Reported expenditure for community equipment for Luton & Milton Keynes includes movement in stock valuation.

The LA Better Care Fund Grant and DFG are funds received by the Local Authority for Social Care. Whilst part of the pool there is no risk share and there is not deemed to be joint control. No expenditure for these funds are accounted for by the ICB.

All services excluding the BCF represent the ICB's share of expenditure only to reflect those costs that pass through the ICB, whereas the BCF shows 100% as it is all health funded.

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 2025/26.

The Department of Health and Social Care is regarded as the parent department. During the year the ICB has had a number of material transactions with entities for which the Department is regarded as the parent department. Under IAS 24 entities in the same group as the Department of Health and Social Care 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
 NHS Cambridgeshire and Peterborough Integrated Care Board
 NHS Hertfordshire & West Essex Integrated Care Board
 Hertfordshire Partnership University NHS Foundation Trust
 Essex Partnership University NHS Foundation Trust,

23 Events after the end of the reporting period

In September 2025, NHS England confirmed that Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB), Cambridgeshire & Peterborough ICB, and Hertfordshire & West Essex ICB would be abolished and replaced by a new organisation, Central East ICB, with effect from 1 April 2026. This transition has now taken place, with Central East ICB formally assuming the functions, assets and liabilities of the predecessor bodies from that date.

This change represents a nationally mandated structural reorganisation of commissioning arrangements. It does not affect the recognition or measurement of assets, liabilities, income or expenditure in the 2025/26 financial statements and is therefore treated as a non adjusting event.

As part of the transition, NHS England has required all ICBs to reduce running costs by up to 50% from 2026/27. The three ICBs have progressed the design of the future operating model and organisational structure for the Central East ICB. As a result of this work, management has identified roles at risk and determined that a legal or constructive obligation for redundancy costs exists at the reporting date. Accordingly, expenditure for redundancy costs has been recognised in the 2025/26 financial statements in line with IAS 37. The costs reflects management's best estimate of the costs expected to be incurred as part of the organisational change programme.

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 2025 to 31 March 2026.

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:

	2025-26 Target	2025-26 Performance	2025-26 Target Achieved	2024-25 Target	2024-25 Performance	2024-25 Target Achieved
Expenditure not to exceed income	2,749,049	2,737,094	Yes	2,514,928	2,514,763	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	2,719,818	2,707,863	Yes	2,483,315	2,483,149	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	21,357	20,850	Yes	18,484	18,357	Yes

26 Losses and special payments**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 2025-26 Number	Total Value of Cases 2025-26 £'000	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Administrative write-offs	2	2	8	21
Fruitless payments	1	0	1	32
Book Keeping Losses	-	-	9	3
Total	3	2	18	56

Special payments

	Total Number of Cases 2025-26 Number	Total Value of Cases 2025-26 £'000	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Compensation payments	1	25	-	-
Total	1	25	-	-

27 Mental Health expenditure

	2025-26 £'000	2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	206,242	180,384
Eligible mental health expenditure	206,441	180,397
Mental health expenditure above/(below) minimum investment required	199	13
Mental health expenditure as a proportion of total expenditure	7.7%	7.3%
Mental Health Investment Standard Achieved	Yes	Yes

28. Accountability and Staff

28.1 Employee benefits

	Admin			Programme			Total		2025-26
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
2025-26 Employee Benefits									
Employee Benefits									
Salaries and wages	9,253	327	9,581	13,101	923	14,024	22,354	1,251	23,605
Social security costs	1,271	-	1,271	1,765	-	1,765	3,035	-	3,035
Employer contributions to the NHS Pension Scheme	2,923	-	2,923	1,691	-	1,691	4,614	-	4,614
Other pension costs	1	-	1	-	-	-	1	-	1
Apprenticeship Levy	95	-	95	-	-	-	95	-	95
Termination benefits	4,041	-	4,041	12,291	-	12,291	16,333	-	16,333
Gross employee benefits expenditure	17,585	327	17,912	28,848	923	29,771	46,433	1,251	47,683
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-	-	-	-	-	-	-
Total - Net admin employee benefits including capitalised costs	17,585	327	17,912	28,848	923	29,771	46,433	1,251	47,683
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits excluding capitalised costs	17,585	327	17,912	28,848	923	29,771	46,433	1,251	47,683

	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
2024-25 Employee Benefits									
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	31,309
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	15,286	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	15,286	13,495	1,750	15,245	28,315	2,216	30,531