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# Health and Care integration in BLMK

Independent Review of Places and Bedfordshire Care Alliance

May 2025

## Introduction

The Bedfordshire, Luton, and Milton Keynes (BLMK) Integrated Care System serves a population of approximately 1 million people living across their four places of Bedford Borough, Central Bedfordshire, Luton, and Milton Keynes - working to increase the number of years people spend in good health and reduce the gap between the healthiest and least healthy across the geography.

As a system, BLMK are uniquely positioned to address the health and care needs of their population, bringing together a number of NHS and Local Authority partners who collaborate at ICB, Place, and Neighbourhood level. These collaborations are formalised through Place-based Boards, which are coterminous with local councils, and Provider Collaboratives, including the Bedfordshire Care Alliance (BCA) and the Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative.

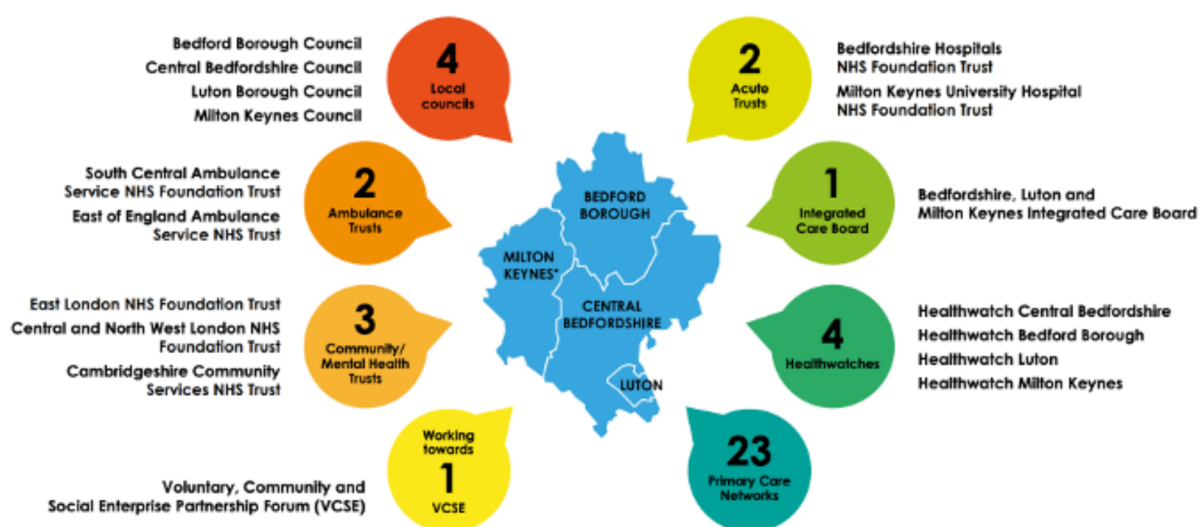


Figure 1. An overview of collaborative arrangements in BLMK

These provider collaboratives have been established with the support of the ICB to enable the delivery of Place plans and priorities. They bring together partners to work together where actions are best delivered at scale, and co-ordinated across multiple Places to ensure a consistent delivery model.

This report sets out findings and learnings from an independent review of these collaborative arrangements in BLMK, since their establishment in 2019. This review has included three places within the Bedfordshire footprint of BLMK; Bedford Borough, Central Bedfordshire, and Luton, in addition to the Bedfordshire Care Alliance. It has included a desktop review of documentation within each place, including meeting Terms of Reference, and Place Strategies; observation of individual Place and BCA meetings to observe governance and current ways of working; and 1:1 interviews with key partners from across Places to explore progress, enablers and opportunities for the future. It builds upon the findings of a previous independent review of collaborative arrangements in Milton Keynes, undertaken by in 2023. The MHLDA Collaborative is out of scope for this review as the committee was only formally established in October 2024.

The findings of this review include a set of suggested next steps to improve the effectiveness of these collaborative arrangements. Spanning three levels of the BCA, Place-based arrangements, and the individual Place-based Boards, they are:

### Findings from the Bedfordshire Care Alliance:

- 1 The BCA in its current form should cease to exist
- 2 People should work together to determine what should be planned or delivered collaboratively across Bedfordshire

### Findings applicable for all three place-based arrangements:

- 3 Create greater strategic alignment between BLMK system priorities and system roles with clarity on language and reports

### Findings for individual Place Boards:

- 4 Bedford Borough: Accelerate progress on key transformational areas already underway
- 5 Central Bedfordshire: Solidify the place as a vehicle for transformation, rather than information sharing
- 6 Central Bedfordshire: Accelerate progress on key transformational areas already underway
- 7 Luton: Focus resource on delivering a smaller number of transformational priorities
- 8 Luton: Strengthen cross-working across local authority teams
- 9 Luton: Redesign meeting structures around delivery workstreams

Figure 2. Overview of Findings

These findings include a set of defined next steps to be progressed to support improvements across the arrangements – however, these should be understood in the current context of the changing ICB landscape, including the recent publication of the Model Integrated Care Board Blueprint.

Once greater clarity exists surrounding the form, structure, and responsibilities of the ICB, the findings of this report should be used to inform an agreed action plan for collaboration throughout BLMK. However, this changing context should not prevent initial progress being made against these next-steps, and an interim plan should be developed to enable collaborative arrangements to proceed in addressing the themes, challenges, and opportunities identified throughout this review.

# Health and Care Integration in BLMK ICS

## The Bedfordshire Care Alliance

The Bedfordshire Care Alliance (BCA) is a partnership of health and social care bodies across Bedfordshire, that works to generate benefits to the population of Bedfordshire and staff working across the partner organisations. The aims of the BCA are to bring partners together to work collaboratively and hold joint accountability for:

- 1. Addressing unwarranted variation in quality, access and outcomes that people experience in different parts of Bedfordshire.**
- 2. Designing, planning and organising health services integrated with social care provision in Bedfordshire - making sure resources are in the right place for the best outcomes.**
- 3. Focusing on the things to implement once across Bedfordshire – standardising where possible if it makes sense to do so**
- 4. Supporting place priorities with coherent engagement from providers covering larger footprint and tailoring where particular place population need requires it.**

The BCA was formed in 2019 and was initially a loose affiliation of bodies that either commission or provide services in Bedfordshire. Their initial aim was to create a forum for transformation and coordination of health and care where it was judged success would be achieved better or faster by those bodies working together across a Bedfordshire geography. As it developed over time, the BCA acquired an extended range of partners including primary care, local authorities and other providers of health and care in the area e.g. the East of England Ambulance Trust.

The BCA was formalised in July 2022 as a committee of the ICB, with representation from key partners including the Integrated Care Board, Bedfordshire Healthcare Foundation Trust NHS (BHFT), East London NHS Foundation Trust (ELFT), Cambridgeshire Community Services NHS Trust (CCS), local authorities, primary care networks and primary care providers. Chaired by a non-executive director of the ICB, the committee was initially established to enable delegation of responsibilities from the ICB to the BCA, with their established governance reflecting this intention.

The BCA is governed by three layers or forums, including:

- The BCA committee - Meets quarterly, to provide strategic direction for the collaborative. It takes escalations from the BCA executive group and escalates into the ICB as required.
- The BCA executive meets monthly, to provide leadership for the BCA-led initiatives. It takes escalations from the system leadership group and escalates into the committee
- The BCA System Leadership Group meets bi-monthly to provide a forum for system-wide coordination across the health and social care landscape. It escalates into the BCA executive group as required



A primary responsibility of these groups is to determine and contribute to progress against six system wide transformation initiatives, with priorities agreed centrally via the BCA committee. These priorities include:

### BCA Priorities:

<b>Virtual Wards</b>	The aims of the projects are to (i) increase the Bedfordshire-wide capacity of the "step-up" virtual ward by involving and aligning hospital and out-of-hospital providers (ii) increasing the range of speciality virtual wards on offer (iii) combine and coordinate the procurement of remote monitoring solutions (iv) make Bedfordshire-wide bids for funding more efficiently and successfully and (v) reduce and ultimately eliminate inequalities of access across Bedfordshire.
<b>Call before you convey</b>	The aim of this project is two-fold (i) to explore how a single number model ('call before you convey') could be implemented and (ii) further develop and streamline the many existing "call before you convey" solutions currently in operation.
<b>Immediate care boards</b>	Whilst intermediate care beds make a significant contribution to the post-discharge pathway, they can do so much more. Several issues combine to reduce the effectiveness of the intermediate bed base available across Bedfordshire - low levels of occupancy, significant delays in access times, different models of commissioning, different operating models and unwarranted discharge delays. This BCS-led project examines these issues and looks at alternative ways of managing this important resource.
<b>End of Life ("EoL")</b>	This project aims to look at the appropriate design of EoL health commissioned services across Bedfordshire, with the aim of specifying the core elements of an integrated pan-county service, encompassing end-of-life services as they present in hospices, in hospitals and in community and domiciliary settings.
<b>Community Services</b>	This project aims to map community and mental health services currently being delivered across Bedfordshire, identify the service requirements that commissioners (both NHS and local authority) currently, then use population health data alongside this mapping to undertake a gap analysis and identify specific areas of focus with the greatest possible opportunity for patient outcome
<b>AI</b>	This project aims to explore the potential to use the data available within health and social care to develop AI solutions to predict patients approaching a crisis, or a hospital admission, and to allow a proactive anticipatory intervention. The project will take stock of work already underway across the ICB and go on to propose investment and commissioning of projects that may be more effectively pursued on a Bedfordshire footprint.

Figure 3. Priorities of the BCA

The effectiveness of work of these priorities varies significantly – with Virtual wards and Call before you convey reported to be the best progressed out of the priorities on the self-measured DICE approach which formed part of an internal assessment of the BCA's recent functioning and progress.

The key enablers for this were self-identified as clear objectives and leadership, adequate resources and funding, effective collaboration, clear governance and accountability, flexibility and adaptability and continuous evaluation and improvement.

It is however suggested that these foundations were not structurally enforced by the BCA, as evidenced by the fact that it enabled some projects but was not able to be implemented as effectively for the remaining 4 priorities.

The BCA was found to be subject to a further set of challenges, including:

- **Lack of Alignment on the purpose:** A set of factors have contributed to a lack of alignment around the core purpose and functions of the BCA, and place in the system amongst key stakeholders. This was reflected in the outputs of a survey undertaken with the alliance – with some respondents stating that they ‘strongly disagree’ that the core purpose of the BCA is clear (*Figure 2*). The significant investment in other collaborative structures such as the Place Boards – supported by substantive resourcing and with their own strategic priorities – has added to the opacity surrounding the role and function of the BCA within the wider system context.

How strongly do you agree with the below statements (1 strongly disagree, 10 strongly agree)

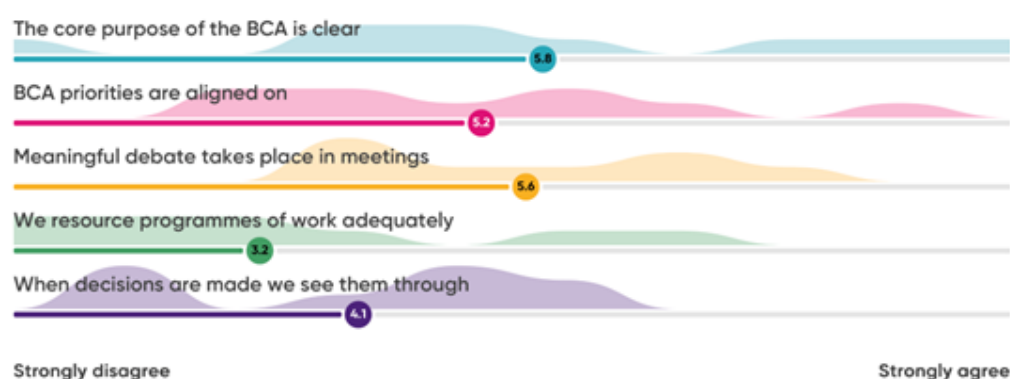


Figure 4. BCA Survey Responses

- **Variable approach to resources and funding:** Whilst the BCA has two link directors who act to connect the BCA to the ICB through sitting on the ICB board, the arrangement lacks substantive resource, limiting the ability to effectively progress BCA priorities. The BCA has two formal programme directors who work around their existing substantive roles within their organisations, and a third unofficial, programme director role, supported by no full-time team members. Therefore, the programmes are both resourced and funded on an ad hoc basis, dependent on good will or businesses cases in each circumstance. There is no joint funding pool or equivalent amongst the providers, and often the business cases are therefore made to the ICB. This limits the ability of the BCA to respond with agility to a changing context, and contributes to confusion for the teams supporting from partner organisations (including Place boards), who end up with conflicting demands on their time and differing direction on how they should support on a project by project and team by team basis.
- **Perception of the BCA as acute-focussed:** Engagement highlighted a perception that the BCA is too acute-focused. When the priorities are reviewed, as 4-5 out of 6 of them

relate to the front or back doors of the hospital, and stakeholders described a focus on leveraging community priorities to capture acute benefit. This contributes to a lack of clarity surrounding the roles partners throughout the BCA, and compounds resourcing challenges outlined above.

- **Governance through ICB Board Committee:** The governance of the BCA aligns with an original intention to enable formal delegation of functions from the ICB, however this has neither happened nor appears to be agreeable in consensus to key stakeholders in the near future. Stakeholders have emphasised that this arrangement does not align to the current function of the BCA – and voiced a desire for ‘form to follow function’ in the future. When taken with the lack of clarity surrounding function of the BCA, this has led some stakeholders to conclude that the BCA is unsustainable as currently constituted.

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*“There is a **misalignment at a chief exec level** about what it should be, and so that leads to **frustrations** amongst the chief execs ending up at **unverbalised disputes**”*

*“The original intention... was to enable the delegation of authority and funds – which didn’t happen - and so now there is only the **downside of the meetings and governance**”*

*“The **BCA doesn’t have a team**... [it’s] difficult... it needs to be **clear where and who the resource, conveners and doers are**”*

*“The **decision-making around how money is spent**... around the system needs to move more swiftly than it is at the moment”*

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Figure 5. Selection of key quotes for BCA engagement

## Place-based arrangements

The Bedfordshire Places of Bedford Borough, Central Bedfordshire and Luton cover a population of over 700,000 – equivalent to approximately 70% of the ICS population. Each of the three Places is uniquely characterised, with their unique context informing their strategy and priorities at a Place level, and ultimately feeding into the system-level strategy, the BLMK Health and Care Strategy.

Whilst each Place has the flexibility to set their priorities, architecture, and delivery framework to best meet the needs of their own population, they share a set of common features that support and strengthen their operational effectiveness.

### Substantive staffing and resourcing

Each Bedfordshire Place is supported by a dedicated, substantively resourced team from the ICB, that provides continuity, local ownership, and capacity to drive forward transformation. All



three Places—Bedford, Central Bedfordshire, and Luton—have a core team structure comprising a Link Director (an ICB Board member), a Place Lead, and a mix of transformation and neighbourhood management staff (Bands 7–8c).

This consistent level of staffing reflects a clear ICB investment for the system in place-based working and has been a key enabler in progressing local priorities.

### Place specialisms

A distinctive feature of the Bedfordshire arrangements is the role of the Link Director, a senior ICB executive who provides strategic oversight to each Place alongside their own portfolio responsibilities. This dual role brings specialist knowledge and stronger system alignment into Place-based discussions. For the Bedfordshire places these currently are:

- Bedford Borough: Chief Nursing Officer
- Central Bedfordshire: Chief People Officer
- Luton: Chief Medical Officer (previously Chief Primary Care Officer)

In practice, this structure has allowed different specialisms to be brought into each Place based on the Link Director's expertise. Regular collaboration—such as weekly meetings between Heads of Place, fortnightly joint sessions with Link Directors, and cross-place working between teams—ensures that expertise and learning are shared across the geography. This reduces the risk of places becoming overly shaped by individual portfolios, while still benefiting from focused strategic support.

### System Commitment to Place Based Working

As a system, BLMK have made significant commitments to place-based working. This is reflected via the dedicated Place resource, and the composition of the ICB board. Each place has significant representation on the ICB board via both the Local Authority CEO, and their respective Link Director. This ensures a two-way conversation at the two levels of the system, with both representation of the place within the ICB, and the representation of the ICB within the place. It also balances health and care representation of the place both within the place and at ICB level.

## Individual Places

Within these arrangements, each Place-board has a unique set of strengths, challenges, and opportunities that could support improvements for their respective populations.

### Bedford Borough

As a Place, Bedford Borough has a primarily urban and ethnically diverse population, that has seen significant population growth over the past 15 years, specifically in their older population. Bedford Borough has the largest life expectancy gap in BLMK between the least and most deprived areas – with key contributing factors including CVD, Cancer, and Dementia.

Bedford's strategic focus aims to address this life expectancy gap, aiming to support equity of outcomes between their deprived and more affluent population, and spans 4 priority themes, and 2 additional overarching key priorities.





## Bedford Borough Priorities:

### Priorities:

<b>Starting Well – Childhood Health</b>	<ul style="list-style-type: none"> <li>Reducing childhood obesity</li> <li>Improving children's oral health</li> <li>Boosting immunisation uptake</li> </ul>
<b>Living Well – Long-Term Conditions</b>	<ul style="list-style-type: none"> <li>Cardiovascular disease (CVD) prevention</li> <li>Increasing cervical and breast cancer screening uptake</li> </ul>
<b>Ageing Well – Older Residents</b>	<ul style="list-style-type: none"> <li>Living independently for longer</li> <li>Frailty &amp; dementia care</li> <li>Improving hospital discharge processes</li> </ul>
<b>Health Estate</b>	<ul style="list-style-type: none"> <li>A joined-up Borough wide strategic vision for health care estate, between the Council and primary, secondary and community care, that aligns with current and future need.</li> <li>A joint approach to developing housing for those with health and social care needs such as severe mental health and Children's Homes.</li> </ul>

### Focus area:

<b>Neighbourhood Teams</b>	<ul style="list-style-type: none"> <li>Develop accessible prevention programs in collaboration with partners and residents, and establish multidisciplinary teams in each Neighbourhood in Bedford Borough to represent all relevant services.</li> <li>Integrate teams from diverse organisations to provide comprehensive care and support within neighbourhoods, utilising local assets to deliver services in accessible locations.</li> <li>Enhance understanding of non-clinical services that support resident independence, ensuring residents use the right services confidently and reduce reliance on GPs and A&amp;E.</li> </ul>
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### Overarching Key Priorities:

<b>Mental Health</b>	<ul style="list-style-type: none"> <li>To engage and support the MHLDA Director and place leads, ensuring a proactive approach to supporting the improvement of mental health is embedded into existing work programmes.</li> <li>Work with Public Health, ELFT and VCSE organisations to raise awareness of place projects and initiatives.</li> <li>Attend relevant Mental Health Alliance events to keep up to date with MH priorities at place.</li> <li>Consider mental health priorities in delivery of place-based schemes where relevant.</li> </ul>
<b>Improving health inequalities</b>	<ul style="list-style-type: none"> <li>Working with residents across the engagement spectrum, including using previous resident feedback to avoid engagement fatigue.</li> <li>Working with the Population Health Intelligence Unit to determine areas of focus and impact based on need and poor health outcomes.</li> <li>Working with and learning how to embed QI approaches from the Institute of Health Improvement (IHI).</li> </ul>

Figure 6. Bedford Borough Priorities

This strategy is captured in their Joint Local Health and Wellbeing Strategy (JLHWS) and the Bedford Borough Place-Based Plan (PBP); however, the PBP is still in draft form and lacks detailed implementation tracking and structured performance frameworks. Associated governance structures are described in the Terms of Reference for the Place, but does not include a clear performance oversight mechanism.

Priorities are delivered through a defined substantive team – including a Link Director, a Head of Place/Place Lead and four full time members of the place team. These are outlined below:

- Link Director (ICB Board Member with a substantive portfolio – Chief Nursing Officer)
- Place Lead (8c)
- Senior transformation manager (8b)
- Transformation manager (8a)
- Integrated neighbourhood manager (8a)
- Integrated neighbourhood support manager (7)

Bedford Borough have also defined a reporting line from the Place lead to the Local Authority CEO, creating effective links into both the ICB and the Local Authority.

### Enablers and Critical Success Factors

This joint reporting reflects one of three key enablers that have contributed to strong progress across Place level priorities to date:

- **Joint reporting** : Bedford Borough the local Place team have further increased a collaborative way of working between the health and social care partners by having joint reporting from the place lead to both the ICB Link Director and the LA CEO. In the other places, the place lead only reports into the ICB Link Director rather than both. This was reported to be working well by all the stakeholders involved, helping to keep both the council and the ICB in step with each other, and ensuring both health and social care were well represented.
- **Strong interpersonal and organisational relationships**: Strong personal and organisational relationships were evident throughout the Place. Stakeholders identified this as a key enabler for effective joint reporting, in that because the relationships were strong and people were capable of having honest conversations, it meant that there was no risk of joint reporting becoming fractious. These relationships also aid conversations within the place across organisational boundaries; with people reflecting that they feel able to set their organisational considerations aside for the sake of the place.
- **Strong internal alignment on place-based priorities**: Bedford Borough has clarity on its place-based priorities, as evidenced in the documentation which outlined the priority elements for the place. Meetings are effectively structured around these workstreams, which helped cement the priorities as a focus of the place discussions.

### Challenges in Bedford

Alongside these enablers, consideration of the challenges Bedford Place faces is helpful in informing a set of next steps that will help to improve and support the effectiveness of the arrangement into the future – these challenges include:



- **Strategic alignment:** Although Bedford's local strategy is clearly defined through its Joint Local Health and Wellbeing Strategy and Place-Based Plan, there is limited articulation of how these align with wider ICB and national priorities. The current documentation does not consistently make the connections between the local priorities and broader system aims explicit, which risks undermining coherence and shared direction across levels. There is an opportunity to reframe existing documents to better show how system and national priorities have shaped local objectives, and to clarify where local nuance has required deviation or additional focus.
- **Clarity and balance of roles:** The complex landscape of organisations operating across the system has created ambiguity around roles and responsibilities. Stakeholders reported that understanding the remit of the place team—and particularly how it interfaces with public health and system-level bodies—is still evolving.
- **Ongoing transformational work:** Progress on two of Bedford's core delivery mechanisms—namely the Better Care Fund (BCF) and Integrated Neighbourhood Working—could be accelerated. There is strong appetite to build these into more robust and central pillars of the place architecture, and thus could be supported by refreshed strategies, clear definitions, and stronger alignment with key partners to ensure joint ownership and accountability.

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*“We have **really gone heavy on the place**; the four Local Authority CEOs are on the ICB board, as is each place director”*

*“Everyone has a **different background** which is useful”*

*“Relationships are there at place and system, **because we have strong relationships we can be open and honest and it works**”*

*“We should **agree priorities at the three levels of system, Bedfordshire, and place** – and for the next two years that should be our focus”*

*“Given the national guidance and picture, putting integrated neighbourhood working at the heart...and wrapping the other things around it could be a refreshed priority”*

”

Figure 7. Selection of key quotes for Bedford Borough

## Central Bedfordshire

Central Bedfordshire have a more affluent population than other Places throughout BLMK. Reflecting the distinct needs of their population, their aging population coupled with the changing pattern of disease means that people are living with multiple long-term conditions, including 61% of the adults being considered overweight or obese, predicted to rise significantly

by 2030. Despite their generally affluent population, there are pockets of rural deprivation that present a significant challenge, exacerbated by the lack of a hospital within their administrative boundary.

As a Place, the Place Plan (2022-2025) and Health and Wellbeing Strategy (2024-2029) provide comprehensive visions for integrated health and social care, focusing on reducing inequalities and improving outcomes. These identify 6 priorities for delivery through the place, including:

### Central Bedfordshire Priorities:

<b>Primary Care &amp; Access (including dentistry)</b>	<ul style="list-style-type: none"> <li>Significant challenges in GP and dental access</li> <li>Improvements in telephony and digital systems are being implemented to address these concerns.</li> <li>Expansion of integrated neighbourhood teams to provide wraparound support at local level.</li> </ul>
<b>Cancer Diagnosis and Improving Outcomes</b>	<ul style="list-style-type: none"> <li>High rates of late-stage cancer diagnosis, particularly among deprived populations.</li> <li>Emergency cancer presentations are above national average, indicating delays in early detection.</li> </ul>
<b>Mental Health, LD and Autism</b>	<ul style="list-style-type: none"> <li>Prevention</li> <li>Treatment and Early Identification</li> </ul>
<b>Children's MH</b>	<ul style="list-style-type: none"> <li>Reduction in referrals to CAMHS single point of entry (SPOE), with a focus on the percentage of referrals accepted and signposted, along with reduced referral to assessment and treatment times.</li> <li>Increased uptake of CHUMS provision and improved mental health and wellbeing of the student population, as demonstrated by SHEU Survey findings, and a decrease in the average SDQ score for the emotional and behavioural health of children in care.</li> <li>More Central Bedfordshire education settings now have a mental health lead, and there is a reduced number of CYP accessing urgent care for emotional well-being and mental health needs.</li> </ul>
<b>Out of Hospital Services</b>	<ul style="list-style-type: none"> <li>Prevention</li> <li>Responding to residents' needs and reducing system pressures</li> </ul>
<b>Excess Weight</b>	<ul style="list-style-type: none"> <li>Prevention</li> <li>Treatment and Early Identification</li> </ul>

Figure 8. Central Bedfordshire Priorities

Although these priorities are well articulated, supporting documents lack explicit links between priorities and outcomes, and there are no clear mechanisms for tracking progress of integrating community feedback. Governance structures emphasize local authority and public health representation, but clinical involvement and alignment with ICS objectives are limited.

Priorities are delivered through a defined substantive team – including a Link Director, a Head of Place/Place Lead and four full time members of the place team. These are outlined below:

- Link Director (ICB Board Member with a substantive portfolio – Chief People Officer)
- Place Lead (8c)
- Senior transformation manager (8b)
- Transformation manager (8a)
- Integrated neighbourhood manager (8a)
- Integrated neighbourhood support manager (7)

### Enablers and Critical Success Factors

Despite this challenge, good progress has been made across priority areas. A set of enablers has contributed to this progress, including:

- **Dedicated resource for place-based activities:** The place is well resourced with both substantive staff and guidance and steer from executives.
- **Strong interpersonal relationships:** Strong relationships between members of place across organisational and sector boundaries were highlighted by stakeholders. On a personal level, this enables direct conversations to avoid lengthy, process-driven resolutions, and close collaboration outside of set governance forums.
- **Strong organisational relationships:** In addition to strong personal relationships, strong organisational relationships were highlighted to stakeholders as being foundational to the strong working in the patch. An example was given where the LA worked with colleagues in health to deliver Dunstable health and care hub; building and funding it before then leasing it back to hospital trust that then sublet it back to partners. This required close organisational collaboration across sector boundaries to be effective, and the trust of the partners involved.

### Challenges in Central Bedfordshire

Alongside these enablers, consideration of the challenges Central Bedfordshire faces is helpful in informing a set of next steps that will help to improve and support the effectiveness of the arrangement into the future – these challenges include:

- **Strategic alignment:** Although Central Bedfordshire has articulated a clear local vision through its strategic documents, the links between local priorities and broader ICB or national ambitions are not consistently evidenced. Stakeholders recognised that while the intention to align is present, it is not clearly or systematically documented, making it difficult to trace a consistent thread from local delivery to system-level outcomes. There is an opportunity to strengthen alignment by explicitly mapping how national and ICB priorities have shaped local choices, and where local nuances have necessitated distinct focus.



- **Meeting architecture:** Meetings at place level are currently structured more as forums for updates rather than operational programme boards. As a result, they lack the rigour needed to drive delivery, monitor risk, and hold stakeholders accountable to shared objectives. Stakeholders noted a desire to pivot toward more outcome-focused governance, with meetings built around key programmes and supported by standardised templates, action tracking, and milestone reporting. This would provide a clearer line of sight from aspiration to action and reinforce collective ownership of delivery.
- **Ongoing transformational work:** As with other Places across BLMK, key delivery programmes—including the Better Care Fund, Integrated Neighbourhood Working, and mental health (particularly children’s mental health) are identified as being of high importance to the place. This work could be accelerated through refreshed strategies, better defined delivery plans, and strengthened alignment with key partners across the system to ensure efforts are joined-up and appropriately resourced.

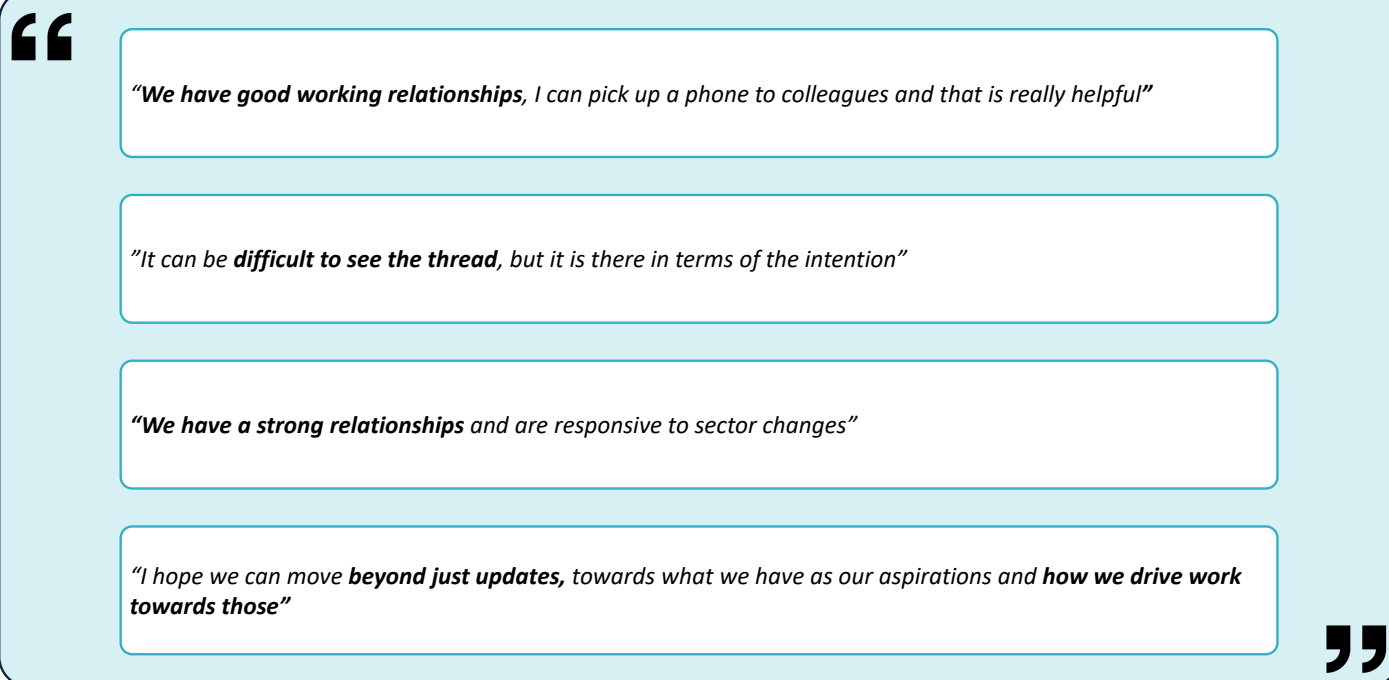


Figure 9. Selection of key quotes from Central Bedfordshire

## Luton

Luton Place has a population of approximately 220,000 people, of the 700,000 across Bedfordshire. In 2022 Luton became a “Marmot Town”, which is a place that actively works to address social determinants of health and reduce health inequalities, based on the recommendations of the Fair Society, Healthy Lives report by Sir Michael Marmot.

Compared to other Places, Luton has a complicated set of demographic and contextual factors, including classification as a place of ‘enduring transmission’ during Covid-19, with 78% of all Covid cases occurring within the most deprived areas of their population. According to the 2019 school census, only 47% of speakers have English as a main language, reflecting significant long-standing Indian, Pakistani, Bangladeshi, African-Caribbean and Irish communities. Furthermore, the 2021 census showed that nearly 2 in 5 residents in Luton were



not born in the UK, one of the highest rates outside of London; which combined with the high levels of private renting and unstable / low-paid employment means that there is high turnover of population in parts of Luton.

To address the specific needs of this population, the Place has aligned its priorities to support the reduction in the socio-economic determinants of poor health outcomes, as well as improvement of services to respond to acute health issues. In line with this, their plan commits to giving every child the best start, developing sustainable communities and tackling inequalities, and reducing frailty. This plan will be delivered through a set of priorities actions:

### Luton Priorities:

<b>Early Intervention and Prevention</b>	Prioritising early intervention and prevention to ensure we are working in an upstream partnership system <ul style="list-style-type: none"> <li>• Cancer detection and early intervention</li> <li>• Vaccinations</li> <li>• Mental Health</li> </ul>
<b>Community Empowerment</b>	Working with and empowering people and communities to build resilience and a sense of control to manage their own health and wellbeing <ul style="list-style-type: none"> <li>• Supporting neighbourhood resilience through a Luton Integrated Neighbourhood Collaborative, aligned to the Fuller recommendations</li> <li>• Develop Community Hubs, aligned to the Fuller Report recommendations, Family Hubs and warm spaces</li> </ul>
<b>SDEC and UEC provision</b>	Provide a streamlined, integrated same day and urgent primary care service for the population <ul style="list-style-type: none"> <li>• Develop a streamlined, integrated same day and urgent primary care service for the residents of Luton, i.e. GP's, (online and face to face) and 111</li> <li>• Ensure the above offers are readily accessible for the population, with an appropriate and strengthened focus on priority cohorts to address inequalities</li> </ul>
<b>Personalised Care</b>	Personalised care and support for people with complex needs and co-morbidities <ul style="list-style-type: none"> <li>• Long term conditions</li> <li>• Frailty and complex care</li> </ul>

Figure 10. Luton Place Priorities

These priorities are clearly illustrated through the Place strategy, emphasizing integration, collaboration, and strong leadership from local authorities and healthcare partners. There is a clear understanding of wider health determinants, but the strategy lacks explicit links to ICB priorities and formal delegation of commissioning roles. Efforts to engage community partners are evident, and the population health approach is well-defined, though specific actions to address determinants like obesity and housing are not clearly outlined.

This strategy is supported by a clear governance and resourcing approach. The main governance forum for Luton Place is the Luton at Place Board. It has representatives from Luton Borough Council, Primary Care, wider NHS providers (including BHFT, ELFT and CCS) and the VCSE sector. It meets on a monthly basis to discuss and review progress on its priorities, intending to coordinate health and care integration efforts in Luton, and will draw on / escalate into system partners such as the ICB or Local Authority as required.



Alongside these priorities, a clear set of strategic goals are documented in their Population Wellbeing Strategy (PWS), aligning with local factors such as Luton 2040 and the Marmot approach. The PWS is well founded in its understanding of the factors of the local populations, their demographic and wider determinants of health factors, and therefore their needs. However, it lacks detailed implementation plans, milestones, and explicit references to ICS priorities, with limited clinical engagement and no structured mechanism for integrating community insights or tracking progress.

As is true of each place generally, Luton has a Link Director, a Head of Place/Place Lead and four full time members of the place team. These are outlined below:

- Link Director (ICB Board Member with a substantive portfolio – Chief Medical Officer (previously Chief Primary Care Officer)
- Place Lead (8c)
- Senior transformation manager (8b)
- Transformation manager (8a)
- Integrated neighbourhood manager (8a)
- Integrated neighbourhood support manager (7)

However, in addition to these substantive team members, there are two additional members from the LA who work closely alongside them, as one larger team.

### Enablers and Critical Success Factors

This clear resourcing is one of 3 key enablers that contributes to the effective operation of the Place, with engagement across the review highlighting factors that have been fundamental to secure direction, alignment, and commitment across Luton's health and care leadership - all essential components for high-performing leadership teams.

- **Dedicated resource for place-based working:** The place is well resourced with both substantive staff and guidance and steer from executives.
- **Additional focused resource from the LA:** Additional resource from the Local Authority works as part of the place team, focussing on the BCF. This has enabled additional emphasis on this work, which has been highlighted as key across the Bedfordshire patch, without requiring capacity from other Place team members.
- **Strong engagement from wider system partners and strong relationships across sectors:** Strong operational and leadership relationships between the different organisations and providers was highlighted both as a strength, and a foundation for other successes. These relationships stretch across community healthcare, primary healthcare, acute healthcare, mental healthcare, social care, and the VCSE sector.

### Challenges in Luton



Alongside these enablers, consideration of the challenges Luton faces is helpful in informing a set of next steps that will help to improve and support the effectiveness of the arrangement into the future – these challenges include:

- **Strategic alignment:** While Luton’s strategic documents articulate a well-founded understanding of local health needs and social determinants, the connection between local priorities and broader ICB and national priorities is not clearly defined. Stakeholders recognised that while alignment is present in intent, it is not made sufficiently explicit in strategy documentation or decision-making structures. There is a need to strengthen this thread by mapping how national and ICS priorities have shaped local plans and demonstrating how local approaches enhance system objectives.
- **Meeting architecture:** Current meetings are largely structured around updates rather than programme-based delivery. Observations and feedback noted that discussions lack clear alignment with workstreams, milestones, and performance metrics. Meetings would benefit from a refreshed format, organised by key programmes with a focus on progress, risk, and decision-making. This would enable a clearer sense of ownership and direction across stakeholders and improve accountability for outcomes.
- **Ongoing transformational work:** As with other Places, Luton continues to work on embedding key initiatives such as the Better Care Fund (BCF) and Integrated Neighbourhood Working. These workstreams are seen as foundational to the success of place-based care, and could be accelerated through a focussed period of development around refreshed strategies, clear definitions, and stronger alignment with key partners to ensure joint ownership and accountability.

“

*“There are lots of people with organisational memory **who understand the locality**”*

*“The **heads of place are very aligned** – the link director roles influence how we focus in place, and where our place strengths are”*

*“There are **strong community service leaders** who have close relationships with ELFT, Care home managers, GP Practices, and 111”*

*“We benefit from the additional dedicated resource – they have a health integration role and, almost like a mini place team, we **all come together and work as one towards the place goals**”*

*“Undoubtably the **ICB has conceived of itself as a place based structure**, and we should build on this moving forwards”*

”

Figure 11. A selection of key quotes from Luton Engagement



## Findings and suggested next steps

This independent review has sought to assess the integrated arrangements throughout the Bedfordshire footprint in BLMK. A set of suggested next steps have been developed to improve the effectiveness of arrangements in how they work to serve the people living throughout the ICS, and within each of the places individually.

### Findings and suggested next steps for The Bedfordshire Care Alliance:

#### 1. The BCA in its current form should cease to exist

There is a clear and widespread misalignment among stakeholders regarding the role, purpose, and function of the Bedfordshire Care Alliance (BCA). In its current configuration, the BCA is no longer fit for purpose. Moving forward, three potential future options have been identified:

- Disbanding the BCA entirely.
- Reconstituting the BCA as a formal vertical provider collaborative, incorporating all providers across the Bedfordshire geography.
- Repositioning the BCA to act as a planning and delivery function within the ICB structure.

A decision on the future form of the BCA should be taken collaboratively by its voting members, which include representation from BHFT, ELFT, CCS, Bedford Borough Council (BBC), Central Bedfordshire Council (CBC), Luton Borough Council (LBC), and Primary Care. Broader input should also be sought from other relevant stakeholders and subject matter experts (SMEs) from these organisations and the ICB.

#### 2. People should work together to determine what should be planned or delivered collaboratively across Bedfordshire

A comprehensive review should be undertaken to assess current programmes delivered at the ICS, BCA, and Place levels. This review should consider:

- Which activities (if any) are best planned or delivered at a Bedfordshire-wide footprint.
- What governance or delivery model-whether formal or informal-is required to support those activities effectively.

Where activities are found to benefit from coordination at this footprint, partners must agree on the most appropriate delivery mechanism. This conversation should directly inform the future role and structure of the BCA. Consideration should be given to whether a formally integrated mechanism is required or if collaboration through existing Place-based governance structures would be sufficient.



## Findings and suggested next steps applicable for all three place-based arrangements:

### 1. Create greater strategic alignment between BLMK system priorities and system roles, with clarity on language and reporting

Across all three Bedfordshire Places, there is a consistent need to better align local strategic priorities with those of the system as a whole. Places should work to strengthen alignment by considering how system priorities have shaped local choices, and where local nuances have necessitated distinct focus. To address this, places should should:

- Establish a common strategic framework that contextualises Place plans within the broader system priorities, whilst ensuring local flexibility is retained to address population-specific needs. This should be clearly reflected in key documents such as Place Plans, Health and Wellbeing Strategies, and programme-level delivery plans.

### 2. Enable place-based priorities to be recognised at ICB level, and enable them to be distinct to each place

Each Place in Bedfordshire is shaped by distinct demographic, geographic, and socio-economic factors. While strategic priorities should align with overarching system goals, there must be space for local nuance and specificity. To enable this, the ICB should:

- Create formalised routes for Place input into system-level decision-making, ensuring priorities developed through local partnerships are represented and supported at ICB level. Support the autonomy of Places to shape their delivery models, recognising the need for differentiated approaches.

## Findings and suggested next steps for individual Place Boards:

### Bedford Borough

#### 1. Accelerate progress on key transformational areas already underway

Two critical programmes — Better Care Fund, Integrated Neighbourhood Working were consistently highlighted as priorities where progress could be accelerated. To achieve this, Bedfordshire should:

- Refresh the strategies around the two projects, and ensure there is clarity and alignment on strategic direction and as well as around an operational delivery plan with key stakeholders. The operational delivery plan need to include resourcing, milestones and actions; which all the key stakeholders are signed up to and in agreement on, in order to ensure that the work can be accelerated.

### Central Bedfordshire

#### 2. Solidify the place as a vehicle for transformation, rather than information sharing

Current governance meetings are structured around updates rather than delivery, with agenda items set on an ad hoc basis, limiting their effectiveness in driving progress.



Observations suggest a lack of consistent templates, tracking, and forward planning. To address this, Central Bedfordshire should:

- Refresh their meeting architecture to align with defined programme workstreams. Use standardised templates to report against milestones, risks, and decisions — shifting from updates to structured delivery oversight, consideration could be made to utilise the Verto system adopted by the system for project/programme management.

### **3. Accelerate progress on key transformational areas already underway**

Three critical programmes — Better Care Fund, Integrated Neighbourhood Working, and Mental Health— were consistently highlighted as priorities. These areas are progressing, but not at the pace or clarity required. To address this, Central Bedfordshire should:

- Refresh strategic direction, clarify roles, and establish clear delivery plans with measurable outcomes for each of these three programmes.

## **Luton**

### **4. Focus resource on delivering a smaller number of transformational priorities**

Luton's current strategy includes nine priorities across four themes, but resources are stretched too thin for deep, system-wide change. There is sufficient capacity at Place level, but impact is diluted across too many initiatives. To address this, Luton should:

- Refocus the Place's efforts on 2–3 core transformational priorities. Align staffing and governance around these areas, and shift delivery towards long-term change rather than incremental updates.

### **5. Strengthen cross-working across Local Authority teams**

Building on the strong relationships that have already been built across different health and social care partners, Luton Place can now take this one step further by building across the different teams that exist within the Local Authority Partner. An interdisciplinary approach will support partners to effectively tackle complex population needs. To address this, Luton should:

- Develop interdisciplinary teams for priority areas, and embed cross-departmental leadership into Place structures to ensure shared accountability.

### **6. Redesign meeting structures around delivery workstreams**

Current governance meetings are structured around updates rather than delivery, limiting their effectiveness in driving progress. Observations suggest a lack of consistent templates, tracking, and forward planning. To address this, Luton should:

- Refresh their meeting architecture to align with defined programme workstreams. Use standardised templates to report against milestones, risks, and decisions — shifting from updates to structured delivery oversight.



## Appendix:

This independent review included assessment of maturity for key bodies against 3 different domains – these assessments are included below:

### The Bedfordshire Care Alliance

#### Maturity Assessment:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

	Area	What we observed
Strategic clarity and purpose	Clear and well-structured documents with a defined purpose	<i>The BCA Meeting Books (March 2024, June 2024, September 2024) provide structured agendas, meeting trackers, and follow-ups. Reports, such as the Portfolio Report (September 2024) and BCA Proposed Projects (2024), outline reporting templates but lack standardised tracking, making it difficult to assess programme effectiveness. The Public Health Annual Report 2024 presents clear health priorities but does not explicitly link them to BCA projects.</i>
	Clarity of vision	<i>The Public Health Annual Report 2024 defines population health priorities and service improvements but lacks a dedicated strategic document detailing long-term BCA transformation goals. Current documents focus on operational priorities rather than a comprehensive strategic direction.</i>
	Alignment with system-partner goals	<i>BCA references BLMK ICS in reports and meeting minutes, but formal reporting structures and shared accountability mechanisms are not consistently outlined. The governance documents do not define how BCA's initiatives align with ICS transformation priorities.</i>
	Focus on PH, prevention and reducing inequalities	<i>The Public Health Annual Report 2024 and BCA Proposed Projects focus on health inequalities and prevention, particularly through initiatives like Call Before You Convey and Virtual Wards. However, no standardised framework measures impact across all programmes.</i>
Delivery and implementation	Clear delivery plan with measurable milestones	<i>The BCA Proposed Projects 2024 and Portfolio Report - BCA Sept 2024 list key workstreams (e.g., Virtual Wards, End-of-Life Care, Intermediate Care) but lack structured milestones, success measures, and lead responsibilities. Meeting books track discussions but do not consistently provide defined timelines for delivery.</i>
	Use of digital and data-driven approaches	<i>The Meeting Book - 19 Sept 2024 discusses using data for hospital admission prevention, but there is no formalised strategy outlining how BCA integrates data analytics into decision-making. The BCA Executive Group ToR mentions data use but does not provide a detailed system-wide intelligence plan.</i>
Governance and leadership	Clear decision-making and leadership structures	<i>The BCA Governance Model, Committee TOR, System Leadership TOR, and Executive Group TOR define governance structures but overlap between these groups leads to a lack of clarity. Decision-making pathways are not always explicit.</i>



	<b>Transparency in governance, accountability and performance oversight</b>	<i>The BCA Committee and Executive Group ToRs define reporting expectations, but there is no consolidated performance monitoring mechanism tracking programme success. The Portfolio Report - BCA Sept 2024 provides updates but lacks a structured accountability framework.</i>
<b>System collaboration and engagement</b>	<b>Collaboration across NHS, local authorities and voluntary sector</b>	<i>The BCA governance structure includes NHS Trusts, local authorities, and social care partners, but voluntary sector engagement is minimal or undefined. The BCA Committee TOR does not explicitly state how VCSE organisations contribute to decision-making.</i>
	<b>Community and patient voice in decision-making</b>	<i>The Healthwatch Chair is included in the BCA Committee membership, but there is no structured mechanism for ensuring patient feedback directly influences governance decisions. The governance documents do not define how resident insights shape policy and programme planning.</i>

### Assesment against NHSE ‘Working Together at Scale’ Guidance:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

<b>Proposed responsibilities for provider partnerships, as set out in NHSE’s ‘Working together at scale’ guidance</b>	<b>Maturity assessment of the BCA provider partnership (with notes)</b>
<b>Partnership building</b> <i>Agree a common purpose aligned to the triple aim and agreed with ICSs and system partners to ensure alignment with system priorities.</i>	<i>Whilst there was clear evidence of common aims and purposes within the documentation, it became clear through the course of the project that this ‘common’ purpose was not universally agreed. For example, in the workshop it received an average score of 5.8 out of 10, but with scores ranging from 1 to 10, as well as spread in between. This was compounded by a lower score for the priorities being agreed on (5.2 out of 10). This means that the core purpose of both what the BCA is, as well as what it could be (a delegated commissioning function, an advisory tier between ICB and place, a horizontal provider collaborative) is effectively in dispute.</i>
<b>Programme delivery</b> <i>Agree a set of programmes that are delivered on behalf of collaborative members and their system(s) and are well informed by people and communities where they will result in</i>	<i>Programme delivery is typically not adequately resourced, with only two official programme directors and one unofficial programme director, and no dedicated delivery resource. This was exemplified by the score in the workshop for resourcing work adequately, which scored only 3.2, with 2 people scoring it 1 out of 10 (the lowest). However, there is a clear set of programmes aligned to the six priorities (despite those not being fully aligned upon as per above); and two of these in particular (Virtual wards and Call before you convey) were deemed to have relative success</i>
<b>Shared governance</b> <i>Work within proportionate shared governance arrangements that enable providers to come together and efficiently take decisions that speed up mutual aid, service improvements and transformation</i>	<i>There is a clear governance structure – with the subcommittee of the ICB, supported by the executive programme board and the system leaders group. However, perspectives on how the layers of governance fitted together, and their respective purposes were somewhat confused – with a recent attempt to redefine the layers underway</i>
<b>Relationships</b> <i>Building and nurturing strong relationships among trust leaders, clinical teams and with system partners at all levels, based on honesty and transparency, is critical. This is a continuous process,</i>	<i>Interviewees reported on the strength of the relationships between the different individuals and the different organisations that comprise the BCA as one of its strengths. However, despite the strength of these relationships</i>



<i>requires hard work and commitment, and even with these can be challenging at times.</i>	<i>personally and operationally speaking, they had not functioned in a way that had resulted in fruitful, difficult conversations about the BCA and its purposes, and instead resulted in silent disagreement</i>
<b>Clinical leadership</b> <i>Clinicians need to be empowered and engaged, as they are best placed to accurately define problems and ensure a solution is evidence-based and meets patient needs. Provider collaboratives should incorporate clinical leadership, which should be closely linked with clinical networks and the ICS clinical and care professional leadership models to be developed before April 2022.</i>	<i>There was clear clinical leadership built into the BCA and its programmes; whether this was by the establishment of the BCA Clinical and Professional Leadership Group as a member of the governance forums, or the appointment of individual clinicians as leaders of programmes where appropriate (e.g. a geriatrician running elements of the priority programmes). However, because of the timeframes of the project, the Clinical and Professional Leadership Group was not able to be observed as one was not scheduled, and therefore its effectiveness and how well integrated it is was not able to be assessed, beyond its existence</i>
<b>People and communities</b> <i>Provider collaboratives should always take into account what matters most to people who access or may access care and support, and people who work in services, communities and community partners. Collaboratives should share and build on the good practice that exists in their member organisations, such as co-production approaches and partnerships with experts by experience. They should draw on the community connections of foundation trust governors, and use insight and feedback from patient surveys, complaints data and partners like Healthwatch.</i>	<i>There was clear inclusion of Healthwatch on its governance forums; with a Healthwatch representative at the Executive Programme Board observed. However, the Healthwatch member was only representative of one area and it was the only clear standardised link to the communities in the observations</i>

## Luton

### Maturity Assessment:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

	Area	What we observed
Strategic clarity and purpose	Clear and well-structured documents with a defined purpose	<i>The Population Wellbeing Strategy (PWS) is structured with clear strategic goals, priorities, and target outcomes. The Terms of Reference (ToR) provides governance clarity. However, the APB Priorities Plan does not clearly outline how the actions will be implemented and tracked. Some documents lack clear version control and timelines.</i>
	Clarity of vision	<i>The PWS presents a strong internal vision focused on improving health and reducing inequalities. It is well aligned with local priorities such as Luton 2040 and the Marmot approach.</i>
	Alignment with system-partner goals	<i>The priorities are aligned with ICS priorities, however the PWS and ToR do not explicitly reference ICS priorities or how Luton's strategy aligns with ICS-wide planning. There is no structured mechanism for ICS collaboration, and no evidence of formalised reporting between Luton At Place and ICS leadership.</i>
	Focus on PH, prevention and reducing inequalities	<i>The PWS emphasises health inequalities, setting key target outcomes for tackling deprivation and social determinants of health.</i>



Delivery and implementation	Clear delivery plan with measurable milestones	While the PWS outlines broad objectives, it lacks detailed milestones and implementation timelines. The APB Priorities Plan does not specify who is responsible for each action or how success is tracked.
	Use of digital and data-driven approaches	The PWS references population health management, but does not define how data will be used to drive decision-making.
Governance and leadership	Clear decision-making and leadership structures	The ToR is mostly represented by local government, voluntary organisations, or community sectors. Only 1 ICS-linked clinical representative is present, indicating limited NHS leadership engagement.
	Transparency in governance, accountability and performance oversight	The ToR provides governance clarity but lacks a defined performance monitoring framework. There is no structured approach for tracking progress across strategic objectives.
System collaboration and engagement	Collaboration across NHS, local authorities and voluntary sector	The PWS and ToR emphasise local collaboration, particularly through the Health and Wellbeing Board and Integrated Care Partnership. However, clinical engagement is weak, with limited direct involvement of ICS stakeholders.
	Community and patient voice in decision-making	The PWS references community engagement through the Fairness Taskforce and community hubs, but there is no structured mechanism to integrate community insights into strategic decision-making.

### Assessment against NHSE ‘Thriving Places’ Guidance:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

Proposed responsibilities for place-based partnerships, as set out in NHSE’s ‘Thriving Places’ guidance	Maturity assessment of the MK place-based partnership (with notes)
<b>Health and care strategy and planning at Place</b> <i>Supporting development and delivery of strategy at place, in line with both local and system-wide priorities</i>	<i>There is a clear strategy for Place with a set of focused priorities and corresponding workstreams. However, the explicit links to the ICB priorities (and how those have either been translated, excluded, or added to) could be made more strongly</i>
<b>Service delivery and transformation</b> <i>Integrate and coordinate the delivery of health, social care and public health services around the needs of local population, and empower people who use the services</i>	<i>There is a clear focus on integration and collaboration, with integrated neighbourhood working being a clear priority and strong leadership from both LA and healthcare partners</i>
<b>Connect support in the community</b> <i>Work with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing</i>	<i>Efforts to engage wider community partners are clear both from the attendees of the governance meetings as well as explicit statement with priorities</i>
<b>Align management support</b> <i>Collectively agree options to align and share resources</i>	<i>There is clear and dedicated resource for both steer (through the governance meetings – with attendance from all system partners) and the Link Directors, as well as delivery capacity (from the 5 person local team) to illustrate collective alignment and resourcing</i>



<b>Promote health and wellbeing</b> <b>Work with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability</b>	<i>There is clear understanding of the wider determinants of health (Luton's Population and Wellbeing Strategy 2023-28 is an 87 page document with clear analysis of ethnicity / language, age and gender, index of multiple deprivation, life expectancy, poverty, impact of covid etc). However, none of the priorities clearly speak to resolving these wider determinants themselves (such as obesity, housing, poverty etc)</i>
<b>Service planning</b> <b>Taking responsibility for elements of the commissioning cycle</b>	<i>There does not appear to be any formal delegation of any commissioning roles from the ICB to place, although the ICB suggests that it is open to be influenced on commissioning priorities / approaches</i>
<b>Population health management</b> <b>Drawing on population health insight to support care redesign locally and address health inequalities</b>	<i>Population health approach is clear, both from extensive inclusion of demographic analysis in the strategic documents (Luton's Population and Wellbeing Strategy 2023-28 is an 87 page document with clear analysis of ethnicity / language, age and gender, index of multiple deprivation, life expectancy, poverty, impact of covid etc), as well as their fourth priority which focuses on two key PHM segments (people with complex needs and comorbidities, explicitly long term conditions and frailty)</i>

## Bedford Borough

### Maturity Assessment:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

	Area	What we observed
<b>Strategic clarity and purpose</b>	<b>Clear and well-structured documents with a defined purpose</b>	<i>The Joint Local Health and Wellbeing Strategy (JLHWS) is well-structured, providing clear goals, core principles, and an action framework. The Bedford Borough Place-Based Plan (PBP) includes defined place-level objectives. The Terms of Reference (ToR) provides governance clarity. However, the PBP is still in draft form, and detailed implementation tracking is not included.</i>
	<b>Clarity of vision</b>	<i>The JLHWS outlines a clear vision to reduce health inequalities and improve wellbeing by strengthening social, economic, and environmental conditions. The PBP translates this vision into place-based priorities focused on prevention, early intervention, and healthcare access.</i>
	<b>Alignment with system-partner goals</b>	<i>The PBP references BLMK ICS priorities, particularly in relation to integrated working, reducing inequalities, and supporting population health management. However, the level of alignment is not always explicitly defined, and there is no clear reporting mechanism from the Place to ICS governance.</i>
	<b>Focus on PH, prevention and reducing inequalities</b>	<i>The JLHWS strongly focuses on health inequalities, emphasising employment, housing, early years, and community engagement. The PBP includes a place-based approach to tackling these issues.</i>



<b>Delivery and implementation</b>	<b>Clear delivery plan with measurable milestones</b>	<i>The PBP and JLHWS contain broad ambitions but lack structured milestones and performance tracking frameworks. The PBP outlines objectives for 'Starting Well, Living Well, Aging Well, and Mental Health,' but without timelines or accountability structures. The PBP is still in draft form, and detailed implementation tracking is not included.</i>
	<b>Use of digital and data-driven approaches</b>	<i>The PBP references integrated digital working, but details on data utilisation remain unclear. The minutes from the Executive Delivery Group (EDG) mention population health insights, but there is no defined role for data analytics in decision-making.</i>
<b>Governance and leadership</b>	<b>Clear decision-making and leadership structures</b>	<i>The ToR establishes governance under the Bedford Borough Executive Delivery Group (EDG), which reports to the Health and Wellbeing Board (HWB). Membership includes local authority, NHS, and ICS stakeholders, ensuring cross-sector collaboration.</i>
	<b>Transparency in governance, accountability and performance oversight</b>	<i>The ToR defines responsibilities and reporting structures, but there is no clear performance oversight mechanism for tracking the effectiveness of place-based initiatives. The EDG meetings include discussions on progress, but no structured performance reporting is outlined.</i>
<b>System collaboration and engagement</b>	<b>Collaboration across NHS, local authorities and voluntary sector</b>	<i>The JLHWS emphasises multi-agency collaboration, including partnerships with local businesses, VCSEs, and public sector agencies.</i>
	<b>Community and patient voice in decision-making</b>	<i>The JLHWS references engagement mechanisms such as Family Hubs, social prescribing, and VCSE partnerships, but there is no formalised process to integrate community feedback into system-wide planning.</i>

### Assessment against NHSE 'Thriving Places' Guidance:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

<b>Proposed responsibilities for place-based partnerships, as set out in NHSE's 'Thriving Places' guidance</b>	<b>Maturity assessment of the MK place-based partnership (with notes)</b>
<b>Health and care strategy and planning at Place</b> Supporting development and delivery of strategy at place, in line with both local and system-wide priorities	<i>There is a clear strategy for Place with a set of focused priorities and corresponding workstreams. However, the explicit links to the ICB priorities (and how those have either been translated, excluded, or added to) could be made more strongly</i>
<b>Service delivery and transformation</b> Integrate and coordinate the delivery of health, social care and public health services around the needs of local population, and empower people who use the services	<i>There is a clear focus on integration and collaboration, with integrated neighbourhood working being a clear priority and strong leadership from both LA and healthcare partners</i>
<b>Connect support in the community</b> Work with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing	<i>Efforts to engage wider community partners are clear both from the attendees of the governance meetings as well as explicit statement with priorities</i>
<b>Align management support</b> Collectively agree options to align and share resources	<i>There is clear and dedicated resource for both steer (through the governance meetings – with attendance from all system</i>



	<i>partners) and the Link Directors, as well as delivery capacity (from the 5 person local team) to illustrate collective alignment and resourcing</i>
<b>Promote health and wellbeing</b> <b>Work with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability</b>	<i>There is clear evidence of a focus on wider health and wellbeing; such as focussing on children's obesity and oral health within their 'start well' priority. The inclusion of improving health inequity also speaks to this</i>
<b>Service planning</b> <b>Taking responsibility for elements of the commissioning cycle</b>	<i>There does not appear to be any formal delegation of any commissioning roles from the ICB to place, although the ICB suggests that it is open to be influenced on commissioning priorities / approaches</i>
<b>Population health management</b> <b>Drawing on population health insight to support care redesign locally and address health inequalities</b>	<i>Improving health inequity illustrates explicit inclusion of the Population Health Intelligence Unit to determine areas of focus based on need</i>

## Central Bedfordshire

### Maturity Assessment:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

	Area	What we observed
<b>Strategic clarity and purpose</b>	<b>Clear and well-structured documents with a defined purpose</b>	<i>Documents are structured with clear sectioning. The Place Plan (2022-2025) and Health and Wellbeing Strategy (2024-2029) provide comprehensive information, but some documents, such as the CBC Place Plan Priorities Delivery v0.2, lack explicit links between priorities and expected outcomes.</i>
	<b>Clarity of vision</b>	<i>The Health and Wellbeing Strategy and Place Plan present a broad vision for integrated health and social care, reducing inequalities, and improving outcomes.</i>
	<b>Alignment with system-partner goals</b>	<i>The Place Board Terms of Reference and Place Plan reference the BLMK ICS, but alignment with ICS objectives is not always explicit. The ToR includes ICS accountability; however, CBC Place Board members are predominantly from local authorities rather than clinical representation.</i>
	<b>Focus on PH, prevention and reducing inequalities</b>	<i>The Health and Wellbeing Strategy focuses on social determinants of health, early intervention, and reducing inequalities. The Place Plan highlights population health management, social prescribing, and early diagnosis.</i>
<b>Delivery and implementation</b>	<b>Clear delivery plan with measurable milestones</b>	<i>The CBC Place Plan Priorities Delivery document outlines broad ambitions but lacks specific milestones. The Health and Wellbeing Strategy includes high-level indicators but does not define precise tracking mechanisms.</i>



	<b>Use of digital and data-driven approaches</b>	<i>The Public Health Annual Report 2024 discusses data-driven population health intelligence, but practical strategies for integrating data into service delivery and decision-making are less developed.</i>
<b>Governance and leadership</b>	<b>Clear decision-making and leadership structures</b>	<i>The Place Board Terms of Reference establishes decision-making accountability, but clinical representation is limited compared to local authority and social care leadership.</i>
	<b>Transparency in governance, accountability and performance oversight</b>	<i>The Terms of Reference for the Place Board and Delivery Assurance Group outline an oversight structure, but there is no clear mechanism for reporting implementation progress to the wider public or stakeholders.</i>
<b>System collaboration and engagement</b>	<b>Collaboration across NHS, local authorities and voluntary sector</b>	<i>There is strong representation from local authorities and public health in governance. The Central Bedfordshire Joint Leadership Group (CBLG) includes some NHS representatives, but primary and secondary care involvement is limited.</i>
	<b>Community and patient voice in decision-making</b>	<i>The Place Plan references community engagement but does not provide details on structured mechanisms for integrating public feedback. The Health and Wellbeing Strategy mentions social inclusion but does not define formal structures for ongoing patient input.</i>

### Assessment against NHSE ‘Thriving Places’ Guidance:

Key ■ Significant existing maturity ■ Some evidence of maturity ■ Limited maturity

Proposed responsibilities for place-based partnerships, as set out in NHSE’s ‘Thriving Places’ guidance	Maturity assessment of the MK place-based partnership ( <i>with notes</i> )
<b>Health and care strategy and planning at Place</b> Supporting development and delivery of strategy at place, in line with both local and system-wide priorities	<i>There is a clear strategy for Place with a set of focused priorities and corresponding workstreams. However, the explicit links to the ICB priorities (and how those have either been translated, excluded, or added to) could be made more strongly</i>
<b>Service delivery and transformation</b> Integrate and coordinate the delivery of health, social care and public health services around the needs of local population, and empower people who use the services	<i>There is a clear focus on integration and collaboration, out of hospital services including a clear focus on ‘one team’ and neighbourhood working, as well as strong leadership from both LA and healthcare partners in the Place</i>
<b>Connect support in the community</b> Work with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing	<i>Efforts to engage wider community partners are clear both from the attendees of the governance meetings as well as explicitly stating the VCSE sector as a partner in certain priorities, such as for excess weight</i>
<b>Align management support</b> Collectively agree options to align and share resources	<i>There is clear and dedicated resource for both steer (through the governance meetings – with attendance from all system partners) and the Link Directors, as well as delivery capacity</i>



	<i>(from the 5 person local team) to illustrate collective alignment and resourcing</i>
<b>Promote health and wellbeing</b> <b>Work with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability</b>	<i>There is clear evidence of a focus on wider health and wellbeing; focussing on excess weight as one of their priorities doesn't just focus on things like uptake of healthy start programmes, but goes even more broadly to consider the density of fast food outlets</i>
<b>Service planning</b> <b>Taking responsibility for elements of the commissioning cycle</b>	<i>There does not appear to be any formal delegation of any commissioning roles from the ICB to place, although the ICB suggests that it is open to be influenced on commissioning priorities / approaches</i>
<b>Population health management</b> <b>Drawing on population health insight to support care redesign locally and address health inequalities</b>	<i>Many of the priorities are clearly rooted in an understanding of the local nuances (such as % of people diagnosed at an early stage, 17% of 4-11 year olds being obese, or obesity being a factor in 4,800 admissions. The place plan showed a clear understanding of basic demographic aspects (such as rural-urban balance, or age and gender), but more could be done to consider population segments (complex needs, long term conditions etc) and their requirements, rather than just segmenting by service type (e.g. cancer) or age (e.g. start well)</i>

