Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Living a longer, healthier life

Bedfordshire, Luton and Milton Keynes
Joint Forward Plan 2025 - 2030

This document has been produced in collaboration with partners from across the BLMK health and Care Partnership. It was originally published in June 2023, and updated again in 2024 as per the requirement to refresh annually. This (April 2025) version – following a light touch update of the previous Plan - outlines our progress in 2024/25 and our plans and priorities for 2025/30 and beyond.

Bedford Borough Council
Central Bedfordshire
Luton
Milton Keynes City Council
Cambridgeshire Community Services NHS Trust
East of England Ambulance Service NHS Trust
Bedfordshire Hospitals NHS Foundation Trust
Central and North West London NHS Foundation Trust
East London NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Contents

Foreword from BLMK ICB Accountable Officer

Welcome to the Bedfordshire, Luton, and Milton Keynes Integrated Care Board Joint Forward Plan.

The BLMK Joint Forward Plan is a journey we must make together if we are to enable more people to stay well throughout their lives.

Our aim is to increase the years of healthy life that every one of our residents have – adding life to years, not just years to life.

To achieve this, we must **change how we work**. We need to collaborate and co-ordinate with all our partners. That starts with Bedfordshire, Luton and Milton Keynes residents. It includes community networks, the voluntary sector, employers and all our public services. The result should be that no matter where you live in our area, you see and feel the benefits of health and care services which are working together to deliver better services. We are proud of the progress we have made to date, and excited about the change we can deliver together over the next five years. More information about what this will look like is set out in this Joint Forward Plan 2025/30 publication – this includes our BLMK Portfolio Tool, setting out progress made and forthcoming milestones across all priority workstreams at system, place and collaborative level.

The NHS was created over 75 years ago to help people who have ill health. We still do that, but we now need to do more, focusing on preventing people becoming unwell in the first place.

Prevention means working in a way that fits with people's lives, making sure that the services we offer are as easy as possible to navigate. They need to be effective and efficient, offering the right support at the right time. To do this we need to work with other services, especially our local council partners and our residents, to address the 80% of things which affect everyone's health, not just the 20% which are affected by the NHS. We look forward to the forthcoming 10 Year Plan for Health & Care which will set out more detail on the Secretary of States three shifts.

We are at the start of this way of working, and we are excited about its potential. This Plan outlines our approach and the change that we as partners in the ICB want to make. In the NHS, long-term tends to mean 5-10 years. However, we believe that this work should look to 2040 and beyond, and this is reflected in our plans.

This Plan reflects our progress in 2024/25 and our plans and priorities over the next five years and beyond. In this document, you will find what we are doing in collaboration to help keep you healthy, and how we are listening to our communities to root out health inequalities wherever we find them. We also set out our priority areas of transformation, and how we are working hard to create more sustainable health services through delivery of our BLMK Health Services Strategy.

This Plan is based on the health of the whole person, rather than specific organisations or clinical specialties. Our commitment is to work as close to residents as possible, something we call subsidiarity. That means building change together with you, co-producing services so that residents' voices are heard, and acted upon, every step of the way. That can only be a good thing.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

We will measure how interventions have better enabled residents to live fulfilling lives. This is all about measuring how you are and your health outcomes. This work should result in fairer access and outcomes across the population.

The changes involve both how we work and what we are trying to deliver. It promises better outcomes for residents across Bedfordshire, Luton and Milton Keynes, and that's what really matters.

In the Plan you will find out more about the issues we are trying to tackle, how we intend working with our partners to keep people healthier, and how we want to improve outcomes and tackle inequalities for our residents.

Finally, your involvement matters so much. If you want to get involved in our ongoing work, please contact blmkicb.contactus@nhs.net. We would love to hear from you.

Felicity Cox
Chief Executive - BLMK Integrated Care Board

What is a Joint Forward Plan?

Every Integrated Care Board (ICB) in England is required to develop a Joint Forward Plan with its Trust partners. It must set out how the Councils, NHS, wider public sector and voluntary organisations intend to arrange or provide our services to meet their population's physical and mental health needs, and tackle inequalities.

The purpose of the Plan is to bring together all the operational and strategic plans for the partners of the ICB to:

- 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;
- Delivery the health service's objectives set out by NHS England; and
- Provide a medium-term view of how these will be delivered, for a minimum of five years.

The Joint Forward Plan is the medium-term, over-arching Plan that sets out how ICB partners will work together to support our communities to thrive.

Our four pillars

Every ICB has four core purposes, which we call our pillars. These are:

- Improving outcomes in population health and healthcare;
- Tackling inequalities in outcomes, experience and access;
- Enhancing productivity and value for money; and
- Helping the NHS to support broader social and economic development.

Helping to overcome difficult challenges

The Joint Forward Plan does not replace individual organisations' own strategic and operational plans. It covers areas where we need to work together to overcome difficult challenges. If we can do that, we will better deliver the outcomes to enable our residents to live more years in good health.

This Plan sets out our most complex challenges. We need to tackle them together to make a real difference to our communities and help us to deliver services with our available resources. It brings the direct voice and experiences of residents too, particularly through the Healthwatch and elected councillors, without which we cannot tackle known health inequalities across BLMK. Resident voice is also reflected through the insights gained by – and follow up work in response to - the landmark Denny Review of Health Inequalities, published in 2023.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Putting residents at the heart of our Plan

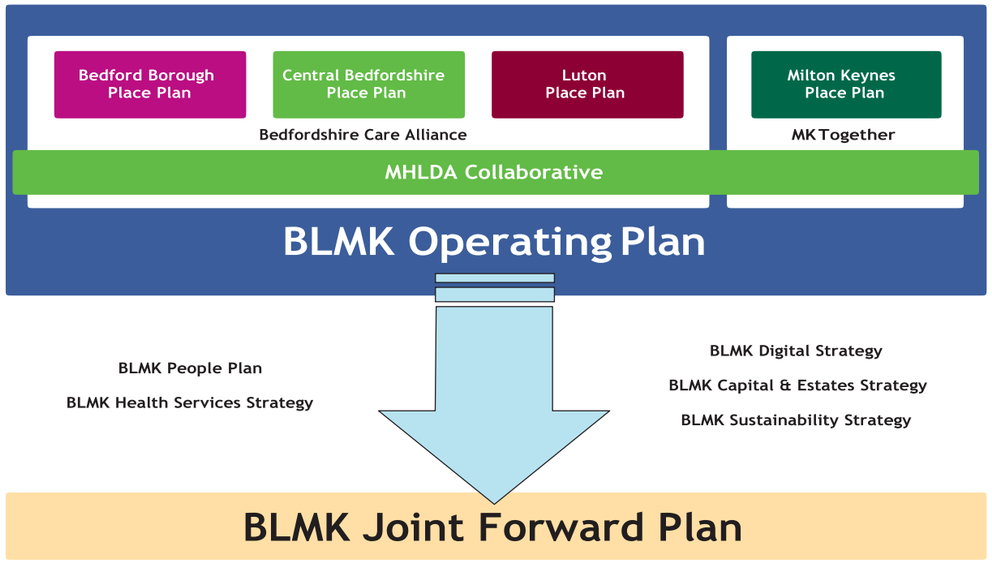
We are committed to making sure the voice of the resident is heard, and that's why we've been listening to residents across BLMK to inform what this Plan presents. Our Joint Forward Plan is centered on the resident. Our focus is on the needs of our communities in each of our four Places. These are Bedford Borough, Central Bedfordshire, Luton and Milton Keynes.

The Integrated Health and Care Partnership

The Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Health and Care Partnership is made up of locally elected councillors, NHS and council chairs, Healthwatch, Voluntary,

Community and Social Enterprise Organisations and wider public sector partners, such as police, fire and criminal justice representatives. It brings together the needs of all our residents, as identified in each Borough's Joint Strategic Needs Assessment, with the strategic priorities of each Place's Health and Wellbeing Board. As our ICB matures, the role of the Integrated Health and Care Partnership will be to hold us account.

The Joint Forward Plan is a medium to long-term strategic Plan. As such it integrates several other strategies and operational plans. This is a complex relationship, summarised below:



The experience of residents

Residents rightly express frustration at having to repeat their story to different health and care professionals. This health and care landscape means that some of our most disadvantaged residents can experience the worst access to healthcare – something the Denny Review of Health Inequalities makes clear, and which is explained further in this Plan. The Denny Review, led by local community leader Rev Lloyd Denny, has seen partners come together to listen in depth to the experience of seldom heard communities across BLMK.

Residents are also clear that they can find it difficult to access primary care, and are worried about backlogs for elective surgery - they want to move on with their lives, recover, and reach their full potential

Our Integrated Health and Care Strategy says “No-one left behind”. A big part of our collaborative efforts is to tackle unfairness, inequality and the root causes of poor health and wellbeing for all our residents. We know – and hear – that lots of residents have a positive experience of local healthcare; we want our full population to expect and experience this.

Our focus

We need to meet population growth and changing needs of residents within the resources we have. We must work together to tackle our most difficult an important shared challenges so that our communities can thrive. Specifically, our Plan will:

- **Focus on working together** to meet changing population needs;
- **Develop our processes and partnerships** to build an integrated system
- **Develop and deliver infrastructure strategies** to tackle inequalities, improve health outcomes and reduce avoidable costs.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Our population

The people of Bedfordshire, Luton & Milton Keynes

Our area covers four places Bedford, Central Bedfordshire, Luton and Milton Keynes - all vibrant, unique and rich in cultural heritage. Our population is diverse with more than 100 languages spoken.

With 2 million jobs we are one of the fastest growing economies in England, contributing £110bn to the economy. We are served by excellent air, rail and road transport links.

BLMK has a diverse population.
Of our population of one million people, 69% Asian, 8% ‘Other White and 6% Black.

We are one of the fastest growing areas in the country. Our population is expected to exceed 1.2m within the next decade and could increase by nearly 90% by 2050.

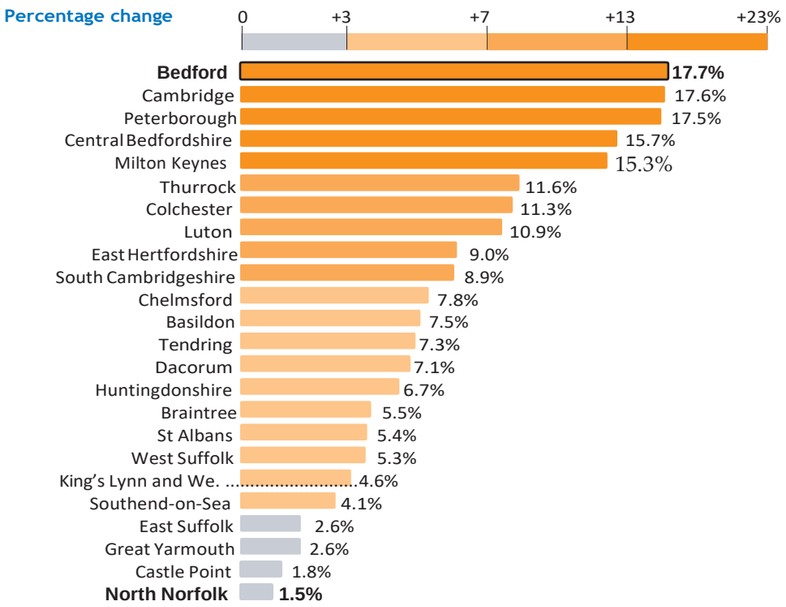
The four Places within Bedfordshire, Luton and Milton Keynes are diverse, and all have rapidly growing population. Over the last 10 years, around 5,000 homes were completed per year across our area. This is likely to increase. Local plans and housing strategies from our Borough Councils suggest around 6,000 new homes will be built each year to 2040 – and this is expected to increase in view of central government policy.

This is significantly more than population projections from the Office for National Statistics (ONS) which assumes growth of around 2,400 homes per year; new housing built in our area is likely to be 2.5 times higher than official, national estimates.

We have one of the fastest growing populations in the UK, and this trend is expected to continue.

Not only will there be more residents in the area over the next 15-20 years, but the demography, health needs and demand of our population will change significantly.

Population change of selected local authority areas in the East of England between 2011 and 2021



Under 18	18-39	40-64	65-74	75+
+13%	+10%	+14%	+33%	+25%

All of our Boroughs have strong plans to grow housing, employment opportunities and prosperity in a sustainable way, focused on the needs of specific communities. This Joint Forward Plan is clear that we cannot do more of the same with our resources to meet this growing and changing population need – that's why we've published our Health Services Strategy, setting out the commitments at the heart a more sustainable system in BLMK.

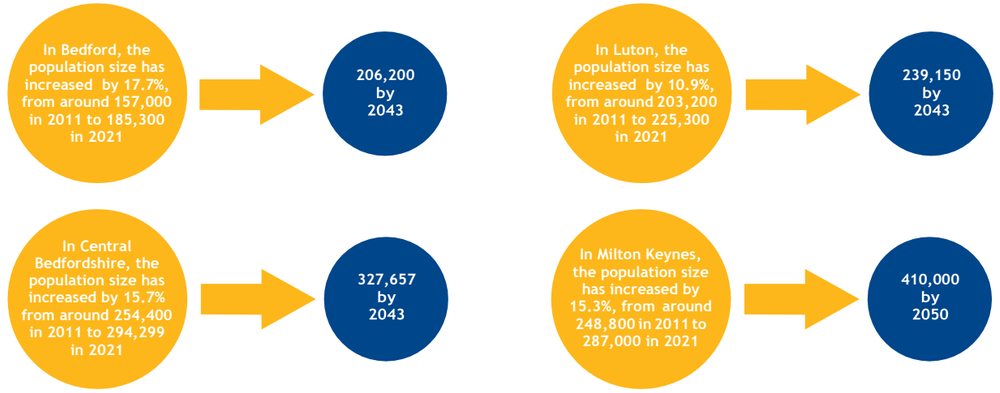
Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

The most difficult issues which this Plan addresses

The known and shared complex, critical and stubborn issues for BLMK are:

- Rapid population growth and demographic shifts, specific to each Place



- Challenges accessing core primary care, including GP and dental services;
- Life challenges experienced by people in our communities including poverty, poor education and other things that may make a person vulnerable to inequalities as set out in the Denny Review of Health Inequalities;
- Impact of COVID on residents, including:
  - Deconditioning of people with frailty
  - Increased safeguarding and mental health issues for children and young people
  - Delays in accessing routine elective surgery;
- Cost of living issues affecting families; and
- Poor health of the population including obesity and long-term conditions.

SECTION TWO: Medium-term affordability

Making sure we can afford the services residents need

The key financial pressures for the NHS in BLMK in the medium term are as follows:

Revenue

• Demand for services;

• Inflationary costs;

• Significant levels of efficiencies needed;

• Achieving elective recovery targets;

• Reduction in ICB running cost allowance of 30% by 2024-25; and

• Impact of delegation of pharmacy, ophthalmology and dental services and future delegation of specialist commissioning.

Capital

• Overall affordability of plans within the Capital Departmental Expenditure Limit (CDEL)

• Ensuring capital allocations are equitably and fairly distributed; and,

• Investment to increase capacity in the primary care estate

To manage these pressures the ICB will need to work in partnership to improve performance and productivity.

It will also need to explore alternative and innovative funding mechanisms.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Local authorities' affordability challenges

All four of our unitary councils are under substantial and sustained financial pressures. If they are not addressed, these pressures will total many millions over the next five years.

The main drivers of these pressures are increasing demand (especially in adults and children's social care and homelessness), inflation and a sustained reduction in central Government financial support for services. A fundamental challenge for local government partners is the short-term nature of the finance settlements which makes planning difficult. Health partners continue to work closely with Local Authority leaders to consider the potential for devolution in the BLMK footprint, following the publication of the Government's Devolution White Paper (Dec, 24).

Mitigations include:

- **Clinical peer-to-peer productivity challenges** (sharing best practice to maximise productivity in clinical services, and reduce waiting times)
- **Multi-agency pathway redesign** - reducing the number of steps in clinical pathways to treat people who need it more quickly)
- **Maximising the effectiveness of clinical support and corporate functions** – in areas such as pathology, prescribing, procurement and agency spend
- **Cross-sector innovation** – for example, introduction of a digital app to monitor epilepsy in children
- **Intra-region (ICB)** – working with other ICBs to share functions and reduce costs
- **ICB internal efficiencies** – for example, continuing health care (CHC), non-pay costs.

Outstanding risk

There are three key risks to affordability over the medium-term:

- Revenue does not keep up with rapid population growth, and the increase in need and demand;
- Having sufficient financial headroom to facilitate transformation of services; and,
- The short-term nature of the finance settlements which makes planning difficult.

Due to the challenged financial position and the requirements on the ICB to produce a balanced financial plan, our commissioning plan and plans to invest-in or transform services may need to change, and we may not be able to do everything we had planned to do within the timeframes expected.

Finance and Investment Committee

The Finance and Investment Committee is a non-statutory executive Committee of the Board. The Committee is accountable to the Board of the ICB and is authorised by the Board to investigate any activity within its terms of reference and to seek the information required to do so, commission any reports it deems necessary to help fulfil its obligations and obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions.

The purpose of the committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- Financial performance of the ICB.
- Financial performance of NHS organisations within the ICB footprint.
- Receipt of ICB and system finance reports with year end forecasts;
- Scrutinising presentations on the system medium term financial plan;
- Discussed and recommended the ICB's 2022/23 Section 75 agreements for approval by the Board of the ICB;
- Review of an update on the planned procurement approach for the ICB strategic data platform and the governance processes and approved the procurement of a strategic development partner;
- Discussions on updates on current key procurement and contracting issues and on the system capital position and progress of key projects;
- Review of and discussion on draft business cases and in particular how they can be designed to support the key ICB objective of reducing health inequalities going forwards;
- Reviewing progress in terms of system transformation and efficiency activities;
- Reviewing capital updates and plans;
- Reviewing updates in terms of digital activities and plans; and
- Review of the finance risk register

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

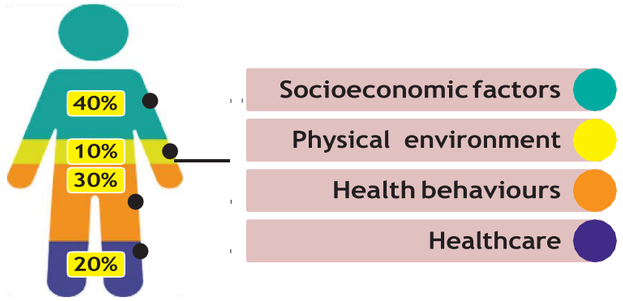
SECTION THREE: Our Strategic Priorities

Our BLMK ICB Strategic Priorities set out our ambition for improving health outcomes and reducing inequalities. Our goal is for everyone in our city, towns, villages, and communities to live a longer, healthier life. It means increasing the number of years people spend in good health and reducing the gap between the healthiest and the least healthy in our community.

Our strategy set out three questions which we will answer by working in partnership:

1. Are we doing the right things to improve health outcomes and tackle health inequalities for our residents?
2. Are we making the best use of partnerships between public services, voluntary, community and social enterprise (VCSE) partners and local communities?
3. Are we working with our people and communities to understand what matters to our residents and co-designing and co-producing sustainable solutions?

Our Joint Forward Plan is firmly grounded in this understanding of what matters to our people and communities, our Joint Strategic Needs Assessments, Health and Wellbeing Strategies and priorities at Place. The benefit of working in partnership is the opportunity this affords us to look at all the factors that affect our chances of living a longer, healthier life.



SECTION FOUR: A Joint Approach - maximising benefit to residents

Our Joint Forward Plan highlights the shared complex, critical and stubborn issues. These are where an innovative, collaborative approach is needed to deliver outcomes for all residents to 2040 and beyond.

As such the Plan is built on a strong shared ethos between all partners in the ICB as to how best to achieve this sustainably:

1. **Prevention and earlier intervention** – preventing or reducing things that have a negative impact on people's health and well-being

2. **Local interventions that meet the needs of residents at a Neighbourhood, Place or System-level** – based on the demographic and health needs of local communities

3. **Right Care, First Time**, especially for those residents who have the:

   a. Worst outcomes, highest risk factors or the greatest inequalities, like those population groups we've listened to through the landmark Denny Review, like people who are homeless or identify as LGBT;

   b. Highest and most complex needs, or unmet needs driving high volumes of interaction with health, care and public sector services, e.g. police;

   c. Highest volume, lowest complexity demand for health care, including elective and same day urgent care.

4. **Co-production with local communities** – working with (not doing to) our residents to design and deliver services and support that enable communities to thrive. We are proud to have trained over 300 BLMK colleagues in co-production approaches to date.

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

5. **Leverage the inter-dependencies and interfaces across health and care services** to:

   a. Make every contact count – build opportunistic prevention, and support for residents to self-care, into existing pathways ofcare;

   b. Reduce low value and repeat interventions for residents; and

   c. Optimise use of resources, including our workforce, estates and finance.

6. **Optimise the operating environment for health, care and civic services** – across traditional service and organisational boundaries to:

   a. Identify and tackle all tackle all health inequalities, wherever we find them;

   b. Stimulate local employment and economic development;

   c. Support the sustainability and green agenda;

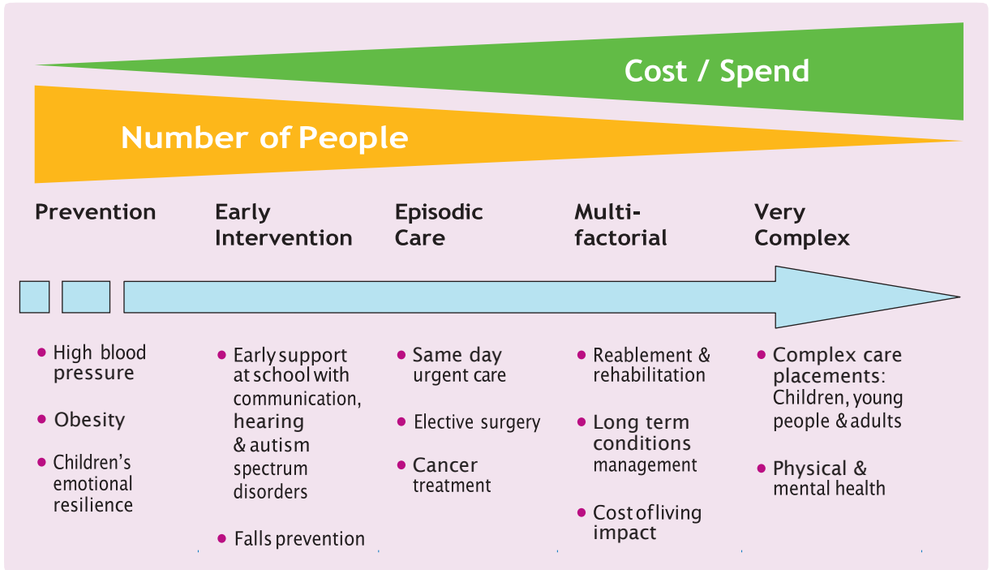
   d. Develop the workforce over long term; and,

   e. Invest in the digital and estates assets.

There are significant differences between existing local authority and NHS planning approaches. The NHS is often focussed on short-term delivery, with a two-year funding cycle and a one-year operating plan. Local authority plans for infrastructure and population growth are over a 15-20 year period. NHS operating objectives are focused on the standards that clinical services must achieve for the patients who access these services. All health and local authority partners in ICBs have a shared responsibility to the populations they serve in their use of public money. BLMK partners are working together to improve their approach to long-term planning, as set out in the BLMK Health Services Strategy.

SECTION FIVE: Our approach

Addressing our shared, major challenges will require a systemic approach, split into different levels, as shown below:



This will shift our focus from: 'What can we afford to do?' to 'Can we afford NOT to do it?'

When the question is changed like this the focus is different. It becomes much more about the people living in BLMK, and how best we tackle inequalities and improve health outcomes. We will focus on:

1. Developing a consistent approach to framing and investigating our shared complex, critical and stubborn issues. The focus will be on defining our target population, supporting co-production and personalisation and using collective resources;

2. Ensuring interventions are evidence-based. Challenging ourselves to achieve and sustain performance within the top 10% of ICBs. Drawing on and contributing to research and innovation, and applying learning from best practice; and

3. Taking an approach to improvement which can adapt according to different circumstances. Measuring outcomes as well as activity and considering both the impact of our actions and the impact on the health and care system or wider society if we fail to act.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Examples of this approach could include:

a) Earlier intervention for children and young people who would benefit from:

- Speech and language help at a younger age or at a lower threshold of need;
- Autism spectrum disorder support and diagnosis at a lower threshold of need; and
- Occupational therapy input for children identified above to support their communication and social interaction at home and school.

The rationale for this earlier intervention would be to support children to meet their earlier developmental and education milestones, rather than delay intervention until the special educational needs and disability (SEND) threshold is met later in childhood.

b) Local integrated offer for people with complex mental health or learning disability needs, whose placement needs are currently met through contracting with independent sector providers. This could include:

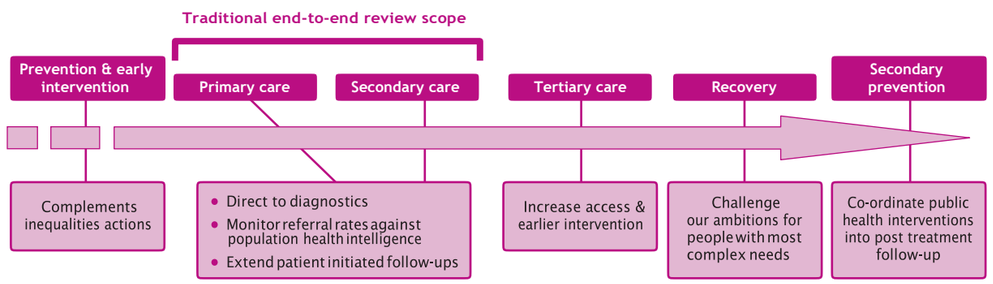
- Creating sufficient supported independent living accommodation within local authority areas to meet local need;
- Extended capacity to bring crisis support to the individual at times of highest need. This would reduce Emergency Department attendance and acute psychiatric admission unless clinically required;
- An approach which supports the individual to address root causes, manage distressing emotions and achieve their potential; and
- If needing to be referred to a mental health professional, supporting residents to decide which provider or clinical team they would like to receive care from as long as that provider has an NHS contract

This population are some of the most disadvantaged in our society. This approach sets out how our whole system can come together to support residents to thrive.

c) Elective clinical pathways review

An end-to-end clinical pathway review typically spans looks at the full journey a resident would take when seeking health and care support. This would start in primary care, when a resident first sees a healthcare professional, to secondary care, if specialist support is required, and the return to primary care for those who access healthcare.

Adopting a truly end-to-end clinical pathway review could better tackle inequalities and improve health outcomes, as shown below:



Anchored in Places, this approach will:

- Identify populations whose risk profile or barriers to access indicates they are at higher risk and require support at a neighbourhood or council ward level;
- Provide engagement tailored to the residents' different needs, such as health promotion and uptake of screening programmes;
- Provide oversight for Place partners – giving a clear view and feedback on managing unwanted variation in services.
- Reduce bureaucracy for GPs in the referral processes. It will encourage greater autonomy for providers of acute care to determine the right clinical pathway
- Inform decision-making on how best to use specialised clinical pathways, known as tertiary care. These are currently under-used in BLMK,
- Allow residents to get the best public health interventions for the
- Promoting choice on where residents can be referred for consultant-led treatment including deciding on which clinical team.

The outcomes sought from this approach are two-fold:

1. To ensure timely access that maximises health outcomes for all residents
2. To manage demand and cost through more effective, targeted interventions based on population need.

d) Partnership in 'Fuller' Neighbourhoods to support residents to tackle the root causes of their need and not just manage symptoms.

The development of Fuller Neighbourhoods is based on a report by Dr Claire Fuller which sets out the future vision for Primary Care services.

It sets out how by bringing together all the professionals who can support residents in specific neighbourhoods with primary care needs we can better sustain delivery of;

- Same day access for urgent care
- Support to people living with long term conditions
- Working with communities and our voluntary sector partners to help people improve their health & well- being
- Working with our partners in emergency services, education and civic functions such as libraries and leisure centres to enable people to access urgent support for mental health crises when they need

BLMK is proud to be pioneering Neighborhood approaches, including the Bletchley Pathfinder.

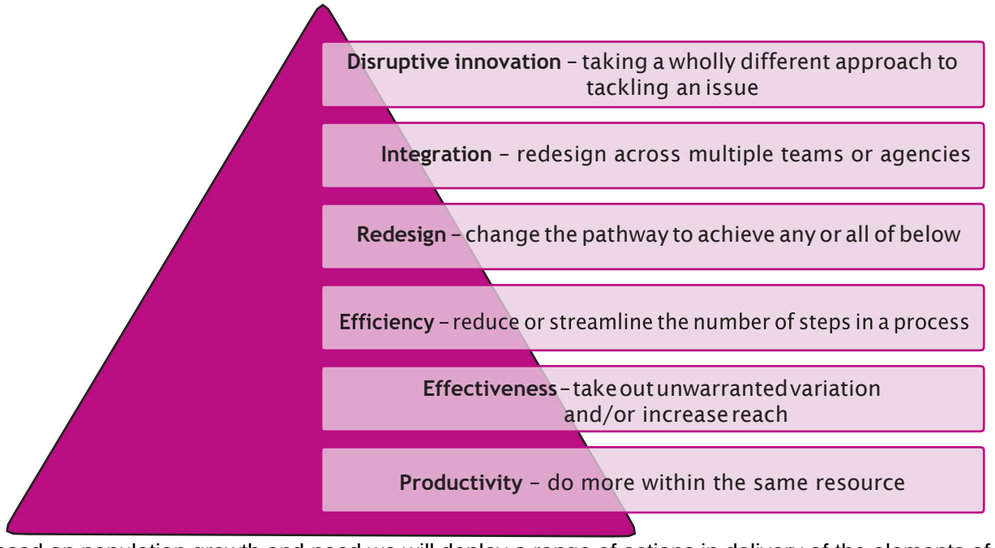
These four examples demonstrate how, when we collaborate to the benefit of specific residents, we can improve outcomes for the individual and reduce avoidable costs.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

As illustrated in these examples, the Joint Forward Plan will aim to move us away from the traditional way we deliver care, which is often not joined up. We will be able to:

- Define our goals by the needs of our population at Place rather than episodes of care or care pathways;
- Move resource to improving prevention and early intervention, to benefit residents and reduce future need and cost; and
- take a long-term view wherever possible.

We will deliver this through quality improvement interventions that are locally owned. They will make it easier for our teams to do the right thing for the resident, first time.



Based on population growth and need we will deploy a range of actions in delivery of the elements of the Joint Forward Plan. We are excited about growing this work together with our partners and the major impact it will have on residents' lives across BLM

Our Key Drivers in BLMK

Key delivery vehicles are our work with partners in our **four Places** that make up our area - Bedford, Luton, Central Bedfordshire and Milton Keynes - and our work with partners in **two collaboratives** - the Mental Health, Learning Disabilities and Autism Collaborative (MHLDA) and the Bedfordshire Care Alliance (BCA). You can read more about these groups and their work in **Section 8** of this Plan.

Adopting Quality Improvement

We are excited to be working alongside the Institute for Healthcare Improvement. Our work together, expected to take place over the next 2-3 years, will develop a system Quality Improvement approach based on the five components of **NHS IMPACT.** We are benefitting from the IHI's expertise and international reach and are proud to have launched our Learning & Action Network in 2024 alongside many partners with whom we're working to reduce inequalities in our four places.

Delivering Our Health Services Strategy

In response to the sustainability challenges we face − financial and otherwise - BLMK system is proud to have published our Health Services Strategy. Like the Joint Forward Plan, the Heath Services Strategy spans the period out to 2040. With medical knowledge growing exponentially, and societal change moving at a rapid pace, the strategy is designed to develop by iteration: the direction of travel and the commitments described are expected to stand the test of time, whilst the programmes of work will evolve with science and society.

The Health Services Strategy is not intended to include each and every aspect of health service provision in BLMK: in many areas, existing collaborative mechanisms work well. Examples include joint management of the Better Care Fund between each Local Authority and the ICB; commissioning and contracting arrangements around the provision of specific health and care services; and, effective relationships between primary care practitioners and local hospitals. Quite rightly, the strategy has relatively little to say on such matters.

The **S**trategy does not seek to 'replace' or 'take over' work being undertaken at place, and in the case of Bedfordshire, through the alliance of organisations delivering services across the three places. Rather, it aims to enable and propel that work, recognising and supporting the uniqueness of each place, but also throwing light on variations that are unwarranted and unwelcome. The Strategy was agreed by the ICB Board in September 2024.

Harnessing the power of our The Population Health Management Unit

We are led by our data, including from our landmark **Population Health Intelligence Unit**, in all our transformation work. Across our system, our five strategic priorities continue to shape everything we do – Starting Well, Living Well, Ageing Well, Growth and Reducing Inequalities. Insights from our residents (including those from our Healthwatch and VCSE partners) are helping us to better understand if our Strategy is working, underpinned by agreed system wide-outcome measures. Our new System Insights Network is a key vehicle for understanding our residents' views in detail.

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Our Transformation Priorities

The ICB Board have agreed three transformation priorities for 2025/26, through these will extend across the next 3-5 years:

1. **Transforming Admission Avoidance & Discharge Pathways**, including those funded by the Better Care Fund;
2. **Transforming End of Life Care**, following our landmark End of Life Review;
3. **Transforming Complex Care**, where costs are spiraling and outcomes can be better.

Each of these Priorities has a clear evidence based, and burning platform for change. The ICB Board is currently agreeing system wide leadership, and working through the quantifiable benefits as part of Operational Planning.

Our BLMK "Golden Threads"

Three "golden threads" are expected to run through everything the system does for the next five years:

- **Tackling Inequalities –** all work across our Partnership has the potential to address heath inequalities, and our ambition to improve health outcomes for the most disadvantaged should run through everything we do. The Denny Review recommendations are the guiding light for this work in our system.
- **Supporting Neighbourhoods** – developing working across organisations at neighbourhood level, including with Voluntary, Community and Social Enterprise partners, to provide specific and localised support to residents within their communities is a multi-year, collective endeavour.
- **Advancing Digital** – we see digital services and tools at the heart of sustainable and modern healthcare in BLMK. From the NHS app to remote monitoring to applying AI, we're committed to embracing digital.

Tracking Our Progress and Setting Out Next Steps: The BLMK Portfolio Tool

Our Portfolio Report contains information on key strategic and transformational portfolios, programmes and projects across BLMK ICS. The first section of the report shows the hierarchy of portfolios, programmes and projects. The second section details the individual highlight report for BLMK portfolios, programmes and projects. This tool, welcomed by the Board, is a "one stop shop" for progress/future milestones on transformation in BLMK.

Measuring and Demonstrating Our Impact:

We are proud to be a leading system in this regard, having developed two clear system missions, each with a measurable baseline, and lead indicators for each of our five strategic priorities: Start Well, Live Well, Age Well, Supporting Growth & Reducing Inequalities. See **Section 9** – out progress in 2024/25 – for more detail.

Regional Models of Care Work

We are pleased to support the work to drive more innovation and consistency across the East of England footprint. Please see the Annex for further detail. We recognize that doing more at scale – but maintaining some local flexibility – can bring significant benefits to residents in the East of England region.

Navigating a Challenging Financial Context

Our local context of continued rapid population growth alongside national economic challenges, and the legacy of the Covid pandemic, mean that during 25/26, our system will need to take difficult decisions about our priorities for investment and the services we commission and provide. Any significant service changes will be subject to equality and quality impact assessments, appropriate engagement and consultation processes, and wider scrutiny. As a system we may also not be able to do everything we had planned to do in 2024/25. We will continue regular communications with partners and residents as we understand this further.

SECTION SIX: Mobilising the Joint Forward Plan

There are several key actions that need to be completed for the Plan to be delivered to maximum effect, and to enable us to measure the difference are we making for our residents.

Population growth and change

There is a critical need to accurately model how the population will grow and the demographics will change for each of our four Places up to 2040. At the same time, the demographic make-up of each Place is changing, with each one specific to its local population. Changes to the numbers of people of different ages, for examples, will have an impact on the services required.

We cannot build, deliver, and assess the impact of a Joint Forward Plan without clear future modelling scenarios of our population size, demographic, and likely future health and civic needs, including where, when and how individuals are most likely to experience health inequalities. The new Population Health Intelligence Unit – hosted by Bedford Borough Council – is providing this vital function, and the projections for Population Growth and Demand Growth are as presented in the Health Services Strategy, and the Directors of Public Health Annual Report.

Implementing the ICS Target Operating Model

The ICB is implementing a new Target Operating Model during 2023-25. The ICB has progressed the first year and 2024/25 is completing the second. The model reflects the ICBs role as a system convenor, bringing together different services to address difficult challenges, and its' own organizational requirement to reduce its own running costs by 30% by 2025. It involves changes in ways of working and extending the responsibilities of Place and Provider Collaboratives to improve health outcomes and tackle inequalities.

improvements for our residents.

The diagram of the TOM is illustrative and not drawn to scale.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

SECTION SEVEN: High Impact Programmes

We – and our partners – must work differently together to achieve our ICB core aims and NHS England Operating Plan targets. This includes, crucially, improving health outcomes and reducing inequalities for our residents – ambitions which are at the centre of our Health and Care Strategy, and of this Joint Forward Plan.

The effects of the COVID pandemic, cost of living crisis and rapid projected population growth means this is a significant challenge. It will require a fundamental shift in how public sector and VCSE services engage and support residents.

ICB partners recognise that we need to take steps to tackle the root causes of poor health outcomes and inequalities. Section Five summarises the approach the ICB will take to achieve this shift towards a focus on prevention of health issues. Section Six described the actions we need to take.

In this section we set out our BLMK High Impact Programmes. These are programmes which ICB partners will deliver in collaboration to realise our Integrated Care Partnership strategy and ICB objectives.

The following sections of the Plan will:

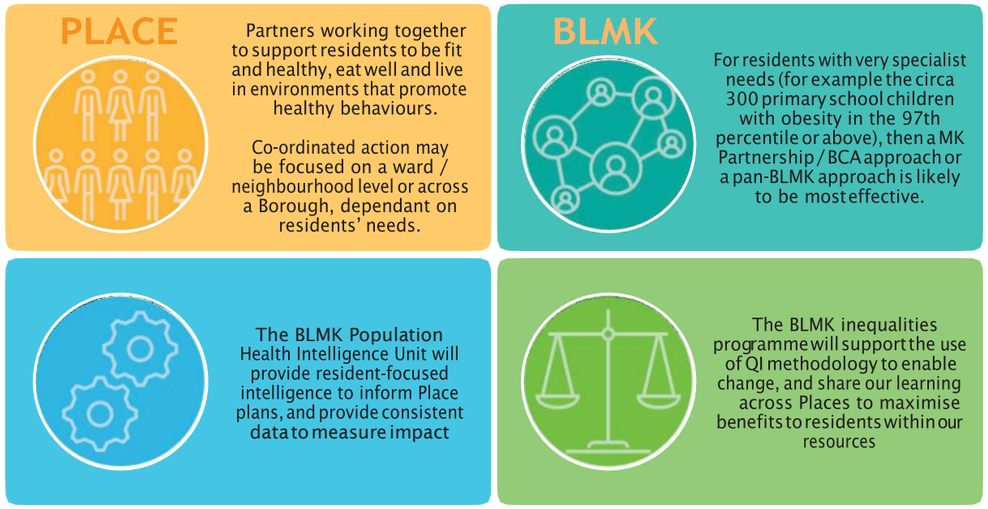
- Clarify how these overarching programmes will come together and enable the delivery of our medium-term Place plans, based on population needs, over the next five years, and beyond where possible.
- Describe the emerging role of our provider Collaboratives to shape and lead delivery of clinical and professional-focused programmes;
- Provide a summary of our key enabler programmes, such as the People Plan or Digital Strategy;
- Detail how this Joint Forward Plan will deliver the standards and targets of the NHS England Long Term Plan; and
- Describe the extent to which the Joint Forward Plan will mitigate the risks outlined in the ICB's Board Assurance Framework, and key risks currently beyond the direct control of ICB partne

The ICB High Impact Programmes are those interventions where we can only achieve the outcomes sought for our residents through collaboration, partnership and innovation.
The ICB's governance and ways of working are based on the principle of **'subsidiarity'**. This means that decisions and responsibility for delivering agreed changes sit as close to the resident as possible.
This principle determines who needs to be involved in leading which aspects of our High Impact Programmes. For example:

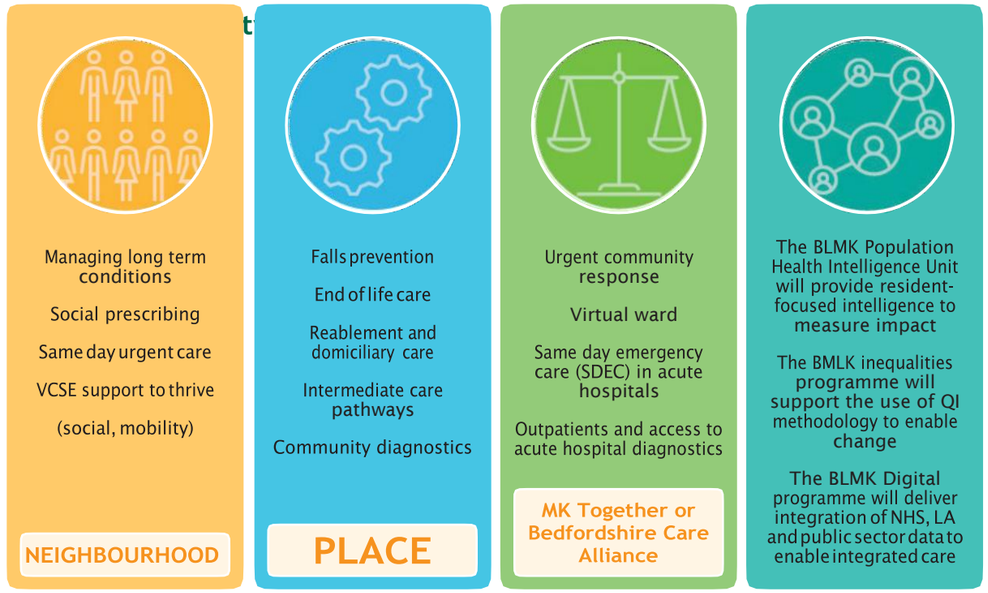
- A single organisation and managed within that organisation's own governance;
- Across partners working together at Place;
- A Collaborative of different health and care Providers and
- Where there is high complexity, acute need and very low numbers of residents, an approach across the whole of our area may deliver the best outcomes

Focusing on residents' needs, rather than the service or intervention required, allows subsidiarity to function effectively.

Example 1 - Obesity



Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan



So, what are our High Impact Programmes?

1. **Advancing Equity,** (reducing harm and promoting safety through the introduction of quality improvement methods and tools)

- Supporting all system partners to develop a population health management approach to tackle the socio-economic and environmental disadvantages in life, and improving the access, experience and outcomes for all our residents.
- Adoption across BLMK of consistent Quality Improvement tools to enable all staff to identify, tackle, test and measure improvements in access, outcomes and experience across our NHS and civic services
- Support to system partners in working to support patient safety by maximising the things that go right and minimising the things that go wrong in health care provision, improving effectiveness and patient experience. Delivering a system supported collaborative approach to new framework for patient safety and reducing harm (NHS patient safety incident response framework- PSIRF)

2. Efficiency & Effectiveness Improvement Programme

- Rolling programme to identify and reduce unwarranted variation in clinical and integrated health and care pathways, tackle inequalities and to reduce unnecessary cost
- Focus on multi-agency pathways and clinical support / corporate delivery (local productivity & improvement is overseen within organisation-specific and Place governance)
- Shared oversight of all efficiency and effectiveness programmes (organisation-specific, issues in common, multi-agency and ICB) to assure overall delivery of required impact / benefits and mitigate unintended consequences of inter-intra-dependency
- Establish digital / automated feedback loops to empower local teams to deliver best practice and address unwarranted variation as close to the service as possible

3. Enabling our Children and Young People to Thrive

- Earlier intervention to support children and young people to thrive (education, long term conditions and mental health and well-being)
- Sustainable recovery-focused strategy for complex needs / placements
- Preparing for adulthood
- Focus on children and young people experiencing the poorest outcomes / most disadvantaged: looked after children, children living in poverty, children who are displaced or experiencing abuse

4. Improved Access and Treatment

- Delivery of elective and emergency care recovery through integration and innovation
- Development of diagnostics and screening to address inequalities of access and outcomes
- Focus on ensuring that our most disadvantaged populations have parity of access and health outcomes, for example those living in deprivation, displaced people, vulnerable children and adults
- Promoting digital innovation to improve diagnostic and elective accessibility whilst safeguarding against digital exclusion.
- Make best use of capacity across all health care sectors and promoting choice where applicable and maintaining compliance with the NHSE Choice Framework (Jan 2024).
- Prioritising care for those with the most urgent clinical need ensuring equity between both children and adults.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

5. Improving Outcomes for people with Mental Illness, Learning Disabilities and / or Autism Spectrum Disorders (MHLDA)

- Development of sustainable early intervention and crisis and recovery pathways for children, young people and adults
- Develop capacity to deliver early local diagnosis and support for people with autism spectrum disorders
- Development and implementation of sustainable recovery-focused models of care for people with complex needs, including shift to default of complex placements being delivered within BLMK
- Capital development in core services, for example mental health inpatients
- Improving physical health access and outcomes for people with severe mental illness, learning disabilities and autism spectrum disorders

6. Integrated Neighbourhood Working

- Delivery of 'Fuller' Neighbourhoods – proactive multi-disciplinary teams focused on local populations to provide same day urgent care and support to manage long term conditions
- Acceleration of prevention and support to tackle the wider determinants of health (falls prevention, optimised end of life care at home, rehabilitation, reablement and recovery post-health crisis, supporting people furthest from employment or training)
- Optimise delivery and outcomes from delegated primary care services (optometry, dental and community pharmacy)
- Continued delivery of the GP recovery plan – together with Place-based strategies to expand primary care capacity to meet population growth

7. Intelligence-led Quality, Outcomes, Performance, & Inequalities Improvement

- Continued Implementation of the Public Health Intelligence Unit and outcomes-based reporting based on specific populations
- Sustainable re-development of business intelligence and analytics capability / capacity to shift performance reporting (i.e. NHS Operating Plan Targets) to be viewed through the lens of impact on local communities
- Digital integration strategy – integration of NHS, LA and public sector data to enable integrated care and embedding digital solutions in care pathways

8. Integrated Care System Target Operating Model

- Structuring ICB staff to focus on core ICB / Place & Collaborative / pan-BLMK / pan-East of England region statutory & mandated responsibilities and delivery of high impact programmes (and deliver required ICB running cost allocations efficiencies)
- Development of Place / Health & Well-being Boards and their relationship with NHS and LA organisational governance
- Evolution of Integrated Health & Care Partnership Board
- Developing ICB Leadership roles and responsibilities to deliver the Target Operating Model
- Develop training to embed the new ways of working
- Due diligence and mobilisation of delegation of specialised commissioning for BLMK population

9. Thriving Eco-systems and Prosperous Communities

- Embed environmental sustainability into decision-making at all levels of the health and care system, to achieve the co-benefits of health improvement, whilst reducing the impact on our ecosystems and the negative impact on people's health and wellbeing.
- Deliver the BLMK ICS Green Plan to achieve a net zero health system, working with partners, VCSEs and residents.
- Establish a collaborative of anchor institutions
- Develop pathways for those furthest from stable employment due to their health to obtain, return to, and stay in work.
- Grow our own workforce across all health and care careers in partnership with educational institutions
- Ensure inward investment through supply chains
- Implement the BLMK Research Hub at the University of Bedfordshire, and build the system Research and Innovation portfolio across all our institutions.

Delivering the Benefits of our High Impact Programmes

'So what?' This is the question we in the ICB have challenged ourselves to focus on when developing our High Impact Programmes.

Each of our High Impact Programmes have clearly defined problem statements. These are focused on our population's needs rather than how services are currently delivered.

This shift in focus is crucial to enable the ICB to:

- Support the health and wellbeing of our residents, using local assets to enable communities to thrive;
- Make best use of resources within current and future constraints; and

Embed sustainable solutions to chronic and growing gaps between demand and capacity. This includes urgent and emergency care, care at home or in residential care, elective demand and SEND.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

What is the problem we are trying to solve?

The problem statements for each of our High Impact Programmes are summarised below:

BLMK High Impact Programme	Problem Statements
1. Advancing Equity	· Too many BLMK residents live in poverty, which is the single biggest predictor of inequalities and poorer health & well-being · Maternity inequalities- poorer outcomes for BAME communities – higher risks mortality in this cohort in pregnancy. Higher risks of still birth, maternal, neonatal and infant mortality in 20% most deprived. · Health promotion challenges – smoking in pregnancy – more to understand current numbers – digital data collection · Residents, including health inclusion groups such as homeless, Roma and Gypsy travelling communities and migrants, experience inequalities in access to health services, impacting health outcomes · Obesity affects over a third of our population, especially those living in deprived areas with constrained income / poorer access to healthy food · Core20+5 highlights populations in BLMK with poorer access / uptake / outcomes in key health areas · Safeguarding numbers and complexity of presentation have increased for example, self-neglect, alcohol related issues, increase in domestic abuse and violence · Sustained improvement in health outcomes and reducing inequalities is complex and takes time to achieve
Efficiency & Effectiveness Improvement Programme	· The cost of continuing to provide services in the current configuration for our growing population exceeds the available resources · There are chronic workforce gaps (mirroring national picture) increasing pay costs and limiting effectiveness. · There are insufficient feedback loops for local teams to monitor compliance with best-practice and assess impact of improvement initiatives · Productivity in key health and care interventions is below top decile in specific services in BLMK
3. Enabling our Children and Young People to Thrive	· Too many of our children in BLMK live in poverty · Over a third of children in BLMK are overweight – this is a key risk in for future health & well-being · Not all children and young people have early key interventions during primary school years to enable them to thrive (communication, diagnosis and support for dyspraxia, autism spectrum disorders, emotional resilience) · There is more we can do to support transition to adulthood for young people with complex needs · BLMK has insufficient 'recovery & thrive' capability and capacity to meet the needs of our most complex children's placements within the patch · There is more we can do to prevent and proactively manage long term conditions for children & young people · Children and young people are waiting too long to access mental health and well-being services
4. Improving Access & Treatment	· Patients are waiting too long for routine elective interventions, compromising health & well-being · Barriers to accessing screening & early diagnosis are adversely impacting the health outcomes of some residents · Cancer diagnostic and treatment capacity in key modalities is insufficient given the increase in demand, and difficult to access for some populations · Urgent & emergency care pathways have higher demand than capacity, adversely impacting patient experience and increasing clinical risk · Uptake of very specialist clinical services in East of England is lower than national average, compromising health outcomes · Delays in paediatric elective treatments can have an impact on development and educational progress. · Traditional face to face elective care delivery models are inflexible and no longer meet the societies work and lifestyle expectations, leading to missed treatment opportunities and poorer outcome

BLMK High Impact Programme	Problem Statements
5. Improving Outcomes for MHLDA	· People in acute mental crisis / distress are not consistently able to access rapid mental health support in their local community · Crisis pathways are focused on immediate safety with insufficient recovery provision · People with severe mental illness and / or learning disabilities are more likely than the general population to die early due to long term conditions · BLMK has insufficient 'recovery & thrive' capability and capacity to meet the needs of our most complex mental health, learning disabilities and ASD placements within our geography · Current Bedfordshire adult inpatient mental health services estate is insufficient for modern models of care and local need / demand
6. Integrated Neighbourhood Working	· Revise and consolidate the process for people in receipt of Section 117 choosing to have a Personal Health Budget · Population growth in specific geographies will exceed primary care capacity (dental, pharmacy and primary medical) without transformation of the current service model. · There is more we can do to help connect people together within the community to address isolation, loneliness including those with caring responsibilities · Our approach to health screening (including cardio-vascular, respiratory, diabetes and cancer screening) needs to adapt and be agile to deliver an acceptable offer to our diverse population · There is more we can do by working with our voluntary sector to help residents live a happy life and to help them to confidently manage their long-term conditions · Seldom heard communities need a bespoke in-reach community offer to increase vaccination rates · The proportion of residents living in a care home with complex care needs continues to increase requiring multidisciplinary proactive anticipatory care to enable residents to be safely managed in an out of hospital setting · There is more we can do to support people/communities to address the root causes of their problems including the wider determinants of health to and reduce reliance on health care or medical interventions · We do not consistently use opportunities to promote wellbeing and physical activity or to sign post residents to community events or activities that support prevention of poor health.
7. Intelligence-led Quality, Performance, Outcomes, and Inequalities Improvement	· Not all health & care data is digitally integrated, causing gaps, duplication and delays in treatment – and requiring residents to repeat their story · There is more we can do to embed population health view into NHS metrics to identify inequalities in access, outcomes and experience; and assess the impact of actions to improve health outcomes and tackle inequalities · There is more we can do to enable residents to manage their health and wellbeing using digital technology · Duplication of reporting has an adverse impact on staff productivity & morale
8. Integrated Care System Target Operating Model	· Our current ways of working don't always make it easy to provide joined-up care for residents · There is more we can do to work with communities to enable them to thrive · There is more we can do to work in partnership with our VCSE to optimise experience and well-being for residents · Our governance will need to adapt as the ICB matures to optimise the impact of Health & Well-being Boards, and ensure collaborative and sovereign governance aligns · We have yet to explore the opportunities to conduct core ICB functions at scale across the East of England Region
9. Thriving Eco-systems and Prosperous Communities	· Environmental concerns are not yet seen as a core part of delivery of services to improve health and reduce avoidable illness. · Climate change and environmental pollution are not bound by geography, sectors, or organisational footprints, and have the greatest impact on those in the most-deprived communities. · We need to better understand accountabilities and responsibilities for delivering thriving ecosystems and prosperous communities across the different partners, organisations and sectors (public, private, VCSE) within the ICS, and develop appropriate governance and sensitive measurement systems to oversee progress.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Outcomes of our High Impact Programmes

This section summarises the benefits of High Impact Programmes to residents and to the sustainable delivery of NHS and local authority services. This is a shift from traditional reporting against performance targets, with a focus on volume and waiting times. Though these remain crucial to monitor the experience of our residents, this approach does not give assurance that we are improving the years lived in good health for all our residents.

The ICB is committed to understanding our performance data against key NHS and local authority standards and targets, with a focus on the local population's health and wellbeing. This

shifts the assessment of our impact from 'are we working hard enough to meet demand?' to 'are

we doing our best to improve health outcomes and tackle inequalities for all our residents?'

Here is an example of why this population perspective is so important.

Luton radiotherapy example:

Cancer performance is Luton was generally above average before the pandemic but there was a perplexing contradiction in terms of health outcomes for residents. There was a long-standing question as why the cancer outcomes for residents in Luton were poorer than other areas of the country.

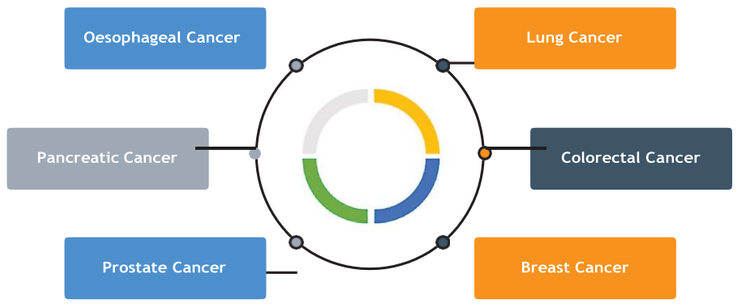
The Luton Cancer Outcomes project was set up to identify the main factors – **medical, behavioural, social and others** – which contribute to variations in cancer outcomes amongst the residents of Luton and make recommendations for improving cancer outcomes.

The project looked at four key **outcome measures**:

1. Stage at diagnosis 2. Emergency presentation 3. One year survival, and 4. Five year survival

And focused on the **six cancers** with the greatest levels of premature mortality for Luton in 2019:

We asked residents of Luton what the barriers were to accessing cancer services and one of the stories we heard was so powerful it formed our driver for change. Nam's story illustrates the complexities that lack of knowledge around how and when to seek help, services able to meet needs of their local population and access to transport or other economic factors can shift patient decision making and therefore patient outcomes.



Patients and carers from Luton have told us about geographical, cost, transport, cultural and socio-economic factors that make accessing care difficult.

For example:

- We have heard about women unable to travel to an appointment without their husband, unable to see a male doctor, or unable to travel very far from home, and whose diagnosis or treatment is delayed as a result.
- We have heard about single parents who cannot afford childcare support and have no one to babysit whilst they attend appointments – the further away those appointments are, the more impossible this becomes.
- We have repeatedly heard about journeys of 90 minutes each way to the current cancer centre and stories of patients who have decided not to have treatment because of the current lengthy travel times or complicated journeys.

The project worked in 4 key workstreams looking at health inequalities, health outcomes data patient experience and strategic factors such as resources, workforce, partnership working. These workstreams developed a set of recommendations which are now in implementation phase.

Key learning

- The factors contributing to poor cancer outcomes in Luton are complex and wide ranging;
- Patients and carers told us about geographical, cost, transport and socio-economic factors that made accessing care difficult
- Barriers to accessing cancer screening are likely to be linked to ethnicity and culture, but barriers to accessing treatment are likely linked to wider determinants such as access to transport and being able to take time off work.
- Prostate cancer diagnosis has been impacted by COVID with men not seeking help early on, we need to reach these men in a different way.
- Patient experience is generally good but we are not hearing from all communities
- People are still presenting late with cancer symptoms and this will continue to have an impact on survival rates if not addressed
- There are opportunities to make small but significant changes to cancer pathways - specifically between Luton & Dunstable and Mount Vernon - to improve experience and outcomes

This example illustrates how working together a on a shared problem can help us deliver a solution that addresses the issues that matter most to our residents.

The table overleaf sets out the outcomes we expect our High Impact Programmes to achieve:

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 -2040
Advancing Equity	· Detailed population growth & demographic shift modelled for BLMK to 2040 · Population health intelligence unit established · Shared Quality Improvement approach embedded across BLMK services · Inequalities targeted funding is aligned to Place JSNA priorities, with clear actions and metrics to evaluate benefit to residents	· Slow or reduce obesity in population · Improved Maternity & neonatal outcomes · Reduced variation in health outcomes, plus increasing access to services, especially for those who are most disadvantaged / have poorest outcomes · BLMK spread of Better Lives campaign of 0-25 year-olds	· Outcome measures demonstrate more residents spending more years of life in good health · Reduce incidence of still births, neonatal, maternal and infant mortality · Reduce smoking rates in our most deprived population · Increase in activity resulting in reduction in obesity in 11-16 year-olds
Efficiency & Effectiveness Improvement Programme	· Programme pipeline established – identification of opportunity · Governance established (organisation-specific, issues in common, pan-BLMK, ICB) · Effective impact metrics established to ensure sustainable shift in use of resources	· Programme supports improvement in health and outcomes and reductions in inequalities through effective use of resources · Programme has sufficient impact to enable local LA and NHS to deliver within resources · Teams will routinely have access to feedback loops highlighting variation to make it easier to ensure treatment pathways are delivered within best practice clinical guidelines	· Investment in our services and infrastructure is configured to anticipate future need as well as current population demand · We can evidence across our services that we are spending public money wisely and achieving optimum outcomes for residents · Our research and innovation is driving improvements in health outcomes, reducing inequalities and delivering sustainable resources
Enabling our Children and Young People to Thrive	· Working jointly with Councils at Place and wider to develop affordable and sustainable placements and/or capacity for children with the most complex needs. · Working at Place to support families to prevent and intervene early for overweight children. · To develop multi-disciplinary pathways of care that provide evidence based, resourced early intervention for children in their early years – to include, hearing, communication, sensory. · Roll-out national pathways for asthma, epilepsy and diabetes to improve outcomes for children and prevent avoidable admissions and deaths. · Provide free, universal, digital mental health support offer for all young people in BLMK Options evaluation with each Borough on sustainable model for complex needs placements completed and plan agreed	· Developing a market management strategy that plans and predicts what will be needed for children with the most complex needs over the next decade. · Speedy access to family support and evidence-based programmes to reduce excess weight in children and manage those requiring specialist services. · Develop place-based pathways of support on a multi-agency basis with a single 'local offer' that is easily accessible for all children and families. · Drive quality improvement through focus on reducing inequalities in the 20% most deprived families (deep-dive practices) · Continue to build early intervention services so that mental health services are focusing on those children with diagnosable mental health problems, providing speedy access and sustained follow-up where appropriate.	· There is sustainable infrastructure for local provision of complex needs placements · Local services work together to prevent, intervene, and manage obesity in children in line with international best practice · An online 'local offer' of services and support, including self-referral ensures developmental needs are addressed at the earliest opportunity. · Readmissions to hospital are reduced and preventable mortality in children is eradicated. · Children and young people know how to access support for their emotional wellbeing and where specialist services are required they can access them within days. This will reduce the number of young people being admitted to mental health beds.

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 -2040
Improving Access & Treatment	· Earlier and faster cancer diagnosis · Health services strategy methodology agreed & implemented · End-to-end pathway reviews and peer-productivity challenges embedded · Community diagnostic centres completed · Flow programmes reduce preventable admissions and delays waiting for discharge	· Cancer infrastructure accessible to all as population grows. Cancer services at point of diagnosis and after treatment are integrated · Access and health outcomes are improved, especially for those currently most disadvantaged · People with frailty are supported to remain well at home or recover better after acute hospital admission · Waiting time for routine hospital and community health treatments are at / close NHS Constitutional standards	· Outcome measures demonstrate more residents spending more years of life in good health · Impact of life's disadvantages on health outcomes has reduced · Cancer survival rates at 1 and 5 years are at / above national mean, including those people who are most disadvantaged · Respiratory and cardiovascular outcomes are at or above national average outcome measures, with systemic attention to prevention, long term conditions management and preventing avoidable admissions
Talk about people with Mental Health, Learning Disabilities and ASD.	· Community crisis and recovery pathways developed and implemented · Options evaluation with each Borough on sustainable model for complex needs placements completed and plans agreed · Implementation of capital investment to increase crisis capacity in Bedfordshire and Milton Keynes	· People in crisis have prompt access to local support to keep them safe and support recovery · Adults requiring inpatient admission can be treated within BLMK · More adults with severe mental illness, learning disabilities and autism spectrum disorders are supported into employment · Increased access to diagnosis and support for people with autism spectrum disorders	· There is sustainable infrastructure for local provision of complex needs placements · We have significantly redressed the poorer long term physical health outcomes experienced by people with severe mental illness, learning disabilities and autism spectrum disorders · All residents in mental health crisis can access local community-based support quickly and easily
Integrated Neighbourhood Working	· Co design meaningful neighbourhoods across the 4 places and put in place the appropriate infrastructure and support for neighbourhood working · A system-wide approach for integrated urgent care to guarantee access for people who require same day primary care services · LTC transformation programme via multi agency groups for diabetes/respiratory/ CVD using bespoke outcome measures (including patient reported outcomes, clinical measures and health inequality metrics)	· All residents of BLMK have access to wellbeing facilities and can access same day primary care services with confidence · Residents and families impacted by long term conditions have access to prevention, advice and support to help them stay well at home · Stay well at home initiatives with local voluntary sector are supporting older people to stay warm, and reduce loneliness and isolation	· We have sustainable primary care capacity to meet population needs (same day urgent care access, support to manage long term conditions) · We will be able to demonstrate the benefit to residents of integrated neighbourhood working based on the things that matter most to residents; and in key health outcome measures

Living a longer, healthier life

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

BLMK High Impact Programme	JFP Mobilisation / Operating Plan Actions 2023-5	Summary of Outcomes: JFP Delivery 2025 - 2030	Summary of Outcomes: JFP Delivery 2031 - 2040
Intelligence-led Quality, Performance, Outcomes and Inequalities Improvement	· Business intelligence / analytics solution identified & delivered · Population Health Intelligence Unit established · NHS performance reporting is routinely split by Place, and understood in the context of health population needs · Benefit measures underpinning transformation quantify the changes in health outcomes and in reducing inequalities – the wider determinants of health (as well as NHS performance, access and value for money)	· High Impact Programmes and QI are driven by integrated data highlighting inequalities and variation in outcomes · NHS and social care data is digitally integrated, enabling more joined up care for residents · Integrated Neighbourhood teams and Place Boards will have intelligence to understand who is not accessing health interventions in a timely way, and tools to engage with residents to ensure that those who find health services most difficult to access are not disadvantaged in their health outcomes	· Residents can manage their long-term conditions with digital support · Population health management intelligence routinely informs service development; and evidences benefit to residents of quality improvement actions · Integrated data enables multi-disciplinary working across settings and organisations to provide seamless, joined-up care for residents · Strategies to support communities to improve their health and well-being are bespoke to local population needs
Integrated Care System Target Operating Model	· Transformation Programme for ICB – including 30% reduction in running costs. · Place based boards established · Compact with VCSE & Healthwatch agreed · ICB approach to contracting with VCSE in place · Denny review report agreed and recommendations implemented · Co-production training delivered · Remuneration approach for co-production implemented · Big conversation delivered to develop our joint forward plan April 24 · Investment in VCSE infrastructure agreed	· Integrated workforce planning to enable planning at a system and place level · Integrated working and shared QI approaches enable staff to work across organisations & settings · Evidence of co-production as part of High Impact Programmes and delivery of Place Priorities · Evidence of positive impact on resident outcomes from VCSE work · VCSE playing a larger role in service delivery and co-production · VCSE partners integral to ICB and place planning and delivery · Evidence of transfer of power to residents via co-production approach	· Joint working across neighbourhood and place supporting organisation models like collaboratives in providers to deliver joined up resident focussed services. · As anchor institutes, all YP & adults furthest from employment have access to support · Improve health outcomes for population groups most affected by health inequalities · Increased resident and stakeholder satisfaction in annual sentiment surveys · Improved sustainability and resilience in VCSE sector · Evidence of transfer of power to residents via co-production approach has supported improved health & well-being for residents
Thriving Eco-systems and Prosperous Communities	· Embed sustainability checklist and environmental literacy into leadership, change-management and governance processes · Delivery plans for Green Plan themes · Establish anchor coalition · Resident co-production of future environmental sustainability strategy · Procurement systems developed to maximise social value and inward investment opportunities · Build on employment and employability pathways, with existing organisations and the proposed MK STEM university · Maturation of the Research and Innovation Hub	· Reduced carbon-equivalent emissions from all sources, with NHS achieving ~48% reduction against 2019/20 baseline by 2032 · Focus on improving health and environment as co-benefits (e.g. air pollution, active travel, diet, and severe weather events) · Barriers to employment within health and care are reduced · Supply chain delivering greater social value benefit for BLMK residents	· NHS is net zero on Scopes 1 and 2 carbon emissions, with overall emissions >80% lower than 2019/20 · Realisation of health co-benefits relating to the environment such as air pollution, active travel, diet, and severe weather events · The healthcare workforce is more representative of the local population, with a greater proportion coming from within BLMK · Within legal frameworks, a greater share of goods and services in the health and care supply chain come from BLMK-based businesses, through improved knowledge, skills and capacity of those businesses to successfully bid for tenders.

Improving health services quality, access, and outcomes for our population

Our population health view focuses on the resident and how services are benefiting our residents. It means that we are committed to understanding the quality, performance, and outcomes of our NHS services as it relates to local populations.

Addressing all the determinants of health

Research shows that health services play only a small part in what supports people and communities to thrive. It is estimated the NHS directly impacts only 20% of what determines an individual's health. The other 80% is determined by wider factors like access to green spaces, educational attendance, attainment and skills, and crime rates.

We are therefore designing a new way of measuring our performance that is solely NHS-focused and more about how we as a system are together improving health outcomes for our population.

At the heart of this is our new "Data Pyramid" – see Section 5, Our Strategy in BLMK, for more detail. This approach is inspired by the best practice shared by the Institute for Healthcare Improvement, with whom we are proud to partner.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

SECTION EIGHT - Place and Provider Collaborative Key Objectives

There are four Places within the ICB area: Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. Each has a Place plan, identifying local priorities that partners can work on together to improve the health and wellbeing of local residents.

These are summarised as below:

Bedford Borough's vision is to thrive as a Place that people are proud of, want to live in and move to. Local plans recognise a growing and strong local economy and an active response to climate change as two important factors in achieving this. From this foundation residents will be able to thrive and realise their potential, supporting and celebrating Bedford Borough's diverse and inclusive communities.

The Bedford Borough Place plan has been developed by the Health and Wellbeing Board and commits to:

- Understanding our communities;
- Promoting prevention and health promotion; and
- Transforming care with primary care and VCSE.

The priority partnership actions identified in Bedford Borough are:

- Tackling obesity; and
- Improving access to primary care.

Central Bedfordshire

The Joint Health and Wellbeing Strategy and Place Plan on a page

"To improve the health and wellbeing of residents in Central Bedfordshire and reduce inequalities now and for future generations."

Our challenges

- Life expectancy and healthy life expectancy has stalled
- Increased population growth, especially older people
- Too many people dying prematurely from preventable illness
- Health inequalities continue to exist
- Too many people living with poor mental health
- Gaps in educational attainment between most and least deprived populations
- Too many people living with excess weight
- Smoking rates are not coming down and are higher in disadvantaged groups
- Too many people are socially isolated

What influences our health?

The King's Fund 4 pillars of population health have informed our 4 key areas of focus for 2024-29

Building blocks of health
- a good education
- a stable job
- adequate income
- good quality housing
- access to green space

Communities we live in and with
- Social and digital connectedness
- Neighbourhood assets
- Transport
- Public safety

Our health and behaviours
- Smoking
- Diet
- Substance misuse
- Physical inactivity
- Sexual health

Intergrated health and care system
- Right care, right place
- Prevention and early intervention

Areas of focus for 2024-29

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

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

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

Luton

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

This is supported by:

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

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

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

The key priority actions identified to deliver this in Luton are to work in partnership to build:

- **Community hubs** and healthy places;
- Improved **mental health services** and interventions to tackle the causes of poor health;
- The Luton **digital programme**, connecting health and care services and helping people to stay independent at home; and
- Capacity across the **VCSE sector**.

Living a longer, healthier life
Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Milton Keynes

The Milton Keynes Health and City Council partners have formed **MK Together**.

It formalises the commitment of the main local NHS partners in Milton Keynes and the City Council to work more closely together, with a focus on:

- **Improving system flow** – targeting urgent and emergency care services for older, frail or complex service users;
- **Tackling Obesity** – helping people lose weight and maintain a healthy weight through easily accessible weight management programmes, use of technology, pharmacological therapies, and education and prevention work;
- **Children and young people's mental health** – good mental health in children and young people helps build resilience, develop healthy relationships and lays the foundation for better mental and physical health and wellbeing throughout their whole lives. Early intervention is key for lifelong wellbeing. 75% of adult mental health issues are present by the age of 24;
- **The Bletchley Pathfinder (neighbourhoods working)** - trialing an integrated neighbourhood approach in an area with high levels of health inequality with a strong focus on prevention of ill health.

Bedfordshire Care Alliance

The Bedfordshire Care Alliance is a Provider Collaborative. It aims to ensure that, where scale and complexity requires us, to provide standardised care across the three Bedfordshire boroughs.

The Alliance has agreed an initial focus on four priority areas:

- **Supported discharge** – improving rehab, reablement and recovery outcomes;
- **Alternatives to acute admission** – stay well at home;
- **Digital infrastructure** – to enable integrated pathways of care across Bedfordshire; and
- Support to Places to optimise **care closer to home**.
- Plans to formally review the BCA, supported by an external expert partner, are underway.

Mental Health, Learning Disability and Autism Collaborative

Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) is the commissioner of Mental Health, Learning Disabilities and Autism (MHLDA) services across Bedfordshire, Luton and Milton Keynes (BLMK). Central and North West London NHS Foundation Trust (CNWL) and East London NHS Foundation Trust (ELFT) are the two main NHS trusts providing MHLDA services in BLMK.

BLMK ICB, CNWL and ELFT have been increasingly working together to plan and deliver all age MHLDA services for BLMK. We have established governance structures MHLDA (e.g. Programme Boards) and associated work streams to monitor the commissioning, delivery, transformation and performance of services across BLMK for our residents, aligned to national and local drivers e.g. the NHS Long Term Plan.

The three organisations have agreed to formalise these arrangements and to align our collective resources by establishing an MHLDA Collaborative across BLMK. Collaboratives have been shown to be effective vehicles in improving services for patients e.g. Specialist Mental Health Collaboratives have supported more patients to be cared for closer to home.

The BLMK MHLDA Collaborative has been established as a Committee of the Board of the ICB and provides the ICB, the NHS, wider partner organisations and service user-representatives with the ability to collaboratively direct and oversee the delivery of high quality MHLDA support and services in BLMK in order to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS to support broader social and economic development
- Contribute to the overall delivery of the ICB objectives, priorities and the Joint Forward Plan by providing oversight and assurance to the Board for the development, transformation and commissioning of mental health, learning disabilities and autism (MHLDA) services

SECTION NINE: Progress In 2024/25

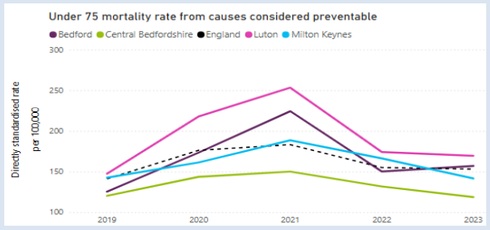
Progress in Strategic Priority Areas in 2024/25

BLMK's Health and Care Strategy (January 2023), agreed by the Health and Care Partnership, established five strategic priorities for the BLMK system. These are set out in the table below, alongside the headline progress made against each in 2024/25. Also set out are the seven 'enablers' presented in the same Strategy, and the work done to advance each. We have selected three highlights per priority and enabler; the list is not exhaustive. Many more interventions across the BLMK system contribute to the performance changes identified than just those presented here.

<table>
<tr><th>Strategic Priority</th><th>Lead Outcome Measure and Performance</th><th>Headline initiatives in 2024/25</th></tr>
<tr>
<td>Start Well</td>
<td>Increasing the % of children who reach a Good Level of Development (GLD) at the end of the Early Years Foundation Stage.

The percentage of children achieving GLD has increased in all four Places since 2021/22. The percentage in Luton remains lower than the national average, though shows the greatest increase since 2021/22.
School readiness: percentage of children achieving a good level of development at the end of Reception.

<table>
<tr><th>Area</th><th>Baseline (2021/22)</th><th>2023/24</th><th>% point change</th></tr>
<tr><td>Bedford</td><td>63.8</td><td>66.2</td><td>2.4</td></tr>
<tr><td>Central Beds</td><td>65.5</td><td>68.9</td><td>3.4</td></tr>
<tr><td>Luton</td><td>56.6</td><td>62.0</td><td>5.4</td></tr>
<tr><td>Milton Keynes</td><td>66.7</td><td>68.4</td><td>1.7</td></tr>
<tr><td>England</td><td>65.2</td><td>67.7</td><td>2.5</td></tr>
</table>
</td>
<td>1. Each Place now has a robust multi-agency Local Area Partnership focussed on improving outcomes for Children & Young People with Special Education Needs and Disabilities. This means that more children have access to some health services more quickly. A good example is new self-referral pathway to Speech and Language Therapy advice for under 5s.
2. We have launched a refreshed Transforming Care Pathway for children with Learning Disabilities & Autism at risk of admission to an inpatient CAMHS provision. The pathway was coproduced with young people and now includes easy to access self-referral, enabling more young people to manage their own long-term needs.
3. Two new Mental Health Support Teams are in place in schools in Luton and MK, meaning that school-age children have more access to mental health support in their school.</td>
</tr>
</table>

Strategic Priority	Lead Outcome Measure and Performance	Headline initiatives in 2024/25
Live Well	**Reducing** preventable premature mortality. Change over time in preventable premature mortality for our four places and England is shown below, starting from the 2019 baseline. All areas saw a large rise over 2020 and 2021 due to COVID-19 with rates then falling in 2022; however in Bedford and in Luton that fall has not continued into 2023 and these areas are still above their 2019 baseline. *Under 75 mortality rate from causes considered preventable: directly standardised rate per 100,000* 	1. Major MSK procurement launched with patient co-production embedded, contract expected to be awarded in April 2025 and go live in November 2025; everyone in BLMK can self-refer for MSK support. 2. Tobacco dependency treatment established across BLMK. 3. Diabetes pre-warning dashboard in primary care using latest to get ahead with preventative diabetes advice and support.

Strategic Priority	Lead Outcome Measure and Performance	Headline initiatives in 2024/25
Age Well	**Reducing** emergency admissions for falls. The rate of admissions for falls in people aged 65+ is significantly lower in 2022/23 than 2019/20 in all four Places. **Area / Baseline (2019/20) / 2022/23 / % Change** Bedford: 2100 / 1725 / -17.9 Central Beds: 2339 / 1842 / -21.3 Luton: 2488 / 1639 / -34.1 Milton Keynes: 2520 / 1999 / -20.7 **England**: 2256 / 1933 / -14.3 *Emergency hospital admissions due to falls in people aged 65 and over. Directly standardised rate per 100,000 population.*	1. BLMK has the highest dementia diagnosis rate in the East of England at 69.8% which is 3.1% above the national ambition and 4% above the England average 2. BLMK exceeded the 80% target for Digital Social Care Record (DSCR) and met a further stretch target with 85% of providers now having a DSCR 3. Nearly 2,000 vulnerable patients supported through Warm Homes project in Bedford Borough. Rural Communities Charity (Beds) & Age UK (MK) commissioned to provide discharge support to prevent readmission. Innovative work on frailty led by the BCA.

Bedfordshire, Luton, and Milton Keynes Joint Forward Plan

Strategic Priority	Lead Outcome Measure and Performance	Headline initiatives in 2024/25
Growth	**Reducing** economic inactivity due to long-term sickness. The percentage of economically inactive people aged 16-64 who are inactive due to long-term sickness has increased in all Places except Bedford since 2019/20. The greatest increases were seen in Central Bedfordshire and Luton **Area / Baseline 2019/20 / 2023/24 / % point change** Bedford: 31.7 / 14.1 / -17.6 Central Beds: 21.9 / 31.8 / 9.9 Luton: 17.5 / 28.9 / 11.4 Milton Keynes: 20.8 / 22.4 / 1.6 **England**: 23.3 / 26.3 / 3.0 *Percentage of economically inactive people aged 16-64 who are inactive due to long-term sickness. Bedford estimates in 2023-24 are calculated from small group sample sizes and may be unreliable.*	1. Launched "Passport to NHSE Careers" across BLMK – a supported employment pathway for residents with lived experience of the care system, unpaid carers and those with neurodiversity. 2. Continued development of the BLMK ICS and University of Bedfordshire Research and Innovation hub. First BLMK ICS research and innovation awards created and funded by the hub in May 2024. 3. 21% reduction (since 2022) in emissions per inhaler prescribed, introduction of recycling and re-use schemes for walking aids, and a reduction in food waste at hospital sites

Strategic Priority	Lead Outcome Measure and Performance	Headline initiatives in 2024/25
Reducing Inequalities	**Reducing** Inequality in average age of onset of first Long Term Condition – *Methodology subject to continued development from BLMK Population Health Intelligence Unit*	1. Launch of new Learning and Action Networks across BLMK, in Partnership with the Institute for Healthcare Improvement, aimed at reducing cardiovascular disease in equal partnership with residents. 2. Review of existing Translation and Interpretation services underway across the system with a view to present an options appraisal in Q1 25/26. Wide-ranging response of all system partners to the Denny Review presented to ICB Board in December 2025. 3. Inaugural BLMK Inequalities Seminar as part of major BLMK inequalities week brought partners to together to listen to residents

Enabler	Headline Initiatives in 2024/25
Data and digital	1. Share for Care use increased, with over 110,000 individual records viewed per month 2. NHS App Launch days across BLMK have brought together primary care leaders, VCSE organisations and elective representatives to promote the app to residents. 3. Population Health Information Unit (PHIU) established and delivering system-level analytical outputs using healthcare activity and outcome data, outcome measures agreed for system strategic priorities
Workforce	1. BLMK is one of two ICSs piloting implementing people-digital transformation – the efficiency and automation of HR process to improve employee experience at work 2. BLMK is the highest performing system in the East of England for completion of the Oliver McGowan training. 3. Launched expanded Health and Care Academy across the full ICS to encourage 14-18yos to pursue careers in health & care.
Ways of working	1. Our unscheduled care hub in Bedfordshire brings together ambulance, community and acute colleagues, meaning more people can get the most appropriate help more quickly, and reduce pressure on A&E. Over 1800 hospital admissions avoided Jan 2024 – Jan 2025. 2. Integrated Neighbourhood Working – we are taking an asset-based approach to the development of our 19 neighbourhoods in BLMK. The four places are facilitating organic development of neighbourhoods in the way that works for them, with several leading examples of progress, including the Bletchley Pathfinder in MK, and the Bedford Queens Park 'Be Active' programme supporting families at risk of diabetes. A further update is presented in more detail below. 3. Launched i) our new Mental Health Learning Disability and Autism Collaborative Committee, and ii) our Portfolio Report providing a transparent and holistic view of transformation activity across the BLMK system
Estates	1. We have delivered 15 out of the 23 primary care estates projects prioritised in 2023, and with further schemes making good progress. This included the new Enhanced Services Centre in Bedford – to provide new accommodation for the largest GP practice in BLMK, the De Parys Group. 2. Continued delivery of a variety of schemes on the Milton Keynes Hospital site as enablers for the New Hospitals Programme. Upgrades to the Bedford Hospital Emergency Department (ED), providing a secure Paediatric ED area, additional cubicles and contingency beds, and extra waiting room capacity 3. Completion of an expanded and refurbished ED at the Luton & Dunstable Hospital, with increased capacity, a new and fully segregated Paediatric Department. As per Luton 2040 Pledge, the ICB has continued to campaign to NHSE to secure funding for a Clinical Diagnostic Centre in Luton Town Centre and a business case is in development. New Community Diagnostic Centre opened at Lloyds Court in MK.

Enabler	Headline Initiatives in 2024/25
Communications	1. We have launched our new System Insights Network, bringing together a wide range of partners and residents to inform our system strategy. The first session, on the 10 Year Plan, was in January, with the next, in May, focused on our Community and Mental Heath procurement. 2. Relationships with new partners, in particular faith leaders, are supporting the reach of crucial communications, including for vaccination and immunization. 3. Our Winter 2024/25 campaign was co-produced with system partners, supporting coordinated messaging to keep more people well at home.
Finance	1. In an increasingly challenged financial environment, BLMK is expecting to deliver a break-even financial position at the end of 2024/25. 2. The system has established significant new infrastructure to oversee delivery of the Financial and Operational Plan for 2025/26. 3. BLMK is exceeding its 6% system efficiencies target- and due to breaking even last year received an additional £2.8M capital allocation for our residents.
Operational and Clinical excellence	1. Our new Health Services Strategy has laid the foundations for a more sustainable healthcare system delivering high quality care over the long term 2. Appointments in primary care in 2024 + 10.4% vs 2023 3. Luton Cancer Outcomes Project PCN prostate cancer case finding pilot is identifying Black men with prostate cancer earlier. This project identified 18 men to date with prostate cancer, all with few symptoms.

Below we go on to set out where we would have liked to have gone further in 2024/25, and our big commitments for the year ahead in BLMK.

Where we would have liked to have done more in 2024/25
Though as a system we are pleased with good progress presented above, there are areas where we would have liked to have gone further, and where, as a partnership, we will redouble our efforts in 2025/26. These include improving our vaccination and immunisation rates (including amongst NHS staff), and further advancing use of the NHS app across BLMK. In terms of transformation, we have agreed three headline transformation priorities for 2025/26. These are transforming our i) admission avoidance/discharge care pathways, ii) end of life care and ii) complex care for adults and children. These priority programmes have been endorsed by the full Integrated Care Board, and we look forward to setting out further detail in the year ahead.

Adopting Quality Improvement
We are excited to be working alongside the Institute for Healthcare Improvement. Our work together over the next two years will develop a system Quality Improvement approach based on the five components of **NHS IMPACT.** We are benefitting from the IHI's expertise and international reach and are proud to have launched our Learning & Action Network in 2024 alongside many partners with whom we're working to reduce inequalities in our four places.

Delivering Our Health Services Strategy
In response to the sustainability challenges we face – financial and otherwise - BLMK system is proud to have published **our Health Services Strategy**. Like the Joint Forward Plan, the Heath Services Strategy spans the period out to 2040. With medical knowledge growing exponentially, and societal change moving at a rapid pace, the strategy is designed to develop by iteration: the direction of travel and the commitments described are expected to stand the test of time, whilst the programmes of work will evolve with science and society.

The Health Services Strategy is not intended to include each and every aspect of health service provision in BLMK: in many areas, existing collaborative mechanisms work well. Examples include joint management of the Better Care Fund between each Local Authority and the ICB; commissioning and contracting arrangements around the provision of specific health and care services; and, effective relationships between primary care practitioners and local hospitals. Quite rightly, the strategy has relatively little to say on such matters. The **S**trategy does not seek to 'replace' or 'take over' work being undertaken at place, and in the case of Bedfordshire, through the alliance of organisations delivering services across the three places. Rather, it aims to enable and propel that work, recognising and supporting the uniqueness of each place, but also throwing light on variations that are unwarranted and unwelcome. The Strategy was agreed by the ICB Board in September 2024.

Harnessing the power of our The Population Health Intelligence Unit
We are led by our data, including from our landmark **Population Health Intelligence Unit**, in all our transformation work. Across our system, our five strategic priorities continue to shape everything we do – Starting Well, Living Well, Ageing Well, Growth and Reducing Inequalities. Insights from our residents (including those from our Healthwatch and VCSE partners) are helping us to better understand if our Strategy is working, underpinned by agreed system wide-outcome measures. Our new System Insights Network is a key vehicle for understanding our residents' views in detail.

Our Transformation Priorities
The ICB Board have agreed three transformation priorities for 2025/26, through these will extend across the next 3-5 years:

1. **Transforming Admission Avoidance & Discharge Pathways**, including those funded by the Better Care Fund;
2. **Transforming End of Life Care**, following our landmark End of Life Review;
3. **Transforming Complex Care**, where costs are spiraling and outcomes can be better.

The ICB Board is currently agreeing system wide leadership and working through the quantifiable benefits in 2025/26.

Our BLMK "Golden Threads" or "Enabling Priorities"
Three "golden threads" are expected to run through everything the system does for the next five years:

- **Tackling Inequalities –** all work across our Partnership has the potential to address heath inequalities, and our ambition to improve health outcomes for the most disadvantaged should run through everything we do. The Denny Review recommendations are the guiding light for this work in our system.
- **Supporting Neighbourhoods** – developing working across organisations at neighbourhood level, including with Voluntary, Community and Social Enterprise partners, to provide specific and localised support to residents within their communities is a multi-year, collective endeavour.
- **Advancing Digital** – we see digital services and tools at the heart of sustainable and modern healthcare in BLMK. From the NHS app to remote monitoring to applying AI, we're committed to embracing digital.

Tracking Our Progress and Setting Out Next Steps: The BLMK Portfolio Tool
Our Portfolio Report contains information on key strategic and transformational portfolios, programmes and projects across BLMK ICS. The first section of the report shows the hierarchy of portfolios, programmes and projects. The second section details the individual highlight report for BLMK portfolios, programmes and projects. This tool, welcomed by the Board, is a "one stop shop" for progress/future milestones on transformation in BLMK.

Measuring and Demonstrating Our Impact:
We are proud to be a leading system in this regard, having developed two clear system missions, each with a measurable baseline, and lead indicators for each of our five strategic priorities: Start Well, Live Well, Age Well, Supporting Growth & Reducing Inequalities. Our "Data Pyramid", agreed by the ICB Board in September 2024, is the basis for our approach to measuring our impact, including in areas outside of health, like school readiness.

Regional Models of Care Work
We are pleased to support the work to drive more innovation and consistency across the East of England footprint. Please see the Annex for further detail. We recognize that doing more at scale – but maintaining some local flexibility – can bring significant benefits to residents in the East of England region.

Next steps for Neighbourhood Working (requested by NHSE).
The ICB continues to work with partners in our 4 places taking an asset-based approach across its 19 neighbourhoods and the with the support of the Population Health Intelligence Unit to design interventions to meet the needs of the population. More than 80% of practices in BLMK are now offering a modern practice access model and work will continue through 25/26 to support primary care development and transformation with the ICBs plan for practice level support that has been recognised as a good practice model regionally and nationally. Through its place and ICB governance there is a focus on a 'share and learn' 'approach to neighbourhood development. New initiatives will be agreed for 25/26 in response to the neighbourhood health guidance and the local gap analysis of this, this work will be concluded by the end of April '26. Initiatives that are currently being delivered incldue new models for multi-disciplinary team working offering proactive care for people with frailty; support for identified carers; High Intensity User schemes; Local Area Networks focused on support for the population identified with Hypertension; a standardised multi-disciplinary problem solving model; and a forum focusing on children at risk of school exclusion in the area due to unmet health and care needs. These will all be evaluated and considered for scaling up where effective.

Navigating a Challenging Financial Context
Our local context of continued rapid population growth alongside national economic challenges, and the legacy of the Covid pandemic, mean that during 25/26, our system will need to take difficult decisions about our priorities for investment and the services we commission and provide. Any significant service changes will be subject to equality and quality impact assessments, appropriate engagement and consultation processes, and wider scrutiny. As a system we may also not be able to do everything we had planned to do in 2025/26. We will continue regular communications with partners and residents as we understand this further.

Section 10 - Risks – Our BLMK risk register can be found here.