Agenda

Health & Wellbeing Board

Date: **Wednesday, 30 September 2026**
Time: **2.00 p.m - 5.00 pm**
Venue: **Council Chamber - Priory House, Monks Walk, Shefford, SG17 5TQ**

Members: Cllr Smith, Cllr Mackey

Substitutes: Cllr Childs

Notes for Participants

Membership of the Health and Wellbeing Board

1 **Apologies for Absence**
To receive apologies for absence and notification of substitute members.

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

3 **Minutes** 9 - 16
To approve as a correct record the Minutes of the meeting of the Health and Wellbeing Board held on 08 July 2026.

4 **Chairman'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 'Integrated Health Service'

5 **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.
6	**'Choose You' Update Report** Presented by Etain McDermott To receive a report on the progress and performance of Choose You, the Central Bedfordshire behaviour change service.	*	17 - 38
7	**Neighbourhood Health Update** Presented by Maria Wogan and Kaysie Conroy To receive updated information on the Neighbourhood Health Plan	*	39 - 50
	Other Items		
8	**Director of Public Health Report 2025/26: High impact areas for improving health & wellbeing** Presented by Vicky Head To receive the statutory Director of Public Health Annual Report	*	51 - 78
9	**Impact of New Leisure Facilities on Public Health and Wellbeing** Presented by Lisa White To receive an update on the progress of the Leisure facilities within Central Bedfordshire	*	79 - 92
10	**BCF End of Year Report** Presented by Andy Sharp To receive and approve the Better Care Fund End of Year Report.	*	93 - 106
11	**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	*	107 - 112
12	**Work Programme 2026-27** 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.	*	113 - 116

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.

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committeemeetings@centralbedfordshire.gov.uk

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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

Ms K Ellis, Director of Operations, Bedfordshire Rural Communities Charity

Item 3 –

Minutes

At a meeting of the **Health and Wellbeing Board** held in The Council Chamber, Priory House, Monks Walk, Chicksands, Shefford, SG17 5TQ on Wednesday 08 July 2026 from 2:00pm – 3:10pm

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 R. Campbell, Service Director, Beds Community Health Services, ELFT A. Sharp, Director of Adult Social Care & Housing, CBC
Substitutes - Remote:	Edwin Ndlovu *for L. Sunduza, Chief Executive, ELFT*
Apologies:	Cllr G Mackey L. Carver, Director of Place and Communities, CBC L. Sunduza, Chief Executive, ELFT M. Wogan, Director of Neighbourhood Health & Partnerships, BLMK C. Scarborough, Deputy Director of Public Health, CBC
Members in Attendance:	Cllr S Owen
Officers in Attendance: **Attendees**	N.Murley, Service Director Commissioning, Contracts &Performance, CBC E. McDermott, Head of Service Health Improvement, CBC D. Uvieghara, Public Health Project Manager, CBC A.Malcolm**,** Local Authority Research Practitioner, CBC K. Conroy, Head of Neighbourhood Delivery, BLMK, Central East ICB G. Brown, Deputy Director of Neighbourhood Partnerships, BLMK, Central East ICB M. Gingell, Public Health Consultant, BLMK K.Ellis, Director of Operations, Bedfordshire Rural Communities Charity L. Manning, Webcaster, CBC M. Presland, Committee Services Officer, CBC

1. Apologies for Absence

Chair welcomed everyone to the meeting and apologies were noted.

NOTED

2. Member's Interests

No interests were declared.

3. Minutes

The minutes of the last meeting, 22 April 2026 were confirmed as a correct record and were signed by the Chair.

APPROVED

4. Election of the Vice Chair

RESOLVED

that Maria Wogan, Director of Neighbourhood Health & Partnerships, BLMK would be elected as Vice-Chair for the Municipal Year 2026/27.

5. 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 'Smoke Free Generation'.

6. Public Participation

None

7. Smoke Free Generation Update

The Board were provided with the presentation, which had been circulated in the meeting pack.

The Board were advised of the smoke free generation grant, the partnership working involved in managing the future priorities of the project.

Points and comments included:

- The Board queried the community health pathways and suggested that ELFT could be incorporated into the programme. The Board was assured that Acute Health and inpatient services were involved in supporting the project.
- The Board received assurance that the team are collaborating with the East of England and other high-performing areas to share best practice and adopt successful approaches and activities.

The Board were asked to note the content of the report and consider the opportunities for the HWB to further increase support, which was provided by the recommendations for ELFT involvement.

NOTED
the Smoke Free Generation Update

8. Update from the Local Authority Research Practitioner

The Board were provided with the presentation, which had been circulated in the meeting pack.

The Board were informed of the areas of focus, the activities to date and the future aspirations for the role.

There was discussion about strengthening collaborative working between the Council and ELFT, including aligning research cultures and identifying opportunities for joint research and engagement activities. It was suggested that Bedford and Milton Keynes could also be involved in these discussions.

Points and comments included:

- The Board noted the work undertaken with the Engagement Team on the citizen voice, including approaches to public involvement and participation. Capturing residents' experiences of services and involving them in service design was highlighted as a key priority for the future plans, alongside developing shared areas of research interest, themes and ways of working.

The Board noted the contents of the report and provided feedback on future plans, as requested, encouraging continued resident involvement in the development and delivery of services.

NOTED
the Update from the Local Authority Research Practitioner

9. Better Care Fund approval letter 2026-27

The Board received information regarding the Better Care Fund Plan and the associated ambitions.

The Board were asked to note the plan, confirmed the collaborative approach and sign off on the 2026-27 plan

The Board were assured of the collaborative approach in development of the plan between the Central East ICB, CBC and Chairman of the Health and Wellbeing Board. Following concern raised by Cllr Owen that the information within was at a high level, which was not circulated to the Executive or Social Care Health and Housing Scrutiny Committee.

The Board formally approved and signed off the 2026/27 Better Care Fund plan following a vote.

APPROVED
the Better Care Fund approval letter 2026-27

10. Neighbourhood Health

The Board were advised on the progress regarding the emerging Central East Neighbourhood Health and Neighbourhood Health Team (NHT), to establish the foundations for neighbourhood-based care.

Points and comments included:

- There was reassurance provided following a raised concern of the lack of resident voice in the decisions on both neighbourhood placement and frailty focus. That an engagement plan is being developed, the resident voice will be core component in the development of the programme.
- The Board were also advised that social isolation and loneliness remain a core health offer and is being addressed alongside the neighbourhood health core delivery priorities.
- The Board heard how the partners plan to challenge themselves to endorse and build on the collaborative approach within the integrated offer.
- The Board were advised of the HWB Development Workshop scheduled to take place after the Board Meeting to discuss in greater detail the oversight and governance required from the HWB.

The Board were asked to note, endorse, support the core delivery plans, the collaborative working and partnership alignment.

NOTED
the Neighbourhood Health Update

11. Change to HWB Membership Proposal

The Board were advised that there are required roles for members of the HWB, and whilst a representative from Primary Care is still outstanding.

The Board were asked to approve the implementation of a representative from the volunteer sector, to have a permanent role onto the Board.
A vote was taken and position was approved, and the role will be fulfilled by Kate Ellis, Director of Operations, Bedfordshire Rural Communities Charity.

The Board noted that the charity hold equivalent roles across Central Bedfordshire and that Kate is a member of the BLMK Strategy Group, providing a link to the Neighbourhood Delivery Group.

APPROVED
the Change to HWB Membership Proposal

12. Central Bedfordshire Joint Leadership Group

The Board received information in the pack regarding the February meeting, where there was a positive update within Gait Smart technology, which has links to the frailty programme.

The main discussions in Mays meeting, were regarding Neighbourhood Health Plans and the Governments Framework. Information regarding hypertension within the Gypsy, Roma communities within Central Beds and the Better Care Fund Plans.

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 30th September, the theme of the meeting will be Integrated Health Service.

NOTED

the 2026-27 Work Programme

Chair …….……

Dated …….……

Item 6 –

'Choose You' Update Report

Central Bedfordshire Health and Wellbeing Board

30 September 2026

‘Choose You’ Update Report

Responsible Officer:

Ciceley Scarborough, Deputy Director of Public Health

ciceley.scarborough@centralbedfordshire.gov.uk

Advising Officer:

Etain McDermott, Head of Service, Public Health

etain.mcdermott@centralbedfordshire.gov.uk

Purpose of this report

To provide the Health and Wellbeing Board with an update on the Choose You Integrated Behaviour Change Service.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Note the progress of the Choose You service and ongoing service development to support more local residents to successfully adopt healthy lifestyle behaviors.
2. Consider the information in the report and suggest how the service can maximise its potential to improve residents’ health outcomes, including through wider integration with other services across the system.

Main body of the report

Introduction

This report provides an overview of the first year / 18 months of Choose You, an integrated behaviour change service supporting residents across Bedford Borough, Central Bedfordshire and Milton Keynes to build healthier habits, particularly focusing on smoking cessation and healthy weight.

Launched on 1 April 2025, Choose You brought together adult weight management, family weight management and refreshed stop smoking services under a single brand and single point of access. Services are delivered in-house by CBC Public Health employed personnel.

Service Vision & Objectives

Choose You is a free-to-access service committed to helping people put their health first by adopting healthier habits through quitting smoking and losing weight. It aims to provide a compassionate, practical and experienced service that fits in with people's lives. If clients are experiencing challenges that limit their ability to make progress towards building healthy habits, those working in the service can signpost to additional support.

As an integrated service Choose You operates smoking cessation and weight management services under a single brand with a single point of referral. The behaviour change aspect of the service is enacted through a focus on and training for staff in the use of motivational interviewing techniques.

The objectives for Choose You were:

1. To simplify and enhance residents' experience of advice, guidance and support, reducing the need for multiple referrals between services.
2. To improve outcomes and the health & well-being of those engaging with services.
3. To reduce smoking and weight-related health inequalities by improving access, experience and outcomes for priority populations.
4. To increase the well-being, training, development and engagement of the workforce.
5. To enable professionals to interact more easily with behaviour change interventions to meet the needs of residents and increase referrals.

Support Pathways

Choose You delivers smoking cessation and weight management services, complemented by health and wellbeing coaching for individuals who are not yet ready to pursue other interventions. The engagement team works with stakeholders to promote and strengthen service delivery.

1. Health & Wellbeing Coaches provide up to four 121 online sessions focused on motivation and readiness and support clients into Choose You services.
2. The Stop Smoking Service offers National Centre for Smoking Cessation and Training (NCSCT) 12-week individual interventions either virtually or by telephone and in-person clinics. We also commission Allen Carr one day seminars
3. Weight management offers adult, family and ante/post-natal support;
    a. Adults receive a 12-week group support session either virtually or in person
    b. Ante and post-natal offers up to 4 online 121 sessions alongside the adult group programme
    c. The family programme offers an 8-week online 121 programme using an established holistic, family centred programme known as HENRY
    d. The Second Nature digital weight management programme was launched in July 2026 offering up to 1300 places. The digital programme supports clinically meaningful weight loss including health coaching

4. The Training & Engagement Team focus on;
    a. Building relationships with defined target groups in local communities
    b. Supporting the delivery of preventative health and wellbeing messages
    c. Increase understanding and access to the integrated behaviour change service
    d. Supporting people to stop smoking, healthy weight and other preventative services
    e. Developing training for internal staff to ensure quality service delivery and provides training on smoking cessation and healthy weight for external partners to increase the reach of Choose You and generate referrals into the service

Overview of Year One Service Delivery

The first year of service delivery marked a period of transition, growth and learning for the Choose You service. Programme launches, workforce development and increased public visibility were achieved, while the service also faced challenges related to capacity, systems implementation and workforce stability. Collectively, this year mobilising the service laid important foundations for future performance improvement and service maturity.

New Brand and Marketing

The introduction of the Choose You brand, alongside a co-ordinated mix of broad and targeted activity significantly increased the service's profile. A mix of local authority channels, paid media and partnering with key influencers expanded reach across diverse audiences and helped drive awareness and engagement.

Together with the new website, www.chooseyou.co.uk this created a more modern, accessible and user-centred public offer. The launch of the Choose You website also enhanced digital access, enabling residents to engage more easily with services.

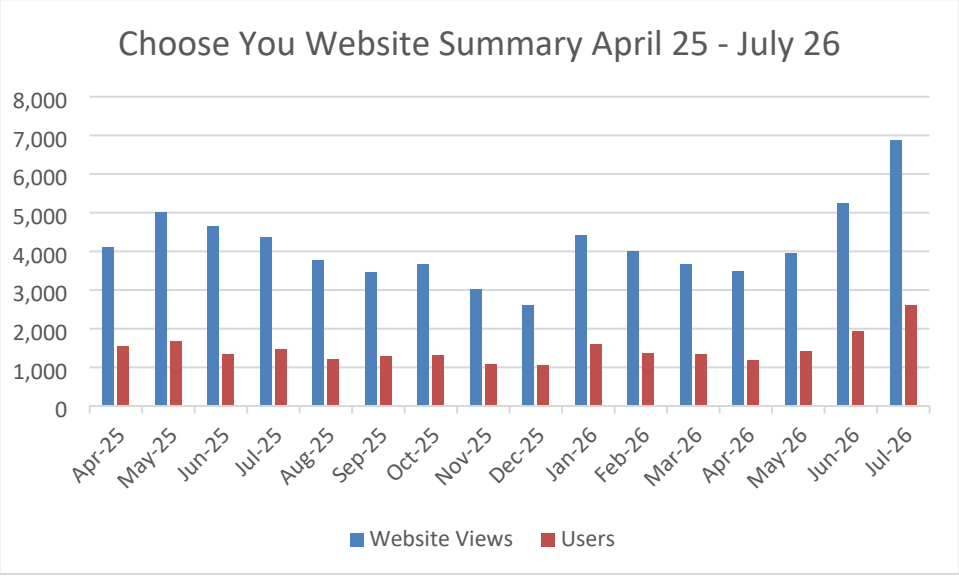

Figure 1. Choose You Website Summary April 2025 – July 2026

Headline Reporting

Weight Management

The Adult Weight Management programme launched, based on NICE guidance and behaviour-change theory. Staff and participant feedback were used to review and update programme content. The launch phase revealed that initial capacity assumptions for adult weight management were insufficient to meet demand. A significant surge in referrals, through a combination of media activity around weight loss medication, the brand awareness campaign and a pause in the service offer by MoreLife resulted in extended waiting times, placing pressure on delivery schedules and negatively affecting user experience. Managing expectations and maintaining engagement for those on extended waiting lists became an ongoing operational challenge.

Despite these challenges, during the 18 months since the launch of Choose You the weight management service has seen:

- A steady increase in engagement with the adult weight management programme throughout 2025/26, which we will ensure continues on-going.
- Approximately 40% have been recorded as still engaged in the programme or lost to follow up. Further analysis is being undertaken to understand the reasons for disengagement and identify opportunities to improve retention.
- Approximately 20% of clients are from the 20% most deprived wards.
- Around 30% are from a BME population.
- We are currently seeing more females attend and complete the adult weight management programme than male, encouraging referrals from male clients will be an on-going priority.
- Waiting list times for attendance in the programme is currently 3 weeks, and we continue to ensure that we have a focus on ensuring wait times remain low for our services.

The family weight management programme experienced delays in launching due to staff vacancies and time taken to recruit. However, we are now have a full cohort of staff, with all trained to deliver family weight management. Our family programme uses an established holistic, family centred programme known as HENRY. HENRY builds on parents and carers strengths to help them set their own goals and strategies for a healthier family life. We have had 67 families attend the programme with 40 remaining engaged. Performance data will be available towards the end of this financial year.

As of September 2026 National Child Measurement Programme (NCMP) follow ups include signposting to our family weight management programme for children that are identified as above the healthy weight range.

The Second Nature digital programme launched in July 2026, providing 1300 places for residents across our shared service who wish to lose weight through a digital app. Second Nature is recommended by NICE as a safe, effective and cost-efficient approach to supporting people living with obesity:

- It uses evidence-based behaviour-change models identifying the psychological, social, and environmental factors that drive eating and activity behaviours.

- The programme is delivered by UK-registered dietitians and nutritionists, trained in behavioural psychology, ensuring guidance is rooted in clinical evidence, not generic weight-loss advice.

Health & Wellbeing Coaching

The implementation of Health and Wellbeing Coaching was introduced in July 2025, initially for clients seeking weight management support and was subsequently extended to stop smoking clients from September 2025.

Triage data covering the period July 2025 to March 2026 shows that a total of 2,007 cases were assessed against established criteria to determine suitability for health and wellbeing coaching. The criteria targeted clients with low or mid-range motivation and/or confidence alongside a history of unsuccessful quit attempts and/or a stated reason for change other than 'other'.

Of the cases assessed, 639 met the criteria for referral to health and wellbeing coaching. Available data indicates that uptake among those offered the service was 15%, equating to 97 individuals.

The full implementation and robust evaluation of the health and wellbeing coaching offer will be a key priority for year two.

Smoking Cessation

Since launching in April 2025, the service has seen;

- Approximately 4,500 clients
- 4,283 of these clients set a 4-week quit date
- A recorded 4 week quit rate of 44.2% (England average 54.9%, EoE average 53.2%)
- Implementation of the Pharmoutcomes system to allow more efficient provision of NRT through pharmacies, reduce admin demand on officers and streamline finance processes and accuracy

Alongside the implementation of Choose You, additional stop smoking resource and interventions were introduced to the service using Smoke Free Generation grant funding. These include;

- Financial incentives for smokers from routine and manual socio-economic groups
- Scoping and implementation of stop smoking advisors in primary care, Drug & Alcohol Services, Bedford Fire & Rescue Service (BFRS) and community mental health services.
- Stop smoking advisors embedded in social housing providers/housing associations.

Training and Engagement Team

The focus of the team is to establish and strengthen connections with underserved communities, promoting healthy behaviours using behaviour modification and health coaching strategies.
Since the launch of Choose You the team have;

- Developed a Training and Development package for external partners and have delivered to CBC Family Centers with plans in place to deliver to other local 3rd sector organisations in the near future
- Identified training dates for the next 18 months
- Oliver McGowan Training completed for the Choose You team which we will implement across our service to increase accessibility.
- Future training opportunities have been identified:
    - LGBTQ+ training
    - Mental Health Awareness

Client Satisfaction & Testimonials/Case Studies

The evaluation of Choose You analysed feedback received from clients about their experience with Choose You staff across both the stop smoking and weight management interventions. In response to closed questions;

- Smoking cessation respondents reported universally positive experiences, the lowest rate of positive or strongly positive experience was 94.5%.
- Weight management respondents reported broadly positive experiences – the lowest rate was 80% positive or strongly positive.

Figure 2: The impact of Choose You

The news section of the Choose You website promotes a range of testimonials from clients who have been supported by the team to make healthy changes in their lives. The direct quotes in **figure 2** make it clear that Choose You staff provide a valuable, knowledgeable, and professional service and are appreciated by clients, helping them feel welcome, supported, and motivated to make changes. Choose You interventions empower individuals to be mindful and motivated while also grounded and realistic about the changes they want to make.

Options for consideration

For information to the Central Bedfordshire Health & Wellbeing Board

Reason/s for decision

No decision is required

Legal Implications

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

Financial and Risk Implications

Choose You service spend is subject to terms and conditions of the Public Health Grant

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.
    - Choose You is intended to improve public health outcomes across the population, with particular benefits for communities that experience higher rates of smoking-related illness, unhealthy weight and premature mortality. Smoking prevalence and unhealthy weight is often highest among people living in areas of deprivation, contributing significantly to health inequalities. Choose You has the potential to reduce long-term inequalities in health outcomes.
    - The service is expected to have a positive impact on protected groups, by reducing exposure to tobacco products, smoking prevalence and unhealthy weight and the associated health risks. It may also benefit children and families through healthy eating education, reduced exposure to second-hand smoke and improved household health and wellbeing. Consideration has been given to fairness and proportionality. This approach seeks to balance individual choice with the wider public interest in protecting public health.
    - Overall, the service 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

Smoking, inactivity, overweight and obesity continue to be the biggest avoidable causes of premature mortality for our residents, as well as contributing significantly to the inequalities in health outcomes that our residents experience.

Over the last 18 months Choose You has made positive steps towards increasing the identification of and supporting the multiple needs of local residents. It has not only increased access to a range of interventions but early evaluation suggests that Choose You is supporting sustained behaviour change and has the potential to improve long-term health outcomes. Choose You will continue to help our residents, not only with support to address their smoking and overweight/obesity, but also with the offer of health coaching through motivational interviewing, to deliver a more person-centered and sustainable intervention.

The development of Choose You has been and continues to be complex, but focused work since launch has meant that we have moved from resolving delivery issues to business as usual. Looking ahead to priorities for the next year means we can focus on improving service delivery where needed and on-going service development.

Appendices

None

Background Papers

- N/A

Report author(s):

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etain.mcdermott@cenrtalbedfordshire.gov.uk

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

CHOOSE YOU

Helping you build healthy habits

Choose You Update

Health & Well Being Board

30/09/2026

Ciceley Scarborough

Service Vision & Objectives

Empower residents across Central Bedfordshire, Bedford Borough and Milton Keynes to live healthier, longer lives by supporting sustainable behaviour change; positively contributing to the prevention of long-term illness and the reduction of health inequalities.

Objectives:

- Reduce the need for multiple referrals between services
- Reduce smoking and weight-related health inequalities for priority population
- Increase training and engagement of the workforce
- Enable professionals to interact more easily with behaviour change interventions and increase referrals

Support Pathways

- **Health & Wellbeing Coaches**
- **Stop Smoking Service**
- **Weight management**
  - Adults
  - Ante and post-natal
  - Family programme
  - Digital weight management
- **Training & Engagement**

Marketing

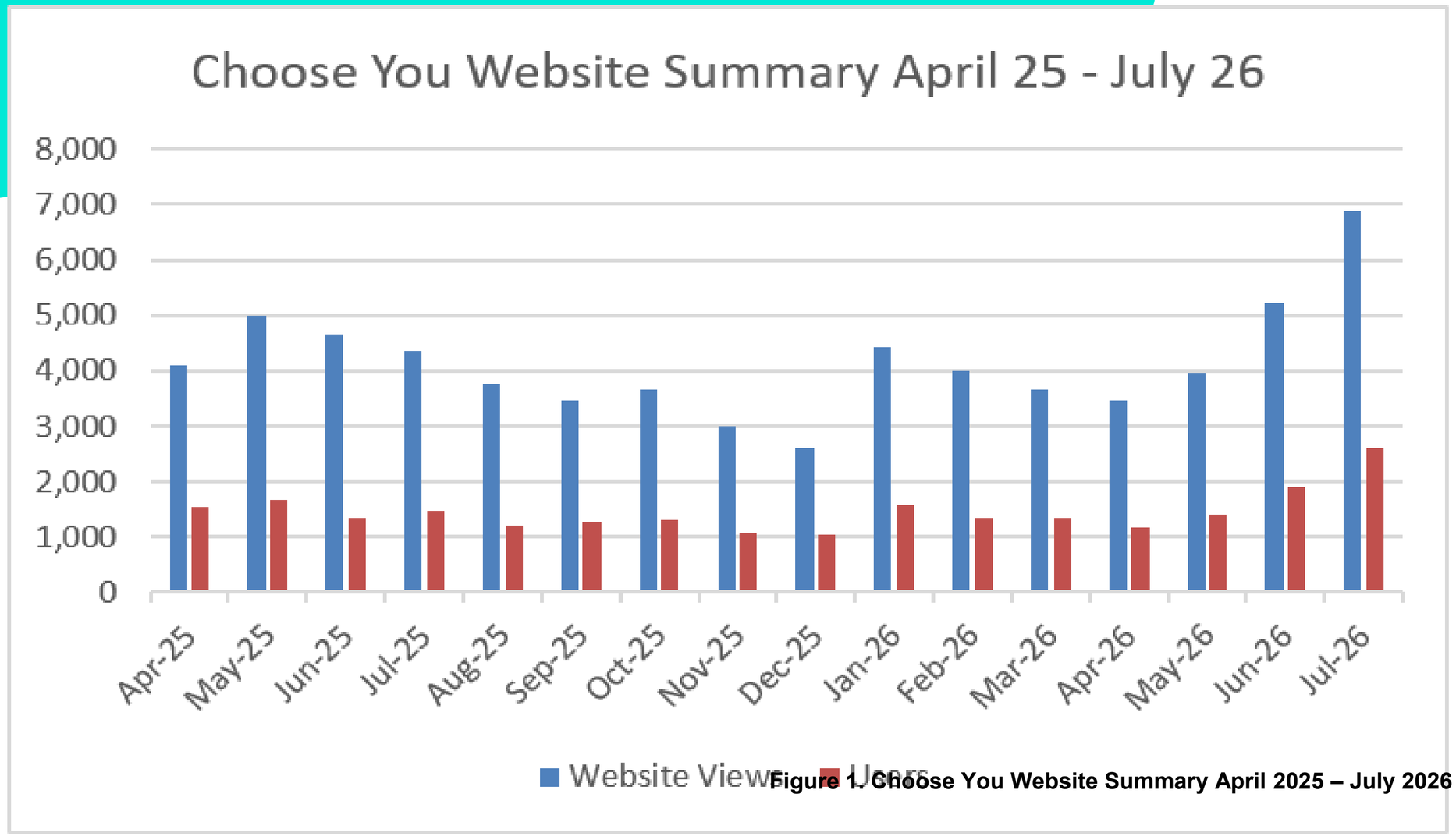


Figure 1. Choose You Website Summary April 2025 – July 2026

Stop Smoking

- Over 4,500 referrals
- Approx 26% from the most deprived wards
- 18% routine and manual workers
- 28% BME
- 12% mental health

Adult Weight Management

April 2025 – to date

- 2839 referrals
- Completion rate of 39.7%
- 40% still engaged in the programme or lost to follow up
- 20% from the most deprived wards
- 30% from a BME population
- More females attend and complete the adult weight management programme than male (approx. 70/30)

Family Weight Management

April 2025 – to date:

- 67 families engaged with so far
- All weight management staff are now trained and delivering
- No waiting list, initial contact after referral within 3 days, with appointment availability within 2 weeks
- National child measurement programme (NCMP) Follow up

Training and Engagement

- Developed a Training and Development package for external partners
- Training dates have been planned for the next 18 months
- Oliver McGowan Training completed by the Choose You team
- Future training opportunities have been identified:
  - LGBTQ+ training
  - Mental Health Awareness

Client Satisfaction & Testimonials/Case Studies

The impact of Choose You in peoples' lives

CHOOSE YOU
Helping you build healthy habits

*'it reinforced that **everybody's journey is different**. You are not just seen as everyone else. People struggle with personal issues and health. You yourself are responsible for your own health. **You matter and are worth taking care of'***

*'**helped [me] to understand how to lose weight**'*

*'**It** has **armed me with invaluable knowledge** that helps me to keep making healthier choices for myself. **I am more confident** in myself. Reduced weight means **I can move easier and exercise more**. The programme focused on both physical and mental elements, which was very helpful'*

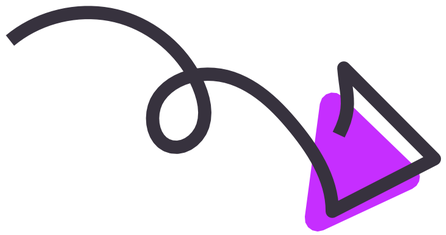
*'this **has made me more aware** of what and how I need to approach things to achieve my end goal'*

*'I think being in a group was a good reminder of basic weight management and listening frankly to how people can be quite obsessive about looking for ways to lose weight without doing really what is necessary which is reducing intake and actually going without some things, except occasionally and in moderation. **It made me realise that I should have the determination and willpower inside of me to take care of myself**. Maybe not a direct intention of the sessions but **it did turn on a switch in me'***

2026-27 Priorities

- Focus on increasing referrals to weight management programme including family weight management and ante/post natal
- On-going evaluation of digital weight management programme
- Training and engagement strategy to ensure quality improvement and increased referrals
- Develop proposals to develop service into a more holistic offer, including physical activity and other lifestyle related support
- Increased and on-going brand awareness
- Targeted / specialist provision development (deprivation, routine & manual, criminal justice, dentistry etc)

Thank you



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CHOOSE YOU

BEDFORD BOROUGH COUNCIL

Central Bedfordshire

Milton Keynes City Council

Working together to improve the health and wellbeing of our communities.

Item 7 –
Neighbourhood Health Update

Central Bedfordshire Health and Wellbeing Board

30 September 2026

Developing the Central Bedfordshire Neighbourhood Plan

Responsible Officer:

Maria Wogan, Executive Director of Neighbourhood Health, Places and Partnerships (NHPP) and Director of Neighbourhood Health, Places and Partnerships, BLMK Central East ICB m.wogan@nhs.net

Advising Officer:

Georgie Brown, Deputy Director Neighbourhood Health, BLMK, Central East ICB georgie.brown8@nhs.net

Purpose of this report

This document provides an update to the Health and Wellbeing Board on progress in developing Neighbourhood Health and sets out the emerging approach to developing a Central Bedfordshire Neighbourhood Health Plan. It brings together the current baseline, the proposed neighbourhood model, the initial focus on frailty, the enabling work required and the decisions needed to move from design into implementation.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Approve the four neighbourhood footprints in Central Bedfordshire as described at Appendix 1.
2. Discuss the approach, core requirements and areas of focus to be included/addressed for the Central Bedfordshire population.
3. Endorse and Delegate development of the Central Bedfordshire Neighbourhood Health Plan to the Joint Leadership Group, with the final Plan coming to a future Health and Wellbeing Board for formal approval.

Main body of the report

1. Executive Summary

1.1. This report provides an update on the development of Neighbourhood Health in Central Bedfordshire and sets out the proposed approach to developing a Central Bedfordshire Neighbourhood Health Plan. Neighbourhood Health aims to improve outcomes, reduce health inequalities and support more people to receive coordinated care closer to home through stronger partnership working across health, care and community services.

1.2. Four established neighbourhoods, aligned to Primary Care Network (PCN) footprints and recognised by local partners, have been identified as the basis for future Neighbourhood Health Teams: Ivel Valley, West Mid Beds, Chiltern Vale and Leighton Buzzard. The initial focus will be people living with frailty, providing an opportunity to develop and test integrated neighbourhood working for a population with complex needs.

1.3. Progress to date includes agreement of neighbourhood footprints, completion of the NHS England maturity assessment, development of the neighbourhood model and commencement of key enabling work relating to workforce, leadership, data, commissioning and governance.

2. The Case for Change

2.1. Central Bedfordshire faces increasing demand for health and care services, driven by an ageing population, rising numbers of people living with frailty and multiple long-term conditions, and growing complexity of need. Residents often require support from multiple services and organisations, which can result in fragmented care, duplication and poorer experience for residents and carers. At the same time, health and care services are operating within constrained resources and increasing workforce pressures.

2.2. There is an opportunity to build on existing strengths across Central Bedfordshire, including strong partnership working, established Better Care Fund arrangements and integrated models of care, to develop a more proactive and coordinated approach to supporting residents. Neighbourhood Health provides a framework for partners to work together around local populations, improving prevention, tackling health inequalities, supporting independence and reducing avoidable reliance on hospital-based care. The development of a Central Bedfordshire Neighbourhood Health Plan will ensure that services are organised around the needs of local communities and focused on delivering better outcomes for residents.

2.3. Neighbourhood Health Plans will be the main statutory partnership plan for health in local areas. Our plan will translate national, Central East ICB and Central Bedfordshire neighbourhood health ambitions into a locally owned strategy. Developed in partnership, it will set out the vision and priorities for neighbourhood health informed by the Joint Strategic Needs Assessment (JSNA). There is currently no formal timeframe for development of Neighbourhood Health Plans, though there is an expectation that local areas are working towards their development. Subject to any emerging national guidance, the intention is to develop the Plan for 2027/28.

3. Proposed Central Bedfordshire Neighbourhood Model

3.1. The proposed model is based on four established neighbourhoods: Ivel Valley, West Mid Beds, Chiltern Vale and Leighton Buzzard. These neighbourhoods are already recognised by health, care and community partners and provide a coherent geography for planning and delivering services around local populations. The footprints are aligned to existing Primary Care Network (PCN) arrangements, supporting collaboration between practices and enabling health, care and community services to work together more effectively to meet local need. Each neighbourhood will have a defined population, shared priorities and clear leadership, providing the foundation for the development of integrated neighbourhood health teams.

3.2. Design principles

- One team, one purpose: Partners work together around a shared population and agreed outcomes.
- Prevention by design: Earlier support, community capacity and population health insight are built into the model.
- Care closer to home: Services are delivered locally wherever this is safe, effective and sustainable.
- Strong clinical and community leadership: Clinicians working alongside local authority and voluntary sector partners.
- Consistent core offer, locally tailored delivery: Every neighbourhood provides a common standard while responding to local need.
- Outcome focused: Progress is measured and approaches are adapted or stopped if they do not deliver the intended impact.

4. Neighbourhood Health Teams

4.1. Part of the neighbourhood health approach is the development of Neighbourhood Health Teams (NHTs). The Central East Our Way Strategy sets out a phased approach to establishing NHTs, bringing partners together around local population needs with a stronger focus on prevention, independence, proactive support and care closer to home. The model aims to improve coordination across services and deliver more integrated, person-centred care, particularly for people with complex needs, including older people living with frailty, those with multiple long-term conditions and residents at risk of avoidable hospital admission.

4.2. Key deliverables are:

- First six months: establish programme governance and measures; define the frailty-first operating model; review pathways and community alternatives to hospital care; and assess neighbourhood readiness, workforce and commissioning requirements.
- Within 12 months: expand early adopter frailty teams; prepare other neighbourhoods; introduce population health reporting, digital care coordination and data-sharing arrangements; align services and investment; and develop approaches for further priority groups.
- At 18 months and beyond: implement agreed commissioning and provider arrangements; mobilise workforce, governance, digital, data and financial enablers; move into live delivery with outcome-based performance management; and extend the model through continuous improvement and benefits realisation.

4.3. The phased approach will build the foundations for earlier support, more joined-up care and stronger community-based services. Detailed delivery will continue to be shaped through local design, testing and commissioning decisions.

4.4. The approach is particularly important for people with complex needs, including older people living with frailty, people with multiple long-term conditions and those at risk of avoidable hospital admission. It also creates an opportunity to embed prevention and community support from the outset rather than treating neighbourhood health only as a clinical integration programme.

5. Initial focus: people living with frailty

5.1. The first neighbourhood health team offer will focus on people living with frailty. This provides a practical route to test integrated working for a population that commonly interacts with several services and is at increased risk of crisis, admission and loss of independence:

- Use risk stratification and local intelligence to identify residents who may benefit from proactive support.
- Provide a shared assessment and coordinated care plan centred on what matters to the person.
- Bring together primary care, community health, mental health, adult social care and voluntary sector support.
- Strengthen rapid response, rehabilitation, reablement and support following hospital discharge.
- Reduce duplication, improve communication and provide clearer routes into specialist advice and diagnostics.
- Support carers and connect people to wider community assets that help them remain well and independent.

5.2. Following the initial focus on people living with frailty, the ICB proposes that the second priority cohort for Neighbourhood Health Teams will be children and young people with special educational needs and disabilities (SEND). Early discussions have commenced with Central Bedfordshire Children's Services to explore how a neighbourhood-based approach could improve coordination, access and outcomes for children, young people and their families.

6. Developing the Central Bedfordshire Neighbourhood Health Team Plan

6.1. The ICB will work with Central Bedfordshire partners in the coming months to collaborate and develop an initial draft of the Central Bedfordshire Neighbourhood Health Team Plan. The purpose of the plan is to translate the national, Central East and Central Bedfordshire neighbourhood health vision into a locally owned strategy and framework for delivery.

6.2. The plan will set out a clear vision, ambition and priorities for Central Bedfordshire and the ambition for neighbourhood health teams, describing how services, partners and communities will work differently to improve outcomes for residents. It will be informed and driven by population health intelligence, the Joint Strategic Needs Assessment (JSNA), and local priorities, ensuring that delivery is tailored to the needs of local communities. Most importantly, it will enable us to clearly state 'What will be different for Central Bedfordshire residents'.

6.3. The plan will describe the key priorities operating model and the outcomes and measures that will be used to monitor progress. In doing so, it will provide a single place-based framework that aligns local delivery with system neighbourhood health teams objectives, whilst reflecting the specific needs, assets and opportunities within Central Bedfordshire.

6.4. Developed jointly with Central Bedfordshire partners, the aim is to present initial drafts to the Bedfordshire Luton & Milton Keynes (BLMK) Neighbourhood Committee in October and at the next Central Bedfordshire Health and Wellbeing Board.

6.5. The Neighbourhood Health Team Plan will include outcome measures, which will be developed in line with identified priorities, which are expected to include:

- More people supported to remain independent at home.
- Earlier identification and proactive support for people at risk of deterioration.
- Fewer avoidable emergency attendances and hospital admissions.
- Improved discharge, rehabilitation and reablement outcomes.
- Better resident and carer experience of joined-up care.
- Reduced variation in access and outcomes between neighbourhoods.
- Stronger use of community assets and preventative support.
- Improved workforce deployment, collaboration and experience.
- Clear evidence that investment is delivering better outcomes and value.

7. Key Delivery Enablers

7.1. Workforce and team design

7.1.1. A workforce mapping programme is being developed to provide a single view of the workforce across primary care, community, acute, mental health, social care, care homes and community organisations. Mapping will identify capacity, skills, gaps and duplication, inform integrated team design and support a neighbourhood workforce transformation and deployment plan and the delivery of coordinated neighbourhood-based care.

7.2. Leadership

7.2.1. Named clinical and operational leadership is required at a neighbourhood level. The model should combine health, local authority and voluntary sector leadership, with clear accountability for delivery, partnership working, performance and tackling barriers.

7.2.2. Clinical leadership will be central to the development of NHTs across Central Bedfordshire to work with health, care and community partners to shape coordinated services around local population needs, improve access, address inequalities and support high-quality, integrated care.

7.2.3. Dedicated partnership roles are being identified across participating organisations to support neighbourhood delivery through system coordination, stakeholder engagement and sustained implementation.

7.3. Data and digital

7.3.1. Partners need shared intelligence to identify priority cohorts, plan services and evaluate outcomes. Workforce, demand, performance, financial and population health data should be brought together through developing a population health system called DELPHII, underpinned by robust information-sharing arrangements. This approach will be described in more detail in a separate agenda item.

7.4. Commissioning and Contracting

7.4.1. Commissioning, funding and contracting arrangements must support collaboration rather than reinforce organisational boundaries. Developing national options for single-neighbourhood and multi-neighbourhood provider

models may offer future routes for integration. Local work will also consider how the BCF, existing contracts and primary care arrangements can be aligned with neighbourhood outcomes.

7.4.2. The NHS England national consultation on the single and multi-neighbourhood provider models closes on the 10 September 2026. NHS England will consider responses and consult further on detailed contract design before final arrangements are confirmed. Local plans will be refined as national policy develops. Further information: https://www.england.nhs.uk/long-read/a-consultation-on-proposed-mnp-and-snp-contracting-models-high-level-summary/

7.5. Community engagement and co-production

7.5.1. Residents and community organisations should help shape neighbourhood priorities, service design and evaluation. The voluntary, community, social enterprise and faith sector should be embedded as a strategic partner, with clear arrangements for involvement and sustainable delivery.

7.6. Governance and Accountability

7.6.1. The neighbourhood plan should sit within the Central Bedfordshire Health and Wellbeing Board arrangements, with clear links to the wider Central East Integrated Care Board (ICB) BLMK neighbourhood health team programme.

7.6.2. National guidance reinforces the role of Health and Wellbeing Boards as the collective system leaders for Neighbourhood Health. HWBs are expected to lead development of Neighbourhood Health Plans, ensure alignment with local health and wellbeing priorities, informed by the JSNA and oversee delivery.

7.6.3. The Health and Wellbeing Board is asked to delegate responsibility for developing the Neighbourhood Health Plan to the Joint Strategic Leadership Group.

8. Risks and Mitigations

8.1. These risks will be mitigated through the structured Central East Neighbourhood Health Team Programme, alongside Central Bedfordshire Strategic Leadership Group and ongoing system-wide leadership and oversight.

Risk	Mitigation
Neighbourhood health is treated mainly as clinical integration.	Embed prevention, social care, public health and community partners in design and governance.
Responsibilities remain unclear across organisations.	Agree named leaders, decision rights, accountability and escalation routes.
Workforce capacity limits delivery.	Complete workforce mapping, prioritise scarce skills and develop shared roles and deployment plans.
Data cannot be shared or connected effectively.	Agree information governance, common measures, and a phased digital roadmap.
Funding and contracts reinforce organisational boundaries.	Align commissioning and pooled funding with shared neighbourhood outcomes.

Legal Implications

9. The development of the Central Bedfordshire Neighbourhood Health Plan is consistent with existing statutory duties and national policy relating to integrated care, partnership working and improving health outcomes. The Health and Wellbeing Board has a key role in providing strategic leadership for neighbourhood health and ensuring alignment with the Joint Strategic Needs Assessment (JSNA) and local priorities. Any future service changes, commissioning arrangements, data-sharing agreements or contractual developments arising from the Plan will be subject to appropriate legal, governance and information governance review before implementation.

Financial and Risk Implications

10. Delivery of the Neighbourhood Health approach will be undertaken within existing resources and commissioning arrangements, with future investment decisions subject to appropriate business cases and governance approvals. This approach seeks to improve the sustainability and value of health and care services through earlier intervention, prevention, improved coordination and reduced reliance on hospital-based care. Key risks include workforce capacity, data-sharing arrangements, organisational alignment and ensuring that funding and contracting arrangements support integrated delivery. These risks will be managed through the Central East Neighbourhood Health Programme, partnership governance arrangements and ongoing system oversight.

Governance and Delivery Implications

11. The development of the Central Bedfordshire Neighbourhood Health Plan will require strong partnership governance across the ICB, Central Bedfordshire Council, provider organisations, primary care and the VCSE sector. Governance arrangements will be aligned to the Health and Wellbeing Board, with oversight delegated to the Joint Leadership Group to coordinate development of the Plan and implementation of agreed priorities. Delivery will be supported through neighbourhood-based leadership, clear accountability, workforce planning, data-sharing arrangements and aligned commissioning approaches to support integrated working and improved outcomes for residents.

Equalities and Fairness Implications

12. Neighbourhood Health aims to improve access, outcomes and experiences for all residents by delivering more coordinated, proactive and person-centred care closer to home. The approach has a strong focus on prevention, reducing health inequalities and ensuring services are designed around local population need. Development of the Neighbourhood Health Plan will be informed by the Joint Strategic Needs Assessment (JSNA), population health data and engagement with residents and communities to ensure that groups experiencing poorer outcomes or barriers to access are identified and supported. An Equality Impact Assessment will be completed as specific service changes and proposals are developed.

Biodiversity and Sustainability Implications

13. The proposed Neighbourhood Health model supports sustainability by enabling more care to be delivered closer to home, reducing travel for residents, carers and staff. It promotes prevention, early intervention and independence, helping to reduce avoidable demand on health and care services and supporting the long-term sustainability of the

system. The model will also maximise the use of local community assets and existing infrastructure, contributing to more efficient use of resources and supporting wider environmental and social value objectives.

Conclusion and next steps

14. Central Bedfordshire is well positioned to develop a neighbourhood health approach that supports prevention, tackles health inequalities and delivers more joined-up care closer to home. Building on existing partnership arrangements and national policy direction, the proposed four-neighbourhood model provides a strong foundation for developing integrated neighbourhood teams and improving outcomes for residents.
15. Subject to Health and Wellbeing Board endorsement, the Joint Leadership Group will lead the development of the Central Bedfordshire Neighbourhood Health Plan, working with health, care, voluntary and community sector partners. A draft Plan will be developed during 2026/27, informed by population health intelligence, the JSNA, stakeholder engagement and co-production with residents. Progress and the draft Plan will be presented to a future Health and Wellbeing Board meeting for consideration and approval.

Appendices

Appendix A: Central Bedfordshire Neighbourhoods (attached)

Report author(s):

Kaysie Conroy, Head of Neighbourhood Delivery BLMK, Central East ICB,
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Central Bedfordshire Neighbourhoods (4)

West Mid Beds – 91,652

PCNs
- Green Vale
- Hillton

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

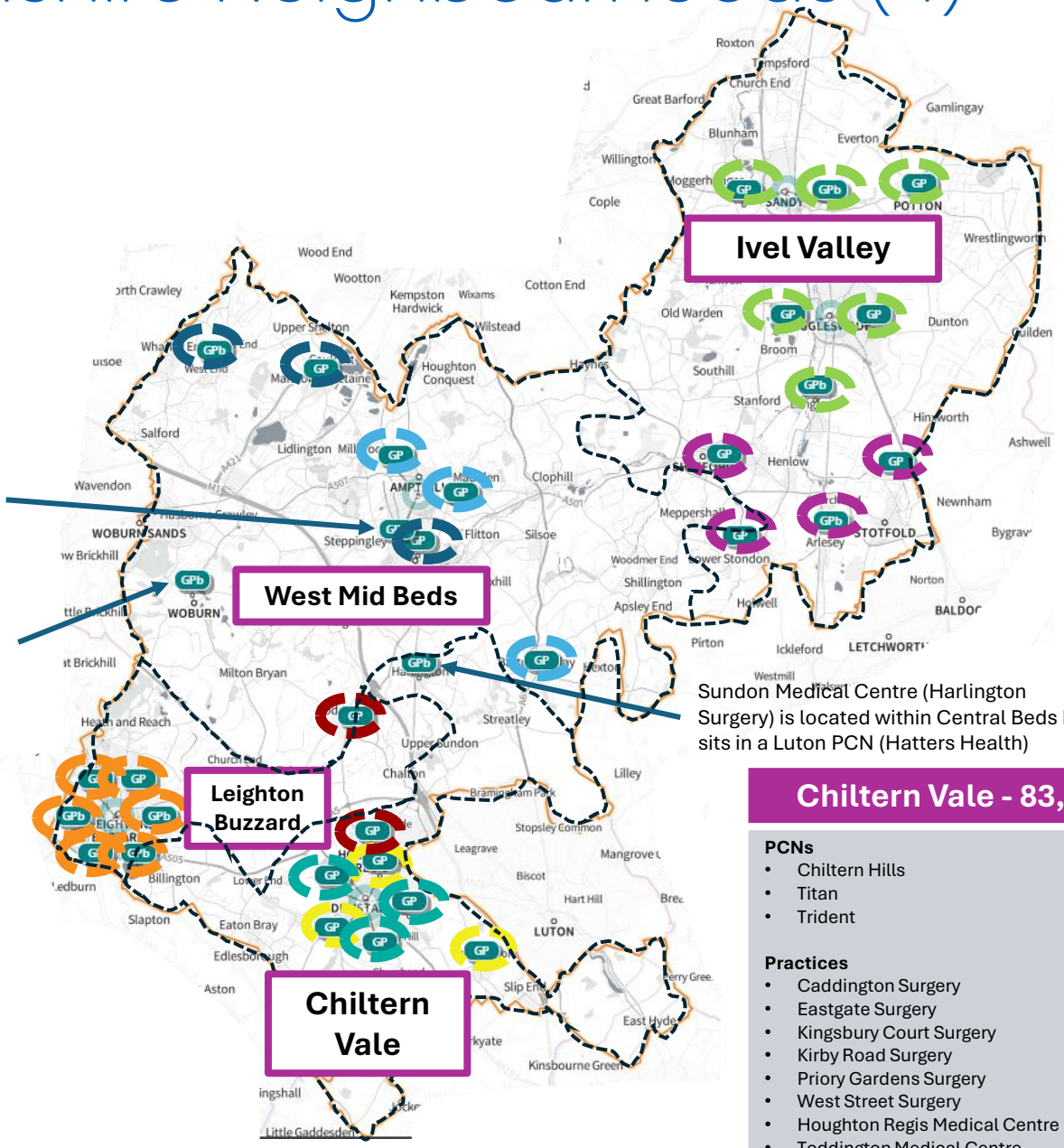
Oliver Street Surgery is located within Central Beds but sits in a Luton PCN (Lea Vale)

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

Leighton Buzzard - 48,036

PCN
Leighton Linslade Connections

Practices
- Dr JL Henderson & Partners
- Leighton Road Surgery
- Salisbury House Surgery



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

Chiltern Vale - 83,629

PCNs
- Chiltern Hills
- Titan
- Trident

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

Ivel Valley – 70,931

PCNs
- Ivel Valley South
- Sandhills

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

Key

GP	Practice
GPb	Branch Practice
	Greenvale
	Hillton
	LLHC
	Ivel Valley South
	Sandhills
	Titan
	Chiltern Hills
	Trident

Item 8 –

Director of Public Health Annual Report 2025/26

Central Bedfordshire Health and Wellbeing Board

30 September 2026

Health and Wellbeing Board

Director of Public Health Annual Report 2025/26

Responsible Officer:

Vicky Head, Director of Public Health, Vicky.Head@bedford.gov.uk

Advising Officers:

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

Purpose of this report

To brief the Health and Wellbeing Board on the 2025/26 Director of Public Health report for Central Bedfordshire.

The report provides an evidence-based overview of the current health and wellbeing needs of Central Bedfordshire and identifies the areas where collective action could have the greatest impact on improving population health and reducing inequalities. Drawing on the Joint Strategic Needs Assessment (JSNA), it examines the key issues affecting residents across the life course, including mental health, healthy weight, physical activity, smoking, housing, employment and support for unpaid carers.

The report enables Board members and partner organisations to review the latest evidence, agree priorities and work together to improve health outcomes.

It also highlights opportunities to strengthen local data, support future JSNA development and help to ensure that the services continue to meet the needs of local communities.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Note the report and consider opportunities to strengthen our whole-system response to the identified high-impact areas by aligning priorities, commissioning and resources, focusing on prevention, reducing inequalities, and improving the wider determinants or building blocks of health, including housing and employment.
2. Support JSNA updates by helping to fill local data gaps and strengthening how we collect and use information on health inequalities - especially for underserved groups (including by specific ethnicity, deprivation level, LGBTQIA+ status, neurodiversity and occupation).

Background

1. Health and wellbeing are shaped by a wide range of factors. While health is often considered in terms of physical or mental illness or life expectancy, it is also influenced by personal, social, economic and environmental conditions – the building blocks of health. The 2025/26 Director of Public Health report draws evidence from the Central Bedfordshire Joint Strategic Needs Assessment (JSNA) to identify the main health and wellbeing needs of the local population and the areas where action could have the greatest impact.

2. The JSNA is a statutory requirement and brings together data on population characteristics, the wider determinants of health, health behaviours and disease to support local planning and service improvement. This report reviews risk factors and health conditions using evidence from the JSNA, assessing them according to:

    - the number of people affected locally;
    - the impact on health inequalities;
    - the long-term trends;
    - a comparison to the England average.

    This helps to identify high impact areas where coordinated action could have the greatest potential to improve health outcomes and reduce health inequalities.

3. The full Director of Public Health report is provided in Appendix A.

Options for consideration

4. Members are asked to note the findings of the Director of Public Health Annual Report 2025/26 and consider, within their respective roles and organisations, the opportunities identified to strengthen partnership working, prevention, reduce health inequalities and improve the use of local data to inform future JSNA development.
5. The Board may also choose to identify any areas where further consideration or action would be beneficial; however, no formal decision is required at this stage.

Reason/s for noting

6. The report is presented to the Health and Wellbeing Board for information and noting. It provides an independent, evidence-based assessment of local health and wellbeing needs and highlights areas where collective action may have the greatest impact on improving health outcomes and reducing inequalities.
7. No specific decision or resource commitment is required as a result of this report. Members are asked to note the findings and consider the implications within their respective roles and organisations.

Legal Implications

8. The Director of Public Health's annual report is a statutory requirement under the Health and Social Care Act 2012. The Director of Public Health has a duty to

prepare and publish an annual report on the health of the local population. The report provides an independent professional assessment of the health and wellbeing needs of the local population and identifies areas where action could improve health outcomes and reduce health inequalities.

9. The report draws on evidence from the Joint Strategic Needs Assessment (JSNA) to inform the assessment of local health needs and priorities. There are no direct legal implications arising from the recommendations in this report. Any future actions, commissioning decisions or changes to services arising from the report will need to comply with relevant legislation and statutory duties.

Financial and Risk Implications

10. There are no direct resource implications from this report.

Governance and Delivery Implications

11. There are no direct governance or delivery implications from this report.

Equalities and Fairness Implications

12. In preparing this report, due consideration has been given to the Council's Public Sector Equality Duty under Section 149(1) of the Equality Act 2010. This requires the Council, in the exercise of its functions, to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not.

13. The report considers health inequalities across the local population and includes analysis, where available, by protected characteristics including age, sex and ethnicity. It also identifies the importance of improving local data to better understand inequalities experienced by underserved groups, including in relation to ethnicity, deprivation, LGBTQIA+ status, neurodiversity and occupation.

14. The recommendations support a whole-system approach to prevention, reducing health inequalities and addressing the wider determinants of health. Strengthening the collection and use of local data will help partners to identify unmet need and ensure that future service planning and commissioning are responsive to the needs of different communities.

15. An Equality Impact Assessment is not considered necessary for this report because it is for information and does not itself propose changes to services, policies or resource allocation. Any future proposals arising from the report that may have an impact on people with protected characteristics should be subject to appropriate equality analysis.

Biodiversity and Sustainability Implications

16. The report has no direct implications for the environment, but an important environmental consideration is the role of some of the building blocks of health such as housing quality and access to healthy environments in shaping health outcomes. This can contribute to healthier living conditions while also supporting broader environmental sustainability and resilience goals.

Implications for Work Programme

17. There are no direct implications for the work programme. However, there is an action for the JSNA team to collect evidence where evidence gaps have been identified.

Conclusion and next steps

18. Improving health outcomes will require sustained, whole community action. Health and care professionals, residents, voluntary and community organisations, the Council and other partners all have an important role in creating healthier communities and reducing inequalities, and this report sets out opportunities for action across these areas.

19. Strengthening the use of local data will support the ongoing development of the JSNA, ensure it is grounded in the local evidence, and help services continue to meet the evolving needs of local communities.

Appendices

Appendix A: Director of Public Health Report 2025/26

Background Papers

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

- None

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High impact areas for Population Health

Director of Public Health Report 2025/26

Image courtesy of Dunstable Town Council

Vicky Head
Director of Public Health

Contents

Introduction from Vicky Head

Our health and wellbeing are shaped by many things, but we often talk about health through a medical lens, in terms of physical or mental illness and life expectancy.

Understanding how common diseases affect our communities and the services they depend on is important and I looked at this in my 2024/25 report. However, we also need to understand the personal, social, economic and environmental factors – the building blocks of health – that contribute to our health and wellbeing.

There are hundreds of these factors, and it can be difficult to answer the question 'what should we work on if we want to have the greatest impact on the health and wellbeing of our local population?'
In my report this year I have chosen to use the findings from the Central Bedfordshire Joint Strategic Needs Assessment (JSNA) to help answer that question.

The purpose of the JSNA is to describe the current and future health, social care and wellbeing needs of the local population. The JSNA is used by the council, the NHS and other local organisations to help service planning, reduce inequalities and improve outcomes for our communities.

The JSNA presents a picture of health and well-being in Central Bedfordshire, using a range of data and insights on the characteristics of the population, the building blocks of health, and patterns of health behaviours and disease. The JSNA is constantly growing, like a library where new books are added as we learn more about our communities.

To identify those areas where we have the greatest opportunity to make a difference, we have reviewed the JSNA and ranked risk factors and health conditions by criteria including the number of people affected locally and the impact on health inequalities.

There are no quick fixes, but we all have a role to play: health and care professionals working with residents; voluntary and community organisations strengthening our communities; the council shaping the environment we live in; and individuals leading healthier lives. Throughout the report I have set out some of the ways we can make a difference.

Introduction

Central Bedfordshire is a combination of rural communities and fast-growing market towns and has significant opportunities for economic development.

Overall, the health of Central Bedfordshire's population follows the national trends. Males currently live an average of 80.4 years and live 16.2 of those years in poor health. Females live longer – 84.1 years – but spend 19.4 of those years in poor health.

The numbers are similar to England, but they hide significant differences across Central Bedfordshire that show that people are not living as long or as well as they should.

Over the period from 2021 to 2023, the latest data available for wards, there were 8.4 years difference in the life expectancy for males between the ward with the highest and lowest and 8.8 years difference for females.

These differences are also reflected in people's perception of their health. In the 2021 Census, females living in Parkside and Tithe Farm wards were around twice as likely to perceive themselves not in good health than those in Aspley and Woburn. Males were 60% more likely to perceive themselves not in good health in Parkside ward compared to Aspley and Woburn. (For more see Inequalities in health perception).

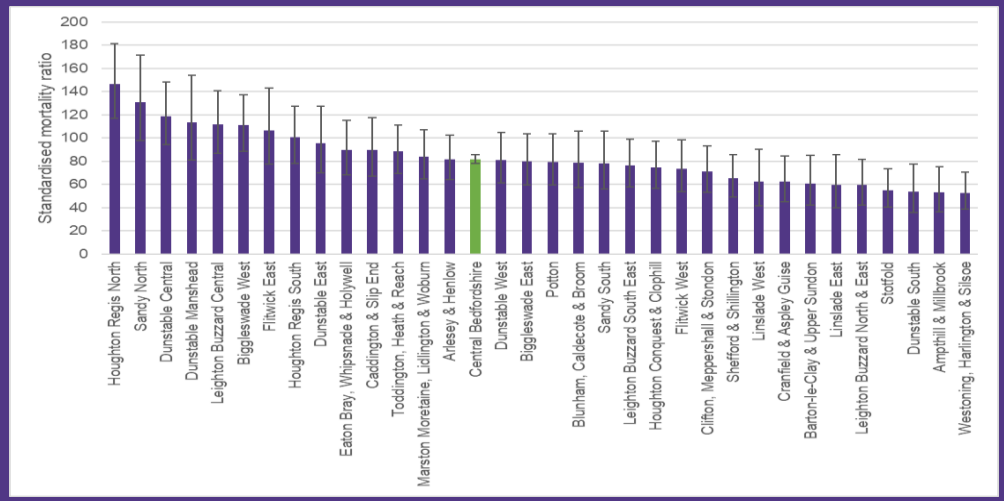
Furthermore, there are areas in Central Bedfordshire where the ratio of deaths in people aged 75 years and under that could be prevented by public health and primary prevention interventions are nearly three times higher than others.

Table 1: Life expectancy and healthy life expectancy 2021-23

Measure	Expected	Gap between highest and lowest wards
Life expectancy at birth male	80.4 years	8.4 years
Life expectancy at birth female	84.1 years	8.8 years
Healthy life expectancy male	64.1 years	8.4 years
Healthy Life expectancy female	64.7 years	8.9 years

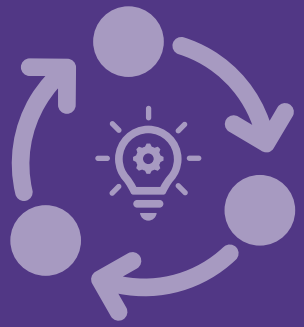
Source: Demographics Dashboard Central Bedfordshire JSNA
https://centralbedfordshire.jsna.uk/jsna/population-place/demographics-dashboard/

Figure 1: Mortality from causes considered preventable in people aged 75 years and under (2019-2023)



Source: Fingertips

Methodology explained



Every part of society has a role to play in improving health, preventing disease and reducing health inequalities. Understanding where to put limited resources to have the greatest impact is not easy – data can help to guide us.

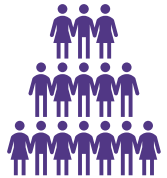
Health and Wellbeing Boards have a responsibility to review the health needs of their local population through the Joint Strategic Needs Assessment (JSNA). The JSNA is comprehensive and detailed, which can make it difficult to summarise. Having an overall sense of the things that have the biggest impact on our health can help different organisations recognise the contribution they can make and to plan and prioritise their efforts.

To do this, we created a tool that estimates the potential impact of different risk factors or health conditions, taking into account:

- The number of people affected;
- How strongly it affects health in Central Bedfordshire, using data from the Global Burden of Disease;
- The extent to which there are health inequalities relating to deprivation and ethnicity;
- The trend over the last five years;
- How the local position compares to the national average.

This report presents the highest impact areas overall and for different age groups.

We have estimated the potential impact of each issue by considering:



The opportunity to impact a lot of people

This takes into consideration both the proportion of the relevant population and the total count of people. The proportion of the population is calculated from the number of people in the group affected or from the total population as measured by the ONS mid-year estimates.

The opportunity to reduce years lost to poor health

This relates the indicator to the causes and risk factors of years lost to poor health through premature death, illness or disability as calculated in the 2021 Global Burden of Disease. It takes into account both the number of causes and risks an indicator is linked to, and how closely the indicator is related to those causes and risk factors.

The opportunity to reduce inequalities

This quantifies the relationship between each indicator and ethnicity and deprivation to identify which are most likely to unequally affect our local communities.

The opportunity to reverse a negative trend

This identifies which indicators have got statistically significantly worse over the preceding five years.

The opportunity to close the gap with comparators

This identifies which indicators are statistically significantly worse than the national average.

High impact areas: **People of all ages**

Image courtesy of Dunstable Town Council

Our analysis highlights four areas that are common across all age groups:

1 Making it easier to be active and maintain a healthy weight	2 Working towards a smoke-free environment	3 Promoting good mental health	4 Supporting those who care for others
• Reduce the proportion of the population that are overweight or obese • Increase the proportion of the population that is physically active	• Reduce the prevalence of smoking • Increase the number of people accessing support to stop smoking services • Reduce hospital admissions related to smoking	• Reduce the prevalence of common mental health conditions • Reduce the number of people needing emergency hospital admission for mental health conditions	• Increase early identification and support • Reduce social isolation • Reduce the inequalities associated with caring responsibilities

1 Making it easier to be active and maintain a healthy weight

Modern life makes it difficult to be physically active, eat well and maintain a healthy weight.

What can we do?

Change is needed across the whole of society. Impactful interventions could include:

- Designing living, learning and working environments that increase activity;
- Using the planning system to limit the impact of unhealthy exposures, such as hot food takeaways;
- Increasing the number of people using services to help them lose weight or maintain a healthier weight;
- Making it easier for people to access fresh, healthy food at low cost.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

By year 6, **1 in 3 children** are overweight or obese. **2 out of 3 adults** are overweight or obese, while more than **1 in 4** are not meeting the 5-a-day fruit and vegetable recommendation. **Approaching half of children** aged 5 to 16 years and **around 1 in 6 adults** do no meet recommended levels of physical activity and **1 in 7 adults** embed physical activity into their daily routine by cycling or walking for travel.

It is a major cause of poor health

Excess weight is among the top risk factors for years lost to poor health for all age groups. Risks rise as people get older and obesity is linked to heart disease, stroke, type 2 diabetes, musculoskeletal disorders and some cancers, all of which are among the top causes of years lost to poor health. People who are physically active have a **20-35%** lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who are sedentary. Physical activity helps prevent major causes of years lived in poor health, including diabetes, osteoporosis, colon and breast cancer, and poor mental health.

It is associated with inequalities

Children living in more deprived areas are **twice as likely** to be living with excess weight or obesity than those from less deprived areas. Although this association isn't as strong for adults, it is still significant and holds true for both levels of physical activity and the proportion of people meeting the 5-a-day fruit and vegetable recommendations.

It will affect more people in the next 5 years

Over the last ten years, **the proportion of children and adults affected by excess weight and obesity has risen steadily**. The arrival of GLP-1 medications may moderate this increase for adults. However, financial constraints could worsen health inequalities. Action on the underlying societal causes is needed to prevent obesity in the first place and reduce the need for medications in the future.

Some elements are worse than England

The proportion of adults that embed exercise in their daily routines by walking as a means of travel is around **14%.** This is **significantly lower** than the average for England (19%) and the **lowest** among other local authorities with similar levels of deprivation. This may reflect the distances many people in Central Bedfordshire have to travel to work and amenities.

2 Working towards a smoke-free environment

Smoking remains the most significant cause of preventable ill health and the leading cause of health inequalities.

What can we do?

The UK Tobacco and Vapes Act is creating a generational shift in the acceptability of smoking. For Central Bedfordshire to fully benefit, impactful local interventions could include:

- Reducing the availability of illicit tobacco products, for example through the work of Trading Standards teams;
- Stopping children and young people from becoming smokers by preventing illegal sales and continuing to inform and educate;
- Making more outdoor spaces smoke-free, in line with new legislation.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

Approximately **10%** of Central Bedfordshire's adult population are current smokers, which equates to approaching **25,000 people**.

round **one in three** non-smokers are exposed to second hand smoke. That is equivalent to over **73,000** people.

It is a major cause of poor health

Smoking is related to **four of the top six causes** of years lost to poor health for the adult population and is the second highest risk factor. It is a major risk factor for lung cancer and chronic obstructive pulmonary disease, which is a leading cause of poor health among older people. Smoking is also associated with cancer in other organs including the lips, mouth, throat, bladder, kidney, stomach, liver and cervix. Children and young people exposed to smoke have a greater risk of asthma, and babies are at higher risk of sudden infant death.

It is associated with inequalities

The proportion of the population who smoke, and hospital admissions attributable to smoking, rise significantly in areas of higher deprivation.

In the most deprived areas smoking prevalence is nearly **50% higher** than in the least deprived nationally, and there are more than double the number of smoking related hospital admissions.

It is not reducing fast enough to reach targets

The proportion of the local adult population that smoke dropped nearly four percentage points from 2022 to 2024, but the decline slowed to just 0.4 percentage points between 2023 and 2024. Such inconsistency suggests reaching the 5% target by 2030 is not certain.

If the 10% figure remained static until 2030, there would be an additional 2,100 adult smokers, based on growth in the population.
If the proportion of the non-smoking population exposed to second hand smoke remained, there would be 7,200 more people exposed in 2030.

3 Promoting good mental health

Good mental health helps us to maintain strong relationships, cope with life's challenges, and achieve our potential, but over time more people are reporting poor mental health.

What can we do?

Impactful interventions could include:

- Equipping young people with the social and emotional skills to manage their lives, develop a sense of purpose, maintain good relationships, and cope with life's challenges;
- Creating healthy, safe, caring and inclusive places and communities;
- Preventing suicide and alleviating mental distress;
- Ensuring people can access timely, appropriate and effective mental health care when they need it.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

1 in 4 adults in the UK experience a mental health problem in any given year. More than **29,000** adults registered with a Central Bedfordshire GP had an unresolved record of depression, while **1 in 4 local people** recorded a high anxiety score. There are around **330** emergency admissions for intentional self-harm each year. **5% of all pupils** and **over a quarter of children** identified with SEND required social, emotional and mental health support. **More than 2 in every 3** social care users aged 65 years and over do not have as much social contact as they would like.

It is a major cause of poor health

Mental health is the **number one** cause of years lost to poor health for children and **number two** for adults of working age. The excess mortality rate for people aged 75 years and under was **3 times higher** for those with severe mental illness.
Poor mental health has a knock-on effect on other risk factors for poor health. For example, people with a long-standing mental health problem are **twice as likely to smoke**, and those with severe mental illness are nearly **four times more likely**.

It is associated with inequalities

There is a **strong relationship** between people affected by deprivation and those with depression. There is **strong negative relationship** with people from ethnic minority groups, meaning that people from ethnic minority groups are less likely to have a record of depression. There is also a **moderate** relationship between deprivation and excess mortality in adults with severe mental illness (SMI), meaning there are more excess deaths among people with SMI from more deprived areas.

It will affect more people in the next 5 years

There is no trend information available for the common mental health indicators at a local level, but the numbers have been increasing for England overall and are expected to continue to rise. Locally, the number of children requiring SEND provision for social emotional and mental health needs is increasing significantly.

If the current rate of growth continues, there would be around 3,800 pupils in Central Bedfordshire's schools needing support by the 2029/30 academic year.

4 Supporting those who care for others

Caring for family and friends is part of everyday life for many people in our community and carers need help to remain healthy themselves.

What can we do?

Ways to support carers could include:

- Encouraging people to recognise that they are providing care and to seek support early to protect their own health;
- Addressing inequalities in the access to and take-up of services for carers;
- Supporting carers to prioritise their own health to be better able to care for others;
- Linking data systems together to make it quicker and easier to access support;
- Recognising that support for carers goes beyond the caring responsibility to include other family, social groups and work.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

About **65%** of the adult population of the UK will become an informal carer at some point in their lives, meaning that everyone will know someone who is a carer if they are not one themselves. In Central Bedfordshire, there are around **43,000** people caring for others. Of these **4%** are young carers aged 5 to 18 years and **25%** aged 65 years and over. The majority, **60%** of carers, were women and more than **60%** were over the age of 50.

It is a major cause of poor health

70% of carers known to GPs have a long term physical or mental health condition, disability or illness themselves. Carers are **1.8 times** more likely to suffer chronic pain and musculoskeletal disorders - the **second greatest** cause of years lost to poor health for working aged females, the **third greatest** for males, and among the **top five** causes for older people. Carers are **2.3 times** more likely to be lonely or socially isolated and **half as likely** to have a good quality of life.

It is associated with inequalities

The proportion of people from ethnic minority communities who identify themselves as carers is **lower than the average** in Central Bedfordshire, and the proportion receiving service or financial support is **even lower**. Over **60%** of unpaid carers worry about the cost of living and **over a quarter** have cut back on essentials such as food and heating. Over **1,200** local carers lived in households classified as deprived in at least three of the dimensions measured through the 2021 Census.

It is increasing over time

The number of carers is **increasing across all age groups.** Increases in the proportion of young carers are driven by more siblings with long term conditions, particularly autism, and an increasing number living in multi-generational homes. Increases in the numbers of adult carers is primarily driven by population change and people living longer with chronic and life-limiting conditions.

Even if the proportions of the population providing care stayed the same, an additional 2,000 people could be expected to be carers by 2030.

High impact areas: **Children & young people**

The overall health and wellbeing of children and young people in Central Bedfordshire is not significantly different from the rest of the country. However, in the UK, there are many more children and young people suffering from poor health than there should be. Recent national policy changes including the Children's Wellbeing and Schools Act, SEND reforms and overhaul of children's social care are all aimed at targeting services where the need is greatest and reducing inequalities.

At a local level, there are wide inequalities in the health and wellbeing of our children and young people that can be reduced.

The high impact areas for children and young people are:

1 Early & continued access to maternity care

- Minimise risk of low birth-weight babies
- Improve the proportion of mothers breastfeeding
- Improve nutrition for mother and baby
- Minimise infections in infants

2 Protecting children and young people from infectious diseases

- Increase population vaccine coverage of routine childhood and seasonal vaccinations

3 Reducing the impact of income deprivation on health and well-being

Reduce the impact of deprivation on:

- Children achieving the expected level of development at the end of Reception
- Young people's Attainment 8 score
- Oral health
- Asthma

1 Early & continued access to maternity care

Maternity care provides families with the care, treatment and advice that enables healthy pregnancy and supports those with more complex needs.

What can we do?

We need to increase understanding of the importance of early antenatal care and make it easier to access it. This could include:

- Using data to identify barriers to booking maternity care and understand the characteristics of women most likely to book care late;
- Strengthening awareness of self-referral routes, making sure information is properly accessible;
- Increasing promotion of early antenatal care through professionals and trusted community settings.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

Early maternity care relates to **100%** of babies and their mothers – around **3,400 births** every year. Currently, around **one quarter** of mothers did not have an appointment booked within 10 weeks of pregnancy as recommended by the National Institute for Health and Care Excellence (NICE) in 2023/24.

It is a major cause of poor health

Timely maternity care helps identify and prevent the **top three causes** of years lost to poor health for children under the age of five. Mothers who receive early and continued care are **24% less likely** to experience a pre-term birth, the primary cause of low-birth-weight babies. Trust in midwives encourages breastfeeding, which helps to prevent malnutrition, which is the **greatest risk factor** for years lost to poor health in children aged under five.

It is associated with inequalities

Around one in six babies in Central Bedfordshire are born to women from ethnic minority groups. Across England, rates of early access to maternity care are significantly lower for ethnic minority mothers. Among women from Black ethnic groups, **less than half benefit** from early access to maternity care. However, nationally they **are nearly three times more likely to die** during pregnancy and birth, while still births are **twice as likely** and neonatal deaths are **one and a half** times more likely.

It is not improving significantly

The proportion of mothers booking an antenatal appointment within 10 weeks of pregnancy has varied around the **70%** mark, with a high of 77% and low of 69%. While this is **significantly higher** than the national average, it remains short of the 100% target.

Parts are worse than England

The rate of early access to maternity care is significantly better in Central Bedfordshire than the national average. However, admissions to hospital for children aged 0 to 4 years for infections is **significantly higher**. The rate of emergency admissions for lower respiratory tract infections was **294 per 10,000**, compared to 212 per 10,000 for England, and the rate for gastroenteritis was **95 per 10,000**, compared to 68 per 10,000 nationally.

2 Protecting children and young people from infectious diseases

Vaccines are the most effective way to protect children against infectious diseases. Engagement from the whole community will help to ensure everyone is protected.

What can we do?

Evidence tells us that the most important thing is to make vaccines as accessible as possible to families, for example by:

- Using a range of local venues at convenient times;
- Making information about vaccines easy to understand in a range of formats and languages;
- Ensuring that professionals working with families take every opportunity to check vaccination status, promote vaccines and signpost accordingly.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

Vaccines are relevant to **all children and young people**. If people stop having vaccines, it is possible for infectious diseases to spread quickly. For example, if 95% of children have the MMR vaccine, measles would be stopped from spreading completely but if that rate drops below 90%, measles, mumps and rubella can quickly spread again.

It is a major threat to good health

The World Health Organization has listed falling vaccine uptake as one of the biggest threats to global health. Therefore, although infectious diseases have not been one of the top causes of years lost to poor health for children in the recent past, declines in vaccine take up have led to outbreaks, particularly of measles. From a COVID-19 affected low of just 2 confirmed cases in England and Wales in 2021, the number rose **to approximately 2,900** in 2024 but fell to 960 in 2025. The average in the 10 previous years was around 560 identified cases per year.

It is associated with inequalities

Smaller proportions of Central Bedfordshire's ethnic minority children and young people are likely to be immunised, as nationally there is a strong negative relationship between take-up and ethnicity, meaning that **fewer children from ethnic minority groups receive vaccines.**

There is potential to improve take up of immunisation through targeting. For example, 86% of children and young people in care are up to date with their vaccinations**, lower than** the rate for children in care in England.

It is declining over time

Over the last five years, the proportion of children receiving two doses of the MMR vaccines in Central Bedfordshire by the age of five has **decreased significantly from 92.2% to 87.9%, significantly below the national average.** The proportion receiving at least one dose also declined significantly, falling to 93.9%.

If the decline in one dose MMR vaccination coverage continues at the same rate as over the last five years, the proportion of children receiving one dose by five years old will fall below the threshold of 90% by 2032.

3 Reducing the impact of income deprivation on health and well-being

As the cost-of-living increases, the effects of deprivation on our children and young people is increasing, often leading to poorer education and health outcomes.

What can we do?

Locally, we can reduce the impact of deprivation by, for example:

- Ensuring that effective local multi-agency support for families is available through Family Hubs as well as community groups and the voluntary sector;
- Helping families access all the financial support that they are entitled to;
- Ensuring that every child is offered a 2 to 2½ year check and appropriate support is provided when needed.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

There are around **7,400 children** and young people aged under 16 living in low-income households, meaning around **1 in 8 children in Central Bedfordshire live in poverty**. If costs associated with housing are factored in, that number rises to **1 in 5**.

It is a major threat to good health

Beyond obesity and mental health, early development, academic attainment, oral health and asthma are the factors most affected by deprivation in children. Early development and academic attainment are **core building blocks of health**, while chronic respiratory disease is the **fifth highest cause** of years lost to poor health for school-aged children and young people. Asthma is the most prevalent condition for children aged 14 years and under with **over 1,100 children** diagnosed and is **a leading cause of hospital admissions.** Tooth decay is the **leading cause of hospital admissions for five- to nine-year-olds**.

It is associated with inequalities

The gap between the proportion of five-year-olds with visually obvious dental decay for the children from the most and least deprived areas is **22 percentage points**, while the rate of hospital admissions due to asthma for people aged under 19 years in the 10% most deprived areas is more than **double** that for least deprived 10%.

It is increasing over time

Between 2021/22 and 2024/25, the proportion of children aged under 16 years living in poverty in Central Bedfordshire increased slightly, with the proportion in relative low income households rising from 11.2% to 11.7%.

If this rate of change continued, the number of children aged under 16 years living in relative low income households would increase by more than 10% by 2030/31.

Parts are worse than England

The proportion of children with free school meal status achieving a good level of development at the end of reception in Central Bedfordshire is 43%, **significantly lower** than the national average of 51%.

High impact areas: **Working-aged people**

Image courtesy of Dunstable Town Council

Employment is one of the most significant social determinants of health. Good work provides financial stability, a sense of purpose, social connections, and daily structure, which lowers mortality rates and protects against mental health issues such as depression and anxiety. Being out of work is widely linked to poorer health outcomes, including a higher risk of limiting long-term illnesses and lower life expectancy.

The health of the working-age population impacts directly on economic productivity, workforce supply, and social wellbeing. A healthy workforce supports economic growth, while poor working-age health strains resources and widens inequalities.

The high impact areas for working-aged people are:

1 Reducing the impact of poor health as a barrier to work

- Reduce the employment gap between those who are disabled and those who aren't
- Support those in routine and semi-routine occupations who are at higher risk of poor health

2 Identify those at risk from long-term conditions and increase early access to preventative care

- Identify those at risk of having long-term conditions and increase early access to preventative care

3 Help people change behaviours that impact on their health

- Reduce the unmet need for drug and alcohol treatment
- Reduce the prevalence of smoking and smoking attributable admissions to hospital

1 Reducing the impact of poor health as a barrier to work

A healthy workforce drives economic growth, while not having work or working in unsatisfactory jobs, can lead to poorer physical and mental health.

What can we do?

Actions to tackle worklessness and poor health as a barrier to work could include:

- Employers creating healthier and more inclusive workplaces;
- Helping people who are in work to stay healthy by improving access to behaviour change support and preventative healthcare;
- Linking people who experience barriers to work with effective support;
- Encouraging job creation through skills development and strategic partnerships with local businesses and education providers.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

80% of people aged 16 to 64 are estimated to be in employment but around **35,000 people are not working,** of whom **30,100** are economically inactive (not seeking work), and of these an estimated **1 in 4** are inactive due to long term poor health. **5,400** are unemployed and claiming benefits.

It is a major threat to good health

Unemployed males in Central Bedfordshire are **twice as likely as** than those in employment to perceive themselves as not in good health and females **over one and a half times more likely.** Long-term physical or mental health conditions are the top causes of years lost to poor health, and people who have these are **17 percentage points less likely** to be in work than the general population. People in routine and manual jobs are 80% more likely to smoke – the **number two** risk factor for years lost to poor health in Central Bedfordshire.

It is associated with inequalities

People working in **elementary jobs**, such as cleaners, delivery drivers, construction labourers, and farm workers; those working in **caring, leisure and other service occupations**; and those working in **sales and customer service,** , as well as male **process, plant and machine operatives,** are all less likely to be in good health than the average for Central Bedfordshire. There is also a moderate relationship between unemployment and ethnicity, suggesting people in our local ethnic minority communities are **more likely to be unemployed**.

Employment gaps are increasing over time

The gap in the rate of employment between people with a long-term physical or mental condition and the overall employment has **increased notably** since the COVID-19 pandemic, although the rate is not significantly different from the England average.
If the 2024/25 rates remain constant, an estimated 33,850 people aged 16 to 64 will be economically inactive and 4,950 unemployed and claiming benefits by 2029/30.

2 Identify those at risk of long-term health conditions and increase early access to preventative care

Working age is when the prevalence of long-term illnesses increases. Prevention and early identification are fundamental to ensuring better outcomes.

What can we do?

Early identification and good management of long-term conditions is important to prevent them getting worse. We could make a difference by:

- Increasing uptake of NHS Health Checks and screening programmes, especially among higher risk groups;
- Being more proactive in the healthcare offered to people with long-term conditions, making sure the care they receive is optimal;
- Supporting people with long-term conditions to live healthy lives, for example by being active, maintaining a healthy weight, socialising, and stopping smoking.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

Among the working aged population, long term conditions are common: **37,700** had anxiety; **28,100** depression; **17,500** hypertension; **12,100** asthma; **10,400** musculoskeletal conditions, **5,600** cardiovascular disease, **7,900** diabetes, and **4,600** cancer. These numbers cannot be added together as many people will have more than one condition, but **at least 1 in 5** working aged people are affected by a physical or mental condition.

It is a major threat to good health

The most prevalent conditions also **impact most on years lost to poor health** e.g. musculoskeletal disorders, mental disorders, cancers, cardiovascular diseases, respiratory diseases and diabetes. Screening and testing programmes relate directly to cancers and cardiovascular disease, **two of the top six causes** of years lost to poor health. NHS Health Checks seek to identify and address major risk factors. However, of the people referred for additional help with weight management or stopping smoking, over 90% declined support.

It is associated with inequalities

There is a very strong relationship between deprivation and deaths that are considered preventable, meaning that people from areas of deprivation are **more likely to die unnecessarily.** Nationally, **people from ethnic minority groups are less likely to have screening** for cervical, bowel and breast cancer, though, in contrast, they are **more likely to receive an NHS Health Check.**

It is getting worse over time

The proportions of the local population with diabetes, hypertension or asthma are increasing, while the proportion of younger females being screened for cervical cancer is decreasing.

If the prevalence of diabetes continues to change at the same rate as for the previous five years, it will rise from 7.9% in 2024/25 to 9.8% in 2029/30. If the rate of decline in cervical cancer screening continues, the proportion of females aged 25 to 49 being screened would fall from 73.9% in 2024 to 71.1% in 2030.

Parts are worse than England

The prevalence of **asthma in the population aged 6 and over is significantly higher in Central Bedfordshire** than England. **The mortality rate for deaths involving hypertensive diseases is significantly higher** than England. In addition, the proportion of people being invited to and receiving NHS Health Checks is significantly lower than the England average.

3 Help people change behaviours that impact on their health

As we age, the cumulative impact of unhealthy behaviours begins to affect our bodies – stiffening arteries, increasing insulin resistance, and damaging organs such as the lungs and liver. In turn this increases the risk of long-term conditions.

What can we do?

Most people know what makes them healthy, but that doesn't necessarily mean they are able to make healthy choices. Changes to our environment to make healthy behaviours easier can have the most impact, but we could also make a difference by:

- Increasing access to and uptake of support to stop smoking and maintain a healthy weight;
- Frontline professionals having more conversations with residents about health behaviours and signpost to support services;
- Preventing alcohol-related harms and increase numbers of people engaging with local support.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

Of Central adult population, an estimated **10%** are **current smokers.** It is also estimated that **approximately 1 in 5 adults drink alcohol regularly** at levels that increase their risk of ill health. **0.85%** are opiate and/or crack cocaine users.

These proportions equate to approaching **25,000 adults smoking** and **50,000 drinking alcohol** at levels that increase their risk of ill health**.** There are also around **2,100 opiate and/or crack cocaine users.**

It is a major threat to health

Smoking is related to **three of the top six causes** of years lost to poor health for Central Bedfordshire's adult population and is the **second highest risk factor**. Alcohol and drug misuse relate to the **seventh highest** cause of years lost to poor health and is the **top risk factor for males.**

It is associated with inequalities

Smoking prevalence, hospital admissions attributable to smoking, and the proportion of dependent drinkers all have a **very strong relationship** with deprivation, meaning the proportions of people affected is significantly higher in areas of higher deprivation. Admissions for alcohol-specific conditions has a **moderate relationship** with deprivation**.**

It is increasing over time

The rate of smoking attributable hospital admissions increased significantly in Central Bedfordshire in the five years to 2019/20 from a low of 1,038 per 100,000 admissions, to 1,330.
If this increase continues at the same rate, by 2029/30, the rate of smoking-attributable admissions would reach 1,392 per 100,000.

Parts are worse than England

The proportion of the local population who successfully quit smoking in Central Bedfordshire is **significantly below** that for England overall and has been for three of the last four years. For females, the potential working years of life lost due to alcohol-related conditions, was **significantly higher** than England in 2024 having increased significantly over the previous five years.

High impact areas: **Older people**

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People aged 65 years and over are the fastest growing age group in Central Bedfordshire, and the group with the greatest number of people in poor health. Helping people stay healthy and independent for as long as possible is important for the wellbeing of our population, and the ability of health and social services to keep up with demand. (See the 2024 Director of Public Health Report for more on how the demand for healthcare may rise). At a local level, there are significant inequalities in the health and wellbeing of our older population.

The high impact areas for older people are:

1 Supporting people with dementia to live better for longer

- Increase the proportion of people with dementia who are diagnosed at an early stage
- Increase awareness of pathways to support for people with dementia

2 Supporting independent living through identification, prevention and support for age-related conditions

- Early identification of sight loss
- Prevention and rehabilitation for falls and fractures

3 Reducing the impact of income deprivation on health

- Improve the quality of living conditions including the suitability of available housing
- Increase the availability and affordability of heating

1 Supporting people with dementia to live better for longer

Dementia is devastating, but addressing underlying causes earlier in life can help reduce the risk. Timely diagnosis means people get the care they need which, in some cases, can slow progression of the disease.

What can we do?

Around 45% of dementia cases are preventable. Adopting healthier behaviours in adulthood reduces the risk of developing dementia. For people who have developed dementia, their quality of life can be improved through, for example:

- Timely diagnosis and access to care;
- Community support for people with a diagnosis and their families and carers;
- Support to maintain independence, particularly to prevent physical frailty.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

There are approximately **2,300 people** registered as living with dementia in Central Bedfordshire
However, it is estimated that over **3 in 10 people with dementia are undiagnosed**, meaning there may be almost **3,000 people living with dementia** in Central Bedfordshire, of whom **approaching 700** are not accessing the support and care that is available because their condition has not been formally recognised.

It is a major threat to health

Dementia is **one of the top four causes** of years lost to poor health for people aged 65 and over in Central Bedfordshire. It accounts for about **12% of deaths in England and Wales** of people aged 65 and over and is the **leading cause of death for people in England and Wales aged 80 years and over.**

Quality of life is heavily impacted by dementia. Maintaining people's independence as long as possible and minimising distress associated with health treatments, particularly hospital admission, is a priority. There were around **1,800 emergency admissions** to hospital for people with dementia, and emergency admissions accounted for a higher proportion of healthcare activities for dementia patients than the average for all conditions.

It is increasing over time

The estimated diagnosis rate for people aged 65 and older was 65.8 % in Central Bedfordshire. This has been increasing steadily since 2021 and has been in line with the England average since 2024.

There is evidence that the rate of dementia is declining as underlying causes in earlier life are addressed. However, as the number of older people is increasing faster, the number of people being diagnosed with dementia is increasing.

The number of people living with dementia in Central Bedfordshire is estimated to increase by 54% to 86% between 2023 to 2043, depending on the model used. This is equivalent to approximately 2,000 additional people living with dementia by 2043.

2 Supporting independent living through identification, prevention and support for age-related conditions

As people age, maintaining their independence becomes both more difficult and more important. Supporting independence in the face of physical challenges is essential to healthy ageing.

What can we do?

We can promote healthy ageing by, for example:

- Making collective efforts to support people to remain as independent as possible, for as long as possible;
- Preventing falls and fractures by promoting strength and balance training, assessing and adapting homes, and identifying and treating osteoporosis;
- Identifying and correcting sight loss early, particularly in diverse communities.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

Falls are the **largest cause of emergency hospital admissions** for older people. In 2024/25, there were **over 1,000 falls involving older people** and **300 hip fractures** in Central Bedfordshire that resulted in hospital admissions.

It is a major threat to health

Musculoskeletal disorders including osteoporosis, unintentional injuries and sense organ diseases are **all in the top 10 causes** of years lost to poor health, while falls are a major predictor of people moving from their own home to long-term nursing or residential care.

Hip fractures are debilitating and associated with higher levels of mortality. On average, **1 in 3 people** with a hip fracture leave their own home to move into long-term care.

It is associated with inequalities

It is expected that hip fractures are **less likely** to be suffered by Central Bedfordshire's ethnic minority groups, as there is a negative relationship between ethnicity and hip fractures nationally.
Conversely, there is a moderate positive relationship between ethnicity and registered blindness in people aged 65-74 years. The relationship weakens in people aged 75 years and over, suggesting that **early sight loss is potentially more common in ethnic minority communities**.

It is increasing over time

The prevalence of osteoporosis increased significantly from 0.5% to 0.7% in the five years to 2024/25. The percentages of people aged 65 and over offered reablement services following discharge from hospital, and of those still at home 91 days after discharge, both declined significantly in the five years up to 2021/22.

If the trends continued, by 2030: the prevalence of osteoporosis would increase to 0.9%; the percentage of people offered reablement after hospital discharge would decline to under 2%; the percentage of people still at home after discharge from hospital into reablement would fall below 65%.

3 Reducing the impact of income deprivation on health

Deprivation has a profound impact on older people, often affecting their housing, heating and nutrition, as well as increasing their risk of physical illness and injury.

What can we do?

Locally, we can reduce the impact of income deprivation by, for example:

- Ensuring that older people access all the financial support that they are entitled to;
- Connecting older people to advice and support to help reduce their energy bills and stay warm in winter;
- Providing opportunities for older people to socialise and develop a network of informal local support.

This has a significant impact on health and wellbeing in Central Bedfordshire because:

Lots of people are affected

It is estimated that **7.2%** of Central Bedfordshire's population aged 60 years and older experienced income deprivation, which would equate to over **4,000 people aged 65 and over living in poverty** in 2025.

The 2021 Census also identified 925 Central Bedfordshire residents aged 65 years and over living in households deprived in the housing dimension, meaning their accommodation was overcrowded, part of a shared dwelling, or had no central heating.

It is a major threat to health

There are **strong relationships** between deprivation and the prevalence of common mental disorders in people aged 65 years and over, the diagnosis rate for dementia, the prevalence of smoking and obesity, as well as good nutrition – all of which are major causes or risk factors for years lost to poor health for older people.

In addition, there are specific living conditions that were associated with higher proportions of older people identifying themselves as not being in good health. The gaps are:

- **22 percentage points (66%)** between renters and those who owned their own home;
- **16 percentage points (47%)** between people living in shared accommodation, flats, terraced houses and mobile homes and those living in semi-detached or detached homes;
- **20 percentage points (58%)** between those without additional bedrooms and those with additional bedrooms.

It is increasing over time

The proportion of older people living in deprivation increased from 5.5% in 2019 to 7.2% in 2025. **By 2030** there would be:

- **approximately 4,700 older people living in deprivation if the proportion remained stable at 7.2%;**
- **approximately 5,800 older people living in deprivation if the proportion continued to increase at the same annual rate as from 2019 to 2025.**

Future JSNA developments

The JSNA continues to evolve and there are areas that have emerged from the data that require greater attention.

Putting inequalities under the spotlight

There are many groups of people in Central Bedfordshire that experience different health and wellbeing outcomes from that desired, or from the average. Some of these inequalities, such as those based on **deprivation** are quite well understood. Others, such as **ethnicity** are understood at a high level, but what this means for specific ethnic communities within Central Bedfordshire is not always as clear. Furthermore, there could be greater understanding of how different services and interventions reach and are received among different groups. Finally, there are personal characteristics that academic research and our analysis of the general health question in the 2021 Census highlight as reasons for unequal health outcomes. These include:

- **LGBTQIA+**
- **Neurodiversity**
- **Occupation**

It is a priority going forward that we put greater focus on addressing these inequalities at a population level. To do that requires stronger and deeper ties with communities, as well as systematic recording of the characteristics. This relies on teams across healthcare, local authorities and the voluntary, community and social enterprise sector working together.

Local evidence gaps

There are a range of different information sources from international trends to academic research papers to reports from service providers in our local areas, which point to issues that are affecting the health and wellbeing of the people of Central Bedfordshire that have yet to be fully identified and understood. These will be the focus of our JSNA work over the next year.

People of all ages

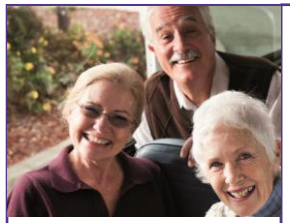
- Physical activity
- Loneliness

Children & young people

- Vaping

Working aged people

- Homelessness



Older people

- Frailty

Item 9 –

Impact of New Leisure Facilities on Public Health and Wellbeing

Central Bedfordshire Health and Wellbeing Board

30 September 2026

Health and Wellbeing Board

Impact of New Leisure Facilities on Public Health and Wellbeing

Responsible Officer:

Lisa White, Head of Leisure lisa.white@centralbedfordshire.gov.uk

Lorna Carver, lead representative of the Board.

Purpose of this report

To provide an update on the data regarding the health and wellbeing improvements recorded which have resulted from the new leisure centres provided by Central Bedfordshire Council.

RECOMMENDATION(S)

The Health and Wellbeing Board is asked to:

1. Note the report and the positive impacts resulting from the provision of new leisure centres.

New leisure facilities

2. The council's provision of new and updated leisure facilities has been guided by the Leisure Facilities Strategy since it was first adopted in 2012.
3. In addition to the facilities delivered via the Recreation Open Space and Outdoor Sports strategies (detailed below), the Leisure Facilities Strategy has supported the council's decisions to invest in the following leisure centre facilities:
    - New Flitwick Leisure Centre in 2016
    - Redeveloped and extended Dunstable Leisure Centre in 2019
    - New Sandy Sports & Leisure Centre – extension to partner facility in 2024
    - New Houghton Regis Leisure & Community Centre in 2025
    - New Leighton Leisure & Community Centre in 2026

4. Saxon Pool and Leisure Centre in Biggleswade remains the only centre assessed in the strategy which has not received a major redevelopment or replacement.

Impact of new leisure facilities

5. In 2016, delivery of the new Flitwick Leisure Centre doubled the swimming pool capacity from a 4 lane 20m pool to an 8 lane 25m pool plus a learner pool; and increased gym space from approximately 40 exercise stations to over 100. It also provided 3 large exercise studios, a dedicated immersive spin bike studio and 4 outdoor all-weather, floodlit pitches.
6. Membership and usage of the new centre doubled within 3 years of opening, and it has consistently been the council's best performing centre.
7. The new Dunstable Centre opened in 2019 provided a similar increase in space and facilities compared to the old centre, but its initial development was halted by the Covid19 pandemic in 2020 which resulted in prolonged facility closures and subsequent reduction in class sizes which both reflected and exacerbated the decline in usage across all activities.
8. At the onset of Covid only the centres at Flitwick and Dunstable had been replaced or completely redeveloped; the remainder of the estate was between 55 and 35 years old and offered significantly reduced pool and activity space.
9. The shift in people's behaviours and exercise habits during and post Covid saw a move away from class/gym-based activities to more home-based and solitary exercise patterns. This change plus ongoing user anxiety continued to negatively impact the usage of leisure centres nationally, into 2023 and 2024.
10. Table 1 below shows the total memberships for fitness (i.e. gym, swim and classes) and swimming (learn to swim), with examples of Covid years under a previous leisure contractor, and comparable figures since the start of the Everyone Active contract in 2024.

Table 1. Memberships

Memberships	**Mar-20**	**Mar-21**	**2024**	**2025**	**2026**
	Example of previous contractor figures/ Covid impact		**Everyone Active contract**		
Fitness	13,422	8,734	13,897	15,399	17,097
Swimming	7,154	6,316	8,733	7,901	7,741
Total	**20,576**	**15,050**	**22,630**	**23,300**	**24,838**

11. The membership numbers for March 2020 and 2021 show the initial impact that the Covid 19 pandemic had on leisure centres usage, and from 2024, the steady and significant increase in memberships.
12. The reduction in learn to swim memberships from 2025 reflects a national trend which is attributed to the economic situation and parents prioritising other expenditure. However, Everyone Active is reporting that memberships currently show signs of increasing again.

Table 2. Attendance for all activities including social/community

	2023/24	24/5	25/6	Variance No.	Variance %
Sandy Sports Centre	28,633	37,859	34,734	-3,125	-8.25
Saxon Pool & Leisure Centre, Biggleswade	501,826	529,901	517,392	-12,509	-2.3%
Tiddenfoot Leisure Centre, Leighton Buzzard	405,488	445,681	429,661	-16,020	-3.3%
The Dunstable Centre	373,579	398,315	356,280	-42,035	-10.5%
Flitwick Leisure Centre	666,970	841,795	869,022	+27,227	3.2%
Houghton Regis Leisure Centre	205,388	200,568	*361,691*	*+ 161,123*	*+80%*
Total	2,181,884	2,454,119	2,568,780	+114,661	+4.6%

13. Table 2 shows attendance figures for all centres including the old Tiddenfoot Leisure Centre which closed in June 2026, when the new Leighton Leisure and Community Centre opened.

14. The reduction in attendance figures between 20245 and 2025/6 (at existing sites other than Flitwick) are as a result of Everyone Active's introduction of a new system to categorise and report attendance. Previously some types of usage including club/school reservations were not linked to the relevant activity, which suppressed overall figures. Going forward, the system will accurately and consistently track all types of usage and individuals.

15. Despite the change in data methodology the overall attendance has increased. The major increase for the new Houghton Regis Centre can be seen from its opening in Spring 2025, and future data will reflect the huge increase in usage of the new Leighton Centre from Summer 2026.

New Houghton Regis Leisure and Community Centre

16. The new Houghton Regis Leisure and Community Centre opened on 29 March 2025, provides an 8 lane 25m pool, learner pool and confidence pool, a 120 station gym, dedicated spin bike studio, 3 large exercise studios and 2 squash courts. In addition, it has a dedicated section for Adult Social Care to deliver its Day Offer, which also enables its clients to easily access the centre's facilities and activities.

17. The previous centre was over 50 years old and had originally been part of a school, meaning spaces weren't purpose built but adaptations of education spaces which limited the range and scale of leisure facilities that could be provided. It offered only a small pool and a gym in a converted assembly hall, and a small exercise studio.

18. In accessibility terms, the centre's location on the Kingsland Campus means that it is ideally placed to serve existing residents of Houghton Regis and new residents moving into the emerging Linmere and Bidwell major developments.

19. One month after its opening the centre has welcomed 25,834 visitors, 425 new fitness members, 202 new swim members and hosted 3,000 people in group exercise sessions and 504 junior gym users.
20. Since then, the centre has grown:
    - the centre has seen a growth of 161,691 users per year
    - it has 1661 fitness members with 653 now on You+ membership
    - it has grown by 522 swim lesson users

New Leighton Leisure and Community Centre

21. The new Leighton Leisure & Community Centre opened on 27 June 2026, replacing the Tiddenfoot Leisure Centre which was 50+ years old and at end of life. Tiddenfoot leisure centre was attached to a secondary school and offered a similar range of facilities as at Houghton Regis.
22. The new centre more than doubled the previous provision with the addition of a wellness studio, dedicated Reformer Pilates studio and 4 sets of changing rooms which will serve the outdoor sports pitches which are to be delivered by the Clipstone Park housing developer.
23. During pre-sales and the opening period of the centre is attracted 2,340 fitness members. Since then, it has exceeded expectations in terms of usage and memberships; during the first month of operation the total participation at the new centre was 64,955 people, compared to an average at the old Tiddenfoot Centre of 35,805.
24. Tables 3 and 4 provides a breakdown of the membership sales and attendance respectively, after one month of operation of the new centre, and a comparison with the old Tiddenfoot centre.

Table 3. Membership at Leighton Leisure Centre

MEMBERS							
	Tiddenfoot LC					New Leighton LC	
	Feb	Mar	Apr	May	June	July	August
Total Fitness Members	2,679	2,641	2,627	2,954	3,517	4,214	4,639
New fitness membership sales	131	110	112	93	1,104	695	541
Total Swim Lesson Memberships	1,644	1,627	1,583	1,546	1,601	1,672	1,735

New swim lesson sales	41	41	51	49	65	124	106

Table 4. Attendance for all activities

ATTENDANCE								
	Tiddenfoot LC					New Leighton LC		
	Feb	Mar	Apr	May	*Jun 1-26*	*June 27-30*	July	August
Swim Attendance	15405	15558	15731	16631	*13,228*	*3478*	24,503	28,774
Group Ex attendance	4602	4805	4569	4206	*4,016*	*1304*	9,681	9,285
Gym attendance	12310	12444	10399	9928	*8356*	*2617*	20487	18,424
Total Attendance	**33041**	**33,403**	**31,140**	**31,213**	***25,982***	***8,737***	**57,190**	**56,484**

Supporting Communities

25. In addition to the sporting facilities and activities physical activities at the council's leisure centre, the council works in partnership with the leisure management operator to offer a range of activities which deliver against wider Council services, including Children Services, Adult Social Care, Fostering and Adoption Service, Community Services and Public Health.

26. The leisure operator has developed and is delivering a programme of activities and events which cater for groups across Central Bedfordshire to support them to access and enjoy leisure activities and improve their physical health and wellbeing.

- Holidays Activity and Food Programme (HAF) - the programme offers opportunities for all ages and in year 1 welcomed over 61,000 users across the leisure centres and theatres.
- SEND Swimming – weekly SEND session sessions and specific holiday time swimming sessions
- Free Panto tickets for Looked after Children, Children in Care, Fostering and Adoption Service.
- Falls Prevention Programme – for those having had a fall or at risk of falling to improve their health and reduce the risk of a fall
- GP Referral Scheme – health care professionals refer patients to physical activity

- Forever Fit - for all GP referral customers and customers not suited to mainstream classes
- EA work with Social Care to enable carers to use the leisure facilities for free whilst in a caring capacity.
- EA have employed 17 young people in apprenticeships across the contract.
- Everyone is Family – low-cost activities across all leisure centres - activities for residents in need, providing affordable, fun and flexible activities for families in summer holidays
- Wellbeing Games – activity day for older people
- Good Boost - app-based therapeutic water exercise programme specifically for people with limited mobility and musculoskeletal (MSK) conditions.
- 50+ low impact sports – activities such as walking netball and walking football
- Wellness Day to introduce the services and activities offered to everyone with focus on older adults
- Everyone Active partners with Parkinson UK charity and has developed a Partnership Activity Programme to organise activities and events which support people living with Parkinsons, and to raise money for the charity.

Impact on Individuals

27. Behind the usage data there are a myriad of individual stories of how residents use our facilities, what they are trying to achieve, and how they reach their goals. Appendices A and B provide two examples of how the trained staff at the leisure centres help, guide and support people with health issues, to attain their goals.

Background

Leisure Strategy

28. The Council's Leisure Strategy provides a detailed analysis of the need for leisure provision across Central Bedfordshire which considers the scale and location of requirements arising from planned housing growth, accessibility and quality of existing provision.

29. The evidence base and facility standards provide Local Plan compliant strategies which secure onsite facilities within new developments, and s106 developer contributions to support new/improved provision. Chapter 1 also supports CBC's decisions regarding capital investment in its estate.

30. The Strategy comprises four chapters:

- **Chapter 1:** Leisure Facilities Strategy 2021. Indoor sports and leisure centre facilities.
- **Chapter 2:** Recreation Open Space 2025. Nine types of recreation space.
- **Chapter 3:** Outdoor Sport 2024. Nine types of outdoor sports facilities.

31. In January 2026 the Board received a report regarding the review of Chapter 4 the Physical Activity Strategy, and will receive a future update to enable it to consider the draft strategy.

Chapter 1: Leisure Facilities Strategy

32. The Leisure Facilities Strategy assesses the supply and demand of indoor sports facilities, specifically multi-activity leisure centres which deliver a broad range of sports, physical activity programmes and opportunities for social interaction and community focus.
33. The assessment uses the Sport England methodology to evaluate national participation data collected by Sport England's Active People database, alongside local data on facility location, usage, capacity, age etc. together with Local Plan housing growth forecasts, to determine where and what provision is needed to meet demand.
34. The evidence base provided by the assessment forms the basis of the Leisure Facilities Strategy, showing where new or increased facilities are required to support sustainable development. As Local Plan compliant policy it also enables the council to calculate the demand from new housing development and secure s106 to support new or improved facilities.

Chapter 2: Recreation Open Space Strategy

35. In addition to the new leisure centres delivered via Chapter 1, the provisions in chapter 2 and 3 also support the health and wellbeing of our residents by ensuring that new development delivers a commensurate level of open space and outdoor sports provision to serve the new residents.
36. Chapter 2 assesses nine types of open space from children's play areas to allotments, countryside recreation spaces to small amenity spaces. It provides parish level details of the scale and range of open spaces available for residents, and sets standards which are applied to new housing applications to secure a commensurate level of open space provision, or s106 contributions to be used locally to improve existing facilities.
37. The strategy focusses on the sites and facilities available for primarily informal recreation. While many sites also have special ecological or heritage status, the strategy's purpose is to ensure that residents have access to green space which can support their activities and enables them to live active, healthy lives.

Chapter 3: Outdoor Sports Strategy

38. Chapter 3 assesses the provision of nine types of the most popular sports, including football, rugby, tennis, bowls, cricket and artificial pitches. It incorporates private and council owned facilities, and works with the Governing Bodies for each sport, to consider national sporting standards and strategies, as well as addressing local need arising from housing growth.
39. It also sets standards for provision in association with new development, securing onsite facilities as well as s106 contributions to improve existing facilities either owned by CBC or local councils.

Reason/s for decision

40. Note report.

Legal Implications

41. While the facilities delivered via the Leisure Strategy do contribute to supporting Public Health outcomes, there are no direct legal implications arising from this report.

Financial and Risk Implications

42. The Strategy has no direct financial implications.

43. Delivery of the Leisure Facilities has been supported by CBC capital and s106 contributions secured for the respective leisure centres.

Governance and Delivery Implications

44. Leisure Services co-ordinates the regular updating of the Leisure Strategy in line with current and future Local Plan policy.

Equalities and Fairness Implications

45. The PSED (Public Sector Equality Duty) requires public bodies to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between 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.

46. The Leisure Strategy secures facilities and s106 contributions on the basis of generic housing growth numbers, as when provision is secured, no homes have been delivered. The facilities required for sites are based on the best practice contained within the strategy which seeks to deliver diverse sites and facilities which enable future residents to enjoy activities which suit their needs and abilities.

Biodiversity and Sustainability Implications

47. The definition of sustainability that underpins the Council's Sustainability Plan is based on the UN Sustainable Development Goals. As well as covering issues such as climate change, it also includes aspects that target ensuring healthy lives and promotion of wellbeing for all, and making our settlements inclusive, safe, resilient and sustainable. The measures detailed in this report contribute to these.

48. There are key actions within the Council's Sustainability Plan that contribute to improving physical activity. For example, the plan includes actions to improve network and infrastructure to increase active travel.

49. The Leisure Strategy seeks the provision of sites and facilities which meet key standard within the strategy itself, and from wider policy such as walking, cycling and public transport accessibility sustainability, but also support residents to embed being active as part of their daily lives.

Implications for Work Programme

50. None

Conclusion and next steps

51. The council's programme of replacing and upgrading its leisure centre estate has delivered modern, welcoming and flexible facilities which support key physical activities while also being reactive to changing needs and exercise trends. By transforming most of its estate, the council has massively increased the capacity of our centres to accommodate more people enjoying more and different activities, and provided facilities in the right places for current and future residents to access easily.
52. By also delivering programmes targeted for health recovery and prevention, as well as social interaction, the centres will continue to make a positive impact on the health and wellbeing of our residents for decades to come.

Appendices

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

Appendix A: Cardiac Patient Case Study

Appendix B: GP Referral Case Study

Background Papers

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

- None

Report author(s):

Lisa White, Head of Leisure lisa.white@centralbedfordshire.gov.uk

Appendix A Cardiac Patient Case Study

HEROES CHANGING LIVES EVERY DAY

Making YOU+ movement for the benefit of all.

Central Bedfordshire contract manager, Gary Foley, requested we share this testament from cardiac rehab patient Suzanne Izzard. It demonstrates how Jacqui (Jax) Ryan, GP Exercise Referral Coordinator, has adopted YOU+ methodology to help inspire and enthuse clients.

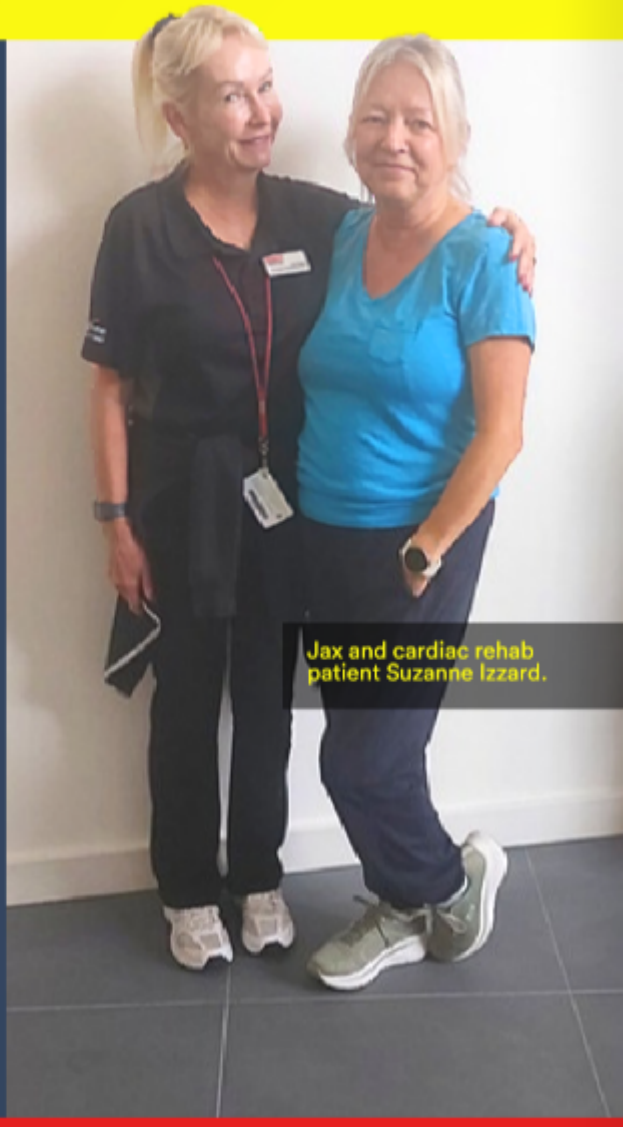
Suzanne writes:
"If laughter and motivation is the best medicine, then Jax must have a PhD in cardio-humour!

"After open heart surgery, I wasn't sure if I'd ever feel like myself again... but then came Jax, armed with expertise, energy, empathy and just the right amount of humour to get my heart back in gear.

"Twice a week, I show up not just for the exercise — but for the motivation, the camaraderie, and the occasional cheeky laugh followed by coffee, chat and a sneaky biscuit! Jax doesn't just lead a class, she leads a comeback! She checks in on us, cheers us on and somehow makes the session feel like a group hug.

Thanks to her, life feels promising again. I'm fitter, happier and even daring to dream of getting back on the tennis court. Jax, you're not just a trainer, you're a heart-healing hero!"

Who are the heroes at your centre/contract? Let us know about the people who showcase the essence of YOU+ by creating a positive, holistic experience for everyone? Share their stories.



Jax and cardiac rehab patient Suzanne Izzard.

SUPPORT AND POSITIVITY CHANGE LIVES

EveryoneActive.com

everyone

Appendix B. GP Referral Case Study

Exercise Referral

CUSTOMER TESTIMONIAL

GP referral testimonial – Flitwick LCI started the GP referral scheme in September 2008 when Jacqui ran it as a gym group session twice a week there were up to 15 participants, and we also did referral class sessions too.I really enjoyed my sessions and was very lucky to be able to support other customers with their journey as I was approached by a colleague and asked to be a mentor for mind which I did for 5 years.Which meant I could also support the colleagues that needed it outside the gym.I joined the new centre when it opened in 2016 and still attends and enjoy doing the gym and swimming on regular basis.In covid, the centre was closed but I kept myself busy everyday walking.I still have a close bond with a few of the participants from that 2008 group and there are still 3 of us that still are members.

Celia Iai

More information

everyone ACTIVE

Item 10 –

BCF End of Year Report

Better Care Fund 2025-26 EOY Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-fram

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

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/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, 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
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Temp
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. 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 are green should the template be sent to: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing the objectives of the BCF
National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)
National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD):
1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.
Populations are based on 2024 mid year estimates, please note this has been updated from the Q2 template to match the DHSC metrics dashboard.
Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Income & Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q3. If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'EOY Actual Expenditure' should include total amount that has been spent at year-end, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan. Note that the extra £50m DFG top-up that had been introduced at the start of the year is now included in the total DFG amount therefore please include this in your total actuals expenditure.

Please also use this section to provide the aggregate End of Year Spend. This tab will also display what percentage of planned income this constitutes.

HM Government

Better Care Fund 2025-26 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. 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 BCE) 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 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.

Health and Wellbeing Board:	Central Bedfordshire	
Completed by:	Rob Winkfield / Daniel Smitton	
E-mail:	rob.winkfield@centralbedfordshire.gov.uk / daniel.smitton@centralbedfordshire.gov.	
Contact number:	0300 300 4731 / 0300 300 5771	
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Wed 08/07/2026	<< Please enter using the format, DD/MM/YYYY

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

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

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

^^ Link back to top

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2025-26 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Central Bedfordshire

Confirmation of Nation Conditions			Checklist Complete:
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter**	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

Better Care Fund 2025-26 EOY Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Central Bedfordshire

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Han

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,522.9	1,540.3	1,618.6	1,566.4	1,575.1	1,444.6	1,757.9	1,505.5	1,592.5	1,592.5	1,437.6	1,592.5
	Number of Admissions 65+	875	885	930	900	905	830	1,010	865	915	915	826	915
	Population of 65+	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0	57,456.0

Assessment of whether goal has been met in Q4:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	We have ended the year slightly over target, with 10,825 total admissions recorded compared to a target of 10,771 (based on data provided via Arden and GEM, as the national BCF dashboard does not contain data for March 2026 against this metric) This is primarily due to higher than expected levels of admissions in December, January and February, with the remaining months in the year either under target or only slightly over. We remain committed to reducing emergnecy admissions through strengthening urgent community response and front door coordination, alongside enhanced triage, assessment and treatment; including close integration with ambulance services, NHS 111, GPs and care homes.

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
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)	2.46	2.40	2.34	2.28	2.22	2.16	2.10	2.04	1.98	1.92	1.86	1.80
Proportion of adult patients discharged from acute hospitals on their discharge ready date	59.0%	60.0%	61.0%	62.0%	63.0%	64.0%	65.0%	66.0%	67.0%	68.0%	69.0%	70.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00

Assessment of whether goal has been met in Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	The data illustrates that we have met our targets for the year, with 85% of patients discharged on their discharge ready date, with the average delay for the remaining 15% at 5.6 days. 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 89.4%, with a 6.32-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.

4.3 Residential Admissions

Actuals + Original Plan

		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	482.8	544.8	147.9	165.3	165.3	182.7
	Number of admissions	270.0	313.0	85.0	95.0	95.0	105.0
	Population of 65+*	57456.0	57456.0	57456.0	57456.0	57456.0	57456.0

Assessment of whether goal has been met in Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	We have finished the year below target, with 337 new admissions during 2025/26. This is based on local CLD data using the same methodology as the CLD derived measure, but is more current than the quarterly CLD submission and more reflective of recent activity. While we have met our target for the year, we are committed to a home first approach and will use the BCF to support activity to promote independence and recovery, supporting people to remain in thier own homes for as long as they can, including reablement and intermediate care pathways, alongside improved anticipatory care, proactive frailty management, falls prevention and rapid community response to support people at home and prevent crisis-led decision making.

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Central Bedfordshire

	2025-26		
Source of Funding	Planned Income	Updated Total Income for 25-26	DFG EOY Actual Expenditure
DFG (including top-up)	£2,558,884	£2,558,884	£2,060,000
Minimum NHS Contribution	£25,297,250	£25,297,250	
Local Authority Better Care Grant	£3,432,402	£3,432,402	
Additional LA Contribution	£7,700,000	£7,700,000	
Additional NHS Contribution	£0	£0	
Total	**£38,988,536**	**£38,988,536**	

		% of Planned Income
End of Year Actual Expenditure	£32,637,536	**84%**

If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	The underspend above relates to unspent capital funds assigned to the BCF via the 'Additional LA Contribution'. This is due to delays in some of the planned capital schemes; these have been carried over into the 2026/27 plan and are expected to be delivered next year.

Better Care Fund 2024-25 EOY Reporting Template

6. Year End Impact Summary

Selected Health and Wellbeing Board: Central Bedfordshire

Confirmation of Statements		
Question statements	**Confirmation**	**If the answer is "No" please provide an explanation:**
Overall delivery of BCF has improved joint working between health and social care	Yes	
Our BCF schemes were implemented as planned in 2025-26	Yes	
The delivery of our BCF plan 2025-26 has had a positive impact on the integration of health and social care in our locality.	Yes	

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:	
Logic model for integrated care - SCIE	
Success and Challenges	**Narrative**

2 key successes observed towards driving the enablers for integration	1.We have seen good success in terms of reviewing our Reablement service by taking a holistic approach in order to create smaller, multidisciplinary teams, which have become more person-centred. The service works with co-production at its forefront and is now therapy-led with staff attending hospital triage calls. As result of this work we have improved from being ranked 115th to 22nd nationally in the ASCOF indicator for the proportion of older people who remained in the community 91 days after discharge to a reablement service. 2.Whilst it is relatively new, the establishment of the Pan Bedfordshire BCF Meeting has strengthened governance and oversight across Bedfordshire. The aim is to provide better understanding of activity by Place which in turn should allow enable us to ensure that schemes are providing value for money and supporting the requirements of the Better Care Fund and Neighbourhood Health development.
2 key challenges observed towards driving the enablers for integration	1.In Central Bedfordshire we continue to experience a considerable increase in both demand and complexity which is in addition to an ageing population and significant financial pressure. As a result, our primary focus is on dealing with demand and complexity which means even with money from the Better Care Fund, there is limited scope to embark on trialling new ways of working on a large scale . 2.Ongoing changes to ICB structures, priorities, and operating models (including leadership changes and restructuring) can create uncertainty and disruption for local integration efforts.

Item 11 –

Central Bedfordshire Joint Leadership Group

Record of outcomes Central Bedfordshire Joint Leadership Group Meeting

Date: Tuesday 5th May 2026

Time: 12.30pm – 13:30pm

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
Arti Patel	Doctor, Sandhills PCN
Ciceley Scarborough	Deputy Director of Public Health, CBC
Kaysie Conroy	Head of Delivery for Neighbourhood Health, Central East ICB
Lorna Carver	Director of Place and Communities, CBC
Michelle Bradley	Director, Bedfordshire and Luton Mental Health and Wellbeing Services
Steve Gutteridge	Head of Integrated Primary Care
Stephen Price	Doctor, Chiltern Vale PCN
Vicky Head	Director of Public Health, CBC
Noleen McLoughlin	Integrated Neighbourhood Support Manager, Beds Place Team
Apologies:	Received: Non-Attendees: Anita Pisani, Alistair Snape, Alison Redman, Christopher Longstaff, Debbie Martin, Edwin Ndlovu, Imran Ismail, John Fitzmaurice, John Wingfield, Nick Murley, Nikki Kynoch, Nina Pearson, Richard Fradgley, Robin Campbell, Roy Boodhun, Sandra Muffett, Sarah Watts, Shalene Daly, 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 3rd February 2026**	**Vicky Head**
	AGREED	

	The previous minutes were approved.	
3.	**Learning Action Network Hypertension Project**	**Kaysie Conroy and Noleen Mcloughlin**
	NOTED The Committee received a presentation on the Learning and Action Network programme, which started November 2024. The presentation will be circulated with the minutes, as Appendix A. LAN uses a collaborative quality improvement approach to improve hypertension outcomes. The project focused on the Gypsy, Roma and Traveller community, identified through data as experiencing inequalities. Work with Public Health and partners informed a range of targeted interventions, including community-based engagement and a simple “health passport” to support access to services. Key challenges include literacy and access barriers, with trusted community relationships proving essential to delivery. The work has now concluded but has been recognised as best practice regionally and has contributed to improved hypertension management locally and will be incorporated into business as usual. The Group noted that engagement with Gypsy, Roma and Traveller (GRT) communities could be expanded upon for other minority groups, with a broader focus on improving hypertension outcomes. It was also highlighted that current data on ethnicity and background is limited, and that more joined-up working is needed to address gaps in data collection.	
4.	**Better Care Fund**	**Kaysie Conroy**
	NOTED The Group received a presentation on the Better Care Fund (BCF) submission for Central Bedfordshire, which will be circulated with the minutes as Appendix B. The numerical plans will be provided as Appendix C. It was noted that the BCF is a joint NHS and local authority initiative focused on pooled funding, integrated working, and prevention, with 2026/27 identified as a year of reform placing greater emphasis on neighbourhood based health and care.	

	The Group were advised that the BCF aims to reduce avoidable hospital admissions, improve timely discharge from hospital and support individuals to remain independent at home. The CB Joint Leadership Group and the Health and Wellbeing Board are to provide leadership on taking the BCF through this process and aligning services to deliver outcomes that maximise value to our residents and within our neighbourhoods. The Group noted that local priorities for the year include strengthening reablement services, redesigning intermediate care, improving alignment between health and social care pathways, embedding neighbourhood-based models and enhancing admission avoidance. It was further noted that no significant changes to commissioned services are proposed for this year; however, there will be a continued focus on reviewing and aligning services to support the transition to neighbourhood health delivery from 2026/27. The Group was informed that the BCF plan is subject to a multi-stage assurance and approval process, with final submission required by 19 May and formal sign-off from the Health and Wellbeing Board Chairman will be sought prior to this deadline. The Group asked about previous feedback received and were advised it had been related to the discharge metric, due to data accuracy concerns raised by Bedfordshire Hospitals Foundation Trust. Work has since been undertaken to improve data quality through dashboard development and regional collaboration	
5.	**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.	
6.	**Any Other Business**	**Vicky Head**
	The Group noted that the Health and Wellbeing Board is an important forum for influencing Central East ICB thinking on neighbourhood health, particularly given the ICB's wider footprint.	

	It was highlighted that stronger, more proactive use of the Board will be required to ensure the Central Bedfordshire voice is effectively represented. The Group were advised that there is scope to discuss how the HWB can evolve, from being solely statutory public focused within a council chamber environment. To considering broader representation and membership, particularly from primary care. The Group were informed there would be a HWB Development Session planned, for members of the Board to discuss how the HWB can operate more constructively going forward. Additionally, for it to be considered how the CB Joint Leadership Group can ensure the requirements issued from HWB are being conducted. For the Group to effectively coordinate and oversee the neighbourhood health activity within Central Bedfordshire. It was noted that a strong primary care focus and support will be essential to the effectiveness of the Health and Wellbeing Board. As such, engagement from CB Joint Leadership members in providing insight and contributing to these discussions would be beneficial.	
8.	**Forward Plan/Work Programme**	**Vicky Head**
	The forward plan was discussed, and it was agreed the following items could be removed as were 2025/26 related: - Update on the prevention of cardiovascular disease - Out-dated Health Service Strategy - Primary care report on immunisation and 2-week cancer rates. - Clinical Interface forum - ICS Critical Priorities For the forward plan to now include: - ICB's infrastructure team and plans and the pipeline for neighbourhood health centres. - update on the clinical and operational strategy for Dunstable Hub. - Central East ICB Priorities The next CB Joint Leadership meeting currently scheduled for July.	
8.	**Date of Next Meeting into 2026** The next meeting is between 12:30pm and 2:00pm on July 14th 2026	

Item 12 –
Work Programme

Health and Wellbeing Board Work Programme

Standing agenda items			
Issue for Decision	**Description**	**Indicative Meeting Date**	**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: TBC
Central Bedfordshire Joint Leadership Group Update	To receive a verbal update and the meeting notes of the Central Bedfordshire Place Board.		Lead Director: Vicky Head Director of Public Health, CBC Contact Officer: Ciceley Scarborough, Deputy Director of Public Health, CBC

Municipal Year 2026/2027			
Date: 27 January 2027 **Theme: Social Isolation and Loneliness** ***(Tackling social isolation and loneliness across all sectors of society)***			
Physical Activity Strategy	To sign off the final strategy document.	Jan 2027	Lead: Howard Hughes, Active Lifestyles Manager, CBC Contact: Ciceley Scarbrough, Deputy Director of Public Health, CBC
Social Isolation and Loneliness Update	To receive an update on the Social Isolation and Loneliness project	Jan 2027	Lead: TBC Contact: Ciceley Scarbrough, Deputy Director of Public Health, CBC
TBC – 21st April 2027 **Theme: Education Attainment** ***(Giving children in Central Bedfordshire the best start in life with a focus on educational attainment)***			

Date: TBC **Theme: Smoke Free Generation** ***(Making Central Bedfordshire a smoke-free place)***			
Date: TBC **Theme: Integrated Health Service** **(Securing improved and integrated health and care outcomes through delivery of our Place Plan)**			
			May Meeting will need to elect Vice Chair again as municipal year
Unscheduled Reports:			
Young Healthwatch Report on Autism, Dentistry and Mental Health	Report on the three key factors, which is written in collaboration with Young People is complete. This will be shared with HWB.	TBC	Lead: A.Bailie. Youth Engagement and Volunteer Officer, Healthwatch or Diana Blackmun