Agenda

Health & Wellbeing Board

Date: **Wednesday, 8 July 2026**
Time: **2.00 p.m.**
Venue: **Council Chamber - Priory House, Monks Walk, Shefford, SG17 5TQ**

Members: Cllr Smith (Chair)
Cllr Mackey

Substitutes: Cllr Childs

Notes for Participants

Membership of the Health and Wellbeing Board

1 Apologies for Absence
To receive apologies for absence.

2 Members' Interests
To receive from Members any declarations of interest.

3 Minutes 9 - 34
To approve as a correct record the Minutes of the meeting of the Health and Wellbeing Board held on 22 April 2026.

4 Election of the Vice Chair
Presented by Cllr Smith

To elect for a Vice Chair for the new municipal year.

5 Chair's Announcements
To receive any matters of communication from the Chair.

To note, following the approval of the HWB Strategy meetings will now be categorised into themes in accordance with the four key areas of focus within the strategy. The theme of this meeting is 'Smoke Free Generation'.

6 Public Participation
To receive any questions, statements or deputations from members of the public in accordance with the Public Participation Procedure as set out in Part 4G of the Council's Constitution.

Implementation of the Joint Health and Wellbeing Strategy

Item	Subject		Page Nos.
7	**Smoke Free Generation Update** **Presented by Etain McDermott and Dominic Uvieghara** To receive an update regarding the 'Smoke Free Generation' programme.	*	35 - 54

Other Items

Item	Subject		Page Nos.
8	**Update from the Local Authority Research Practitioner** **Presented by Andy Malcolm** To receive up to date information on the research conducted for 2025/26.	*	55 - 68
9	**Better Care Fund approval letter 2026-27** **Presented by Kaysie Conroy & Nick Murley** To receive information obtaining to the Better Care Fund from NHS England for 2026/27.	*	69 - 106
10	**Neighbourhood Health** **Presented by Georgie Brown** To receive updated information on the Neighbourhood Health Plans.	*	107 - 116
11	**Change to HWB Membership Proposal** **Presented by Cllr Smith** To propose a change to the Terms of Reference in order to request for a change to the membership	*	117 - 120
12	**Central Bedfordshire Joint Leadership Group** **Presented by Vicky Head** To receive a verbal update and the meeting notes from the Central Bedfordshire Joint Leadership Group	*	121 - 124
13	**Work Programme 2026/27** **Presented by Cllr Smith**	*	125 - 126

To consider and approve the work programme.

A forward plan ensures that the Health and Wellbeing Board remains focused on key priorities, areas and activities to deliver improved outcomes for the people of Central Bedfordshire.

Speaking at meetings

A member of the public who wishes to speak at this meeting can register online by completing the register to speak electronic form.

Please note this meeting is a hybrid meeting, if you wish to attend and speak at the meeting remotely you must register online at least two clear working days before the meeting and notify us if that you would like to speak via Teams.

Webcasts

This meeting will be filmed by the Council for live and/or subsequent broadcast online and can be viewed via the Councils webcast library. Any footage will be on the Council's website, a copy of it will also be retained in accordance with the Council's data retention policy.

By joining the meeting, you are deemed to have consented to being filmed by the Council. Hard copies of agendas Hard copies of the papers for this meeting are not routinely made available to those in attendance. Should you require a copy of please download this from the Council website beforehand.

For any further information on this meeting contact:
committeemeetings@centralbedfordshire.gov.uk

This page is intentionally left blank

Notes for participants

Please do not attend this meeting in person if you have tested positive for COVID-19 within the previous 5 days or if you feel generally unwell or have symptoms of a respiratory infection. Similarly, please do not attend if you have had close contact with someone who has tested positive for COVID-19.

Speaking at meetings

A member of the public who wishes to speak at this meeting can register online by completing the register to speak electronic form.

Please note this meeting is a hybrid meeting, if you wish to attend and speak at the meeting remotely you must register online at least two clear working days before the meeting and notify us if that you would like to speak via Teams.

Webcasts

This meeting will be filmed by the Council for live and/or subsequent broadcast online and can be viewed via the Councils webcast library.

Any footage will be on the Council's website, a copy of it will also be retained in accordance with the Council's data retention policy. By joining the meeting, you are deemed to have consented to being filmed by the Council.

Hard copies of agendas

Hard copies of the papers for this meeting are not routinely made available to those in attendance. Should you require a copy of please download this from the Council website beforehand.

For any further information on this meeting contact:
committeemeetings@centralbedfordshire.gov.uk

This page is intentionally left blank

Members of the Health and Wellbeing Board

Cllr M Smith, Chair of the Health and Wellbeing Board

Cllr G Mackey, Executive Member for Children's Services

Ms D Blackmun, Chief Executive, Healthwatch Central Bedfordshire

Ms M Wogan, Director of Neighbourhood Health, Places and Partnerships, BLMK

Mr D Carter, Chief Executive, Luton and Dunstable Hospital

Mrs L Carver, Director of Place and Communities

Mr M Coiffait, Chief Executive, CBC

Mrs V Head, Director of Public Health, CBC

Mr A Sharp, Director of Social Care, Health & Housing, CBC

Ms A Gordon, Director of Children & Families, CBC

Mr L Mecyzkowski, Service Director Education, SEND & Inclusion, CBC

Ms L Sunduza, Chief Executive, East London NHS Foundation Trust

Mr R Campbell, Service Director, Bedfordshire Community Health Services, EFLT

This page is intentionally left blank

At a meeting of the **Health and Wellbeing Board** held in The Council Chamber, Priory House, Monks Walk, Chicksands, Shefford, SG17 5TQ on Wednesday 22 April 2026 from 2:00pm – 3:40pm

Present:	Cllr M. Smith, Deputy Leader and Executive Member for Adult Social Care and Health, CBC (Chair of the meeting)
HWB Members:	V. Head, Director of Public Health, CBC D. Blackmun, Chief Executive Officer, Healthwatch M. Wogan, Director of Neighbourhood Health & Partnerships, BLMK
Substitutes:	D. Newbolt for *A. Gordon, Director of Children and Families, CBC*
Apologies:	Cllr G Mackey L. Carver, Director of Place and Communities, CBC L. Sunduza, Chief Executive, ELFT
Members in Attendance:	Cllr V Harvey Cllr S Goodchild
Officers in Attendance: **Attendees** **Remote Participants:**	C. Scarborough, Deputy Director of Public Health, CBC F. Side, Head of 0-19 Support & Intervention, CBC S. Lawrence, Public Health Principal - C&YP, CBC L. Manning, Webcaster, CBC M. Presland, Committee Services Officer, CBC K. Conroy, ICB Head of Place A. Sharp, Director of Adult Social Care & Housing, CBC R. Campbell, Service Director, Beds Community Health Services, ELFT C. Jones for *D. Carter, Chief Executive, Luton and Dunstable Hospital* Cllr L Childs Cllr M Versallion

1. Apologies for Absence

Chair welcomed everyone to the meeting and apologies were noted.

NOTED

2. Minutes

The minutes of the last meeting, 28 January 2026 were confirmed as a correct records and were signed by the Chair.

APPROVED

3. Member's Interests

No interests were declared.

4. Chair's Announcements

The Chairman reiterated to Members that Health and Wellbeing Board meetings have been categorised into thematic areas aligned with the four key priorities of the strategy.
The theme of this meeting was Educational Attainment.

5. Public Participation

To respond to general questions and statements from members of the public in accordance with the Public Participation Procedure as set out in Part 4G of the Constitution.

There are two registered interests for speaking, firstly Mr Tom Wise, a Volunteer from Leighton Buzzard Volunteer Patient Driver.

Mr Wise raised concerns about inadequate ICB governance and funding, limited infrastructure support, and a lack of transparency, including perceived failures in applying the Freedom of Information Act.

It was noted that local volunteers and Patient Participation Groups had not been adequately consulted on the Neighbourhood Health Operational Plan. Uncertainty remains regarding the future of Tiddenfoot Leisure Centre and the relocation of services outside the area, raising questions about accessibility. He questioned when residents would be formally consulted about local needs and how their views would be acted upon.

Maria Wogan, Director of Neighbourhood Health & Partnerships responded to advise that neighbourhood planning is at an early stage and remains subject to forthcoming government guidance to the ICB.
Four proposed neighbourhoods are currently being developed and require finalisation. Initial work will focus on coordinated care for older and frail residents, bringing services closer to home to address transport and access issues, and improving coordination across local trusts and communities.

Engagement with residents has not yet formally begun, but early conversations are planned, particularly with those aged over 65, frail residents, and the VCSE sector, to understand local needs and existing community support. Members were invited to work collaboratively over the coming year to co-design services with communities and clinicians, with a commitment to continuous improvement.

Performance data will be reported back to the Board to ensure accountability. The ICB has been asked to develop proposals for neighbourhood health centres based on population need, with a plan due by the end of May and a further update to be presented at the July meeting.
Any Freedom of Information request will be addressed outside the meeting.

The second registered speaker, Ms Janet Woolsey, a member of Leighton and Linslade Health Provision Group

Ms Woolsey raised concerns that promised additional clinic capacity from new rooms by July 2025 had been overstated, with delivery dependent on staffing, leading residents to feel misled.
Surveys highlighted ongoing capacity shortfalls, access and safety issues and facilities not being fit for purpose.
It was noted that BLMK has the largest population but least investment, resulting in residents travelling to other towns due to the lack of community diagnostic and significant health facilities locally.

Maria Wogan clarified that the figure of 56,000 additional appointments assumes the clinic rooms are fully operational, with current delays due to staffing constraints.
The ICB committed to reporting back with performance data after July and again within a year.
It was emphasised that neighbourhood health plans require a joined-up approach, using available infrastructure to deliver care closer to home. Work will continue to assess needs in Leighton Buzzard, where six clinic rooms are currently in place against an identified need for ten.

The speakers were thanked for their time and invited to stay for the duration of the meeting.

6. Best Start in Life

The Board received a strategy and local plan within the meeting pack, which has been received by Executive.

The Board were advised the ‘Best Start in Life’ launched in July 2025 aims at giving every child the best start in life, helping children to achieve and thrive.
The strategy aligns with the neighbourhood health plan and the poverty strategy and reflects a national focus on prevention and early health development.

The strategy, currently in draft, will be published by the end of April and includes a high-level plan supported by a detailed delivery plan. Key priorities include early years support, childcare, school readiness, and improving educational attainment, with a national target for 75% of children being school-ready by 2028.

Proposals include the use of family hubs, enhancement of existing buildings, targeted work in areas of deprivation, and a pilot in Dunstable, alongside outreach activity and a virtual offer. Governance will sit within the Health and Wellbeing Board, with regular updates, and

delivery will be supported by a three-year grant, with action commencing immediately based on identified need.

Points and comments included:

- The Board asked for case study examples of the work conducted, as part of their role in the Governance of the programme. Understanding the partnership connections involved in the process would be of benefit for monitoring success.
- The Board were reassured that whilst Dunstable had been chosen as a pilot, this was locational, due having an accessible building for the hub base. The Children's Services Team are proactivity working within local communities to identify other locations. The outreach activity itself will be being conducted throughout Central Bedfordshire.
- The Board raised concerns about sustainability once initial grant funding ends. Assurance was provided that a risk plan is in place, including a dedicated role for community participation and engagement. A sustainable model will be developed through upskilling within local communities, working with academies, establishing a Parent Champion Network and maintaining close links with the voluntary sector, all of whom are involved in programme development.
- The Board were advised that Public Health are working collaboratively, providing a joined-up approach with Children's Services on this programme and will be providing some additional funding.
- The Board noted that the collaboration of partners, working groups and the Boards Governance will be of great benefit to the programme.

The Board were asked to acknowledge, note the next steps within the content of the report.

NOTED

the 'Best Start in Life' Information

7. Neighbourhood Health Plan

The Board received an updated presentation which will be circulated with the meeting minutes, as Appendix A.

The Board noted that the neighbourhood health plan approach represents a significant change in ways of working, driven by both national requirements and local need.
The ICB will commission neighbourhood teams and support primary care through coordinated digital, hospital, urgent care, and neighbourhood services, under a single-team approach and a clear strategic framework for BLMK.

The Health and Wellbeing Board was advised that it is now expected not only to agree the strategy but to lead on signing off the neighbourhood health plan and holding partners to account.

It was agreed that a HWB Development Session will be held for Members prior to Julys HWB Board to discuss the approach in greater detail, to establish and understand how the Board can take ownership of the plans.

Points and comments included:

- The Board noted that the ICB provides funding to the voluntary sector alliance for representative roles and this funding could be used to support voluntary sector representation on the Board, if required, as part of rebuilding relationships.
- The Board were advised that the four neighbourhoods proposed have been defined by existing working practices and established neighbourhoods. These may evolve over time, with housing infrastructure growth, however this will be monitored closely.
- The Board were advised the benefit of working within established defined areas is the ability to work with knowledgeable, engaged local communities to provide holistic care at a microlevel. It is key that the neighbourhoods reflect best working practices and the Board are encouraged to analyse proposals to ensure that through its leadership.
- The Board were advised that there is a level of performance monitoring, capturing residents feedback and joined up working from non-health colleagues in ensuring the plans are fit for purpose and meet requirement. Co-design with involved residents/ patients is the aspiration for all networks within the individual plans.
- However, the Board were reminded that there has been mandated requirement set out, which need to be met, such as the initial workstream focus being on frailty within the older demographic. This will be changed approach to health provision, as wrap around care which will ultimately be rolled out after this first stipulated stage.
- The Board were additionally advised that the ICBs were requested as of w/c 13 April by NHS England, to produce a pipeline plan on neighbour health centres, which is to identify the asset rather than the practices within the building, by the end of May 2026.

The Board acknowledged the update provided by BLMK and the proposed next steps.

Members were advised of the Framework and the new requirement of the Health and Wellbeing Board in leading and supporting delivery.

While the Board recognised the significance of this role, further discussion is required to determine how it wishes to proceed within its governance arrangements.

NOTED

the Neighbourhood Health Plan

8. BLMK Integrated Care Board and Integrated Care Partnership Update

The Board received information on the recent appointments made into the new ICB teams.

Maria Wogan, is the Director responsible for Neighbourhood Health across BLMK, within Central East. Two deputies have been appointed;

- Georgie Brown will be responsible for Bedford Borough and Central Beds, she will begin to attend HWB and act a deputy for Maria.
- Kaysie Conroy has been appointed as Head of Delivery for Neighbourhood Health across BLMK.

The new teams continue to appoint positions as the transition is ongoing as the new formed Central East launched this month.

The Board noted the content of the report.

NOTED

the BLMK Integrated Care Board and Integrated Care Partnership Update

9. Central Bedfordshire Joint Leadership Group

The Board received information regarding the February meeting. The main discussions were regarding Neighbourhood Health Plans and the policies around them, prior to the Governments Framework being published. This will be discussed further in Mays meeting.

There was a positive update within Gait Smart technology and the assessment based recommendations it was able to provide patients on a personalised level. There was also information shared on the community services health inclusion for the Gypsy, Roma communities within Central Beds.

NOTED

the Central Bedfordshire Joint Leadership Group update

10. Work Programme 2026-27

The Board considered the work programme for 2026-27. All partners were encouraged to contribute future agenda items to the Work Programme.

Advised the next meeting will take place on the 8th July, the theme of the meeting will be Smoke Free Generation.

NOTED

the 2026-27 Work Programme

Chair …….

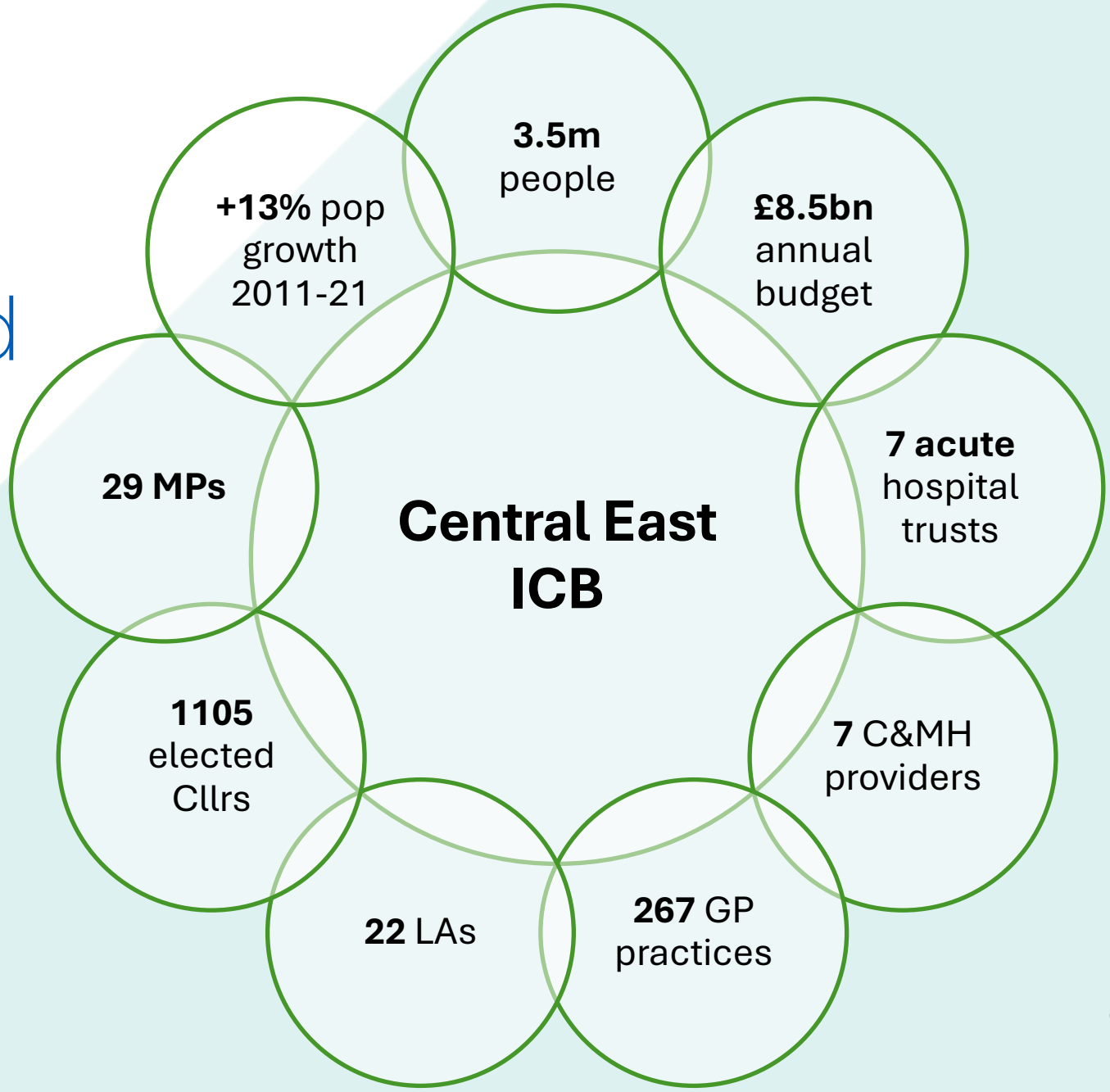
Dated …….

Briefing:
Central East Integrated Care Board

NHS
Central East
Integrated Care Board

April 2026

Central East: England's Second Largest Integrated Care Board

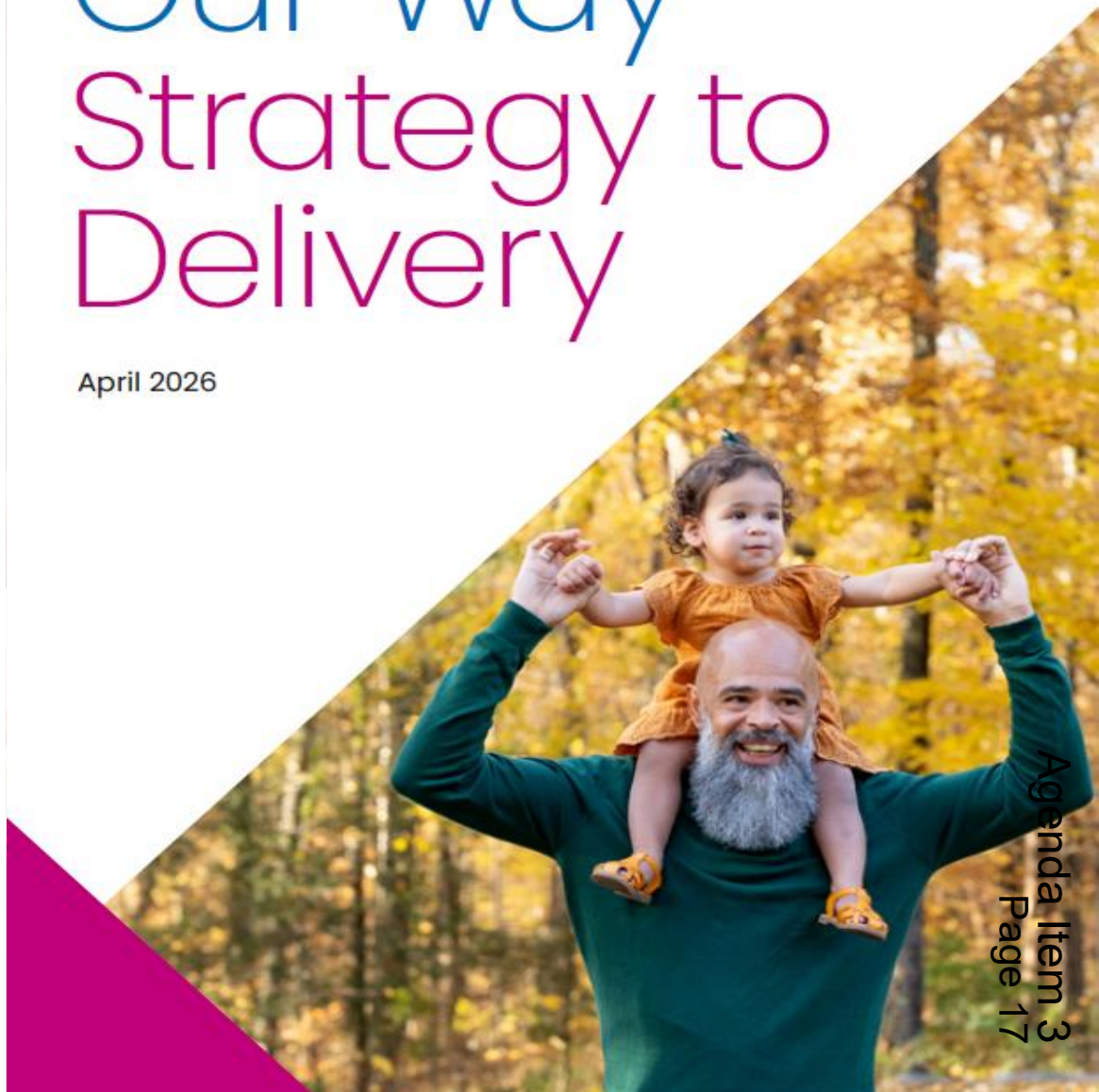


On 01 April, we launched our new strategy

NHS
Central East
Integrated Care Board

Our Way – Strategy to Delivery

April 2026



Headlines:

- **Quality is our Strategy**. Improving quality—access, experience, outcomes, and effectiveness —is how we will deliver a sustainable NHS.

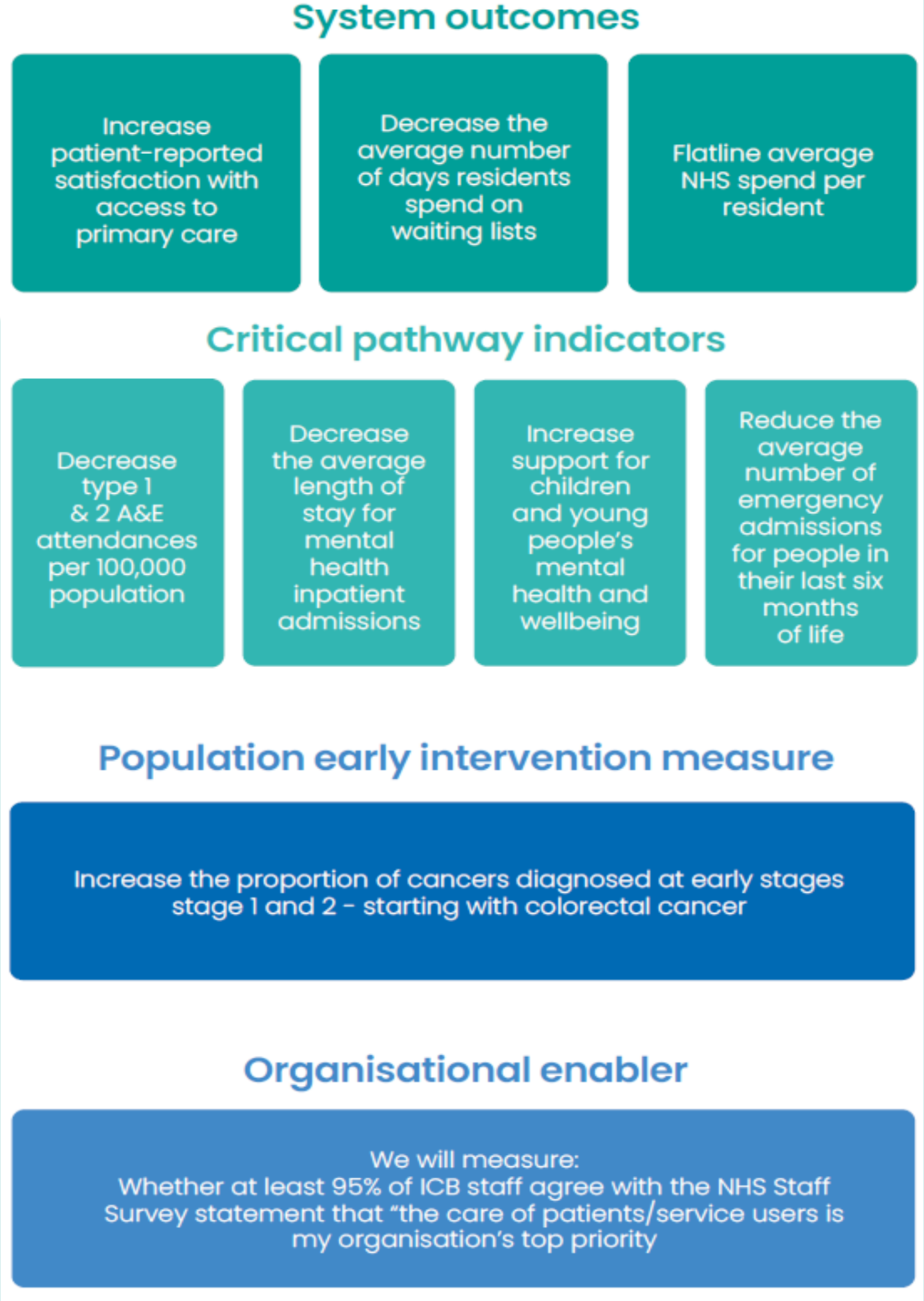
- We will **focus relentlessly on what matters most:**
  - Improving access;
  - Making the NHS financially sustainable and more productive;
  - Supporting people to stay in work and remain economically active

- Our approach is disciplined and repeatable: **improve, codify, scale.**

- Overall, we will do **less of what doesn't add value, and more of what does**

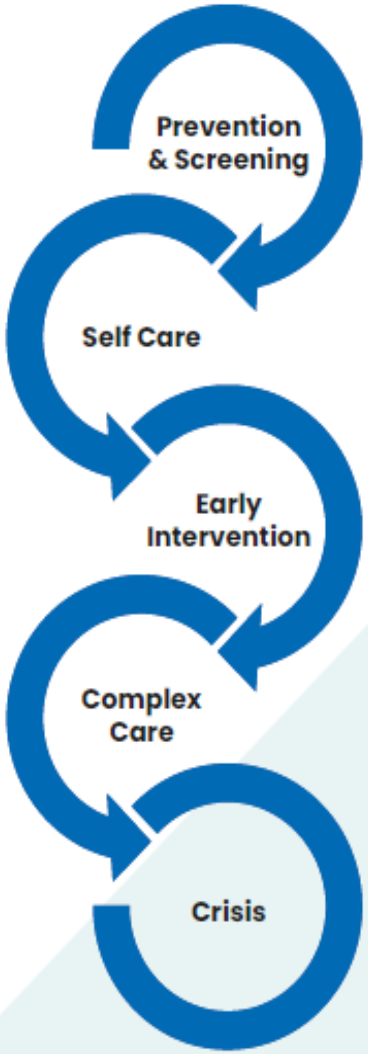
We will **measure whether the strategy is delivering** what it is intended to achieve.

Key measures are deliberately few, to ensure focus and prioritisation are made easier.



Delivery summary

Care Delivery Model



Managed Care Delivery

Data sharing
Enable timely safe access to information across organisations and settings

Population segmentation & stratification
Define population groups and identify those most likely to benefit from tailored interventions

Proactive outreach
Shift from reactive care to planned anticipatory care and engagement

AI enabled triage
Direct people to the right care at the right time reducing unnecessary demand

Care Co-ordination
Coordinate care seamlessly across services to ensure timely, integrated support for individuals

Priority Starter Programmes

B1. Prevention and screening for cancer
Increase uptake consistently and timeliness of cancer prevention screening and early detection

B2. Self care for MSK
Roll out the use of AI self care technology for MSK pathways to increase attendance at work

B3. Utilisation risk management in cardiology
Reduce avoidable utilisation and escalation by identifying people at risk earlier and intervening proactively

B4. Care coordination for advanced illness
Provide coordinated person-centred care for people with advanced illness through managed care approach

B5. Acute care pathway for mental illness
Improve outcomes and experience for people with severe mental illness by ensuring rapid access to the right care first time

Commissioning Provider Collab Models

C1. Dermatology pathway
Recommission dermatology services using an already designed pathway to simplify access and reduce unnecessary demand

C2. Diabetes pathway
Recommissioning the diabetes pathway using existing proven specification developed in one place scaling it system wide

C3. Neurodiversity
Commence the product development cycle.

C4. NHTs
Commence the product development cycle for neighbourhood health teams and delivery services

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

NHS Cambridgeshire & Peterborough Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Central Bedfordshire Health & Wellbeing Board
Developing a BLMK Neighbourhood Strategic Plan

22nd April 2026

Driven by one question: what best serves our population?

Central Bedfordshire Neighbourhoods (4)

West Mid Beds - 70,931

Practices: Flitwick Surgery, Marston Forest Healthcare, Cranfield Surgery (branch of Marston Forest), Barton Le Clay, Greensand Surgery (Ampthill), Houghton Close Surgery

PCNs
Green Vale, Hillton

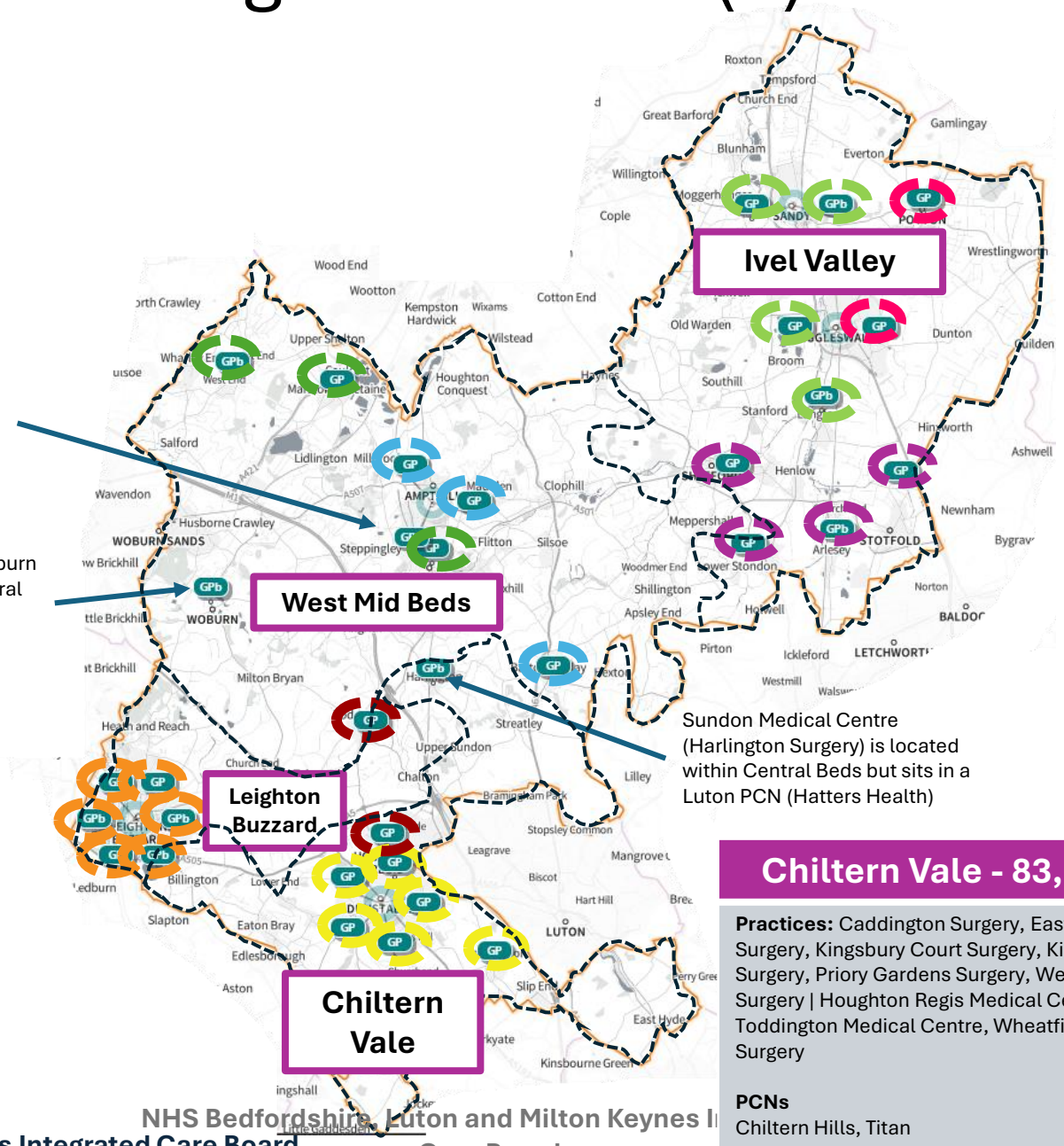
Oliver Street Surgery is located within Central Beds but sits in a Luton PCN (Lea Vale)

Asplands Medical Centre (Woburn Branch) is located within Central Beds but sits in an MK PCN (Ascent)

Leighton Buzzard - 48,036

Practices: Dr JL Henderson & Partners, Leighton Road Surgery, Salisbury House Surgery

PCN
Leighton Linslade Connections



Sundon Medical Centre (Harlington Surgery) is located within Central Beds but sits in a Luton PCN (Hatters Health)

Ivel Valley - 91,652

Practices: Shefford HC, Lower Stondon, Larksfield and Arlesey Medical Practice | Saffron Health Partnership, Sandy Health Centre | Greensands (Potton), Ivel Medical Centre

PCNs
Ivel Valley South, Sandhills, 2 Managed PCN services practices

Chiltern Vale - 83,629

Practices: Caddington Surgery, Eastgate Surgery, Kingsbury Court Surgery, Kirby Road Surgery, Priory Gardens Surgery, West Street Surgery | Houghton Regis Medical Centre, Toddington Medical Centre, Wheatfield Surgery

PCNs
Chiltern Hills, Titan

Key

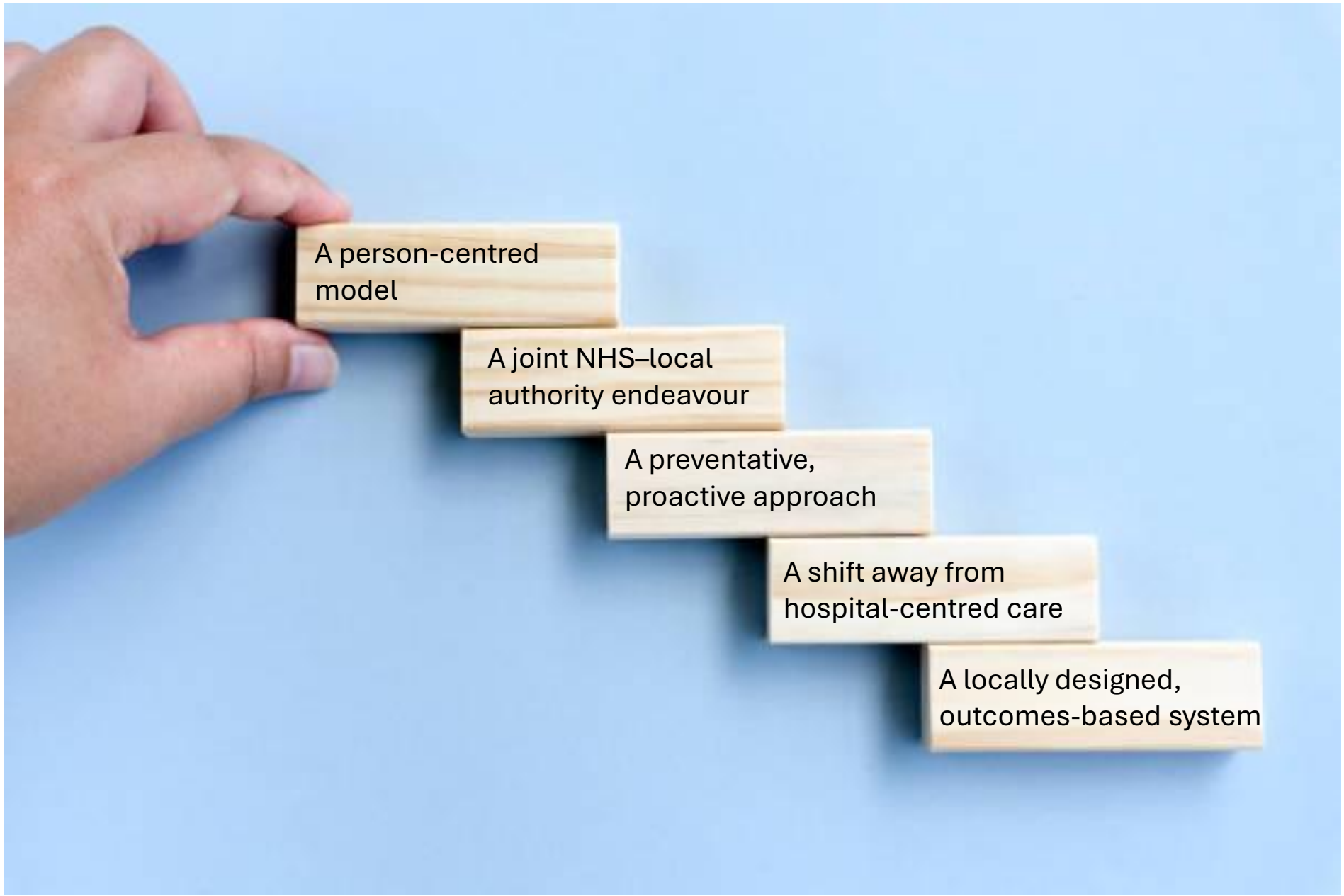
GP	Practice
GPb	Branch Practice
	Greenvale
	Hillton
	LLHC
	Ivel Valley South
	Sandhills
	Titan
	Chiltern Hills
	2 Managed PCN Services practices

What is Neighbourhood Health?

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

NHS Cambridgeshire & Peterborough Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board



Neighbourhood Health

National Guidance on Neighbourhood Health

Between March - April, NHS England (NHSE) and the Department of Health & Social Care (DHSC) published the Neighbourhood Health Framework, Population Health Delivery Models & Neighbourhood Health Centres Design & Performance Specification – links below:

https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework
https://www.england.nhs.uk/long-read/fit-for-the-future-towards-population-health-delivery-models/
https://www.england.nhs.uk/long-read/neighbourhood-health-centres-design-and-performance-specification/#brief

Neighbourhood Health Framework (NHSE/DHSC)
Sets out a national framework that enables ICBs, local authorities and HWBs to jointly design and deliver a neighbourhood health service that integrates care around local populations and accelerates the shift from hospital to community-based, preventative care.

Population Health Delivery Models (NHSE)
Describe the new population-based contract models – Single Neighbourhood Provider (SNP) – Multi-Neighbourhood Provider (MNP) - Integrated health organisation (IHO) - that will support ICBs to commission services around defined populations and incentivise joined-up, preventative, neighbourhood-focused care.

Neighbourhood health centres: design and performance specification
Sets out the national requirements and standards to guide the consistent design, delivery, and performance of neighbourhood health centres, ensuring they provide accessible, integrated, high-quality care tailored to local population needs.

National Guidance on Neighbourhood Health

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board
NHS Cambridgeshire & Peterborough Integrated Care Board
NHS Hertfordshire and West Essex Integrated Care Board

Improve	Improve	Improve	Improve	Improve
GOAL 1: **Improve health outcomes for priority groups** • Focus on frailty, long-term conditions, end-of-life care, care home residents, housebound people, children and young people. • Example metric: Reduce non-elective admissions and bed days for people with moderate–severe frailty, care home residents and housebound patients by 10% by March 2029.	GOAL 2**: Improve access to general practice** • Ensure people can get clinically urgent and routine GP care in a timely and consistent way. • Example metric: 90% of clinically urgent patients should be seen the same day by March 2027.	GOAL 3: **Improve experience of planned care** • Reduce unnecessary hospital referrals and move more outpatient care into neighbourhoods. • Example metric: Achieve at least a 25% diversion rate through single points of access for 10 high-volume specialties by March 2027.	GOAL 4: **Improve urgent and emergency care performance** • Reduce avoidable ED attendances, ambulance conveyances and delays in discharge through better community-based urgent care. • Example metric: Increase Type 1 ED four-hour performance to an interim 82% by March 2027, supporting progress toward 85%.	GOAL 5: **Improve patient and staff satisfaction** • Strengthen proactive care, ensure personalised care planning, and improve neighbourhood staff experience. • Example metric: By 2027, 95% of people with complex needs should have an agreed care plan; neighbourhood staff experience measures will be introduced with year-on-year improvement trajectories.

National Guidance on Neighbourhood Health

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board
NHS Cambridgeshire & Peterborough Integrated Care Board
NHS Hertfordshire and West Essex Integrated Care Board

Stage 1 (2026/27): Foundational Year

The Framework defines 2026/27 as a foundational year for HWBs. During this stage, HWBs are not expected to deliver against the five neighbourhood health goals. Instead, the focus is on establishing the enabling conditions required to support neighbourhood health in subsequent years. In practice, this means HWBs should concentrate on:

- Jointly develop the local approach to neighbourhood health
- Agree the neighbourhood footprints (geographies)
- Agree early priorities for neighbourhood delivery (linked to the national goals)
- Begin joint planning and governance arrangements
- Ensure alignment with JSNAs and wider local reforms

This foundational work in 2026/27 is critical to ensuring HWBs are well-placed to move into delivery in later stages of the Framework.

National Guidance on Neighbourhood Health

The Framework also sets out **Stage 2 (2027/29): Longer-term Reform:**

- Develop a full Neighbourhood Health Plan
- Confirm final neighbourhood geographies
- Define governance, roles and accountability
- Translate national goals into local delivery
- Agree the longer-term delivery and contracting model
- Put in place enabling infrastructure

Local Planning on Neighbourhood Health

- BLMK is aiming to produce a single **Neighbourhood Strategic Plan** that discharges the NHSE/DHSC requirement to ‘create the conditions for neighbourhood health’ (as per the previous slide)

- The BLMK **Neighbourhood Strategic Plan** will set out the approach for neighbourhood health locally whilst seeking to adopt the Central East consistent-versus-local model, providing a consistent approach to key elements of neighbourhood health such as the development of Integrated Neighbourhood Teams (INTs)—while reflecting local context, place-based priorities, and neighbourhood-level population needs.

- The plan will align with Central Bedfordshire’s strategies, local neighbourhood plans and forums, the JSNA and associated priority programmes, alongside national guidance, the Central East 5-Year Strategic Plan (‘Our Way’), the emerging Central East Neighbourhood Target Operating Model (TOM), the BLMK Core Narrative, and the outputs from the two BLMK Neighbourhood Delivery Committee Workshops held in Dec-25 and Feb-26.

- The **Neighbourhood Strategic Plan must align with our Better Care Fund Plans for 2026/27.**

- The following slides set out some of our joint work to date…

BLMK Neighbourhood Health Core Narrative

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board
NHS Cambridgeshire & Peterborough Integrated Care Board
NHS Hertfordshire and West Essex Integrated Care Board

1 Final

Neighbourhood Health Core Narrative

Central East ICB
Bedfordshire, Luton and Milton Keynes

Audience: All readers
Style: Clear and straightforward
Purpose: Inspire, encourage, and present a simple vision

Building better neighbourhood health in Bedfordshire, Luton and Milton Keynes

The government has a clear plan to help people stay healthy in their own homes and local neighbourhoods. This plan means more care close to where people live, easier access to services, better experiences for everyone, and improved health for the future.

All areas in England are expected to use this neighbourhood health approach in their communities.

This short booklet explains what we hope to achieve in Bedfordshire, Luton and Milton Keynes. It has been written so that everyone can read and understand it. Other documents will be available if people want more detailed information.

The government's goals are to:

To improve people's health and wellbeing and address health inequalities.

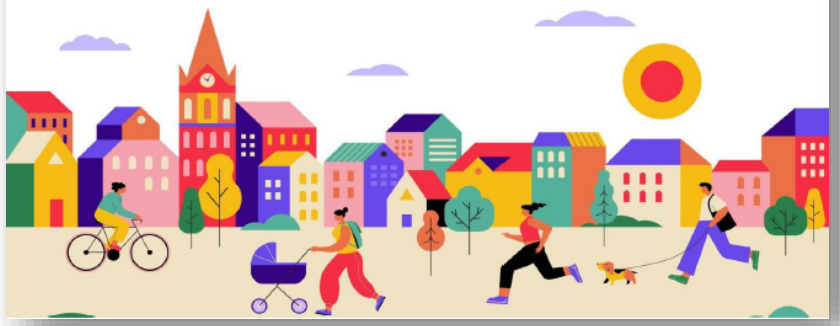
To help people take care of themselves in local communities.

To improve access to core general practice services and how it works with other services.

To support people with one or more long term conditions to live happier and healthier lives.

To streamline and localise access to specialist medical opinion and diagnostics.

To improve care outside hospital for people with complex needs, especially the elderly and those nearing end of life



2 Final

In Bedfordshire, Luton and Milton Keynes, different organisations have been working together to answer the government's call to improve local health and social care. So far, we have already done a lot, including:

Made plans to work better together by agreeing on 16 local neighbourhood areas and setting up a group to lead neighbourhood health work.

Tried new ways of giving care, such as supporting people at home instead of in hospital, and helping schools better support children with special educational needs and disabilities.

Created extra support for people who need it most, including care for people at the end of their lives, and using tools in GP services to spot people who need help earlier.

Helped community groups give local people chances to take part in activities that support health and wellbeing.

At a meeting in December 2025, leaders from local organisations agreed how they will work together on neighbourhood health.

They agreed on seven simple principles to guide their work, so everyone works towards the same goals while still meeting local needs. We can build on these principles as the national and the Central East Integrated Care Board (ICB) strategy evolves. The principles are:

1. One team, one purpose

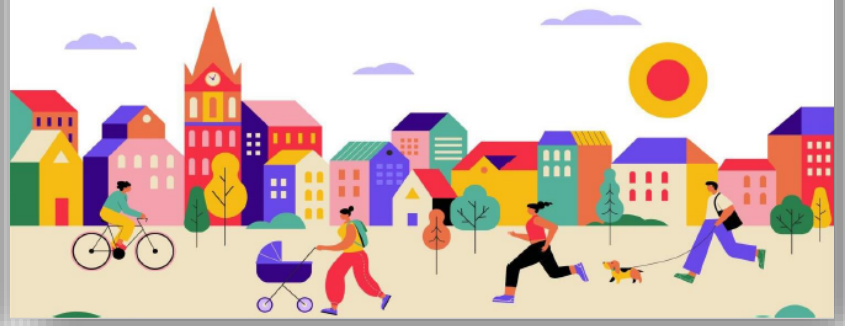
Our neighbourhood health approach is all about delivering proactive, joined up, and consistent care and support at the right time and for those who need it most in local geographic areas.

2. People first, not conditions

We know everyone has a unique story, values, and goals and that empowering them to help themselves and lead their own care is best all-round.

Taking a person-centred approach is essential to improving the experience residents have of the care and support offered to them and to help us break free of our traditional thinking – like the separation between mental and physical health.

Health and support services are given in many places, including in people's homes. But leaders agree that each neighbourhood also needs a neighbourhood co-ordination centre.



3 Final

3. A neighbourhood co-ordination centre

The point of the centre is to identify and then help people who need support from more than one service. It helps make sure these people get the right help at the right time by bringing services together.

The co-ordination centre will also be a place where members of the neighbourhood team can meet, support each other, and take part in training to help them do their jobs better. It will also be a place where the team can look at facts and figures to work out what issues are more of a problem in the neighbourhood and plan what to do about it.

In some neighbourhoods, the centre may be in a building. In other areas, it may be online, using video calls and other digital tools offering support and a collaboration space.

4. Unlocking the full potential in our neighbourhoods

Each of our neighbourhoods are full of brilliant organisations, from large schools to small volunteer-led clubs and groups. We want to maximise the contribution all organisations in the neighbourhood can make to improving health and wellbeing. We'll do that by making them feel part of the collective effort in the neighbourhood and work together in partnership.

recognise that many services will continue to operate on a larger level, including many hospital services.

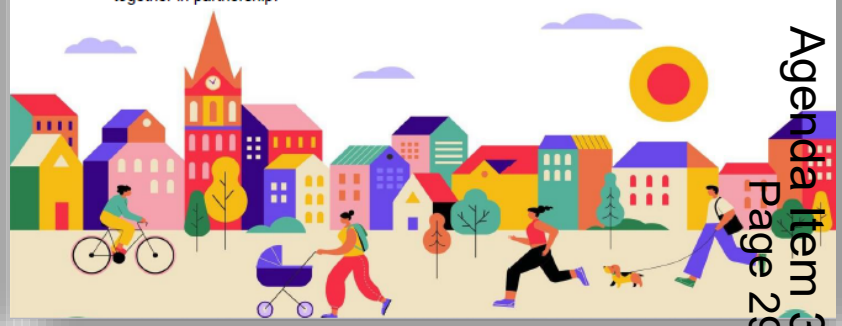
5. Strong neighbourhood leadership

We know credible, visible and committed leadership in each of our neighbourhoods is essential, that's why we commit to having neighbourhood directors who will be responsible for how the neighbourhood works as a small system. These director roles will most likely be existing clinical and other leaders who will lead a neighbourhood in addition to their regular duties.

6. Fewer priorities, greater impact

In year one of neighbourhood establishment, we will have a specific focus on older people who are frail or at the end of their life. We will also deliver the requirements of the neighbourhood framework in line with government expectations.

In year two we aim to concentrate on children and young people (those with special educational needs and disabilities to be specific). Each year thereafter we will agree a priority group for us to focus on.

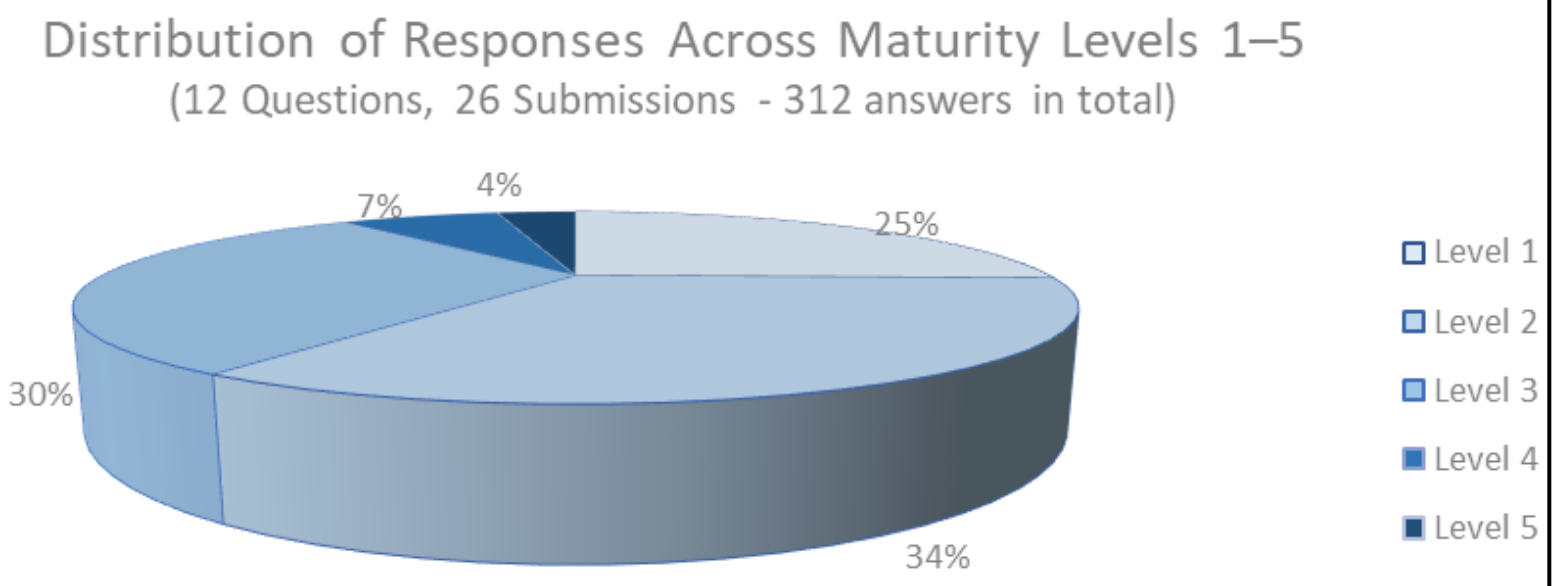


Neighbourhood Maturity Assessment

- Thank you to everyone who completed the Neighbourhood Maturity Assessment – 26 Responses to date
- We will leave the MS Form open for more people to complete the assessment
- Responses were a good mix of BLMK wide, Place and individual neighbourhoods – and whole population vs segments

Maturity Level Definitions

- **Level 1** - **Initial**: No structured approach; siloed working; reactive services; minimal coordination **(25%)**
- **Level 2** - **Developing**: Initial steps taken; early partnerships forming; basic processes established; some coordination **(34%)**
- **Level 3** - **Established**: Clear structures and processes; integrated teams forming; consistent practices; regular engagement **(30%)**
- **Level 4** - **Mature**: Mature integration; operational delivery; shared accountability; data-driven decisions; measurable outcomes **(7%)**
- **Level 5** - **Optimising**: Continuous improvement; system-wide optimisation; innovation embedded; exemplary practice; sustainable transformation **(4%)**



- The responses suggests neighbourhoods are mostly at early maturity (Levels 1–2), with gaps in leadership structures, data systems, and integrated multidisciplinary teams.
- Some progress is emerging (Levels 2–3) in culture, behaviours, and community collaboration, but advanced maturity (Levels 4–5) remains rare, highlighting a major opportunity to strengthen PHM capability, leadership accountability, and fully integrated working.

Importance of working with the Voluntary, Community and Social Enterprise (VCSE) sector

VCSE organisations are **key partners in improving population health and reducing inequalities**.

Bring **local insight and trust**, reaching communities least engaged with statutory services.

Support **prevention and early intervention**, aligned to HWB priorities.

Address **wider determinants of health** (social isolation, housing, employment, mental wellbeing).

Enable **co-production and community voice** in strategy and service design.

Deliver **culturally competent, inclusive approaches** to reduce health inequalities.

Strengthen **community resilience, social capital and neighbourhood capacity.**

Support **place-based, integrated working** and system transformation.

Reminder: the role of Health and Wellbeing Boards

In the context of the 10-Year Health Plan, Health and Wellbeing Boards will be expected to:

- **Lead** the development and sign-off of neighbourhood health strategies and delivery frameworks.
- **Align** system plans and prevent fragmentation.
- **Convene** and coordinate cross-sector collaboration.
- **Strengthen** governance and accountability.
- **Expand** inclusivity and representation.
- **Drive** integration and collective ownership.

Their role is not simply advisory, but foundational - acting as the democratic, system-wide steward of neighbourhood health improvement.

To note: HWBs still have to undertake their statutory functions i.e. oversee prep of JSNA/ PNA, produce a HWB Strategy and have a core membership as defined by Health and Social Care Act.

Taken from: LGA Requirements to ensure system readiness and coherent, partnership led delivery

Next Steps...

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board
NHS Cambridgeshire & Peterborough Integrated Care Board
NHS Hertfordshire and West Essex Integrated Care Board

Continue the good work we have started on **jointly developing** our **approach** for Neighbourhood Health in BLMK.

Continue our **engagement** work with **NHS, Local Authority** and **system partners** including **VCSE** on shaping our approach to Neighbourhood Health.

Building up on the BLMK Core Narrative to jointly produce a **BLMK Neighbourhood Strategic Plan** that creates the conditions for neighbourhood health to be delivered from April 2027.

To bring a draft of the **BLMK Neighbourhood Strategic Plan** back to a future HWB.

This page is intentionally left blank

Item 7: A Smoke Free Generation

Central Bedfordshire Health and Wellbeing Board

08 July 2026

A Smoke Free Generation

Responsible Officer:

Vicky Head, Director of Public Health,

Vicky.Head@Bedford.gov.uk

Advising Officer:

Ciceley Scarborough, Deputy Director Public Health

Ciceley.Scarborough@Centralbedfordshire.gov.uk

The following sections of this report are exempt:-

None

Purpose of this report

To provide the Health and Wellbeing Board with information with regard to CBC's approach towards becoming Smoke Free.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Note the planned use of the Local Stop Smoking Services and Support Grant (LSSSASG) as well as ongoing service development, to support more people to stop smoking.
2. Consider opportunities available through the Health & Wellbeing Board to build on and further increase the support available to residents to reduce smoking prevalence.

Main body of the report

Introduction

- Smoking prevalence has steadily been decreasing for decades, due to comprehensive tobacco control measures which have been implemented both nationally and locally. However, progress is now at risk of stalling. Without further action, England will miss the Smokefree 2030 ambition of 5% smoking rates or less by seven years, with the poorest areas not meeting it until 2044.
- Recent data indicates that smoking prevalence in Central Bedfordshire has fallen. However, we need to continue to be innovative in our approach to ensure that more smokers are supported to quit, and to address local inequalities in smoking prevalence. Additional funding in the form of the Local Stop Smoking Services and Support Grant (LSSSASG) is enabling us to do more.

Background

- Historically The Stop Smoking Service was hosted by Central Bedfordshire Council on behalf of the shared Public Health Service for Milton Keynes, Bedford Borough and Central Bedfordshire.
- However, in May 2025 Public Health developed the Choose You service, offering an integrated approach to supporting residents across Bedford Borough, Central Bedfordshire and Milton Keynes to make long term improvements to their health and wellbeing through stop smoking and weight management support. The overarching aim of the Stop Smoking Service is to reduce both the smoking prevalence in the local population; and to reduce health inequalities caused by in smoking by increasing access to stop smoking support for vulnerable groups.
- Helping individual smokers to quit is a vital component to reducing smoking prevalence and remains a key priority for the service. Of equal importance are evidenced-based tobacco control measures which serve to change social norms around smoking, reduce the number of people who start smoking and prevent residents from being exposed to second-hand smoke.

Smoking Prevalence

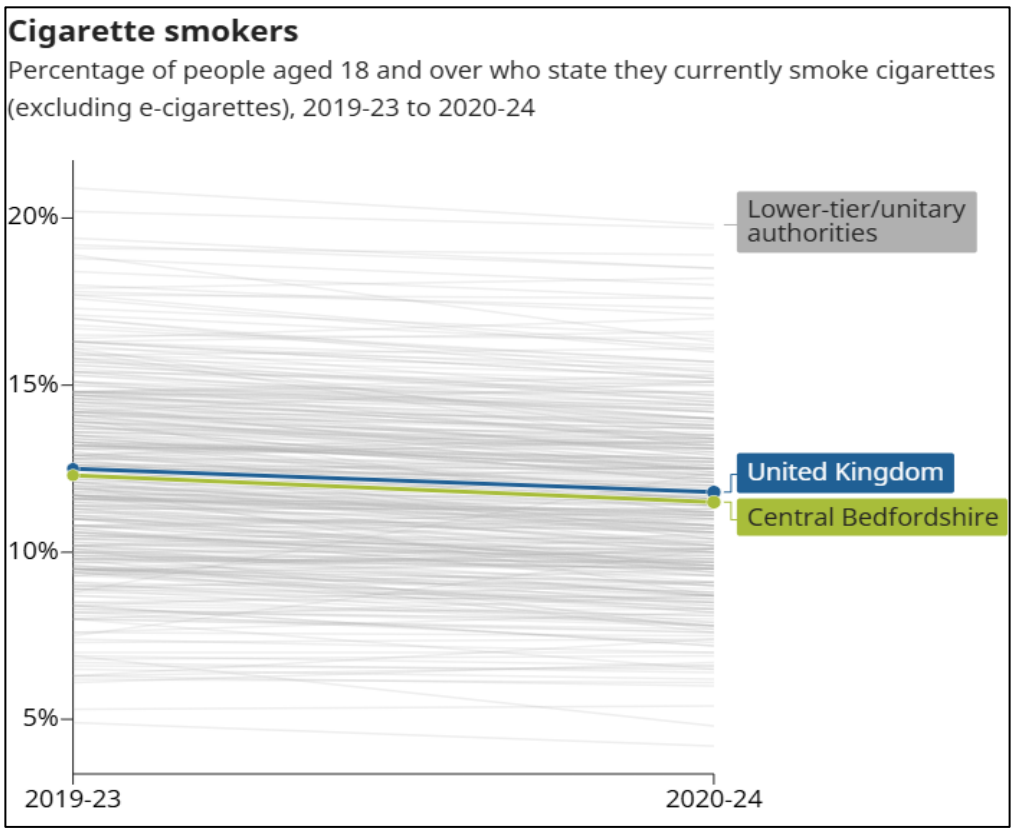
- It is estimated that 10.4% of adults in Central Bedfordshire smoke [1] (Fig. 1), which equates to around 25,000 adults. Compared to the previous report (2023), which estimated smoking prevalence at 10.6%, this 2024 data indicates that smoking prevalence in Central Bedfordshire has remained relatively stable (0.2% decrease). Whilst this trend is encouraging, it is based on a survey and the confidence intervals are wide. Therefore, the improvement should be interpreted with caution and additional years of data will be needed to confirm this trend.
- Central Bedfordshire smoking prevalence data shows 10.4% of the population are current smokers, which is the same as the England average rate of 10.4% (2024). It is

[1] Office for Health Improvement and Disparities. Public Health Profiles. 2024. https://fingertips.phe.org.uk/ © Crown copyright 2024. Smoking Profile – Smoking Prevalence in adults (aged 18 and over (2023).

significantly better than the worst performing local authority (20.8% Boston), but the best performing local authority has a much lower comparable prevalence rate of 3.1% (Woking).

- At least half of smokers will die prematurely if they do not give up smoking. In between 2022 and April 2023 approximately 2,172 Central Bedfordshire residents were admitted to hospital because of smoking[2] (latest data) and over 853 residents die of smoking-related illnesses[3] per year.

Figure 1: Smoking prevalence in Central Bedfordshire and England



Source: Office for National Statistics

- There are ongoing inequalities in smoking prevalence. In Central Bedfordshire you are more likely to smoke if you have a diagnosed long-term mental health condition.

[2] Public Health profiles. Smoking attributable hospital admissions, 2024 - Fingertips | Department of Health and Social Care

[3] Office for Health Improvement and Disparities. Public Health Profiles. 2024. https://fingertips.phe.org.uk/ © Crown copyright 2024. Smoking Profile – Smoking attributable mortality (2017-2019)

Between 41.5% (alcohol) and 68.7% (non-opiates) of adults in treatment for drug and alcohol misuse are smokers.

- Smoking tobacco is the biggest contributing factor in the life expectancy gap between the poorest and the most affluent, and between those with and without long-term mental health issues.
- In 2025-2026, 1435 Central Bedfordshire residents successfully quit smoking following an intervention from the Choose You Service. Almost triple the number in 2024-25.

National Policy Change

- In October 2023 the Department of Health and Social Care (DHSC) published their command paper: *'Stopping the start: our new plan to create a smokefree generation'*. This paper outlined the ambition to achieve a smoke free generation by 2030.
- On 5 November 2024 the new government introduced the Tobacco and Vapes Bill, 2024-25. They hailed this as the "biggest public health intervention in a generation"
- Provisions in this Bill are similar to those proposed in the Tobacco and Vapes Bill 2023-24, which was introduced by the previous government in April 2024 but did not complete its parliamentary stages prior to the general election and consequently fell when Parliament was dissolved.
- A summary of the policy background and all the clauses in the bill are available in a Government Library briefing, Tobacco and Vapes Bill 2024-25 (22 November 2024).
- As of 29th of April 2026 it reached Royal Assent and passed into UK Law. Passing the Bill into law makes the UK the first country to introduce a "Smokefree Generation". It's a historical moment which comes on the back of decades of work collecting data and evidence and lobbying for change across the whole of tobacco control.

- In summary, the Bill contains provisions:
    - on the supply of tobacco, vapes and other products, including prohibiting the sale of tobacco to people born on or after 1 January 2009,
    - on the licensing of retail sales and the registration of retailers,
    - to enable product and information requirements to be imposed in connection with tobacco, vapes and other products,
    - to control the advertising and promotion of tobacco, vapes and other products, and
    - on smoke-free places, vape-free places and heated tobacco-free places.

Additional Investment

- As a precursor to this legislative change, the LSSSASG has been made available to council Public Health teams to increase local capacity and resources to support achieving this ambition. This is in addition to significant funding for national tobacco marketing campaigns, the 'Swap to Stop' scheme, and financial incentives for pregnant smokers. The government is investing an additional £70 million per year nationally to support local authority-led stop smoking services and support.
- Alongside the legislation, this LSSSASG has been regarded as a once in a lifetime opportunity to focus on supporting our residents to quit smoking, further changing the way smoking is perceived in our society and reduce smoking harm.
- Central Bedfordshire has been awarded up to an additional £379,284 per year for five years starting in 2024/25, which approximately doubles our investment in smoking. It is an expectation that most of the LSSSASG will be spent on:
    - Leadership, co-ordination and commissioning
    - Increasing local resources to help people quit
    - Increased referrals and improved pathways
    - Increased promotion of local stop smoking support
    - Working together with partners to fund services
- Outside these criteria, additional activities are permitted but would be expected to demonstrate good evidence of effectiveness.
- Progress will be measured against the key outcomes for success in the grant funding framework:
    - number of recorded quit dates set per 100,000 smokers
    - percentage of people engaging with services who successfully quit smoking (recorded quit rate)
    - number of recorded quits per 100,000 smokers

Planned use of the Smokefree Generation Grant

- The following uses of SFG funding are planned:
    - Following the commissioning of 800 free places for smokers to attend the Allen Carr programme one day seminars, we plan to commission an initial 399 places for this financial year with a view to review dependent on uptake. This will continue to be offered to smokers across Central Bedfordshire, Milton Keynes and Bedford Borough and reviewed to ensure that all future commissioning of this intervention is based on take-up and effectiveness.

- Funding of Tobacco Dependency Treatment offer:
    - For adults with Severe Mental Illness across Bedfordshire and Milton Keynes. This funding aims to create a seamless continuation of care from inpatient settings into the community, delivered through community mental health teams (CMHTs).
    - For adults in the drugs and alcohol recovery pathway the posts will be embedded within the recovery services offered by the East London NHS Foundation Trust (ELFT) and Central and North West London NHS Foundation Trust (CNWL) and delivered through specialist drug and alcohol services to increase access to stop smoking support and improve quit outcomes.
- Recruitment of additional Public Health Officers into the Choose You Stop Smoking Service. Using this additional capacity we:
    - Launched a new face to face offer within Path 2 Recovery (P2R), the Public Health-commissioned drug and alcohol treatment service.
    - Specifically offered support to smokers who attend a Targeted Healthy Lung Check to receive immediate advice and support to quit smoking.
    - Worked with social housing providers to offer stop smoking support to their residents where we know there is a higher prevalence of smoking.

- We are funding promotional activities to increase awareness of and engagement with the Choose You Service by increasing the budget for our communications campaign. This allowed us to:
    - Be targeted, increasing engagement and uptake of support for groups of residents with higher smoking prevalence, areas of deprivation and Routine and Manual workers in particular.
    - Enhance our digital advertising, which has been shown to be the most effective route to increasing engagement with the service.
    - Use ‘out of home’ paid advertising using platforms such as billboards, bus stops and phone boxes in high traffic areas like shopping centres and local focal points in Central Bedfordshire.

- Pilot an evidence based financial incentive scheme:
    - This scheme launched in January 2026 and offers vouchers at key points through the stop smoking programme to motivate smokers to sign up and complete the programme and increase the number of 4-week quit outcomes

- It is targeted at smokers with serious mental illness, long term physical health conditions, those in a routine and manual occupation and those who are unemployed.
- A formal evaluation of the scheme is planned at 6 and 12 months following implementation to assess impact on engagement and quit outcomes.

- There are a range of additional activities, undertaken both by the Council and other partners which can support the work that Public Health do to protect our residents from smoking-related harm, but which cannot be supported through the LSSSASG, some of which have been funded separately by central government. An example would be the enforcement against and reduction in supply of illegal and counterfeit tobacco products, on which we work collaboratively with our colleagues in Trading Standards. Through the Public Health strategic reserve, we fund an Enforcement Officer post to assist with this work. Colleagues from Trading Standards are providing a report to outline their work on tobacco control and smoking in this HWB meeting.
- The final strand of work being funded through LSSSASG is an example of local authorities working together across the East of England, taking a similar approach to the 'Fresh and Balance', as successfully piloted by local authorities across North East of England.
- According to the framework for delivering services and support, local areas can jointly fund activity over a greater geographical area, for example by region, to co-ordinate key activities including:
    - marketing and advocacy
    - service design and delivery
    - wider tobacco control activities geared to stimulate quits.

- The proposed work comprises the following areas:
    - Assessment of health equity system and data on health inequalities and the social determinants of health
    - Development of recommendations, action plans and monitoring systems
    - Exploring and collaborating with Parties across the whole system
    - Advocacy and commitments across the whole system.
    - Provision of a regional coordination post to provide support for this work.

Options for consideration

- For information to the Central Bedfordshire Health and Wellbeing Board

Reason/s for decision

No decision required

Legal Implications

There are no direct legal implications arising out of this report.

Financial and Risk Implications

- Local SSS service is subject to terms and conditions of spend.

Governance and Delivery Implications

No Implications

Equalities and Fairness Implications

- Central Bedfordshire Council has a statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
    - The proposal to create a smoke-free generation is intended to improve public health outcomes across the population, with particular benefits for communities that experience higher rates of smoking-related illness and premature mortality. Smoking prevalence is often highest among people living in areas of deprivation, contributing significantly to health inequalities. By preventing future generations from taking up smoking, the policy has the potential to reduce long-term inequalities in health outcomes.
    - The proposal is expected to have a positive impact on protected groups, particularly younger people, by reducing exposure to tobacco products and the associated health risks. It may also benefit children and families through reduced exposure to second-hand smoke and improved household health and wellbeing. Consideration has been given to fairness and proportionality. The policy does not restrict existing adult smokers from purchasing tobacco products but instead focuses on preventing uptake among future generations. This approach seeks to balance individual choice with the wider public interest in protecting public health.
    - Overall, the proposal is assessed as having a positive equality impact, supporting the Council's commitment to reducing health inequalities and improving health outcomes for all residents.

Biodiversity and Sustainability Implications

No Implications

Implications for Work Programme

No Implications

Conclusion and next steps

- The paper provides an overview of this exciting opportunity and area of work. The additional funding is welcome, and Public Health will ensure that this additional expenditure will provide the extra capacity and support needed to push the stop smoking agenda in Central Bedfordshire forwards.

Appendices

The following Appendix is attached/ provided through an electronic link.

Policy paper: '*Stopping the Start: Our plan to create a smoke free generation*'

House of Commons briefing paper: *Tobacco and Vapes Bill 2024-25*

Tobacco and Vape Bill: Tobacco and Vapes Bill becomes law

Background Papers

The following background papers, not previously available to the public, were taken into account and are available on the Council's website:

- NA

Report author(s):

Dominic Uvieghara, Public Health Project Manager
dominic.uvieghara@centralbedfordshire.gov.uk

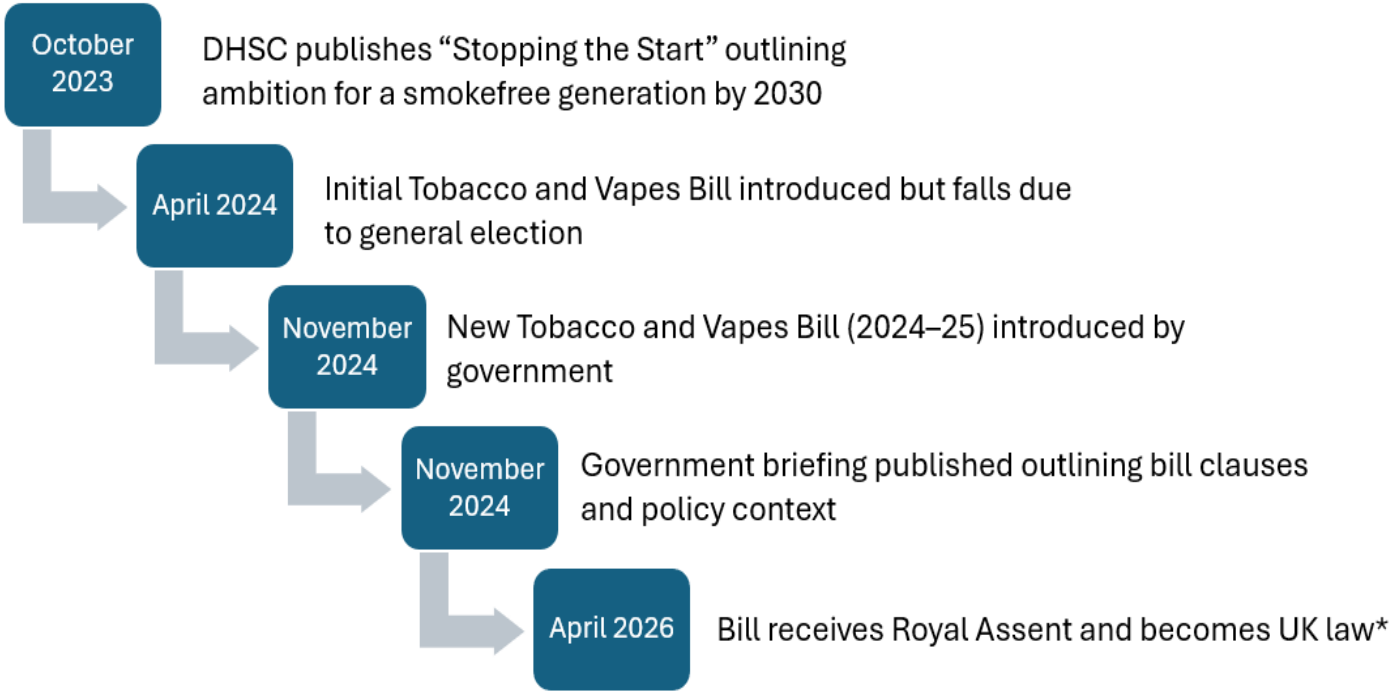
Etain McDermott, Head of Service – Health Improvement,
etain.mcdermott@cenrtalbedfordshire.gov.uk

Ciceley Scarborough, Deputy Director Public Health,
Ciceley.Scarborough@Centralbedfordshire.gov.uk

Smoke Free Generation

Etain McDermott – Head of Service - Health Improvement, Public Health
&
Dominic Uvieghara – Public Health Project Manager

A Historic Change in Tobacco Control



Smoking remains the leading preventable cause of ill health and premature death

Central Bedfordshire:

- Around **25,000 adults smoke**
- **Approximately 2,172 smoking-related hospital admissions**
- More than **853 smoking-related deaths each year**
- Smoking remains the largest contributor to health inequalities

Measure	Previous Report (2025)	Latest Position
Smoking Prevalence	10.6%	10.4%
Comparison with England	Better than England Average	Same as England Average
Comparison with other areas		Worst performing – Boston 20.8% Best Performing – Woking 3.1%

The Choose You programme delivered a substantial increase in impact in 2025/26, helping nearly 1500 residents to quit smoking, three times as many people in 2024/25

Tacking Health Inequalities

Smoking is not evenly distributed; residents are more likely to smoke if they:

- Have a severe mental illness
- Are in drug and alcohol treatment
- Live in more deprived communities
- Work in routine and manual occupations

Local data

- Smoking prevalence among adults in treatment:
- Alcohol treatment: **41.5%**
- Non-opiate treatment: **68.7%**

Strategic Focus - Our investment is increasingly targeted towards populations with the highest smoking prevalence and greatest health inequalities.

Smoke Free Generation Grant

Central Bedfordshire has been awarded up to an additional £379,284 per year for five years starting in 2024/25, which approximately doubles our investment in smoking.

Funding priorities:

- More stop smoking support
- Stronger referral pathways
- Increased promotion and awareness
- Partnership working
- Targeted interventions for priority groups

Smoke Free Generation Grant

Supporting more residents to quit:

- Allen Carr Easyway
- Mental Health Tobacco Dependency Treatment
- Drug & Alcohol Recovery Pathways
- Additional Public Health Capacity

Reaching more smokers:

- Financial Incentive Scheme (FINPS) - Launched January 2026
- Targeted Communications Campaigns

Partnership Working

Current Partnerships:

- NHS Trusts
- D&A Recovery Services
- Housing providers
- Trading Standards
- East of England regional tobacco control programme

Future Priorities:

- Workforce
- Smoke-free environments
- Targeted communications
- Community engagement
- Mental health
- Drug and alcohol services
- Deprived communities
- Routine and Manual workers

Thank you and Questions?

This page is intentionally left blank

Item 8:
Local Authority Research Practitioner update

Central Bedfordshire Health and Wellbeing Board

08 July 2026

Health and Wellbeing Board

Local Authority Research Practitioner update

Responsible Officer:

Ciceley Scarborough, Deputy Director of Public Health,
ciceley.scarborough@centralbedfordshire.gov.uk

Advising Officer:

Andrew Malcolm, Public Health Principal - Local Authority Research Practitioner,
andrew.malcolm@centralbedfordshire.gov.uk

The following sections of this report are exempt:-

n/a

Purpose of this report

To appraise the health and wellbeing board of the Local Authority Research Practitioner (LARP) role, progress to date, and future plans.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Note the update on the LARP role and progress to date
2. Provide feedback on the future plans for the LARP role

Main body of the report

3. The Local Authority Research Practitioner role is focused on developing research culture, capacity, and infrastructure within a local authority. It is funded by the National Institute for Health and Care Research (NIHR), via the Specialist Centre for Public Health based at Newcastle University.
4. The Specialist Centre for Public Health (SCPH) has agreed funding for a total of 88 LARPs across the country. The SCPH coordinates a network for the LARPs focused on mutual support, sharing of learning and resources, and strategic coordination.
5. LARPs focus on a wide variety of activities that are informed by the context in which they work. Some of the activities commonly undertaken by LARPs include:

- mapping existing research activity,
- building relationships and developing research culture,
- supporting the use of evidence to inform decision making,
- identifying research priorities,
- working with academic and external research partners,
- contributing to research governance and infrastructure, and
- strengthening public and community involvement

6. Why do this work?
    - Every day our council provides hundreds of services. Research can help us better understand our influence and make use of evidence to further improve the positive impact of our services.
7. What do we mean by research?
    - Research empowers us to understand and enhance the impact of our services, taking a structured approach to learning, analysing the information we already hold, or collecting and analysing new data.
8. In Central Bedfordshire Council the LARP role sits within the public health team but has a focus on developing research culture, capacity, and infrastructure across the whole council.
9. The application to fund the LARP role at Central Bedfordshire Council focused on four areas:
    - Strengthening our use of evidence to inform policy and practice
    - Developing infrastructure and support for staff who are research interested and may become research active
    - Growing mutually beneficial relationships with local universities
    - Empowering citizen voice by involvement in local research
10. Activity to date for the LARP has focus on these core areas by:
    - Developing and delivering training on evaluation, supporting the team to embed evaluation into our smoking cessation and healthy weight service, undertaking an evaluation of this service, completing scoping reviews of research evidence to inform policy work, and successfully supporting a colleague to apply for a grant to undertake a small evaluative research project.
    - Working with an interest group to scope out a staff research network, launching and organising this network (currently 54 members from across the council), planning and delivering an awayday focused on research for the shared Bedfordshire and Milton Keynes public health service, and drafting successful funding applications for two additional LARPs within the shared public health service (for Bedford Borough and Milton Keynes City Councils).
    - Establishing collaborative relationships with academics at both the University of Bedfordshire (UoB) and University of Hertfordshire (UH). This includes the delivery

of a keynote presentation from a UH professor at the public health awayday, a successful funding application for our LARP to join a research project at UH for eight months, the development of a collaboration agreement to facilitate UoB MSc public health students to undertake research questions set by our public health team for their dissertations, and exploratory discussions of similar student collaborations with UH.

- Attending and supporting the existing Community Engagement network run by Sarah Hughes, providing comments and input on the recently developed Community Engagement Framework, exploring and developing ideas for a public and community partnership funding award with colleagues from both Central Bedfordshire and Public Health in Bedford Borough Council with an unfortunately unsuccessful bid from the latter being submitted.

11. Future plans for the LARP role are outlined below, grouped under the four areas of work:

- Strengthening our use of evidence to inform policy and practice
    - Providing training to public health and social care staff about their ability to access academic research, setting them up with relevant credentials and supporting them to search for relevant evidence.
    - To continue to contribute research skills to projects where they add value, *showing by doing*, to encourage the development of our research culture.
- Developing infrastructure and support for staff who are research interested and may become research active
    - To identify a steering group for the staff research and insight network and fully establish this group so that it is visible and accessible to all colleagues across the council. Growing a sustainable and positive research culture, providing internal development opportunities, and access to a range of resources and opportunities to support the development of research capacity.
    - Providing support to colleagues interested in research as an opportunity for career development / diversification. There are a number of fellowship/small grant schemes that seek to develop the research skills and capacity of local authority staff. To support staff who express an interest in these opportunities to develop applications for funding.
    - To consider the development of research governance to support consistent and effective engagement with research activity.
- Growing mutually beneficial relationships with local universities
    - To review the collaboration with the University of Bedfordshire after the first group of students have completed MSc dissertations based on research questions set by the public health team. To extend this collaboration with the University of Bedfordshire into additional areas of work and to develop similar opportunities with the University of Hertfordshire.
    - To complete the LA SPARC placement with the University of Hertfordshire building on our existing connection and identifying further opportunities to collaborate.

- To develop areas of research interest / service research needs for our shared public health service, publishing these alongside our Joint Strategic Needs Assessment, and promoting these to academic institutions and researchers to encourage collaboration.
- To work with local university partners to offer fellowships to local authority staff, building and formalising cross-institution connections for our staff who are interested in and engaged with research.

- Empowering citizen voice by involvement in local research
  - To continue to attend the Community Engagement Network, offering support to colleagues working in this space where there is overlap between community engagement and research – this particularly relates to citizen voice, public involvement and engagement, and co-production.
  - To consider next steps with the evidence and evaluation team within public health evidence and intelligence after the unsuccessful bid to develop public and community research.

Options for consideration

12. While this report has been bought to appraise the health and wellbeing board of the LARP role and progress to date. Input or reflections on either the work to date or the planned activities would be greatly appreciated.

Reason/s for decision

13. n/a

Legal Implications

14. n/a

Financial and Risk Implications

15. n/a

Governance and Delivery Implications

16. n/a

Equalities and Fairness Implications

17. Not applicable - there are no service, policy or organisational changes being proposed.

Biodiversity and Sustainability Implications

18. n/a

Implications for Work Programme

19. If the board would like to continue to be updated on progress with the LARP role and the aim of developing our research culture, capacity, and infrastructure a follow up report can be added to the work programme.

Conclusion and next steps

20. This report is to inform the board and receive their input on the planned activities for the LARP role. If the board would like a further report at the end of the second year, this can be added to the work programme.

Appendices

n/a

Appendix A: XX

Appendix B: XX

The following Appendix is attached/ provided through an electronic link.

Background Papers

The following background papers, not previously available to the public, were taken into account and are available on the Council's website:

- n/a

Report author(s):

Andrew Malcolm, Public Health Principal - Local Authority Research Practitioner,
andrew.malcolm@centralbedfordshire.gov.uk

This page is intentionally left blank

The Local Authority Research Practitioner role in Central Bedfordshire Council

Activities commonly undertaken by LARPs include:

- mapping existing research activity
- building relationships and developing research culture
- supporting the use of evidence to inform decision making
- identifying research priorities
- working with academic and external research partners
- contributing to research governance and infrastructure
- strengthening public and community involvement

The application to fund the LARP role at Central Bedfordshire Council focused on four areas:

- Strengthening our use of evidence to inform policy and practice
- Developing infrastructure and support for staff who are research interested and may become research active
- Growing mutually beneficial relationships with local universities
- Empowering citizen voice by involvement in local research

Activity to date for the LARP has focus on these core areas:

- Work on evaluation
- Staff network
- Away day
- More LARPs
- Collaborations with universities
- Supporting research funding applications

Future plans for the LARP role:

- Training to support public health and social care staff to access research
- Continue *showing by doing*
- Embed and strengthen the staff network
- Support staff to apply for research opportunities
- Consider developing research governance processes
- Grow our collaborative work with university partners
- Explore how to further embed evaluation and lived experience research into our public health practice

Any reflections or questions?

- While this report has been bought to appraise the health and wellbeing board of the LARP role and progress to date.

- Input or reflections on either the work to date or the planned activities would be greatly appreciated.

This page is intentionally left blank

NHS
Central East
Integrated Care Board

Item 9:
Better Care Fund Approval Letter

Central Bedfordshire Health and Wellbeing Board

08 July 2026

Central Bedfordshire Better Care Fund

Responsible Officer:

Maria Wogan, Director of Neighbourhood Health, Places and Partnerships, BLMK – Central East Integrated Care Board, maria.wogan@nhs.net

Advising Officer:

Kaysie Conroy, Head of Neighbourhood Delivery, BLMK - Central East Integrated Care Board, Kaysie.conroy@nhs.net

Nick Murley, Service Director, Commissioning, Contracts & Performance – Central Bedfordshire Council, nick.murley@centralbedfordshire.gov.uk

Purpose of this report

The purpose of this report is to seek Health and Wellbeing Board (HWB) approval and formal sign-off for the Central Bedfordshire Better Care Fund (BCF) 2026/27 Plan, comprising the Narrative Plan and the Numerical Template, in line with national Better Care Fund requirements.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Note the Better Care Fund (BCF) 2026/27 Narrative and Numerical Plans for Central Bedfordshire and the assurance provided regarding alignment with the national BCF framework and conditions.
2. Confirm that the BCF plan has been jointly developed and agreed by the Integrated Care Board and Central Bedfordshire Council, and that appropriate governance, monitoring and assurance arrangements are in place.
3. Approve and formally sign off the Better Care Fund 2026/27 Plan for Central Bedfordshire, including the associated ambitions for national BCF metrics.

Main body of the report

1. The Better Care Fund (BCF) 2026/27 is a national policy framework designed to drive closer integration between health and social care, with the overarching aim of improving outcomes for people, supporting independence, and making best use of public resources. It provides a pooled budget between the NHS and local government to enable joint planning, commissioning, and delivery of services at place level.

2. The primary purpose of the BCF is to support people, particularly older adults and those with complex needs to live well, safely, and independently in their own homes and communities for as long as possible. This includes preventing avoidable hospital admissions, supporting timely discharge from hospital, reducing delays, and avoiding unnecessary long-term residential care where community-based support is more appropriate.
3. For 2026/27, the BCF framework places a strong emphasis on prevention, early intervention, and neighbourhood-based models of care. Local systems are expected to align BCF investment with the development of integrated neighbourhood health and care services, supporting multidisciplinary working, proactive care, and joined-up pathways across health, social care, housing, and the voluntary and community sector.
4. The framework also reinforces the importance of improving system flow and productivity. This includes targeted investment in urgent community response, intermediate care (both home-based and bed-based), reablement, discharge infrastructure, and community capacity to relieve pressure on acute hospitals and improve the experience of care transitions for residents.
5. A core component of the BCF is the requirement for joint accountability and governance. Plans must be jointly developed and agreed by Integrated Care Boards and local authorities, with formal sign-off through Health and Wellbeing Boards. This ensures shared ownership of priorities, funding decisions, and performance against national metrics.
6. Performance and value for money are central to the BCF. Local areas are required to set ambitions and monitor progress against national outcome measures, including non-elective admissions for people aged 65 and over, discharge delays, long-term residential admissions, and reablement outcomes. This provides transparency and assurance that pooled funding delivers tangible benefits for residents and the wider system.
7. From 2026/27, assurance of the Better Care Fund is jointly led by NHS England and the Department of Health and Social Care, strengthening the BCF's role as a genuinely shared health and social care programme. BCF plans are now reviewed through a single, integrated assurance process, requiring clear evidence of joint planning, robust governance, and demonstrable impact across the whole system. The Health and Well Being's role is therefore reinforced as the key forum for local accountability, ensuring that pooled funding is used effectively to deliver shared place-based priorities and improved outcomes for residents.
8. The Narrative Plan (Appendix A) sets out the strategic rationale for BCF investment, reflecting the demographic profile of Central Bedfordshire, including a growing older population with increasing levels of frailty and complexity. BCF funding is targeted towards:

    8.1. Integrated intermediate care and reablement

    8.2. Admission avoidance, including Urgent Community Response and falls prevention

    8.3. Hospital discharge and system flow (Home First)

    8.4. Preventative community and VCSE-led support

9. The plan articulates clear ambitions for the national BCF metrics, including non-elective admissions for people aged 65 and over, delayed discharges, prevention of avoidable long-term care admissions, and improved reablement outcomes, supported by robust monitoring and governance arrangements.
10. The Numerical Template (Appendix B) confirms the full allocation of the pooled BCF budget for 2026/27, compliance with NHS minimum contribution and adult social care spending requirements, and alignment between planned expenditure and the priorities described in the Narrative Plan.
11. For residents, the Better Care Fund means getting the right support earlier and closer to home. It helps people avoid unnecessary hospital admissions, leave hospital sooner when they are ready, and get the right help to recover and stay independent. By strengthening community, neighbourhood and voluntary sector support, the BCF improves people's experience of care and helps them feel safer and more supported at home.

Legal Implications

12. The Better Care Fund 2026/27 Plan complies with national BCF guidance and statutory requirements, including Section 75 pooled budget arrangements under the NHS Act 2006. The plan is jointly agreed by the Integrated Care Board and Central Bedfordshire Council and subject to formal Health and Wellbeing Board sign-off. No additional legal implications have been identified beyond existing statutory and governance obligations.

Financial and Risk Implications

13. The Better Care Fund 2026/27 pooled budget is fully allocated and compliant with national funding conditions. Financial and delivery risks are managed through joint governance, routine monitoring of spend and performance, and active stewardship of BCF-funded schemes. While demographic growth and system pressures remain key risks, these are mitigated through targeted investment in prevention, reablement, admission avoidance and discharge pathways, with clear escalation and review arrangements in place.

Governance and Delivery Implications

14. Delivery of the Better Care Fund 2026/27 Plan will be overseen through established joint governance arrangements between Central Bedfordshire Council and the Central East Integrated Care Board, with strategic oversight provided by the Joint Better Care Fund Group and formal accountability to the Health and Wellbeing Board. These arrangements ensure effective financial stewardship, monitoring of delivery against national and local BCF metrics, and active management of risk, value for money and performance. The Health and Wellbeing Board retains its statutory role in providing local democratic assurance and approving the BCF plan, with delivery supported through routine performance reporting and agreed escalation routes where corrective action is required.

Equalities and Fairness Implications

15. The Better Care Fund 2026/27 Plan supports equitable access to care and reduced health inequalities by prioritising preventative, community-based and neighbourhood-level services for older people and those with frailty, long-term conditions or at risk of social isolation. Investment in admission avoidance, reablement, urgent community response and VCSE-led support help improve access to timely care, maintain independence and reduce avoidable reliance on hospital and long-term care, supporting fairer outcomes across Central Bedfordshire.

Biodiversity and Sustainability Implications

16. The Better Care Fund 2026/27 Plan supports sustainability objectives by prioritising care closer to home, reducing avoidable hospital admissions, length of stay and travel associated with acute care. Investment in community-based services, reablement and neighbourhood delivery models contributes to a reduced environmental footprint and more efficient use of resources. Where possible, partners will continue to align service delivery with wider system commitments to sustainable practices, estate use and long-term environmental responsibility.

Conclusion and next steps

17. In summary, the Better Care Fund (BCF) 2026/27 Plan provides a robust, jointly agreed and well-governed framework for delivering integrated, preventative and person-centred care in Central Bedfordshire. The plan aligns resources to key system priorities, including admission avoidance, improved discharge flow, reablement and support for independence, and demonstrates clear compliance with national BCF requirements and assurance expectations.
18. The Health and Wellbeing Board is asked to approve and formally sign off the Better Care Fund 2026/27 Plan for Central Bedfordshire, including the Narrative Plan and Numerical Template, to ensure compliance with NHS England and the Department of Health and Social Care.
19. Delivery will then be monitored through established governance arrangements, with regular reporting on financial performance, national metrics and outcomes. Ongoing review of BCF-funded schemes will ensure resources remain targeted towards those interventions delivering the greatest impact, with any required adjustments brought back through governance and, where appropriate, to the Board for oversight.

Appendices

Appendix A: BCF Narrative Plan 2026/27 – Central Bedfordshire

Appendix B: BCF Numerical Plan 2026/27 – Central Bedfordshire

The following Appendix is attached.

Report author(s):

Kaysie Conroy, Head of Neighbourhood Delivery – BLMK, Central East Integrated Care Board. Kaysie.conroy@nhs.net

This page is intentionally left blank

Choose an item.

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Better Care Fund 2026-27
Narrative return

Introduction and guidance

This return has been designed to enable ICBs and local authorities, working with Health and Wellbeing Boards (HWBs), to submit information which demonstrates how their plans for the Better Care Fund (BCF) meet the national conditions and planning requirements for 2026-27. Completing and submitting the BCF narrative return is a required part of the overall BCF submission process. Planning leads should ensure that all questions within this narrative return are fully addressed.

This year, the length of the narrative return has been reduced. This reflects feedback on the benefits of a more focused BCF assurance process. In completing the return, HWBs, ICBs and local authorities may wish to develop more detailed joint plans for BCF expenditure for their own use and/or draw on other joint plans.

Each question in the return has a suggested length of around a page (around 500 words) and we would generally expect the overall submission to be around 2500 words. These act as a guide to support a more focused assurance process rather than strict limits.

The narrative provided in this return should align with the expenditure plans and the ambitions for the national metrics set out in your BCF excel numerical return.

When completing the narrative return, please use the following documents for guidance and support, these can be found on the BCF Exchange:

- **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
- **Metrics Handbook:** provides the formal technical specifications for the national metrics within the framework, including the rationale, methodology, required data inputs and worked examples.

Submission Requirements:

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.
- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.
- The deadline for completing this narrative return is **19 May 2026.**

- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

Mandatory to complete, please do not submit a return without completing the details below:

Adapt as necessary	**HWB area 1**	**HWB area 2**
HWB	**Central Bedfordshire**	
ICB	**Central East ICB**	
ICB		
ICB		

1. **Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.**

   Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

The Better Care Fund (BCF) is a critical enabler of integrated, preventative and person-centred neighbourhood health and social care services in Central Bedfordshire. By pooling NHS and local authority resources and aligning commissioning intentions, the BCF supports whole-system approaches that organise care around individuals, families and communities rather than organisational boundaries. This approach is fully aligned with NHS England priorities, the Central Bedfordshire Joint Health and Wellbeing Strategy and the Central East ICB Our Way Strategy, as well as the ICB five-year strategic commissioning plan, which emphasise prevention, integration, addressing health inequalities and supporting people to live independently at home for longer. Primary Care is central to delivering neighbourhood health, with the Better Care Fund (BCF) enabling alignment of commissioning and governance that will connect to the Primary Care Plan.

Central Bedfordshire has the largest older population within BLMK, with an estimated 60,899 residents aged 65 and over, including 16,570 aged 80+, and this cohort continues to grow. This demographic profile creates sustained and predictable demand on health, social care and community services. Levels of complexity within the older population underline the need for a proactive, integrated approach. Around 8.3% of residents aged 65+ are identified as having high complexity multi morbidity and 4.9% are living with frailty. Almost 28% live alone, increasing the risk of crisis presentations, unplanned admissions and poorer outcomes. BCF funding is therefore strategically targeted to early intervention, prevention and coordinated neighbourhood responses that reduce escalation and improve outcomes for older people and those with complex needs.

BCF investment is prioritised to strengthen integrated neighbourhood health and social care services that prevent crisis, support recovery and reduce reliance on acute and long-term institutional care. Community assessment, hospital discharge pathways, step-up and step-down intermediate care, reablement and falls response services are aligned and delivered as a coordinated neighbourhood offer. This enables timely, short-term interventions across organisational boundaries to stabilise people during periods of vulnerability, maintain independence and improve system flow.

Intermediate care and reablement are core BCF priorities, reflecting their central role in admission avoidance, discharge facilitation and prevention of long-term dependency. Planning is informed by local understanding of demand and capacity pressures linked to frailty, falls and hospital discharge. Central Bedfordshire Council directly provides step-up and step-down intermediate care capacity targeted at key neighbourhood and system pressure points, supporting prevention of admission, timely discharge from hospital and reduced reliance on residential and nursing care.

BCF funding also supports a neighbourhood-based Falls Prevention Service as a key component of integrated preventative care. The service provides a single point of access, holistic assessment and evidence-based strength and balance interventions, working closely with primary care, community health services, adult social care and acute pathways. Using risk stratification tools, residents at increased risk are proactively identified and offered targeted interventions to reduce falls, prevent deterioration and avoid hospital admission. Clear pathways are in place to wider neighbourhood and

community support, including VCSE provision, digital tools (i.e. GaitSmart) and community-based activities, enabling self-management, resilience and care closer to home.

Investment through the BCF further enables integrated support for people with complex and advanced needs, including joined-up Palliative and End of Life Care (PEoLC) provision. This approach embeds early identification, anticipatory care planning and multidisciplinary neighbourhood working to prevent crisis deterioration and avoid unnecessary hospital admissions. It supports personalised care, equity of access and continuity across health and social care services, aligned with system priorities for proactive and coordinated care.

The BCF also plays a vital role in supporting neighbourhood integration between statutory services and the voluntary, community and social enterprise (VCSE) sector. VCSE partners contribute significantly to prevention and early intervention, addressing wider determinants of health such as loneliness, carer strain and low-level support needs, particularly for underserved populations. This enhances community capacity, reduces inequalities and complements statutory provision.

BCF funding is used as the primary mechanism to shift investment upstream into integrated, neighbourhood-based preventative services, enabling partners to reduce avoidable hospital use, manage growing demographic demand and deliver the ICB's place-based care model. BCF priorities in Central Bedfordshire are therefore focused on: (1) integrated intermediate care and reablement, (2) neighbourhood-based admission avoidance including falls prevention and UCR alignment, (3) effective hospital discharge and flow, and (4) preventative community and VCSE-led support.

Looking ahead, BCF governance and annual BCF reviews will continue to ensure funding is targeted to interventions with the greatest impact on neighbourhood and system priorities. During 2026/27, a key focus will be strengthening the role of the Community Services Complex Care Team, with closer integration with the Urgent Community Response (UCR) offer, to enhance rapid, neighbourhood-based admission avoidance.

In summary, the rationale for using BCF funding in Central Bedfordshire enables delivery of integrated, preventative neighbourhood health and social care services that align with ICB and place-based priorities, improve outcomes and experience for residents, reduce avoidable demand on acute services and support long-term system sustainability.

2. **Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

   Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Non-Elective Admissions (65+) and Delayed Discharge Ambitions

Goals for non-elective admissions among people aged 65 and over, and for reducing delayed discharges, have been set in recognition of the significant and growing impact that older people have on emergency activity, bed occupancy and system flow in Bedfordshire. These goals are informed by historic activity, demand trends, population growth projections and analysis of key drivers of avoidable demand, particularly frailty, falls, dementia and long-term conditions.

Older residents account for a disproportionate share of emergency admissions, bed days and delayed discharges. Falls-related admissions and exacerbations of long-term conditions present a clear opportunity for prevention. The agreed approach therefore focuses on sustained, incremental improvements in admission avoidance and reductions in length of stay, which at scale deliver meaningful system benefit and improved patient experience.

Delivery is underpinned by scaled, evidence-based interventions rather than time-limited pilots. Central to this approach are the Bedfordshire Community Urgent Care Hub (UCCH) and the BCF-funded Urgent Community Response (UCR). These provide rapid, multidisciplinary community alternatives to hospital admission for older people, supporting timely assessment and treatment at home or in community settings. Strong performance to date, alongside plans to extend UCCH operating hours, supports confidence in achieving the non-elective admissions (65+) goals.

Monitoring and Governance

Progress against non-elective admissions and delayed discharge goals will be monitored through routine, place-based performance dashboards. These include emergency admission rates, falls-related admissions, length of stay and delayed discharge metrics. Performance is reviewed through established place, urgent and emergency care, and BCF governance arrangements. Where performance deviates from agreed trajectories, targeted operational actions will be implemented, including adjustments to community capacity, front-door pathways and discharge processes, ensuring responsiveness to winter pressures and emerging risks.

Alignment between BCF expectations and the Medium-Term Plan (MTP) trajectories has been reviewed and confirmed. While the MTP reflects whole-population positions and includes trust-specific assumptions (for example regarding zero length-of-stay admissions and discharge delay), the BCF focuses on improvement for the 65+ cohort (non-elective admissions). Taken together, the trajectories are consistent in direction, operating at different levels of granularity and definition.

Non-Elective Admissions (65+) Target and Baseline

For 2026/27, the target is a 1% reduction against the 2025/26 baseline for monthly emergency admissions among residents aged 65 and over. Actual activity data are available for April to December 2026. For the remaining period (January to March 2026), the year-to-date average has been applied to forecast the expected outturn. All figures are aligned with, and consistent with, the published BCF dashboard.

The 1% reduction remains a challenging target for Central Bedfordshire considering demographic growth, the population aged 65+ is forecast to increase by 3%, (local population health forecasts), placing an upward pressure on demand.

Delayed Discharges and Data Methodology

During 2025/26, Bedfordshire Hospitals NHS Foundation Trust (BHFT) and system partners agreed to focus on Discharge Ready Date (DRD) performance using PHEW (BHFT's Patient Discharge Management System) rather than SUS. This provided a more complete and operationally meaningful dataset, particularly for patients with complex care pathways, and reduced distortion from nationally recognised data quality issues such as NULL values.

While this approach created inconsistency with the nationally prescribed SUS methodology and was more labour-intensive, learning from 2025/26 has informed the extrapolation of PHEW data to SUS to support the setting of 2026/27 targets. For Central Bedfordshire, the 2026/27 end-of-year target for percentage of patients discharged on the discharge ready date is 91.3%, with a 6.55-day average delay for complex patients.

From September 2026, local discharge data collection will transition from PHEW to Nerve Centre (the Trust's electronic patient record system). BHFT is actively managing the transition. From October 2026, Nerve Centre will inform SUS reporting, supported by local monitoring through live patient flows and retrospective reporting. This transition is expected to improve accuracy and efficiency.

Preventing Avoidable Long-Term Care Admissions

Preventing avoidable long-term admissions to residential and nursing care, and maximising independence following illness or hospital discharge, is a core objective of BCF investment. Locally

this is delivered through proactive frailty management, falls prevention, rapid community response, integrated discharge pathways, intermediate care and reablement. These interventions reduce admission-related deconditioning, minimise delayed discharges and ensure that permanent care is not the default response to crisis or hospitalisation.

Progress will be monitored through agreed metrics and trend analysis, including long-term care admissions, routes of admission, use of step-down and reablement, and reablement outcomes. Particular focus will be placed on the proportion of people remaining at home following reablement, including at 12 weeks. Where numeric targets exist, progress will be reviewed through joint governance; where they do not, improvement will be driven through trend monitoring, pathway review and service improvement.

Reablement and Residential Care Targets

Reablement and discharge pathway performance is reviewed routinely, with learning used to refine referral routes, eligibility criteria and alignment with step-down and intermediate care. This supports Home First principles and underpins delivery of BCF national metrics for non-elective admissions (65+) and delayed discharges.

The residential care target is based on linear forecasting of quarterly performance against the ASCOF 2C measure. Forecasts have been calculated using in-house analysis, applying the published ASCOF 2C methodology to Client Level Data to ensure consistency. Locally calculated figures are marginally higher than those published via the Athena platform, reflecting timing and recording lags. Ongoing validation provides assurance that the approach is robust and that the target represents a prudent and transparent assessment of expected performance.

3. **Please provide a short explanation of the planned impact of BCF funding on achievement of goals.**

   Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Planned Impact of BCF Funding on Achievement of Goals

BCF investment in Central Bedfordshire is planned to deliver measurable impact against key local system goals, particularly reducing avoidable non-elective admissions for older people, improving discharge flow and delayed discharge performance, and preventing unnecessary long-term residential and nursing care admissions. Funding is deliberately focused on addressing the core drivers of demand associated with frailty, falls, long-term conditions and population growth through scaled, place-based delivery rather than short-term pilots.

Reducing Avoidable Non-Elective Admissions

BCF funding will support reduced non-elective admissions for residents aged 65 and over by strengthening urgent community response and front-door coordination. Investment in Urgent Community Response (UCR), delivered through the Bedfordshire Urgent Care Coordination Hub (UCCH), enables rapid clinical intervention in people's own homes or usual places of residence when at risk of hospital admission.

Enhanced multidisciplinary triage, timely assessment and treatment, and close integration with ambulance services, NHS 111, GPs and care homes supports admission avoidance, particularly for falls, frailty crises and acute deterioration of long-term conditions. This provides a credible and responsive alternative to hospital attendance, reducing pressure on emergency departments and acute beds.

Improving Discharge Flow and Reducing Delayed Discharges

BCF funding will also deliver impact on delayed discharge and length of stay through a strengthened Home First approach. Investment in intermediate care, reablement and step-down pathways increases local capacity to support timely discharge once acute care is no longer required.

These services reduce admission-related deconditioning, minimise delays linked to care package availability and ensure discharge planning is focused on recovery and independence. As a result, length of stay for older people is reduced and system resilience improves, particularly during periods of heightened pressure such as winter.

Preventing Avoidable Long-Term Care Admissions

Preventing unnecessary admissions to permanent residential and nursing care is a core planned impact of BCF investment. Funding prioritises anticipatory care, proactive frailty management, falls prevention and rapid community response to stabilise people at home and prevent crisis-driven decisions.

Reablement and intermediate care services are designed to maximise independence following illness or hospital admission, enabling more people to return home safely rather than enter long-term care. This supports local ambitions to reduce long-term care admissions and improve long-term outcomes following discharge.

Active Stewardship and Demand-Led Commissioning

BCF resources in Central Bedfordshire are actively stewarded using a robust demand and capacity approach to ensure alignment with population need and maximum impact. In 2024/25, detailed analysis of Discharge to Assess (D2A) demand, throughput and bed utilisation identified a mismatch between commissioned bed-based capacity and actual patterns of demand.

Under-utilised beds were decommissioned, with resources reinvested into community-based reablement and intermediate care where demand was increasing and outcomes were strongest. This rebalancing aims to improve alignment between demand and capacity, reduces unwarranted variation and supports discharge flow without increasing reliance on long-term bedded provision.

To manage seasonal and cohort-specific pressures, the system introduced targeted, time-limited commissioning of dementia-specific beds during winter, informed by demand forecasting and flow analysis. This provided flexible surge capacity for people with complex needs while avoiding structural over-capacity.

End of Life Care and Integrated Community Impact

BCF funding for Palliative and End of Life Care (PEoLC) will contribute to system goals by reducing avoidable admissions, supporting earlier discharge and improving experiences and outcomes. This is achieved through strengthened neighbourhood-based multidisciplinary working and closer integration with UCR and community services.

Future Impact and Neighbourhood Health Alignment

Looking ahead to 2026/27, the impact of BCF funding will be enhanced through alignment with neighbourhood health ambitions. The BCF will act as a key enabler of integrated, preventative and person-centred care at neighbourhood level, supporting multidisciplinary working across health, social care and the voluntary and community sector.

Ongoing, systematic review of BCF-funded schemes at place level will ensure continued alignment with non-elective admission reduction, discharge and care-closer-to-home goals, enabling the system to scale what works and deliver sustained improvement against agreed priorities.

4. **Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.**

   Please provide a concise statement of around one page (e.g. around 500 words) please provide your response below:

In line with national guidance and emerging expectations for 2026/27, BLMK system partners have taken a proactive and structured approach to assuring value for money and improving the productivity of BCF-funded services. Rather than relying on historic allocations, the ICB and local authority partners have jointly implemented a system-wide programme of review and challenge to ensure BCF investment is clearly linked to outcomes, demand management and system flow.

During Q4 2025/26, this approach culminated in a comprehensive review of Place-based, Pan Bedfordshire and Milton Keynes BCF schemes, reflecting both the scale of investment and the opportunity to address historic variation, duplication and partial funding arrangements. The reviews were undertaken collaboratively and aligned to wider financial planning, neighbourhood health development and preparation for transition to the ICB Integrated Care Funding Framework.

The Pan Bedfordshire and Place-based reviews applied a consistent framework to assess services against their original objectives, contribution to BCF national metrics, alignment with system priorities, and evidence of outcomes and demand management. This has enabled a clearer distinction between services that demonstrably support prevention, timely discharge and community resilience and to identify those services that will need further review during 2026/27.

In addition, reviews of the Local Authority Minimum Spend and Local Authority Better Care Grant assessed opportunities to strengthen the sustainability of the adult social care market against the rising operational costs, including inflationary and National Living Wage pressures, and an increasing prevalence of age-related conditions and complex needs. Partners focused on Value in Care and Home First principles. This included reviews of care fee structures as a key mechanism to move toward equity across the geographical footprint, increasing investment in pathways 1 and 2, including the strengthening of the reablement and enablement offer, intensive dementia support and personalised end of life care, ensuring we are able to prioritise the shift care from hospital to home and reduce discharge delays.

As a result of these reviews, mitigation actions and proposed changes have been identified for a number of schemes, including opportunities for consolidation, disinvestment or decommissioning where value for money cannot be sufficiently demonstrated. These actions are reflected in the 2026/27 BCF plans and are a step forward in delivering a sustainable investment plan that is equitable across all places.

Productivity is being improved through a greater focus on pathway-based investment, including shifting resource towards reablement, enablement and Home First models, reducing reliance on bed-based care, improving flow, and supporting timely discharge. Consolidation of services, clearer expectations on outcomes, and alignment of funding with activity and demand are expected to increase system productivity and reduce unwarranted variation across places.

Governance and engagement have been central to the approach, with detailed scheme reviews discussed through joint BCF groups, officer level forums and Pan Bedfordshire review meetings, ensuring shared ownership of decisions and clarity on financial and service impacts by place. This has enabled early identification of residual risks, including differing starting positions across local authorities, and ensured these are being worked through collaboratively with finance and commissioning leads.

In summary, the programme of joint Pan Bedfordshire and Place-based reviews represents a significant step forward in strengthening assurance, financial discipline and consistency across BCF-funded services. It provides a robust and growing evidence base to demonstrate where investment is delivering clear preventative impact, improved flow and better outcomes, and where change is required to improve value for money.

While further work is planned during 2026/27 to address partially funded and legacy arrangements, the actions already embedded within the BCF plans reflect a clear commitment to treating the BCF as an active investment mechanism. Through ongoing review, consolidation and pathway-based commissioning, partners are confident that BCF resources are increasingly focused on interventions that deliver measurable benefit for residents, support system sustainability and raise productivity across health and adult social care.

5. **Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.**

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Central Bedfordshire has clear, robust joint governance arrangements in place to manage BCF expenditure, ensure value for money and support continuous improvement in outcomes.

The Joint Better Care Fund (BCF) Group provides the primary strategic oversight of pooled BCF funding on behalf of Central Bedfordshire Council and the Central East Integrated Care Board (ICB). The Group is responsible for planning, approving and monitoring BCF-funded schemes in line with national BCF policy and planning requirements. It routinely reviews financial performance, delivery progress and impact against agreed national and local BCF metrics, using this information to assess effectiveness, manage risk and inform decisions on continuation, redesign or disinvestment.

Impact and value for money are assessed through regular performance reporting, scrutiny of scheme-level outcomes and comparative review of investment against activity and utilisation. Where under-performance or under-utilisation is identified, schemes are reviewed collaboratively with system partners and corrective actions agreed. These may include refocusing eligibility criteria to better target preventative impact, re-profiling funding in line with demand, adjusting skill mix or operating models to improve throughput, strengthening integration with upstream or downstream pathways, or consolidating services to reduce duplication. Where improvement cannot be demonstrated, funding may be reduced, time-limited or exited to ensure resources are deployed effectively.

At system level, a Pan-Bedfordshire BCF governance arrangement has been established to oversee joint schemes delivered across Bedfordshire and BLMK. This provides transparency of partner contributions, utilisation and equity of funding, and supports proportionate decision-making on future investment. It also enables the safe review of historic funding arrangements, supports continuous improvement and reduces the risk of unintended destabilisation of core services.

Formal assurance and accountability are provided through regular reporting to the Joint Leadership Group and the Health and Wellbeing Board, which approves the BCF plan, ensures alignment with the Joint Health and Wellbeing Strategy and holds partners to account for delivery. Operational and financial assurance is further strengthened through the BLMK Neighbourhood Health Delivery Committee, which oversees place-based finance, performance and service integration, including intermediate care and neighbourhood health priorities supported by BCF funding.

Together, these arrangements provide a clear line of sight from scheme-level delivery through to system-level assurance, ensuring BCF expenditure is well-governed, outcome-focused, represents value for money and drives continuous improvement in integrated health and care delivery.

Better Care Fund 2026-27 Numerical Template

Data Sharing Statement

Data Sharing Statement

Please see below important information regarding data sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided.

Purpose of data collection

NHS England is collecting data on behalf of Better Care Fund (BCF) partners to fulfil statutory duties, including improving healthcare quality, efficiency, and transparency. The data supports operational and strategic planning, financial management, workforce planning, and system feedback, as mandated by the NHS Act 2006 and relevant regulations.

Type and scope of data

Patient-level data, including identifiable information like NHS numbers, is not required.
Data includes finance, activity, workforce, and planning information as specified in the national guidance documents.
The BCF numerical template is categorised as "Management Information," and aggregated data, including narrative sections, will be published on the NHS England website and gov.uk.

Access, sharing, and publication

The BCF numerical template is categorised as 'Management Information' and data submitted will be published in an aggregated form on the NHS England website and gov.uk. This will include a narrative section. Please also note that all BCF information collected here is subject to Freedom of Information requests.
Internal Access: Data will be accessed by NHS England national and regional teams on a "need-to-know" basis and may be shared internally to support statutory responsibilities.
External Sharing: Data and information from this numerical template and associated narrative return may be shared with partner organisations and Arm's Length Bodies (ALBs) including BCF partners (i.e. Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and NHS England) for joint working and policy development.
Publication: Local Health and Wellbeing Boards (HWBs) are encouraged to publish local plans. Until publication, recipients of BCF reporting data (including those accessing the Better Care Exchange) cannot share it publicly or use it for journalism or research without prior consent from the HWB (for single HWB data) or BCF national partners (for aggregated data).

Storage and security

Data will be securely stored on NHS England servers. Shared data will be minimised and handled per confidentiality and security requirements.
The BCF template is password-protected to ensure data integrity and accurate aggregation. Breaches may require resubmission.

Data analysis and use

NHS England will analyse data submissions for feedback, reporting, benchmarking, and system improvement.
Triangulation with other data may be conducted to support deeper analysis and insights and inform decision-making.

Concerns

For any questions about data sharing, please contact your regional Better Care Managers or the national Better Care Fund team england.bettercarefundteam@nhs.net

This page is intentionally left blank

Better Care Fund

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS England

Better Care Fund (BCF) 2026-27 Numerical Template

1. Guidance

Overview

The numerical return is designed to capture planned BCF spend, goals and assurance statements. Together with the narrative return these will enable local areas to demonstrate how they meet the national funding conditions, in line with the published BCF 2026-27: https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027.

Completed numerical returns are due by Tuesday 19 May 2026 (noon)

Submissions should be sent to the national BCF team at england.bettercarefundteam@nhs.net, as well as to regional Better Care Managers.

This guidance provides an overview of how to complete this numerical return. Further guidance is provided in the BCF Planning Principles guidance and and supporting documents which can be found on the Better Care Exchange - https://future.nhs.uk/bettercareexchange/view?objectID=70716560

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one (refer to tab 6) outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. Please enter date of expected sign off if not yet signed off. **This accountability must not be delegated**.

Data completeness and data quality:
- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the BCF team: england.bettercarefundteam@nhs.net (please also copy in your better care manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission. Please contact your regional BCF team if you have any issues.

3. Income

This sheet should be used to specify all funding contributions to the HWBs BCF plan and pooled budget for 2026-27. This section will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant (DFG) and Local Authority Better Care Grant (LABCG). For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your better care manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and local authority. You will be able to update the value of any additional contributions (local authority and NHS) income types locally. If you need to make an update to any of the funding streams, select 'Yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information as this will ensure section is marked as complete.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

4. Expenditure

Please see tab '4a. Expenditure guidance' for further information.

5. Metrics

For 2026-27, local authorities, integrated care boards (ICBs) and HWBs will be expected to monitor performance and improvement for the four metrics listed in the Metrics Handbook https://future.nhs.uk/bettercareexchange/view?objectID=27764141 3, available on the Better Care Exchange:

It is a national requirement for partners to set local goals in relation to the following two metrics:

- Non elective admissions to hospital for people aged 65 and over per 100,000 population
- Average length of discharge delay for all acute adult patients

HWBs are also encouraged to set goals for the metric on long-term admissions to residential and nursing homes for people aged 65 and over per 100, 000 population.

We also expect HWBs to monitor and drive improvements for the metric on the proportion of people aged 65 and over discharged from hospital with reablement provided partly or solely by local authorities who remained in the community within 12 weeks of discharge.

Further details on the metrics, can be found below:

1. Non-elective admissions to hospital for people aged 65 and over per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions. The population figure is pre-populated using the latest available mid-year estimates.
- This will then auto populate the rate per 100,000 population for each month
Source statistics: https://digital.nhs.uk/supplementary-information/2026/non-elective-inpatient-spells-at-english-hospitals-occurring-between-1-april-2020-and-30-november-2025-for-patients-aged-18-and-65

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This is calculated as the sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients discharged in that month.
In completing the table for 2026-27 we ask areas to set out these two components and sheet automatically calculates the average figure:
- In a given month, the total number of patients discharged on the same day as their Discharge Ready Date, divided by the total number of patients discharged in that month.
- The sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients delayed by at least 1 day and discharged in that month.
Source statistics: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

3. Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population
- Admissions data is taken from the Client Level Data (CLD) source published on a quarterly basis and presents admissions as a rolling 12-month total, calculated to the end of each quarter and reported as a rate per 100,000 population.
- Population are based on a calendar year using the latest available mid-year estimates.

Any improvement planned in reablement can be noted in the narrative template but does not need to be included in this numerical template.

For missing pre-populated actuals data from November 2025 to date, please check the BCF dashboard on the DHeXchange which will have more recent data as it becomes available.

6. National conditions

This section requires local authorities, ICBs and HWBs to confirm whether the three BCF national conditions and planning requirements detailed in the published BCF 2026-27 guidance will be met. The assurance statements in this section refer to specific planning requirements, supplementing the information provided in the narrative template and this numerical template.

This sheet requires the local authories, ICBs and HWBs to confirm 'Yes' or 'No' to the assurance statements. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the national conditions are as below:

- ***National condition 1:*** ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding.
to deliver more integrated and preventative care, linked to the wider development of neighbourhood health and social care services.
- ***National condition 2:*** ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must
maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.
- ***National condition 3:*** ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.

This page is intentionally left blank

Better Care Fund 2026-27 Numerical Template

2. Cover

Version 1.0

Please Note:
- The BCF numerical template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

Health and Wellbeing Board:	Central Bedfordshire	
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	No	
If no indicate the reasons for the delay.	Timing of the next HWBB does not aling with the approval of the B	
If no please indicate when the HWB is expected to sign off the plan:	Wed 08/07/2026	<< Please enter using the format, DD/MM/YYYY

Submitted by:	Kaysie Conroy
Role and organisation:	Head of Neighbourhood Delivery Team - BLMK, Central East ICB
E-mail:	kaysie.conroy@nhs.net
Contact number:	7557084146
Documents submitted (please select from drop down) **In addition to this template the HWB are submitting the following:**	Narrative

	Role:	Professional title (e.g, Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and wellbeing board chair	Cllr	Mark	Smith	mark.smith@centralbedfordshire.gov.uk	Central Bedfordshire Council
	Health and wellbeing board chair					
Named accountable person	Local authority chief executive	Mr	Marcel	Coiffait	marcel.coiffait@centralbedfordshire.gov.uk	Central Bedfordshire Council
	ICB chief executive 1	n/a	Jan	Thomas	jan.thomas@nhs.net	Central East ICB
	ICB chief executive 2 (where required)					
	ICB chief executive 3 (where required)					
Finance sign off	LA section 151 officer	Mr	Denis	Galvin	denis.galvin@centralbedfordshire.gov.uk	Central Bedfordshire Council
	ICB finance director 1	n/a	Sarah	Griffiths	sarah.griffiths45@nhs.net	Central East ICB
	ICB finance director 2 (where required)					
	ICB finance director 3 (where required)					
Area assurance contacts	Local authority director of adult social services	Mr	Andy	Sharp	andy.sharp@centralbedfordshire.gov.uk	Central Bedfordshire Council
	DFG lead	Mr	Andy	Sharp	andy.sharp@centralbedfordshire.gov.uk	Central Bedfordshire Council
	ICB place lead 1	n/a	Maria	Wogan	m.wogan@nhs.net	Central East ICB
Please add any additional key contacts who have been responsible for completing the plan	ICB place lead 2 (where required)					
	ICB place lead 3 (where required)					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your better care manager(s).

	Complete:
2. Cover	Yes
3. Income	Yes
4. Expenditure	Yes
5. Metrics	Yes
6. National Conditions	Yes

^^ Link back to top

This page is intentionally left blank

Better Care Fund 2026-27 Numerical Template

3. Income

Selected HWB: Central Bedfordshire

Local authority contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Central Bedfordshire	£2,476,580
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum local authority contribution (exc local authority BCF grant)	**£2,476,580**

Local authority better care grant (LABCG)	Contribution
Central Bedfordshire	£3,432,402
Total Local authority better care grant	**£3,432,402**

Are any additional local authority contributions being made in 2026-27? If yes, please detail below	Yes

Local authority additional contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Central Bedfordshire	£6,351,000	Carry over from previous years and capital schemes
Total additional local authority contribution	**£6,351,000**	

NHS minimum contribution	Contribution
NHS Central East ICB	£26,005,033
Total NHS minimum contribution	**£26,005,033**

Are any additional NHS contributions being made in 2026-27? If yes, please detail below	No

Additional NHS contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total additional NHS contribution	**£0**	
Total NHS contribution	**£26,005,033**	

	2026-27
Total BCF pooled budget	**£38,265,015**

Funding contributions comments For any useful details please use the text box below (for no additional comments, insert 'NA')
N/A

This page is intentionally left blank

Better Care Fund 2026-27 Numerical Template

4. Expenditure

Selected Health and Wellbeing Board: Central Bedfordshire

	2026-27		
Running Balances	Income	Expenditure	Balance
DFG	£2,476,580	£2,476,580	£0
NHS Minimum Contribution	£26,005,033	£26,005,033	£0
Local Authority Better Care Grant	£3,432,402	£3,432,402	£0
Additional LA Contribution	£6,351,000	£6,351,000	£0
Additional NHS Contribution	£0	£0	£0
Total	**£38,265,015**	**£38,265,015**	**£0**

Required spend on adult social care from NHS minimum allocations

	2026-27	
	Minimum required spend	Planned Spend
Adult Social Care services spend from the NHS minimum allocations	£7,950,244	£9,747,191

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27 (£)
1	Urgent community response	2 Hour community response to support admissions avoidance	NHS Minimum Contribution	No	£3,138,505
2	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Step down beds for discharge pathways 2 and 3 - Contracted	NHS Minimum Contribution	No	£1,304,848
3	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Additional Therapy support to discharge beds	NHS Minimum Contribution	No	£43,651
4	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Medical cover for discharge beds	NHS Minimum Contribution	No	£60,842
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Acute clinical team providing support in the community (Hospital at Home)	NHS Minimum Contribution	No	£301,606

6	Other	Phychiatrist working in A&E departments to navigate patients to most appropriate	NHS Minimum Contribution	No	£995,271
7	Long-term home-based community health services	Specialist nursing services providing case mangement, education and advice.	NHS Minimum Contribution	No	£218,449
8	End of life care	Palliative care home team - co-ordinating end of life care	NHS Minimum Contribution	No	£1,282,277
9	Long-term home-based community health services	Primary care home team - multidisciplinary teams supporting primary care	NHS Minimum Contribution	No	£4,192,006
10	Long-term home-based community health services	Primary care home team - case management of complex patients	NHS Minimum Contribution	No	£351,678
11	Assistive technologies and equipment	Specialist wheelchair and postural seating assessment and provision	NHS Minimum Contribution	No	£590,658
12	Discharge support and infrastructure	A dedicated social work team to deal with hospital discharges requiring further Social care	NHS Minimum Contribution	Yes	£131,895
13	Support to carers, including unpaid carers	Carers in Bedfordshire support service	NHS Minimum Contribution	No	£293,649
14	Other	Primary mental health link worker based in each GP practice	NHS Minimum Contribution	No	£151,898
15	Assistive technologies and equipment	CES - Provision of Equipment to support care and enable independence at home	NHS Minimum Contribution	No	£1,388,789
16	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Step down beds for discharge pathways 2 and 3 - Spot Placements	NHS Minimum Contribution	No	£431,637
17	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Specilalist bedded placements for stroke & ABI patients	NHS Minimum Contribution	No	£447,341
18	Other	UEC System IT Support - SHREWD System	NHS Minimum Contribution	No	£45,704
19	Bed-based intermediate care (short-term bed-based	MH Step Down Beds	NHS Minimum Contribution	No	£190,129
20	Discharge support and infrastructure	Clinical Community Bed Managers & Support	NHS Minimum Contribution	No	£74,396
21	Home-based intermediate care (short-term home-based	Delirium Pathway	NHS Minimum Contribution	No	£57,122
22	Discharge support and infrastructure	Patient transport extra capacity	NHS Minimum Contribution	No	£100,807
23	Discharge support and infrastructure	Discharge Hub MH Social Workers	NHS Minimum Contribution	No	£193,516

24	Discharge support and infrastructure	VCSE Capacity - Red Cross	NHS Minimum Contribution	No	£64,761
25	Other	Oversight & management of pathways - IT System Phew	NHS Minimum Contribution	No	£14,113
26	Discharge support and infrastructure	Neuro Rehab TOC	NHS Minimum Contribution	No	£64,127
27	Long-term residential/nursing home care	Pharmacy support to Care homes	NHS Minimum Contribution	No	£69,898
28	Discharge support and infrastructure	Reablement bridging gap	NHS Minimum Contribution	Yes	£211,000
29	Discharge support and infrastructure	Pathway 1 Development	NHS Minimum Contribution	No	£110,166
30	Other	Contingency	NHS Minimum Contribution	No	£79,998
31	Home-based intermediate care (short-term home-based	Reablement (Protecting Social Care) - NHS funded	NHS Minimum Contribution	Yes	£670,161
32	Bed-based intermediate care (short-term bed-based	Access to community beds (Step up/Step Down)	NHS Minimum Contribution	Yes	£1,196,714
33	Assistive technologies and equipment	Community Equipment Service	NHS Minimum Contribution	Yes	£646,638
34	Assistive technologies and equipment	Self care management (Telecare)	NHS Minimum Contribution	Yes	£217,263
35	Discharge support and infrastructure	Delayed transfers of care (hospital social work teams) -	NHS Minimum Contribution	Yes	£1,078,347
36	Long-term home-based social care services	Integrated Care Packages	NHS Minimum Contribution	Yes	£4,070,271
37	Support to carers, including unpaid carers	Core Carers Support	NHS Minimum Contribution	Yes	£182,363
38	Wider local support to promote prevention and independence	Proactive Care and MDT (Stroke Focus)	NHS Minimum Contribution	Yes	£63,936
39	Other	Data sharing, Systems and Programme Support	NHS Minimum Contribution	Yes	£99,366
40	Long-term home-based social care services	Integrated Care Packages (Care Act)	NHS Minimum Contribution	Yes	£658,801
41	Bed-based intermediate care (short-term bed-based	Out of Hospital Community Beds (Ferndale and Marigold	NHS Minimum Contribution	Yes	£234,528
42	Support to carers, including unpaid carers	Mobilise Digital Support for Carers	NHS Minimum Contribution	Yes	£58,126
43	Wider local support to promote prevention and independence	Increased OT capacity	NHS Minimum Contribution	Yes	£101,727
44	Other	Increased Safeguarding Capacity	NHS Minimum Contribution	Yes	£63,897
45	Home-based intermediate care (short-term home-based	Domiciliary Care; additional Home Recovery	NHS Minimum Contribution	Yes	£62,158
46	Disabled Facilities Grant related schemes	Core DFG activity	DFG	Yes	£2,476,580
47	Long-term residential/nursing home care	Acquisition of long term care home in Sandy	Additional LA Contribution	Yes	£2,000,000
48	Assistive technologies and equipment	TEC and Equipment capitalisation and support	Additional LA Contribution	Yes	£751,000

49	Disabled Facilities Grant related schemes	Adaptation of Buildings to support intermediate care	Additional LA Contribution	Yes	£3,600,000
51	Discharge support and infrastructure	Trusted Assessors	Local Authority Better Care Grant	Yes	£144,408
52	Other	Care Home Association Investment	Local Authority Better Care Grant	Yes	£81,923
53	Other	Project Support	Local Authority Better Care Grant	Yes	£221,240
54	Discharge support and infrastructure	Additional hospital discharge social workers	Local Authority Better Care Grant	Yes	£321,629
55	Bed-based intermediate care (short-term bed-based	Integrated Care Packages	Local Authority Better Care Grant	Yes	£2,663,202

4a. Expenditure Guidance

Guidance for completing expenditure sheet

1. Please enter spend information in the bottom table starting cell B30 including the category of spend which is a dropdown containing the categories listed in the table below. You must also enter scheme-level detail for the line of spend in 'Description of Scheme' with the appropriate level of information keeping this relatively succint, for example 'Community Health Rehabilitation' or 'MSK services' or 'Integrated Crisis and Rapid Response' would be sufficient. Please also enter source of funding which determines the total spend appearing in the source of funding table at the top. Ensure a 'Number' is entered in the 'Expenditure for 2026-27 (£)' so that the validation boxes can be marked as complete.

2. Please ensure 'Adult Social Care Spend' is marked 'Yes' when the money is spent on Adult Social Care across any funding source.

Scheme Types

Number	Category of scheme	Description
1	Assistive technologies and equipment	Using technology in care processes to support self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing.
5	Short-term home-based intermediate care (rehabilitation, reablement and recovery services)	Short-term (up to 6 weeks), therapy-led services in the person's usual residence (home or care home), following the 'Home First' principle. For adults 18+ to regain independence post-illness/injury/discharge (step-down) or prevent admissions/long-term care (step-up). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus support from unregistered workers and other professionals (nurses, doctors, social workers). Outcomes: better function, confidence, wellbeing; less carer reliance and long-term care demand. Domiciliary social care (personal care, domestic help) included only within a rehab/reablement-focused package.
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Short-term domiciliary social care (e.g. personal care, help with domestic tasks, voluntary sector support), except where it is provided as part of a package that also includes rehabilitation, reablement and/or recovery services.
7	Long-term home-based social care services	Ongoing social care services (e.g. personal care, help with domestic tasks), helping people continue to live at home and maintain independence.
8	Long-term home-based community health services	Ongoing health services provided in people's own homes or in other non-residential community-based settings.
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Short-term (up to 6 weeks), therapy-led services in a community bed-based setting (e.g. community hospital, care home bed or designated facility). For adults 18+ to regain independence post-hospital stay (step-down) or prevent avoidable admission/long-term residential care (step-up from community). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus multi-disciplinary support (unregistered workers, nurses, doctors, others as needed). Where safe and appropriate, transition to home-based intermediate care is required to continue recovery at usual residence. Outcomes: improved function, confidence, wellbeing; reduced acute admissions, readmissions and long-term social care demand. May include mixed health and social care interventions.
10	Long-term residential or nursing home care	Ongoing care provided in a residential care home or nursing home for people who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Schemes specifically designed to provide care and support for people nearing the end of life.
13	Support to carers, including unpaid carers	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Schemes that monitor or evaluate the impact of integrated care schemes. Schemes or services that enable integrated care, such as (but not necessarily limited to): - Joint commissioning arrangements - Integrated care planning - Helping people navigate services - Workforce development or recruitment and retention
15	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

This page is intentionally left blank

Better Care Fund 2026-27 Numerical Template

5. Metrics for 2026-27

Selected Health and Wellbeing Board: Central Bedfordshire

5.1 Non-Elective admissions

		Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Non elective admissions to hospital for people aged 65 and over per 100,000 population	Rate	1,514	1,610	1,558	1,549	1,505	1,497	1,601					
	Number of admissions 65+	870	925	895	890	865	860	920					
	Population of 65+*	57,456	57,456	57,456	57,456	57,456	57,456	57,456					
		Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
	Rate	1,508	1,594	1,542	1,534	1,490	1,482	1,585	1,447	1,706	1,544	1,544	1,544
	Number of admissions 65+	866.25	915.75	886.05	881.1	856.35	851.4	910.8	831.6	980.1	887.04	887.04	887.04
	Population of 65+	57,456	57,456	57,456	57,456	57,456	57,456	57,456	57,456	57,456	57,456	57,456	57,456

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

5.2 Discharge delays

*Dec Actual onwards are not available at time of publication

	Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.78	0.75	0.70	0.81	0.92	0.99	0.88	0.91				
Proportion of adult patients discharged from acute hospitals on their discharge ready date	87.9%	86.4%	86.5%	84.1%	83.0%	83.7%	84.7%	84.3%				
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.5	5.5	5.2	5.1	5.4	6.1	5.7	5.8				
	Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
Average length of discharge delay for all acute adult patients	0.60	0.69	0.75	0.69	0.65	0.74	0.64	0.82	0.60	0.61	0.52	0.75
Proportion of adult patients discharged from acute hospitals on their discharge ready date	90.4%	88.6%	89.8%	88.8%	89.7%	89.2%	90.0%	87.0%	90.7%	89.6%	90.2%	88.6%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.24	6.03	7.38	6.12	6.34	6.87	6.36	6.31	6.42	5.83	5.32	6.59

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

5.3 Admissions to residential and nursing care homes

		Rolling 12 month total until end of quarter date indicated							
		Actual Ending 31 12-2024	Actual Ending 31 03-2025	Actual Ending 30 06-2025	Actual Ending 30-09-2025	2026-27 Plan Ending 30-06-2026	2026-27 Plan Ending 30-09-2026	2026-27 Plan Ending 31-12-2026	2026-27 Plan Ending 31-03-2027
Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population	Rate	647.5	572.6	523.9	539.5	576.1	563.9	562.2	565.7
	Number of admissions	372	329	301	310	331	324	323	325
	Population of 65+*	57,456	57,456	57,456	57,456	57,456	57,456	57,456	57,456

*Population of people aged 65 and above are based on the latest available mid-year estimates from the ONS

This page is intentionally left blank

Better Care Fund 2026-27 Numerical Template

6: National Condition Planning Requirements

Health and wellbeing board: Central Bedfordshire

HM Government

NHS England

National Condition	Planning requirement	Assurance statement	Yes/No to assurance statement	Where the planning requirement or assurance statement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
National Condition 1: effectively support the delivery of integrated and preventative care ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.	ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.	Named ICB and local authority chief executives and named HWB chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care.	Yes			Yes
	ICBs and local authorities must set out plans that: - show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges - show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement - include the specific contribution of BCF-funded services.					
	ICBs and local authorities must demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity					
National Condition 2: comply with expenditure and grant conditions ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.	ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities are able to voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded.					
	The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area. Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding.	ICBs and local authorities confirm compliance with BCF national grant and funding conditions, and that they will deliver in accordance with approved spend and BCF numerical return, including maintaining the NHS minimum contribution to adult social care.	Yes			Yes
		ICBs and local authorities confirm they will pool funds through Section 75 agreements by 30th September 2026.	Yes			Yes
National Condition 3: - effective governance, reporting and engagement ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.	ICBs and local authorities must have effective joint governance is in place to ensure local accountability for delivery of outcomes, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track.					
	ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes	ICBs and local authorities confirm full compliance with BCF planning and reporting requirements and will adhere to the BCF oversight and support processes.	Yes			Yes

This page is intentionally left blank

NHS
Central East
Integrated Care Board

Central Bedfordshire

Item 10: Neighbourhood Health Report

Central Bedfordshire Health and Wellbeing Board

08 July 2026

Central Bedfordshire Health and Wellbeing Board

Neighbourhood Health

Responsible Officer:

Maria Wogan - Director of Neighbourhood Health, Places and Partnerships, BLMK (m.wogan@nhs.net)

Advising Officer:

Georgie Brown - Deputy Director Neighbourhood Health, Places and Partnerships, BLMK (georgie.brown8@nhs.net)

Purpose of this report

This report provides an update on the emerging Central East Neighbourhood Health and Neighbourhood Health Team (NHT) delivery approach, including progress across 2026/27 to establish the foundations for neighbourhood-based care. It summarises key system developments, including national planning submissions and local progress in Central Bedfordshire, and sets out the next phase of delivery as the system aims to transition towards a more consistent and scalable neighbourhood model from 2027 onwards.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

- **Note progress** in developing the Central East Neighbourhood Health and Neighbourhood Health Team (NHT) delivery approach and the focus on 2026/27 as a foundation year for delivery
- **Support neighbourhood health as the core delivery model** for improving outcomes, particularly for older people and those with frailty in Central Bedfordshire
- **Endorse continued system-wide alignment** of services, investment and commissioning to neighbourhood footprints, including through BCF, Primary Care and community services
- **Support partner engagement and participation** in the next phase of development, including system workshops and the planned national visit on 15th July
- **Continue to strengthen local leadership and governance**, including system stewardship and oversight of neighbourhood delivery

Main body of the report

This report builds on previous updates to the Board on the Central East Our Way – Strategy to Delivery, which sets out the quality improvement approach and commissioning lifecycle for testing, codifying and scaling best practice in neighbourhood health, and the BLMK Core Narrative outlining the local vision. This paper summarises the emerging Central East neighbourhood health and Neighbourhood Health Teams (NHT) delivery plan, recent system engagement and submissions, local progress in Central Bedfordshire, and the next phase of development, including system-wide workshops and a national visit with Claire Fuller on 15th July.

Emerging Neighbourhood Health Teams (NHTs) Plan

Significant progress has been made in developing the Central East approach to Neighbourhood Health Teams (NHTs), with a clear focus on establishing the foundations required to enable delivery at scale from 2027 onwards. Building on the national Neighbourhood Health Framework, the "Our Way" strategy, and BLMK Core Narrative, the emerging plan sets out a series of priority tasks for 2026/27 to create the conditions, and to define, test and prepare the NHT model, with an initial focus on frailty as the priority cohort.

At a system level, the approach recognises that while there are many existing examples of neighbourhood working across Central East, there is currently no single, consistent model. The plan therefore focuses on creating the conditions for NHTs to succeed, while systematically identifying, strengthening and learning from existing services, pilots and good practice to inform a more consistent, evidence-based model over time.

The Central East NHT plan for 2026/27 is structured around a set of priority deliverables, designed to establish the core conditions and components required for effective neighbourhood delivery. These include:

Baseline and system understanding - a comprehensive baseline and asset mapping of existing Neighbourhood Health Teams and frailty services across the system, providing a clear view of current provision, variation and opportunities for improvement. ***– to be completed during Q1/Q2 2026/27***

Development of a consistent clinical and delivery model - the development of a single NHT frailty model and emerging service specification, drawing on system-wide best practice to define the core functions, workforce model and delivery expectations for neighbourhood teams. ***– to be completed during Q1/Q2 2026/27***

Early adopter mobilisation and testing - the identification and mobilisation of early adopter NHT sites across Central East during 2026/27, using non-procurement routes to test and refine delivery approaches in real settings and build the evidence base for future scale. ***– testing being undertaken throughout 2026/27***

Data, population health and performance infrastructure - the rollout of key enablers, including risk stratification tools (DELPPHI), neighbourhood profiles, and performance dashboards, to support proactive population health management and consistent measurement of outcomes at neighbourhood level. ***– to be completed during Q2/Q3 2026/27***

System enablers and integration - progression of system-wide data sharing arrangements, interoperability solutions and workforce development plans to support

effective multidisciplinary working across organisations. ***– to be completed during Q3 2026/27***

Alignment of services, contracts and investment - delivery of community services and contract baselining reviews, alongside alignment of Better Care Fund (BCF) and other system investments to neighbourhood priorities, to ensure resources support the emerging model. ***– to be completed during Q3/Q4 2026/27***

Preparation for future commissioning - development of the commissioning approach, including preparatory work for the use of the Provider Selection Regime (PSR) and the potential use of Single and Multi-Neighbourhood Provider contract archetypes from April 2027 (SNPs & MNPs). ***– to be completed during Q3/Q4 2026/27***

Collectively, these deliverables represent a coordinated system-wide plan to "create the conditions" for neighbourhood health during 2026/27. This reflects the national expectation that the current year is focused on establishing the model, infrastructure and partnerships required to enable delivery, rather than full implementation at scale.

Through this structured approach, NHTs will be developed as the core operational model for delivering proactive, coordinated, neighbourhood-based care. This will enable a shift towards earlier intervention, improved care coordination and reduced avoidable hospital utilisation, particularly for people living with frailty and complex needs.

The emerging plan therefore positions 2026/27 as a critical development year, bringing together system leadership, delivery capability and local innovation to support the transition to a more consistent and scalable neighbourhood model from 2027 onwards.

The plan remains in draft form, and continued engagement with Central Bedfordshire partners will be critical to ensure that the emerging Central East NHT model, and wider Quality Improvement approach, aligns with local priorities, plans and progress. This engagement will be progressed through established Central Bedfordshire forums.

System leadership alignment and engagement

Since 8th April 26, there has been a focus on strengthening system leadership and alignment through engagement, to support the transition to neighbourhood health as the core delivery model for the Central East ICB.

This has been progressed through key ICB & system forums including the BLMK Neighbourhood Delivery Committee (NDC), ensuring a consistent and coordinated approach across partners.

BLMK Neighbourhood Delivery Committee (NDC)

At its meeting on 1st May 2026, the Committee reviewed progress in establishing the conditions for neighbourhood health delivery across BLMK and considered priorities for 2026/27.

The Committee reaffirmed:

- Neighbourhood health as the core delivery architecture for Our Way, with Neighbourhood Health Teams (NHTs) as the operational model
- Frailty as the initial priority cohort, with a clear focus on proactive care coordination and reducing avoidable hospital utilisation
- The requirement to take a disciplined quality improvement approach — testing, codifying and scaling neighbourhood models across the system

The Committee also endorsed a set of priority areas for 2026/27, including:

- Development of a consistent NHT model and service specification
- Establishment of a proactive neighbourhood frailty model
- Implementation of system-wide risk stratification and population health approaches
- Alignment of community services, primary care and commissioning arrangements to neighbourhood footprints
- Strengthening data sharing, workforce capability and resident engagement

These priorities provide the delivery foundation for 2026/27 and are being progressed through system and place-based plans.

Key Planning Submissions

As set out in the Executive Summary and reflected through system governance, significant focus across Central East ICB and partners has been on the development and submission of key NHS England planning requirements during April and May 2026.

These submissions are aligned and mutually reinforcing the delivery of neighbourhood health.

The Better Care Fund (BCF) – submitted to NHSE/DHSC on 19th May

The Better Care Fund (BCF) is a national pooled budget bringing together NHS and local authority funding to support integrated, preventative, community-based care, enabling people to remain independent and reducing avoidable hospital utilisation. For 2026/27, BCF plans have been developed across Central East, with Central Bedfordshire's approach aligned to its Joint Health and Wellbeing Strategy and focused on strengthening integrated neighbourhood health and social care services. This planning round represents a transitional year of reform, with an increasing focus on aligning BCF investment to neighbourhood health priorities—particularly intermediate care, reablement, hospital discharge and admission avoidance—alongside strengthening joint governance, value for money and outcomes.

In Central Bedfordshire, this is reflected through targeted investment in integrated intermediate care, Home First and discharge pathways, falls prevention, urgent community response and reablement services, supported by strong partnership working across

health, social care and VCSE organisations. Collectively, this approach focuses on proactive, neighbourhood-based support for older people and those with complex needs, reducing reliance on acute care and supporting independence. 2026/27 is therefore being used as a transition year to align BCF investment more closely to neighbourhood health and lay the foundations for delivery at scale from 2027 onwards.

Primary Care Action Plan (PCAP) – submitted to NHSE on 29th May

Primary Care Action Plans (PCAPs) have been developed through the NHS Medium Term Planning Framework to set out how ICBs will deliver primary care transformation over the next 3–5 years, with a detailed focus on 2026/27 as the first year of delivery. The plans build on the Integrated Strategic Commissioning Strategy and align national priorities and the wider Our Way approach, focusing on improving access (including same day urgent access), strengthening workforce capacity, reducing unwarranted variation, accelerating digital transformation, and aligning primary care to neighbourhood health delivery. Underpinned by a strong emphasis on outcomes, accountability and partnership working, PCAPs provide a key delivery mechanism for neighbourhood health, reinforcing primary care's role in integrated, proactive and population-based models of care. As the submission is recent, feedback is awaited and will be shared with Central Bedfordshire colleagues once received.

Same Day Access – submitted to NHSE on 30th April

Central East ICB has submitted a compliant Same Day Access plan, aligned to the national requirement to achieve 90% of clinically urgent primary care demand being managed on the same day by April 2027.

This programme supports neighbourhood health delivery by improving access, streamlining patient pathways, and reducing avoidable demand for urgent and emergency care services through better coordination across primary care, community services and system partners.

Neighbourhood Health Centres (NHCs) – submitted to NHSE on 28th May

Central East ICB submitted its Neighbourhood Health Centre (NHC) planning return in line with national guidance, setting out a pipeline of schemes across BLMK, Cambridgeshire & Peterborough and Hertfordshire. The programme supports delivery of neighbourhood health through the development and optimisation of integrated, community-based estate, bringing together primary care at scale with community, mental health, local authority and voluntary sector services to improve access and enable care closer to home.

Within Central Bedfordshire, the emerging pipeline includes a mix of existing sites being optimised and expanded—such as Grove View Integrated Health and Care Hub, which already delivers co-located services for a population of around 50,000—as well as proposals to repurpose existing estate (e.g. Steppingley Hospital) and develop new provision aligned to areas of population growth and unmet need, including Houghton

Regis, Leighton Buzzard and East of Biggleswade. The Shefford Health Centre scheme is progressing as a Wave 1 NHC, supporting co-location of general practice and community services.

Across Central Bedfordshire, the pipeline reflects a combination of:

- Existing hubs being optimised to improve utilisation and integration (e.g. Grove View Hub)
- Repurposing of existing estate to support neighbourhood models (e.g. Steppingley Hospital)
- New-build proposals aligned to population growth, housing development and areas of high need (e.g. Houghton Regis, Biggleswade, Leighton Buzzard)

All proposals are being developed in line with national criteria, including alignment to neighbourhood health, deliverability, financial sustainability and partnership maturity, and are designed to support a shift of care from acute to community settings and improved population outcomes.

This list represents a wide set of ambitions, many of which are at concept stage. Inclusion of a scheme on the list at this stage does not mean that the ICB is agreeing to fund the revenue consequence or that we are agreeing to its affordability or viability – this will need to be determined before any final decision is made.

As the submission is recent, feedback is awaited and will be shared with Central Bedfordshire colleagues once received.

Claire Fuller visit to Central East – 15th July 26 & Central East Frailty workshop – 16th July

A visit from Claire Fuller (NHS England) is planned for 15 July 2026, providing a key opportunity to showcase Central East's progress in delivering neighbourhood health. The visit will focus on demonstrating the system's unified approach to neighbourhood health, with coordinated partner engagement underway.

Plans are in place for a Central East-wide frailty workshop in July, bringing together clinical and operational leaders from across the system to share best practice already delivering impact in neighbourhood settings. The session will focus on building a shared understanding of best practice, strengthening the collective model for frailty, and supporting the scaling and spread of the most effective approaches. It will also provide an opportunity for the ICB to set out its commissioning approach for neighbourhood health teams and the next phase of development. Central Bedfordshire colleagues will receive invitations once final arrangements are confirmed.

Neighbourhood Health and Neighbourhood Health Team Development – Central Bedfordshire

Central Bedfordshire has the largest older population within BLMK, with 60,899 residents aged 65 and over, including 16,570 aged 80+, and this cohort continues to grow year on year. While disease prevalence is broadly comparable to neighbouring areas, the scale of the older population generates sustained demand on health, social care, and community services, particularly during winter.

Around 8.3% of residents aged 65+ are living with high complexity multi morbidity and 4.9% with frailty. Almost 28% live alone, increasing the risks of crisis presentation, emergency admission, and delayed discharge. These demographics underline the importance of strong neighbourhood based, preventative and proactive models of care. Addressing social isolation and loneliness is a key priority within the Joint Health and Wellbeing Strategy, with VCSE organisations playing a vital role in neighbourhood delivery.

Following discussion at the Health and Wellbeing Board, there is a clear commitment to strengthen leadership and system stewardship for neighbourhood working through a dedicated HWB development session in Q1 2026/27.

As part of the 2026/27 foundational year, Central Bedfordshire will review neighbourhood geographies to ensure they are of a sustainable and effective scale for delivery, recognising that the current Ivel Valley neighbourhood significantly exceeds national population guidance. This review will take account of planned housing development and population growth to ensure neighbourhoods remain fit for the future and capable of supporting integrated, multidisciplinary working.

In parallel, partners across health and social care are committed to reviewing Intermediate Care provision to improve alignment of services and pathways. This will support the development of a more coherent and sustainable neighbourhood model, strengthen care closer to home and deliver improved outcomes and experience for local people.

Options for consideration

This paper does not contain any options for consideration.

Reason/s for decision

This paper is not seeking a formal decision.

Legal Implications

Neighbourhood Health delivery will operate within existing statutory and contractual frameworks, with any required changes to commissioning or data sharing arrangements managed in line with legal and regulatory requirements.

Financial and Risk Implications

Neighbourhood Health delivery will be achieved through the realignment of existing resources and investment, with risks mitigated through phased implementation, strong governance and a focus on demonstrating impact before scaling.

Governance and Delivery Implications

Neighbourhood Health delivery will be embedded within existing governance structures, with clear accountability across partners and coordinated programme management to support implementation at neighbourhood and place level.

Equalities and Fairness Implications

Neighbourhood health supports improved equality and fairness by targeting interventions toward higher-risk and underserved populations, promoting access to care closer to home, and embedding a focus on reducing health inequalities

Biodiversity and Sustainability Implications

The neighbourhood health model supports sustainability through increased delivery of care closer to home, reducing travel, hospital utilisation and associated environmental impact, while promoting prevention and community-based care

Implications for Work Programme

Neighbourhood Health delivery will be incorporated into the existing work programme, with activity aligned to current priorities including frailty, population health management and integrated neighbourhood team development.

Conclusion and next steps

Significant progress has been made in establishing the foundations for neighbourhood health across Central East, with 2026/27 acting as a critical development year to define, test and align the Neighbourhood Health Team (NHT) model.

The next phase will focus on strengthening local engagement, finalising the NHT model, and progressing early adopter sites, alongside continued alignment of services, investment and commissioning to neighbourhood priorities. Partners will also work together to build the enabling infrastructure for delivery at scale from 2027 onwards.

A neighbourhood development session will take place after the Health and Wellbeing Board meeting, involving board members. This session will support the ongoing development of the neighbourhood plan for Central Bedfordshire.

Central Bedfordshire partners will play a key role in shaping this next phase through ongoing system collaboration, including participation in workshops, governance development and the planned national visit.

Appendices

None

Background Papers

None

Report author(s):

Matt Hollex – Associate Director of Neighbourhood Health Planning & Coordination
(matthew.hollex@nhs.net)

Item 11:
Health and Wellbeing Board Membership

Central Bedfordshire Health and Wellbeing Board

01 May 2026

Health and wellbeing board membership

Responsible Officer:

Vicky Head, Director of Public Health, Vicky.head@centralbedfordshire.gov.uk

Advising Officer:

Ciceley Scarborough, Deputy Director of Public Health,
ciceley.scarborough@centralbedfordshire.gov.uk

The following sections of this report are exempt:-

N/A

Purpose of this report

The Health and Wellbeing Board is asked to:

Consider and approve the proposed change to the membership of the Board.

To request that the Monitoring Officer make a consequential amendment to the Terms of Reference (Part 3B para 9) under delegated authority.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Agree to additional membership of the board from Community and Voluntary Sector in Central Bedfordshire

Main body of the report

2. The Health and Wellbeing Board was established as a committee of the Council in April 2013 and membership of the Board was last reviewed and updated in March 2023.
3. The Health and Social Care Act 2012 prescribes the core statutory membership of the Board as follows (last updated March 2023)
   - The Leader of the Council and/or at least one Member of the Council nominated by

the Leader;
- The Council's Director of Adult Social Services;
- The Council's Director of Children's Services;
- The Council's Director of Public Health;
- A representative of the Local Healthwatch organisation for the area; and
- A representative of the Integrated Care Board

Other Members

The Council and the Health and Wellbeing Board may each appoint such additional persons to be members of the Board as they think appropriate.

On the advice of the Health and Wellbeing Board the Council has made the following arrangements:
- Executive Member for Health;
- Executive Member for Adults, Social Care and Housing Operations;
- Executive Member for Families, Education and Children;
- Council's Chief Executive;
- Clinical Leader from the Clinical Commissioning Group;
- The Community Services Director, Central Bedfordshire Council;
- A representative from the Primary Care sector;
- Representatives from Acute Care sector;
- A representative from Mental Health sector;
- A representative from Community Health sector.

4. As outlined above the proposal is to add an additional member to the Health and Wellbeing Board from the Community and Voluntary sector.

Reason/s for decision

5. New requirements of the Health and Wellbeing Board in the light of the new Neighborhood Plan requirements as part of working with health colleagues and more broadly.

Legal Implications

6. Pursuant to Part 3B of the Council's Constitution: 9.2.2 The Council and the Health and Wellbeing Board may each appoint such additional persons to be members of the Board as they think appropriate. As such, this Board is authorised to make the appointments identified in this report.

Financial and Risk Implications

7. There are no financial or risk implications arising directly from this report.

Governance and Delivery Implications

8. N/A

Equalities and Fairness Implications

9. N/A

Biodiversity and Sustainability Implications

10. N/A

Implications for Work Programme

11. N/A

Conclusion and next steps

12. The Health and Wellbeing Board has a broad remit to improve the health and wellbeing of residents. The Voluntary and Community Sector have an important role in this agenda locally, providing support and care to individuals and supporting wider community capacity which is an important building block of health. The government's 'neighbourhood health' approach emphasizes the importance of working together across sectors in local communities. Expanding the membership of the Board will better reflect its ambition to improve the health and wellbeing of residents, as set out in the Joint Health and Wellbeing Strategy and in light of the new neighbourhood health agenda.

Appendices

N/A.

Background Papers

N/A

Report author(s):

Ciceley Scarborough, Deputy Director of Public Health,
ciceley.scarborough@centralbedfordshire.gov.uk

Record of outcomes Central Bedfordshire Joint Leadership Group Meeting

Date: Tuesday 3rd February 2026

Time: 12.30pm – 13:45pm

Place: Microsoft Teams

Attendees: -	
Abdullah Khan	Chiltern Vale PCN
Amana Gordon	Director of Children and Families, CBC
Andy Sharp	Director of Adult Social Care and Housing, CBC
Ciceley Scarborough	Deputy Director of Public Health, CBC
Maria Wogan	Director for Neighbourhood Health and Partnerships, BLMK
Lorna Carver	Director of Place and Communities, CBC
Robin Campbell	Service Director – Bedfordshire Community Health Services, EFLT
Steve Gutteridge	Head of Integrated Primary Care – *substituting for Amanda Flower*
Vicky Head	Director of Public Health, CBC
Sarah Pearson	Senior Transformation Manager, Beds Place Team
Noleen McLoughlin	Integrated Neighbourhood Support Manager, Beds Place Team
Sarah Lawrence	Public Health Principal, BLMK
Melaine Haynes	Head of 0-19 & Children in Care, CCS
Nina Wright	Deputy Director for Mental Health, BMLK - *substituting for Michelle Bradley*
Sanhita Chakrabarti	Deputy Chief Medical Officer, BLMK
Apologies:	Received: Kaysie Conroy, Stuart Mitchelmore and John Henderson Non-Attendees: Anita Pisani, Alistair Snape, Alison Redman, Christopher Longstaff, Debbie Martin, Edwin Ndlovu, Imran Ismail, John Fitzmaurice, John Wingfield, Michelle Bradley, Nick Murley, Nikki Kynoch, Nina Pearson, Richard Fradgley, Roy Boodhun, Sandra Muffett, Sarah Watts, Shalene Daly, Steven Price, Stuart Short, Tammy Angel, Tracey Wells.

No	**Agenda Item**	*Lead(s)*
1.	**Welcome, introductions and apologies**	**Vicky Head**
	Vicky welcomed everyone to the meeting and held a round of introductions. Apologies had been noted.	
2.	**Notes of the meeting held on 25th November 2025**	**Vicky Head**

	AGREED The previous minutes were approved. Members were reminded that the minutes are publicised as part of the HWB Meeting Pack and are available to view online.	
3.	**Neighbourhood Health Profiles**	**Vicky Head**
	DEFERRED The item is to be deferred to Mays meeting, for Public Health Team to present.	
4.	**Neighbourhood Health Partnership Framework for BLMK and Better Care Fund**	**Maria Wogan**
	NOTED Maria advised that BLMK is awaiting final guidance from NHS England on the required approach to developing a Neighbourhood Health Plan. In the meantime, both strategic and operational plans have been produced, each with dedicated chapters setting out delivery expectations. These plans will be taken through the Health and Wellbeing Board for approval. The strategic plan will be signed off at their next meeting on the 22nd April. The draft strategy is being developed around key principles for implementing neighbourhood health. This includes defining the relevant population cohort and identifying the integrated neighbourhood teams that will support that population. It also involves establishing leadership arrangements and considering the delivery of services such as frailty care, end-of-life support, housebound care, and other core primary care functions. Another area to consider when future planning the strategy, is the Integrated Care Funding Framework, formerly known as the Better Care Fund. This framework is currently undergoing reform, with its future objectives expected to place a stronger emphasis on neighbourhood and community-based healthcare. The outcome of the review and how funding will be allocated under the revised framework is yet to be revealed. Given that there is limited capital funding available, Central Bedfordshire is keen to maximise existing resources and make full use of the assets already in place. The Group discussed the importance of co-production in shaping the overall approach, noting that maintaining consistency across	

	the Central East regions would be beneficial. Engaging the Health and Wellbeing Board in the development of the strategic plan was seen as a key part of this. Members agreed that a workshop-style session would be a helpful way to support this engagement. It was also agreed that, in the interim, a dedicated Integrated Neighbourhood Working Group should be established for Central Bedfordshire. This group would focus collectively on estates planning and bring together colleagues who currently work in siloes.	
ACTIONS		
1.	Arrange a workshop for HWB Members to engage with the Neighbourhood Health Strategic Plans, prior to April sign off.	Maria Wogan
2.	Create a dedicated Integrated Neighbourhood Working Group for Central Bedfordshire	Nikki Barnes/ Kaysie Conroy
5.	**Evaluation from the Gait Smart Project**	**Sanhita Chakrabarti**
	NOTED A presentation was shared which will be circulated with the meeting minutes. The group was advised that the Gait Smart Project was piloted, as an innovation to help with falls prevention and has been recommended to continue within the community primary care function. The Project is the use of a system which uses straps placed around the waist, knee, and ankle. The person walks 10 metres there and back and the device then produces a report showing their walking pattern compared with an ideal walking pattern. The report highlights areas for improvement using a traffic light rating. The tool then generates six personalised exercises to help improve those areas. These exercises are explained to the individual by a trained staff member, such as a healthcare assistant, health coach, or physical activity assistant. The data shows the pilot schemes have been successful, and work continues for another year, under current Council led Activity Strategy funding. The Group will monitor the progress to assess if further take up is warranted.	
6.	**Health Inclusion Practitioners**	**Melanie Hayes**

	The Group were advised of the work underway by a specialist health visitor and a specialist community nursing nurse specifically with the Gypsy Roma traveller population in Central Bedfordshire. The scheme has been a success with knowledge and access to healthcare in these communities vastly improving, especially for children. The team advised that as the traveller community does form as a neighbourhood, they are trying to secure further funding as part of the new Neighbourhood Health Plans. The Group agreed that this should be considered and the Public Health Team would be investigating further.	
7.	**Emerging Issues for Scrutiny and/or Health and Wellbeing Board**	**Vicky Head**
	SCHH OSC Work Programme had been shared and noted to make members aware. No comments received on items to be discussed at either Board or Committee.	
8.	**Any Other Business**	**Vicky Head**
	Public Health provided an update regarding a recent sad death of a young person from meningococcal disease in Central Bedfordshire. The Team are currently liaising closely with the UK Health Security Agency (UKHSA) regarding the case, including screening and follow-up processes. There has been some community discussion about offering additional vaccinations in the affected area. We are seeking further advice to ensure a consistent and appropriate response. If any members become aware of local concerns, reports, or questions, please notify the Public Health team so communications can be managed accurately and sensitively.	
8.	**Forward Plan/Work Programme**	**Vicky Head**
	The next CB Joint Leadership meeting currently scheduled for May.	
8.	**Date of Next Meeting into 2026** The next meeting is between 12:30pm and 2:00pm on May 5th 2026	

Health and Wellbeing Board: Work Programme

Standing agenda items		
Issue for Decision	**Description**	**Lead Director and Contact Officer(s)**
ICB and ICP update	To receive an update on the progress of the Integrated Care Board and/or Partnership (ICB/ICP).	Lead: Maria Wogan, Director of Neighbourhood Health & Partnerships, BLMK
Central Bedfordshire Joint Leadership Group Update	To receive a verbal update and the meeting notes of the Central Bedfordshire Joint Leadership Group, formally known as Place Board.	Lead Director: Vicky Head Director of Public Health Contact Officer: Ciceley Scarborough, Deputy Director of Public Health

Municipal Year 2026/2027		
Date: 30 September 2026 **Theme: Integrated Health Service (Securing improved and integrated health and care outcomes through delivery of our Place Plan)**		
Neighbourhood Health Plan	Quarterly update on the NHP	Lead: Maria Wogan - Director of Neighbourhood Health, BLMK
'Choose You' Update Report	Update on the programme	Lead: Ciceley Scarbrough, Deputy Director of Public Health
Impact of New Leisure Facilities on Public Health and Wellbeing	To receive an update on the progress of the Leisure facilities.	Lead: Lisa White, Head of Leisure.
Date: 27 January 2027 **Theme: Social Isolation and Loneliness *(Tackling social isolation and loneliness across all sectors of society)***		

Social Isolation and Loneliness Update	Update on the programme	Lead: Dr George Roberts, Specialty Registrar in Public Health
Neighbourhood Health Plan	Quarterly update on the NHP	Lead: Maria Wogan - Director of Neighbourhood Health, BLMK
TBC – 21st April 2027 **Theme: Education Attainment *(Giving children in Central Bedfordshire the best start in life with a focus on educational attainment)***		
Best Start in Life	Update on the programme	Lead: Fiona Side, Head of 0-19 Support & Intervention
Neighbourhood Health Plan	Quarterly update on the NHP	Lead: Maria Wogan - Director of Neighbourhood Health, BLMK
Unscheduled Reports:		
Young Healthwatch Report on Autism, Dentistry and Mental Health	Report on the three key factors. Written in collaboration with Young People.	Contact: Youth Engagement and Volunteer Team at Healthwatch